VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: LEILA HADDAD ZACKRISON, M.D.
License No.: 0101-045689

ORDER

In accordance with the provisions of Sections 54.1-105, 54.1-110, 2.2-4020, and 2.2-4021 of the Code of Virginia (1950), as amended ("Code"), a formal administrative hearing was convened before the Virginia Board of Medicine ("Board"), on Thursday, February 19, and Friday, February 20, 2015, in Henrico, Virginia, to inquire into allegations that Dr. Zackrison may have violated certain laws governing the practice of medicine and surgery in the Commonwealth of Virginia. These matters are set forth in the Board's Notice of Hearing and Statement of Particulars dated August 11, 2014.

Pursuant to Section 54.1-2400(11) of the Code, the hearing was held before a panel of the Board with a member of the Board presiding. Erin L. Barrett, Assistant Attorney General, was present as legal counsel for the Board. The proceedings were recorded by a certified court reporter. The case was prosecuted by Senior Assistant Attorney General, James E. Schliessmann, assisted by LaTonya D. Hucks, Adjudication Specialist. Dr. Zackrison appeared at the formal administrative hearing and was represented by counsels, Jacques G. Simon, Esquire; Jason Hicks, Esquire; and Gregg Skall, Esquire.

FINDINGS OF FACT

Now, having properly considered the evidence and testimony presented, the Board makes the following findings of fact by clear and convincing evidence:

1. Leila Haddad Zackrison was issued license number 0101-045689 by the Board to practice medicine in the Commonwealth of Virginia on August 1, 1990. Said license is currently active and will expire on September 30, 2016, unless renewed or otherwise restricted.

2. During the course of treatment of Patient A, Dr. Zackrison diagnosed Patient A with reactive arthritis/spondyloarthropathy. The patient was HLA B27, erythrocyte sedimentation rate, and C-reactive protein negative, making this diagnosis less likely, although it would not exclude this diagnosis. However, the clinical presentation and lack of radiographic findings such as sacroilitis are not supportive of a diagnosis of chronic reactive arthritis.

3. Dr. Zackrison's medical record for Patient A dated in or about August 2003 diagnosed Patient A with systemic vasculitis. Dr. Zackrison admitted she mistakenly used the term systemic vasculitis instead of SLE.

4. In or about February 2005, Dr. Zackrison diagnosed Patient A with calcium pyrophosphate dihydrate ("CPPD") disease/pseudogout and prescribed colchicine to treat the condition, although the basis of the diagnosis in the patient's medical records is unclear. Medical records do not include any radiographic documentation of chondrocalcinosis, or synovial fluid crystal analysis. Dr. Zackrison testified that Patient A refused to submit to synovial fluid crystal analysis. However, no documentation existed in the medical records with respect to the refusal of Patient A to submit to such test.

5. In regards to Dr. Zackrison's diagnosis and treatment of Patient A for Lyme disease beginning in or about October 2003:

a. Dr. Zackrison diagnosed Patient A with Lyme disease although medical records do not convincingly note a history of symptoms or signs compatible with the diagnosis, such as erythema migrans skin lesions, arthritis of the large weight bearing joints, carditis, Bell's palsy, acute radiculopathy, or lymphocytic meningitis.

b. After initial lab tests (Western blot and ELISA) were negative, Dr. Zackrison ordered repeat tests on approximately sixteen (16) occasions, with each result being negative. Moreover, on approximately nine (9) occasions Dr. Zackrison ordered polymerase chain reaction ("PCR") tests on urine, although this test is not approved by the U.S. Food and Drug Administration to diagnose Lyme disease. Dr. Zackrison testified that Patient A presented to her early in Dr. Zackrison's career learning about alleged chronic Lyme disease. She testified that she wanted to see if she could get a positive result on an ELISA test and then a Western blot. Dr. Zackrison also testified that at the time she ordered the PCR testing, she did not realize its low diagnostic yield for Lyme disease.

c. On two occasions for durations of approximately three months each (November 6, 2003 to February 13, 2004; and July 28, 2006 to November 2, 2006), Dr. Zackrison treated Patient A with long-term antibiotic therapy (ceftriaxone). This type of treatment placed Patient A at risk for infection from a PICC line as well as antibiotic side-effects. The Board's infectious disease expert, Dr. William Petri, testified that the patient derived no clinical benefit from her prolonged exposure to antibiotics.

