BEFORE THE VIRGINIA BOARD OF MEDICINE

IN RE: LEILA HADDAD ZACKRISON, M.D.
License Number: 0101-045689
Case Numbers: 161559, 175503, 183943, 187023, 194466

ORDER

JURISDICTION AND PROCEDURAL HISTORY

Pursuant to Virginia Code §§ 2.2-4020, 2.2-4024(F), and 54.1-2400(11), a panel of the Virginia Board of Medicine ("Board") held a formal administrative hearing on February 20-22, 2020, in Henrico County, Virginia, to inquire into evidence that Leila Haddad Zackrison, M.D., may have violated certain laws and regulations governing the practice of medicine and surgery in the Commonwealth of Virginia.

Leila Haddad Zackrison, M.D., appeared at this proceeding and was represented by Jacques G. Simon, Esquire, and Dan Alpert, Esquire.

Upon consideration of the evidence, the Board adopts the following Findings of Fact and Conclusions of Law and issues the Order contained herein.

FINDINGS OF FACT

1. On August 1, 1990, the Board issued License Number 0101-045689 to Leila Haddad Zackrison, M.D., to practice medicine and surgery in the Commonwealth of Virginia. Said license was summarily suspended by Order of the Board entered September 12, 2019. At all times relevant hereto, said license was in full force and effect.

2. In the care and treatment of Patient A, a female relative of Dr. Zackrison's, between approximately 2010 (when the patient was 14 years old) and 2015 (age 18), Dr. Zackrison ordered or directed her employees to order medically unnecessary tests, made diagnoses without sufficient justification, and initiated and continued potentially harmful treatment (such as long-term oral and

intravenous antibiotics, anti-fungal medications, and corticosteroids) without appropriately weighing possible side effects or adverse outcomes versus the likelihood of the treatments being effective. Further, in response to non-specific or transient symptoms such as fatigue, palpitations, near-syncope, headache, constipation, insomnia, concentration issues, excessive thirst, and loss of appetite in this pediatric patient, Dr. Zackrison ordered or directed her employees to order repeated tests for a variety of tick-borne illnesses,[1] parasitic or bacterial infections,[2] and other rare diseases or conditions.[3] Upon review of negative or slightly abnormal test results, Dr. Zackrison diagnosed or directed her employees to diagnose Patient A with, and aggressively treated her for, multiple simultaneous illnesses without regard to the likelihood of the disease process or whether the diagnoses made biological sense in relation to the symptom complex the patient was experiencing.

a. Patient A was diagnosed with Lyme disease in April 2008 at age 12,[4] apparently based on a positive Western blot (IgM +23 and +41). However, data suggests that of all people who test positive for those particular two IgM bands, only approximately 40 percent have Lyme disease, and a review of Patient A's chart from 2010 through 2015 indicates that she did not have acute or persistent Lyme disease. After Patient A was diagnosed with Lyme disease, Dr. Zackrison ordered or directed her employees to order repeated serologic testing for Lyme without medical justification. These tests were ordered on 4/2/10, 7/27/10, 11/12/10, 6/22/11, 12/16/11, 3/28/12, 5/11/12, 8/14/12,

[1] Including Lyme disease, Rocky Mountain spotted fever, babesiosis, and anaplasmosis.

[2] Including giardia, echinococcus, Chlamydophila, Mycoplasma, schistosomiasis, bartonella, Entamoeba histolytica, strongyloides, toxoplasma, and trichinella spiralis.

[3] Such as Q fever, murine typhus, actinomycosis, cysticercosis, brucellosis, WA1, heavy-metal poisoning, and toxic mold exposure.

[4] A hospital ED record from July 30, 2014 states that Patient A was being treated at Dr. Zackrison's practice for "medical issues which include history of Lyme, [Rocky Mountain spotted fever], babesiosis, possible [diabetes insipidus] and [postural orthostatic tachycardia syndrome]. She first had symptoms at age 4 with migratory arthritides." Additionally, documentation from a pediatric cardiologist who saw Patient A at age 16 in 2013 states that "She apparently has had chronic Lyme for 10 years."

10/8/12, 11/20/12, 2/4/13, 2/26/13, 5/13/13, 8/5/13, 11/12/13, 4/18/14, 6/5/14, 6/30/14, 8/8/14, 10/1/14, 3/10/15, 4/8/15, and 8/10/15. A flow sheet in Patient A's chart indicates she was also tested for Lyme on 7/16/07, 4/2/08, 6/6/08, 8/8/08, 10/2/08, 12/30/08, 6/11/09, 7/8/09, 10/2/09, and 11/11/09. Despite 33 negative tests, and without appropriately weighing the risks, Patient A was aggressively treated for an extended period for diagnoses of Lyme disease and "polymicrobial state."[5] For example, the patient was treated with Omnicef (cefdinir) for more than six months in 2011; Cipro (ciprofloxacin) in mid-2011; doxycycline from late 2012 through approximately late 2013, and late 2014 through early 2015; intravenous Rocephin (ceftriaxone) in February 2013, November 2013, and April 2014; and intravenous acyclovir, Vfend (voriconazole), and Invanz (ertapenem) in 2014.

b. It is unclear from Patient A's chart when she was first diagnosed with Rocky Mountain spotted fever ("RMSF"). Based on her persistently low-positive titer, it is possible that she had an asymptomatic or marginally symptomatic infection with Rickettsia rickettsiae. Once Dr. Zackrison or her staff made this diagnosis for Patient A, however, there was no justification for repeated serological testing for RMSF. Despite this lack of medical justification, Dr. Zackrison ordered or directed her employees to order testing on 4/2/10, 6/4/10, 7/27/10, 10/22/10, 1/4/11, 5/4/11, 6/22/11, 12/16/11, 3/28/12, 5/11/12, 8/14/12, 10/8/12, 11/19/12, 2/4/13, 2/26/13, 5/13/13, 8/5/13, 4/18/14, 6/5/14, 6/30/14, 8/8/14, 10/1/14, 1/16/15, 2/24/15, and 4/8/15. Patient A's chart indicates that she was also tested for RMSF on 4/2/08, 8/8/08, 6/11/09, and 10/2/09. Moreover, assuming the diagnosis of RMSF was correct, Patient A was incorrectly treated. Even in severe cases of acute RMSF, treatment consists of timely administration of seven to 14 days of doxycycline. Individuals who have a positive IgG titer but are not showing symptoms referable to RMSF -- such as Patient A --

[5] At various locations in Patient A's chart, the term "polymicrobial state" is applied to combinations of allegedly coexisting infections, including but not limited to Lyme, Rocky Mountain spotted fever, Rickettsia bacteria, Typhus/murine typhus, "tick-borne diseases," anaplasma, C. pneumonia, Bartonella, babesia, candida/yeast, Q fever, Legionella, and WA1 (a variant of babesia).

do not require therapy at all. However, on multiple occasions between 2010 and 2014, Patient A was aggressively treated with multiple medications for diagnoses of RMSF and "polymicrobial state."[6] For example, she was prescribed Lariam (mefloquine) in 2010; albendazole, mebendazole, Biltericide (praziquantel),[7] and Ketek (telithromycin) in 2011 and 2012; Alinia (nitazoxanide) in or about 2011 through 2014; Coartem from 2012 through 2014; doxycycline in or about 2012 through 2015; unspecified "IV antibiotics" in 2013; and Vfend in 2014.

c. Between 2010 and 2015, Patient A lacked a documented history suggestive of anaplasmosis, yet she was repeatedly tested for this tick-borne disease. Patient A was tested on 6/22/11, 12/16/11, 5/11/12, 8/14/12, 11/19/12, 2/4/13, 5/13/13, 8/5/13, 11/12/13, 4/18/14, 6/5/14, 8/8/14, and 4/8/15. While some of the tests were positive, given that Patient A was asymptomatic or only marginally symptomatic for anaplasmosis, no treatment was required. However, on multiple occasions between 2011 and 2015, as detailed above in Findings of Fact 2(a) and 2(b), Patient A was aggressively treated with antibiotics for diagnoses of "multiple tick-borne diseases" and "polymicrobial state," both of which were defined or explained in the patient's chart as including anaplasma/anaplasmosis.

d. Without making an appropriate risk/benefit assessment, Dr. Zackrison ordered or directed her employees to order antibiotics and antifungals, vitamins, supplements, and hydration to be administered intravenously to Patient A to treat these multiple diagnoses.[8] Although the patient's chart does not indicate that she was unable to take medication or hydration orally, Dr. Zackrison or her

[6] See footnote 5 above.

[7] According to Dr. Zackrison's testimony, Patient A, in consultation with Dr. Zackrison, decided not to take some medications, including praziquantel. The prescribing nurse practitioner was not notified, however.

[8] The diagnoses included, but were not limited to, tick-borne diseases, "polymicrobial state," yeast/fungal overgrowth, and "detox dysfunction."

staff ordered surgical placement of indwelling catheters in March 2013[9]; mid-September 2013 through October 2014; November and December 2014; and April through September 2015.[10]

(i) Due to this excessive use of intravenous medication and catheters, Patient A required monitoring for deep vein thrombosis with frequent blood work and ultrasounds. An ultrasound on 3/22/13 confirmed the existence of deep vein thrombosis, which required removal of a peripherally inserted central catheter ("PICC") from Patient A's left arm and required a prescription of anticoagulants. Patient A underwent follow-up scans on 4/1/13 and 6/7/13 as a result of the previous deep vein thrombosis. On 11/8/13, Patient A had an ultrasound of her right arm to check for possible deep vein thrombosis, and on an unspecified date in April 2014 had another ultrasound of her right arm for the same reason. On 6/5/14, Patient A had yet another ultrasound of her right arm to check for deep vein thrombosis, and on 10/6/14 had an ultrasound of her right arm for possible deep vein thrombosis followed by the replacement of a midline catheter due to complaints of poor functioning.

(ii) After Patient A had been receiving IV infusions at home with parental assistance for some time, she began self-administration. In November 2014 she was authorized by Dr. Zackrison to self-administer IV hydration at school if she felt ill and a family member was unable to pick her up.

(iii) A nurse practitioner who treated Patient A while working at Dr. Zackrison's practice between late 2010 and early 2015 stated to the Board's investigator that she did not believe Patient A was chronically ill. In response to this allegation, Dr. Zackrison testified that this statement was the result of the nurse practitioner's own health, but did not elaborate.

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[9] Patient A was 16 at this time.

[10] The patient's chart also indicates she had a PICC in her left arm from approximately June through November 2009, when she was 12 years old.

(iv) Notes in Patient A's chart indicate that the patient herself did not always support the IV treatments. For example, another provider who treated Patient A at the practice e-mailed Dr. Zackrison on January 13, 2011 (when the patient was 14) saying that the provider "hope[d] she would have begun IVs" already, and Dr. Zackrison replied: "[s]he is dragging her feet again." Likewise, when a representative of the company providing supplies for home infusions e-mailed Dr. Zackrison on June 24, 2014 (when the patient was 17) asking if the company should deliver more Invanz and hydration that week, Dr. Zackrison replied: "[s]he is has [sic] become less compliant. Pls do not send any further supplies including hydration at this time."

e. On multiple occasions, Dr. Zackrison ordered or directed her employees to order excessive tests, tests without an appropriate medical indication, and tests which did not reasonably serve a clinical purpose in the treatment of Patient A.

- Patient A was tested for HHV-6 (human herpesvirus) antibodies on multiple occasions, including on 6/22/11, 11/19/12, 2/26/13, and 8/10/15.[11] There is no medical indication for ordering this test once, let alone multiple times, in a teenaged patient. Almost all children over the age of five would have been previously infected and therefore would test positive for this antibody, as HHV-6 is ubiquitous and infects most children by that age. Further, there is no specific treatment for an active HHV-6 infection, and the typical symptoms of fever and rash generally subside in 3 to 5 days.

- On June 5, 2014, Patient A was tested for coxsackie virus, otherwise known as "hand, foot, and mouth disease." This is a mild, common enterovirus for which there is no specific treatment.

- At an office visit on June 27, 2014, a nurse practitioner at Dr. Zackrison's practice ordered the following tests for Patient A: comprehensive metabolic panel, serum osmolality, 24h urine total sodium, 24h urine osmolality, and 24h total uric acid (osmolality, NA, K+, CA). Three days later, without examining Patient A, Dr. Zackrison ordered approximately 65 lab tests[12] for 35 assessed problems.[13] At the related office visit with the nurse practitioner,

[11] Patient A's chart also indicates she was tested for HHV-6 on 12/30/08 and 6/11/09. The same test was also ordered on 5/27/11, although the lab was unable to complete it due to gross hemolysis, requiring a redrawing of blood.

[12] Specifically: angio-tension converting enzyme, anti-thyroid antibodies, ASO, Streptozyme, DNAase, CA Ionized, intact PTH (frozen specimen) fasting, C4a, CBC with differential and platelets, fasting insulin, ACTH hormone, FSH/LH, prolactin, insulin growth factor-1 (IgF-1), 17 hydroxyprogesterone, 17 beta estradiol, progesterone, pregnenolone, DHEA-S, estrone, estradiol, estriol androstenedione, hemoglobin A1C, H. pylori, iron/TIBC, ferritin, G6PD, total serum copper, ceruloplasmin, methylmalonic acid (MMA), PA-intrins. fact. block antibody & gastric parietal cell antibody, TAT,

Patient A had reported that on most days her joint/muscle pain was at a level of 1 to 2 out 10, and she rated her fatigue on most days as 2 out of 10. Similarly, on September 23, 2014, a lab order for Patient A completed by Dr. Zackrison requested approximately 25 tests for 25 assessed problems. Despite Patient A's complaints being minimal, the lab tests ordered and problems assessed were numerous.

- On at least six occasions (on 6/22/11, 12/16/11, 11/19/12, 6/30/14, 1/16/15, and 2/24/15), Patent A was tested for H. pylori antibodies, although her differential diagnosis/assessment did not include peptic ulcers. Further, urea breath tests and stool antigen tests are more accurate than serologic tests to detect an active infection with H. pylori.[14]

- Patient A had blood tests for candida albicans antibodies on at least 11 occasions (on 10/22/10, 12/16/11, 8/14/12, 11/19/12, 2/26/13, 6/5/14, 6/30/14, 8/8/14, 1/16/15, 6/3/15, and 8/10/15). This test is not useful, as healthy individuals may test positive, and the most accurate method of testing for candida is by blood culture, not serologic antibody testing.

- On October 8, 2014, Patient A had rectal/fecal swabs taken to be tested for candida albicans and Actinomyces israelii, organisms that commonly are found in the digestive tract. At the time, Patient A did not have clinical symptoms of actinomycosis or invasive candidiasis, so no testing was warranted. Further, the most accurate method of testing for candidiasis is by blood culture, and actinomyces is identified by microscopy and culture of sputum, pus, or a biopsy specimen, not from a fecal sample.

f. During her hearing testimony, Dr. Zackrison repeatedly stated that the prescribing nurse practitioner was the sole health care provider responsible for Patient A's care at Dr. Zackrison's practice. During the dates detailed in Patient A's record, however, nurse practitioners in

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prothrombin fragment, free testosterone, total testosterone, sex-hormone binding globulin, zinc, selenium, L-carnitine, 25 hydroxy vit. D, Candida AB & AG (antigen), NH3, AL, PB, urine CHO, plasma renin & aldosterone, 24h urine creatinine clearance and serum creatinine, 24h urine porphyrines [sic], 24h urine total calcium, total oxalate, 24h total uric acid (spot urine, osmolality, NA, K+, C1), antiphospholipid antibody list (cardiolipin AB (IgA, IgM, IgG), PTT, lupus coagulant), serum osmolality, comprehensive metabolic panel, phosphorus, magnesium RBC level, GGT, LDH, total & direct bilirubin, and RMSF.

[13] Specifically: abdominal pain, abnormal stool, adrenal glands disorder, anemia–iron deficiency unspecified, babesiosis, calcium metabolism disorders, candidiasis–thrush/vulva, chest pain/cough, chronic-fatigue syndrome, circulating anticoagulants, coagulation abnormality, constipation, dehydration, dysautonomia, enteritis–regional, fibromyalgia/chronic fatigue syndrome, fracture (closed), gastritis/gastroenteritis NOS, headache, hormonal imbalance/endocrine, hypomagnesemia, hypophosphatasia, hypothyroidism, L-carnitine deficiency, lymph nodes enlarged, malaise and fatigue, myalgia (unspecified), neutropenia (leucopenia), palpitation, paresthesia, polyarthritis inflammatory, renal insufficiency, RMSF, sleep disturbance/sleep apnea, thrombocytopenia, and weakness (muscle).

[14] In another example of failing to notify the purportedly treating practitioner of changes or non-compliance, Dr. Zackrison testified that Patient A did not perform two of these tests. Patient A's record, however, does not include this information. Notably, Patient A's chart, which Dr. Zackrison did not consult during her testimony, only reflected one ordered test for H. pylori that was not completed. All other tests that were ordered for Patient A had corresponding results in the record.

the Commonwealth could not practice autonomously. Nurse practitioners were required to be supervised by a physician, which in this case was Dr. Zackrison. Additionally, the Board believed that Dr. Zackrison was intimately involved in treating Patient A based on her testimony that she participated in Patient A's medical decisions and kept a second patient care chart at home, which was not shared with the nurse practitioner.

3. Patient B, a 13-year-old female, was treated by Dr. Zackrison between approximately September 2016 and November 2017. Dr. Zackrison ordered tests, made diagnoses, and initiated and continued potentially harmful treatment for Patient B, such as long-term oral and intravenous antibiotics and steroids, without sufficient justification and without appropriately weighing possible side effects or adverse outcomes of such treatment versus the likelihood of the treatment being effective. Patient B's chart from Dr. Zackrison's practice includes the following non-specific symptoms: fatigue, palpitations, malaise, headache, weight loss, and several episodes of collapsing or fainting. In response to these vague symptoms, Dr. Zackrison recommended or ordered numerous tests, including: blood work on 15 occasions and urine tests five times over a 15-month period; stool tests; multiple cardiology studies, including a 30-day heart monitor, despite Patient B's prior negative workups; a brain MRI and 72-hour continuous EEG, despite Patient B's prior negative neurological workups; and a lumbar puncture/spinal tap. Upon receipt of negative or slightly abnormal test results, Dr. Zackrison diagnosed Patient B with and aggressively treated her for multiple simultaneous illnesses[15] without regard to the likelihood of the disease process or whether the diagnoses made biological sense in relation to the symptom complex the patient was experiencing.

