

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
BOARD OF MEDICINE**

IN RE :
 :
JOSEPH G. JEMSEK, M.D. :
MD038331 :
Respondent :

FINAL DECISION AND ORDER OF THE BOARD

This matter comes before the District of Columbia Board of Medicine (the “Board”) pursuant to the Health Occupations Revision Act (HORA), D.C. Code § 3-1201.01 *et seq.* The Board has broad jurisdiction to regulate the practice of medicine and to impose a variety of disciplinary sanctions upon a finding of a violation of the HORA. D.C. Code, § 3-1201.03; *Mannan v. District of Columbia of Medicine*, 558 A.2d 329,333 (D.C. 1989). The Council of the District of Columbia, in amending the HORA, “intended to strengthen enforcement of its licensing laws.” *Davidson v. District of Columbia Board of Medicine*, 562 A.2d 109, 113 (D.C. 1989). And the HORA “was designed to ‘address modern advances and community needs *with the paramount consideration of protecting public interest.*’” *Joseph v. District of Columbia Board of Medicine*, 587 A.2d 1085,1088 (D.C. 1991) (*quoting* Report of the D.C. Council on Consumer and Regulatory Affairs on Bill 6-317, at 7 (November 26, 1985)) (emphasis added by court).

D.C. Code § 3-1205.19 authorizes the Board to conduct hearings and issue final decisions. The Board may delegate its authority to conduct a hearing to an Administrative Law Judge (ALJ) (*See* D.C. Code § 3-1205.19(i); *see also* 17 D.C. Mun. Regs. § 4114 (Hearings by Administrative Law Judges)). The ALJ shall issue a recommended decision which the Board may accept or reject in whole or in part in issuing its final decision. 17 D.C. Mun. Regs. § 4114. If the decision of the Board is adverse to the Respondent, it shall issue its proposed order to the

Respondent with an opportunity to file exceptions and written argument within ten (10) days of service. 17 D.C. Mun. Regs. §4114.7. The Board shall consider any exceptions filed in issuing its final decision.

Dr. Jemsek was represented by counsel throughout the hearing procedures, but the representation ceased after the issuance of the ALJ's recommended decision and prior to the issuance of the *Proposed Final Decision and Order of the Board*. Dr. Jemsek remains unrepresented in this case.

Background

Dr. Joseph Jemsek ("Respondent") was originally licensed in the District of Columbia on September 15, 2009. The Board issued Respondent a *Notice of Intent to Take Disciplinary Action* (NOI) on May 4, 2020. The NOI was based on four (4) complaints the Board had received involving four (4) different patients. The NOI listed the following charges:

1. Respondent failed to conform to standards of acceptable conduct and prevailing practice within the health profession in violation of D.C. Code § 3-1205.14(a)(26) for patients J.K.M., P.V., J.S.A., and W.P.;
2. Respondent demonstrated a willful or careless disregard for the health, welfare or safety of a patient in violation of D.C. Code § 3-1205.14(a)(28) for patients J.K.M., P.V., J.S.A., and W.P.;
3. Respondent made a false or misleading statement regarding his skill or the efficacy or value of a medicine, treatment, or remedy prescribed or recommended by him, at his discretion, in the treatment of any disease or other condition of the body or mind in violation of D.C. Code § 3-1205.14(a)(40) for patients J.K.M., P.V., J.S.A., and W.P.

Respondent submitted a timely request for a hearing, and the Board elected to refer the hearing to the Office of Administrative Hearings (OAH). The hearing in this matter was held over several days, November 28-30, 2022; January 30-31, 2023; and February 17, 2023. The Board was represented by Assistant Attorney General Walter Adams¹. Witnesses for the Government included patients J.S.A. and P.V.; Evan Karp, M.D., a pediatrician who treated Patient J.K.M.; and Jason Prior, M.D., a physician who treated Patient W.P. Eugene David Shapiro, M.D. testified as an expert witness on behalf of the Government. Witnesses for Respondent included the Respondent and two expert witnesses: Kenneth A. Bock, M.D. and Robert Bransfield, M.D.

The ALJ issued a *Recommended Final Order* (“Recommended Decision” or “Rec. Dec.”) on March 11, 2025. See ALJ *Recommended Final Order*, attached as **Exhibit 1**. The Board considered the Recommended Decision at its March 26, 2025, meeting and accepted its factual and legal conclusions in whole. See 17 D.C. Mun. Regs 4114.5.

The *Proposed Final Decision and Order of the Board* was mailed to Respondent via certified mail at his home address (USPS Tracking No. 70181830000095340270). The certified mail was unclaimed and the envelope returned. Service is therefore deemed to have occurred on June 10, 2025, when notice was left at Respondent’s home address of the certified mail. See 17 DCMR 4105.5. Respondent’s timeframe for submitting written exceptions has expired. See 17 DCMR 4114.7. Thus the Board can proceed with its final decision.

Respondent also submitted an affidavit surrendering his license dated July 2, 2025, and subsequently sent an email on July 24, 2025 stating his “desire and hope to resolve the four

¹ At the time of the hearing, Walter Adams was Assistant Attorney General with the D.C. Office of the Attorney General. Since that time, he has joined the D.C. Department of Health as Assistant General Counsel. Mr. Adams does not work on Board of Medicine cases.

pending complaints without further hearings or litigation.” The Board considered the lack of exceptions, Respondent’s affidavit of surrender, and his July 2, 2025 email at its meeting on July 30, 2025 and determined to issue the following:

Findings of Fact

The Board adopts the Findings of Fact of the ALJ, numbered 1 -5. *See* Exhibit 1, *Recommended Final Order*. These facts are incorporated by reference into the body of this document as if set forth in full.

Conclusions of Law

The Board adopts the following Conclusions of Law from the *Recommended Final Order*:

1. Respondent violated D.C. Code § 3-1205.14(a)(26) (failed to conform to standards of acceptable conduct and prevailing within the health profession) and D.C. Code § 3-1205.14(a)(28)(demonstrated a willful or careless disregard for the health, welfare or safety of a patient) when he failed to perform the proper diagnostic tests to confirm Lyme disease in his patients J.K.M., P.V., J.S.A., and W.P., and prescribed treatments that were not supported by legitimate scientific evidence for each. Each of Dr. Jemsek’s patients was subjected to “treatment for persistent Lyme disease and co-infections that was known to have adverse side effects, some severe, without confirming that the patients had Lyme or co-infections. And,

despite the patients experiencing adverse side effects, many of which were life threatening, Dr. Jemsek continued treating the patients.” Exh. 1 at 13.

2. Respondent violated D.C. Code § 3-1205.14(a)(40) (made false or misleading statements regarding his skill or the efficacy or value of a medicine, treatment, or remedy prescribed or recommended by him, at his discretion, in the treatment of any disease or other condition of the body or mind), in that he diagnosed each of the patients with Lyme disease based on insufficient evidence, and caused the patients to believe his prescribed treatment would be valuable in alleviating their symptoms. As the ALJ stated:

Dr. Jemsek had no basis for communicating to the patient in question that his treatment would be valuable in treating Lyme [disease]. The record evidence shows that Dr. Jemsek diagnosed each of the patients with Lyme disease based on insufficient evidence that any of those patients were suffering from the disease at the time treatment began. Each patient suffered from symptoms which were non-specific to Lyme disease. Dr. Jemsek did not engage in additional testing which could have provided sufficient evidence to confirm or deny the diagnoses before starting treatment.

The words of the consent forms were statements that caused these patients to believe Dr. Jemsek’s prescribed treatment would be valuable in alleviating their symptoms and that the prescribed medication would be valuable in treating Lyme disease. However, there was no value in pursuing treatment for Lyme disease for which Dr. Jemsek had insufficient bases for diagnosing. Nor was there value in taking medications not recommended for the treatment of Lyme disease. By causing the patients to believe in the value of his prescribed treatment and medication when there was no such value, Dr. Jemsek’s (sic) misled the patients. Therefore, the statements in the consent form concerning the value of Dr. Jemsek’s prescribed treatment and medication constitute violations of D.C. Official Code § 301205.14(a)(40). (Exh. 1 at 14).

SANCTION

The ALJ recommended disciplinary action, but did not propose a specific sanction. The Board has a mission to protect the health, safety and well-being of the residents of the District of

Columbia, as well as those individuals who receive medical treatment in the District. The Board considered the findings in this case, and determined that the Respondent is committed to his unconfirmed diagnoses and often harmful treatment of persistent Lyme disease, a practice which he has pursued for more than twenty (20) years. He has done this without confirmation of a disease, and despite a steady reporting of complaints, most of which have involved serious and sometimes life-threatening adverse medical effects.

The first complaint against Dr. Jemsek referenced in this case was filed March 23, 2012 by patient J.K.M.'s primary care physician due to his concerns about Dr. Jemsek's treatment plan. Despite the pediatrician's concern, J.K.M.'s mother continued his treatment with Dr. Jemsek.

The second complaint was filed December 30, 2014 by patient P.V. after he was hospitalized and diagnosed with, among other things, aseptic meningitis. The hospital doctors "concluded that the meningitis was the result of the treatment for Lyme and recommended that P.V. stop treatment with Dr. Jemsek. . . Dr. Jemsek recommended that P.V. complete his antibiotic treatment." (Exh. 1 at 10).

The third complaint, filed July 26, 2016 by patient J.S.A., was filed after J.S.A. was admitted to Johns Hopkins Hospital and diagnosed with "drug-induced liver failure due to the long-term treatment protocol administered by Dr. Jemsek." J.S.A. did not continue treatment with Dr. Jemsek.

The last complaint under consideration in this case was filed November 14, 2016 by another physician who treated Dr. Jemsek's patient W.P. at George Washington University Hospital for septic shock. "Septic shock is a dramatic drop in blood pressure that can damage the lungs, kidneys, liver and other organs caused by the body's improper response to an infection

or sepsis. The sepsis originated from the catheter used by Dr. Jemsek to administer the medications.” *Id.* After his hospitalization, patient W.P continued his treatment with Dr. Jemsek.

The tremendous harm that Dr. Jemsek caused some of his patients, and the risk of harm he brings to his other patients, without establishing any underlying medical diagnoses, must be stopped. Based on Dr. Jemsek’s statements and his treatment of these patients, Dr. Jemsek displays no recognition that his medical practices are unjustified despite the unwarranted risks these practices cause for his patients. “By emphasizing favorable results and minimizing the possibility of failure as an anomaly, the consent forms created an unrealistic sense of certainty that Dr. Jemsek’s treatment for Lyme disease would be effective in treating patients’ symptoms.” Exh. 1 at 7. Dr. Jemsek’s testimony reflects this same “unrealistic sense of certainty.” Therefore, the Board does not believe that remediation is possible in this case.

Revocation of a license is an extreme sanction, used in cases in which the Board believes no lesser sanction will protect the public. When the risk of harm is great and the chance of remediation is low, revocation is the appropriate action.

The Board is also in possession of Respondent’s *Affidavit of Joseph Jemsek, M.D., to Surrender License*, dated July 2, 2025. Following such a submission, the Board may issue an order accepting, suspending or revoking Respondent’s license. *See* D.C. Code § 1205.17. Respondent stated in his email that he hoped the Board would accept the affidavit and his decision to “retire from the practice of medicine” . . . “in lieu of any findings of inappropriate treatment.” Given the history of Respondent’s practice, the Board finds revocation the appropriate response to the surrender.

ORDER

UPON CONSIDERATION of the evidence and testimony presented at the hearing in this matter on November 28-30, 2022, January 30-31, 2023, and February 17, 2023, and the entire record herein, it is

ORDERED that the medical license of Joseph Jemsek, M.D., shall be and is hereby **REVOKED**.

DISTRICT OF COLUMBIA BOARD OF MEDICINE

Aug. 14, 2025

Date



By: Andrea Anderson, MD, MEd, FAAFP
Chairperson

Judicial Review of Final Actions by a Board

Pursuant to D.C. Official Code § 3-1205.20:

Any person aggrieved by a final decision of a board or the Mayor may appeal the decision to the District of Columbia Court of Appeals pursuant to D.C. Official Code § 2-510.

NOTE: Any appeal noted to the Court of Appeals must be filed within 30 days of the final decision of the Board. See D.C. Court of Appeals Rule 15(a)(2).

D.C. Official Code, §2-510 provides:

(a) Any person suffering a legal wrong, or adversely affected or aggrieved, by an order or decision of the Mayor or an agency in a contested case, is entitled to a judicial review thereof in accordance with this subchapter upon filing in the District of Columbia Court of Appeals a written petition for review. If the jurisdiction of the Mayor or an agency is challenged at any time in any proceeding and the Mayor or the agency, as the case may be, takes jurisdiction, the person challenging jurisdiction shall be entitled to an immediate judicial review of that action, unless the Court shall otherwise hold. The reviewing Court may by rule prescribe the forms and contents of the petition and, subject to this subchapter, regulate generally all matters relating to proceedings on such appeals. A petition for review shall be filed in such Court within such time as such Court may by rule prescribe and a copy of such petition shall forthwith be served by mail by the clerk of the Court upon the Mayor or upon the agency, as the case may be. Within such time as may be fixed by rule of the Court, the Mayor or such agency shall certify and file in the Court the exclusive record for decision and any supplementary proceedings, and the clerk of the Court shall immediately notify the petitioner of the filing thereof. Upon the filing of a petition for review, the Court shall have jurisdiction of the proceeding, and shall have power to affirm, modify, or set aside the order or decision complained of, in whole or in part, and, if need be, to remand the case for further proceedings, as justice may require. Filing of a petition for review shall not in itself stay enforcement of the order or decision of the Mayor or the agency, as the case may be. The Mayor or the agency may grant, or the reviewing Court may order, a stay upon appropriate terms. The Court shall hear and determine all appeals upon the exclusive record for decision before the Mayor or the agency. The review of all administrative orders and decisions by the Court shall be limited to such issues of law or fact as are subject to review on appeal under applicable statutory law, other than this subchapter. In all other cases the review by the Court of administrative orders and decisions shall be in accordance with the rules of law which define the scope and limitations of review of administrative proceedings. Such rules shall include, but not be limited to, the power of the Court:

(1) Subject to subsections (c) and (d) of this section and so far as necessary to decision and where presented, to decide all relevant questions of law, to interpret constitutional and statutory provisions, and to determine the meaning or applicability of the terms of any action;

(2) To compel agency action unlawfully withheld or unreasonably delayed; and

(3) To hold unlawful and set aside any action or findings and conclusions found to be:

(A) Arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;

(B) Contrary to constitutional right, power, privilege, or immunity;

(C) In excess of statutory jurisdiction, authority, or limitations or short of statutory jurisdiction, authority, or limitations or short of statutory rights;

(D) Without observance of procedure required by law, including any applicable procedure provided by this subchapter; or

(E) Unsupported by substantial evidence in the record of the proceedings before the Court.

(b) In reviewing administrative orders and decisions, the Court shall review such portions of the exclusive record as may be designated by any party. The Court may invoke the rule of prejudicial error.

(c) In reviewing an order or decision of the Mayor or an agency in any court or administrative proceeding, including but not limited to proceedings under subsection (a) of this section, the reviewing tribunal shall defer to the Mayor's or agency's reasonable interpretation of a statute or regulation it administers; provided, that the interpretation is not plainly wrong, or inconsistent with the statutory or regulatory language or the legislature's intent.

(d) In reviewing a rule adopted by the Mayor or an agency, the reviewing tribunal shall defer to the Mayor's or agency's reasonable interpretation of a statute it administers; provided, that the interpretation is not plainly wrong or inconsistent with the statutory language or the legislature's intent.

Copies to:

Dr. Joseph G. Jemsek



Respondent
(Via certified mail and email)

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JOSEPH JEMSEK, M.D.
Petitioner,

v.

DEPARTMENT OF HEALTH,
Respondent.

Case No.: 2020-DOH-00024

RECOMMENDED FINAL ORDER

I. INTRODUCTION

On June 29, 2020, Petitioner Joseph Jemsek, M.D., requested a hearing on the May 4, 2020 Department of Health's (DOH) Notice of Intent to Take Disciplinary Action pursuant to D.C. Official Code § 3-1205.14(c). The Notice alleged that Dr. Jemsek violated D.C. Official Code § 3-1205.14, sections (a)(26)(28) and (40).

II. PROCEDURAL HISTORY

On December 2, 2020, the first status hearing was held. Jacques Simons, Esquire appeared as counsel for Petitioner. Assistant General Counsel Walter Adams appeared on behalf of DOH. An evidentiary hearing was held over several days, November 29, 2022-December 5, 2022; January 30-February 8, 2023; and February 17, 2023. The following witnesses testified on behalf of DOH: Eugene David Shapiro, M.D.; Department of Health's medical expert; Evan Karp, M.D. and Jason Prior, M.D., doctors who treated two of Dr. Jemsek's patients, and JSA and PV, patients of Dr. Jemsek. Dr. Jemsek testified on his own behalf. Kenneth A. Bock, M.D.; and Robert Bransfield, M.D., testified as Petitioner's medical experts.

Alexander M. Pytlarz, PhamD, was offered as an expert in the area of pharmacology, pharmacokinetics and drug interactions. He was not accepted as an expert because he did not have experience in diagnosing or treating Lyme disease, or drug interactions.

III. FINDINGS OF FACT

1. Introduction to Lyme

There is no dispute regarding the pathology, etiology and clinical presentation of Lyme disease. Lyme is a bacterial infection (spirochete *Borrelia burgdorferi*) carried by the deer tick. Ninety-five percent of the reported cases of Lyme disease are in 7 states: Connecticut, Massachusetts, Minnesota, New Jersey, New York, Rhode Island and Wisconsin. If the deer tick attaches itself to a human and is not removed within a specific period, the tick passes on the bacterial infection. Generally, the first sign that a person has contracted Lyme disease is Erythema Migrans (EM), a red skin rash at the site of the bite. The skin rash usually appears in the shape of a bullseye one to two weeks after infection and occurs in 65 to 70% of cases. This is defined as “early” Lyme disease. The treatment for “early” Lyme diagnosed by the EM rash is 10 days of either Doxycycline or 14 days of Amoxicillin or Cefuroxime. As the bacteria moves through the blood stream, additional red rashes may appear on the skin. Other signs of infection can be neurological, i.e., facial palsy, meningitis, or inflammation of the heart, also known as carditis. This is defined as “second stage Lyme” or early dissemination of the bacteria and is treated with 14-21 days of the same antibiotics.

There is a “third” stage of Lyme or late Lyme, which is manifested by arthritis or joint swelling and treated with a 28-days of Doxycycline or Amoxicillin.

If a patient seeks treatment for symptoms associated with Lyme without exhibiting the EM rash, facial palsy, or carditis, doctors are encouraged to evaluate a patient’s clinical presentation or “physical manifestations” and presence in one of the seven states where Lyme disease is prevalent. If a patient has not been in a state where Lyme disease is prevalent, it is unlikely that the patient is infected with the Lyme bacteria.

There is a 2-tier blood test that identifies antibodies that develop in the first 3 or 4 weeks after being infected with the Lyme bacteria. The first tier is the quantitative Enzyme-Linked

Immunosorbent Assay (ELISA), which identifies elevated levels of antibodies present in an infected person. If the first test is positive, a second test, Western Immunoblot, is required to conclude that a patient is infected. However, if the ELISA test is negative, the patient does not have Lyme disease, and no further testing is required.

The ELISA antibody test is not without limitations. Because the test does not identify antibodies until after the first 3-4 weeks of infection, if given too early in the infection, it will not identify the antibodies resulting in a false negative. However, the test sensitivity increases considerably after 3-4 weeks after infection, making the ELISA test useful in diagnosing the third stage of the disease. Another limitation to the testing is the prevalence of misinterpretation by health professionals. *DOH Ex. 219* However, in this case the misinterpretation of test results is not an issue because there is no evidence that Dr. Jemsek tested any of the patients for Lyme disease before or during treatment.

a. Persistent Lyme Disease

Persistent Lyme is defined as a chronic debilitating illness resulting from having Lyme disease that is unresponsive to the standard regiment of antibiotics for treating Lyme disease. However, persistent Lyme is not generally recognized by medical professional as a medical condition. *DOH Ex 229*.

The treatment protocol for persistent Lyme utilized by doctors that recognize persistent Lyme includes long term dosing, or “pulse dosing” [REDACTED] of combinations of antibiotics along with other medications and supplements to counter the impact of long-term antibiotic therapy. Diagnosing persistent Lyme is accomplished through patient interviews where patients describe subjective symptoms such as fatigue, arthralgia, myalgia, poor concentration, headaches, and irritability, as well as a broad array of symptoms for which there is no conclusive scientific evidence of a relationship to *B. burgdorferi* infection, the bacteria that causes Lyme. *DOH Ex. 220* pg. 3866.

There are several reasons why the larger medical community does not recognize persistent Lyme as a true medical condition. First, although many of the “persistent Lyme” symptoms are seen in patients with Lyme disease, the same symptoms are also associated with other medical

conditions, and alone, are not enough information to diagnose Lyme. Unlike the traditional diagnosing of Lyme, which includes a clinical history, distinctive character of conditions, and history of exposure to ticks in an area where Lyme disease is epidemic, persistent Lyme is diagnosed with a clinical judgement and not a defined clinical criterion, laboratory studies or evidence that the patient was in a tick epidemic location. *DOH Ex. 220* pg. 3866. As a result, many patients who are treated for persistent Lyme do not actually have the disease and are subjected to prolonged antibiotic therapy treatment that is known to have adverse side effects including nausea, vomiting, allergic reactions, and less common but more serious side effects such as liver damage and hallucinations.

Despite the lack of support by some in the larger medical community for identifying persistent Lyme disease as a medical condition, Dr. Jemsek is part of a network of physicians and other health professionals that diagnose and practice prolonged antibiotic treatment for persistent Lyme. *DOH Ex. 229* pg. 2.

b. Co-Infections

In addition to recognizing persistent Lyme as a medical condition, the health professionals believe that the same bacteria that causes Lyme can lead to co-infections or “the simultaneous infection of a person with multiple pathogen species”, in the case of Lyme, Babesia or Bartonella. They further believe that Lyme cannot be eradicated without also treating co-infections.

Babesiosis is often asymptomatic, and most patients clear the infection on their own. Generally, the symptoms are chills, sweats and muscle pain. However, it can be fatal in the immunocompromised such as the elderly. The symptoms of severe Babesiosis are fever, anemia, shock and respiratory distress. The treatment protocol for Babesiosis is Azithromycin plus Atovaquone. Unlike Lyme, there is testing to definitively determine whether a patient has Babesiosis.

2. Medical Experts

Dr. David Shapiro testified as an expert in tick borne disease including Lyme and Babesiosis. *DOH Ex 216* Dr. Shapiro testified that there is no such medical diagnosis as persistent Lyme and that once a patient receives the standard course of antibiotics for Lyme, the disease is

eradicated. Those patients who continue to exhibit non-specific symptoms months and years after treatment, do not have Lyme disease and should not be treated for Lyme. In short, Dr. Shapiro testified that persistent Lyme is not a legitimate medical condition. And, prescribing medications long term is not an appropriate treatment.

Dr. Kenneth Bock, testified as an expert in the treatment and diagnosis on tick borne diseases. *PX 126* He testified that persistent Lyme is a true medical condition, and that prescribing antibiotics long term is a valid method of treating the condition. However, Dr. Bock did not define how long is “long term”.

Because the expert testimony as to the existence of persistent Lyme is in equipoise, the court finds that persistent Lyme, while not a widely recognized medical condition, is not an illegitimate medical condition. The court also finds that because there is no definitive answer to the question of what is “long-term” when prescribing antibiotics and other medications for the treatment of persistent Lyme, the long-term medication treatment plans for Lyme disease as prescribed by Dr. Jemsek are not an appropriate.

Dr. Bramsfield testified as an expert in the neuropsychological symptoms of Lyme disease and treatment. *PX 129*. The Court finds that his testimony is not relevant to the issues presented in this case as there is no dispute that there may be neuropsychological symptoms of Lyme.

3. Dr. Jemsek

Dr. Jemsek is a doctor who is Board Certified as an infectious disease specialist *PX 106*. He was licensed to practice medicine in the District of Columbia in 2009. *PX 102* (Jemsek CV)

In 1983, Dr. Jemsek became interested in the treatment of Human Immunodeficiency Virus (HIV) and for the next 23 years focused his practice on the treatment of the disease.

In 2001, Dr. Jemsek started to see several patients who reported having Lyme disease with complaints of overwhelming fatigue, joint pain, headache, rashes, mental health disorders, and neuropathic pain, several months or years after an initial Lyme diagnosis. Applying his experience with HIV, Dr. Jemsek concluded that even after receiving the standard Lyme treatment, a person would experience symptoms months or years later because the initial treatment did not eliminate

the Lyme causing bacteria. Instead, the bacteria remain dormant in the body and could be triggered to be released causing symptoms years after the initial infection. Dr. Jemsek also concluded that Bartonella or Babesia are co-infections with Lyme disease and require additional medications to fully eradicate a Lyme infection. In short, Dr. Jemsek embraced the persistent Lyme theory to treat the disease.

In 2006, Dr. Jemsek's North Carolina license to practice medicine was suspended for 12 months because of his prolonged use of medications, oral and intravenously, in the treatment of Lyme disease. The North Carolina Medical Board (NC Board) found that Dr. Jemsek "engaged in unprofessional conduct, including, but not limited to, departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession, irrespective of whether a patient is injured." *PX* 104. The suspension was stayed pending Dr. Jemsek following special terms and conditions imposed by the Board. *Id.* The following year, Dr. Jemsek placed his license on inactive status.

In 2006, Dr. Jemsek applied for a license to practice medicine in the District of Columbia. The District of Columbia Board of Medicine (DC Board) required Dr. