State Medical Board of Ohio

30 road St., 3rd floor
Columbus, Ohio 43215
(614) 466-3934
www.med.ohio.gov

July 14, 2021

Larry Everhart, M.D.
300 Glen Village Court
Powell, OH 43065

RE: Case No. 20-CRF-0064

Dear Dr. Everhart:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Ronda Shamansky, Esq., Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on July 14, 2021, including motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio, and adopting an Amended Order.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Any such appeal must be filed in accordance with all requirements specified in Section 119.12, Ohio Revised Code, and must be filed with the State Medical Board of Ohio and the Franklin County Court of Common Pleas within (15) days after the date of mailing of this notice.

THE STATE MEDICAL BOARD OF OHIO

Kim G. Rothermel MD

Kim G. Rothermel, M.D.
Secretary

KGR:jam
Enclosures

CERTIFIED MAIL NO. 91 7199 9991 7038 7114 0447
RETURN RECEIPT REQUESTED

CC: Gerald T. Sunbury, Esq.

Mailed 8-9-2021

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of Ronda Shamansky, State Medical Board Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on July 14, 2021, including motions approving and confirming the Findings of Fact, Conclusions and Proposed Order of the Hearing Examiner as the Findings and Order of the State Medical Board of Ohio, and adopting an amended Order; constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of Larry Everhart, M.D., Case No. 20-CRF-064, as it appears in the Journal of the State Medical Board of Ohio.

This certification is made by authority of the State Medical Board of Ohio and in its behalf.

Kim G. Rothermel, M.D.
Secretary

(SEAL)

July 14, 2021
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF	*	
	*	CASE NO. 20-CRF-0064
LARRY EVERHART, M.D.	*	

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on July 14, 2021.

Upon the Report and Recommendation of Ronda Shamansky, State Medical Board Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the modification, approval, and confirmation by vote of the Board on the above date, the following Order is hereby entered on the Journal of the State Medical Board of Ohio for the above date.

It is hereby ORDERED that:

A. **PERMANENT REVOCATION:** The license of Larry Everhart, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

B. **FINE**: Within thirty days of the effective date of this Order, Larry Everhart shall remit payment in full of a fine of three thousand five hundred dollars ($3,500.00). Such payment shall be made via credit card in the manner specified by the Board through its online portal, or by other manner as specified by the Board.

This Order shall become effective immediately upon the mailing of the notification of approval by the Board.

Kim G. Rothermel, M.D.
Secretary

(SEAL)

July 14, 2021
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

In the Matter of	*	
		Case No. 20-CRF-0064
Larry Everhart, M.D.,	*	
		Hearing Examiner Shamansky
Respondent.	*	

REPORT AND RECOMMENDATION

Basis for Hearing

By letter dated May 13, 2020 ("Notice"), the State Medical Board of Ohio ("Board") notified Larry Everhart, M.D., that it proposed to take disciplinary action against his license to practice medicine and surgery in the State of Ohio.

The Board's proposed action was based on several different allegations with respect to Patients 1-10, whom Dr. Everhart treated between about January 24, 2005 and July 24, 2019. First, the Board alleged that Dr. Everhart relied on the Meridian Stress Assessment ("MSA"), an unproven electrodermal diagnostic device that uses acupuncture theory and galvanic skin response to make specific diagnoses in the correlated organs, to diagnose and treat Patients 1-10. It alleged that Dr. Everhart failed to confirm the MSA test results with appropriate laboratory testing and/or consultation from a specialist before employing treatment measures for the diagnoses he made.

The Board's action was also based on Dr. Everhart's prescribing of medications for Patients 1-10. The Notice alleged that Dr. Everhart inappropriately prescribed mebendazole, a drug commonly used to treat parasitic intestinal worms, in excess of the recommended dosages, for Patients 1-10, without appropriately confirming their diagnoses. Similarly, the Notice alleged that Dr. Everhart inappropriately prescribed multiple antibiotics for Patients 1-10 and prescribed them in excess of the recommended dosage to treat Lyme disease, Babesia infections, and other diagnoses that he did not appropriately confirm.

Finally, the Notice alleged that Dr. Everhart's records for Patients 1-10 were incomplete and/or illegible.

The Board alleged in the Notice that Dr. Everhart's acts, conduct, and omissions, individually and/or collectively, constituted a "departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Ohio Revised Code Section ("R.C.") 4731.22(B)(6).

In addition, the Board alleged that Dr. Everhart's acts, conduct, and omissions, individually and/or collectively, constituted the "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as that clause is used in R.C. 4731.22(B)(2).

The Board advised Dr. Everhart of his right to request a hearing, and he requested one through his counsel's filing that was received by the Board on May 21, 2020. (State's Exhibits ("St. Exs.") 14a, 14b, 14c).

Appearances

Dave Yost, Attorney General, and Melinda Ryans Snyder and Kyle Wilcox, Assistant Attorneys General, on behalf of the State of Ohio.

Gerald Sunbury, Esq., on behalf of Dr. Everhart.

Hearing Dates: March 15-18, 2021

PROCEDURAL MATTERS

Because of the ongoing public health emergency surrounding the COVID-19 pandemic, the hearing was held using videoconferencing software.

Pursuant to Ohio Administrative Code Rule ("OAC") 4731-13-03(B), certain portions of the hearing were closed to the public when patients testified. Those portions of the transcript will also be sealed, along with the patient keys used by the parties, which were admitted under seal as State's Exhibit 11 and Respondent's Exhibit B-1.

The Respondent's Exhibits were re-labeled at the end of the hearing, at the hearing examiner's request. The exhibits had been initially marked as Respondent's Exhibits A through zzzz, with each of almost 100 patient letters marked as separate exhibits. Although some exhibits were referred to by their original designations during the testimony, Dr. Everhart's counsel later agreed to re-label the patient testimonial letters collectively as Respondent's Exhibit B, with the remaining exhibits admitted into evidence as Respondent's Exhibits ("Resp. Exs.") A through G. (Hearing Transcript ("Tr." at 583-586) Following the hearing, additional redactions were made to the letters in Respondent's Exhibit B when some identifying information that had not already been removed from the patient letters was found.

Finally, due to a printing error, it was discovered after the hearing that State's Exhibit 16 contained only the odd-numbered pages of that document. After the hearing, the Board's counsel substituted a complete copy of that exhibit, without objection from Dr. Everhart's counsel.

SUMMARY OF THE EVIDENCE

All exhibits, even if not specifically mentioned, were thoroughly reviewed and considered by the Hearing Examiner prior to preparing this Report and Recommendation.

Medical Education and Practice

1. Larry Everhart, M.D., earned a medical degree from The Ohio State University in 1973 and was licensed the same year. He then completed a one-year internship at Riverside Methodist Hospital in which he did monthly rotations in various specialties; however, he testified that most of his internship was in internal medicine. After his internship, Dr. Everhart stayed at Riverside Hospital and finished a two-year residency in internal medicine in 1976. Dr. Everhart acknowledged during his testimony that he had practiced as an internist throughout his nearly 50-year career, and that he has never done a fellowship or any post-graduate medical training in acupuncture, immunology, allergy medicine, or gastroenterology. He has been board-certified in internal medicine since 1976, and is able to maintain that certification without testing to recertify. Dr. Everhart's entire practice has been in Ohio, and he has never been licensed in any other states. (Tr. at 28-30, 35; Resp. Ex. A)

2. After finishing his residency, Dr. Everhart worked with Johnson, Everhart & Irwin, an internal medicine practice that was closely associated with Riverside Hospital from 1976 until 1986. He testified that, at that time, there were no hospitalists or intensivists, so he spent half of his workday in the hospital, and the other half in the office. (Tr. at 30-31; Resp. Ex. A) Dr. Everhart recalled that he and his practice partners managed the care of 45-100 patients per day, and that he grew "quite comfortable" in intensive care from working in that position. (Tr. at 30-31)

3. In 1986, Dr. Everhart began working as a hospitalist with Everhart, LaHue & Gramann, where he worked for the ensuing 13 years. He testified that during that time, he also helped establish Central Ohio Primary Care ("COPC,") during the years between 1996 and 1998, although that position is not included on his C.V. Dr. Everhart explained that he had been the lab director for other practices, and he helped set up the lab at COPC, serving as its initial lab director and assuring that the lab work was done accurately. (Tr. at 31; Resp. Ex. A)

4. Since 1999, Dr. Everhart has worked in his practice at The MANNA Institute. Some of the patients from his previous practice came with him to his new practice, and he now has approximately 3,000 active patients, of which about 1,200 see him regularly and the others see him only periodically.[1] Dr. Everhart testified that he sees about 16 patients per day, working four days per week. He occasionally sees patients under the age of 18, but

[1] The transcript indicates that Dr. Everhart testified that he has 3,000 active patients, but the hearing examiner believes he stated that he had 2,000 active patients. (Tr. at 33)

he agreed that his internal medicine practice is not primarily geared toward pediatrics, and he has had no training in pediatrics, except for the pediatric rotation during his internship. (Tr. at 34-36, 50-51)

Introduction to the Meridian Stress Assessment Machine in or about 1998

5. Dr. Everhart testified that he began to get interested in alternative medicine in 1998, when one of the nurse practitioners at Grant Hospital introduced him to the Meridian Stress Assessment machine, while he was helping with pre-admission testing for COPC patients there. (Tr. at 31-32, 36) He recalled, "One of the nurse practitioners suggested that you might want to look at this, and I did decide to look at it." (Tr. at 36) Dr. Everhart testified that soon after he learned about the MSA machine, he established a solo practice, The MANNA[2] Institute, Inc., using that machine to further his interest in integrative medicine:

> [I]n '98, I was exposed to this MSA technology. And in '99, I set up a solo practice to go forward with that. I found the MSA technology gave me information that had taken me months to figure out. I found it helpful for establishing treatment protocols. One of the concerns -- I was interested in alternative medicine because they, quite honestly, use less pharmaceuticals and try to get to the root of the problem and treat the root of the problem, so that was my focus.

(Tr. at 31-32)

6. Dr. Everhart conceded that his decision to use the MSA machine in his practice was one of the reasons he left COPC, because that practice was averse to the use of the MSA, as it was "an unknown." (Tr. at 165-166) He explained that he knew he would not be able to integrate the MSA into his practice there:

> I wanted to pursue this, using this technology, and I felt that it was – it was new, there was no realistic hope the insurance companies would -- believe me, I wanted to stay in Central Ohio Primary Care. I thought it was a good organization. It was good long term for me financially and personally, but I felt there was no way that I could include this technology in a separate practice when they were going after big insurance contracts and insurance companies weren't going to okay this.

(Tr. at 163-164)

[2] Dr. Everhart testified that "MANNA" is an acronym for "Medical and Natural Nutritional Alternatives." (Tr. at 33)

7. Dr. Everhart testified that after the nurse practitioner at Grant Hospital suggested that he look into the MSA machine, he looked up the manufacturer of the machine in Utah, and discovered that the company had a representative in Lancaster, Ohio. He contacted the representative, and she came to his office to give a demonstration. Dr. Everhart acknowledged that he had not been trained about the use of this machine in medical school, nor in his internship or residency, and he was not aware of any hospitals, urgent cares, or other healthcare facilities that used it. (Tr. at 36, 39) However, he related that he was so impressed by the demonstration of the machine by the company's representative on three people that he had present at his office, including his own medical assistant who later became his MSA technician, that he decided to incorporate the MSA machine into his practice:

> Now, the reason I got into it is, when they did the demonstration, I had three people there. One was a 30-year-old person who had developed drug-induced lupus with hypertensive medication. That takes -- that whole process takes two or three months or four months; one month to develop the lupus, and three, four more months to -- or four to six months to get free of it. So she was one. The machine showed that the medication was stressful, don't use it.
>
> Another one was the technician who you asked about with the dark hair, or somebody asked about. She was a Navy brat. Toured a lot of different places. She tested for a load of heavy metals, if you will. Her interesting story beyond that is she used to run a pulse rate of 150 on a regular basis. I had her see the cardiology team at Ohio State. They suggested an ablation and a pacemaker. We ended up doing IV chelation on her, and she's off medication and has a pulse rate of 80. So that extra -- that was another example which I thought there was a real benefit to it.
>
> And then another one was a Lyme patient that we had treated that had Lyme disease, and it gave information that basically showed that that was an issue. So based on those three complicated patients, it kind of threw me over the edge.

(Tr. at 164-165)

8. Dr. Everhart recalled that in the case of the patient with "drug-induced lupus," the particular patient had been on a calcium channel blocker, and he explained that patients can sometimes develop lupus from the use of anti-arrhythmic or anti-hypertensive drugs, as well as calcium channel blockers. He stated that in such cases, when the patient stops taking the medication, the lupus can go away in three to six months. (Tr. at 166-167)

9. After these demonstrations, Dr. Everhart bought his MSA machine at an estimated cost of $15,000 to $18,000 from BioMeridian, a company now called International Health

Technologies, after a change in ownership. In 1998, he went to Orem, Utah, for a one-week training course about the use of the MSA machine at the company's home office. He recalled that that training took place over five days, for about 8-9 hours each day. Dr. Everhart stated that people who worked for the company conducted the training, and that the trainers had various healthcare backgrounds, most of them nurses or nurse-practitioners. He said that two or three years after his initial training, in about 2001, he returned for four days of more advanced training. (Tr. at 37-39, 552)

10. Dr. Everhart testified that a medical assistant who was also with his practice went with him to Utah in 1998 to have the training at the same time, before he began using the machine. She then began serving as the MSA technician at the MANNA Institute. (Tr. at 43-44, 161-162) Dr. Everhart stated that there is a technical skill involved in conducting the test, and he said that while he is able to perform the test himself, his technician is "experienced and adept" at it. (Tr. at 44) Later in his testimony, he added, "[S]he's been a very stable individual. And she has great dexterity as far as doing the test." (Tr. at 553) Dr. Everhart began using the MSA machine in his practice in about 2000, and had used it for more than 20 years, as of the time of the hearing. (Tr. at 32-33, 96-97)

Dr. Everhart's Use of the MSA Test

11. Dr. Everhart stated that the MSA test takes one to two hours to administer to a patient, depending on the experience of the technician. The machine consists of a monitor, a keyboard, and a base, from which a sensor or probe extends, attached to the base by a cord. In March 2019, at the Board's request, Dr. Everhart came to the Board's office with Carol Starr, his MSA technician, to give a demonstration of the MSA test. At the hearing, the State presented a video of that demonstration, showing the test being conducted on Dr. Everhart's wife, Lori. During the video, Dr. Everhart described the test as a bio-electric test that uses electric dermal screening. The test is a non-invasive one in which the technician places a probe at places between the fingers and toes of the test subject. Green bars appear on the monitor, showing ranges of different values, as well as black bars, which Dr. Everhart explains in the video correlate to toxic heavy metals. At the hearing, Dr. Everhart testified that there about 40 different "control points" on the hands and feet, which correspond to the electrical pathways or "meridians" used in acupuncture. (Tr. at 43, 134-135, 145, 167-168, 303, 551-552; St. Ex. 15) He explained:

> So for acupuncture they put the needles in certain places to deliver what they're trying to do, and I think it's energy through the needles. I think the needles function as antennae to focus towards a certain point. So there are places on hands and feet called control points, and we test about 40 different ones that go to different organ systems.

(Tr. at 167-168)

12. At the end of the demonstration shown in the video, Dr. Everhart's counsel emphasized that Dr. Everhart does not use the MSA test as the sole diagnostic tool to evaluate patients. He asked the Board to take into consideration that Dr. Everhart has practiced medicine for nearly 40 years and has never had any Board action, and that many of his patients are referred to him from other doctors after they have suffered with symptoms for many years without resolution. In those cases, he reviews the charts sent to him from other physicians as part of his treatment of the patients. He also represented that in online patient ratings, Dr. Everhart one of the highest rated of all physicians in the United States, particularly in categories related to the attention the doctor pays to his patients, despite the fact that he has no website, and does not do any advertising or social media outreach. Finally, he stated that 50% of Dr. Everhart's practice has nothing to do with MSA. (St. Ex. 15)

13. When Dr. Everhart was asked to explain how the machine works at the hearing, he offered,
"The machine puts out a very small current. The patient is put into the circuit of electricity. Stimulations from the machine are put in, and it's read how the patient responds to those." (Tr. at 40) He testified that the MSA technology is based on homeopathy, and that it provides biofeedback, but it was not clear from his explanation exactly what the machine does:

> The technology was first put into practice by a German, and he used homeopathy. So the signals that come out that say they're either helpful or not helpful are based on homeopathic signals that have been put into the machine.
>
> I think the best way to describe it is, in my best understanding and quite honestly I'm not an electrical engineer, but on the current, those signals -- the best way I understand it is frequency can piggyback on the electric current. Just like when you get radio or TV, they broadcast at a certain frequency and so we get all kinds of signals off a signal frequency that's broadcast the same way this does.
>
> When exposed to frequencies, the biofeedback that the body says this normalizes conduction or optimizes conduction or -- so with the reading on the machine it's either stress -- it's stresses, or it basically decreases conduction or optimizes conduction. So it's based on that.

(Tr. at 40-41)

14. Dr. Everhart testified that bacteria, fungi and other organisms have "resonant frequencies" that they give off, which are detected by the MSA test. (Tr. at 145) He agreed that during his demonstration at the Board's office, when he was asked how those frequencies were assigned, he stated that that was proprietary information, and that the

machine's manufacturer did not explain to him or to anyone else how those values were reached. (Tr. at 145; St. Ex. 15) Although he stated that he did not know how the machine determined the resonant frequencies of the different bacteria, fungi or other organisms, he offered, "Well, it's based on homeopathic signals." (Tr. at 42) He later explained, "[A]s far as the machine codes, they're related to homeopathy which indirectly relates to the, I think my interpretation, the resonant frequency of those bacteria, fungus, those organisms." (Tr. at 145)

15. At the hearing, Dr. Everhart attempted to clarify what was meant by the "resonant frequencies" of such organisms, but he cautioned that he was limited by his knowledge of engineering in explaining the device:

> Q. [By Hearing Examiner] Are you saying that bacteria and various types of fungus give [off] radio frequency waves?
>
> A. Not radio. They have -- "resonant frequency" is the right term. So all those things have resonant frequency.
>
> Q. Can you explain what that is?
>
> A. I will do the best I can. Again, I'm not an engineer. Probably vibratory identity; does that make any sense to you?
>
> Let me go like this. We used to think matter -- all of the medical education is based on Bohr's theory with electron orbital theory. When we got the electron microscope, and you can look this up any place, you get a picture of the atom; and what's it doing? It's vibrating. So all matter has its own vibratory frequency and it varies. So it's a point of identity for all kinds of substances. So bacteria, viruses, fungus fit into that. Metals fit into that, wood, everything.
>
> I alluded to, during that demonstration, about Ohio State. There's a couple interesting examples of this. Ohio State has a -- in the '50s had a thing where they figured out the resonant frequency of a bridge over a creek in Ohio, and they had an amplifier directing the resonant frequency to it, and the thing starts moving and it eventually self-destructs.
>
> One of the creators of the atom bomb, when they were building the * * * [Empire State Building], calculated the resonant frequency of just the structure with just the steel beams. So he takes his amplifier out on the street, plugs it in, starts broadcasting that frequency, and the thing just started to move a little bit. So he unplugged it and said my calculations are correct.

> That's the concept of resonant frequency. So everything has its own resonant frequency. That's the best I can do for you. I don't have an engineering degree.

(Tr. at 145-147)

16. Dr. Everhart later implied that the resonant frequency of such organisms could be used to suggest a homeopathic remedy to treat various conditions, explaining "[T]he concept of homeopathy is 'like cures like.' So basically that frequency of that homeopathic correlates with the frequency of those organisms." (Tr. at 162-163) In describing his training in homeopathy, Dr. Everhart testified that he had attended a CME conference about homeopathy in Cleveland, presented by Bruce Sheldon. (Tr. at 49-50) He described homeopathy as "the longstanding European approach to medicine." (Tr. at 49)

17. Dr. Everhart maintained that the MSA machine only produces homeopathic signals, and that he ultimately determines whether the patient should be treated for a particular type of infection, based on all of the information he has from his examination of the patient. (Tr. at 59) During his cross-examination by the Assistant Attorney General, Dr. Everhart agreed that the charts of Patients 1-10 concern bacterial or parasitic infections that he diagnosed, but he explained that those diagnoses were not strictly based on the results of the MSA test:

> A: So the machine doesn't diagnose those problems. It's based on homeopathic signals that suggest homeopathy, for those things that show up, would be helpful.
>
> Q. [By Mr. Wilcox] And in many of these charts that we're going to look at, you diagnose -- or the machine reports babesiosis and Babesia; is that correct?
>
> A. The machine suggests, from a homeopathic standpoint, that a homeopathic for that would be helpful. It's up to me to sort through those and decide if what I'm seeing is consistent with those kind of problems. So the diagnosis is made by me, not by the machine. So I decide what -- there's all kinds of signals that come out of that, as you see in those reports. I don't find all those to be diagnostic, if you will. I make the diagnosis based on what I see there, and decide what to treat based on the patient's condition, what they've said to me, and if it fits the disease that might be -- that the homeopathic would be helpful.

(Tr. at 42-43)

18. When Dr. Everhart was asked to estimate how often he disagreed with the signals produced by the MSA test, he explained that the printout from the machine produced a

long list of homeopathic suggestions, and he offered, "I think it's a matter of when do you choose to ignore or disagree, whatever you want to use for terminology." (Tr. at 161) He estimated that he might choose to ignore 10 to 20% of the suggestions made, based upon the "intensity of the homeopathics tested," in cases where signals were just slightly positive, but that as the findings were narrowed down over a patient's treatment time, that percentage would decrease. (Tr. at 160-161)

19. In its rebuttal case, the State presented literature written in 1998 by Dennis W. Remington, M.D. from BioMeridien, the manufacturer of Dr. Everhart's MSA machine, which explains the theories on which the machine is based. (St. Ex. 16) However, that literature also does not provide a clear explanation about how the machine works. It states that meridian stress assessment instruments have been used widely in Europe and around the world for allergy testing as well as for a variety of other purposes, but have only recently been used in the United States. The literature suggests that many procedures used in modern medical practice are not supported by scientific testing:

> There is a great deal of controversy in medicine today over the issue of what techniques are considered experimental, and which ones are considered to be adequately proven. This issue was investigated by the Office of Technology Assessment of the Congress of the United States. They produced a 133-page report entitled, "Assessing the Efficacy and Safety of Medical Technologies." This report stated that "it has been estimated that only 10 to 20 percent of all procedures currently used in medical practice have been shown to be efficacious by controlled trials."

(St. Ex. 16 at 11)

Another paragraph of the literature from the machine's manufacturer states:

> Whether or not a diagnostic or therapeutic modality is fully understood has absolutely no bearing on its effectiveness or usefulness. It is beyond the scope of this paper (and of this writer), to attempt to explain the phenomena involved in the meridian stress assessment. In fact, it would seem better to have no explanation at all than to have an incorrect theory.

(St. Ex. 16 at 10-11)

20. Dr. Everhart testified that the manufacturer of the MSA performs periodic software updates electronically, with the machine remaining in his office. He stated that he has had a maintenance contract for that service since he bought the machine, for which he pays about $600 per year. However, he said that he did not know the details of what is done in the software updates. Dr. Everhart denied doing any maintenance or calibration of the machine, such as testing its readings against known values. (Tr. at 39-40, 142, 157, 553) He related, "If there's something wrong, it just basically quits working. It's used

every day. We have a good idea of what is normal operation. And it's electrical, so if it goes bad, it's like a refrigerator goes bad." (Tr. at 157)

21. Patients at Dr. Everhart's practice who have the MSA test pay $300 to $350 for an initial test, and typically $125 for each follow-up test, which he said concentrates on areas found to be abnormal in the first test, or on any new complaints. Dr. Everhart conceded that this test is not covered by any insurance companies, so patients pay for the test with cash, a check, or a credit card. (Tr. at 44-46, 160) However, he disagreed with a suggestion that insurance companies do not pay for the MSA test because it is not a legitimate medical test, and asserted that it is recognized in the insurance industry as beneficial to patients:

> Q. [By Mr. Wilcox] And that's because it's not recognized anywhere as a legitimate medical tool?
>
> A. I wouldn't say that. There's -- one of the patients I have, contacted a nurse practitioner who is a specialist for their problem cases in Denver, I think, where she's out of. And she said, well, the people that are being followed with the machine tend to do better than some others. Although they don't pay for it, there's people in the insurance industry who recognize its value and benefit.

(Tr. at 45)

22. Dr. Everhart asserted that the MSA test is used at major institutions in the western part of the United States, even though it is not as widely used in other regions:

> It is felt to be legitimate at many places; UCS -- USC, UCLA. So maybe we're dealing with a thing that things are a little slower to catch on in the Midwest than in the west, and even slower in the east.

(Tr. 45-46)

In later questions, Dr. Everhart stated that it was his understanding that the MSA is used on the West Coast, because patients had told him that they had the test in California. However, he conceded that he knew of no literature showing that the test was, in fact, in use at research universities such as USC or UCLA. (Tr. at 160)

23. Dr. Everhart emphasized that his patients are not required to have the MSA test, but that it is an optional procedure. He introduced two versions of a release that clients must sign before undergoing the MSA test, one of which he previously used, and the current version that he created in March 2020. (Resp. Ex. E) The first version of the release stated that the patient understood they were "voluntarily undergoing a procedure referred to by the FDA as electro-dermal screening (EDS)," a form of "modern bio-energetic

science we refer to as MSA (Meridian Stress Assessment.)" (Resp. Ex. E at 1) It stated that the procedure was noninvasive and therefore completely safe, and Dr. Everhart submits that it adequately cautioned the patient that the MSA was non-diagnostic in nature:

> Please note that the equipment utilized is non-diagnostic in nature. This procedure is approved by the FDA for evaluation of functional health and will help the doctor determine what medicines or nutritional supplements will be needed to address your specific health needs.
>
> The doctor may recommend certain nutritional supplements which can be purchased on site from HOST NUTRITION, LTD. You may choose to purchase similar products elsewhere; however, we can only vouch for the quality and effectiveness of the specific products we have tested you for on the MSA machine. The majority of these products are produced in reputable labs and are only sold by health care providers. You cannot purchase these brands in retail stores.

(Resp. Ex. E at 1)

Finally, the release stated that the patient understood that insurance did not cover this procedure and that payment in full for the test was expected at the time of service, with the cost ranging from $150 to $350, plus the cost of an office call with the doctor. (Resp. Ex. E at 1)

24. The second release that Dr. Everhart presented was the one he stated that he had modified in March 2020. (Tr. at 260-261, 552; Resp. Ex. E at 2) This release is similar to the earlier release, but in addition, it contains the following language within the form:

> There are no significant risks of harm to you from this procedure. Please note, however, that this procedure is NOT generally accepted or used by medical doctors in Ohio.
>
> We use this procedure to help us collect some information that we will use, along with other information we have obtained, to help guide us in your diagnosis and treatment. We do NOT rely on the MSA, exclusively, to diagnose or treat your condition. It is simply one of the various tools that we sometimes utilize for those purposes.
>
> You are NOT required to undergo this procedure if you do not wish to voluntarily do so.

(Resp. Ex. E at 2)

25. Dr. Everhart emphasized throughout his testimony that the MSA was only one tool that provided information to him, and that the results of the MSA test were not used to make a diagnosis. Instead, he maintained that he diagnosed Patients 1-10 by examining them, and by conducting a lengthy interview, in which he gathered information about their histories and their symptoms, as well as any other information provided by the MSA or any diagnostic tests that were available. (Tr. at 42, 62, 66, 536) At one point he offered, "The machine doesn't make the diagnosis. It shows homeopathics for different things." (Tr. at 66) He compared the MSA results to an EKG produced by an EKG machine, stating, "It is a piece of information that is very helpful. The best comparison is it's a Class II device as is the electrocardiogram." (Tr. at 536) Dr. Everhart explained that the machine gives useful information to the physician, but does not actually make the diagnosis:

> I'll frequently make a diagnosis of previous MI, anterior myocardial infarction, or acute MI. That computer cannot make that diagnosis. Any cardiologist you want to talk to, will see times when EKG is very bothersome and, of course, we have to further evaluate it, but many times the diagnosis can be pericarditis, I mentioned the one where it was cholecystitis. So, again, that is a test that's widely used, a computer does a printout, and the physician has to make the diagnosis.
>
> The MSA device is in the same class and the same -- it's true about how you use it. So it gives information. The physician has to say, "Does this fit with what I'm seeing?" I'm the physician that does this and I use this as a tool to give me information. It does not make the diagnosis. Does it give me useful, accurate clinical information? I absolutely believe it does.

(Tr. at 536-537)

Dr. Everhart's Treatment of Patients 1-10; Review by State's Expert Curtis Taylor, M.D.

26. Dr. Everhart testified that at some point, the Board subpoenaed 15-20 of his patient charts, and he cooperated completely, taking two boxes of records to the Board's office in person within the time the Board asked. He said that he sent complete copies of the patient records that were requested, as well as his appointment books. Ten of those patient charts, for patients identified as Patients 1-10, were admitted into evidence at the hearing, along with a confidential patient key. Dr. Everhart acknowledged that he treated each of those patients, and that each patient had at least one MSA test during his treatment of them. (Tr. at 47-48, 52, 550-551; St. Exs. 1-11)

27. Each of the patient charts in this case was reviewed by the State's expert witness, Curtis Taylor, M.D., who wrote a report summarizing his opinions of whether Dr. Everhart's treatment of those patients met the standard of care. Dr. Taylor graduated from Tufts University School of Medicine in 1976, and then earned a master's of public health from

Harvard University in 1980. He has been licensed in Ohio since 1992, and is board-certified in internal medicine, most recently re-certifying in 2017. Dr. Taylor testified that his entire career has been in internal medicine. He currently practices at Winton Road Primary Care in Cincinnati, and has privileges at Mercy West Hospital; however, he stated that he rarely sees inpatients, so he does not often use his hospital privileges. Dr. Taylor was declared an expert without objection by Dr. Everhart's counsel. (Tr. at 190-196, 200-203; St. Exs. 12, 13) At hearing, Dr. Taylor testified that all of his opinions were within a reasonable degree of medical certainty. (Tr. at 204, 258)

28. Dr. Everhart uses paper charts; he does not use electronic medical records. He agreed that for the cases of Patients 1-10, he took "throw-away" notes of each new patient's initial presentation, which he would later type up, and place in the patient's record. Except for the initial note, which summarized the patient's symptoms and his impressions from Dr. Everhart's interview and examination, the rest of each patient's office visit notes are handwritten. He also includes a medication sheet to show any drugs that were prescribed at each visit. (Tr. at 47, 64-65, 72)

29. Some of the patient charts for Patients 1-10 were reviewed in detail during the testimony, and that testimony is summarized below. However, because the diagnoses and treatments prescribed were similar in many of the patient cases, the treatment of some of those patients was discussed only in the reports of Dr. Everhart and Dr. Taylor, and was not discussed at length during the testimony that was presented.

Patient 1

30. Patient 1 was an 18-year-old male at the time he first presented to Dr. Everhart's office on January 29, 2019. He was 6'5" tall and weighed 179 pounds at that visit. (St. Ex. 1 at 28-29; Tr. at 53-54) Dr. Everhart's typewritten summary of that visit shows that the patient complained of fatigue, joint pain, and some stomach issues, stated in his History of Present Illness ("HOPI"):

> **HOPI**: Patient complains of increasing fatigue over the last two months. He has intermittent abdominal pain with queasy feeling and nausea related to heavy meals. He started having some fatigue five months ago and stomach issues after that. When he plays basketball he may get intermittent back and neck pain over the last two years. He worked on a farm this past summer and had a lot of insect bites. He has had recent blood testing, which included CBC, mono test, thyroid function studies. He had wisdom teeth extraction summer 2018.

(St. Ex. 1 at 28)

31. Dr. Everhart's physical exam of this patient, according to the records, showed no remarkable findings, with no tenderness, masses, or organomegaly found in his abdomen.

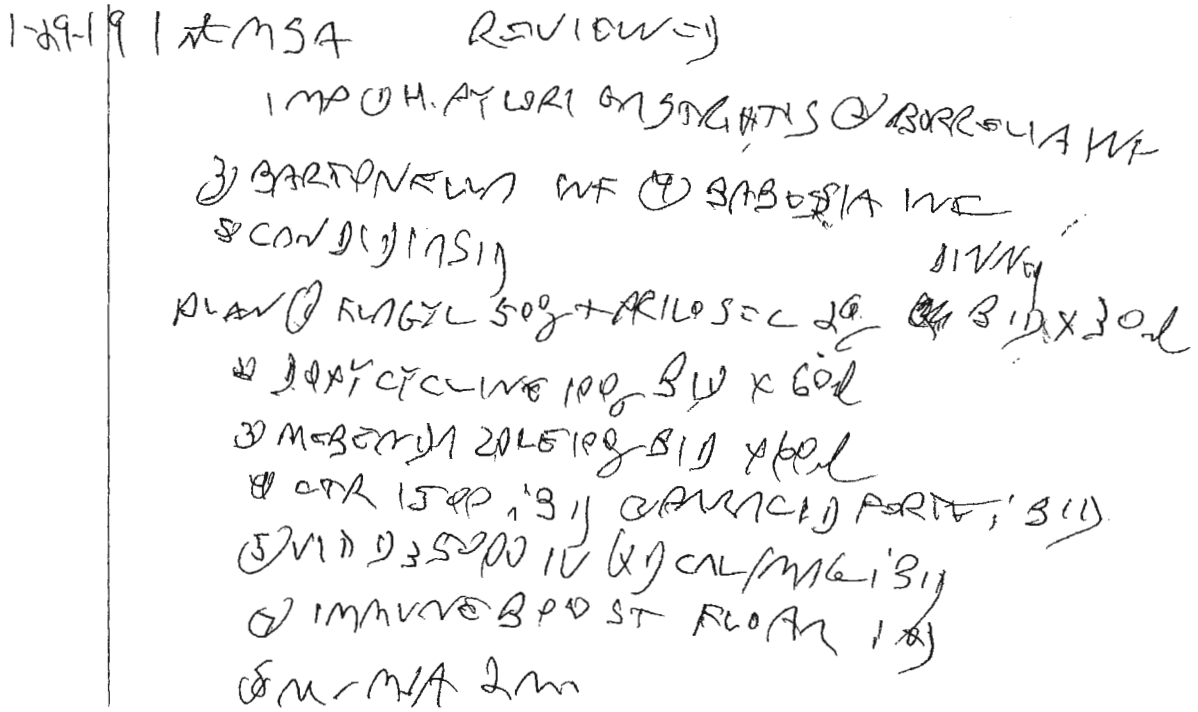
(St. Ex. 1 at 29; Tr. at 54-56) Dr. Everhart's initial office visit note showed the following impression and treatment plan at that time for Patient 1:

IMPRESSION:
1. Abdominal discomfort.
2. Fatigue.
3. Back and neck pain.