[15] This includes rare and unlikely diseases (bacteremia – anaerobics, pseudomembranous pharyngitis, and PANDAS); diseases for which Dr. Zackrison lacked confirmatory test results (Lyme disease, Bartonella, babesiosis, streptococcus, thrush, inflammatory arthritis, juvenile rheumatoid arthritis (juvenile idiopathic arthritis), undifferentiated connective tissue disease, sinus arrhythmia, dysautonomia, Ehlers-Danlos Syndrome, mast cell activation syndrome, and adrenal insufficiency); and conditions that are not accepted medical diagnoses (gut infections, "strep syndrome," "suspect parasites," "increased microbial burden," and "presumed bacteremia").

a. Without referring Patient B to an appropriate specialist, Dr. Zackrison incorrectly diagnosed and treated Patient B for Addison's disease, adrenal insufficiency, "adrenal fatigue," and "adrenal hypoperfusion." Adrenal insufficiency is diagnosed based on low morning cortisol levels, with confirmatory adrenocorticotropic hormone (ACTH) stimulation testing showing a peak cortisol level below 18 mcg/dL or insufficient rise from baseline cortisol. Tests of morning salivary cortisol levels are not recommended as a primary diagnostic tool due to low sensitivity and specificity. Without ordering and reviewing appropriate testing, on May 4, 2017, Dr. Zackrison diagnosed Patient B with adrenal insufficiency. The patient's chart lacked a documented ACTH level and the serum samples submitted for lab testing, collected on 7/27/17, 8/31/17, 10/13/17, and 11/14/17, were not obtained in the morning. The patient's morning salivary cortisol level from a sample submitted on 4/11/17 was within the normal range. After making this incorrect diagnosis, beginning on September 12, 2017, Dr. Zackrison unnecessarily prescribed hydrocortisone at doses ranging from 20mg to 30mg per day. This prescription level,[16] in a child that did not have adrenal insufficiency, can create chronic adrenal suppression. This causes direct harm by inducing an illness that did not exist previously. Based on the incorrect diagnosis of Addison's disease, on October 16, 2017, Dr. Zackrison provided Patient B with a prescription for a stress dose of intravenous hydrocortisone to be administered during the patient's tonsillectomy, scheduled for October 28, 2017.

b. Patient B was diagnosed with and treated for Lyme disease, Bartonella/ bartonellosis, and "tick-borne diseases" absent an appropriate medical indication.

(i) At her first office visit, Dr. Zackrison documented a history of a tick bite, but she did not note where or when this occurred, nor did she document whether the patient

[16] Dr. Zackrison testified that she prescribed a lower dosage of this medication, but did not refer to Patient B's chart in the record before the Board or explain the discrepancy. Dr. Zackrison appeared to be testifying solely from memory. The Board believed the dosage in Patient B's chart and on copies of written prescriptions from Dr. Zackrison accurately represented the amount prescribed.

experienced symptoms indicative of Lyme disease following the tick bite, such as erythema migrans rash,[17] facial palsy, or joint swelling. Additionally, in Patient B's chart Dr. Zackrison referred to Bartonella as a tick-borne disease and often paired it with the Lyme diagnosis; however, no study in the United States has shown that Bartonella can be transmitted to humans by ticks. While Dr. Zackrison disputes this, she did not specifically cite any research or documents before the Board which demonstrated otherwise. Despite a lack of clinical symptoms and numerous negative antibody titers for Lyme disease[18] and Bartonella,[19] Dr. Zackrison treated these conditions with long-term antibiotics (cefuroxime and rifampin), vitamins and supplements (which included intravenous infusions administered at the practice from approximately March through June 2017), and a multitude of homeopathic substances.

(ii) In a written statement provided to the Board's investigator in late 2017, Dr. Zackrison explained that Patient B's Lyme diagnosis was "proven by PCR on the tonsils." However, in addition to this polymerase chain reaction ("PCR") test being conducted *after* the patient had been treated with antibiotics for many months, this test was useless because B. burgdorferi is not a pathogen in the tonsil or the throat, and there are no vetted PCR tests for B. burgdorferi in tonsillar tissue. In her testimony, Dr. Zackrison did not address the unreliability of this test given the long-term use of antibiotics before the test was run. The Board received expert testimony that this test had no validated clinical relevance.

c. At Patient B's first office visit, on September 15, 2016, Dr. Zackrison documented that she suspected a streptococcus infection, which she listed as a possible "trigger" or

[17] Dr. Zackrison testified that a rash was present, although she did not specify the type. Patient B's chart for this initial visit documents "occasional" and "mild" "rash, hives."

[18] Results from samples collected on 9/30/16, 12/15/16, 3/20/17, 7/26/17, 7/27/17, 8/31/17, and 10/13/17 were negative.

[19] Results from samples collected on 3/20/17, 5/11/17, and 7/26/17 were negative.

"root cause" of the 13-year-old's nonspecific complaints. At Patient B's second office visit, on September 29, 2016, Dr. Zackrison diagnosed "strep syndrome" and Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections ("PANDAS") without a reasonable basis. "Strep syndrome" is not an accepted medical diagnosis, and PANDAS is a rare condition for which Patient B exhibited no relevant symptoms. For example, Patient B had no history of abruptly showing signs of an obsessive compulsive or tic disorder shortly following a known strep infection. Following these diagnoses, Dr. Zackrison ordered serum testing for streptococcus on 12/15/16, 4/25/17, 5/31/17, 6/26/17, 7/27/17, 8/31/17, and 10/13/17. Dr. Zackrison continued to treat the patient for a diagnosis of "systemic" strep,[20] although streptococcal infection generally is not diagnosed via serology.

(i) Even if Patient B had been properly diagnosed with streptococcus, the antibiotics regimen prescribed was incorrect. For example, on January 2, 2017, Dr. Zackrison documented her plan to use "conventional therapy" for strep infection; however, she did not prescribe a standard course of treatment for strep, such as a single antibiotic for a total duration of ten days. Instead, Dr. Zackrison prescribed the following unconventional and unproven antibiotics regimen (which she noted in the patient's chart "also covers Lyme"): cefuroxime 250mg/5cc suspension to be taken 1 cc QD for one day, 1cc BID for 2 days, 2cc BID for 2 days, 3cc BID for 3 days, then 5cc BID until finishing the medication, at which time the patient was to switch to cefuroxime capsules, 500mg BID for 3 weeks, then increasing to 1,000mg BID for an unspecified duration. While taking the cefuroxime, Patient B also was instructed to increase her vancomycin dose from 125mg BID to 250mg BID. Two simultaneous antibiotics were not indicated for Patient B. The Board received expert

[20] At various times the diagnosis was listed in the patient's chart as "? strep flush," "strep/working dx PANDAS," "intestinal strep," "strep infection," "strep flare – systemic," "strep rash," "strep flare with joint flare," "PANDAS flare," and "systemic strep (PANDAS)."

testimony that strep is sensitive to short courses of penicillin or ampicillin. Dosing rates that rise and lower in this manner are not effective or medically indicated.

(ii) On September 29, 2016, Dr. Zackrison ordered a rectal swab that was tested for streptococcus, among other pathogens. This PCR test is not FDA approved, and the lab report noted that the test is used to "analyze samples for most commonly found bacteria in wound or ear, nose, and throat samples." Dr. Zackrison wrote on the laboratory order form that the specimen source was a rectal wound, although in the patient's chart she referred to the test as a "rectal swab," and the patient was not documented as having a rectal wound. The swab was negative for all tested bacteria.

d. Without appropriately weighing possible side effects or adverse outcomes in a pediatric patient verses the likelihood of the treatment being effective, Dr. Zackrison prescribed antibiotics and antivirals to Patient B continuously for over a year. These prescriptions included the following:

- Vancomycin from approximately October 2016 to November 2017;
- Cefuroxime from approximately January to March 2017, in July 2017, and in October 2017;
- Azithromycin in July and October 2017;
- Rifampin from approximately March to August 2017;
- Clindamycin in June 2017, and from approximately July to October 2017;
- Acyclovir in November 2017; and
- Intravenous Rocephin in late October to November 2017 (the patient was noted to have a hep-lock placed on October 31, 2017, for home administration).

Long-term use of antibiotics can result in gastric distress and opportunistic infections, such as C. difficile, and contributes to antibiotic resistance. Intravenous catheters carry a risk of line infection, bacteremia, and, more rarely, sepsis. These risks outweighed the treatment given the lack of clinical diagnoses.

4. On October 25, 2017, when contacted by Patient B's mother regarding the patient continuing to experience insomnia after taking two tablets of Benadryl and 20mg of melatonin, Dr. Zackrison did not advise that Patient B was consuming an abnormally high melatonin dose which may cause insomnia.[21] Dr. Zackrison instead replied: "[t]ry one of the Flexeril's you have on hand – one at dinner." Nothing in the patient's chart indicates that Dr. Zackrison had prescribed Flexeril, a muscle relaxant, to Patient B, or that she had recently been prescribed Flexeril by another provider.[22]

5. In the care and treatment of Patient C, a 13-year-old female, between September 2017 and April 2018, Dr. Zackrison ordered unnecessary tests, made diagnoses without sufficient justification, and initiated and continued potentially harmful treatment -- such as long-term oral and intravenous antibiotics (cefdinir, azithromycin, vancomycin, ceftriaxone, doxycycline, and amoxicillin) and anti-fungal or anti-parasitic medications (Mepron and Coartem) -- without an appropriate indication and without ensuring that the potential benefits of the treatment outweighed the risks.

a. Over an eight-month period, Dr. Zackrison diagnosed Patient C with, and treated her for, numerous diseases and conditions that are unlikely to simultaneously coexist in a single patient and which lacked an appropriate medical basis.

- At the patient's third office visit, on October 5, 2017, Dr. Zackrison diagnosed dysbiosis/bacteroides, apparently based on a non-FDA-approved fecal PCR test from a sample collected on September 21, 2017. Bacteroides infection is typically diagnosed by isolation of the organism in culture from blood or another normally sterile body fluid. Since bacteroides[23] normally inhabits the gut, its identification in stool is not proof of

[21] Dr. Zackrison had recommended melatonin to Patient B at an office visit on March 20, 2017, but she did not document a dosing recommendation.

[22] Dr. Zackrison testified, without referring to the record, that Patient B's mother specifically asked Dr. Zackrison about whether Patient B could take Flexeril. The e-mail between Dr. Zackrison and Patient B's mother contained in the documentary evidence before the Board does not support Dr. Zackrison's testimony. The Board did not find Dr. Zackrison's testimony credible.

[23] Bacteroides is another ubiquitous substance. Yet, Dr. Zackrison used a positive test for this abundant substance that is normally found in the human body and on surfaces throughout a home or office to diagnose and treat other conditions.

infection. Moreover, the relevant lab report specifically states that the results "are intended for Research Use Only" and "are not intended for the diagnosis, treatment, or prevention of disease."

- On October 5, 2017, Dr. Zackrison diagnosed babesiosis apparently based on an IgG test for Babesia microti from a sample collected on September 21, 2017. Babesiosis generally is diagnosed by blood smear examination, not a serum antibody test. Elsewhere in the lengthy progress notes for the same office visit, Dr. Zackrison described this as a "clinical" diagnosis. Patient C's medical chart does not confirm or support this diagnosis, clinical or otherwise.

- On October 5, 2017, Dr. Zackrison diagnosed the patient with borreliosis (another name for Lyme disease) and "suspect[ed] bartonellosis" (described elsewhere in that day's progress note as "suspect[ed] Bartonella bacteroides (intestinal)"). This diagnosis was made despite test results from a blood sample collected on September 21, 2017 that were negative for Lyme and Bartonella henselae.

- On October 5, 2017, Dr. Zackrison diagnosed the patient with "suspected" intestinal parasites. This diagnosis was without basis. A PCR stool test from a sample collected on September 21, 2017 showed no evidence of parasitic infection.

- On October 5, 2017, Dr. Zackrison diagnosed the patient with "sinusitis/mold?" although she did not document symptoms suggestive of either sinusitis or a mold infection at that office visit. At the patient's seventh office visit on January 31, 2018, Dr. Zackrison noted they would "soon" begin "empiric antimold Tx," and on Patient C's ninth office visit, on March 23, 2018, Dr. Zackrison noted "suspect mold infections" absent evidence of such. No reasonable basis existed for these diagnoses and treatment plans.

b. At Patient C's first office visit, on September 20, 2017, Dr. Zackrison documented "joint deformities consistent with" juvenile idiopathic arthritis ("JIA"), a diagnosis originally made in March 2017 by providers at a local children's hospital. However, on March 22, 2018, Dr. Zackrison improperly diagnosed Patient C with Lyme septic arthritis. This diagnosis was apparently based on Patient C's report at her first office visit of receiving a tick bite on her right arm during a trip to New York three months before, although the patient's family told Dr. Zackrison that Patient C did not have a rash and experienced no change in symptoms following the tick bite. In addition to a lack of early symptoms of Lyme disease following the tick bite, testing of three blood samples, collected on 9/21/17, 12/11/17, and 1/31/18, was not indicative of Lyme septic arthritis. The

1/31/18 sample exhibited two positive bands (+41 and +23) on IgM Western Blot, but these bands have been shown to be the most common false-positive results, and Patient C's sample from that day lacked five positive IgG bands, which would be expected in a patient with Lyme arthritis. Moreover, the patient did not undergo joint fluid analysis, as would be needed to diagnose and properly treat septic arthritis. At an office visit on March 23, 2018, Dr. Zackrison clarified that the patient had a "clinical diagnosis" of Lyme arthritis, and that despite her parents' request to stop antibiotics, Dr. Zackrison documented that Patient C "must" be treated with antibiotics for this diagnosis.[24] At multiple office visits Dr. Zackrison appropriately recommended that the patient's JIA be treated with disease-modifying anti-rheumatic drugs ("DMARDs") and biologic response modifiers ("biologics," such as those known by the brand names Remicade or Humira). When the patient's parents refused, however, Dr. Zackrison continued to treat Patient C with long-term antibiotics for an apparent working diagnosis of joint pain caused by Lyme and other "persistent" tick-borne diseases without appropriate evidence for these diagnoses or treatment.

c. The treatment provided to Patient C demonstrates that Dr. Zackrison has an incorrect understanding of the disease process of JIA. At the patient's first office visit, Dr. Zackrison listed a diagnosis of inflammatory polyarthritis with extensive synovitis and joint deformities consistent with JIA, but explained to the patient and her family that she aimed to treat the "root causes" of this condition, which she documented as infections (strep, parasite, mold, and viruses), increased toxins (petrochemicals and mold toxins), and "increased heavy metal burden." At the patient's third office visit, on October 5, 2017, Dr. Zackrison documented explaining that while Patient C was diagnosed with JIA under "conventional medicine" standards, under "conventional + functional medicine" her symptoms were explained in part by infections -- further defined by Dr. Zackrison as

[24] Before this office visit, Patient C had been administered IV Rocephin daily and was taking oral Zithromax every other day, as prescribed on March 5, 2018.

viral, bacterial (suspected intestinal Bartonella bacteroides), fungal (suspected), parasites, and tick-borne diseases (including babesia and Lyme). In fact, the "root causes" identified by Dr. Zackrison have not definitively been demonstrated as being associated with JIA.

d. Between September 2017 and March 2018, Dr. Zackrison failed to properly diagnose, monitor, and respond to Patient C's significant weight loss and low weight. Although Dr. Zackrison testified that a significant portion of Patient C's weight loss occurred prior to her first visit with Dr. Zackrison, the Board finds that Dr. Zackrison did not appropriately respond to the patient's previous weight loss and ongoing failure to gain weight.

(i) As of her first appointment with Dr. Zackrison on September 20, 2017, Patient C had lost approximately 40 pounds over the prior six months. Her weight at this appointment was approximately 60 lbs., down from 101 lbs. in March 2017. Dr. Zackrison diagnosed failure to thrive and significant weight loss. At that office visit, Dr. Zackrison documented explaining that the patient's weight loss was caused by vaccine mercury. In her testimony, Dr. Zackrison stated that she documented that portion of the chart incorrectly, and that she is aware that vaccine mercury does not cause weight loss.[25]

(ii) During Patient C's treatment at the practice, her weight was only documented at four out of nine office visits, and it was not taken during the 32 occasions at which she presented to receive IV supplements or medication. Dr. Zackrison testified that she was not able to document Patient C's weight at several visits because Patient C could not stand unassisted on the scale. Dr. Zackrison failed to appropriately document this in the patient's chart.

[25] Additionally, there is no mercury or thimerosal in Gardasil, the HPV vaccine to which the patient's parents attributed Patient C's ill health.

(iii) At her first office visit, the patient's parents reported that she was on a restricted diet.[26] Rather than referring Patient C to a dietician or requesting a food diary, Dr. Zackrison recommended eliminating all sugar and for the parents to "read up on casein free" without a valid medical basis.[27] On March 20, 2018, after reviewing results from additional serologic testing for IgG antibodies related to cow milk, wheat, egg yolk and egg white exposure,[28] Dr. Zackrison recommended that Patient C continue to "stay off eggs and dairy," although she could begin eating sprouted grains.[29] While maintaining the patient on a restricted diet based on non-verified tests, Dr. Zackrison attempted to have a PICC or gastrostomy tube placed "in hopes to start [total parenteral nutrition]." She failed, however, to recommend other options after the pediatric gastroenterologist (to whom Patient C was referred by her pediatrician) declined the treatment because the patient did not have demonstrated malabsorption issues or evidence of an improperly functioning gut.

(iv) During this time, based on Dr. Zackrison's orders or instructions, the patient was taking approximately 38 pills per day, 140ml of "therapeutic" oils, and over the counter supplements. Dr. Zackrison did not address the dichotomy between Patient C's ability to ingest large quantities of pills and supplements and Dr. Zackrison's claim that the gastrostomy tube needed to be placed.

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[26] Patient C's parents reported the child had been on a low-sugar, all organic, and "strict" gluten-free diet for the prior two weeks.

[27] Dr. Zackrison had previously ordered a "Food Inflammation Test," but she had not received the results when she instructed the patient on dietary changes, and the lab report from the testing notes that the test has not been cleared by the FDA.

[28] This test was ordered from a different lab than the "Food Inflammation Test" from September 2017, but the lab report similarly notes that it "was performed using a kit that has not been cleared or approved by the FDA."

[29] Dr. Zackrison testified that she did not recommend eliminating dairy because of Patient C's weight loss. This statement was not supported by the documentary evidence before the Board.

6. In her care and treatment of Patients A and C, Dr. Zackrison or her subordinate employees acting under her direction provided inaccurate or incomplete information to outside medical providers concurrently treating the patients.

a. In early March 2013, a provider at Dr. Zackrison's practice referred Patient A to a radiology practice for placement of a PICC with a history of connective tissue disease and adenopathy. The PICC was inserted on March 13, 2013. Prior to the placement of the PICC, Patient A's most recent office visit at Dr. Zackrison's practice was on December 5, 2012, when she was seen by a nurse practitioner, and progress notes from that date do not mention connective tissue disease or adenopathy. Additionally, Patient A's pediatrician, who began treating her in 2007, never documented diagnoses of connective tissue disease or adenopathy.

b. On August 26, 2013, a provider at Dr. Zackrison's practice referred Patient A to a radiology practice for placement of a new PICC due to a history of encephalitis. The PICC was inserted on September 13, 2013. Other than the September 2013 PICC order, the only documentation in the patient's chart for the period from 2010 through 2015 mentioning encephalitis is a printout labelled "Diagnosis History," which indicates Patient A was diagnosed with or treated for Japanese encephalitis on August 14, 2012, and was diagnosed with or treated for encephalitis/ myelitis/encephalomyelitis NOS on August 20, 2013. Progress notes from August 14, 2012 and August 5, 2013, however, do not include such diagnoses. Moreover, there is no indication in the patient's chart in 2012 that she recently had traveled to Asia or the Western Pacific, where the virus causing Japanese encephalitis is contracted. Furthermore, Patient A's pediatrician never documented a diagnosis of encephalitis, nor was a history of encephalitis reported to specialists seen by Patient A during this time. Dr. Zackrison testified that this was a clerical error and that Patient A did not have Japanese encephalitis.

c. On March 6, 2018, Dr. Zackrison signed an order for IV home infusion of Rocephin for Patient C for a diagnosis of sepsis, although the patient had not been diagnosed with sepsis at her most recent office visit. Dr. Zackrison testified that septic arthritis, rather than sepsis, should have been marked on the order.

d. Dr. Zackrison testified that at least two of these instances were clerical errors attributed to her staff. However, by her testimony Dr. Zackrison indicated that non-medical staff fills out orders, which are at times invasive orders for IV treatment, without Dr. Zackrison checking or verifying that those orders are correct.

7. In the care and treatment of Patient D, a 35-year-old male, from late 2012 to early 2013, Dr. Zackrison improperly diagnosed and treated multiple simultaneous infections and disorders. The patient tested negative for these infections and disorders. Additionally, these diagnoses are unlikely to coexist in a single patient who reported being in "excellent" general health.

a. On October 11, 2012, Patient D attended his fifth office visit at the practice, but his first with Dr. Zackrison. At that visit, Dr. Zackrison told him he was "unhealthy" and prescribed Omnicef for a diagnosis of Lyme disease, "suspect chronic status," despite being aware of significant evidence indicating that he did not have Lyme disease.[30] For example, after being bitten by ticks in mid-May 2012, Patient D did not exhibit an erythema migrans rash, facial palsy, or joint swelling. Additionally, following his first office visit, the practice sent the ticks (which Patient D had saved) to be analyzed, and the lab identified them as lone star ticks, which do not carry or spread Lyme. Furthermore, a PCR test on the ticks was negative for Lyme. Blood tests from samples collected on 6/7/12, 6/26/12, and 9/28/12 were negative for Lyme based on CDC criteria. At the office visit with Dr. Zackrison, she apparently made a "clinical" diagnosis of "chronic" Lyme disease and based her

[30] The nurse practitioner who treated Patient D at his first four office visits had not diagnosed Lyme disease during that time.

diagnosis on test results that did not meet CDC criteria, without informing Patient D of such. Dr. Zackrison testified that the "raw data" showed specific bands to Lyme, but in continued testimony stated that only one band tested positive. The Board heard expert testimony that Lyme disease cannot be diagnosed from serology showing a single positive IgM band.

b. In addition to incorrectly diagnosing Patient D with Lyme disease, at the same office visit Dr. Zackrison diagnosed Patient D with multiple infections. These included acute anaplasmosis, acute ehrlichia, mycoplasmosis,[31] legionellosis, "suspect chronic" babesiosis, "questionable" bartonellosis, and "polymicrobial state," PANDAS, "[chronic fatigue syndrome] with viral overload[32] vs. encephalopathy/encephalitis," and cranial neuritis. In response she prescribed medication and supplements, recommended that the patient "start IV nutrients/support" to be administered at the practice, and ordered approximately 27 lab tests[33] for 20 diagnoses,[34] although the patient had undergone four rounds of blood work over the prior four months in addition to urinalysis and stool testing on two occasions. Dr. Zackrison testified that her concern, diagnoses, and subsequent tests had a medical basis, yet did not direct the Board to anything in the record that supported her

[31] Patient D subsequently told another provider that Dr. Zackrison had informed him that mycoplasmosis "is chronic and often misdiagnosed as an allergy. This may be why I have to clear my throat a lot."

[32] Described in progress notes as including HSV 1, EBV, and [HH]V6.

[33] Specifically: C1Q, C3a, C4a, CBC with differential and platelets, HS-CRP (cardiac), homocysteine, methylmalonic acid (MMA), IgE PCN-G + PCN-VK, antiphospholipid antibody list (cardiolipin, AB (IGA, IGM, IGG), PTT, Lupus anticoagulant), hepatitis list (includes multiple subparts which are difficult to read on form), complete metabolic panel (basic metabolic + TP, ALB, bili, CA/CA++, akl phos, protein, AST, ALT), phosphorus, lyric acid, magnesium RBC level, legionella titer IgG/IgM, CA ionized, intact PTH (frozen specimen) fasting, C-telopeptide, 25 hydroxy Vit D, urine cytology, urine creatinine clearance and serum creatinine, 24h urine protein electrophoresis, 24h urine total protein, 24h urine total calcium, total oxalate, urine N-telopeptide (second void of the morning) (osteomark), and chemistry panel – phosphorus.

[34] Specifically: Abdominal pain, abnormal kidney or renal function, abnormal weight loss, babesiosis, circulating anticoagulants, coagulation anomaly, fatigue (general weakness) (identified twice), gastritis/gastroduodenitis NOS, hormonal imbalance/endocrine (identified twice), hypomagnesemia (identified twice), L carnitine deficiency, lymph nodes enlarged, malabsorption, malaise and fatigue (identified twice), myalgia unspecified, peripheral neuropathy, paresthesia, flushing, CTD - diffuse/unspecified, and hyperglycemia/hypoglycemia.

testimony. Dr. Zackrison made these diagnoses and prescribed azithromycin and Coartem[35] without sufficient evidence.[36] Blood tests for babesia collected on 6/7/12, 6/26/12, and 9/28/12, and bartonella on 6/26/12, were negative, and his chart did not contain a test for ehrlichia. Lone star ticks such as those brought in by Patient D do not transmit babesia. Furthermore, babesia is identified by peripheral blood smear examination, not the immunoglobulin testing ordered by Dr. Zackrison. Patient D was not exhibiting symptoms of pneumonia consistent with an acute mycoplasma or legionella infection, nor was he exhibiting symptoms of acute anaplasmosis. Additionally, PANDAS is a rare condition that is not generally diagnosed in adults, and Patient D did not provide a history consistent with PANDAS in childhood, such as sudden development of obsessive-compulsive disorder or tic symptoms following a known strep infection.[37] Finally, two practitioners who subsequently examined Patient D disagreed with Dr. Zackrison's diagnoses and treatment plan, as described below.

- On November 5, 2012, less than one month after he saw Dr. Zackrison, Patient D was examined by a physician assistant at an infectious disease practice. After taking his history and reviewing test results that he brought from Dr. Zackrison's practice, the physician assistant explained to Patient D that his tests were either negative or had been performed at non-standard laboratories, and therefore "should be interpreted with caution." Given that the patient had never felt very ill, she said that he did not need to take the medications prescribed by Dr. Zackrison. The physician assistant did not recommend additional testing.

- On March 20, 2013, Patient D had an office visit with an infectious disease specialist at Johns Hopkins, who examined him and reviewed his prior test results. The specialist noted that the Lyme tests had been negative, and that some of the tests ordered by Dr. Zackrison had been performed at a specific lab in which he did not have confidence. The specialist also informed Patient D that many of the positive blood tests referenced by Dr. Zackrison "merely represent past exposure to bacteria and/or latency of normal viruses of the human

[35] Coartem is an antimalarial medication.

[36] Prior to his office visit with Dr. Zackrison, Patient D had taken several courses of antibiotics as prescribed by the nurse practitioner (doxycycline for approximately three months and Levaquin for two weeks), making it unlikely that he had multiple acute infections.

[37] Dr. Zackrison testified that this should have been marked as a diagnosis that was being considered in the chart, rather than a final diagnosis. That testimony did not alleviate the Board's concerns.

> condition,"[38] or lack relevance because the patient had no signs of active infection or inflammatory processes.[39] Finally, the specialist told Patient D that the "style of practice that Dr. Zackrison follows is not evidence-based and tends towards a liberal diagnosis of multiple simultaneous infections in long-term therapy." The specialist provided recommendations for several other health conditions going forward, but he did not concur with Dr. Zackrison's primary diagnoses, including tick-borne diseases and other infectious agents, or related treatment plan for Patient D.

c. After consulting with other providers and his health insurance company, Patient D exchanged several e-mail messages with staff members at Dr. Zackrison's practice, requesting a refund of some of the fees he paid for what he concluded was unnecessary testing and incorrect treatment. In a reply sent to Patient D on January 4, 2013, Dr. Zackrison stated:

> It is my desire to address your concerns. …To get an accurate feedback on our evaluations and recommendations you will need to see providers for a 2nd opinion that understand, are trained in, and practice functional medicine as is practiced in my office. Physicians who are additionally experts in the complexity of tick-borne diseases. There are 2 standards of care currently being practiced in medicine: the average provider who does not usually treat cause, but only symptoms[,] which leads to poor outcomes when dealing w/ diseases that are complex and chronic[,] as compared to advanced thinkers that treat causes leading to significantly improved outcomes. The two physicians you consulted for 2nd opinions are from the average standard of care. The 2nd standard is much higher in that we seek to treat your symptoms and the condition that causes them, proactively seeking a better outcome for you and all our patients.

This exchange demonstrates that Dr. Zackrison does not practice evidence-based medicine or adhere to the standard of care.

8. During her care and treatment of Patients B-D between 2010 and 2018, Dr. Zackrison ordered or recommended numerous vitamins, minerals, and food supplements (including homeopathic substances) to be taken topically, orally, and intravenously without consistently documenting the rationale for such treatment and without having a reasonable expectation that their use would result in favorable patient outcomes or provide a greater benefit than would be achieved without such use.

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[38] Herpes simplex virus 1, Epstein-Barr virus, and cytomegalovirus are all common viruses contracted by healthy adults at some point in their lives.

[39] This comment related to Dr. Zackrison's diagnoses of legionella and Babesia duncani.

- On July 26, 2017, Dr. Zackrison instructed Patient B to take the following supplements without specifying the specific conditions for which they were indicated or the results expected from their use:
  - Golden Pearls – 1 QD, working up to 2 BID
  - ashwagandha – TID
  - CytoTyme-AD – 1 Q AM
  - Cytozyme-SP – 1 QD
  - fish oil – increase to BID
  - methyl B-12 – BID
  - Moon Pearls – "put name on waiting list"
  - Women's Phase I – BID
  - Peace Pearls – 2 BID

- On October 18, 2017, Dr. Zackrison instructed Patient C to take the following supplements without specifying the specific conditions for which they were indicated or the results expected from their use:
  - Nrfz Activator – 2 TID
  - Serretia – 1 QD
  - Bio Allay – 2 BID
  - Kapp Arrest – 2 TID
  - Liposomal curcumin – TID
  - Frankincense/bergamot – 8-10 drops each, QID
  - Pro DHA 2000 – BID
  - Algo med – 2 TID
  - Iron bisglycinate – BID
  - Buffered Vit C 500mg – BID
  - CBD/Hemp oil – no dose specified

- On October 11, 2012, Dr. Zackrison instructed Patient D to take daily methyl B-12 10,000mcg (PO 2 qAM and 2 qPM, under tongue), taurine 500mg (2 BID), milk thistle (1 BID), CoQ Power (1 PO qAM), and Pro Omega (2 TID), to continue to drink "medical shakes," and to "start IV nutrients/support" at her practice, without specifying the specific conditions for which these substances were indicated or the results expected from their use.

Although Dr. Zackrison testified before the Board regarding what these supplements were intended to treat, Dr. Zackrison did not document any of her bases for their use in the relevant patient charts. Dr. Zackrison testified that anyone who had "taken integrative medicine" would know why they were prescribed, indicating that it is not the practitioner's responsibility to maintain an accurate file. She further testified that she explained the purpose of these supplements to the patients they were prescribed to, but did not document that explanation in any patient chart before the Board. Information

in the charts of Patients B and D indicates that Dr. Zackrison's practice was selling many of these substances to those patients.

9. In the care and treatment of Patients A-D, Dr. Zackrison ordered or directed her staff to order medically unproven testing and ordered or recommended diagnostic or treatment modalities that are outside of evidence-based medicine and whose risks are not outweighed by potential benefits.

- Without objective evidence that Patient A had heavy-metal poisoning, providers at the practice recommended that the patient undergo chelation on 3/28/12, 9/20/12, 12/5/12, and 11/12/13. Dr. Zackrison testified that Patient A did not have heavy-metal poisoning, but that chelation was used as a "biofilm buster."

- On 5/3/11, 5/17/11, 12/17/11, 3/15/12, 3/28/12, 10/3/12, and 4/10/14, providers at the practice recommended that Patient A undergo "muscle testing" or be tested with Asyra, an electrodermal device that allegedly measures galvanic skin response to provide information regarding the health of internal organs, allergies, and recommendations for substances to use or take to "rebalance" the body.

- On 10/8/10, 11/12/10, 11/17/10, 1/4/11, 11/17/11, 12/16/11, 3/28/12, and 4/24/12, providers at Dr. Zackrison's practice recommended that Patient A undergo liver or gallbladder "detoxification," "flushing," or "cleansing."

- At an office visit on July 28, 2011, Patient A was instructed to utilize weekly coffee enemas to kill "[p]arasites & atypical bacteria." Patient A was 14 years old at the time.

- At an office visit on October 11, 2012, Dr. Zackrison instructed Patient D to "Please start IV nutrients/support" by "speak[ing] with IV staff," although there was no indication the patient was unable to take vitamins or supplements orally.

- On July 5, 2017, Dr. Zackrison instructed Patient B to undergo testing with ZYTO, an electrodermal device in use at her practice whose proponents made similar claims to those made by proponents of the Asyra device described above. That same day, Dr. Zackrison recommended that Patient B begin homeopathy treatment relating to the "[t]op 88 foods" that the ZYTO device allegedly identified as affecting her. Similarly, on December 11, 2017 and March 6, 2018, Dr. Zackrison recommended that Patient C undergo testing with ZYTO.

- On December 11, 2017, Patient C was instructed to "Cont[inue] Long distance energy work."

- On October 25, 2016, Dr. Zackrison instructed Patient B to treat her headaches with a specific brand and formula of essential oil, which she recommended the patient apply to the top of her forehead, the "knobs" on the back of her head, the back of her neck, and "along

inner wrists." At the same appointment, Dr. Zackrison recommended another essential oil from the same brand to treat nausea.

10. Dr. Zackrison's records for Patients A-D, dating between 2010 and 2018, are inaccurate or incomplete.

a. It is difficult or impossible to determine comprehensive treatment plans for each patient, including estimated duration of each recommended treatment modality, and when or if the treatment plans changed based on test results or how the patients responded to specific treatment modalities.

b. It is difficult or impossible to readily determine patient medication regimens from the patients' charts. The charts lack flow sheets and do not contain copies of all prescriptions. Additionally, progress notes do not consistently list medications and supplements prescribed at each office visit, nor do the notes consistently and accurately document the doses prescribed or recommended. Lastly, the diagnosis or symptom for which each medication or supplement was prescribed or recommended frequently cannot be discerned from progress notes, as shown below.

- When asked to "[p]lease list your medications & supplements" at office visits between 2010 and 2015, Patient A often left that portion of the form blank, wrote in a question mark, or wrote that the provider should ask a parent for the information. The providers treating the patient consistently did not complete such information and the chart lacked a flow sheet by which all medications and supplements the patient was taking orally or intravenously could be determined as of each office visit.

- In an e-mail to her staff dated March 22, 2012, Dr. Zackrison requested that the following prescriptions be ordered by mail for Patient A: #120 Coartem 20/120mg (3 BID), #60 mebendazole 100mg (TID), and #120 albendazole 200mg (2 BID), although the most recent progress note, from an office visit with a nurse practitioner on January 5, 2012, does not include such a treatment regimen. Progress notes from a subsequent office visit, on April 24, 2012, include a "Rotation schedule based upon tolerance" for treatment of "Polymicrobial state" which listed five medications (biltracide [sic], Alinia (nitazoxanide), Coartem, albendazole, mebendazole, and Tindamax (tinidazole)), but did not include any dosing information, including the length of each "rotation."[40]

[40] All of these medications are used to treat parasite, worm, and malarial infections.

- On or about April 14, 2015, Dr. Zackrison e-mailed a member of her staff to inquire about "the status of the compounded vaginal Vanco Rx I wrote in March" for Patient A. Staff responded that it had been delivered to the patient's home on March 7th. Patient A did not have a documented examination at the practice in February or March 2015, and her file does not otherwise contain information about this prescription or its indication.

- Dr. Zackrison documented recommending melatonin to Patients B (on 3/20/17) and C (on 3/6/18), but she did not document the dose recommended to these underweight pediatric patients.

- On November 7, 2017, Dr. Zackrison prescribed to Patient C #14 Zithromax plus one refill (1 PO QD), #60 vancomycin plus one refill (1 PO BID), and #60 Augmentin 500mg plus one refill (1 PO BID) without clearly documenting related rationales. Progress notes from that day include the following diagnoses: PsA sine psoriasis, juvenile idiopathic arthritis, marked synovitis, failure to thrive, multiple food sensitivities, anti-neutrophil cytoplasmic antibody and undifferentiated connective tissue disease, antiphospholipid antibodies, persistent tick-borne diseases, strep, detox dysfunction, pain management, 100% disabled, along with "Strong Hx of Toxin Burden Ppt illness ie Gardasil" and "microbial burden," which was explained as including Babesia and strep.

- On multiple occasions, progress notes indicate that intravenous treatment had been recommended or that patients were receiving intravenous infusions, but the dates of such treatments were not consistently documented in patient charts, nor were the substances being infused or recommended for infusion consistently or clearly documented.

    - Progress notes for office visits on 9/29/16 and 10/25/16 indicate that Dr. Zackrison recommended intravenous "nutrients," "detoxing," and "natural antimicrobials" to Patient B, but no additional information was included in such notes.

    - Records for Patients A (on 11/12/13, 7/8/14, and 9/14/15), B (on 3/20/17, 4/7/17, and 5/4/17) and C (on 12/11/17, 2/23/18, and 3/5/18) indicate they were receiving infusions of "Miss" or "MISS" without detailing what substances were contained in the IV solution. Patients B and C both reported adverse reactions to these treatments.

    - At an office visit on 11/7/17, the plan for Patient C included "[s]tart IV detoxing," but this was not further defined in the progress note.

    - At an office visit on October 11, 2012, Dr. Zackrison instructed Patient D to "[p]lease start IV nutrients/support" by "speak[ing] with IV staff," but progress notes do not indicate a rationale, doctor-recommended infusion schedule, or information on what substances were recommended for infusion.

c. Dr. Zackrison provided patients with medication dosing instructions that differed from dosing instructions provided to the pharmacy on the corresponding written scripts.

Patient	Date	Script - Medication & Dose	Dosing Instructions to Patient
B	11/22/16	#60 Vancomycin 125mg – 1 PO BID	1 a day x 2 wks [then increase to] 1 twice a day
	1/2/17	cefuroxime 250mg/5cc liquid +2RF - 5cc BID	1cc QD x 1 day; 1cc BID x 2 days; 2cc BID x 2 days; 3cc BID x 3 days; 5cc BID - "finish and switch to capsules."
	1/2/17	#120 cefuroxime 500mg – 2 PO BID	1 PO BID for three weeks, then increase to 2 PO BID[41]
	3/20/17	#60 rifampin 150mg - 1 PO BID	1 QD for 7 days, then increase to 1 PO BID
	7/5/17	#20 Zithromax 500mg – 1 PO QD	"Start in 5 days 1 a day x 5 ds ½ a day x 5 ds ½ 3x/wk @ Dinner"
	7/5/17	#60 Vancomycin 250mg – 1 PO BID	"1 a day"
	7/26/17	#60 Vancomycin 250mg – 1 PO BID	"Continue Vanco 250[mg] 1 a day"
	10/16/17	#20 Zithromax 500mg – 1 PO QD	"1 every other day"
C	10/18/17	#300cc Mepron 7.5mg/5cc liquid – 5cc PO BID	"See previous titration schedule." At the prior office visit on 10/5/17 the patient was instructed as follows: ½ tsp every other day x 10 days; 1 tsp every other day x 10 days; 1 tsp 2x a day every other day x 10 days. (The chart does not include a script for the 10/5/17 prescription.)
	11/7/17	#60 doxycycline 100mg +1RF – 1 PO BID	"Start doxycycline 100mg 1 @ dinner w/ lots food Before + after taking Doxy 3x/wk."

[41] At the patient's next appointment on 2/13/17, Dr. Zackrison instructed the patient to take cefuroxime 250mg tablets as follows: 2 in the morning and 3 in the evening for 7 days, increasing to 3 in the morning and 3 in the evening for 7 days, increasing to 3 in the morning and 4 in the evening for 7 days, then increasing to 4 in the morning and 4 in the evening or 500mg 2 tabs BID. There was no corresponding script in the chart for 250mg tablets of cefuroxime on this date, and the progress note does not indicate how many dosage units were prescribed. After the appointment, the patient's mother emailed Dr. Zackrison for clarification, saying, "[t]here was some confusion today about how many mg of Cefuroxime [Patient B] has been taking. I checked the previous notes and prescriptions and [she] has been taking 1000mg 2 times per day since February 5th, as per your instructions. This is probably why she is having headaches. The plan we established at today's appointment was to build her up to this dose of Cefuroxime over the next three weeks, but we are already there."

	12/11/17	#300cc Mepron 750mg/5cc liquid - 5cc PO BID	1 tsp every other day
	12/11/17	#60 Omnicef 300mg BID	1 at dinner x 5 days, increasing to 1 twice a day
	1/31/18	#20 Zithromax 600mg – 1 PO QD	Zithromax 600mg ½ a day @ Dinner #30
	3/6/18	#80 Coartem 20/120 – 2 PO BID	1 every other day
D	10/11/12	#24 Coartem 20/120mg – 3 PO BID	One tablet twice a week for the first week, increasing to two tablets together twice a week for the second week, then on the third week increasing to two tablets together three times a week.

d. The charts for Patients A, B, and C are incomplete or contain erroneous information. For example:

- Patient A's chart does not contain reports or other documentation from the use of the Asyra device, which apparently was used on Patient A on March 28, 2012. The results appear to be referenced in the patient's chart.

- On May 13, 2013, Dr. Zackrison ordered radiology studies of Patient A's left elbow and thumb for "Cellulitis/fasciitis L elbow pain eval for effusion" and "Trauma to L thumb w/ pain + swelling + [decreased] ROM." However, Patient A had not had an office visit with examination at the practice since April 8, 2013, and such symptoms were not noted on that progress note.

- Per Dr. Zackrison's letter to the Board's investigator dated October 21, 2015, Patient A had a PICC placed in March 2013 "for the purpose of infusing IV antibiotics and IV fluids. The rationale behind the upgrade to IV antibiotics was a medical judgment [by a nurse practitioner at the practice]. The patient failed several attempts at oral antibiotic treatments." However, prior to placement of the PICC, Patient A had not presented for an office visit for approximately three months, and progress notes from the previous office visit on December 5, 2012 do not address the need for a PICC. Additionally, the patient's chart does not include an order related to this PICC placement.

- Per Dr. Zackrison's letter to the Board's investigator dated October 21, 2015, Patient A was evaluated for a possible deep vein thrombosis in April 2014 in relation to her PICC; however, the patient's chart does not include a related radiology report.

- Patient B's chart does not contain reports or other documentation from the use of the ZYTO device, which apparently was used on Patient B on July 5, 2017. Dr. Zackrison referenced results of the use in the patient's chart.

- On October 31, 2017, Patient B's mother e-mailed Dr. Zackrison to report that her daughter was "unable to tolerate the oral antibiotics. … Her throat [after recent tonsillectomy] is still

too sore and swollen to swallow the pills." Dr. Zackrison instructed staff to "set up a phone consult URGENTLY with NP (consider bringing in for IM or IV Rocephin QD x4)." Staff replied to Dr. Zackrison that the patient would be coming in that day for administration of IV Rocephin and "going home with a hep lock to do IV at home as well." However, the IV Rocephin dosing was not specified, the patient's chart does not include documentation from the in-office infusion performed that day, nor does the chart include instructions on whether the patient was advised to discontinue her oral antibiotics while taking IV Rocephin. As of her last office visit two weeks prior, Patient B was prescribed oral cefuroxime (liquid and pills), vancomycin, and Zithromax (liquid and pills).

- On November 8, 2016, in relation to a telephone call with a cardiologist and neurologist involved in the care of Patient B, Dr. Zackrison told the other providers that Patient B had met with a psychiatrist and been diagnosed with obsessive-compulsive disorder; however, there is no documentation of such a diagnosis by an outside provider in Patient B's chart or any evidence of coordination of care by Dr. Zackrison with such a provider.

- On March 23, 2018 Dr. Zackrison referred Patient C for x-rays, but there is no copy of the referral slip in the patient's chart. Such copies are normally kept in patient charts.

- Patient C's weight was only documented at four out of nine office visits, although this pediatric patient had been diagnosed with failure to thrive and low weight. Additionally, the weight documented at her first office visit on 9/20/17 may be incorrect, as both her weight and height were recorded as the same number (60.2). Further, in her written statement to the Board's investigator dated April 20, 2018, Dr. Zackrison noted that the weight recorded at the patient's fourth office visit on 10/18/17 -- which would have represented significant weight gain -- might be incorrect, as "Mom was supporting her on the scale; not sure this is accurate."

- In November 2017 Dr. Zackrison or a member of her staff at her direction ordered placement of a PICC for Patient C. Said PICC was placed by an outside practice on November 21, 2017, but the patient's chart lacks a copy of such order. Additionally, on March 22, 2018 during a telephone call with Patient C's pediatrician, Dr. Zackrison stated that she "has had confirmatory xrays for placement" of Patient C's PICC, but no such documentation is found in Patient C's chart.

e. Although Dr. Zackrison stated that the nurse practitioner maintained the chart for Patient A, Dr. Zackrison testified about instances when she ordered infusions, tests, or medications for Patient A. Notably, Dr. Zackrison could not provide specific information regarding a prescribed infusion, which she signed for, due to lack of information contained in Patient A's chart. Dr. Zackrison further testified that Patient A had two medical charts, one at the practice office and one at home, and that the charts contained different information.

11. Dr. Zackrison made false and deceptive statements relating to the practice of medicine.

a. On April 1, 2016, Dr. Zackrison provided false information during questioning under oath in a legal matter involving her care of Patient D. Dr. Zackrison provided the following sworn testimony during a deposition:

> Q: "Are you board certified?"
> A [Dr. Zackrison]: "Yes."
> Q: "In what fields?"
> A [Dr. Zackrison]: "In both internal medicine and rheumatology."
> ...
> Q: Well, you're board certified as a rheumatologist.
> A [Dr. Zackrison]: Correct.

Dr. Zackrison's board certification in internal medicine had expired approximately four years earlier, and her board certification in rheumatology expired approximately two years earlier.

b. On September 22, 2016, Dr. Zackrison provided false information on her Board of Medicine Practitioner Profile (located at www.vahealthprovider.com). Her profile stated that she became Board Certified in "Internal Medicine: Rheumatology" in 2016. In fact, she became board certified in this specialty in 1994, which expired in 2014. The false information remained on her profile at least until November 23, 2016.

c. In late November or early December 2017, Dr. Zackrison provided false information to the Board's investigator. Dr. Zackrison submitted a CV which stated: "Board Certified – Diplomat, American Board of Internal Medicine. September 1991. Recertified – Diplomat, American Board of Internal Medicine[] 2012," thus giving the impression that she held active board certification in internal medicine, although her certification had expired approximately five years earlier.

d. In her testimony before the Board, Dr. Zackrison admitted the substance of these allegations. She testified that it was not intentional and "an oversight." The Board did not find this

explanation sufficient given the number of instances in which this information was falsely provided, including during sworn testimony at a deposition.

12. On December 4, 2017 and December 5, 2017, Dr. Zackrison willfully refused to provide information as requested by the Board's investigator pursuant to an investigation. Dr. Zackrison refused on both dates to answer follow-up questions posed by the Board's investigator regarding the care she provided to Patient B.

13. Dr. Zackrison exploited the practitioner/patient relationship for personal gain. Beginning in mid-September 2019, Dr. Zackrison requested financial contributions in the amount of $100,000 from her patients via an online fundraiser posted at https://www.gofundme.com/f/2defenddrz. The stated purpose was to help pay for her legal bills related to her disciplinary case before the Board and associated court costs. The page consisted of a personal plea from Dr. Zackrison herself to her patients for funds.

14. Dr. Zackrison knowingly allowed a subordinate to jeopardize patient safety and to provide patient care outside the scope of the subordinate's practice area in late 2018 through early 2019. Dr. Zackrison was aware that Employee 1, who worked primarily at the practice's front desk, was also working in the "IV lounge." There, Employee 1 mixed IV solutions, performed supervised and unsupervised venipunctures, and administered IV treatments. Employee 1 had not completed appropriate training as a medical assistant, was not qualified or sufficiently trained to perform such tasks, and incompetently performed such tasks on more than one occasion.

a. On January 29, 2019, Patient E[42] informed Dr. Zackrison by e-mail that earlier in the day Employee 1 "could not manage to successfully puncture any of my veins to draw blood" for

[42] Although Dr. Zackrison testified before the Board that Patients E and F, and the allegations related to them, were "reversed," she did not refer to any documents in the record before the Board or otherwise demonstrate that the allegations were not correctly associated to the proper patients. The documentary evidence before the Board supports the findings of fact detailed herein for Patients E and F.

use during an "IV ozone treatment." The patient further stated that after another employee drew her blood, Employee 1 "filled a small bag with my blood and mixed in the ozone, but when she set up the IV, it stopped dripping very quickly. She tried several things to get the IV going, but nothing was working. When she tried to reinsert the needle in a different spot, she just couldn't do it. By then it was almost 5:30, and we had to give it up. I felt bad for her (she was trying hard)...." In response to this message, Dr. Zackrison replied: "Oh No! [T]hanks for recognizing [Employee 1]'s sincerity and effort[;] best wait for [the LPN who usually performed such procedures] to come back!" Three days later, after receiving an IV treatment with the LPN, Patient E wrote to Dr. Zackrison that the LPN "thought that the spot that was used on Monday [by Employee 1] was too close to a valve in my vein, which would not allow the blood to flow back into my body."

b. On February 8, 2019, Employee 1 administered what she believed to be "IV ozone infusion" and "IV hydration" to Patient F. During the treatment, Employee 1 told Patient F that her "blood was very dehydrated." Patient F reported that, following the treatment, her "urine was basically blood for two or three hours." After leaving Dr. Zackrison's practice, Patient F began to experience chills, weakness, nausea, and severe abdominal pain, and she subsequently presented to the emergency department of a local hospital, where she was diagnosed with hematuria. When questioned by the Board's investigator regarding the differential diagnoses for Patient F's hematuria, Dr. Zackrison acknowledged that it may have been caused by "human error," i.e., the patient may have been administered sterile water by Employee 1 rather than lactated ringers.

15. Dr. Zackrison submitted over 7,000 pages of material to the Board in support of her defense. The documents mostly consisted of articles, studies, abstracts, and PowerPoint presentations. Despite the volume of documents submitted, the Board found these documents insufficient to support the care and treatment of the patients detailed in this Order. Dr. Zackrison did not refer to these

documents during her testimony except in ambiguous terms. She failed to identify any of the documents submitted to the Board and reviewed by the panel as explicit support for her treatment methods.[43]

16. The Board carefully considered the testimony of all designated experts, including Dr. Zackrison, but ultimately gave more weight to the testimony of the Commonwealth's experts. The Board was struck by Dr. Zackrison's significant deviation from accepted standards of care and evidence-based medicine that put the patients in this Order at significant risk. Several experts for the Commonwealth noted that, while almost anything was possible in medicine, the frequency of numerous exceedingly rare diagnoses being made together in one patient, despite lack of clinical presentation and supporting test results, recurring over multiple patients, was virtually impossible. These experts noted that the amount of testing, number of diagnoses, and long-term treatment with medications and supplements were unnecessary and not supported by evidence-based medicine. The expert testimony and evidence before the Board demonstrated substantial patient risk and harm. The Board found the facts detailed in this Order more egregious because Patients A, B, and C were vulnerable pediatric patients. The Board was concerned that a significant portion of Dr. Zackrison's practice treats complex pediatric patients, yet she has had no formal pediatric training, such as a pediatric residency.

17. The Board finds that many of these patients may have developed iatrogenic diseases or conditions. Several of the diseases diagnosed and subsequently treated by Dr. Zackrison were created or exacerbated by Dr. Zackrison's own treatment, which was unnecessary to begin with.

18. The Board heard testimony from multiple patients and relatives of patients of Dr. Zackrison. While the Board heard testimony from individuals supportive of Dr. Zackrison's treatment

[43] For example, when asked a question on direct examination regarding the testing of a patient for HHV-6, an abundant virus in the human population that does not generally require treatment, Dr. Zackrison stated only "[i]t's supported in the documents that were on the CD." The Board found these imprecise responses inadequate.

and methods, the Board also heard testimony and received documents from individuals who believed her treatment was unnecessary and caused harm. Notably, several of the patients the Board heard testimony about were pediatric patients.

19. Dr. Zackrison testified before the Board that her diagnoses and treatment of Lyme disease was based on documented guidelines from the International Lyme and Associated Diseases Society ("ILADS"). The patients documented in this Order, however, received multiple diagnoses[44] otherwise unrelated to Lyme disease, which cannot be explained by either guidelines put forth by ILADS or another national organization, the Infectious Diseases Society of America. The Board, by this Order, does not make a finding that one national organization presents the definitive treatment regimen or diagnosis requirements, but only that the care documented in this Order does not meet any applicable standard of care.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes that:

1. Findings of Fact Nos. 2-5 and 9 constitute violations of Virginia Code § 54.1-2915(A)(3), (13), and (16).

2. Finding of Fact No. 6 constitutes a violation of Virginia Code § 54.1-2915(A)(1), (3), (13), (16), and (18) and 18 VAC 85-20-26(C) of the Regulations Governing the Practice of Medicine ("Regulations").

3. Finding of Fact No. 7 constitutes a violation of Virginia Code § 54.1-2915(A)(3), (13), (16), and (18) and 18 VAC 85-20-28(A)(1) of the Regulations.

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[44] For example, Patient B's diagnoses included bacteremia – anaerobics, pseudomembranous pharyngitis, PANDAS, streptococcus, thrush, inflammatory arthritis, juvenile rheumatoid arthritis (juvenile idiopathic arthritis), undifferentiated connective tissue disease, sinus arrhythmia, dysautonomia, Ehlers-Danlos Syndrome, mast cell activation syndrome, adrenal insufficiency, gut infections, "strep syndrome," "suspect parasites," "increased microbial burden," and "presumed bacteremia."

4. Finding of Fact No. 8 constitutes a violation of Virginia Code § 54.1-2915(A)(3), (13), (16), and (18) and 18 VAC 85-20-28(A)(1) and 18 VAC 85-20-40(A)-(C) of the Regulations.

5. Finding of Fact No. 10 constitutes a violation of Virginia Code § 54.1-2915(A)(3), (13), (16) and (18) and 18 VAC 85-20-26(C) of the Regulations.

6. Finding of Fact No. 11 constitutes a violation of Virginia Code § 54.1-2915(A)(1), (16), and (18) and 18 VAC 85-20-300(B) of the Regulations.

7. Finding of Fact No. 12 constitutes a violation of Virginia Code § 54.1-2915(A)(16) and (18), as further defined by Virginia Code § 54.1-111(A)(7), and 18 VAC 85-20-105 of the Regulations.

8. Finding of Fact No. 13 constitutes a violation of Virginia Code § 54.1-2915(A)(12), (13), (16), and (18) and 18 VAC 85-20-29(A)(3) of the Regulations.

9. Finding of Fact No. 14 constitutes a violation of Virginia Code § 54.1-2915(A)(3), (11), (12), (13), (16), and (18) and 18 VAC 85-20-29(A)(1) of the Regulations.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, the Virginia Board of Medicine hereby ORDERS that the license of Leila Haddad Zackrison, M.D., to practice medicine and surgery in the Commonwealth of Virginia is REVOKED.

Pursuant to Virginia Code § 54.1-2408.2, should Dr. Zackrison seek reinstatement of her license after three years, the reinstatement of Dr. Zackrison's license shall require the affirmative vote of three-fourths of the members at a formal administrative proceeding convened by the Board. At such time, the burden shall be on Dr. Zackrison to demonstrate that she is safe and competent to return to the practice of medicine and surgery. Dr. Zackrison shall be responsible for any fees that may be required for the reinstatement and/or renewal of the license prior to issuance of the license to resume practice.

Pursuant to Virginia Code §§ 2.2-4023 and 54.1-2400.2, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

FOR THE BOARD

for Jennifer L. Deschenes

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

ENTERED: 3/23/20

NOTICE OF RIGHT TO APPEAL

As provided by Rule 2A:2 of the Supreme Court of Virginia, you have 30 days from the date you are served with this Order in which to appeal this decision by filing a Notice of Appeal with William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233. The service date shall be defined as the date you actually received this decision or the date it was mailed to you, whichever occurred first. In the event this decision is served upon you by mail, three days are added to that period.