6. In regards to Dr. Zackrison's diagnosis and treatment of Patient A for salmonella, salmonellosis, and/or reactive arthritis due to chronic salmonellosis beginning in or about May 2003:

a. Dr. Zackrison diagnosed the patient with salmonella without any positive cultures of blood, stool, or urine to support the diagnosis. Although the patient had multiple positive serologic screens for salmonella, such tests cannot distinguish between past and present infection.

b. Despite the lack of usefulness of serologic tests for salmonellosis, Dr. Zackrison ordered such tests on approximately nine (9) occasions.

c. Although Patient A lacked any culture-confirmed evidence of salmonella infection, Dr. Zackrison treated her with ciprofloxacin for approximately five (5) months (May 5, 2004 to October 18, 2004).

7. In regards to Dr. Zackrison's diagnosis and treatment of Patient A for babesiosis and/or reactive arthritis due to babesiosis beginning in or about January 2004:

a. Dr. Zackrison diagnosed the patient with babesiosis without positive identification of the parasite on thin blood smears and in the absence of well-established clinical signs and symptoms of the disease, such as history of tick exposure in an endemic area for babesiosis or history of blood transfusion, and presentation of the patient with fever, hemolytic anemia, or thrombocytopenia. Dr. Zackrison testified that these diagnosis criteria refer to acute babesiosis rather than chronic babesiosis. The panel was not presented with convincing evidence that Patient A suffered from chronic babesiosis.

b. Dr. Zackrison apparently diagnosed the patient with babesiosis based on a positive Babesia microti PCR on one occasion, a positive Babesia microti IgG on two occasions, and a persistently positive WA1 IgG. However, on multiple occasions the patient had negative Babesia microti PCR results, raising the issue of a false positive or contaminated specimen. Moreover, serologic tests cannot distinguish past from current infection. Finally, Dr. Zackrison did not consult with or refer the patient to an infectious diseases specialist who would be more acquainted with the reliability and significance of such assay results. Dr. Zackrison represented to the panel that she did not believe she needed to refer Patient A to an infectious disease specialist because she felt she could effectively treat Patient A. Dr. Zackrison testified that Patient A refused to see other medical specialists, although there is no evidence in the medical record to support this claim.

c. After ordering an initial blood test for Babesia antibodies, Dr. Zackrison ordered repeat tests on approximately seventeen (17) occasions, although the patient never had positive identification of the parasite on thin blood smears and she no longer had exposure to potential infection from Babesia during the time she was under Dr. Zackrison's care.

d. Even if the diagnosis of babesiosis had been correct, Dr. Zackrison incorrectly and excessively treated Patient A with antibiotics for this disease. Standard treatment for babesiosis lasts 7 to 10 days, unless continued parasitemia on blood smears is documented. However, without such test results, Dr. Zackrison treated the patient with antibiotics during the following approximate date ranges:

Medication	Date(s)
Biaxin	2/16/04 to 5/5/04 2/3/06 to 6/20/06 5/21/07
Atovaquone	2/16/04 to 5/5/04 3/3/05 to 5/21/07
Ketek	4/13/05 to 5/13/05
Clindamycin	4/21/06 to 9/15/06
Azithromycin	6/20/06 to 7/25/06 (intravenous) 4/21/06 to 5/21/07 (oral)

8. On or about October 13, 2003, Dr. Zackrison diagnosed Patient A with "candida yeast infection of stool/gut" based on a single stool culture with the absence of an appropriate clinical presentation to suggest the presence of the disease. Dr. Zackrison treated the patient with fluconazole for a one-year period (October 13, 2003 to October 18, 2004).

9. Although an established diagnosis of one or more active infections was not supported in the patient's medical records, as discussed in the allegations above, Dr. Zackrison treated Patient A with antibiotics for multiple conditions on an approximate continuous basis from approximately late 2003 to mid-2007.

10. The panel found the opinions presented by the Commonwealth's experts to provide convincing evidence that Dr. Zackrison's care of Patient A fell below the standard of care.

11. The panel heard and considered testimony from Dr. Richard Horowitz, a tick-borne disease expert who was presented on behalf of Dr. Zackrison. In addition, the panel reviewed and considered Dr. Horowitz's presentation on tick-borne diseases and his review of Patient A's care. The panel concluded that Dr. Horowitz's testimony was not sufficient to refute the Commonwealth's expert testimony.

12. The panel felt the use of excessive laboratory testing and the prolonged use of antibiotics was outside the standard of care and put Patient A at risk for harm. Additionally, the panel believes Dr. Zackrison failed to appropriately evaluate the patient for the more common diagnoses of non-infectious cognitive impairment.

13. Dr. Zackrison was very respectful to the panel of the Board. However, her attorneys were repeatedly aggressive, abusive, and dismissive of the Board of Medicine and this panel. They demonstrated a disrespect for the Board of Medicine and the administrative process of the Commonwealth of Virginia.

CONCLUSIONS OF LAW

1. Finding of Fact #2 constitutes a violation of 54.1-2915.A(3)[1] and (13) of the Code.

2. Finding of Fact #4 constitutes a violation of 54.1-2915.A(3) and (13) of the Code.

3. Finding of Fact #5 constitutes a violation of 54.1-2915.A(3) and (13) of the Code.

4. Finding of Fact #6 constitutes a violation of 54.1-2915.A(3) and (13) of the Code.

5. Finding of Fact #7 constitutes a violation of 54.1-2915.A(3) and (13) of the Code.

6. Finding of Fact #9 constitutes a violation of 54.1-2915.A(3) and (13) of the Code.

7. Finding of Fact #10 constitutes a violation of 54.1-2915.A(3) and (13) of the Code.

ORDER

WHEREFORE, based on the above Findings of Fact and Conclusions of Law, it is hereby ORDERED that Dr. Zackrison is issued a REPRIMAND.

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[1] Prior to July 1, 2003, Section 54.1-2915.A(3) was codified as Section 54.1-2915.A(4) as written to include gross ignorance or carelessness in the practice, or gross malpractice. After July 1, 2003, it was rewritten to include intentional or negligent conduct in the practice that causes or is likely to cause injury to the patients.

It is further ORDERED that the license of Dr. Zackrison is placed on INDEFINITE PROBATION subject to the following TERMS and CONDITIONS:

(1) Within twelve (12) months from entry of this Order, Dr. Zackrison shall submit evidence satisfactory to the Board verifying that she has completed six (6) hours of Board-approved continuing medical education ("CME") in the subject of antimicrobial stewardship and;

(2) Within twelve (12) months from entry of this Order, Dr. Zackrison shall submit evidence satisfactory to the Board verifying that she has completed six (6) hours of Board-approved CME in the subject of cognitive impairment.

Such CME shall be approved in advance of registration by the Executive Director of the Board, and shall be completed through face-to-face, interactive sessions (*i.e.*, no home study, journal, or Internet courses). Any CME hours obtained in compliance with the above terms shall not be used toward compliance with the Board's continuing education requirements for license renewal. Upon submission of satisfactory completion of the above terms and conditions, the Board authorizes the Executive Director to terminate the probation imposed on Dr. Zackrison's license.

Violation of this Order may constitute grounds for suspension or revocation of Dr. Zackrison's license. In the event that Dr. Zackrison violates this Order, an administrative proceeding may be convened to determine whether such action is warranted.

As provided by Rule 2A:2 of the Supreme Court of Virginia, Dr. Zackrison has thirty (30) days from the date of service (the date she actually received this decision or the date it was mailed to her, whichever occurred first) within 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. In the event that this decision is served by mail, three (3) days are added to that period.

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

FOR THE BOARD:

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

ENTERED: 2/25/2015