PLAN:
1. Lab, check chemical profile.
2. MSA testing.

(St. Ex. 1 at 29)

32. At his initial office visit on January 26, 2019, Patient 1 signed Dr. Everhart's release form, and underwent his first MSA test. (St. Ex. 1 at 27; Tr. at 54-56) The printout from that test is shown in the record, with some handwritten notes by Dr. Everhart at the end of the summary. (St. Ex. 1 at 20-26; Tr. at 65) Dr. Everhart's notes indicate his review of the MSA at that visit:



(St. Ex. 1 at 11)

33. In his testimony at the hearing, Dr. Everhart agreed that he came up with five diagnoses at Patient 1's first visit, based on the results of his physical exam and interview with the patient, and the MSA testing. Those diagnoses included H. pylori gastritis, an infection

of the gastrointestinal tract; Borrelia, an infection also known as Lyme disease; Bartonella, a co-infection with Lyme disease; Babesiosis, a parasitic infection that Dr. Everhart qualified as a "protozoan," or "sort of a mix between a bacteria and a parasite;" and candidiasis, a yeast infection with candida. (Tr. at 56-58, 77; St. Ex. 1 at 10-11) He testified, "Based on the patient's history, exam, and his complaints to me, I came up -- in combination with the information on the MSA, that he was dealing with those things." (Tr. at 58)

34. At this first visit, Dr. Everhart prescribed 30 days of Flagyl 500 mg., an antibiotic to be taken twice a day, which he testified was intended to treat Patient 1's H. pylori gastritis and the Borrelia infection. He also prescribed 60 days of doxycycline 300 mg., to be taken twice a day, and 60 days of mebendazole 100 mg., an anti-parasitic drug, which he said was needed to treat Babesiosis. He also prescribed Prilosec. Although his notes are somewhat difficult to read, it appears that he also prescribed or recommended several supplements, and a repeat MSA test in 2 months. Dr. Everhart testified that Items 139-155 on the MSA printout are readings for various types of parasitic infections. He testified that he prescribed the supplements indicated in the record based on what he knew about this patient's conditions, and not based on a recommendation from the MSA test. (Tr. at 59-61, 64-67; St. Ex. 1 at 11, 19-25)

35. Dr. Everhart agreed in his testimony that he did no other testing before he reached the diagnosis of H. pylori or Babesiosis in Patient 1. (Tr. at 62-63) With respect to his diagnosis of H. pylori gastritis, Dr. Everhart testified that he did not order any lab tests to confirm that diagnosis, but that he was able to reach a clinical impression based on the patient's history of stomachaches and nausea. However, he admitted that not every patient with those symptoms has an H. pylori infection. (Tr. at 61-62)

36. The State's expert, Dr. Curtis, testified that gastrointestinal diseases are diagnosed by various medical and laboratory tests, such as endoscopy, colonoscopy, x-rays or CT scans, or stool analysis, but that they cannot be diagnosed by an MSA machine. (Tr. at 238-239) With respect to the H. pylori diagnosis, Dr. Taylor testified that H. pylori is a bacteria that infects the stomach and can cause an ulcer. (Tr. at 225-227) He explained that there is an easy and efficient lab test than can confirm or rule out an H. pylori infection, where a doctor suspects it may be present:

> There is an excellent test called the urea breath test that is easy to do. You just swallow a pill, a urea pill, that's labeled with radioactive isotope. The H. pylori secretes urease which will split the urea into ammonia and carbon dioxide. And you have them breathe into a machine after that, and the labeled carbon dioxide can be measured. So it's an excellent test that has excellent sensitivity that approaches 100 percent, and specificity that approaches 100 percent.

(Tr. at 226)

37. Dr. Taylor said that the breath test is easy to order and easy for the patient to tolerate, and it takes only about 20 minutes. He characterized it as the easiest test that would meet the standard of care to diagnose an H. pylori infection. Dr. Taylor added that false positives are rare on this test, while a negative test would rule out an H. pylori infection. (Tr. at 226-228) He concluded, "So why he didn't use it, I don't know." (Tr. at 227)

38. Dr. Taylor stated that, if Dr. Everhart had any lingering question about whether this patient had an H. pylori infection after doing the breath test, he could send the patient to a gastroenterologist for an endoscopy. He testified that during the endoscopy, a tissue sample could be obtained that could be analyzed, and he added that if a patient is sick and could have an ulcer, the physician would want to refer them to a gastrointestinal specialist to make sure they do not have stomach cancer. He maintained that the standard of care in internal medicine requires some kind of laboratory testing to confirm the diagnosis of an H. pylori infection. (Tr. at 227)

39. Dr. Everhart agreed that there are several laboratory tests that can be done to diagnose H. pylori, but he stated, "And all those are not 100 percent." (Tr. at 63) He testified that he does not believe the lab tests that Dr. Taylor referred to for H. pylori are reliable, because they sometimes do not detect the infection in a patient who has it:

> A. It's not that I doubt the accuracy. It's sometimes they miss it when it's there. I don't think they're inaccurate.
>
> Q. [By the Hearing Examiner] You believe they show false negatives.
>
> A. Correct.
>
> Q. And which tests are those?
>
> A. Any of them.

(Tr. at 158)

40. With respect to the breath test, Dr. Everhart maintained that the test sometimes misses an H. pylori infection, and he offered, "[I]f you're dealing with a condition that you can have bleeding ulcers from, what percentage of miss is acceptable?" (Tr. at 158) He testified that there is also a blood test for H. pylori antibodies, but he said it is not reliable because it can remain positive even after the patient has been treated and the condition has resolved. (Tr. at 158-159) Likewise, Dr. Everhart testified that a tissue biopsy, done in conjunction with an endoscopy, can also miss cases of H. pylori infection, and for that reason, he prefers the data that the MSA test provides to him to the information that he could get from the standard tests for H. pylori:

> Q. [By the Hearing Examiner] Do you think that one also sometimes misses H. pylori when it's there?
>
> A. It does, because you're not going to biopsy every square inch of the stomach and duodenum when you go to do a biopsy. Most likely the gastroenterologist is going to pick the area that he sees inflamed or is most suspicious about, but there's a percentage of time that you get misses on that.
>
> * * *
>
> Q: * * * Do you think the MSA machine is more accurate for picking that up?
>
> A. I think it's a useful tool.
>
> Q. Do you prefer it over the lab tests that we've just been discussing?
>
> A. I do.

(Tr. at 159-160)

41. Based on the reasons he described, Dr. Everhart asserted, "The confirmatory tests [for H. pylori] can be very difficult." (Tr. at 61) When he was pressed on how he reached the diagnosis of H. pylori in Patient 1, Dr. Everhart testified that it was based on the patient's complaints in combination with the MSA results, but he nonetheless held to his position that the MSA was not diagnostic in nature:

> Q. [By. Mr. Wilcox] * * * [M]y question to you, because you have to explain this to the Medical Board, is what test did you run, and -- and the internal medicine standard of care requires you to run, to diagnose H. pylori gastritis?
>
> A. Again, the implication from the MSA was that H. pylori was there; in combination with the patient's complaints.
>
> Q. So just so we're clear: The patient's complaint of stomachaches, essentially, and what the machine, the MSA result told you, is what you used to diagnose this patient and prescribe antibiotics; is that correct?
>
> A. It gave me a piece of information. It is not diagnostic. It gave me information and an implication. And from that implication, I treated him.

(Tr. at 62)

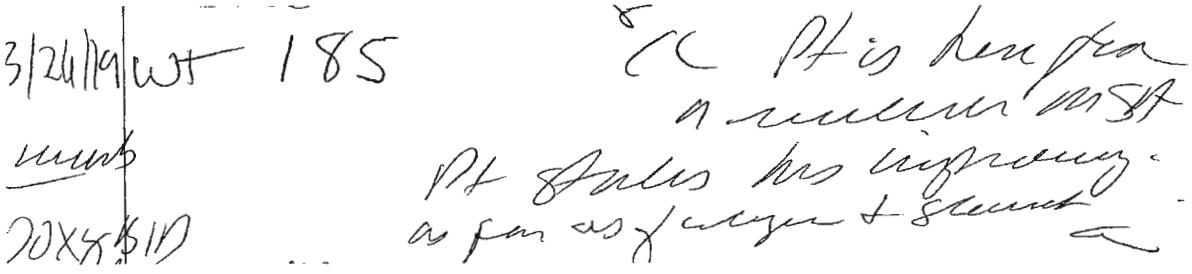
42. Dr. Everhart disagreed with a suggestion by the Assistant Attorney General that the standard of care for the treatment of an H. pylori infection requires one of the types of confirmatory testing that were discussed:

> Q. But those are what the standard of care requires in internal medicine, correct?
>
> A. I don't think it requires. I don't think that's a fair statement that internal medicine requires that. I don't think that's accurate.
>
> Q. Okay. But certainly internal medicine doesn't rely upon a readout from a machine called the MSA, correct? You would agree with that?
>
> A. I wouldn't agree with that.
>
> Q. Do you believe the internal medicine standard of care in Ohio allows an MSA machine to be used to either diagnose or assist in the diagnosis of a patient?
>
> A. I think it's an appropriate tool in the right hands.

(Tr. at 64)

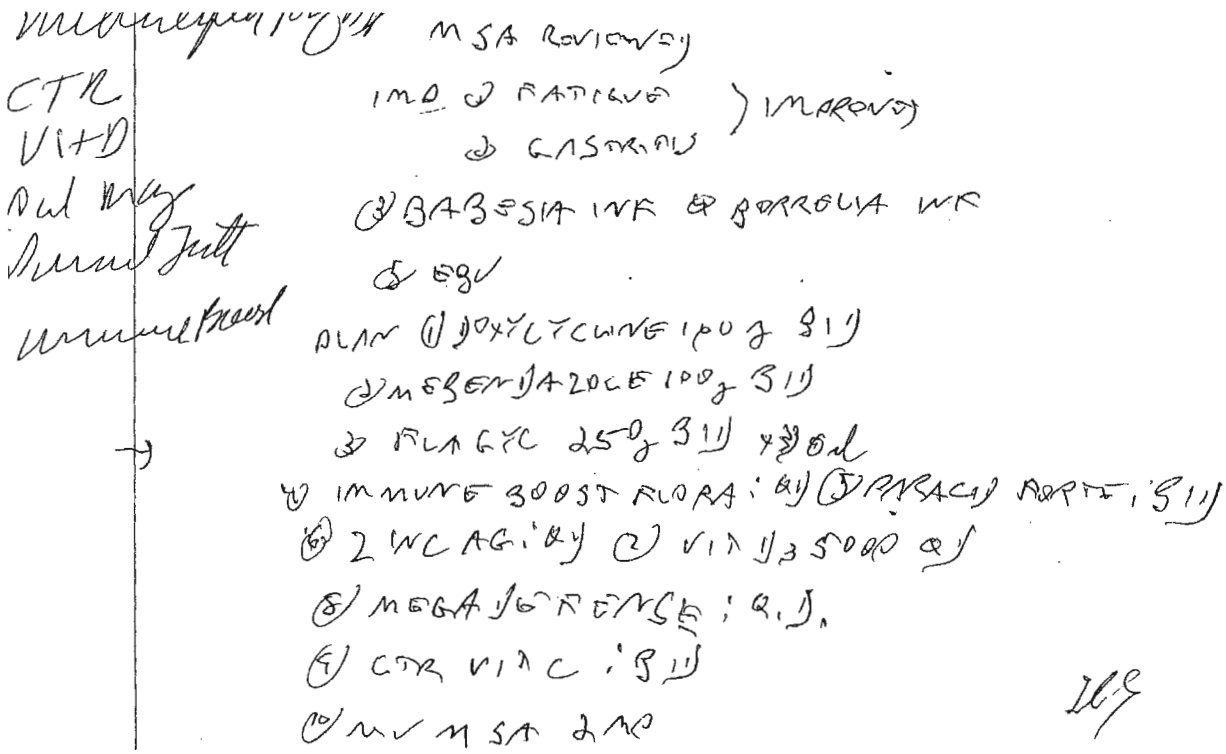
43. With respect to his diagnosis of a Babesia parasitic infection in Patient 1, when Dr. Everhart was asked if that infection is diagnosed by analysis of the patient's blood under a microscope, he responded, "That is not correct." (Tr. at 63) Although he agreed that he did no other testing to confirm the diagnosis of a Babesia infection, Dr. Everhart maintained that he prescribed antibiotics and supplements, as well as mebendazole, that he believed were the most appropriate for the diagnoses he made at Patient 1's initial visit. (Tr. at 63, 66-68)

44. Patient 1 returned to Dr. Everhart's office on March 26, 2019, and had a second MSA test. (St. Ex. 1 at 14-18) Dr. Everhart acknowledged that his notes say that the patient was there for a recheck MSA, and that he stated he was improving, as far as fatigue and stomach:



(St. Ex. 1 at 10; Tr. at 69-70)

45. Dr. Everhart agreed that at Patient 1's second visit, he did not document an exam of the patient or even that any vital signs were taken, but that his impression was that the patient's gastritis and fatigue were improving. He stated that at this appointment, he continued to diagnose the Babesia and Borrelia infections, and that he added a new diagnosis of Epstein-Barr Virus ("EBV"). (Tr. at 69-70) He agreed that his notes indicate he reviewed the second MSA test, and directed the patient to continue taking the antibiotics doxycycline and Flagyl, and to continue to take the mebendazole to treat the parasitic infection:



(St. Ex. 1 at 11; Tr. at 69-70)

Dr. Taylor's Report on Patient 1's Medical Treatment

46. In his report, Dr. Taylor summarized Dr. Everhart's care of Patient 1, and his conclusion that it fell below the standard of care:

> Dr. Everhart provided care for [Patient 1] from 01-29-2019. Treatment was for a five month history of fatigue, intermittent abdominal pain and nausea. The patient also complained of neck and back pain and insect bites. Medications included Doxycycline, Flagyl and other antibiotics including Amoxicillin (Allergy), Mebendazole, Vitamin D, other vitamins and medications sold by Dr. Everhart to the patient for indications that are

not stated in the record. Too many broad spectrum antibiotics were given and for too long for no specific reason. Labs were done on the initial visit and revealed mild dehydration, and elevated potassium and an elevated bilirubin. No review of these results appears in the record.

The main diagnostic tool that Dr. Everhart used was an electrodermal diagnostic device known as Meridian Stress Assessment (MSA). MSA is an unproven diagnostic tool. No consultation reports from gastroenterology or any other consultant appear in the record.

Mebendazole was prescribed on the initial visit for a 60 day, twice a day course. This drug is used for treatment of worms in the GI tract and is usually given for a maximum of 3 days. This treatment was continued on the 2 month follow up visit on 03/26/2019 as well. No diagnosis was established by blood tests or visualization or microscopic identification of GI worms. Mebendazole given for a prolonged period can cause abdominal pain and nausea. It was overused for this patient with no clear indication. Antibiotic overuse from antibiotics dispensed by Dr. Everhart could ultimately produce more harm than good from potential side effects.

The written notes that Dr. Everhart provided were extremely difficult to read. The initial visit was typed but follow up notes were not.

Dr. Everhart appears to have prescribed Amoxicillin for treatment of this patient's illness. The patient was allergic to Amoxicillin as stated on his initial visit.

* * *

The following is my expert opinion to a reasonable degree of medical certainty: that Dr. Everhart violated Sections 4731.22(B)(2) and 4731.22(B)(6), Ohio Revised Code, in his care of this patient. He overprescribed antibiotics. The patient was allergic to one of those antibiotics. He failed to seek consultation from a GI specialist and resorted to unproven methods for diagnosis of GI disease, Meridian Stress Assessment. Meridian Stress Assessment is an unproven electrodermal diagnostic device that cannot diagnose gastrointestinal disease according to the literature. The use of the antiparasitic drug, Mebendazole was not appropriate for this patient with unproven parasitic GI worm disease. Other expensive vitamins and other medications dispensed by the physician to the patient were also not indicated for treatment of the presenting complaints.

Finally, abnormal labs including hyperbilirubinemia and hyperkalemia were not explained or repeated as a matter of good routine medical follow up.

(St. Ex. 12 at 2-3)

47. In his testimony at the hearing, Dr. Taylor testified that after he submitted his report, he discovered a mistake with respect to his finding that Dr. Everhart had prescribed amoxicillin for Patient 1. (Tr. 233) He explained, "The patient had an allergy to amoxicillin and I thought it had been prescribed and that's an error on my part." (Tr. at 233)

Dr. Everhart's Response to Dr. Taylor's Report on Patient 1:

48. In response to Dr. Taylor's report, Dr. Everhart prepared his own report, with these comments:

> This patient was seen by me on January 29, 2019. He had previously been evaluated in Cincinnati, without definitive diagnosis or helpful treatment.
>
> Based on clinical presentation and with helpful information from the MSA testing he was diagnosed with Lyme Complex Disease and H-Pylori gastritis. He was treated appropriately for these conditions with improvement. Expert relates that he was treated with amoxicillin, which is not correct, it was not prescribed by me.
>
> His abnormalities included slight elevation of potassium, with the presence of blood pressure and normal renal function, was attributed hemolysis related to transport of the sample to the testing lab from my office. Elevated bilirubin was noted, and best explained by his diagnosis of babesiosis, which is noted in the chart.
>
> Mebendazole was used for treatment of babesiosis and combination with doxycycline or macrolide, frequently requires four to five months of treatment. Patient did improve with treatment.
>
> The Expert evaluation reflects ignorance of the appropriate diagnosis and treatment of these conditions. I disagree with his conclusion that the treatment was inappropriate.
>
> I found the Meridian Stress Assessment to be a useful tool in the management of these complex challenging, infections.

(Resp. Ex. F at 1)

Patient 2

49. Although Patient 2 was called as a Respondent's witness at the hearing, Dr. Everhart did not testify in detail about his care of this patient. Patient 2 testified that she first saw Dr. Everhart in approximately November 2015, and continued seeing him for several years. (Tr. at 495-496) She recalled that she first consulted him because she had become severely ill in May 2015 with a condition that another physician ultimately diagnosed as Lyme disease, after she had seen various other specialists:

> I had seen neurology, cardiology, rheumatology, infectious disease. I bounced from doctor to doctor and they could not figure out what was wrong with me. I saw an internal medicine specialist in Cincinnati, and Lyme disease showed up on blood work, and there wasn't a doctor in Dayton or Cincinnati that would treat it.

(Tr. at 496)

50. The patient related that she was in the Dominican Republic in February 2015, and she got a lot of mosquito bites while she was there. She recalled that when she was first admitted to the hospital in May 2015, she had one bite under her arm that she thought was a typical bug bite, except that it was there for a long time. She later had a western blot test at the University of Cincinnati that was positive for Lyme disease, and an integrative medicine doctor in Cincinnati referred her to Dr. Everhart for treatment. (Tr. at 496-497, 499-500, 505) The patient said that no other doctors had been willing to prescribe any medications for her except "head medicine" because she explained, "[T]hey thought I was crazy." (Tr. at 497)

51. Patient 2 said that her first appointment with Dr. Everhart in November 2015 lasted "probably an hour" and that he was "very thorough." (Tr. at 498) During that appointment, Dr. Everhart reviewed the records that she brought him from her previous treatments and hospitalizations, which she estimated was a file "6-inches thick," and asked her questions about her treatments. (Tr. at 498) She testified that Dr. Everhart wanted to run an MSA test, and she believed the test was done two or three months into her treatment with him. Patient 2 said that in addition to the MSA test, Dr. Everhart ordered the IgM antibody test as well as other bloodwork, and that he later prescribed antibiotics and mebendazole in January or February 2016. She added that Dr. Everhart was the first one to diagnose her with Babesia. (Tr. at 499-502, 505)

52. Patient 2 described the effect that the Lyme disease was having on her entire body:

> [I]t affected every part of my body. I had severe, severe headaches. I had numbness and tingling on one side of the body or the other. I would break out in a rash and hives. I had extreme fatigue. There was probably about a month or two where I was bedridden and couldn't get out of bed at all. My

> whole body was shutting down. I was having heart problems. I was seeing a cardiologist. My kidneys were affected. There wasn't a single part of my body that wasn't affected by the Lyme disease.

(Tr. at 501-502)

With respect to her previous treatments for Lyme disease with other doctors, the patient opined, "They were all treating individual symptoms and wouldn't look holistically about what was going on." (Tr. at 502)

53. The patient testified that she took the mebendazole that Dr. Everhart prescribed, along with the antibiotics, in early 2016 for about 90 days, and that she recovered from her illness. She said that after a two-year illness, she is well now, and except for a single sinus infection, she has not been sick in the past year. (Tr. at 502-504) Patient 2 stated that she attributes her recovery to Dr. Everhart's care when other doctors could not help her, and she related, "[N]o one would treat or touch the Lyme disease. They all wanted to look at different symptoms and try to treat some other things." (Tr. at 503)

54. The patient concluded:

> Dr. Everhart was the first and only doctor who listened to me and who was willing to dig in deep and look at the whole system and everything that was happening to my body and treat it. And he successfully treated it. I don't know where I would have been if he didn't take the time with me and do everything that he did in order to get me better.

(Tr. at 503-504)

55. On cross-examination, Patient 2 testified about her understanding of the purpose of the 18 MSA tests that she had at Dr. Everhart's office:

> Q. [By Mr. Wilcox] * * * What do you think that those tests were being administered for?
>
> A. I thought that the tests were being administered to provide or shed light on the whole system, on everything that's going on, without ordering lots of other tests. So just more insight information. MSAs have been administered for a very, very long time. So, I mean, it uses your meridians which is used through acupuncture. I think it just kind of gives you an overall picture of other things that could be going on with your body.

(Tr. at 508)

Dr. Taylor's Report on Patient 2's Medical Treatment

56. In his report, Dr. Taylor described the following aspects of Dr. Everhart's care of Patient 2:

> Dr. Everhart provided care for [Patient 2] from October 29, 2015 until January 14, 2019. He began treatment of the patient after testing her for Lyme disease with an ELISA test and a confirmatory Western Blot test. The Western Blot IgM test was positive, the initial test was not. He used his office MSA testing to establish a diagnosis of Babesiosis. Treatment began for Lyme disease with antibiotics and Babesiosis was treated with Mebendazole.
>
> The patient became ill in May of 2015 and did not see Dr. Everhart until October 29, 2015. That is important because of the suspected Lyme disease on the basis of a positive IgM antibody test done by Dr. Everhart on the day that she was first seen. This was more than 5 months after she became ill and more than 8 months after the mosquito bite in the Dominican Republic. A key point to remember however with the diagnosis of Lyme disease is that a positive IgM result should be disregarded if the patient has been ill for more than 30 days. Regardless of the lab test results for Lyme disease however, if the patient had symptoms of the disease and lived in an endemic area, antibiotics should have been started as Dr. Everhart did. The ongoing treatment of what Dr. Everhart diagnosed as chronic Lyme disease with months and months of treatment with oral antibiotics however is not supported in the literature.
>
> He also treated the patient for Babesiosis on the basis of a positive MSA test (an unproven testing method for fungal disease.) The patient eventually developed side effects from this treatment which included elevated liver enzymes, kidney disease and GI upset. Mebendazole was continued much longer than needed for treatment of this disease and was only discontinued when the patient complained about the effect of the drug on her liver.
>
> Much of the information in the chart is written by hand and illegible which made a comprehensive review of the chart almost impossible. Dr. Everhart did seek consultation from gastroenterology who followed up with abdominal imaging studies and an upper endoscopy and colonoscopy. Consultation was also sought from the Cleveland Clinic for her GI complaints. It is unclear from the chart whether suggested treatment for irritable bowel syndrome and bacterial overgrowth was continued by Dr. Everhart.
>
> * * *

> The following is my expert opinion to a reasonable degree of medical certainty: that Dr. Everhart violated Sections 4731.22(B)(2) and 4731.22(B)(6), Ohio Revised Code, in his care of this patient. He overprescribed antibiotics to this patient for Chronic Lyme disease. Ongoing treatment after the first month with antibiotics has not been shown to improve symptoms or have any effect on the disease. He treated the patient for Babesiosis on the basis of result of Meridian Stress Assessment, an unproven electrodermal diagnostic device that cannot diagnose GI disease according to the literature. The use of the antiparasitic drug, Mebendazole was not appropriate for this patient with unproven parasitic GI worm disease. Only after the patient complained about the side effects of elevated liver enzymes did the physician take steps to stop or decrease the dose of the drug after months of treatment. Even after that clear indication of hepatic toxicity he continued to want to treat the patient with the drug.
>
> Consultation was sought for her chronic GI complaints with Gastroenterology. It is unclear whether the suggestions from GI were followed by Dr. Everhart. Other specialists also saw the patient but there are no notes from Infectious disease or parasitology. Confirming the diagnosis of chronic Lyme disease and Babesiosis should have been his chief concern for this patient after treatment failure with antibiotics and Mebendazole hepatic toxicity.

(St. Ex. 12 at 4-5)

Dr. Everhart's Response to Dr. Taylor's Report on Patient 2:

57. In response to Dr. Taylor's report, Dr. Everhart prepared his own report, with these comments:

> This patient was first seen by me on October 29, 2015. Patient was diagnosed with Lyme Complex Disease, and appropriately treated.
>
> She had temporary elevation of liver function studies, which did resolve. CAT scan done January 14, 2019 showed a normal liver.
>
> Experts in the field of tick related illness confirm that long term antibiotics are frequently necessary for appropriate treatment. Mebendazole is used as an appropriate treatment for babesiosis.
>
> The Expert opinion reflects his ignorance of Lyme Complex Disease, the appropriate and recommended treatment by experts in the field, and that

> lyme testing is inconsistent and unreliable. This is consistent with the Ohio Statute regarding lyme testing.[3]

(Resp. Ex. F at 2)

Patient 3

58. Patient 3 was a 49-year-old woman at the time she first presented to Dr. Everhart on January 25, 2019. She was 5'6" tall and weighed 115 pounds. (Tr. at 71-73; St. Ex. 3 at 38-39) Dr. Everhart's notes show the following summary of this patient's history of present illness:

> **HOPI**: Patient presents for further evaluation of thyroid issues. She has had hashimoto's since 1993 with variable levels. She has occasional night sweats. She denies hot flashes. She has had increased emotional changes over the past year. She may have intermittent pins and needle feeling. She has been seeing Judy Piper a natural path. In December she developed some new symptoms with head to toe pins and needles. Currently her menstrual cycles are ending, her periods tend to be longer.

(St. Ex. 3 at 38)

59. Dr. Everhart testified that he examined this patient and found nothing remarkable, as indicated in his Physical Exam findings, except for a hyper-reflexive patella reflex, listed under "NEURO" as "DTR 2.5+." (Tr. at 73; St. Ex. 3 at 39) He documented his impressions, consisting of a thyroid condition, as well as the paresthesia "pins and needles" sensation, and a history of Epstein-Barr virus, and his formulation of a treatment plan in the notes of the initial office visit:

> **IMPRESSION**:
> 1. Thyroiditis.
> 2. Parathesia's [*sic*]
> 3. History of EBV.
>
> **PLAN**:
> 1. Lab evaluation.
> 2. MSA testing.

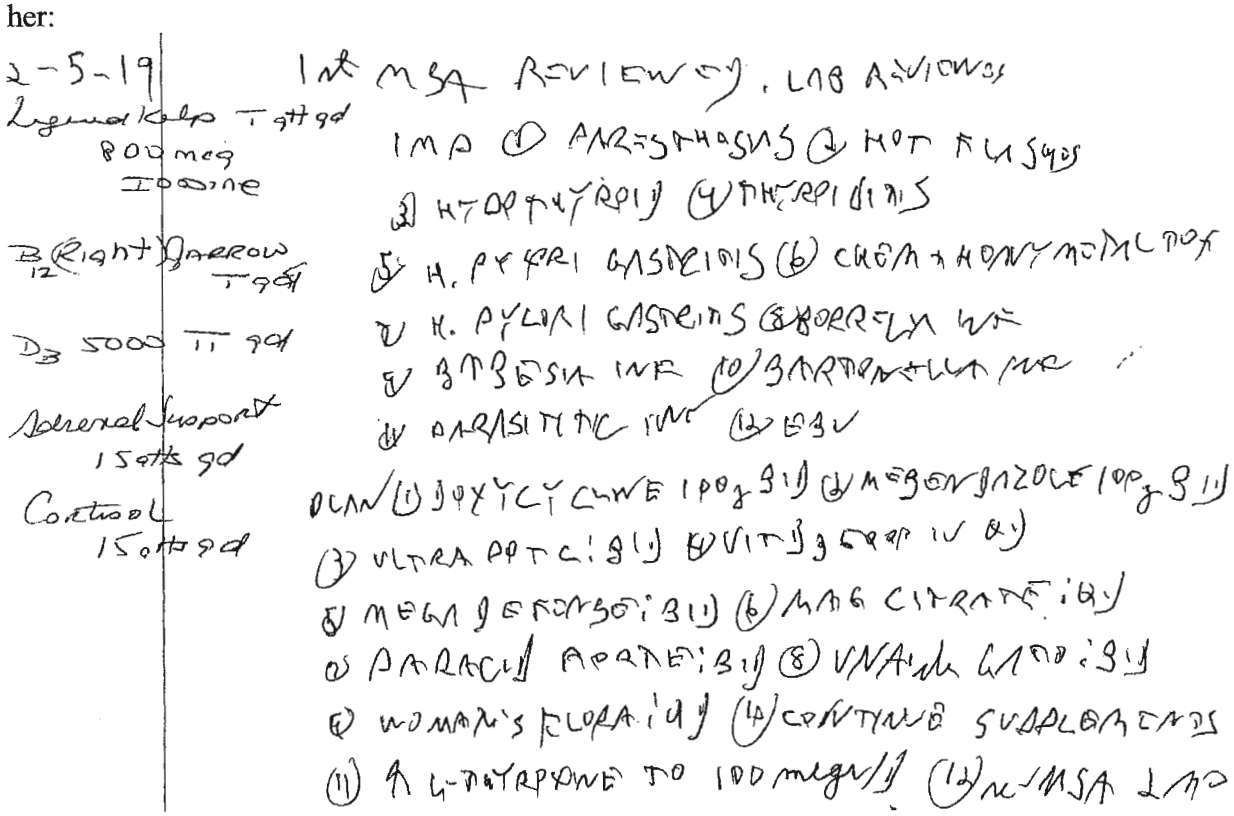
---

[3] A search of the Ohio Revised Code by the hearing examiner produced only one statute regarding Lyme disease, contained in Chapter 4741, concerning the practice of veterinarians. R.C. 4741.49(A) states, "A person holding a license, limited license, or temporary permit to practice veterinary medicine who orders a test for the presence of Lyme disease in an animal under the person's care may report to the department of health any test result indicating the presence of the disease." In addition, Rule 3701-3-02(B)(36) of the Ohio Administrative Code states that Lyme disease is a Class B disease that must be reported to the board of health.

(St. Ex. 3 at 39; Tr. at)

60. Dr. Everhart testified that he ordered a standard blood panel, along with an antinuclear antibody ("ANA") test, which was performed on blood collected from the patient at that visit. The results of that test are in the patient's record, showing that a negative result for the presence of auto-immune diseases. (Tr. at 74-75, 83; St. Ex. 3 at 8-9)

61. Patient 3 returned to Dr. Everhart's office on February 5, 2019, about a week after her initial exam, to have an MSA test. She signed the release stating that her use of the MSA test was voluntary and that the equipment used was non-diagnostic in nature. The printout from that test appears in her records, as well as Dr. Everhart's handwritten notes, indicating that he reviewed the results of the MSA test with her that same day. (Tr. at 75-76; St. Ex. 3 at 28-37) In his notes, Dr. Everhart recorded his impressions of this patient's diagnoses, as well as the medications and supplements he was prescribing for her:



(St. Ex. 3 at 13)

62. Dr. Everhart testified that his diagnoses included paresthesia, hot flashes, hyperthyroid, thyroiditis, H. pylori gastritis, and chemical and heavy metal toxicity; as well as Epstein-Barr Virus, which causes chronic fatigue; a Borrelia infection, which he testified was from Lyme disease; Bartonella, a co-infection with Lyme disease; and a parasitic Babesia

infection. Dr. Everhart stated that the former name for Bartonella was "cat scratch fever," and that he diagnosed it in Patient 3, along with the other conditions. (Tr. at 75-77)

63. Based on those diagnoses, Dr. Everhart prescribed doxycycline 100 mg., an antibiotic to be taken twice a day; mebendazole 100 mg., an anti-parasitic to be taken twice a day; and numerous supplements. Dr. Everhart explained that he prescribed the doxycycline to treat the H. pylori gastritis, as well as Lyme disease and Lyme complex that he diagnosed. However, he agreed that he did not do a breath test, blood test, or any endoscopy testing to confirm the H. pylori diagnosis. (Tr. at 78, 81; St. Ex. 3 at 13)

64. With respect to the order for mebendazole, Dr. Everhart testified that he prescribed that medication to treat Babesia, the parasitic infection that he diagnosed in this patient. (Tr. at 81-82) He acknowledged, however, that he did not do any other tests to confirm that Patient 3 had a parasitic infection, and that he relied only on the patient's description of her symptoms and the MSA test to make that diagnosis:

> Q. [By Mr. Wilcox] * * * Did you do any of the confirmatory tests which include a blood -- taking the patient's blood and having it examined under a microscope to see if there were parasites in the blood? Did you do that?
>
> A. No.
>
> Q. So you base your diagnoses and treatment of this patient solely on the MSAs that you conducted, as well as your, I guess, speaking with the patient and talking about her symptoms; is that correct?
>
> A. Correct.

(Tr. at 82)

65. Similarly, Dr. Everhart testified that he diagnosed Lyme disease in Patient 3, even though there was no tick bite or rash documented in this patient's presentation. (Tr. at 80) When he was asked the basis for his conclusion that the patient had Lyme disease, Dr. Everhart responded:

> [S]he lives out in the country. And her symptoms of paresthesias, they're electrical sensations that are not -- they're very typical for Lyme, the way she described it. Those are highly suggestive of Lyme disease.

(Tr. at 79)

66. Dr. Everhart implied that there was no reason for him to ask Patient 3 if she had been bitten by a tick, explaining, "Not necessarily. I think any insect bite can carry Lyme."

(Tr. at 79) He referred to an article in *The Columbus Dispatch* that he had read, but did not submit to the record, that said Lyme disease could also be transmitted by mosquitoes, and he maintained that many kinds of insects and even spiders could carry Lyme disease:

> [I]t doesn't have to be a tick bite at all. I think that a tick is felt to be maybe the most common, but to say you can only get it from that is false.
>
> Q. [By Mr. Wilcox] Okay. Just so we're clear, your testimony to the State Medical Board of Ohio is that Lyme can be transmitted to humans from mosquitoes, spiders, no-see-ums, and other insects; is that my understanding of your testimony?
>
> A. It is. That is correct.

(Tr. at 80)

He agreed that he did not do a confirmatory blood test for Lyme disease in Patient 3, explaining, "[T]hose tests are, for the most part, not helpful." (Tr. at 85)

67. In addition, Dr. Everhart stated that he did not order any imaging tests, even though the patient's history notes that she had pain in her shoulders, chest, and torso. (Tr. at 83; St. Ex. 3 at 40) He explained that he did not believe any imaging was needed, but implied that he was instead going to test the accuracy of his diagnosis by observing the patient's response to the medications he prescribed:

> No. I had no reason to. I had a working diagnosis. If she improved with what I treated her for, I had the answer. She had no physical findings that would suggest that other imaging should be ordered at that time; like abnormal reflexes or range-of-motion problems in her joints.

(Tr. at 84)

68. Patient 3 returned to Dr. Everhart's office about two months later on April 4, 2019 and had a second MSA test. The printout from that test is contained within her patient record, along with Dr. Everhart's notes of his impressions, diagnoses, and the drugs he prescribed. At this appointment, Dr. Everhart continued the patient on doxycycline 100 mg., and added Flagyl, amoxicillin, and Biaxin -- three additional antibiotics, to be taken for 30 more days. He also continued the prescription of mebendazole, the anti-parasitic medication, for 60 more days. (Tr. at 84-85; St. Ex. 3 at 20-26) Dr. Everhart testified that he prescribed those medications for the treatment of "Lyme and Lyme complex, which included Babesia." (Tr. at 85)

69. According to Dr. Everhart's testimony, he believed that many of Patient 3's diagnoses stemmed from Lyme disease. He acknowledged that there is a blood test that can analyze

a patient's blood for titers that indicate exposure to Lyme disease, but he stated that he did not believe that test gave accurate results, so he did not order it for this patient. (Tr. at 85-86) He also represented that the Ohio legislature requires patients who have that test to sign a statement indicating that the test is of questionable value:

> The state law on Lyme testing is the patient should, and we have them do this, sign a form that when they get a Lyme test, if it shows something, it doesn't mean they have it; and if it doesn't show anything, it doesn't mean they don't have it. So that's of questionable value when you put it in those terms.

(Tr. at 85)

However, when he was asked to cite to a source showing that any law required that disclaimer, Dr. Everhart stated that he believed it was an Ohio law, but did not know where to find it. (Tr. at 152-153)

70. When Dr. Everhart was asked if he had any specific training in infectious disease, he offered that he had taken CME courses in infectious diseases, and that much of his experience as an internal medicine practitioner involved the treatment of infectious disease, with hospital inpatients as well as outpatients seen in his office. He confirmed that in Patient 3's case, he was able to make the diagnoses that he made, using the results of the MSA test, as well as the patient's history and the complaints she stated to him. (Tr. at 86-88) Dr. Everhart maintained that he believed the MSA test was a more reliable indicator of Lyme disease and the Babesia parasitic infection than traditional testing:

> Q: [By Mr. Wilcox] * * * [I]s it your testimony to the Medical Board that you believe this MSA testing is more reliable than testing for things like Lyme disease and Babesia?
>
> A. I think it gives me more accurate information to work with than those blood tests.

(Tr. at 88)

Testimony of Patient 3

71. Patient 3 was called as a Respondent's witness at the hearing, and she testified about her experience with Dr. Everhart from the time she first sought treatment with him in 2019 until the present. She stated that she continues to see him as her physician for the treatment of a recurrence of Lyme disease and cat scratch fever. (Tr. at 512-513)

72. Patient 3 testified that she had a "laundry list" of complaints when she first sought treatment with Dr. Everhart, including headaches, foggy memory, pain shooting down

her legs, fatigue, and a sensation "like an MS hug, when your muscles in your torso seize." (Tr. at 514) She stated that she had been ill for years, and that she was worried she might have multiple sclerosis. She also said that she had previously been diagnosed with depression, which she believed may have been the result of a thyroid and Vitamin D deficiency. (Tr. at 513-515) Patient 3 explained why she sought treatment with Dr. Everhart when other doctors had not been able to help her:

> I had heard that Dr. Everhart was somebody who was open to discussion with patients, was willing to look at his patients as a whole person, and so I decided that that was what I was looking for in a doctor and so I made an appointment.
>
> * * *
>
> I had spent years trying to get off all of this medication I had been put on, and in doing so, I had gone to different doctors. And when my symptoms would come back up, they would say, "Oh, we should just probably put you back on the medicine." I would say, "No. We're trying to get to the bottom of what causes this. Not putting a bandaid back on." And I was looking and looking and looking for the cause of what is going on.

(Tr. at 513-515)

73. Patient 3 recalled that she was surprised by how quickly she was able to get an appointment with Dr. Everhart, and that at her first appointment, he spent 45 minutes to an hour with her. (Tr. at 515-516) She added, "I mean, it was an amazing amount of time just talking with me." (Tr. at 516)

74. The patient stated that after Dr. Everhart's examination and interview with her at the first appointment, he told her that he believed she had Lyme disease, and that he believed she had probably had it for a very long time. (Tr. at 517) In addition to ordering some lab work to check her thyroid, as well as Vitamin D and cholesterol levels, he also offered her the MSA test:

> And he said, you know, I think based on what you are telling me, based on what I'm seeing and hearing, he said I think you have Lyme. And he says it's hard to detect but I do think you have Lyme. And then -- and he asked, you know, if I wanted to use the MSA because that was an optional thing to do, which I did want to do, and he uses it kind of as a quantitative tool. Does it back up what he's seeing; does it not.

(Tr. at 516)

75. Patient 3 scheduled the MSA test for an upcoming appointment, and subsequently had several more MSA tests with Dr. Everhart. When she was asked if she signed a release notifying her that the MSA was not a diagnostic test, she quickly agreed that she knew

the MSA was not diagnostic, though she could not remember what was on the disclosure. (Tr. at 519) The patient further testified about what she believed the MSA test was being used for:

> Q. [By the Hearing Examiner] * * * If it wasn't a diagnostic test, what did you think the purpose of that test was?
>
> A. It was to -- so he does the diagnosing, and that was a tool to say, okay, if this is the right diagnosis, you know, again, it gives a quantifiable baseline of here's where we are. And then as we progressed with treatment and continue to do the MSA, you know, every several months where are we, are the findings from the MSA, do they correlate to the progress being felt.
>
> And I would say sometimes that progress feels darn slow, but as you can see with the test, yes, you're making progress. The numbers or whatever way that it works, the results I'll call them, are in line with getting better, so we're going to stay the course.
>
> Or, you know, at one point it re-flared and I could feel that and the MSA confirmed that and so we changed the treatment plan at that point and continued. It was really more of a quantitative tool, I guess, to just -- it's a way to see what you are feeling and what -- with his experience. Just kind of backing up his experience. If that makes sense.

(Tr. at 525-526)

76. Patient 3 testified that Dr. Everhart also recommended "minerals and herbs and things that would support the body so that it would be able to be part of the healing." (Tr. at 520) She stated that over the course of her treatment with Dr. Everhart, her condition began to improve slowly. She no longer had headaches, she was less fatigued and was able to work with her kids and her animals again, and she did not have the pain in her legs. (Tr. at 520-521) The patient said that she "absolutely attributes her improved health to Dr. Everhart's care and the medications that he prescribed for her. (Tr. at 521) She added:

> I think that he spends time with his patients, which is a rarity today. He wants to know who you are, how you're doing. You know, he kind of -- you're not just a chart or a number. You are a person and that comes into that conversation when you're seeing him.

(Tr. at 522)

77. Patient 3 testified that Dr. Everhart was the first physician who ever diagnosed her with Babesiosis, and she explained, "That is part of the Lyme. That is part of what came back with the MSA and that was part of the confirmation that he said those are typically involved with Lyme." (Tr. at 524) On cross-examination, the patient confirmed that no one had ever diagnosed her with Lyme disease before she began seeing Dr. Everhart. (Tr at 523)

78. When Patient 3 was asked how she was presently feeling, she stated that she had recently had a relapse of Lyme disease and cat scratch fever:

> I'm pretty good. I, unfortunately, got bit by a spider and I have a relapse of Lyme. And I was attacked by my daughter's injured cat and I spent six weeks on crutches because it nicked a tendon. And I don't know if you can see my fingers but they're all warped from the cat scratch fever. It's in my knuckles. So, other than that, I'm doing great.

(Tr. at 521)

79. Patient 3 confirmed that Dr. Everhart diagnosed her with the Lyme disease relapse after the spider bite:

> I know I had this darn cat thing and I said I had a spider bite. I said, you know, I didn't realize spiders could carry Lyme; otherwise, I would have been back in his office way faster. But he said yes, they do carry Lyme and that is definitely -- you should have been concerned with that mark. It wasn't just a not-healing spider bite.

(Tr. at 526)

The patient stated that she had another MSA test at that visit, "to confirm that everything had been maintaining clear." (Tr. at 527)

Dr. Taylor's Report on Patient 3's Medical Treatment

80. Dr. Taylor prepared a report that summarized Patient 3's medical treatment from Dr. Everhart and his opinions about that care:

> Dr. Everhart's records for [Patient 3] describe three subsequent visits after the initial visit on January 25, 2019 for the presenting complaints. Meridian Stress Assessments (MSA) were done on all subsequent visits, February 2, 2019, April 4, 2019, and the last recorded visit on May 31, 2019. MSA is an unproven diagnostic tool which uses acupuncture theory and galvanic skin responses to make specific diagnoses in the correlated

organs. Dr. Everhart used multiple MSA tests to guide his treatment decisions throughout the recorded care for this patient.

Most of the follow up notes are written and were very difficult to read. The only outcome information is given on the last visit and seems to suggest that the patient was constipated throughout the course of care and treated with magnesium citrate. No diagnostic or treatment plans were mentioned. Bilateral jaw pain was also mentioned but no treatment or further diagnostic plans were mentioned.

No lab testing was done after the initial visit. The patient had an elevated cholesterol and was on levothyroxine for thyroid replacement since 1993. The levothyroxine dose was increased on the second visit in spite of normal thyroid function tests.

Multiple broad spectrum antibiotics were used at the same time for treatment of diagnoses suggested by the MSA device. The reasons for mega doses of these drugs, however, some given twice a day for 60 days at a time were not explained. The reason for giving Mebendazole, an antiparasitic drug, twice a day for two months at a time repeatedly is not given either. Mebendazole is used for treatment of worms in the GI tract and is usually given for a maximum of 3 days. No consultation reports from gastroenterology or any other consultant appear in the record.

Vitamin D and other vitamins and in house medications and supplements were sold to the patient for indications that are not documented in the record.

* * *

The following is my expert opinion to a reasonable degree of medical certainty: that Dr. Everhart violated Sections 4731.22(B)(2) and 4731.22(B)(6), Ohio Revised Code, in his care of this patient. He overprescribed antibiotics. He failed to seek consultation on GI diseases suggested by the MSA testing done on three of the visits to see him. Meridian Stress Assessment is an unproven electrodermal diagnostic device that cannot diagnose gastrointestinal disease, the reason for paresthesia, fatigue, or anything else, according to the literature.

Finally, Dr. Everhart failed to recognize the potential side effects of his polypharmacy. The overuse of antibiotics may have caused the patient's chronic constipation and jaw pain and may have prolonged her illness.

(St. Ex. 12 at 6-7)

Dr. Everhart's Response to Dr. Taylor's Report on Patient 3

81. In his own expert report, Dr. Everhart presented the following response to Dr. Taylor's report:

> In response to the Expert review of records the MSA is an approved tool by the FDA for evaluation of functional health.
>
> Expert relates that the record indicates the patient was constipated through the course of care. There is no evidence of this in the record.
>
> Expert suggests that jaw pain was never treated but diagnosis of herpex simplex infection was made and treated.
>
> Expert relates and suggests that thyroid dosing was inappropriate, no further lab testing was done. Records clearly reviews [*sic*] that follow up lab testing was done, and his interpretation of normal thyroid function studies is not optimal in women of this age, subsequent lab testing confirmed this.
>
> The patient was treated for Lyme Complex disease and long term use of antibiotics for babesia and borrellia [sic] infections were appropriate.

(Resp. Ex. F at 3)

Patient 4

82. Patient 4 sought treatment of Lyme disease with Dr. Everhart in or about July 2018, and brought records of her previous treatment. She was 14 years old when she first saw Dr. Everhart on July 20, 2018. (St. Ex. 4 at 50-83) Dr. Everhart's notes describe her History of Present Illness:

> **HOPI**: Patient presents for further evaluation of treatment. She was diagnosed with Lyme disease in 2016. She has been treated with Doxycycline, Rifampin, and Amoxicillin. She stopped antibiotics in September 2017. She has noted to have stretch marks. She has joint pains, fatigue, and irritability. The last couple of months she has had increasing joint pains and mood swings. She had a spider bite four years ago and has a rash up her legs. She took two weeks of antibiotics at that time.

(St. Ex. 4 at 49)

The patient had an MSA test at her first appointment, and the results of that test appear in the file, along with Dr. Everhart's notes of his review of the test. (St. Ex. 4 at 38-47) At that appointment, Dr. Everhart prescribed the following medications for Patient 4, as well as several supplements not shown below:

If you experience stomach distress taking medication on an empty stomach, try taking with crackers and/or juice.

* MEDICATION AND DOSAGE	Before Breakfast	Before Lunch	Before Dinner	Before Bedtime	
Anti Parasitic Meds Supplements Can Contain Black Walnut RIFAMPIN 300mg	One-	Once	a Day	X	60 days
WATCH FOR Change in Color Stools → Call IF Needed					
BIAXIN 250mg	One-	Twice	a Day	X	60 days
Amoxicillin 500mg	One-	Twice	a Day	X	60 days
mebendazole 100mg	One-	Twice	a Day	X	60 days

(St. Ex. 4 at 37)

Testimony of Patient 4's Mother

83. Patient 4's mother, who is also one of Dr. Everhart's patients, testified that she believed her daughter had contracted Lyme disease in 2012 as a result of a tick or bug bite, but that she did not exhibit symptoms until 2016, and did not seek treatment with Dr. Everhart until 2018 when she was 14 years old. (Tr. at 555-558; St. Ex. 4) The patient's mother recalled that her child was previously diagnosed with Lyme disease by a different physician, who treated her for Lyme disease for two years or more:

> We didn't realize that it was Lyme disease. It wasn't until 2016 that she exhibited symptoms and so we saw a physician, we asked for an opinion of a physician on a symptom, let's say, pretty extreme stretch marks, she was maybe 13 years old, so we asked -- you know, I took her to that physician that we were seeing, about these stretch marks. They mentioned that that could be a symptom of Lyme and then they transferred us to a Lyme expert. So she saw that doctor specifically for about two, two and a half years for Lyme.

(Tr. at 558-559)

84. Patient 4's mother described the symptoms her daughter was having as a result of her Lyme disease:

> She would have symptoms of fatigue, symptoms of joint pain, some mood swings. Kind of not -- she described it as just feeling icky and just not

> feeling good on the inside, so that would affect her just kind of overall demeanor.

(Tr. at 565)

85. The patient's mother testified that her daughter was referred to Dr. Everhart for treatment on the recommendation of a family friend who was having other health issues and thought Lyme disease could be a factor contributing to Patient 4's complaints. She stated that the doctor who had previously been treating Patient 4 was moving his practice, and they elected to begin treatment with Dr. Everhart even though it required them to drive about two hours each way. (Tr. at 560-563)

86. Patient 4's mother went to the appointments with her daughter. She recalled that no tests were done at the initial appointment, but that Dr. Everhart spent about 45 minutes interviewing her child, and asking about her symptoms, how she felt when she was first diagnosed with Lyme disease and throughout her previous treatment, activities that she liked to do, and how her life was affected by how she was feeling. (Tr. at 562-563)

87. Patient 4's mother testified that after they met with Dr. Everhart in the morning, he recommended that her daughter have the MSA test. Because of the distance they had driven, the office worked them into the afternoon schedule, so that after having lunch out, they returned to the office for her daughter's first MSA test that same day. Then, they saw Dr. Everhart a second time that afternoon, and he went over the results of the test with them. Patient 4's mother stated that she did not believe Dr. Everhart ordered any additional tests that day, but he did write prescriptions for her daughter. (Tr. at 563-564)

88. The patient's mother emphasized that her daughter had previously taken antibiotics to treat Lyme disease, but that Dr. Everhart's prescribing seemed to be more individually tailored to her:

> She might have just been on the same antibiotic throughout the entire treatment at our previous physician, but this one he would tailor it according to each appointment and where she was in her symptoms. So she had been on doxycycline, amoxicillin, rifampin, Diflucan, but I don't remember the specific -- not all of them at once, but I don't remember the specific order that they would have gone in.

(Tr. at 566)

89. Patient 4's mother stated that she noticed an improvement in her daughter's condition after about four or five weeks after starting treatment with Dr. Everhart, and that she continued to see Dr. Everhart for about a year longer, during which time her condition significantly improved. She testified that sometimes the antibiotics hurt her daughter's stomach, but that he had told them to reach out to him if they noticed any side effects.

She recalled that this happened a few times, and that Dr. Everhart was responsive, once changing a medication that caused her daughter's asthma to flare up, and another time intervening to have a medication compounded without the pink dye that it typically had in it, after she believed that was having an adverse effect. (Tr. at 567-572)

90. Patient 4's mother agreed during her testimony that Dr. Everhart made clear that the MSA was an optional test, and she signed a release before her daughter had that test. (Tr. at 570) When she was asked if it was made clear that the MSA was not a diagnostic test, the patient's mother responded, "It was my understanding that he would take all of our information into account, coupled with his expertise, what have you, or his experience." (Tr. at 571)

Dr. Taylor's Report on Patient 4's Medical Treatment

91. Although Patient 4's treatment was not discussed in detail at the hearing, Dr. Taylor provided the following assessment of his review of this patient's treatment:

> Treatment of this patient, a 14 year old girl, by Dr. Everhart began in July 2018 and continued for a year for chronic fatigue, joint pains and an equivocal diagnosis of Epstein Barr Virus infection. She had previously been treated by another physician with Doxycycline, Rifampin and amoxicillin for EBV. She was treated for a year with antibiotics before seeing Dr. Everhart and had some improvement in her fatigue on Doxycycline. Diagnoses that were added after MSA (Meridian Stress Assessment) testing by Dr. Everhart were a confirmed diagnosis of Epstein Barr Virus infection, Lyme disease, Babesia and Fungal pneumonitis. Medications prescribed on the basis of MSA testing were Mebendazole, Amoxicillin, Doxycycline, Rifampin, Diflucan, Vitamin D, Vitamin C, and many other supplements dispensed by the pharmacy at the doctor's office. MSA testing an unproven diagnostic tool was used throughout the treatment for diagnosis and treatment decisions on at least 3 visits during the year of treatment. Lab results done on the initial visit were within normal limits except for a slightly elevated total eosinophil count. No labs were done after the initial visit. No infectio[us] disease consultation was included in the chart. The records from the previous physician and the conclusion was that the patient might have an Epstein Barr virus infection because the test results were equivocal.
>
> The patient developed nausea from Rifampin and Mebendazole two months after her treatment began. These medications were stopped for a brief period but eventually restarted twice a day and continued twice a day for 60 days at a time. Other antibiotics were continued in spite of her GI complaints. A gastroenterology consult would have been appropriate before starting the patient back on the offending drugs.

> This summary of his treatment and medications prescribed is limited by the poorly written follow up notes. Many of the drug entries are illegible and very difficult to correlate with the text and timeline.
>
> * * *
>
> The following is my expert opinion to a reasonable degree of medical certainty: that Dr. Everhart violated Sections 4731.22(B)(2) and 4731.22(B)(6), Ohio Revised Code, in his care of this patient. The patient was diagnosed and treated on the basis of an unproven diagnostic device, the Meridian Stress Assessment. None of the drugs prescribed were supported by any other diagnostic evidence. No lab tests were done to confirm the diagnosis of chronic Epstein Barr infection and the diagnosis according to the previous physician's chart was equivocal on the basis of standard antibody titres in 2016. Dr. Everhart made the diagnosis of fungal pneumonitis on the basis of MSA testing and did not get a chest x ray or any other lung imaging study or seek pulmonary consultation. The diagnosis of Lyme disease was not supported by any confirmatory lab tests yet the patient was treated aggressively for this disease for a year with large doses of antibiotics.
>
> Misdiagnosis is inevitable if unproven diagnostic tools are used to make diagnoses and govern treatment decisions. It was extremely important for Dr. Everhart to seek consultation at some point during the year of treating this adolescent patient and he did not. His polypharmacy with multiple antibiotics, mebendazole, vitamins and other supplements caused GI problems. Since the record does not indicate any clear benefit to the patient from any of the medications, the GI side effects experienced by this patient after 2 months of treatment should have been a clear indication to stop the drugs. Treatment was continued for another 10 months by Dr. Everhart.

(St. Ex. 12 at 8-9)

Dr. Everhart's Response to Dr. Taylor's Report on Patient 4

92. In his own expert report, Dr. Everhart presented the following response to Dr. Taylor's report:

> I first saw this patient on July 20, 2018 for further evaluation of increasing problems. Her problems started in 2013 after she had a spider bite associated with bulls eye rash. She was at that time treated with Doxycycline for two weeks. She was diagnosed with Lyme disease in 2016 by another physician and was treated with Doxycycline, rifampin,

> and amoxicillin over the next year. Initially she had increasing joint pains, fatigue, irritability, mood swings and increasing stretch marks.
>
> Stretch marks in a young woman, height 5'3" weight 125 is unusual and highly suggestive of bartonella infection. Initial lab showed lymphocytosis, but improvements in the white blood count and lymphocytosis compared to previous testing of 2016.
>
> She had a history of intermittent wheezing. Based on her history, current complaints, physical exam, previous testing, and previous treatment, she was diagnosed with Lyme Complex disease, and possible fungal pneumonitis and likely chronic Epstein Barr Virus process. She was appropriately treated for these infections.
>
> The Meridian Stress Assessment was helpful in confirming the clinical diagnosis, monitoring her progress, appropriate dosage estimates and medications were made, side effects of treatment when appeared. After a year of treatment the patient's temper complaints and problems resolved except for exercise induced asthma.
>
> The patient's resolution of problems are the best confirmation of the accuracy of diagnosis and appropriateness of treatment.

(Resp. Ex. F at 4)

Patient 5

93. Patient 5 was a 24-year-old man at the time he first presented to Dr. Everhart on February 4, 2019. He was 5'10" tall and weighed 148 pounds. (Tr. at 88-89; St. Ex. 5 at 36-37) Dr. Everhart's notes show the following summary of this patient's history of present illness:

> **HOPI**: Patient presents for further evaluation of increased sinus problems since fall of 2018. He does have a history of black mold exposure. He also has had a lot of exposure to tick bites. He had been to minute clinics and has had Levaquin. He complains of right TMJ pain for the last six months. Several years ago he had a headache that lasted for a month. He works overtime and is going to school two nights per week. He likes to sing and play guitar.

(St. Ex. 5 at 36)

94. Dr. Everhart's notes of this patient's examination show no remarkable findings. (St. Ex. 5 at 37) He documented his impressions, consisting of chronic sinusitis, acute mold

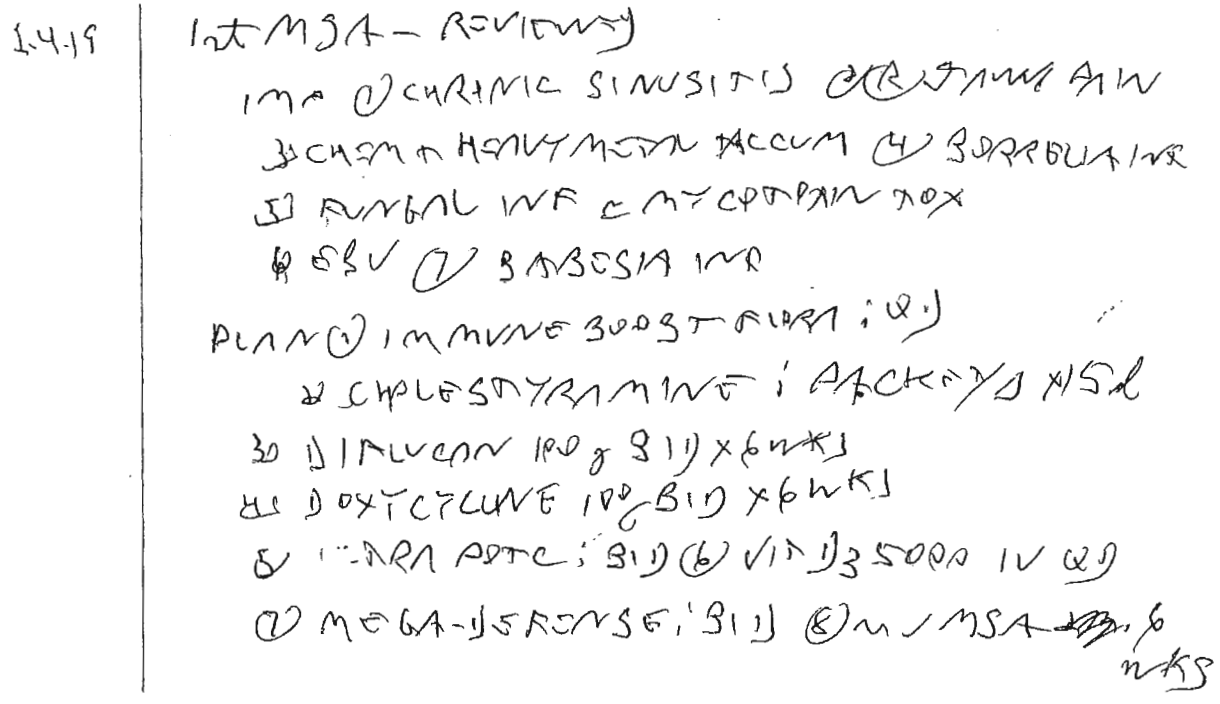
exposure, and joint pain (TMJ), as well as his treatment plan, which included an MSA test:

IMPRESSION:
1. Chronic sinusitis
2. Acute mold exposure
3. Joint pains, especially right TMJ

PLAN:
1. Lab evaluation.
2. MSA testing.

(St. Ex. 5 at 37; Tr. at 90)

95. Dr. Everhart ordered standard blood work with a complete blood count, lipid panel, and liver and kidney function tests. The results of the testing done on blood collected at the initial visit appear in the patient's chart. (St. Ex. 5 at 8-9) At the initial visit, Patient 5 also signed a release and had the MSA test. The printout from that test and Dr. Everhart's notes of his review of it also appear in Patient 5's record. (St. Ex. 5 at 26-34) Dr. Everhart recorded his impressions of Patient 5's diagnosis, as well as the medications and supplements he was prescribing for him in this patient's chart:



(St. Ex. 5 at 14)

96. In his testimony at the hearing, Dr. Everhart acknowledged that he diagnosed Patient 5 at his initial visit with chronic sinusitis, right jaw pain, chemical and heavy metal accumulation, Borrelia or Lyme disease, a fungal mycotoxin infection, Epstein-Barr Virus, and Babesia. (Tr. at 90-91; St. Ex. 5 at 14)

97. Dr. Everhart testified that he did not do a culture on the patient's sinuses or to confirm the sinusitis diagnosis, explaining, "Fungal cultures take two to four weeks to come out, and I think frequently are negative when there's something there. So they can be very frustrating and ineffective to deal with." (Tr. at 92-93) He stated that he did not believe any other testing was necessary, adding, "[H]e gave a history of black mold exposure. So he had been exposed to that environmentally. So his history was strongly suggestive that that was a factor with his chronic sinusitis." (Tr. at 93)

98. For the fungal mycotoxin infection, Dr. Everhart prescribed cholestyramine, a medication that he said was useful in removing mycotoxins in a patient's body, as suggested by the results of the MSA test:

> So certain mold, if they're in your system, put out chemicals that stick to tissues, and you won't see them in blood tests. This is a nice indirect way to get an idea that they're there.
>
> The cholestyramine -- Richard Shoemaker, Ritchie Shoemaker, has written a book about that. So the cholestyramine will pull the mycotoxins out of the system but it's important to treat the mold conditions so they don't keep forming mycotoxins that stay in the body. So mycotoxins can be very toxic.
>
> Q. [By Mr. Wilcox] The MSA machine came up with that analysis?
>
> A. It indicated the homeopathic treatment for that would be -- for those mycotoxins would be effective. I've found that the cholestyramine approach is more effective than the homeopathic approach or other approaches.

(Tr. at 91-92)

99. Patient 5's records indicate that Dr. Everhart also prescribed doxycycline 100 mg., an antibiotic to be taken twice a day for six weeks; and Diflucan 100 mg., and anti-fungal, to be taken twice a day for six weeks, as well as several supplements. (St. Ex. 5 at 25, 34-35; Tr. at 92)

100. With respect to his diagnosis of Babesia in this patient, Dr. Everhart testified that he was treating this patient for Lyme disease, and the related parasitic infection of Babesia. He

agreed that he ordered no other blood panels for Patient 5 except for the standard blood work that would be ordered for any patient. (Tr. at 93-94) He again explained that he believed a blood test would only show a negative result for Lyme that could not be trusted, stating, "I don't know that you should be expected to do panels that are going to be false negatives. So I don't think that should be expected." (Tr at 94)

101. Dr. Everhart also prescribed several supplements for Patient 5, including Megadefense, a zeolite preparation that he said would remove heavy metals that had accumulated in the patient's body. (Tr. at 93-95; St. Ex. 5 at 14) For this diagnosis, Dr. Everhart once again testified that he used the results of the MSA test, in combination with what he knew about the patient from his initial visit:

> Q. [By Mr. Wilcox] How does the MSA know that this person has exposure to metals or toxins, or heavy metal exposure in their blood?
>
> A. Again, it suggests a homeopathic remedy for those. The history that confirms that is he's working as an electrician. He does some soldering. And with his exposure to doing that, you heat up metals that you're trying to connect, they come into a gaseous form and they're easy to get into your system. So people that do that for a living are at high risk for having those problems. * * * I don't think the machine does know it. It suggests a homeopathic remedy might be helpful. Combined with his history of what he does for a living, what he's exposed to, I make the decision and the diagnosis in this case.

(Tr. at 94-95)

102. Patient 5 returned for two more MSA tests, conducted on March 26, 2019 and May 21, 2019, which ultimately resulted in the patient being prescribed Ceftin 250 mg. and Biaxin 250 mg., both antibiotics; and mebendazole 100 mg., an anti-parasitic, with all three of those medications added for 60 days. (St. Ex. 5 at 15-18, 20-24)

103. During his testimony at the hearing, Dr. Everhart agreed that a physician who prescribes antibiotics must do so cautiously and watch for any potential problems, such as abnormalities in the gastrointestinal tract. He stated that he tries to recommend probiotics to all of his patients to help avoid such problems, and he advises his patients to notify his office if they see any GI tract abnormalities. (Tr. at 97-98)

104. When he was asked why his patients take the MSA test, at a cost of $350 for the initial test, instead of other tests that could be used to diagnose the conditions he found in Patients 1-10, Dr. Everhart suggested that it is a relatively cost-effective way to screen for certain conditions that are unlikely to show up on any other kind of test:

> The reason to do it is because it gives information that I think is hard to find any other way. For instance, mycotoxins will never show up on a blood test. Heavy metals are tissue-bound. They'll never show up on a blood test.
>
> So from a standpoint of why, as you put it, put somebody through that, it gives you a lot of information that's very cost effective compared to looking at other ways and not coming up with the true answers.

(Tr. at 95-96)

Dr. Taylor's Report on Patient 5's Medical Treatment

105. Dr. Taylor prepared a report that summarized his conclusions about Patient 5's medical treatment from Dr. Everhart:

> The patient was previously treated for sinusitis and came to Dr. Everhart for further treatment of his chronic sinusitis, treatment of mold exposure and right sided temporomandibular joint dysfunction. Labs were done and MSA testing. Conventional labs were remarkable for an elevated cholesterol. MSA testing, short for Meridian Stress Assessment involved using the meridians of acupuncture with an electrical device that was used by Dr. Everhart to diagnose disease and guide treatment choices. Apparently MSA testing has FDA 510(k) clearance (which is not the same as FDA approval). Clearance was given by the FDA for biofeedback or for measuring electrical resistance of the skin only. Dr. Everhart's use of the machine for diagnosis was therefore not approved by the FDA. There is no scientific evidence that validates the use of bio meridian testing for diagnosis of disease. His release form for MSA states that "The equipment utilized is non-diagnostic in nature." My review of this patient's chart however revealed that Dr. Everhart relied heavily on the results of frequent MSA measurements to guide treatment of this patient's complaints. The diagnoses rendered by the machine are the same as his diagnoses included in the chart notes. He goes on to say that "This procedure is approved by the FDA for evaluation of functional health and will help the doctor determine what medicines or nutritional supplements will be needed to address your specific health needs." Both of these statements in the release form are misleading and not true.
>
> Dr. Everhart prescribed the following medications on the basis of MSA testing[:] Mebendazole (an antiparasitic drug). 100 mg twice a day was prescribed from the post MSA visit in January 2019 until the last note on 6/21/2019. The longest dosing recommendation that I could find in the literature recommended for this drug for a maximum of one month at that

dosage. Amoxicillin, Biaxin, Doxycycline, Azithromycin, and Ceftin and Vibramycin (antibiotics) were given for most of the time that the patient was seen by Dr. Everhart. Mebendazole and antibiotics were continued even though the patient complained of stomach upset from Doxycycline after 4 months of continuous antibiotic treatment. The patient did get some relief of his chronic sinus congestion but stated that he had recently purchased an air purifier.

Ongoing black mold exposure is addressed separately in the record. Avoidance of further exposure to mold and glucocorticoids if needed is the standard of care for mold exposure if severe enough to cause hypersensitivity pneumonitis. The record states that the patient had moved out of the basement by the second month of treatment. Dr. Everhart treated the patient with the antifungal drug, Diflucan, for at least two months for fungal sinusitis/pneumonitis.

Dr. Everhart also diagnosed Babesia with the MSA machine. Babesia, a parasitic infection, can only be confirmed by microscopy or polymerase chain reaction. Treatment is only warranted for patients with symptoms of the disease. Antibiotics should not be given to patients who are asymptomatic. The patient did not have symptoms of Babesia. If Dr. Everhart thought that the patient did have this disease, he did not try to confirm it with microscopy or PCR testing. The chart also lists a diagnosis of Lyme disease. No testing other than MSA is provided to confirm this diagnosis as well.

* * *

The following is my expert opinion to a reasonable degree of medical certainty: that Dr. Everhart violated Sections 4731.22(B)(2) and 4731.22(B)(6), Ohio Revised Code, in his care of this patient. He overprescribed antibiotics. He used the antiparasitic drug Mebendazole for 5 months to treat the patient which is too long for any parasitic infection. Treatment of an unconfirmed diagnosis of Lyme disease with multiple broad spectrum antibiotics for 5 months was inappropriate. Treatment of unresolved chronic sinusitis for longer than 10 weeks with multiple antibiotics was also not supported in the literature. According to the last note on 6/21/19, "There was no significant change in any of the patient's symptoms." Mebendazole and antibiotics, especially doxycycline, may have caused GI side effects. These drugs were continued despite the side effects. An air purifier purchased by the patient did give him some symptom relief.

Dr. Everhart misrepresented the MSA testing that he used almost exclusively to guide treatment as FDA approved. He indicated in the release form for the use of the Meridian Stress Assessments that the

> noninvasive MSA testing was not being used for diagnosis. The record says otherwise.
>
> Diflucan was used to treat chronic black mold exposure. There is no evidence in the literature that this course of treatment was appropriate for black mold exposure.
>
> The patient presented with symptoms of temporomandibular joint dysfunction (TMJ). No imaging studies were done to further investigate this complaint and no treatment was given that I could find in this brief and frequently illegible record that covers five months of care.
>
> Finally, no attempt is made to properly diagnose and treat this patient's illnesses. No consults were sought for any of the patient's complaints. The patient should have been referred to an ENT physician for treatment of unresponsive chronic sinusitis early in the course of treatment. The useless MSA testing kept the patient coming back for potentially dangerous treatments that were unnecessary and needlessly expensive.

(St. Ex. 12 at 10-11)

Dr. Everhart's Response to Dr. Taylor's Report on Patient 5

106. In his own expert report, Dr. Everhart presented the following response to Dr. Taylor's report:

> This patient was first seen on April 20, 2019. Patient complains of chronic sinus issues, neck pain, jaw pain, and history of multiple tick bites.
>
> The Expert review suggests elevated cholesterol, when in fact cholesterol was normal at 192 with a good cholesterol HDL ratio at 3.6.
>
> In response to the Expert's opinion of treatment of aspergillosis. It was best treated with anti-fungal medication. Steroids tend to prolong the illness and sometimes turn it into a more chronic condition.
>
> Clinical presentation of the patient, supports the diagnosis of babesiosis and Lyme disease and he was appropriately treated. The patient is the best witness to the appropriateness and success of my care, as he returned to normal function.

(Resp. Ex. F at 5)

Patient 6

107. Dr. Everhart's care of Patient 6 was not specifically discussed in the testimony at the hearing, but was reviewed in the expert reports submitted by Dr. Taylor and Dr. Everhart.

Dr. Taylor's Report of Patient 6's Medical Treatment

108. Dr. Taylor prepared a report that summarized his conclusions about Patient 6's medical treatment from Dr. Everhart:

> Dr. Everhart provided 12 years of records for the care of [Patient 6]. She had sinus surgery in 2006 and continued her postsurgical care with him for repeated sinus infections starting in 2007. She did receive consultations from endocrinology at The Ohio University, a dentist about her TMJ and an allergist about immunodeficiency concerns. She did not have immunodeficiency. Dr. Everhart sought consultation early in this patient who had had repeated episodes of sinusitis over more than 20 years. However, by 2014 the doctor had departed from following the consultants' suggestions regarding treatment of her sinusitis. No cultures were found in the record of sinus fluid after those done by the infectious disease consultant in 2009. Treatment of frequent sinus infections continued through the last visit recorded for this patient in June of 2019. The patient had bacteria in the sinus secretions that were resistant to Penicillin in 2009 but Dr. Everhart continued to treat her sinus infections with Amoxicillin and Augmentin for the last 6 years of her chart history. Treatment failure with treatment of resistant organisms with a penicillin derivative should have been anticipated and the patient should have been cultured again. The recommendation was for specialty care follow up for her nasal symptoms in August of 2010 by the allergist.
>
> Even though it is almost impossible to follow the record notes provided in a chronological order, it is clear that rather than follow the treatment suggestions given to him by the consultants regarding treatment of the patient's chronic sinus symptoms, Dr. Everhart proceeded with her care on the basis of frequent MSA testing. That testing which is not FDA approved for diagnosing illness was used to guide treatment of most of the patients' complaints. Antibiotics were over prescribed. No reason for this was identified in the record. Antiparasitic drugs and antifungal drugs were also prescribed throughout the treatment period for diagnoses made with the MSA machine. Lyme disease, fungal infections and parasitic infections were treated but never confirmed by standard laboratory investigation.

The patient was seen by a gastroenterologist on February 23, 2017 for her heartburn and omeprazole was recommended and follow up upper endoscopy if no better after 7-10 days. The GI consultant believed that her complaints could have been due to a virus or Candida. She was also seen by the endocrinologist for her hair loss and thyroid nodule.

Chart number 5 includes the most recent care given by Dr. Everhart in 2018 and 2019. The patient continued to complain of gastritis, upper respiratory symptoms and fatigue. Multiple broad spectrum antibiotics continued to be prescribed to this patient so it appears from the record that the MSA machine diagnoses and suggested treatment was heeded by the physician rather than consultations based on the standard of care. Dr. Everhart's polypharmacy even extended to treatment of straightforward skin infections. Amoxicillin, Biaxin, Ceftin and Diflucan were given to this patient for a puncture wound of her thumb from an accident with scissors in May of 2019. The first three drugs are broad spectrum antibiotics and any one of them could cover a skin infection. The last is an antifungal medication and never used to treat a skin infection unless clearly indicated by culturing the wound.

He also treated the patient for Lyme disease on the basis of a positive MSA test (an unproven testing method for confirmation of chronic Lyme disease). The patient eventually developed side GI effects from the long list of antibiotics used and the herbal supplements used throughout her care. Mebendazole was continued much longer than needed for treatment of suspected parasites and probably contributed to her GI complaints.

Much of the information in the chart is written by hand and illegible which made a comprehensive review of the chart almost impossible. Dr. Everhart did seek consultation from gastroenterology who followed up with abdominal imaging studies and an upper endoscopy and colonoscopy. The patient was treated for a positive breath test, which indicated GI bacterial overgrowth, with Xifaxin.

* * *

The following is my expert opinion to a reasonable degree of medical certainty: that Dr. Everhart violated Sections 4731.22(B)(2) and 4731.22(B)(6), Ohio Revised Code, in his care of this patient. He overprescribed antibiotics to this patient for Chronic Lyme disease diagnosed by MSA testing. On going treatment after the first month with antibiotics has not been shown to improve symptoms or have any effect on the disease. He treated the patient for Babesiosis on the basis of results of Meridian Stress Assessment, an unproven electrodermal diagnostic device that cannot diagnose GI disease according to the literature. The use of the

> antiparasitic drug, Mebendazole was not appropriate for this patient with unproven parasitic GI worm disease.
>
> Consultations and medications prescribed for this patient were appropriate during the first 3-4 years of treatment by Dr. Everhart for chronic sinusitis, TMJ and fatigue. He did not seek consultations for the last 6 years of her care for repeated sinus infections, which was her most frequent complaint. Multiple broad spectrum antibiotics continued to be prescribed for each episode of sinusitis on the basis of results of MSA electrodermal testing. Infectious disease should have been asked to become involved again to help the physician find appropriate antibiotics to treat her chronic sinusitis which had become resistant to multiple antibiotics at least a decade before.

(St. Ex. 12 at 12-13)

Dr. Everhart's Response to Dr. Taylor's Report on Patient 6

109. In his own expert report, Dr. Everhart presented the following response to Dr. Taylor's report:

> This patient has been under my care since 2007 for chronic sinusitis, otitis, thyroid nodule, fatigue, and aortic valve disease with aortic regurgitation as seen on echo. She has a tendency towards recurrent strep infections.
>
> She has been aggressively treated for bacterial infections, because in my opinion the risk of post strep heart valve complications out weigh the risk of antibiotic treatment.
>
> She has had no clinical progression of aortic valve disease over the last thirteen years.

(Resp. Ex. F at 6)

Patient 7

110. Dr. Everhart's care of Patient 7 was not specifically discussed in the testimony at the hearing, but was reviewed in the expert reports submitted by Dr. Taylor and Dr. Everhart.

Dr. Taylor's Report on Patient 7's Medical Treatment

111. Dr. Everhart's written report offered the following response to Dr. Taylor's opinions about his care of Patient 7:

This patient was seen for diabetes, and labs revealed an elevated blood sugar and A1c treated with Lantus insulin and Metformin. An elevated PSA (prostate specific antigen) which is a screening test for prostate cancer and prostate enlargement, was followed for 3 years and then the patient was referred to urology. The PSA had risen to 10.6 before referral to the urologist. The upper limit of normal for most labs is 4.0. Antibiotics were prescribed when the first elevation was recorded.

Labs were done frequently to follow the patient's blood sugars, PSA, and elevated cholesterol. A GI consultation was done by Ohio Digestive Care on 8/31/18 for GI complaints. The upper endoscopy was positive for gastritis but negative for H. pylori stomach bacteria. The biopsies were benign.

Lyme disease was diagnosed by the MSA machine (Meridian Stress Assessment) (not approved by the FDA) as well as Epstein Barr Virus infection and H. pylori gastritis. No laboratory confirmation of any of these diagnoses is included in the chart. Frequent visits for MSA (Meridian Stress Assessment) was justification for dispensing multiple antibiotics and supplements. The second chart has 68 pages of charges for medications and supplements dispenses by Dr. Everhart in 2019. I could not tell from the chart notes what Dr. Everhart was treating and why.

* * *

The following is my expert opinion to a reasonable degree of medical certainty: that Dr. Everhart violated Sections 4731.22(B)(2) and 4731.22(B)(6), Ohio Revised Code, in his care of this patient.

The elevated PSA should have been addressed at least two years earlier than it was. Antibiotics is not the standard of care for treatment of an elevated PSA. It seems that the delay in referral was due to a trial of therapy with antibiotics and other drugs and supplements. Referral for a digital rectal exam or documentation of a digital rectal exam by Dr. Everhart should have been included in the chart. The patient needed a prostate biopsy by urology in 2015 not 2017.

Over prescribed antibiotics and polypharmacy with unnecessary supplements was not consistent with the standard of care. Treatment of unsubstantiated parasitic and fungal infections was of no documented benefit to the patient.

Finally, legible chart notes have become the standard of care in the age of the electronic medical record. It is impossible to tell what Dr. Everhart was treating and why in this record because the notes are so poorly written and frequently out of sequence.

(St. Ex. 12 at 14-15)

Dr. Everhart's Response to Dr. Taylor's Report on Patient 7

112. Dr. Everhart's written report offered the following response to Dr. Taylor's opinions about his care of Patient 7:

> This patient first presented to me in 2015 with a history of multiple bug bites and concerned about possible Lyme disease based on symptoms of back pain, neck pain and neurological symptoms.
>
> Initial lab by his primary care physician at that time showed a PSA of 6.0. He was evaluated with the Meridian Stress Assessment was found to have Lyme complex disease and prostatitis.
>
> A follow up PSA in December of 2015 was 4.7. In 2017 PSA was 9.1. Based on PSA variation patient was treated for prostatitis, a follow up PSA in October of 2017 was 10.6.
>
> Patient was referred to a urologist at that time treated him for prostatitis with a thirty day course of Cipro. He has been treated for prostate cancer. In retrospect, a prostate biopsy should of [*sic*] been done earlier. Based on the variable PSA, the urologist and I definitively felt the elevation of the PSA was related to infectious process, and the patient was not eager to proceed with the biopsy.

(Resp. Ex. F at 7)

Patient 8

113. Patient 8 was a 34-year-old man at the time he first presented to Dr. Everhart on January 14, 2019, after being hospitalized at The Ohio State University with significant medical issues, which continued during his treatment with Dr. Everhart. (Tr. at 99-100; St. Ex. 8 at 63-64) Dr. Everhart's notes show the following summary of this patient's history of present illness, after examining him:

> **HOPI**: Patient presents for further evaluation. He was diagnosed with lyme disease in the fall. He has a five-year history of chronic fatigue and recurrent skin issues. He has had GI symptoms with constipation two years ago and had surgery for scar tissue. He may have bowel movements for three days in a row, then none for a better part of the week. He has muddled thoughts. He is aware of decreased cognition. He has lost forty pounds. He has a GI tube and indwelling IV port for hydration. He has had the port since March of 2018. He had a twenty pound weight loss in July. He has had swelling of his joints, ankles and toes for the last five months. He gets infections easily. He was never sick before five years

> ago. He has a positive Lyme antibody test and positive western blot. He follows with Dr. Amy Rushing of OSU surgery department, which is managing the GI and the port. A typical day of food is cheese and crackers in the morning, organic waffle, or may have half a turkey sandwich. He is not sure of his blood type. He tries to get 2000 calories a day in. Dinner he may have chicken, potatoes, carrots or rice, ground meat.

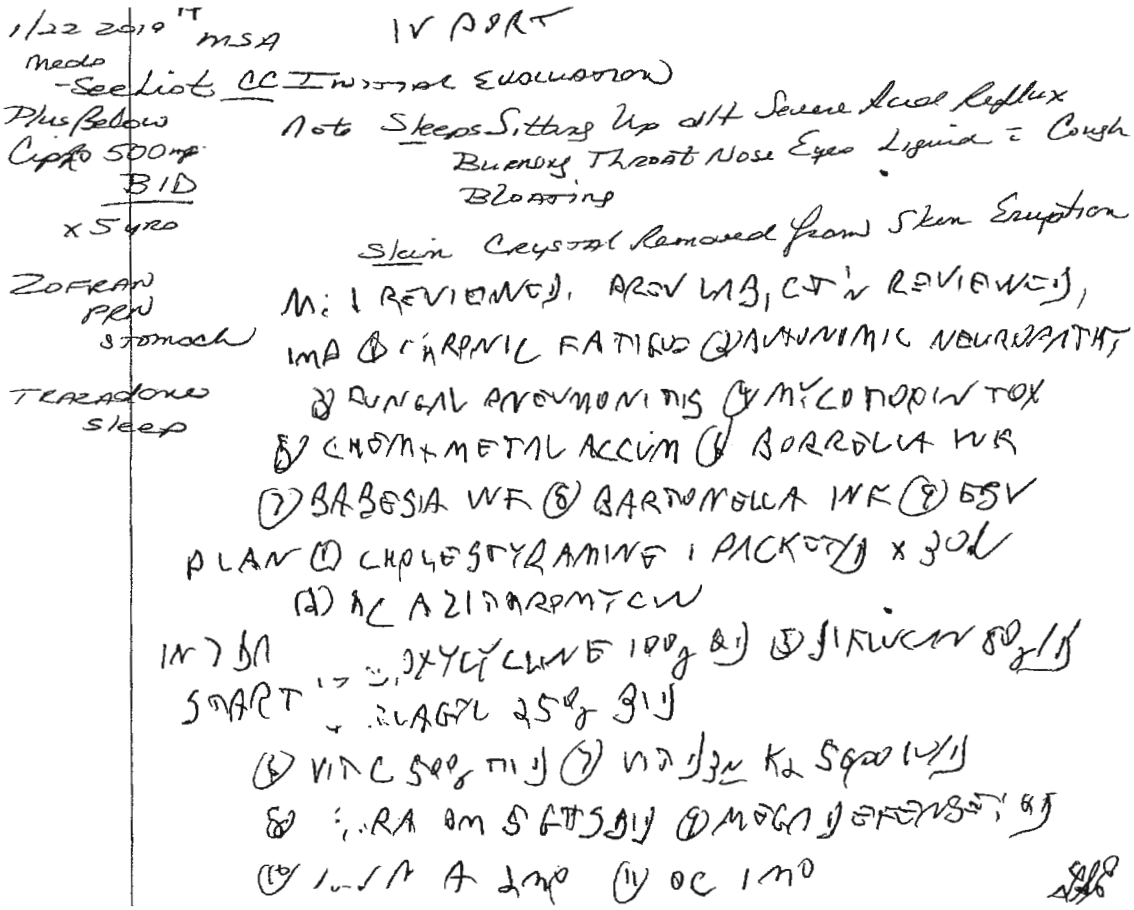
(St. Ex. 8 at 63)

114. Dr. Everhart documented his impressions of this patient's conditions, which included chronic Lyme disease and chronic fatigue, and he documented his treatment plan, which called for an MSA test and a review of lab work the patient had already had through his other physician:

> **IMPRESSION**:
> 1. Chronic Lyme disease
> 2. Chronic fatigue
> 3. Joint pains
> 4. GI issues
> 5. Weight loss
> 6. Cognitive changes
>
> **PLAN**:
> 1. Review previous lab.
> 2. MSA testing.

(St. Ex. 8 at 64; Tr. at 90)

115. Patient 8 returned to Dr. Everhart's office about a week after his initial visit for his first MSA test. He signed the release on January 22, 2019 and had the test that same day. (St. Ex. 8 at 53-61) Dr. Everhart reviewed the MSA results along with his previous lab work and CT scans, and made multiple diagnoses. Dr. Everhart recorded his impressions of Patient 8's diagnoses, as well as the medications and supplements he was prescribing for him in this patient's chart:



(St. Ex. 8 at 32)

116. At the hearing, Dr. Everhart testified that those diagnoses included chronic fatigue, autonomic neuropathy, fungal pneumonitis, mycotoxin toxicity, chemical and metal accumulation, Lyme disease/Borrelia infection, Bartonella infection, and Epstein-Barr Virus. He testified that he started the patient on cholestyramine to eliminate mycotoxins, and he discontinued azithromycin that the patient was taking for the treatment of Lyme disease because he does not believe that is an adequate treatment for the disease. He also prescribed two other antibiotics for Patient 8, including doxycycline 100 mg., and Flagyl 250 mg., and an antifungal medication, Diflucan, 80 mg. (Tr. at 101-103, 106, 149-150; St. Ex. 8 at 52)

117. Dr. Everhart testified that he treated Patient 8 for mycotoxins, which he explained as follows:

> Mycotoxins are chemicals that yeast put out in the vicinity where the infection is, that attach to tissue. They tend to be tightly tissue-bound. And for a lot of people, unless you do something to clean those out of the

> system, they remain up there indefinitely even after you've cleaned up the yeast infection.

(Tr. at 149)

118. When Dr. Everhart was asked how he reached the diagnosis of fungal pneumonitis, he stated, "[O]n physical – or, history, he had a chronic cough. He had – on the MSA he had, again, homeopathic signals for mycotoxins and for mold." (Tr. at 103) Dr. Everhart added that he looked at CT scans from Ohio State that Patient 8 showed him on his phone, and that he asked for a paper copy, but never got one. (Tr. at 103-105) He also referred to the impressions of a CT PE study, which noted "diffuse nodular opacities throughout the bilateral lungs in addition to centrilobular nodules is favored to represent an infectious/inflammatory process such as atypical pneumonia," and recommended additional imaging in 4-6 weeks to assess the condition for resolution. (St. Ex. 8 at 14; Tr. at 104) Dr. Everhart said that there was a previous study, which showed "some infiltrative process which was also suggestive of fungal disease or an infectious disease process of some kind." (Tr. at 104)

119. Dr. Everhart testified that the best way to eliminate the mycotoxins is with the use of cholestyramine, which he also prescribed for this patient:

> [C]holestyramine is a bile resin binding thing. And it's approved for cholesterol lowering, but it pulls bile out of the liver. And I don't completely understand this, I know it works and it's been documented, and I mentioned Ritchie Shoemaker wrote a book about it.
>
> And we, to my satisfaction, proved it works. Indirectly -- pulling the bile out of the liver somehow indirectly, again I don't completely understand the process, but it will rid the system of those mycotoxins. And I don't know any better way to do it.

(Tr. at 149-150)

120. Dr. Everhart explained that he opted to treat the patient's Lyme disease with doxycycline, instead of azithromycin, adding that this patient had been previously diagnosed with that condition in the fall of 2018, before presenting to his office. However, he acknowledged that he did not have any records to show that Patient 8 had been diagnosed with Lyme disease, but was relying on what the patient told him. (Tr. at 105-107) Dr. Everhart stated that he did not believe that azithromycin therapy was a standard treatment for Lyme disease in Ohio, and that this was not only his opinion, but the opinion of "all practitioners [he] cross[es] paths with." (Tr. at 106-107) However, when he was asked which other practitioners he consults with concerning Lyme disease in Ohio, Dr. Everhart named no one, and admitted that many practitioners do not believe the disease even exists in Ohio:

> Q. [By Mr. Wilcox] Who are some of the physicians that you consult with regarding Lyme disease in Ohio?
>
> A. Well, that's a problem because, for the most part, the infectious disease community for a long time has denied the existence of Lyme disease. Some have even said it doesn't exist in Ohio. Most recently, the Cleveland Clinic said there is no Lyme disease. Most recently they say we don't treat chronic Lyme disease.
>
> So there's been an evolution over the last, I don't know, five to ten years as far as awareness of Lyme disease. And it's slowly being accepted as an entity, but it's been a problem for a lot more than the five or ten years that it's been accepted.

(Tr. at 107)

121. Patient 8 returned to Dr. Everhart's office for another MSA test on March 18, 2019, and after reviewing those results, Dr. Everhart continued the patient's prescriptions for doxycycline, Diflucan, and cholestyramine, as well as several supplements that he recommended. Patient 8 had an additional MSA test in May 2019, after which mebendazole 100 mg., was prescribed, and yet another MSA test occurred in July 2019, in which the mebendazole was continued, and antibiotics Ceftin 250 mg. and Biaxin 250 mg were added. (St. Ex. 8 at 25, 28-30)

122. Dr. Everhart agreed on cross-examination that he did not order any blood cultures or microscopic analyses of Patient 8's blood before reaching his diagnoses of the Bartonella and Babesia infections, and Lyme disease. (Tr. at 108-109) With respect to the test for Bartonella, which he stated was previously called "cat scratch fever," Dr. Everhart stated, "It's another one of those that is very hard to diagnose." (Tr. at 108) He stated that he took the patient's word for the fact that he had a positive western blot test for Lyme disease, and did not order a titer, even though he did not get any additional information to confirm the earlier diagnosis. Dr. Everhart likewise acknowledged that he prescribed mebendazole to treat the diagnosis of Babesiosis, without ordering any microscopic blood tests to confirm the diagnosis. (Tr. at 109)

Dr. Taylor's Report on Patient 8's Medical Treatment

123. Dr. Taylor prepared a report that summarized his conclusions about Patient 8's medical treatment from Dr. Everhart:

> The patient was seen by Dr. Everhart for further evaluation of his previously diagnosed Lyme disease, and a 5 year history of chronic fatigue. He also had a gastric feeding tube for reasons that are not

explained, weight loss and decreased cognition. The G tube was taken care of by the OSU surgery department. His medications included Trazodone at night for sleep, Adderall twice a day, Azithromycin, Acyclovir, prednisone and IV hydration. He was allergic to Monocycline and Doxycycline according to Dr. Everhart's initial note on 1/14/19. The patient was allergic to Doxycycline and he was given the drug repeatedly over a 4 month period in response to MSA testing which identified it as appropriate for treatment of his ongoing Lyme disease. No cultures of anything were ever done according to the physician's in house records. The elevated alkaline phosphatase and liver enzymes while on this drug may have been an allergic side effect. To the doctor's credit he did stop Diflucan, Biaxin and Mebendazole. Ceftin was held and labs were ordered to be repeated in 3 weeks and blood cultures. I cannot tell if Doxycycline as well was stopped when the alkaline phosphatase (indication of potential liver toxicity) was even higher after 3 weeks. No hepatology consult was included in the record for this extremely complicated patient after this marked elevation in liver function tests.

On March 18, 2019 the patient was thought to have Mycotoxin toxicity, Heavy metal toxicity and Epstein Barr Virus according to the MSA (Meridian Stress Assessment) results that were done every two months. Doxycycline and Diflucan were given to treat the problem. Two months later the patient was diagnosed with Babesiosis and Lyme disease by the MSA machine. More antibiotic treatment with multiple broad spectrum antibiotics followed for Lyme disease and Mebendazole for Babesiosis. By the last note entry on 7/1/19 the patient is on most of the medications that he was on when Dr. Everhart started seeing him in January of 2019. Ceftin 250 mg was continued to treat one of the diagnosed illnesses by the MSA machine. The notes do not reflect what was being treated. Prednisone was increased to 30 mg a day for lung spots. Multiple vitamins and supplements were added to the list of medications. There are no notes that indicate improvement in any of the patient's symptoms after all of the treatment provided by Dr. Everhart.

* * *

The following is my expert opinion to a reasonable degree of medical certainty: that Dr. Everhart violated Sections 4731.22(B)(2) and 4731.22(B)(6), Ohio Revised Code in his care of this patient. The patient was diagnosed and treated on the basis of an unproven diagnostic device, Meridian Stress Assessment. None of the drugs prescribed were supported by any other diagnostic evidence. No lab tests were done to confirm the diagnosis of chronic Lyme disease infection by Dr. Everhart. He stated that the patient had the diagnosis according to the previous physician's chart but no evidence confirming a positive Western Blot test was included in the chart notes.

> Misdiagnosis is inevitable if unproven diagnostic tools are used to make diagnoses and govern treatment decisions. It was extremely important for Dr. Everhart to seek consultation at some point during the six months that he treated this very sick patient. His polypharmacy with multiple antibiotics, mebendazole, vitamins and other supplements did not improve the patient's symptoms according to the chart notes.
>
> Dr. Everhart treated the patient with Doxycycline. He was allergic to Doxycycline and Monocycline. Among the potential side effects of an allergy to Doxycycline is liver toxicity. This antibiotic may have been responsible therefore for rising liver values (alkaline phosphatase, bilirubin, ALT and AST) on 5/7/19 and for further increases in those values over the next three weeks. I believe that Dr. Everhart eventually realized the need to stop this antibiotic because it is not included in the list of medications in his last note. No repeat liver panel, however, was done to prove that the elevated liver values had returned to normal.

(St. Ex. 12 at 16-17)

Dr. Everhart's Response to Dr. Taylor's Report on Patient 8

124. Dr. Everhart's expert report provided the following response to Dr. Taylor's review of his care of Patient 8:

> This patient first presented to me on January 14, 2019 for further evaluation and treatment of Lyme disease. He had been ill for about five years and was previously diagnosed with positive antibody test and positive Western Blot. He complained of muddled thoughts, decrease of cognition and had lost forty pounds. He had both a G-Tube and indwelling IV port, for feeding and hydration.
>
> He was treated for Lyme complex with appropriate antibiotics. On September 9, 2019, he wanted to try Doxycycline for a more effective treatment of his Lyme. He and I were both aware of a history of an allergy, he wanted to try this. He did not tolerate it and it was changed after the third day of trial.
>
> It was a very complicated case under the care of multiple specialists at Ohio State, for his chronic elevation of liver function studies. The ultrasound of the abdomen, did not suggest liver pathology. Cardiac testing showed significant pulmonary hypertension and the liver abnormalities felt to be the passage of congestion to the liver.

> He was followed closely by multiple specialists, including pulmonologist at OSU and cardiologist at Ohio Health during the course of his treatment.

(Resp. Ex. F at 8)

Patient 9

125. Patient 9 was a 27-year old woman at the time she first presented to Dr. Everhart on February 26, 2018. Her medical record maintained by Dr. Everhart indicates that she was 5'9" tall and weighed 139 pounds at that time. (Tr. at 112, 301, 318; St. Ex. 9 at 141-142) Dr. Everhart's notes show the following summary of this patient's history of present illness:

> **HOPI**: Patient complains of chronic digestive issues. She has a family history of chronic GI problems involving her sister and dad. Her sister has done well on a gluten free diet. Patient complains of diarrhea multiple times per day, with a lot of bloating and gas. She may have nausea. She grew up in Centerville near Dayton. She has recurring hives and lesions on her face. She was active in dance and cheerleading. A typical day of food include[s] breakfast an english muffin and banana. Lunch she may have a salad mix with quinoa and a vegetable. Snack she may have a cliff bar. Dinner she may have hello fresh dinners.

(St. Ex. 9 at 141)

126. At the hearing, Patient 9 testified that throughout her life, she had had "just kind of a sensitive stomach." (Tr. at 301) She recalled that in 2018, her fiancé, now her husband, suggested that she go see Dr. Everhart because his sister and his mother had seen him for stomach and allergy problems, and achieved good results. Patient 9 said that up to this time, she had always been very healthy. She took no medications except for a multivitamin and birth control. Her only health concern was what she characterized as a "very minor" stomach issue. (Tr. at 300-302, 321-322) She described this as a "nuisance" that caused diarrhea, requiring her to have frequent bathroom visits on some days, or sometimes having to leave a restaurant. (Tr. at 301-302, 315, 320, 322) However, she denied having vomiting, nausea, or headaches, except for occasional headaches that accompanied carsickness, and she said that her symptoms were not debilitating. The patient said that she had tried probiotics and believed that she was taking them when she first consulted Dr. Everhart. (Tr. at 301, 314-316, 322-323)

127. Patient 9 stated that Dr. Everhart was the first physician she ever saw for this concern, and that she probably would not have seen him if not for the urging of her fiancé, who tended to be more proactive than she was. (Tr. at 321) She described her first visit with Dr. Everhart as "a little odd," but she said that she understood that his practice was non-

traditional. (Tr. at 301) Patient 9 stated that Dr. Everhart's focus was on "toxins and bacteria" in the system and how those affected her digestive tract. (Tr. at 301)

128. Dr. Everhart's physical exam of Patient 9 noted nothing remarkable. He ordered a basic blood panel at the patient's first visit, which showed normal results except that her cholesterol was slightly elevated, though her ratio was acceptable. (Tr. at 113-114; St. Ex. 9 at 156-157) Dr. Everhart documented his impressions of "GI issues," and his formulation of a treatment plan in the notes of the initial office visit:

> **IMPRESSION**:
> 1. GI issues
>
> **PLAN**:
> 1. Lab evaluation
> 2. MSA testing

(St. Ex. 9 at 142; Tr. at 113)

129. A few weeks after her first visit with Dr. Everhart, Patient 9 returned to his office on April 10, 2018 and had an MSA test. The results of that test are contained in her medical record, along with Dr. Everhart's notes of his impressions. (Tr. at 115, 303; St. Ex. 9 at 171-179) The patient described the MSA test as a long, but non-invasive process that involved a probe that was placed between her fingers and toes. (Tr. at 302-303) She recalled that she understood that this test "allowed them to see toxins and bacteria in [her] system that could be throwing off [her] gut health." (Tr. at 303)

130. Patient 9 testified that, aside from the blood work done on the sample collected at her initial visit, Dr. Everhart did not order any tests such as a colonoscopy or a stool analysis. (Tr. at 304-305) She testified that they discussed the MSA test at her first visit, and she had the test done at her second visit. Patient 9 related what Dr. Everhart told her about the benefits of the MSA test:

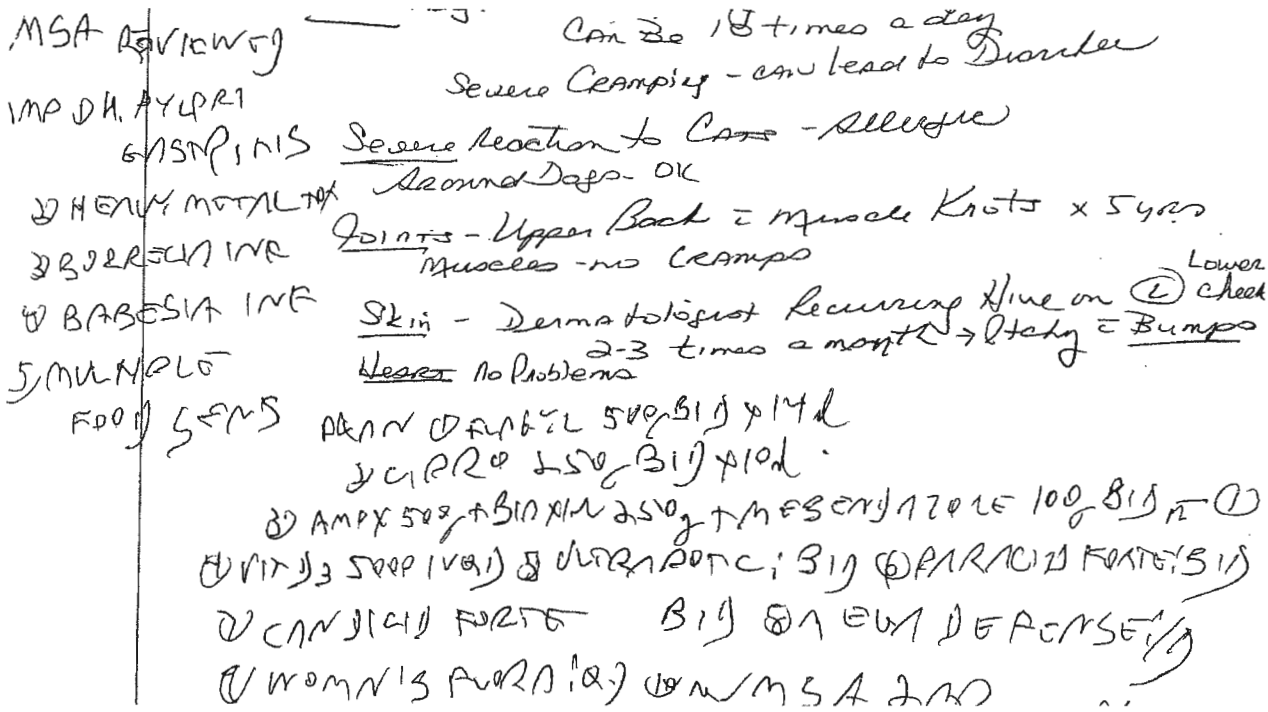
> Q. [By the Hearing Examiner] Do you remember anything that he told you about the benefits of that test, if he told you any such thing?
>
> A. So I feel like he, you know, took a nontraditional approach in that more traditional doctors might not be able to find these metals and bacteria and parasites in your system, and this test can find those and that it can be resolved.
>
> Q. You felt as though he was telling you this test could find toxic metals and parasites in your system.
>
> A. Correct.

> Q. Did it seem to you that Dr. Everhart was using his interview with you and his examination with you as the primary means of diagnosis rather than the MSA test, or did you understand that the MSA test was used to make those diagnoses?
>
> A. To me, it seemed like the MSA test was going to be the primary way of receiving those results.

(Tr. at 333-334)

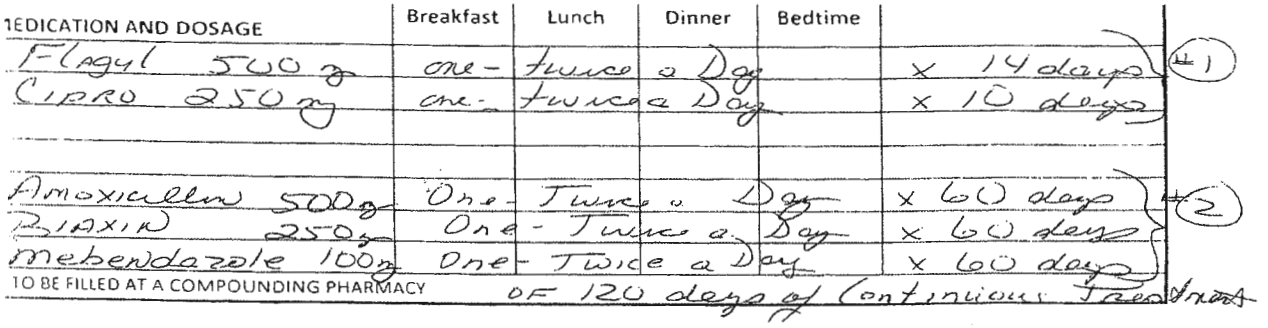
131. After Patient 9 had the MSA test, Dr. Everhart reviewed the results of that test with her. The patient recalled that Dr. Everhart made a handwritten list of the "[t]oxins, bacteria and parasites" that were found. (Tr. at 307) She stated that she took that list away from her appointment, but did not get any other printout of results. (Tr. at 303-304, 334) Patient 9 related that Dr. Everhart told her, "he had found toxins and some bacteria that was in my gut that he believed he could fix with medications and supplements and then maybe I would no longer have those symptoms." (Tr. at 303) She also recalled that there were some heavy metals and a couple different bacteria, one of which was H. pylori, and she stated, "I remember he discussed a lot about that bacteria's life cycle and why it was important to be on medicine for the entire life cycle of the bacteria to remove it." (Tr. at 304)

132. Dr. Everhart's notes of his review of the MSA test and his impressions indicate that he made several diagnoses, including H. pylori gastritis, heavy metal toxicity, Borrelia (Lyme) infection, a Babesia parasitic infection, and multiple food sensitivities. (Tr. at 114-115; St. Ex. 9 at 160) The notes appear as follows in Patient 9's chart, with the notes of the MSA test review in the margin of the office visit notes of her appointments on January 26, 2018 and April 4, 2018:



(St. Ex. 9 at 160)

133. At the patient's second visit on April 4, 2019, Dr. Everhart prescribed multiple medications including four antibiotics and mebendazole, an anti-parasitic drug:



MEDICATION AND DOSAGE	Breakfast	Lunch	Dinner	Bedtime		
Flagyl 500 mg	one	twice	a Day		x 14 days	#1
Cipro 250 mg	one	twice	a Day		x 10 days	
Amoxicillin 500 mg	One	Twice	a Day		x 60 days	#2
Biaxin 250 mg	One	Twice	a Day		x 60 days	
Mebendazole 100 mg	One	Twice	a Day		x 60 days	

TO BE FILLED AT A COMPOUNDING PHARMACY — OF 120 days of Continuous Treatment

(St. Ex. 9 at 146; Tr. at 117)

134. In addition to the prescription medications, Patient 9 testified that Dr. Everhart also recommended "a lot of supplements," which are listed on the same medication page as the drugs listed above. (Tr. at 305; St. Ex. 9 at 146) Dr. Everhart testified that he prescribed the Cipro and Flagyl for Patient 9 to treat "[h]er variety of GI issues she's dealing with." (Tr. at 118)

135. At the hearing, Dr. Everhart testified that he prescribed the amoxicillin, Biaxin, and mebendazole for 60 days each, and he explained, "Those were directed primarily at H. pylori." (Tr. at 119) He said that those three drugs were to be taken after Patient 9 finished the Flaygl and Cipro that were prescribed for the first 60 days, and he stated that the second round of drugs covered "both the H. pylori and Borrelia." (Tr. at 119) When Dr. Everhart was asked how he diagnosed the H. pylori infection in Patient 9, he explained that he based that diagnosis on what the patient told him, as well as the results of her MSA test:

> Q. [By Mr. Wilcox] Okay. Besides the MSA, can you tell us each and every test that you ran to confirm this patient, Patient 9, had H. pylori gastritis?
>
> A. Again, the patient's initial complaint and chronic problems and then the inference from the MSA were used.

(Tr. at 115-116)

136. Dr. Everhart agreed that he did not do a blood test for H. pylori, explaining, "There is none." (Tr. at 116) Dr. Everhart agreed that that breath test for H. pylori "infers" a diagnosis, and when he was asked if it was the standard test that an internal medicine physician would order to confirm the presence of H. pylori, he stated, "Many would." (Tr. at 116) However, he agreed that he did not use a breath test, nor a blood or stool test, nor an endoscopy to confirm the diagnosis he made of an H. pylori infection in Patient 9. (Tr. at 116-117)

137. Patient 9 testified that she began taking the antibiotics after her second appointment with Dr. Everhart, and she recalled, "I was on some type of antibiotic continuously throughout that April to August." (Tr. at 334-335) She stated that she was taking over 20 pills a day, and that she could not get the medications at a regular pharmacy, but had to purchase them from a small compounding pharmacy. (Tr. at 305-306)

138. In addition to the prescribed medications, Patient 9 also began taking various supplements recommended by Dr. Everhart, which she primarily bought at his office. She agreed that she was not required to purchase the supplements, and that they were very costly. (Tr. at 118, 305-306, 327; St. Ex. 9 at 146) She related that despite the cost, she decided to follow the treatment that Dr. Everhart recommended for her:

> I was very hesitant after the first appointment, especially just seeing the cost of the supplements, but he really encouraged me to move forward because he's like even though it's not major health problems, it's something minor that it could really, you know, help out and could be resolved within a year. So I decided to move forward.

(Tr. at 321)

139. When Patient 9 returned to Dr. Everhart's office for her next visit on June 18, 2018, she had another MSA test, and he adjusted her medications. (Tr. at 306; St. Ex. 9 at 165-170) The patient recalled her understanding of the results of the second MSA test:

> So I believe in that June test, like some of those metals were no longer showing up due to the antibiotics but the H. pylori was still present in the system and that's again when he was explaining their life cycle is a lot longer, I forget the specific amount of days, and that you have to be on antibiotics the entire time to truly get rid of that.

(Tr. at 306)

140. Referring to his record of Patient 9's June 18, 2018 office visit, Dr. Everhart testified that he instructed the patient to finish taking the 60 days of Flagyl and Cipro that he prescribed earlier, and then start the Biaxin and Ceftin, taking each of those antibiotics twice a day for 60 days. In addition, he advised her to continue taking the antiparasitic drug, mebendazole, for 60 more days:

MEDICATION AND DOSAGE	Breakfast	Lunch	Dinner	Bedtime	
Complete Current Cycle #2 Meds Before Starting Listed Cycle Below					
Biaxin 250 mg	One-	Twice a Day	x		60 days
Ceftin 250 mg	One-	Twice a Day	x		60 days
mebendazole 100 mg	One-	Twice a Day	x		60 (Last of 120 day Total)

* TO BE FILLED AT A COMPOUNDING PHARMACY

(St. Ex. 9 at 144; Tr. at 119-120)

141. Patient 9 returned to Dr. Everhart's office for the last time on August 14, 2018 and had a third MSA test. (Tr. at 120, 307, 318; St. Ex. 9 at 161-164) At that time, he again adjusted her medications, instructing her to stop taking the Biaxin and mebendazole, and to begin taking Ceftin 500 mg., and Diflucan 100 mg., for 2 months:

MEDICATION AND DOSAGE	Breakfast	Lunch	Dinner	Bedtime	
Ceftin 500g	One	twice	a day		X 2 months
Diflucan 100g	One	twice	a day		
Stop Biaxin + Mebendazole					

(St. Ex. 9 at 143; Tr. at 120)

At the hearing, Dr. Everhart testified that the medications he prescribed for Patient 9 were needed to treat the bacterial and parasitic infections that he had diagnosed. (Tr. at 121) He confirmed that those diagnoses were made on the basis of the patient's presentation in his office, as well as the MSA test:

> Q. [By Mr. Wilcox] And all of these were medications that you prescribed based on what you thought was her presentation to you and what the MSA machine recorded after the test; is that correct?
>
> A. Correct.

(Tr. at 121)

142. Patient 9 testified that in late August 2018, she began having flu-like symptoms including a fever, chills, and diarrhea, but she stated, "I just assumed it was a flu and I would get over it in a few days." (Tr. at 308-309) She recounted that her symptoms started getting better, but then began to worsen quickly. Patient 9 stated that in early September, her co-worker told her she should go home because she did not look well, but that when she began driving herself home, she found she had no energy. She related that she decided to drive to her fiancé's house because it was closer than her own, but that she was so weak by the time she arrived there that she fell on the stairs. Her fiancé found her there, and took her to an urgent care for treatment. (Tr. at 308-309, 313)

143. Patient 9 related that the urgent care physician was shocked by the medications she was taking and suggested that she could have a C. difficile ("C. diff") infection, which required an evaluation at a hospital:

> He was taken aback by the medications I was on. He couldn't believe it. I still remember his face as I was saying it, and I remember feeling embarrassed, telling him this, because it's like why didn't I look more into this.
>
> So he was the first one to say it could potentially be C. diff based on the medication I'm on and the symptoms I'm having, but he said C. diff would be very rare in a healthy 28-year-old, but he's like based on what you have, it's very possible. So he said you need to immediately go to the hospital.

(Tr. at 309)

144. Patient 9 testified that her fiancé drove her to the Emergency Department of Dublin Methodist Hospital, and that the physician there also "couldn't believe the meds [she] was on." (Tr. at 310) That physician agreed that she likely had a C. diff infection, and started her on medications for it before her lab work even came back. She said that the lab work confirmed that diagnosis when it was returned the next day. (Tr. at 309-310) Patient 9 described her experience during her hospital stay:

> I was in the hospital almost four to five days because my temperature would not break. It was over 103. It kept spiking. And they wouldn't even allow me to have water because they feared I would have to go into emergency surgery at any time to remove part of my intestines. So it was very scary and rough.
>
> No one could really visit me because C. diff is really contagious. So everyone coming in, wearing gowns -- now that doesn't sound that crazy because of COVID but at the time it was very scary and knowing I could go into surgery at any time.

(Tr. at 310)

145. Patient 9's records from her hospitalization from September 6-9, 2018 are included with her records of Dr. Everhart's treatment. (St. Ex. 9 at 1-139; Tr. at 313, 323) After she was discharged from the hospital, Patient 9 needed constant care, so she stayed with a relative who cared for her over the next two weeks. She stated that she needed medication to treat the infection, and that her fever at home reached 104 at times. (Tr. at 310-311) She described the long recovery process she went through, even after she returned to work:

> I was off work for a full three weeks. And even when I went back, I had to go back part time just because I didn't have the energy to get through the day. Severe stomach cramping, vomiting at work. So it was a rough transition getting back. So it took weeks to even feel somewhat normal; months to gain back my strength. Not to mention, I mean, the thousands in hospital bills.
>
> And this all happened a couple months before my wedding, so when you look back at photos, I don't even look like myself because I lost 20 pounds throughout the process and I'm not really -- I didn't have weight to lose at the time.

(Tr. at 311)

146. On cross-examination, Patient 9 was asked if she was taking probiotics when she was admitted to the hospital, and she replied, "I was taking everything that Dr. Everhart had

prescribed. So whatever is listed on my record, I would have been taking." (Tr. at 323) She conceded that she did not call Dr. Everhart when she began getting sick in late August 2018, but she stated, "I honestly did not think it was related. I thought I was just getting the common flu." (Tr. at 331)

147. Patient 9 agreed on cross-examination that when she first began treatment with Dr. Everhart, her symptoms improved and her diarrhea was not as frequent, following the first two weeks of antibiotics that he prescribed. (Tr. at 339) However, she said that when she was released from the hospital, she called Dr. Everhart's office to cancel all further treatment, adding, "[A]fter the hospital, I did not want any contact with him." (Tr. at 332)

148. Dr. Everhart testified that he first learned Patient 9 was hospitalized when his office received a call from the hospital, asking for her records on September 6, 2018. Some of her hospital records were reviewed at the hearing, including the diagnosis of sepsis due to C. difficile colitis, with a resulting fever, tachycardia, abdominal pain, and leukocytosis. Her sepsis resolved after she was treated with Vanco[mycin] at the hospital. (Tr. at 121-123, 148; St. Ex. 9 at 20) He agreed that her lab result showed a white blood cell count of 17,000, which represented a "significant infection." (Tr. at 138)

149. On cross-examination, Dr. Everhart agreed that he had been prescribing multiple antibiotics for this 28-year-old patient, and that this is a "potential landmine" when such medications are used that way. (Tr. at 123) Dr. Everhart testified that he did not know of any other patients who developed C. diff infections or were hospitalized, but he agreed that it is a potentially dangerous infection. (Tr. at 124-125) While he stated that Patient 9 initially saw some improvement with the treatment he prescribed, he conceded that the last course of antibiotics he prescribed for her at her August visit may have contributed to the infection that caused her to be hospitalized:

> Q.[By Mr. Wilcox] Is it correct to theorize that the multiple antibiotics that you placed this young patient on had an effect of essentially breaking down her immune system to the point where she developed a serious infection?
>
> A. I think her immune system was actually better on August 14th when she came in. She relates she's feeling good, GI is good, still is getting lesions on her right cheek. Unfortunately, I would directly attribute the C. diff to the combination of things we gave her at that visit, but the previous things that she had been taking had been effective and done what they were supposed to. I don't think her immune system was down because of that. I think she had GI alteration of gut bacteria because of the last course of what I had prescribed for her on August 14th. And she had tolerated everything else before that very well and had improved.

(Tr. at 124-125)

150. When he was re-called to testify after Patient 9's witness testimony, Dr. Everhart said that he was sorry for what this patient had gone through. Dr. Everhart stated that he tries not to use clindamycin, as it is the antibiotic that is statistically most likely to lead to a C. diff infection. He admitted that diarrhea and C. diff infections can happen when patients are taking antibiotics, but he said that he recommends probiotics to minimize that risk, and he always instructs patients to contact his office if they experience any side effects. Dr. Everhart asserted that it was not clear if Patient 9 was taking the probiotics he advised her to take, as her hospital record did not list the probiotics in the list of medications she reported that she was taking. (Tr. at 539-540; St. Ex. 9 at 14-15) He concluded that Patient 9 might have been able to avoid this infection if she had reached out to his office earlier:

> If she had gotten to us early when this started, she mentioned two weeks before she went into the hospital, I certainly think she would not have been septic and I think she would not have required the hospital admission.
>
> I think her symptoms on admission -- or, for the two weeks before that, were not real typical of C. diff colitis so I can understand why she might have tried to treat it herself. She called it a viral illness. But, after two or three days, you should be looking for some help somewhere, better answers, and we certainly would have been available to help with that

(Tr. at 540)

Dr. Taylor's Report on Patient 9's Medical Treatment

151. Dr. Taylor provided the following summary of Dr. Everhart's care of Patient 9:

> The patient was seen for digestive issues including diarrhea, bloating and nausea. There was a family history of gluten sensitivity. Medications included a multivitamin, probiotic and birth control pills. The initial exam was unremarkable and Dr. Everhart proceeded to order labs and do MSA testing short for Meridian Stress Assessment. MSA is an electrodermal screening test that is not approved by the FDA for screening for disease. The cholesterol was elevated but the rest of the standard labs were unremarkable. The physical exam was unremarkable.
>
> The first MSA was positive for H. pylori gastritis, heavy metal toxicity, Lyme disease, Babesia and multiple food allergies. Treatment was started with Flagyl, Cipro, amoxicillin, Biaxin, Mebendazole, Vitamin D and other supplements from

> Dr. Everhart's pharmacy. The medications listed with few exceptions were [reordered] after each MSA test at two month intervals.
>
> He used Herbal tea for a total detox regimen during the first two weeks of therapy and asked her to limit her coffee intake. He asked the patient to eliminate old fish, sushi and unwashed fruit from her diet. No mention is made of a trial on a Gluten free diet before any of the antibiotics, antifungals and antiparasitic drugs or supplements were started. This patient had symptoms consistent with gluten sensitivity and a family history of improvement in GI symptoms (sister) on a Gluten free diet.
>
> * * *
>
> The following is my expert opinion to a reasonable degree of medical certainty: that Dr. Everhart violated Sections 4731.22(B)(2) and 4731.22(B)(6), Ohio Revised Code, in his care of this patient.
>
> A GI consultation might have saved this patient the risk of potential GI side effects from multiple antibiotics used for treatment of her GI symptoms. There is no documentation of consultation by gastroenterology. By the end of her 6 months of treatment her symptoms of abdominal bloating, cramping and diarrhea had subsided but it is impossible to tell what worked to improve her symptoms. Some of the physician's diet changes may have helped but the antibiotics, antifungals and antiparasitic drugs should have never been prescribed for this patient without addressing a possible gluten sensitivity or other causes in the differential. No standard laboratory testing was done to confirm any of the diagnoses. Standard laboratory testing should have been used to confirm a diagnosis of H. pylori bacterial infection. None of these diagnoses could have been made with a Meridian Stress Assessment machine.
>
> Finally, failure to seek appropriate consultation and the practice of polypharmacy violated his oath as a physician, "First Do No Harm."
>
> (St. Ex. 12 at 18-19)

Dr. Everhart's Response to Dr. Taylor's Report on Patient 9

152. Dr. Everhart's expert report provided the following response to Dr. Taylor's review of his care of Patient 9:

> This twenty-seven year old female presented to me on February 26, 2018 with multiple complaints. She complained of chronic digestive issues with bloating, gas and multiple episodes of diarrhea, sometimes up to ten times per a day. She also had intermittent nausea, fairly recurrent hives and lesions on her face. In addition she had a fifteen year history of headaches, and had two seizures at age ten. She complained of muscle

> knotting in her upper back for five years. She had seen a dermatologist without resolution of her recurring skin problems.
>
> Lab evaluation was within normal limits, but lymphocytes predominance was suggested. Clinical presentation and Meridien Stress Assessment suggested multiple organisms as the cause of her GI symptoms.
>
> She was treated appropriately with resolution of bloating, acid reflux, diarrhea and intestinal cramping. Intermittent appearance of hives resolved.

(Resp. Ex. F at 9)

Patient 10

153. Dr. Everhart's care of Patient 10 was not specifically discussed in the testimony at the hearing, but was reviewed in the expert reports submitted by Dr. Taylor and Dr. Everhart.

Dr. Taylor's Report of Patient 10's Medical Treatment

154. Dr. Taylor's report summarized Dr. Everhart's care of Patient 10, and stated his opinions of that care:

> This patient was seen in 2005 for Parkinson's disease and eventually started on chelation therapy for Mercury toxicity from amalgam tooth fillings after the patient had the fillings removed. He was given chelation therapy for more than five years each week [*sic*]. According to the record, the patient did have improvement in hand tremors with this treatment and other supplements. He was followed by the neurology department at The Ohio State University for Parkinson's. No updates on the patient's progress were included from OSU. Lab values were followed during the period from 2005 through 2011 and consults were requested frequently. The MSA machine was used extensively during this period as well to make diagnoses. Later during the period of care between 2016 through 2019, however, lab values are hard to find.
>
> The patient was also seen for an elevated cholesterol and treated with appropriate lipid therapy. Coreg, Lisinopril and chlorthalidone were used to treat the elevated blood pressure and were effective in keeping the patient's blood pressure under control. By 2007 the patient was being seen for follow up by cardiology for coronary artery disease and angina. Plavix, aspirin, atenolol were prescribed after the patient received a stent.

Most of the second chart is dedicated to recording his chelation therapy treatments. His heavy metal toxicity was diagnosed using the Meridian Stress Assessment machine. I did not see labs indicating confirmation of heavy metal toxicity. Chart notes, however, almost impossible to follow in chronological order. Notes from the period between 2005 and 2011 are frequently interrupted by notes from 2018 and 2019.

Throughout the initial 6 years that the patient was seen by Dr. Everhart from 2005 to 2011 his care was frequently consistent with the standard of care. The six years of chelation therapy without confirmation by appropriate lab tests was not consistent with the standard of care. When the patient reestablished care with him after a 7 year hiatus in 2018; antibiotics, antifungals and antiparasitic drugs were prescribed for upper respiratory symptoms, Lyme disease and Babesiosis. All were prescribed on the basis of a machine which Dr. Everhart believed could diagnose and suggest treatment for various diseases. These drugs were overprescribed and there is no documentation of any clear benefits.

* * *

The following is my expert opinion to a reasonable degree of medical certainty: that Dr. Everhart violated Sections 4731.22(B)(2) and 4731.22(B)(6), Ohio Revised Code, in his care of this patient.

He started his patient on a 6 year chelation therapy program without confirming that he had heavy metal toxicity (mercury) with appropriate lab tests. Chelation therapy for heavy metal toxicity is appropriate sometimes for patients who are thought to have Parkinson's from heavy metal exposure from mercury amalgam tooth fillings but should not be started on the basis of Meridian Stress Assessments.

Dr. Everhart overprescribed antibiotics, antifungal and antiparasitic drugs without appropriate laboratory testing from 2018 through 2019.

Objective assessment of improvement of this patient's Parkinson's symptoms by Neurology at OSU should have been included in the chart notes during the 6 years of chelation therapy. Claims of neurological improvement on chelation therapy were clearly stated repeatedly in the chart by Dr. Everhart. The patient had been started on Sinemet by OSU when he returned to Dr. Everhart for care in 2018. Sinemet is consistent with the standard of care for this disease.

(St. Ex. 12 at 20-21)

Dr. Everhart's Response to Dr. Taylor's Report on Patient 10

155. Dr. Everhart's expert report provided the following response to Dr. Taylor's review of his care of Patient 10:

> This patient seen me [*sic*] for chelation therapy in 2007 through 2010 with high resolution of CT imaging of the heart and hyperlipidemia, total coronary plaque burden of 10 lesions, agatston calcium score was 546 percentile. He was at high risk for cardiovascular events.
>
> In December of 2018 he established for further care because of increasing tremor and a diagnosis of Parkinson's and some changes in cognition. This has a high association with Lyme disease and Parkinson's. Lyme complex was suggested on the MSA and treated appropriately.

(Resp. Ex. F at 10)

156. Although Patient 10's case was not discussed in detail during the testimony at the hearing, Dr. Everhart briefly revisited his treatment of this patient. He recalled that he provided multiple years of chelation therapy by IV infusion for this patient, an attorney, as a treatment for heavy metal toxicity, which may have been as often as every two weeks. Dr. Everhart said that the heavy metal toxicity gleaned from the MSA test was corroborated by the results of calcium artery scoring, which showed that Patient 10 had a high amount of accumulated calcium in his arteries. He recounted that the patient was treated for several years in the early 2000s, and then returned after a hiatus for treatment in around 2015-2017, at which time he continued MSA testing and was diagnosed with parasitic infections and started on mebendazole. (Tr. at 140-141)

Validity of the Meridian Stress Assessment; Comparison with Standard Lab Tests

Testimony of Dr. Taylor

157. Dr. Taylor testified that in his 38 years of practice internal medicine, he had never heard of the Meridian Stress Assessment machine until he began reviewing this case. He stated that he had practiced in several different jurisdictions and had never seen the MSA machine used in any hospital or training institution that he was familiar with. He added that it was not accepted by any accrediting body of internal medicine as an appropriate diagnostic tool. (Tr. at 204-206, 208-209) Dr. Taylor said that the first time he had ever seen this machine was on the video where Dr. Everhart gave a demonstration of the machine at the Board's office, and he conceded, "It's all Greek to me. I don't know very much about acupuncture." (Tr. at 206-207)

158. Dr. Taylor stated that because he had never heard of the MSA, he had to research it. (Tr. at 239) He acknowledged that he had read that it was used in some other parts of the

country, but he asserted, "That doesn't make the test any more valid." (Tr. at 239) Dr. Taylor stated that the machine is supposed to measure a galvanic skin response and then make diagnostic and treatment suggestions, but he maintained that the results of the test were not valid. (Tr. at 206, 240) On cross-examination, Dr. Taylor acknowledged that he did not research whether any other practitioners in this region use the MSA device, and he was not aware of any increased use of it in Central Ohio. (Tr. at 253-255, 257) However, he stated, "[I]t's not the standard of care, because if it was, I would know about it." (Tr. at 207)

159. Dr. Taylor testified that in all ten of the patient charts he reviewed, the MSA test was used, and that he found that it was done to make an initial diagnosis and to follow the patient's progress, about every two months. He agreed on cross-examination that he was aware of Dr. Everhart's disclaimer in the release form that patients signed, stating that the MSA was not used for diagnostic purposes, and he was also aware that the manufacturer of the MSA machine said it was not a diagnostic tool. (Tr. at 207-208, 256) However, Dr. Taylor said that, in fact, it appears from the patient charts that Dr. Everhart was using it to make a diagnosis because he did not do any other standard testing that would otherwise be used to make his diagnoses:

> [H]e used this test, I believe, to make -- help him make the diagnosis. And it looks, from my review, that some of the MSA testing was used exclusively to make the diagnosis because I just didn't see any other confirmatory testing. So it's clinical judgment and the MSA testing, but it seemed to be mostly the MSA testing because the drugs that were identified as appropriate for the diagnoses came from the MSA machine as far as I can tell.

(Tr. at 207-208)

160. Dr. Taylor pointed out that, in each case, the patient would come in for a history and physical with Dr. Everhart, and he would plan to do routine bloodwork and to conduct the MSA test. (Tr. at 207) Then, after the MSA test was conducted, Dr. Everhart prescribed "lots of drugs," apparently based on the results of that test, because he said there was nothing else to show why those drugs were being prescribed. (Tr. at 207-208)

161. Dr. Taylor testified that all ten of the patients whose charts he reviewed were prescribed mebendazole to treat a diagnosis of Babesiosis, a parasitic infection that can sometimes be transmitted along with Lyme disease. (Tr. at 210-211) He explained why he was suspicious of that diagnosis:

> Babesia is a parasite that can live in the red cell that can cause anemia, belly pain, and it's an infection that also causes fever and chills. And it's a pretty nasty infection that I would suspect would have a lot more symptoms than many of the patients in which it was diagnosed.

> So I'm suspicious of the diagnosis made by this machine on the basis of a history and physical exam, but he made it. And he treated a lot of patients with mebendazole. According to him, that was the drug of choice that he used to treat these patients.

(Tr. at 211)

162. Dr. Taylor testified that he believed Dr. Everhart was, in fact, using the MSA test to diagnose the Babesia infection, explaining, "I didn't see any other confirmatory evidence for this diagnosis with lab tests or PCR testing or anything." (Tr. at 210-211) Dr. Taylor stated that he had trained for a year in pathology, and that in order for a physician to diagnose a patient with a parasitic infection the physician must try to find that parasite. This can be done with a microscopy test, in which a thin prep blood sample is prepared and sent to a lab for analysis to show whether that parasite is found in the patient's blood cells. He stated that the lab test can confirm if that patient has the infection, according to pathology standards, and that a patient with this condition may also be anemic and have an enlarged spleen. (Tr. at 212-213; St. Ex. 13)

163. Dr. Taylor described the microscopy test as "pretty definitive." (Tr. at 242) He agreed that it was not infallible, but he said that in cases where a patient had a subclinical infection not shown by that test, that patient would be asymptomatic. (Tr. at 242) In addition, Dr. Taylor testified that there was a PCR test using a ribosomal DNA marker that can identify "just about any bug, just about anything that could possibly infect you" that can be used as a second confirmatory test for Babesiosis. (Tr. at 213-214)

164. Dr. Taylor said that he did not see either of those lab tests used in the charts of Patients 1-10 to confirm the diagnosis of Babesiosis or to rule it out, and that the standard of care to diagnose that infection requires the use of a confirmatory test recognized in internal medicine. He stated that using the MSA test alone to diagnose Babesia did not meet the standard of care in Ohio or anywhere else in the country, to his knowledge. (Tr. at 214-215) Dr. Taylor characterized Babesia as "a serious infection," and added, "[Y]ou need to make a definitive diagnosis of the infection before you start treating it." (Tr. at 213) He also offered, "[F]or most of these patients, I would not suspect Babesia." (Tr. at 213)

165. Dr. Taylor testified that mebendazole could potentially cause liver toxicity if it was taken when there was no actual infection of the parasite that causes Babesiosis, and that he saw this result in the chart of Patient 2, whose lab values showed an elevated alkaline phosphatase. He noted that this patient's liver enzymes AST and ALT went up while she was on the mebendazole, but then dropped when she stopped taking it. Dr. Taylor testified that he believed those elevated enzymes were attributable to the patient's use of mebendazole, and that they were signs of liver toxicity in Patient 2. (Tr. at 243-246; St. Ex. 2 at 30; St. Ex. 12 at 4-5)

166. Dr. Taylor also identified various types of bacterial infections that it appeared Dr. Everhart diagnosed with the use of the MSA machine, including GI infections and lung infections, and he stated that patients with such infections would usually have symptoms including fever, chills, and abdominal pain. (Tr. at 216-217) He testified that it was "fairly easy" to diagnose a bacterial infection using a lab culture, and that it was important to grow the culture from some body fluid or tissue to make sure that the appropriate antibiotic was prescribed for the patient who has the infection. (Tr. at 217) For example, he said that to diagnose a bacterial sinus infection, the physician could take a swab of sinus fluid and put it on some medium that was amenable to the growth of bacteria, to see if it grows into an identifiable bacterial infection. (Tr. at 217-218)

167. In other cases, Dr. Taylor said that Dr. Everhart diagnosed fungal infections, such as fungal pneumonitis, with the use of the MSA machine. He described fungal pneumonitis as an inflammation of the lungs from an active fungal infection, and he said that a physician's first step to diagnose that infection would be to order a chest x-ray, to see if it looks like the patient has a fungal infection and if so, how widespread it is. Depending on the results of the chest x-ray, the physician could order a bronchoscopy, where a small tube is used to take a tissue sample from the lungs that can be cultured. However, he stated that he would refer a patient to a pulmonologist if he suspected fungal pneumonitis, and that the pulmonologist would then make treatment recommendations based on the test results. (Tr. at 218-220)

168. Dr. Taylor maintained that the standard of care requires a physician to use one of those tests to either confirm or rule out the diagnosis of fungal pneumonitis, explaining, "This is a serious infection. You have to make sure that it's what you think it is." (Tr. at 220) He testified that he saw the diagnosis of fungal pneumonitis made in several of the ten charts he reviewed, but that Dr. Everhart did not order a chest x-ray or bronchoscopy to confirm the diagnosis in any of the recent cases. Dr. Taylor explained that there seemed to be a point when Dr. Everhart stopped referring patients out for additional testing when he suspected that infection:

> Early on, I think around 2005, I think he was referring patients out, and that I applaud, but later on I just did not see a lot of referring or confirmatory testing or even a chest x-ray. I looked for it, but I didn't see that ordered when it should have been.

(Tr. at 220)

He concluded that, in the later cases, where only the MSA test was done before the diagnosis of fungal pneumonitis was made, Dr. Everhart did not meet the standard of care:

> Using the MSA is definitely not the standard of care. If that's all you're going to do is look on the machine and say they've got fungal pneumonitis, that's not good medicine and it's below the standard of care.

(Tr. at 220)

169. With respect to the frequent diagnosis of Lyme disease, also known as a Borrelia infection, in the ten patient charts that he reviewed, Dr. Taylor testified that he had never diagnosed a case of Lyme disease, though he has seen patients who have it. He testified that, to his knowledge, it is rare in Ohio. He said that he had never seen it in his practice area, Cincinnati, but that it may be more common farther North. Although Dr. Everhart testified that Lyme disease could be carried by various insects and spiders, Dr. Taylor said that to his knowledge, only blacklegged ticks transmit Lyme disease, and he had never heard of it being transmitted by mosquitoes, no-see-ums, or any other insect. (Tr. at 221-222, 247, 253)

170. Dr. Taylor testified that in the early stages of Lyme disease when a person has been bitten by a tick in an endemic area, there is a characteristic "bullseye rash." (Tr. at 221) He said that if the physician sees the bullseye rash, or if the patient describes having it, the physician would treat it for 10-14 days without having to wait for the results of a lab test. He stated that if it is early in the diagnostic stage but the bullseye rash is not present, the standard of care requires the use of an immunoassay test, with the western blot test as a confirmatory test for Lyme infection. Both are lab tests that analyze the patient's blood serum. (Tr. at 222-225)

171. Dr. Taylor stated that for later presenting cases, there is a test that can identify an IgG identifier for Lyme disease, but that it takes time to develop in a person, so if the test is done in the first three weeks after exposure, the patient would not test positive for it, even if the patient is infected. However, he said that the late-occurring IgG antibody would remain in a patient's system and would show if someone had had a previous infection of Lyme disease. (Tr. at 222-225, 246) Dr. Taylor stated that the IgG antibody test would show a positive result in patients who were more than six weeks from the date of exposure, and that the test was accurate. (Tr. at 225, 246) He emphasized, "If you have it, you have the disease, yes." (Tr. at 246)

172. In these ten charts, Dr. Taylor found that none of the patients had a bullseye rash present when they saw Dr. Everhart. He testified that he did not see any lab testing used by Dr. Everhart to confirm a Lyme disease diagnosis, except for a few cases in which a patient had had a positive test for it prior to seeing Dr. Everhart. More importantly, Dr. Taylor said that he found instances where some of the patients had, in fact, had the test, and the IgG identifier was negative for Lyme disease, but Dr. Everhart still treated the patient for that infection. He testified that it was not within the standard of care to simply rely on the patient's stated history of a tick bite, along with vague symptoms and the MSA test, to diagnose and treat Lyme disease. (Tr. at 224, 229, 246-247)

173. Dr. Taylor found fault with Dr. Everhart's prescribing of long courses of antibiotics for the treatment of unconfirmed Lyme disease in patients, and he explained that it is not the currently recommended treatment:

> Since 2007, the Infectious Diseases Society has recommended against ongoing, frequent treatment of symptoms of post-Lyme disease syndrome with antibiotics because of the possible side effects, including death, from ongoing antibiotic treatment and just getting rid of the normal flora in the gut. That's my main concern was the treatment of symptoms for this disease on an ongoing basis when we know now that the treatment of the symptoms with multiple doses of antibiotics does not do anything to reduce the symptoms.

(Tr. at 223-224)

174. Dr. Taylor acknowledged on cross-examination that if Lyme disease is diagnosed soon after the patient is infected with it, the recommended treatment is a 7-14 day course of antibiotics, and that when found early, antibiotic therapy is usually successful. He also agreed that there was research to support a course of antibiotics, including the use of IV antibiotics, for longer than 14 days if a patient was symptomatic of that infection. (Tr. at 266, 268, 279-280) However, Dr. Taylor stated that courses of longer than a month were not recommended, and he added:

> [T]he Infectious Diseases Society of America has found that treating symptomatic Lyme disease with repeated courses of antibiotics is not recommended. * * * When patients have prolonged Lyme disease symptoms, it usually does not reduce that.

(Tr. at 280)

175. On cross-examination, Dr. Taylor conceded that a "post-Lyme disease syndrome" does exist, and that some patients with that condition may have symptoms for up to six years, even after being treated for Lyme disease. (Tr. at 258, 281-282) He acknowledged that some of Dr. Everhart's patients may have been in the middle of the natural symptomatology for that disease, but he maintained that treating those patients with long-term antibiotics was not supported by the research, explaining, "[T]he antibiotics have not been shown to improve those symptoms if you look at controls compared to patients who are treated." (Tr. at 282) In the case of Patient 9, who developed the C. diff infection and was hospitalized, Dr. Taylor suggested that her long-term use of antibiotics may have contributed to that complication:

> [P]rolonged courses of antibiotics are a known cause of Clostridioides difficile infection. So it's certainly possible that continuing antibiotics in this patient contributed to the eventual sepsis from C. diff.

(Tr. at 282)

176. Dr. Taylor also disagreed with the way in which Dr. Everhart reached the diagnosis of a Bartonella or "cat scratch fever" infection in some of his patients. He stated that Bartonella was a rare infection that he had never seen in his entire career. He testified that Bartonella causes fever, chills, abdominal pain, and pain in the shins, and that doxycycline was the drug of choice to treat a Bartonella infection. (Tr. at 231, 247-248) However, he added, "[B]ut you have to diagnose it first. I wouldn't treat it without." (Tr. at 231)

177. Dr. Taylor said that the minimum standard to diagnose a Bartonella infection requires confirmation of the disease using one of three lab tests: PCR testing, growing a culture from a blood sample, or checking a blood antibody titer. However, he said that he did not see any of those tests done in the ten patient charts he reviewed. (Tr. at 231-232) Instead, he observed, "It was always MSA testing." (Tr. at 232)

178. Likewise, with respect to the diagnosis of the Epstein Barr virus in these ten patients after MSA testing, Dr. Taylor found that Dr. Everhart did not meet the standard of care in his diagnosis or treatment of that condition. Dr. Taylor testified that the Epstein-Barr virus is the same virus that causes mononucleosis when it becomes virulent, and that the mono-spot test or a serum blood titer can be used to diagnose the infection. He said that if the patient is actually sick, an anti-viral medication can be used to treat the patient's symptoms. However, he said that this is an "extremely common viral infection" and that most patients do not have symptomatic illness with Epstein-Barr, even though most people would have positive serology for that virus. He added that if the patient has had a positive mono-spot test, the titer for the Epstein-Barr virus will remain positive. In any event, Dr. Taylor said that it was below that standard of care to treat a patient with antibiotics for this condition without doing a serum blood test. He maintained that the blood tests for the Epstein-Barr virus are accurate to confirm or deny the presence of that infection, and that they are the standard in internal medicine to identify that infection. (Tr. at 215-216; 230-231, 269-270, 279) Dr. Taylor added, "[Y]ou need to be able to prove it. If you think they have an Epstein-Barr infection, yes, you need blood in order to diagnose it. An MSA test is not sufficient." (Tr. at 230)

179. Dr. Taylor concluded that in the charts he reviewed, he did not see the standard lab tests used to confirm the various diseases that Dr. Everhart diagnosed, but instead, he stated, "All I saw was MSA testing early on in seeing the patients." (Tr. at 232) At another point in his testimony, he recalled, "I didn't see it in any of the charts, and I looked very hard." (Tr. at 228)

180. With respect to the MSA machine's FDA approval, Dr. Everhart testified that 510(k) approval, according to his research, means only that the device is similar to another "predicate device" that is already on the market; it does not mean that the device is safe and effective. However, he said that he did not know what the device already on the market was or what it was used for. Dr. Taylor said that the 510(k) approval from the FDA was much easier to obtain than the kinds of FDA approval that required scientific testing. (Tr. at 274-275, 277-278) He summarized his understanding of how 510(k) approval compared to full FDA approval of a device or treatment:

> I read the summary on the FDA website, and 510(k) approval is just a 90-day authorization or warning before the product, the medical device, is released by the FDA. It does not require any kind of scientific background. It's just approved on the basis of a similar product already out on the market which has been approved. That product, a source product, may have been recalled. So it's not a very stringent approval and it's fairly easy to get.
>
> FDA approval means that there's been rigorous testing in human patients, and it's received double-blind studies that are the standard for the industry in approving a product. It's much more rigorous. FDA approval is a level ten steps above 510(k) approval from what I read in the FDA report.

(Tr. at 273-274)

181. During his cross-examination, Dr. Taylor testified that according to his understanding, after the initial 90-day approval, the 510(k)-approved product can remain on the market, unless it has been recalled. He agreed that since Dr. Everhart had been using his MSA machine for 20 years, it apparently had not been recalled. (Tr. at 274, 276) Although he agreed that useful medical devices such as defibrillators and even surgical masks had 510(k) approval, he added, "We're not using masks to diagnose disease." (Tr. at 275)

182. On cross-examination, Dr. Taylor agreed that the MSA test did not appear to be harmful to a patient. He also agreed that he was aware Dr. Everhart had patients sign a release form stating that they understood the MSA test was optional and that it was not a diagnostic test. (Tr. at 257, 260-262) However, he said that despite the language in Dr. Everhart's release form, it appeared from the charts he reviewed that the MSA test was, in fact, used for the purpose of diagnosing these patients:

> Q. [By the Hearing Examiner] If it is not being used for diagnostic purposes here, do you see any other purpose that it is being used for, from the charts you reviewed?
>
> A. It looked as though the MSA machine was being used for diagnostic purposes. I did not see any other reason it was being used.

> Q. Despite what the waiver says.
>
> A. Well, the chart says differently. The notes reflect use of the MSA machine, followed by diagnoses that are exactly what the MSA machine said.

(Tr. at 282-283)

183. Also on cross-examination, Dr. Taylor agreed that the physician's interview with the patient is an important part of making a diagnosis, and that the interview should be thorough and complete. He further agreed that a differential diagnosis can sometimes be made after the first interview, and that it was possible that Dr. Everhart reached his diagnosis before he administered the MSA test to a patient. (Tr. at 258-260) But in later questioning, he clarified that a thorough patient interview could not take the place of standard diagnostic tests used in internal medicine:

> Q. [By the Hearing Examiner] Could a lengthy interview with the patient substitute for any of the traditional lab tests that you talked about in your testimony as diagnostic tools?
>
> A. In most cases, no. A lengthy interview can't make the diagnosis. It can't make an irrefutable diagnosis because the examination is not that specific. There are too many diseases out there that one disease can mimic. For a lengthy interview to be sufficient to meet the standard of care, you have to do the test. Diagnosis is not easy.

(Tr. at 240-241)

184. Dr. Taylor also conceded on cross-examination that he has never treated a patient for Lyme disease, and that he relied on research to support his conclusions about Dr. Everhart's treatment of that disease. He said that he used resources including "UptoDate," an internet service that he subscribes to that summarizes multiple peer-reviewed journals and research on any disease. (Tr. at 264-265, 279)

185. Finally, Dr. Taylor testified on cross-examination that he had read testimonial letters from Dr. Everhart's patients, including some from patients whose charts he reviewed, and he agreed that Dr. Everhart's patients said in their letters that they were very satisfied with his care. (Tr. at 262-263, 272, 278-279; Resp. Ex. B) When he was later asked if he had any explanation for why these patients would feel as though the MSA testing had helped them, Dr. Taylor stated that he had no explanation for why patients would be happy with the MSA testing and the treatment they received from Dr. Everhart, but he acknowledged that there could be a placebo effect from the use of the MSA machine.

(Tr. at 249-250) He also suggested that the patients may feel better because of the time that Dr. Everhart spends listening to them, and he offered the following explanation:

> [T]hese are vulnerable patients who come in to see someone after they've seen physicians who said, "I don't know what's wrong with you. I can't help you." You come to see a physician who gives you a test and says, "I can help you." These vulnerable patients may feel better because the doctor has finally listened to them.
>
> Half of the patients -- 75 percent of the patients who are in the waiting room, we think are depressed and want somebody to listen to them. If a physician doesn't, then the patient may move on to another physician who will. Dr. Everhart, I applaud him for listening to patients. That may be why they're so satisfied.

(Tr. at 250)

Testimony of Dr. Everhart

186. In his testimony, Dr. Everhart described several experiences in the early 2000's that cemented his confidence in the usefulness of the MSA device, relating the following cases:

> Early, when I started using this in about 2002, a patient came to me. He had multiple previous visits to major institutions in the United States. He had a distended abdomen and he was getting fluid drained at the intensivist weekly. He had been to Sloan Kettering, Cleveland Clinic, Ohio State, MD Anderson, to name the major ones, and he had been diagnosed with 1 of 10 cases of mesenteric-lympho-something which they said was a malignancy and would need chemotherapy.
>
> By referral of I don't know who, he came to my office. We used the MSA and one of the things that was suggested by it was a parasitic infection. Based on his distended abdomen and that finding, we did start mebendazole. Within a month, he was no longer getting fluid drained and he was eventually cured of that condition which was not a malignancy. It was interesting because at MD Anderson he had seen obviously multiple specialists including their parasitologist. So at that point in time I was impressed that the information that the MSA gave me was very helpful in his treatment.

(Tr. at 531-532)

In another case, Dr. Everhart related the MSA correctly pointed him to a gallbladder problem, as opposed to a cardiac issue that was suggested by a patient's EGK results:

> I had another situation where a gentleman came in with chest pain and actually EKG changes. We certainly referred him to cardiac care, but the Median test had suggested that the gallbladder was stressed. That was certainly put on the back burner, but eventually the diagnosis was cholecystitis and he had a cholecystectomy with relief of his symptoms.

(Tr. at 533)

187. Dr. Everhart testified that he treats many cases of Lyme disease, often in patients who have been referred to him by other doctors who do not treat Lyme disease. He estimated that about half of his day is spent in general internal medicine, and the other half is devoted to more complicated cases, of which 90 to 95% are related to chronic Lyme disease. Dr. Everhart estimated that he sees about seven patients a day whose cases are Lyme-related, and that about 75% of his practice consisted of word-of-mouth referrals from other patients who have referred someone to him. (Tr. at 179, 181-182, 543) When he was asked what is the standard of care among healthcare practitioners for the treatment of a patient with Lyme disease, Dr. Everhart responded, "[F]or the most part, it's either telling them that chronic Lyme doesn't exist or telling them that they don't know how to treat it." (Tr. at 180)

188. Dr. Everhart explained that he believes there are two standards for how Lyme disease can be treated. (Tr. at 547; Resp. Ex. G) He acknowledged that the Infectious Diseases Society, which Dr. Taylor referred to, supports the use of lab testing to diagnose Lyme disease, but he asserted that there is a difference of opinion in other literature:

> This would seem to me to be an infectious disease process, but the Infectious Diseases Society of America has basically had the attitude that unless you make the diagnosis by western blot with the screening ELISA, then they don't have it. The CDC certainly put that out until I'm not sure what year, but within the last two to five years that Lyme should be made on the basis of clinical diagnosis.
>
> There's a recent article by -- which it probably would be appropriate to include in the record -- by Lorraine Johnson who is a JD, MBA. It talks about two standards of care in Lyme disease: the Lyme -- the International Lyme and Associated Diseases Society versus the Infectious Diseases Society of America. So there's been a big diversion on that. I think that should be addressed.

(Tr. at 546-547)

189. Dr. Everhart offered the article "Two Standards of Care in Lyme Disease," by Lorraine Johnson that he referenced into evidence, and it was admitted. The author of the article identifies herself as "J.D., M.B.A.," and does not indicate that she is a physician or a scientist of any kind. (Resp. Ex. G)

190. Dr. Everhart also explained the relationship between Lyme disease and Lyme complex, which were diagnosed in many of the patient charts:

> Lyme disease purely is just Borrelia burgdorferi. Lyme complex involves co-infections such as Babesia and Bartonella. So you have one or more co-infections, that's considered Lyme complex as opposed to just Lyme disease. And it's important to treat those other infections because you'll never become cured of Lyme disease without curing those others along the way.

(Tr. at 143)

191. Dr. Everhart conceded that a patient's negative lab tests alone would not support the use of antibiotics to treat Lyme complex, including Lyme with Babesia or Lyme with Bartonella, but he explained that he believes the tests sometimes fail to detect an infection when it is there:

> Based on the findings of a negative lab, you can't justify it. * * * I think the standard of care is relative. I think the key comment on that is minimum standard of care which I think a lot of physicians have followed by doing the appropriate test. And when I say "appropriate," the ones that Dr. Taylor mentions. But if they're non-diagnostic and they're low yield, then the physician is stuck with, "Well, I think it's this, but the test didn't show it. Where do I go from here?"

(Tr. at 542-543)

In those cases, he maintained, "[T]he Meridian Stress Assessment test gives me information as far as what I'm going to treat." (Tr. at 542)

192. Dr. Everhart explained that some of the patients he treats have seen many different doctors before they come through his door, and were "getting nowhere," even after having numerous tests done by other providers. (Tr. at 544) He stated that he does use many standard lab tests, such as a 21-test complete metabolic panel, broader than the 12-test panel that most physicians use, to check a patient's electrolytes, blood sugar, kidney and liver functions and a complete blood count. Urinalysis is also standard in his practice, and if indicated by a patient's history or exam, he does a thyroid test. (Tr. at 541) However, he stated that he sometimes has young patients "terrified of the thought"

of a blood test, and that when he has insisted on blood work, he has sometimes lost the patient. Therefore, he believes that must be a judgment call. (Tr. at 541)

193. Dr. Everhart reiterated that the conditions he treats are often missed by the traditional lab tests for those conditions, and that there are other drawbacks to some of the tests more frequently used by other practitioners to diagnose these conditions. He testified that there are tests for Lyme disease and the related co-infections of Babesia and Bartonella that go along with Lyme complex, offered by commercial labs such as Mayo, Quest, and CBL. However, he said that they are known to be inaccurate, and that they will not detect Lyme disease or Lyme complex. He also stated that the stool tests to identify the parasites involved in Lyme complex have historically been poor detectors of such infections. Dr. Everhart conceded that the test offered by the IGeneX company in California is recognized as accurate, but he said that the test can cost upwards of $1,000 to $1,200. (Tr. at 143-145) And, he added, "We've checked those and had those tests correlate with the MSA findings on a consistent basis." (Tr. at 143-144)

194. Referring to the work of Dr. James Shaller, Dr. Everhart said that the lab test for the parasite Babesia is rarely positive, and that he believes it is frequently inaccurate:

> [M]ost the time with a slide test on Babesia, 98 percent of the time the slide test will not be interpreted as positive. His comments are that the pathologist has to spend a half hour to an hour on a 1,000-time magnification; so unless you have a pathologist who specifically looks for it like that, that test is not going to be fruitful. If it's a 2-percent yield, I don't find it cost effective or worthwhile to the patient to do it.

(Tr. at 535)

195. Likewise, referencing a book called *How Can I Get Better*, by Dr. Richard Horowitz, Dr. Everhart said that the related infection of Bartonella is often overlooked, as well:

> [D]oing the antibody test for Bartonella, it is a false negative 85 percent of the time; and his research showed that Bartonella has a tendency, in general, to decrease the body's ability to make antibodies and so many of our standard tests are related to antibody tests. So if you're not making antibodies then you're not going to test positive on a lot of things. And if Bartonella is part of Lyme, if it's part of Babesia, if it's part of, obviously, Bartonella, standard diagnostic tests may miss it which is the reason why I think people end up in my office.

(Tr. at 535-536)

196. With respect to the tests for the Epstein-Barr virus, Dr. Everhart recalled that when the PCR test for the virus first became available, he ordered it for several patients, but he

related, "I felt that, clinically they had activation of Epstein-Barr and the PCR test didn't show it. * * * I found it to be unfruitful as far as correlation with the patient's condition." (Tr. at 534) In comparison, he offered, "With the MSA, I've been able to monitor Epstein-Barr, so it gives me useful information for that." (Tr. at 534)

197. Dr. Everhart said that Epstein-Barr is a difficult condition to diagnose because the monospot test will be positive only the first time a patient has the disease; after that, the test is not worthwhile. He agreed that the immunoglobin IgG test would remain positive indefinitely after a patient had first been infected, so he also did not find it useful. In response to Dr. Taylor's testimony that he would treat a symptomatic patient with an anti-viral medication, Dr. Everhart said that he was not aware of any antiviral treatment for the Epstein-Barr virus. (Tr. at 533-534)

198. Concerning the diagnosis of heavy metal toxicity, Dr. Everhart testified that there is a blood test that some practitioners use, but that he does not believe it is accurate because the heavy metals in a patient's body are usually tissue-bound and will not be detected on a blood test. (Tr. at 169-170) He also acknowledged that there is a urine test that relies on chromatography, but he said that that test is only as good as the chromatographer who performs the test. Instead, when he was asked, "And is it mostly the MSA machine that tells you when a person has heavy metals in their system?" Dr. Everhart replied, "Yes." (Tr. at 170)

199. In summary, Dr. Everhart agreed that he found the MSA test more helpful than some of the more commonly used tests for the conditions that he treats, because of various drawbacks to the standard tests:

> Q. [By the Hearing Examiner] It sounds like you believe that there are other tests that can diagnose some of these same conditions that the MSA machine can diagnose or can find * * * but there are drawbacks to those other tests.
>
> A. Correct.
>
> Q. Either in the nature of the test, or side effects to the other tests, or in terms of the accuracy of the other tests that are more generally accepted. Would you agree with that?
>
> A. I agree.

(Tr. at 171)

When he was asked if he knew of any studies that have evaluated the MSA machine as a diagnostic tool, Dr. Everhart responded, "Not off the top of my head. But for certain things, I think there's information out there." (Tr. at 171-172)

200. Dr. Everhart appeared to agree that when he purchased the MSA machine, he was relying on the manufacturer's demonstration of it, rather than scientific data about the machine's effectiveness:

> Q. [By the Hearing Examiner] When you decided to purchase this machine, it wasn't important to you to see any studies that evaluated how effective it was?
>
> A. Well, again, from that limited experience, I was impressed by what knowledge could be obtained from it. Certainly the people at the company had people that presented, that talked about the usefulness and how it could be used, but, quite honestly, before I purchased the machine the demonstration that I had showed me the potential of what could be done with it.

(Tr. at 172)

201. Dr. Everhart concluded that he believes his use of the MSA test, performed by a competent technician and combined with his clinical knowledge, serves a valid purpose:

> [T]he other big issue here is what's the appropriate use of the Meridian Stress Assessment. I think I've used it appropriately. It's been very helpful to me. I think in the right hands, with the right clinical knowledge, it provides accurate, helpful information.
>
> Does the test make the diagnosis? The physician makes the diagnosis which is the key in all the tests we use. So it takes, I think, an experienced, knowledgeable physician to know how to use the technology. Also it takes an experienced, artful technician to do the test optimally too, so that's another issue for the Board to consider. I think we've done that on a consistent basis very well.

(Tr. at 549)

202. Dr. Everhart testified that he believes the MSA test will "catch on" someday. (Tr. at 537) He asserted that acupuncture took a couple thousand years to be recognized in Western medicine, and he concluded, "So I think the technology and the basis of what it does will catch on. I'm not sure how long it will take. (Tr. at 537-538) He testified that he believes his success in treating his patients demonstrates the validity of the MSA machine:

> Q. [By Mr. Wilcox] What gives you such confidence that this machine * * * that rubs a wand over your hand and your feet, is my understanding, and you don't have confidence in every other test that we've talked about

> which are what internists throughout the state of Ohio use to diagnose disease?
>
> A. Well, the conditions I deal with are under-diagnosed or misdiagnosed throughout the state of Ohio. As witnesses will testify to, and the letters that have been written to tell their story, one after the other tell the problems in the state of Ohio as far as disease being missed, untreated, or poorly treated. So based on my experience using this for 20 years, * * * I've gained a lot of confidence in what we do with this. * * * That's the best I can tell you is the results we get. Ask my patients. They're my best evidence. They reaffirm my confidence in it on a regular basis.

(Tr. at 96-97)

203. Dr. Everhart asserted that the use of the MSA in this region has increased in the past 20 years, and he believes it will someday be more widely accepted. He said that he knew of four or five practitioners in Central Ohio who also use the MSA machine, and that there are chiropractors, nurse practitioners, and nutritionists who advertise the use of the test on their websites or in their literature. (Tr. at 39, 175-178) He rejected the Assistant Attorney General's description of the MSA machine as "bogus," and maintained, "[I]t has, over the years, given me accurate, helpful information." (Tr. at 536)

Testimony of Geraldine Urse, D.O.

204. Geraldine Urse, D.O. is a recently retired physician who graduated from the Ohio University College of Osteopathic Medicine in 1993, after a career in nursing that dated from 1972. She then completed a one-year internship followed by a two-year family practice residency at Doctors Hospital. She is a board-certified by the American College of Osteopathic Family Physicians, and she has completed a two-year fellowship in Integrative Medicine through the Academy of Integrative Health and Medicine, where she was trained in auricular acupuncture, but she is not licensed as an acupuncturist. Dr. Urse also obtained her master's degree in Medical Education for Health Professionals from Michigan State University in 2014. Dr. Urse is licensed as an osteopathic physician in Ohio, and for most of her career, she worked in a capacity in which she taught residents, in Ohio and previously in Nevada. In Dr. Urse's most recent position, she served as the Director of Medical Education at Doctor's Hospital from 2014 until her retirement in 2020.[4] (Tr. at 342-346, 355, 460-461)

205. Dr. Urse is familiar with Dr. Everhart because he is a personal friend. She stated that she had known him for about four years, and kept in contact with him once or twice a month. She conceded that she was not paid for her testimony, nor for her review of the charts or the writing of her expert reports. Dr. Urse testified that she covered Dr. Everhart's

[4] The Respondent did not offer a C.V. from Dr. Urse into evidence.

practice, seeing his patients for about two weeks in December 2020, when he was out to attend to a family illness. And, prior to that time, Dr. Urse was a patient of Dr. Everhart, seeing him in 2018 and accompanying a family member who saw Dr. Everhart around the same time. A letter from Dr. Urse appears among the patient letters that Dr. Everhart submitted.[5] (Tr. at 357-360, 411-412, 415, 418, 461; Resp. Ex. B at 132-134)

206. At hearing, Dr. Urse stated that her opinions were to a reasonable degree of medical certainty. (Tr. at 350) She also prepared two documents that were admitted as expert reports. The first document, addressed, "Dear Board," provided an overview of the MSA machine and its use in electromedicine. (Resp. Ex. C) In her second report, Dr. Urse addressed the charges against Dr. Everhart, including both his use of the MSA test and the legibility of his patient records. Although the document is titled, "Independent Chart Review," it does not speak specifically to each patient's chart in the cases of Patients 1-10, but instead concerns the general allegations against Dr. Everhart that are common in the cases of the patients involved. (Resp. Ex. D; Tr. at 351) Dr. Urse was described as an expert witness by Dr. Everhart's counsel, and she provided her opinion to a reasonable degree of medical certainty at the hearing. She was treated as an expert at the hearing, and her two reports were admitted to the record as expert reports, but neither party at the hearing moved to have her recognized as an expert. (Tr. at 22, 26, 350)

207. Dr. Urse estimated that she had instructed over 200 residents during her career, while also maintaining a part-time independent practice. (Tr. at 345-347) She said that she was involved in the treatment of "probably 30, 40 cases of Lyme over the years," and she estimated that she was involved in the diagnosis of Lyme disease on "a handful of occasions." (Tr. at 347) She related that later in her career, as she became more involved with integrative medicine and the complexities of chronic disease, she became more interested in Lyme disease. Dr. Urse testified that she had patients in her independent practice who kept coming back to her with the same complaints, but did not seem to fit any disease pattern normally seen. (Tr. at 347-348) She began researching the medical literature, where she said she was introduced to Lyme disease as the "great masquerader." (Tr. at 348)

208. Dr. Urse testified that she reviewed the ten patient charts presented in this case, and that she believed Dr. Everhart had provided appropriate care for patients in various stages of Lyme disease. Dr. Urse explained that she did not believe there was a good laboratory test currently in use for Lyme disease, because she said that patients can still have the disease, even if the basic ELISA testing and the western blot tests are negative. (Tr. at 349-350, 400, 433-434, 459) She testified, "[T]he two-tiered testing that is recommended is so unreliable and unpredictable in its results. It can miss up to 70 percent of the cases depending on when the test is done." (Tr. at 459) For this reason, Dr. Urse said that the

[5] Dr. Urse agreed that she was opting to testify in open session despite the fact that she is a patient of Dr. Urse, because she was also offering her opinions as an expert. (Tr. at 342)

physician must rely on a physical exam and taking a thorough history in order to diagnose the disease:

> [Y]ou can have negative tests on the ELISA and the western blot and still have disease. So physical exam, a thorough history, those are the things that have to be relied upon for the diagnosis of Lyme. The rash is hit or miss too. You may or may not see the rash with Lyme disease. It may be just ignored for whatever reason and the patient not treat it.

(Tr. at 459-460)

209. Dr. Urse also took issue with the reliability of the standard lab tests for the other bacterial, fungal, and parasitic infections that Dr. Everhart diagnosed in these cases. For the bacterial infection such of H. pylori, Dr. Urse stated that her diagnosis of that condition would consist of taking a history from the patient and examining the patient, and evaluating whether the complaints persist with treatment. (Tr. at 435-436) She explained that for most GI complaints, she would first do a trial of a medication, but conceded that she would also refer the patient for consultation, if the patient did not respond to treatment:

> [W]hen I treat for reflux disease or GI complaints, I will trial the patient on an H2 blocker or a proton-pump inhibitor for a period of time. And if I don't have response to that, then I will send them to a GI for a referral for either endoscopy or further management.

(Tr. at 435-436)

210. With respect to fungal infections, Dr. Urse said that they are almost impossible to culture because they grow slowly, so it can take months to get a culture back. Therefore, she said that the diagnosis of a fungal infection, such as a fungal nail infection, is usually made by the physician's clinical evaluation of the patient. However, she agreed on cross-examination that for a suspected internal infection that was fungal, such as fungal pneumonia, she would order a chest x-ray. (Tr. at 436-438)

211. Similarly, Dr. Urse testified about some of the difficulties in the lab tests for parasitic infections. She said that parasitic infections are ideally diagnosed by isolating the parasite, such as in a stool sample, but she added that not every parasite has associated body fluid that can be analyzed. (Tr. at 438) She testified, "[I]f we're talking about some of the parasitic infections like Babesia, for instance, that very organism is very difficult to culture out and to identify, so then it would just be empiric treatment." (Tr. at 438) In her expert report, Dr. Urse wrote, "Currently there are no tests approved for the diagnosis of Babesia." (Resp. Ex. D at 6)

212. Dr. Urse also testified about her familiarity with the MSA machine and the Meridian Stress Assessment test. She testified that she owns a smaller, more portable MSA machine than the one Dr. Everhart uses, which she purchased after attending a conference in Indiana sponsored by ZYTOS, the manufacturer of her machine, in the fall of 2019. She recalled that she received training on the use of the MSA machine at that seminar, which was attended by about 35 healthcare providers. Dr. Urse said that she did not use her MSA machine in her previous practice at Doctor's Hospital, or in her own independent practice because she was only seeing patients one-half day per week. She testified that she does plan to use it going forward in her practice of integrative medicine and osteopathic manipulative medicine. (Tr. at 363-365, 368-369, 399, 408-409, 453) However, she agreed that residents at Doctor's Hospital are not trained in the use of the MSA machine and she conceded, "[T]he hospital at this point in time does not support that particular device." (Tr. at 409)

213. In her letter written as a patient testimonial, Dr. Urse explained the MSA test's relationship to principles of acupuncture:

> All things in nature have a unique energy frequency – cells, organs, plants, microorganisms, metals, and toxins. Traditional Chinese Medicine recognizes in humans channels for this energy, meridians, which transport vital energy (Qi) to all parts of the body. This understanding is basic to acupuncture which interrupts the flow of Qui between two points on a meridian. MSA records the electrical conductivity at meridian points typically found on the hands and feet. Stresses or dysfunctions within various organs and systems are demonstrated by an altered conductivity between the meridian points.

(Resp. Ex. B at 133)

214. At the hearing, Dr. Urse offered the following summary to her explanation of how the MSA machine works:

> [W]hen we talk about science, and everything is made up of protons and electrons and neutrons, that's kind of a basic understanding. And we know that they all vibrate at their own frequency. And so everything in nature has its own frequency of vibration. * * * [A]ll chemicals, all metals, all organisms demonstrate their own frequency.
>
> Q. [By Ms. Snyder] Right. So how does the machine measure the frequency?
>
> A. It completes an electric current in the body. When you hold a ground in one hand for the MSA machine, and then the probe, which is the other part of the circuit, is touched on the meridian point that has been identified,

> those were identified in traditional Chinese medicine for the meridians for acupuncture, and so you put the other point on the meridian for let's say we're going to test the liver, so we put it on the meridian for that, then that completes the circuit and it would measure the frequency point for the liver meridian.

(Tr. at 427-428)

215. However, when the Assistant Attorney General referred to the section of Dr. Urse's expert report in which she said that substances have their own frequencies or fingerprints, and asked Dr. Urse if she knew the frequency of H. pylori or the frequency of Babesia, she responded that she did not know. (Tr. at 426-427, 429) She explained that the physician using the MSA machine would not be expected to know the frequencies of those organisms because that data was already programmed into the machine by the manufacturer:

> Q. [By Ms. Snyder] Okay. Would you expect [Dr. Everhart] to know what those frequencies are if he's using this type of machine?
>
> A. No. Those are expected -- that would be programmed into the machine if the machine was being used to identify the signals.
>
> Q. Okay. So you mentioned software and programming. So you agree that when you use this machine, you're dependent completely on whoever built the software, right, and their accuracy and their knowledge?
>
> A. That's -- that's a fair statement.

(Tr. at 429)

216. When she was asked if she knew of any studies to validate the effectiveness of the MSA in identifying infectious organisms, Dr. Urse maintained that the MSA can identify the signals produced by such organisms, even though there were no studies that she knew of:

> Q. [By the Hearing Examiner] * * * Are there any studies that you're aware of that have looked at the effectiveness of the MSA machine as an indicator of certain bacterial or viral infections?
>
> A. Again, I think that the MSA machine is designed to identify the electrical frequency signals of organisms. It can identify all of those. Is it designed or has it been studied to identify each one specifically? Again, I don't know that there are any studies that have done that.

(Tr. at 468)

217. Dr. Urse maintained throughout her testimony that the MSA machine was not designed to make diagnoses. (Tr. at 462) She reiterated that it merely identifies "the frequencies of different organisms and different entities within nature," adding, "So we can see heavy metals, we can toxins, we can see all those things. It's set up to identify those things." (Tr. at 461) However, Dr. Urse cautioned that while she believes the MSA test gives good information that serves as "an additional piece of the puzzle," it is not the only piece of the puzzle. (Tr. at 463)

218. Dr. Urse compared the MSA machine to a piece of medical equipment such as an EKG machine, or a scale that a doctor would use to weigh a patient. She explained that those devices provide information, but it is the physician who actually renders the diagnosis, based on the information gleaned through the use of medical equipment, as well as other information gained from the physical examination and patient history, and any other testing that is done. (Tr. at 367, 369, 376-377, 465-466) Dr. Urse emphasized that a physician could not make a diagnosis strictly on the basis of the MSA report, and she insisted, "You need that history and physical examination." (Tr. at 376) She concluded that she does not believe Dr. Everhart used the MSA machine or its test results for diagnostic purposes in the cases of the ten patients here. (Tr. at 367-368)

219. Dr. Urse testified that the MSA machine has Class II approval as a medical device by the FDA. She explained that there are multiple classifications of FDA approval, ranging from Class I devices that do not pose any danger to the patient, to Class III devices such as pacemakers that are implanted into a patient's body. She said that in addition to the MSA machine, Class II devices include things like electric wheelchairs, EKGs, and pregnancy tests, that fall somewhere in the middle of the FDA's risk assessment. Dr. Urse stated that a 510(k) FDA approval is granted when a device is similar to a machine or instrument that already has approval, and it lasts through the life of the product, so long as no changes are made to the product and no other indications are found for its use. Although she did not know how long the MSA machine had had its 510(k) approval, Dr. Urse said that the machine had been used since the introduction of electric acupuncture, by Voll, in the 1930's.[6] She agreed, however, that the machine is not FDA approved to diagnose disease. (Tr. at 351-354, 397)

220. Dr. Urse testified that the MSA machine generates a report after each test. She emphasized that the MSA report does not state a diagnosis, but does identify signal frequencies for various organisms or substances that are present within the patient's body:

[6] A pamphlet published by the manufacturer of the MSA machine refers to Reinhold Voll, a German physician who developed an electronic testing device for finding acupuncture points electrically in the early 1950's. (St. Ex. 16 at 4)

> The report, in and of itself, provides evidence of stress within the meridians of the body. It will also identify the signal frequency for things like heavy metals, for any organisms or bacterias, or even medications, sometimes, that are present within that system.
>
> * * *
>
> [I]f we were to look at the meridian for the liver for instance, we may see that within that meridian for the liver that there's a stress recognized there and that stress may be attributable to, let's say, alcohol, which would have a stress frequency that would show up and so that may lead us down that path of alcohol. Or it may have a stress related to a viral infection, viral hepatitis for instance, and it may lead us down that path. So it will read for us the stresses within the meridians and relate those to frequencies of occurrence.

(Tr. at 375-376)

221. She clarified, however, that the stresses in the meridians that are shown on the MSA test results could be from conditions other than Lyme disease:

> Stress comes from many things, not just from Lyme disease. The stresses within meridians can be reflected from heavy metal exposure, from toxins like pesticides, and those type of things. So it's not just a disease, but it's any upheaval or any stress within the system and how it's reflected in the MSA.
>
> (Tr. at 365)

And finally, Dr. Urse maintained that the MSA machine was not a diagnostic device:

> MSA does not do anything diagnostic. MSA only identifies stress within the meridians of the body. It identifies signal patterns of organisms so that if you're having stress within the meridian of the body that is the skeletal meridian and the signal pattern or the frequency pattern for Borrelia shows up as a stressor for that, then it kind of guides you in that pathway. But it does not diagnose that. It only reflects the stresses in that meridian.

(Tr. at 460)

222. Dr. Urse testified that there has been controversy in the acceptance and diagnosis of Lyme disease and chronic Lyme, but she said that Dr. Everhart's prescribing of long courses of antibiotics was consistent with the guidelines of the International Lyme and Associated Diseases Society. (Tr. at 385, 387) She said that according to those guidelines, a long course of antibiotics is often required to gain control of the Lyme disease as well as the other diseases associated with it because of "the different forms that

the organisms can take to shelter themselves from being killed by the antibiotics." (Tr. at 385) Dr. Urse stated, "[P]eople who are on the cutting edge are the ones that are treating with the multiple antibiotics, looking for multiple phases of disease, and treating for longer periods of time." (Tr. at 387)

223. Dr. Urse said that when a patient is bitten by a tick that carries Lyme disease, the patient is usually inoculated with Borrelia, but can also have co-infections including Babesia, Bartonella, and several others. (Tr. at 391) She testified that the MSA can provide information to identify a parasitic infection such as Babesia in the stomach meridian, even if a stool analysis failed to detect the infection:

> Q. [By the Hearing Examiner] * * * Do you think the MSA can serve as a basis for identifying whether a patient has a parasitic infection?
>
> A. I think it can be a piece of information that will help you make that decision. If you -- if you come in with let's say a bowel parasite, and we do a physical exam, you got the belly cramping, the pain, and we do a stool examination but we don't see any parasite on it. We do an MSA and we get a positive ener -- positive frequency identification of a parasite in the stomach meridian, then that helps us guide to treat you even though we have a negative stool culture because you're still symptomatic.
>
> Q. You would still treat that patient for a parasitic infection?
>
> A. If I have a patient who is having physical complaints, I can't identify on culture that they're having a parasite but they're having the diarrhea, they're having the abdominal pain and complaints, then I do an MSA and I see that I have a parasite as a stressor in the stomach area in that stomach meridian, then that would guide me to treat that patient as if they had a parasite; that is correct.

(Tr. at 463-464)

224. Likewise, Dr. Urse was careful to say that the MSA test does not "diagnose" heavy metals in a patient's body, while in the same sentence offering, "but it can identify if there are heavy metals in a stress area for the patient. Again, it doesn't diagnose. It just identifies." (Tr. at 464) Dr. Urse stated that a physician would also be looking for evidence of exposure to heavy metals during the interview with the patient, such as if the patient had worked as a mechanic, with exposure to brake linings that contain large amounts of heavy metals. She offered that when she had her two MSA tests with Dr. Everhart, one of the things she was concerned about was whether she had had environmental exposure to heavy metals after teaching in China on several occasions. (Tr. at 416, 456, 465)

225. While Dr. Urse did not believe that Dr. Everhart would be able to make a diagnosis with only the printout from the MSA test, she asserted that doctors are sometimes able to make a diagnosis just from a preliminary interview with a patient, in combination with taking a good history and doing a physical exam. She stated that when additional information is taken into account, such as the results of lab testing or an EKG, that can change or narrow the differential diagnosis. Dr. Urse believes that because Dr. Everhart conducted thorough interviews and physicals examinations of his patients, he was not using the MSA to arrive at his diagnoses, but merely incorporating the information from the MSA into the physical findings, in order to make a diagnosis. (Tr. at 367, 369-370, 377, 446-447, 462, 468-469)

226. For example, in Dr. Everhart's diagnosis of H. pylori gastritis in Patient 1, Dr. Urse stated that the patient's statement during the interview that his stomach was "queasy," combined with the MSA results, supported Dr. Everhart's diagnosis of an H. pylori infection. She explained:

> When we look at the stress in the stomach, the meridian there, it shows us that the stress is present in the gastro -- or, in the stomach area and the stressor that is present looks like H. pylori. So I think that utilizing that tool, combined with the patient's complaint, is how he came to that diagnosis.

(Tr. at 448)

Dr. Urse confirmed that she believed that met the standard of care for the diagnosis of H. pylori gastritis, stating, "For initial treatment, it would suffice." (Tr. at 448) She added that at the patient's visit on March 26, 2019, he reported a positive response to the initial treatment, so at that point, she would not have done any further investigation to confirm the H. pylori diagnosis. (Tr. at 448-450)

227. Although she did not comment on Dr. Everhart's care of each patient, Dr. Urse also asserted that Dr. Everhart properly diagnosed Patient 1 with Babesia, on the basis of the patient's complaints and the results of the MSA test:

> Q. [By Ms. Snyder] * * * [B]ased on your review of the records, on what did he base that diagnosis of Babesia?
>
> A. Again, on the patient complaints as well as -- let me scroll into the -- as well as the stressors that came up on the MSA for the spine and joint areas. * * * Basically in the physical exam there is no -- there are no physical findings that show any changes in the joints or the extremities. There are good physical exam findings that show that the reflexes are symmetric and those type of things. So it's based on the patient's migratory joint complaints of pain.

(Tr. at 451-452)

At the same time, she agreed on cross-examination that there could be other causes of joint pain in a 19-year old who plays basketball, such as a cervical spine fracture or a whiplash injury. (Tr. at 452)

228. Dr. Urse testified that there are other practitioners she has met at conferences who use the MSA machine, including one other person in Central Ohio, but she said that she was not aware of the Board taking disciplinary action against anyone else for their use of the MSA. (Tr. at 362-363, 368-369) At two separate points in her testimony, when she was asked if there was anyone whom she considered an authority on the MSA, or anyone she considered an authority on Lyme disease, she was unable to name any professional. (Tr. at 364-365, 453-454) Dr. Urse suggested that she believes the MSA machine will become accepted as a proven device once it is used more in "mainstream" practice, suggesting, "[W]e have to use these things * * * for them to become more mainstream." (Tr. at 433)

229. Dr. Urse confirmed that after reviewing the charts in question, as well as Dr. Taylor's reports with his findings, she believed that Dr. Everhart met or exceeded the standard of care in his treatments of Patients 1-10 and his use of mebendazole to and antibiotics to treat Lyme disease, Babesia, and Bartonella infections. (Tr. at 383-384, 396, 400) She summarized:

> When I looked through the charts and looked at the antibiotics that were prescribed and the diagnoses of Dr. Everhart, I did not feel that there was any mis-prescription of antibiotics, nor did I think there was an abnormal length of prescribing for the diagnoses that Dr. Everhart was working with.

(Tr. at 381)

In her answers to later questions, Dr. Urse conceded that her opinion that Dr. Everhart prescribed appropriate treatments for those conditions assumed that his diagnoses of those conditions were accurate. (Tr. at 467)

230. On cross-examination, Dr. Urse agreed that only about 5% of her practice between 2014 and 2020 was clinical; the remaining 95% was administrative. (Tr. at 407) She acknowledged that when she wrote her first expert report, Respondent's Exhibit C, she had not yet reviewed any of the ten patient charts in this case, and that she intended to address the use of the MSA machine and treatment of Lyme disease in general. She said that she did this as a courtesy to Dr. Everhart, who has been her physician as well as the physician of several family members, as well as a social friend. Dr. Urse added that she had referred people to Dr. Everhart to have an MSA test in the past. She testified that she

prepared her second expert report, Respondent's Exhibit D, it was after she had spent about 12 hours reviewing Dr. Everhart's charts of Patients 1-10. (Tr. at 412-416; Resp. Exs. C, D)

231. In Dr. Urse's second expert report, she disputed Dr. Taylor's comments in his report that the MSA was "useless" and not FDA approved to diagnose disease. (St. Ex. 12 at 10-11; Resp. Ex. D at 2) In response, Dr. Taylor wrote that it was "quite common for practitioners who are unfamiliar with a technology to deem it useless and feel it is unproven." (Resp. Ex. D at 2) In the next few pages of her report, Dr. Urse cited information purportedly from a report of the Office of Technology Assessment of the Congress of the United States, as well as historical information about the use of electricity in medicine. (Resp. Ex. D at 2-4) On cross-examination, Dr. Urse conceded that some parts of her second report were reprinted verbatim from a document published by Biomeridian, the manufacturer of the MSA machine, titled, *A History of Meridian Stress Assessment*, by Dennis Remington, M.D. (Tr. at 421-423; St. Ex. 16) Dr. Urse conceded that some of the information in her report came directly from this document published by the maker of the MSA machine:

> Q. [By Ms. Snyder] So did you use his pamphlet for a lot of information?
>
> A. I certainly referenced his pamphlet as well as the other things that are listed in my reference list.

(Tr. at 425-426)

232. Dr. Urse was asked on cross-examination if she believed that because the author of that pamphlet, Dr. Remington, wrote it for a company that sells the machine, he might not be an objective source of information. (Tr. at 426; St. Ex. 16) She responded that she believed the historical information in the pamphlet was objective, but she admitted, "if we're looking at his report of the MSA machine, of his company, then probably not; it's probably directed towards that." (Tr. at 426)

Expert Testimony about the Adequacy of Dr. Everhart's Charting

233. At the hearing, Dr. Everhart did not testify about the legibility of his records, except for agreeing with the Assistant Attorney that he usually typed the initial presentation note, and handwrote the remaining office visit notes of his patients' visits. (Tr. at 72)

Testimony of Dr. Taylor

234. In his testimony, Dr. Taylor provided the following explanation of why he found Dr. Everhart's charting and recordkeeping insufficient to meet the standard of care:

> The charting was sometimes difficult to follow. Well, it was always difficult to follow. Sometimes things are out of sequence. Reading these charts was difficult, definitely difficult for an intensive review which is what I conducted. I'd have to go back and look at the initial history and physical just to figure out where he was going with diagnoses on a regular basis. So the charting is not what I would expect; it's poor.
>
> I understand that he's doing -- he's alone. He's writing the follow-up visits by hand and that's something that he probably should have abandoned 10 years ago. There are adequate dictation systems available so that the chart is legible so you can follow it. I thought that all the 10 charts had some serious problems with continuity. And the chart notes, many of them don't have a physical exam for the follow-up visits. So the charts were not adequate and very difficult to follow.

(Tr. at 234-235)

235. On cross-examination, Dr. Taylor agreed that Dr. Everhart's patient charts usually had one or two typed office visit notes, including the notes of his initial interview with the patient, but he said that the rest of the charts had handwritten notes of any follow-up visits. (Tr. at 260, 280-281)

236. Dr. Taylor confirmed that he was not saying that the standard of care requires the use of electronic medical records. (Tr. at 248) He agreed that a physician can "absolutely" maintain paper charts for patients, so long as the charts are legible and complete. (Tr. at 248) He testified that the records must be legible because most charting is collaborative, and other physicians might have to rely on his notes to inform their treatment of a patient who is referred to them. (Tr. at 235-236) He explained:

> [I]t should be legible so another physician can make out what the physician wrote. That's the standard of care. You have to -- somebody is eventually going to read it. If you refer a patient out, you have to send the chart out, and that physician has to read it. Yes, legibility is the standard of care.

(Tr. at 248-249)

Testimony of Dr. Urse

237. Dr. Urse also offered opinions about the adequacy of Dr. Everhart's charting. She stated that it is common for physicians to use abbreviations in their charting, particularly in a practice that is paper-driven, as Dr. Everhart's practice is. Dr. Urse stated that she had reviewed all ten of the patient files in this case. She said that she believed Dr. Everhart's handwriting was legible, and that his files were consistent and orderly. (Tr. at 372-373,

457-458) With respect to the handwritten office visit notes, Dr. Urse offered, "It's not the clearest I've ever read, but yes, I was able to decipher all those notes. (Tr. at 373)

238. Dr. Urse stated that she tells her residents as a general rule that if two practitioners cannot read the same note, it is illegible. (Tr. at 373-374) In this case, however, she disagreed with Dr. Taylor that Dr. Everhart's handwriting is not legible, and stated that she found his notes "totally decipherable." (Tr. at 374)

Mitigation Evidence

Testimony of Patient R.R.

239. In the presentation of his case, Dr. Everhart offered testimony from R.R., a patient who has seen him since September 2014. R.R. testified that he and his son had been on a trip where they got ticks on them. He recounted that they returned from their trip on a Sunday night, and the following day, he saw a doctor, who removed one tick that was embedded in his arm and prescribed a couple weeks' worth of antibiotics. R.R. stated that after three or four months, he still felt very tired, and had joint aches, malaise, and "brain fog." (Tr. at 475) However, he said that his bloodwork at his family doctor's office was fine, and the doctor just told him that he needed to slow down from his active lifestyle. (Tr. at 476-477)

240. R.R. related that, as time went on, his fatigue increased and he had trouble remembering his sons' names. He had no energy at all, and he saw a cardiologist because his heart was skipping beats. (Tr. at 476-477) He related:

> And he told me, the cardiologist at Riverside Hospital, that every time I hit the button while I wore his monitor for a couple weeks, there was something going on with my heart but it was reacting to something else in my system and he suggested strongly that I find out what it is.

(Tr. at 477)

241. When a nurse practitioner referred R.R. to Dr. Everhart, he made an appointment and went to see him. He related that he brought his records from his past office visits with other doctors and the results of previous lab work. (Tr. at 477-478) R.R. recalled his experience at his appointment with Dr. Everhart:

> [H]e just listens to every detail intently. And he wanted to know when the symptoms started, how they progressed, how I felt at different periods, and how this -- how this whole thing was coming on and getting worse. * * * [H]e spent an inordinate amount of time with me, examining me."

(Tr. at 478)

He later added:

> When you're in his office, you would think he has nothing else to do that day because he spent such an inordinate amount of time making sure he gets to the underlying issue.

(Tr. at 480)

242. R.R. stated that the MSA test was offered to him, and he knew it was not mandatory, but he believed it would be "just another tool in [Dr. Everhart's] toolbox" in addition to his blood work, physical examination, and thorough questioning. (Tr. at 481-482) R.R. testified that he had faith in the ability of the MSA machine to provide information, even though he was initially skeptical:

> I was like, "You tell me how that machine is telling me I feel." And it was always spot on. And sometimes it picked up some things, I had a little light GI thing going on, and they asked me about that, and I had never brought it up. It was because I ate some bad fish about 10 days earlier. I mean, it was amazing.

(Tr. at 482)

243. R.R. testified that he had the MSA test about six times over the two years that he was in treatment with Dr. Everhart, until he was cleared of Lyme disease. (Tr. at 483) He added that Dr. Everhart later diagnosed Lyme disease as well as heavy metals in his son, who is a welder, and he concluded, "So as far as I'm concerned, that thing is spot on." (Tr. at 483) R.R. explained that his son had begun having seizures, and had no resolution even though he saw a neurologist and was hospitalized, until he was treated by Dr. Everhart. (Tr. at 478-479) R.R. related that with respect to his son's illness, "it wasn't neurological. It was a disconnect in his nervous system." (Tr. at 481)

244. R.R. credits Dr. Everhart for saving his life, and his son's life. He stated that he was "absolutely thrilled" with Dr. Everhart's treatment, and that he had sent at least ten people to him, all of whom said that he had made their lives better. (Tr. at 478-479; 485)

Testimonial Letters Written by Patients

245. Dr. Everhart offered into evidence approximately 88 letters written by patients, which he received in response to a single letter that he sent asking patients to comment on their experiences at The MANNA Institute. These include letters from some of the patients identified in this case as Patients 1-10. Dr. Everhart pointed out that several of the letters are from healthcare professionals, and he counted 24 letters in which the author wrote

that he had saved their lives or allowed them to return to normal life. (Tr. at 545-546; Resp. Ex. B)

246. In the letters, the patients describe Dr. Everhart's kindness and dedication to his patients, and they emphasize the amount of time that Dr. Everhart spends listening to them. The patients routinely describe being frustrated with persistent, debilitating symptoms that did not resolve until they began treatment with Dr. Everhart, in many of those cases for Lyme disease or Lyme complex. (Resp. Ex. B) They also consistently believe in the information produced by the MSA test, which many describe as a diagnostic test or a diagnostic technology, with one patient writing, "The MSA testing is one of the most valuable tools in medicine I have ever encountered." (Resp. Ex. B at 52) One patient wrote that the MSA test was successfully used to find the cause of elevated PSA numbers. (Resp. Ex. B at 63) Another wrote that her daughter had been sick for years until the MSA test revealed that she had an H. pylori infection that had never shown up on any other test. (Resp. Ex. B at 123) Yet another wrote that Dr. Everhart had used the MSA machine to find a Coxscakie virus affecting her heart. (Resp. Ex. B at 128) One patient wrote that upon learning of a history of heart attacks in both of her parents, Dr. Everhart immediately scheduled an MSA test which led to a course of homeopathic vitamins and weekly chelation therapy. Two months later, she had to undergo an emergency angioplasty to remediate a blocked artery. That patient wrote, "I believe that your treatment, Dr. Everhart, most likely saved my life in that you immediately began cleaning out arteries and veins with the course of chelation therapy." (Resp. Ex. B at 135)

247. Dr. Everhart disputed Dr. Taylor's suggestion that his patients were vulnerable to misdiagnoses and unproven treatments:

> These are not weak, vulnerable people. For the most part, they're well educated and don't take something without questioning it; and a lot of times something inside tells them there's something wrong here, and as you heard from some of the witnesses, "I'm not crazy."

(Tr. at 539)

248. Dr. Everhart testified that many of the charts reviewed by Dr. Taylor were for patients that he successfully treated, and he added that his patients say on a consistent basis that the standard of care they receive from him is "far above" what they have had elsewhere. (Tr. at 179-180) He submits that the testimony of some of his patients and the letters he offered into evidence show that he met or exceeded the standard of care:

> I think the testimonials and the witnesses will reflect that we have exceeded the standard of care because we addressed the problem, made a proper diagnosis, and treated them with success; and not chronic illness, but resolution of their sy[mptom]s.

(Tr. at 543)

Dr. Everhart's Plans for Future Practice

249. Dr. Everhart has practiced medicine for nearly 50 years. He testified that his mission as a physician is to make an accurate diagnosis and deliver cost-effective care that treats the patient effectively to resolve any problems, and to help the patient maintain their own good health through healthy habits. He stated that he worked many hours in the earlier years of his practice, but that he decreased his work to 60 hours per week after he reached the age of 50, and he now generally works 40-45 hours per week. (Tr. at 530-531, 550) He wants the Board to know that he has devoted his life to being a physician, and that he wants to continue working in that capacity as long as he is able to:

> The other thing, I guess, to address the Board is, I've dedicated my life to being a physician. I enjoy doing it. I would like to continue doing it for as long as I think I'm mentally and physically capable. * * * As long as I can add 2 and 2 and get 4, and maintain my mental sharpness and the physical ability to get to work and function, I would like to continue to do that. But I'm very sensitive to when it's time to quit. So those are my comments to the Board. I would like to continue to help people. That's why I get up in the morning.

(Tr. at 550)

FINDINGS OF FACT

1. From on or about January 24, 2005 to July 24, 2019 Dr. Everhart provided care to Patients 1-10 as identified in the Patient Key. He relied on the Meridian Stress Assessment ("MSA") to diagnose and subsequently treat Patients 1-10. The MSA is an unproven electrodermal diagnostic device that uses acupuncture theory and galvanic skin response to make specific diagnoses in the correlated organs. Furthermore, Dr. Everhart failed to confirm MSA results through appropriate laboratory testing and/or consultation from a specialist before employing treatment measures.

2. In his care of Patients 1-10, Dr. Everhart inappropriately prescribed the antiparasitic drug Mebendazole and prescribed it in excess of recommended dosages. Mebendazole is commonly used to treat parasitic intestinal worms, diagnoses that he did not appropriately confirm as stated in Finding of Fact 1.

3. In his care of Patients 1-10, Dr. Everhart inappropriately prescribed multiple antibiotics, in excess of recommended dosages to treat Lyme disease, Babesia, and/or other diagnoses that he did not appropriately confirm as stated in Finding of Fact 1.

4. Additionally, Dr. Everhart's medical records for Patients 1-10 were incomplete and/or illegible.

CONCLUSIONS OF LAW

1. Dr. Everhart's acts, conduct, and/or omissions as alleged in Findings of Fact 1 through 4, individually and/or collectively, constitute "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease, as that clause is used in R.C. 4731.22(B)(2).

2. Dr. Everhart's acts, conducts, and/or omissions as alleged in Findings of Fact 1 through 4, individually and/or collectively constitute "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in R.C. 4731.22(B)(6).

3 Because the conduct alleged in Findings of Fact 1 through 4 continued after September 29, 2015, the Board is authorized to impose a civil penalty for those violations pursuant to R.C. 4731.225.

The Board's fining guidelines for Dr. Everhart's violation of R.C. 4731.22(B)(2) provide as follows:

Maximum Fine: $18,000
Minimum Fine: $ 2,500

The Board's fining guidelines for Dr. Everhart's violation of R.C. 4731.22(B)(6) provide as follows:

Maximum Fine: $20,000
Minimum Fine: $ 3,500

DISCUSSION OF PROPOSED ORDER

Dr. Everhart has practiced internal medicine in Central Ohio for nearly 40 years, and he is beloved by his patients for his gentle, caring manner and the time that he spends listening to his patients. This was evident in his testimony, the many patient letters, and in the demonstration that Dr. Everhart conducted for the Board when he was asked to bring the MSA machine to the

Board's office in March 2019, which the Board members have available to them to watch. He appears sincere in his belief that this device provides useful information that helps him care for his patients, many of whom have sought his advice when no other doctor was able to help them. But despite Dr. Everhart's sincere belief in the validity of the MSA test, the evidence in the record shows that this is an unproven device that he relied on in lieu of the established scientific methods for the diagnosis of disease, and that by doing so, he practiced below the standard of care in his treatment of Patients 1-10.

The record contains no scientific evidence to support Dr. Everhart's belief that MSA machine provides valid information about bacterial, viral, parasitic, and fungal infections that can be present in a patient's body. Dr. Everhart and his expert witness, Dr. Urse, submit that the organisms that cause those infections have unique resonant frequencies that are like fingerprints, identifying the particular bacteria, parasite, fungus, or even heavy metal that is present. However, neither he nor his expert witness was able to produce any scientific literature to prove the validity of that assertion, despite the ten months that elapsed between the issuing of the Notice and the date of the hearing. The pamphlet published by the machine's manufacturer, which Dr. Everhart and Dr. Urse quoted and relied on, does not give a credible explanation of how the machine works. Instead, it contains an admission that how the device works cannot be explained, and it suggests that such an explanation should not be required.

There were other indications that the MSA machine has no scientific validity. Dr. Everhart testified that he has never had to calibrate the machine, or test its readings against substances with known values. Instead, he relies only upon the manufacturer's occasional software updates, which are conducted remotely. And although Dr. Everhart testified that the MSA is used in research institutions such as UCLA, he was not able to offer any evidence of any legitimate institution that uses it, aside from having heard from a patient that he or she had an MSA test in California.

Most suspect, however, is Dr. Everhart's acceptance of the notion that the specific resonant frequencies of the bacteria, parasites, viruses and fungi that the MSA identifies are proprietary information known only to the machine's manufacturer. If it were true that each parasite, bacteria, virus, and fungus emits a known resonant frequency that is unique to that organism, it would seem to be a known scientific fact, in the same way that the speed of sound or the atomic weight and atomic number of any given element are known scientific facts, available to anyone. It would not be information that only the manufacturer of the BioMeridian MSA machine knows and has available for use, especially when the machine has been produced for at least 20 years.

Dr. Everhart's insistence that he does not use the MSA as a diagnostic device is a fiction. He and his patients were careful to say in their testimony that the MSA is not a diagnostic device, and patients sign a legal disclaimer to that effect, but the evidence shows that, in fact, it is used to diagnose specific and sometimes rare illnesses in patients. This was shown by Dr. Everhart's and Dr. Urse's testimony, the testimony of the patients, and the information in his patient charts. Dr. Everhart repeatedly stated that the machine gave him accurate, reliable information that he was unable to get through any other means, and he admitted that he preferred the information

provided to him from the MSA test to information that could be provided to him by generally accepted lab tests, which he dismissed as inaccurate and useless. Time after time, when he was asked how he diagnosed various kinds of disease conditions found in his patients, he said it was on the basis of what the patient told him and the MSA test. Likewise, Dr. Urse's insistence that the machine only "identifies" parasites, bacteria, and such, but does not "diagnose" them seems to be a meaningless difference of semantics.

Dr. Everhart's patients also believe that the MSA test was able to accurately determine the cause of their illnesses when nothing else could. This was shown again and again in their testimony and in the letters that some of them wrote. Although patients sign a release stating that the MSA is not a diagnostic test and they were careful to recite this in their direct testimony, it was clear when they were questioned further that in fact, they did believe it was the MSA test that ultimately identified the parasitic, bacterial, or fungal infections that Dr. Everhart diagnosed them with.

Finally, the evidence in the patients' charts shows that the MSA test was, in fact, the test that Dr. Everhart relied on to arrive at his patients' diagnoses. Although Dr. Everhart characterized the MSA test as one of many "tools" that he uses to reach a diagnosis, the evidence in the patients' charts shows that it in most of those cases, it was the only such tool he relied on, despite the availability of widely accepted lab tests to diagnose the same conditions that he contends are identified by the MSA test. He did not order any other confirmatory testing, and he did not send the patient to any specialists to verify his suspected diagnosis in the vast majority of the cases reviewed. Dr. Taylor testified that he looked very hard for evidence of any other diagnostic test or consultation in the Dr. Everhart's patient charts, but he concluded, "All I saw was MSA testing." (Tr. at 232)

Dr. Everhart emphasized that he also conducts a thorough intake interview and physical exam of each patient, and his patients' testimony confirmed that he does, in fact, spend an unusual amount of time talking with them and listening to their description of their symptoms. But in many of the patient cases, Dr. Everhart diagnosed conditions including intestinal parasites, bacterial infections, fungal disease, and heavy metal toxicity, and then treated patients for those conditions, without using any type of generally accepted empirical testing. He made the diagnosis on the basis of his interview with the patient and one or more MSA tests. Dr. Taylor gave persuasive testimony that a physician's interview and physical exam of a patient cannot substitute for diagnostic testing, particularly when diagnosing parasitic and bacterial diseases. Dr. Taylor also gave credible testimony that there are accurate, reliable laboratory tests that are the standard of care for most of the conditions that Dr. Everhart diagnosed using only the MSA test and a patient's description of their symptoms. The patients' complaints were often fairly vague, such as a queasy stomach or abdominal pain, fatigue, and joint pains, and their physical exams and standard bloodwork often noted no remarkable findings. Yet in each case reviewed, Dr. Everhart diagnosed a multitude of parasitic, bacterial, and viral infections, often accompanied by a diagnosis of fungal infection and heavy metal toxicity.

On the basis of these questionable diagnoses, Dr. Everhart prescribed long courses of mebendazole, a drug usually prescribed for no more than three days to treat intestinal worms, as well as long courses of multiple antibiotics. Dr. Taylor testified credibly that the long-term use of mebendazole can cause liver toxicity, and he noted elevated liver function data in Patient 2's blood work. He also gave persuasive testimony that the overuse of broad-spectrum antibiotics can be harmful to a patient, as it was in the case of Patient 9, who was hospitalized with a life-threatening C. difficile infection and sepsis after being on multiple antibiotics for several months. The evidence was compelling that using this unproven device as a diagnostic tool is not harmless, but that it presents a potential danger to patients, who rely on the fact that Dr. Everhart is a physician licensed by this Board when they put their healthcare in his hands.

Dr. Everhart and his counsel asserted several times during the hearing that Dr. Everhart's patients are the best witnesses as to whether his care was appropriate or not, because in their testimony, their letters, and their online reviews, his patients express that they are very satisfied with his care. But patients do not necessarily know what the standard of care is. The public is not expected to have knowledge of what constitutes good, competent medical treatment that meets the minimal standards of care. Instead, members of the public place their trust in the Board to regulate the practice of the physicians whom it licenses in order to protect and enhance the health and safety of the public. This is the very purpose of the Board.

Finally, while the adequacy and legibility of Dr. Everhart's charts was not as zealously contested as his use of the MSA machine, the State presented at least a preponderance of evidence that the charts would be very difficult for another provider to read, if the patient was cared for by another physician, and therefore, Dr. Everhart's practice also falls below the standard of care in that respect.

The proposed order would impose an indefinite suspension of Dr. Everhart's license, while he completes additional training that will address any deficiencies in his diagnostic and medical record keeping skills and fine him $3,500. Following reinstatement, he would be placed on probation for two years and be required to have a practice plan and a monitoring physician.

PROPOSED ORDER

A. **SUSPENSION OF LICENSE**: Commencing on the thirty-first day following the date on which this Order becomes effective, the license of Larry Everhart, M.D., to practice medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of time.

B. **FINE**: Within thirty days of the effective date of this Order, Larry Everhart shall remit payment in full of a fine of three thousand five hundred dollars ($3,500.00). Such payment shall be made via credit card in the manner specified by the Board through its online portal, or by other manner as specified by the Board.

C. **CONDITIONS FOR REINSTATEMENT OR RESTORATION**: The Board shall not consider reinstatement or restoration of Dr. Everhart's license to practice medicine and surgery until all of the following conditions have been met:

1. **Payment of Fine**: Dr. Everhart shall have fully paid the fine as set forth in Paragraph B of this Order.

2. **Application for Reinstatement or Restoration**: Dr. Everhart shall submit an application for reinstatement or restoration, accompanied by appropriate fees, if any. Dr. Everhart shall not submit such application for at least one year from the effective date of this Order.

3. **Additional Evidence of Fitness To Resume Practice**: In the event that Dr. Everhart has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to application for reinstatement or restoration, the Board may exercise its discretion under 4731.222, Ohio Revised Code, to require additional evidence of his fitness to resume practice.

4. **Post-Licensure Assessment Program**: Prior to submitting his application for reinstatement or restoration, Dr. Everhart shall have undergone an assessment and completed the recommended educational activities, as developed for Dr. Everhart by the Post-Licensure Assessment System [PLAS] sponsored by the Federation of State Medical Boards and the National Board of Medical Examiners. Dr. Everhart's participation in the PLAS shall be at his own expense.

   a. Prior to the initial assessment by the PLAS, Dr. Everhart shall furnish the PLAS copies of the Board's Order, including the Summary of the Evidence, Findings of Fact, and Conclusions of Law, and any other documentation from the hearing record that the Board may deem appropriate or helpful to that assessment.

   b. Should the PLAS request patient records maintained by Dr. Everhart, Dr. Everhart shall furnish copies of the patient records at issue in this matter along with any other patient records he submits. Dr. Everhart shall further ensure that the PLAS maintains patient confidentiality in accordance with Section 4731.22(F)(5), Ohio Revised Code.

   c. Dr. Everhart shall ensure that the written Assessment Report by the PLAS includes the following:

      - A detailed plan of recommended practice limitations, if any;
      - Any recommended education;
      - Any recommended mentorship or preceptorship;

- Any reports upon which the recommendation is based, including reports of physical examination and psychological or other testing.

Moreover, Dr. Everhart shall ensure that, within 14 days of its completion, the written Assessment Report by the PLAS is submitted to the Board.

d. Any Learning Plan recommended by the PLAS shall have been developed subsequent to the issuance of a written Assessment Report, based on an assessment and evaluation of Dr. Everhart by the PLAS. Dr. Everhart shall successfully complete the educational activities as recommended in the Learning Plan, including any final assessment or evaluation.

e. At the time he submits his application for reinstatement or restoration, Dr. Everhart shall submit to the Board satisfactory documentation from the PLAS indicating that he has successfully completed the recommended educational activities.

5. **Medical Records Course(s)**: At the time he submits his application for reinstatement or restoration, or as otherwise approved by the Board, Dr. Everhart shall provide acceptable documentation of successful completion of a course or courses on maintaining adequate and appropriate medical records. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

In addition, at the time Dr. Everhart submits the documentation of successful completion of the course(s) on maintaining adequate and appropriate medical records, he shall also submit to the Board a written report describing the course(s), setting forth what he learned from the course(s), and identifying with specificity how he will apply what he has learned to his practice of medicine in the future

D. **PROBATION**: Upon reinstatement or restoration, Dr. Everhart's license shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least two years:

1. **Modification of Terms**: Dr. Everhart shall not request modification of the terms, conditions, or limitations of probation for at least one year after imposition of these probationary terms, conditions, and limitations.

2. **Obey the Law**: Dr. Everhart shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.

3. **Declarations of Compliance**: Dr. Everhart shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which Dr. Everhart's license is restored or reinstated. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

4. **Personal Appearances**: Dr. Everhart shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which Dr. Everhart's license is restored or reinstated, or as otherwise directed by the Board. Subsequent personal appearances shall occur as otherwise directed by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.

5. **Post-Licensure Assessment Program**: Dr. Everhart shall practice in accordance with the Learning Plan developed by the PLAS, unless otherwise determined by the Board. Dr. Everhart shall cause to be submitted to the Board quarterly declarations from the PLAS documenting Dr. Everhart's continued compliance with the Learning Plan.

   Dr. Everhart shall obtain the Board's prior approval for any deviation from the Learning Plan.

   If, in a manner not authorized by the Board, Dr. Everhart fails to comply with the Learning Plan, Dr. Everhart shall cease practicing medicine and surgery beginning the day following Dr. Everhart's receiving notice from the Board of such violation and shall refrain from practicing until the PLAS provides written notification to the Board that Dr. Everhart has reestablished compliance with the Learning Plan. Practice during the period of noncompliance shall be considered practicing medicine without a license, in violation of Section 4731.41, Ohio Revised Code.

6. **Practice Plan and Monitoring Physician**: Within 30 days of the date of Dr. Everhart's reinstatement or restoration, or as otherwise determined by the Board, Dr. Everhart shall submit to the Board and receive its approval for a plan of practice in Ohio. The practice plan, unless otherwise determined by the Board, shall be limited to a supervised structured environment in which Dr. Everhart's activities will be directly supervised and overseen by a monitoring physician approved by the Board. The practice plan shall, as determined by the Board, reflect, but not be limited to, the PLAS Learning Plan. Dr. Everhart shall obtain the Board's prior approval for any alteration to the practice plan approved pursuant to this Order.

At the time Dr. Everhart submits his practice plan, he shall also submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary and Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Everhart and who is engaged in the same or similar practice specialty.

The monitoring physician shall monitor Dr. Everhart and his medical practice, and shall review Dr. Everhart's patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Everhart and his medical practice, and on the review of Dr. Everhart's patient charts. Dr. Everhart shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Everhart's declarations of compliance.

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Everhart shall immediately so notify the Board in writing. In addition, Dr. Everhart shall make arrangements acceptable to the Board for another monitoring physician within 30 days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Dr. Everhart shall further ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefor.

The Board, in its sole discretion, may disapprove any physician proposed to serve as Dr. Everhart's monitoring physician, or may withdraw its approval of any physician previously approved to serve as Dr. Everhart's monitoring physician, in the event that the Secretary and Supervising Member of the Board determine that any such monitoring physician has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

7. **Required Reporting of Change of Address**: Dr. Everhart shall notify the Board in writing of any change of residence address and/or principal practice address within 30 days of the change.

8. **Tolling of Probationary Period While Out of Compliance**: In the event Dr. Everhart is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Order.

E. **TERMINATION OF PROBATION**: Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Everhart's license will be fully restored.

F. **VIOLATION OF THE TERMS OF THIS ORDER**: If Dr. Everhart violates the terms of this Order in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his license.

G. **REQUIRED REPORTING TO THIRD PARTIES; VERIFICATION**:

1. **Required Reporting to Employers and Others**: Within 30 days of the effective date of this Order, Dr. Everhart shall provide a copy of this Order to all employers or entities with which he is under contract to provide healthcare services (including but not limited to third-party payors), or is receiving training, and the Chief of Staff at each hospital or healthcare center where he has privileges or appointments. Further, Dr. Everhart shall promptly provide a copy of this Order to all employers or entities with which he contracts in the future to provide healthcare services (including but not limited to third-party payors), or applies for or receives training, and the Chief of Staff at each hospital or healthcare center where he applies for or obtains privileges or appointments.

   In the event that Dr. Everhart provides any healthcare services or healthcare direction or medical oversight to any emergency medical services organization or emergency medical services provider in Ohio, within 30 days of the effective date of this Order, he shall provide a copy of this Order to the Ohio Department of Public Safety, Division of Emergency Medical Services.

   Further, within 30 days of the date of each such notification, Dr. Everhart shall provide documentation acceptable to the Secretary and Supervising Member of the Board demonstrating that the required notification has occurred.

   This requirement shall continue until Dr. Everhart receives from the Board written notification of the successful completion of his probation.

2. **Required Reporting to Other Licensing Authorities**: Within 30 days of the effective date of this Order, Dr. Everhart shall provide a copy of this Order by certified mail to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Administration, through which he currently holds any professional license or certificate. Also, Dr. Everhart shall provide a copy of this Order by certified mail at the time of application to the proper licensing authority of any state or jurisdiction in which he applies for any professional license or reinstatement/restoration of any professional license.

Additionally, within 30 days of the effective date of this Order, Dr. Everhart shall provide a copy of this Order to any specialty or subspecialty board of the American Board of Medical Specialties or the American Osteopathic Association Bureau of Osteopathic Specialists under which he currently holds or has previously held certification.

Further, within 30 days of the date of each such notification, Dr. Everhart shall provide documentation acceptable to the Secretary and Supervising Member of the Board demonstrating that the required notification has occurred.

This requirement shall continue until Dr. Everhart receives from the Board written notification of the successful completion of his probation.

This Order shall become effective immediately upon the mailing of the notification of approval by the Board.

Ronda Shamansky

Ronda Shamansky, Esq.
Hearing Examiner

State Medical Board of Ohio

30 E. Broad St., 3rd Floor
Columbus, Ohio 43215
(614) 466-3934
www.med.ohio.gov

EXCERPT FROM THE DRAFT MINUTES OF JULY 14, 2021 IN THE MATTER OF LARRY EVERHART, M.D.

.....

REPORTS AND RECOMMENDATIONS

Ms. Montgomery asked the Board to consider the Reports and Recommendations appearing on the agenda. Ms. Montgomery asked if each member of the Board received, read and considered the Hearing Record; the Findings of Fact, Conclusions and Proposed Orders; and any objections filed in the matters of: Vilma Kistner Briggs, M.D.; Martin Escobar, M.D.; Larry Everhart, M.D.; Joseph Peyton, D.O.; and Hong Wang. A roll call was taken:

Dr. Rothermel	Y
Dr. Saferin	Y
Mr. Giacalone	Y
Dr. Schottenstein	Y
Dr. Johnson	Y
Mr. Gonidakis	Y
Dr. Kakarala	Y
Dr. Feibel	Y
Dr. Reddy	Y
Dr. Bechtel	Y
Ms. Montgomery	Y

Ms. Montgomery further asked if each member of the Board understands that the Board's disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from Dismissal to Permanent Revocation or Permanent Denial. A roll call was taken:

Dr. Rothermel	Y
Dr. Saferin	Y
Mr. Giacalone	Y
Dr. Schottenstein	Y
Dr. Johnson	Y
Mr. Gonidakis	Y
Dr. Kakarala	Y
Dr. Feibel	Y
Dr. Reddy	Y
Dr. Bechtel	Y
Ms. Montgomery	Y

Ms. Montgomery further asked if each member of the Board understands that in each matter eligible for a fine, the Board's fining guidelines allow for imposition of the range of civil penalties, from no fine to the statutory maximum amount of $20,000. A roll call was taken:

Dr. Rothermel	Y
Dr. Saferin	Y
Mr. Giacalone	Y
Dr. Schottenstein	Y
Dr. Johnson	Y
Mr. Gonidakis	Y
Dr. Kakarala	Y
Dr. Feibel	Y
Dr. Reddy	Y
Dr. Bechtel	Y
Ms. Montgomery	Y

Ms. Montgomery stated that in accordance with the provision in section 4731.22(F)(2), Ohio Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of any disciplinary matters. In the disciplinary matters before the Board today, Dr. Rothermel served as Secretary and Dr. Saferin served as Supervising Member. In addition, Dr. Bechtel served as Secretary and/or Supervising Member in the matters of Dr. Escobar, Dr. Everhart, and Dr. Peyton

During these proceedings, no oral motions were allowed by either party. Respondents and their attorneys addressing the Board were allotted five minutes to do so. The assistant attorneys general are subject to the same limitations.

.....

Larry Everhart, M.D.

.....

Dr. Johnson moved to approve and confirm the Proposed Findings of Fact, Conclusions, and Order in the matter of Dr. Everhart. Dr. Kakarala seconded the motion.

Ms. Montgomery stated that she will now entertain discussion in the above matter.

Dr. Schottenstein stated that the field of medicine is one in which the principles of science are applied. The scientific method is used to provide results that are reproducible by other scientists, bias is controlled by random sampling and blinding of the subjects and researchers of experiment, and the results are subject to peer review. Results are quantified, such as confidence in the level of accuracy and the margin of error. Scrutiny and attempts to repudiate results are welcomed. Adherence to the principles of science is indispensable to the advances achieved in the field of medicine in modern times.

Dr. Schottenstein stated that the Meridian Stress Assessment (MSA) machine is not based on science; rather, it is based on pseudoscience. Pseudoscience claims to be based on scientific principles, but in fact it is inconsistent with scientific method, is without scientific foundation, and is actually the opposite of science. Dr. Schottenstein noted that early 20th Century philosopher Karl Popper talked about the concept of falsifiability as a way of distinguishing science from

pseudoscience. In the field of science, results are inherently falsifiable, which means it is rationally possible to contradict them through competing observation. By contrast, pseudoscientific claims are based on an inherently unfalsifiable belief system: If one cannot prove it is wrong, then it must be true. Pseudoscience is substantially dependent on confirmation bias, which means one favors information that supports what one already believes. In pseudoscience, attempts to refute the claims of the practitioner are rejected instead of welcomed and there is a lack of willingness to have outside experts assess the claims of benefit, as has been seen with the description of the MSA technology as proprietary.

Dr. Schottenstein continued that Dr. Everhart embraces patient testimonial accounts to justify his practice, even though patient testimonials never qualify as evidence in the field of medicine. Dr. Schottenstein stated that Dr. Everhart has taken a dagger to the heart of the medical profession by relying on and defending technology that is rooted in pseudoscience. Every diagnosis Dr. Everhart makes and every decision he makes based on this technology is inherently flawed. Dr. Schottenstein disagreed with Dr. Everhart's characterization of this technology, opining that it is not a useful tool, does not give good information, is not an appropriate tool in the right hands, and does not help one get to the root of the problem. Dr. Schottenstein stated that any conversation about chronic Lyme disease and the criteria for its diagnosis becomes meaningless in the context of the use of this machine.

Dr. Schottenstein stated that Dr. Everhart goes to great lengths to rationalize his use of this machine. For instance, Dr. Everhart had testified that he has heard of people in the insurance industry who recognize the value of the machine, even if they don't pay for the test. Also, Dr. Everhart had heard of practitioners who use the machine, but he did not name one person or institution with certainty that do so anywhere. Dr. Everhart further rationalized that the machine is very effective because he gets great reviews online and there were many patient testimonials that vouch for his practice. However, Dr. Schottenstein noted that Dr. Everhart spends a lot of time with his patients and his patients like him, and those testimonial letters really speak to that more than anything. As Dr. Schottenstein had previously noted, in the field of medicine patient testimonials never qualify as evidence. Nonetheless, Dr. Everhart perceives the testimonials as proof of the validity of his practice.

Dr. Schottenstein continued that another rationalization is the practice of having patients sign a form in which they acknowledge that the machine does not diagnose medical conditions. Dr. Everhart relies on that form and the use of semantics that the machine is just a tool that provides useful information. Dr. Schottenstein stated that that form and those semantics are contradicted by Dr. Everhart's actual behavior. Testimony and records clearly show Dr. Everhart's use of the machine to engage in diagnosis of medical conditions. Dr. Schottenstein stated that Dr. Everhart cannot have a patient sign a form that the machine is not being used to diagnose medical conditions, and then proceed to do exactly that.

Dr. Schottenstein observed that when Dr. Everhart is asked how the machine works, he says that he is not an engineer and it is good enough for him that someone at the manufacturing company knows what they are doing. Dr. Schottenstein commented that the representatives of the company, which makes money if Dr. Everhart uses their product, assured Dr. Everhart that they have people who know how this arcane technology works. The fact that no one can prove otherwise is a hallmark of pseudoscience because it is unfalsifiable; the company's information is proprietary and not subject to any scientific scrutiny.

Dr. Schottenstein stated that in his testimony, Dr. Everhart blithely referenced the fact that the machine is based on principles of homeopathy. Dr. Schottenstein was uncertain if Dr. Everhart understands how badly this hurts his credibility and what that sounds like to practitioners who are based in science. Dr. Schottenstein stated that homeopathy is an example of pseudoscience and has no place in the practice of medicine.

Dr. Schottenstein stated that Dr. Everhart's claim that this machine provides actionable intelligence in the diagnosis of rare infections based on its ability to determine pathogen resonant frequencies by measuring electrical skin resistance is extraordinary. Dr. Schottenstein stated that it would be miraculous if such a machine actually existed. Dr. Schottenstein quoted Carl Sagan that extraordinary claims require extraordinary evidence. Dr. Schottenstein questioned where the extraordinary evidence is in this case. Dr. Schottenstein also questioned where the ordinary evidence is, or the supporting data.

Dr. Schottenstein stated that Dr. Everhart is not using this machine because there have been good, reliable, reproducible studies that have shown its validity for purposes of medical diagnosis. Rather, Dr. Everhart was impressed with the demonstration by the company's representatives as to the benefits of the machine. Dr. Schottenstein stated that it is unethical to use a machine for purposes of medical diagnosis or treatment if the source of information is the company's representatives who profit if the machine is purchased. Dr. Schottenstein stated that the company's representatives are salespeople and their job is to put on a great show. It is up to the physician to maintain a healthy skepticism when confronted with a demonstration of a product by company representatives.

Dr. Schottenstein continued that Dr. Everhart is diagnosing serious, rare medical conditions with this machine based on his own personal opinion that these conditions are ubiquitous and underdiagnosed in central Ohio. Dr. Schottenstein stated that there is no evidence to that effect, and it is actually contrary to Centers for Disease Control and Prevention (CDC) data. Further, the machine is being used in lieu of actual laboratory tests and imaging studies that are available. The machine was a contrivance that allowed Dr. Everhart to justify the diagnosis which he was essentially otherwise making up out of whole cloth from a variety of nonspecific physical complaints. Dr. Schottenstein stated that Dr. Everhart's treatment of these conjectured conditions was grossly negligent, as illustrated by the treatment-induced liver toxicity in Patient 2 and the hospitalization and treatment-induced sepsis of Patient 9.

Dr. Schottenstein stated that, sadly, Dr. Everhart has used this machine to diagnosis unfounded problems in numerous patients over the years. This has the effect of tempting vulnerable patients away from legitimate medical care that is science-based, which has negative repercussions in terms of both physical and emotional health for these individuals and for society at large.

Dr. Schottenstein noted defense counsel's closing argument in which he expressed surprise, given the concerns that have been raised about the MSA device, that the Medical Board has never previously taken action against either against the company that manufactures the device or against other health care providers that may have used it. Dr. Schottenstein stated that this is a fair question, and answered it by saying the Medical Board is a complaint-driven organization. The Board does not take it upon itself to spontaneously investigation medical

technology or go into doctors' offices to investigate their practices. The Board responds to complaints, and someone lodged a complaint about Dr. Everhart's practice with the Board. Dr. Schottenstein commented that if Dr. Everhart's activities had been more mundane such as diagnosing vitamin deficiencies and recommending nutrition changes, that would probably have stayed under the radar. Dr. Schottenstein added that not every healthcare provider is licensed by the Medical Board, so practitioners using this technology who are licensed by other entities would not be in the Board's jurisdiction.

Dr. Schottenstein stated that Dr. Everhart and his counsel ultimately rely on their argument that there were many long-suffering patients who got better with Dr. Everhart's treatment. Dr. Schottenstein pointed out that it is still not known if the patients actually had the conditions for which they were being treated because there were no science-based diagnostic tests. Further, it is not known if Dr. Everhart's approach to treatment, in which he gave patients several broad-spectrum agents, treated something that was not even on his list of diagnoses, essentially treating those patients by accident. It is not known if the patients would have gotten better in time without treatment, nor is it known if there was a placebo response because there is no control group regarding Dr. Everhart's approach. Dr. Schottenstein felt that this is a difficult concept for those who are not educated in scientific principles, but he was incredulous that Dr. Everhart does not seem to understand these basic and obvious flaws in his theory that he must be practicing medicine appropriately because some patients got better.

Dr. Schottenstein respectfully disagreed with the Hearing Examiner's Proposed Order, which conceptualizes Dr. Everhart as someone who can be remediated with additional medical study and training. Dr. Everhart's testimony did not indicate any insight, regret, or resolve to practice according to the standard of care. The job of the Medical Board is to protect the citizens of Ohio and the medical profession itself from quackery, and its response should be unequivocal. The Medical Board exists to act as a bulwark against the pseudoscience that would infect the medical profession and put Ohio's citizens at risk. Dr. Schottenstein opined that the Board should send a letter to the FDA informing them of the details of this case and how their 510(k) clearance was used to provide a veneer of credibility to Dr. Everhart's use of this technology.

Dr. Schottenstein moved to amend the Proposed Order to a permanent revocation of Dr. Everhart's Ohio medical license. Dr. Feibel seconded the motion.

Mr. Giacalone stated that the FDA's approval process and its clearance process are very different from each other. The clearance process means clearance to market a medical device and requires substantial equivalence to something already on the market. The "clearance" process is not akin to prescription drug or medical device "approval." The "approval" process is very regimented and involves clinical studies establishing safety and effectiveness. Mr. Giacalone stated that the MSA machine, as it currently exists, does not fall into the category which requires a PMA (Premarket Approval) by the FDA. Mr. Giacalone opined that characterizing the use of this medical device as being somehow equivalent in value or utility to an EKG, as Respondent's attorney stated, is a farce.

Mr. Giacalone stated that an FDA guidance document from August 1994 that skin response measurement devices such as the MSA device ". . . were intended only for measurement of skin resistance (i.e., conductance). Any other intended use diagnostic capability must be supported by valid scientific data." The document further states that the FDA is ". . . not aware

of any galvanic skin response (GSR) device that has any specific diagnostic capability, nor is there any scientific evidence that GSR devices can be used to diagnose any particular disease."

Responding to a question from Ms. Anderson, Mr. Giacalone stated that the document to which he is referring is not part of the hearing record for this case, but it is a publicly-available record from the FDA and can be found online. Ms. Anderson recommended that the Board's discussion be confined to the hearing record. Mr. Giacalone stated that the FDA document is relevant to this matter and strikes at the validity of what is being purported by the manufacturer of this device and the Respondent as to the intended use of the MSA medical device. In short, the claims purported to be made by the manufacturer and the Respondent regarding the diagnostic capabilities of this device are clearly contrary to the FDA's regulations and the FDA's opinion of such devices.

Mr. Giacalone continued that the FDA issued numerous warning letters for GSR medical devices. Mr. Giacalone found it interesting that Geraldine Urse, D.O., who testified as an expert in support of Dr. Everhart, used a hand-held GSR medical device manufactured by ZYTOS in her own practice. This same company, ZYTOS Technologies, Inc., had received a Warning Letter from the FDA pertaining to the company's handheld GSR device, the ZYTOS Hand Cradle. Specifically, the FDA issued a warning letter to ZYTOS regarding inappropriate and unsubstantiated claims that the ZYTOS medical device could be used for "diagnosing a disease." Mr. Giacalone stated that if this product actually did what it is purported to do in terms of diagnostic capabilities, any legitimate medical device company would have moved forward to obtain an FDA approval through the premarket approval process given that the diagnostic capabilities attributed to such a device would be revolutionary. Mr. Giacalone stated that the purported diagnostic claims for this device are clearly out of scope for its FDA clearance as a GSR device. That said, he questioned how a medical professional could have been taken in and relied upon such unsubstantiated claims.

Ms. Montgomery commented that it is important that the Board's decision is based on the hearing record.

Dr. Feibel stated that he appreciates Mr. Giacalone's comments, but he will not use those comments in forming his determination in this matter. Dr. Feibel agreed with Dr. Schottenstein's comments. Dr. Feibel stated that it is important to understand that Dr. Everhart earned a lot of money on this device. Dr. Feibel noted the following passage from Dr. Everhart's consent form:

> Please note that the equipment utilized Is nondiagnostic in nature. This procedure is approved by the FDA for evaluation of functional health and will help the doctor determine what medicines or nutritional supplements will be needed to address your specific health needs.
>
> The doctor may recommend certain nutritional supplements which can be purchased on site from HOST NUTRITION, LTD. You may choose to purchase similar products elsewhere; however, we can only vouch for the quality and effectiveness of the specific products we have tested you for on the MSA machine. The majority of these products are produced in reputable labs and are only sold by health care providers. You cannot purchase these brands in retail stores.

Dr. Feibel opined that this is an effort to get patients to purchase products from Dr. Everhart, which he found to be wholly unethical and a harm to the public.

Dr. Johnson stated that there is great concern about the medications that were prescribed by Dr. Everhart and the process for prescribing them in terms of the public pharmacy. Dr. Johnson noted that a patient became very ill and septic as a result of this exposure, which is verry concerning in itself.

Referring to his previous comments, Mr. Giacalone clarified that the FDA approval process and clearance process was discussed *ad nauseum* in the hearing testimony, and the information he had discussed simply delineates what is in the scope of the clearance and the approval processes. Mr. Giacalone reiterated that it is publicly-available information, no different than a statute or a regulation. Mr. Giacalone opined that it is relevant because it is important to understand the product is not being used for what it was cleared to be used for by the FDA, and, furthermore, that the FDA sent Warning Letters that were sent in similar situations shows that it is being used inappropriately.

Ms. Montgomery opined that Dr. Everhart has not been truthful when claiming that he does not use the machine for diagnostic purposes. Ms. Montgomery stated that the Assistant Attorney General clearly established that the machine is being used for diagnosis. Ms. Montgomery also expressed concern that the diagnoses seem to be routinized. Further, the medications are prescribed in large amounts and appear to contradict each other in some cases.

As a consumer representative on the Board, Ms. Montgomery was concerned that the MSA machine was being inappropriately used as a diagnostic tool, that the diagnoses from the machine are not reliable, and as a result the medications prescribed in some cases seem to be dangerous. Ms. Montgomery believed that the record reflects a real danger to the public in terms of how Dr. Everhart is practicing medicine.

Dr. Reddy stated that Dr. Everhart is treating lesions which could have been diagnosed easily and treated very nicely, rather than the way Dr. Everhart treated them. Dr. Reddy stated that the MSA machine may have given some evidence of the condition, but Dr. Everhart never proved that that particular condition existed before starting treatment.

Responding to a question from the Board Parliamentarian, Dr. Schottenstein clarified that his motion to amend to a permanent revocation was not intended to alter the $3,500 fine that was in the original Proposed Order. All Board members agreed that that was their understanding as well.

A vote was taken on Dr. Schottenstein's motion to amend:

Dr. Rothermel	Abstain
Dr. Saferin	Abstain
Mr. Giacalone	Y
Dr. Schottenstein	Y
Dr. Johnson	Y
Mr. Gonidakis	Y

Dr. Kakarala	Y
Dr. Feibel	Y
Dr. Reddy	Y
Dr. Bechtel	Abstain
Ms. Montgomery	Y

The motion to amend carried.

Dr. Feibel moved to approve and confirm the Proposed Findings of Fact, Conclusions, and Order, as amended, in the matter of Dr. Everhart. Dr. Johnson seconded the motion. A vote was taken:

Dr. Rothermel	Abstain
Dr. Saferin	Abstain
Mr. Giacalone	Y
Dr. Schottenstein	Y
Dr. Johnson	Y
Mr. Gonidakis	Y
Dr. Kakarala	Y
Dr. Feibel	Y
Dr. Reddy	Y
Dr. Bechtel	Abstain
Ms. Montgomery	Y

The motion to approve carried.

State Medical Board of Ohio

30 E. Broad St., 3rd Floor
Columbus, Ohio 43215
(614) 466-3934
www.med.ohio.gov

May 13, 2020

Case number: 20-CRF-0064

Larry Everhart, M.D.
300 Glen Village Court
Powell, Ohio 43065

Dear Doctor Everhart:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to grant or register or renew or reinstate your license or certificate to practice medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

(1) From on or about January 24, 2005 to July 24, 2019 you provided care to Patients 1-10 as identified in the attached Patient Key (Key is confidential and to be withheld from public disclosure.) You relied on the Meridian Stress Assessment (M.S.A.) to diagnose and subsequently treat Patients 1-10. The M.S.A. is an unproven electrodermal diagnostic device which uses acupuncture theory and galvanic skin response to make specific diagnoses in the correlated organs. Furthermore, you failed to confirm M.S.A. results through appropriate laboratory testing and/or consultation from a specialist before employing treatment measures.

a. In regard to your care of Patients 1-10, you inappropriately prescribed the antiparasitic drug Mebendazole and you prescribed it in excess of recommended dosages. Mebendazole is commonly used to treat parasitic intestinal worms, diagnoses that you did not appropriately confirm as stated in paragraph (1).

b. In regard to your care of Patients 1-10, you inappropriately prescribed multiple antibiotics and you prescribed them in excess of recommended dosages to treat Lyme disease, Babesia, and/or other diagnoses that you did not appropriately confirm as stated in paragraph (1).

c. Additionally, your medical records for Patients 1-10 were incomplete and/or illegible.

Your acts, conduct, and/or omissions as alleged in paragraphs (1) and (1)(a) through (1)(c) above, individually and/or collectively, constitute a "departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) and (1)(a) through (1)(c) above, individually and/or collectively, constitute "[f]ailure to maintain minimal standards applicable

Mailed 5-14-2020

to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as that clause is used in Section 4731.22(B)(2), Ohio Revised Code.

Furthermore, for any violations that occurred on or after September 29, 2015, the board may impose a civil penalty in an amount that shall not exceed twenty thousand dollars, pursuant to Section 4731.225, Ohio Revised Code. The civil penalty may be in addition to any other action the board may take under section 4731.22, Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to grant or register or renew or reinstate your certificate or license to practice medicine and surgery or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that "[w]hen the board refuses to grant or issue a license or certificate to practice to an applicant, revokes an individual's license or certificate to practice, refuses to renew an individual's license or certificate to practice, or refuses to reinstate an individual's license or certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a license or certificate to practice and the board shall not accept an application for reinstatement of the license or certificate or for issuance of a new license or certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,

Mark Bechtel, M.D. /SML

Mark Bechtel, M.D.
Acting Secretary

KGR/LAM/jb
Enclosures

CERTIFIED MAIL # 91 7199 9991 7038 7137 5405
RETURN RECEIPT REQUESTED

cc: Gerald Sunbury, Esq.
35 East Livingston Avenue
Columbus, OH 43215

CERTIFIED MAIL # 91 7199 9991 7038 7137 5412
RETURN RECEIPT REQUESTED

cc: Bill Mann, Esq.
211 Bradenton Avenue
Dublin, Ohio 43017

CERTIFIED MAIL # 91 7199 9991 7038 7137 5023
RETURN RECEIPT REQUESTED

IN THE MATTER OF LARRY S. EVERHART, MD

20-CRF-0064

MAY 13, 2020, NOTICE OF OPPORTUNITY FOR HEARING - PATIENT KEY

SEALED TO PROTECT PATIENT CONFIDENTIALITY AND MAINTAINED IN CASE RECORD FILE.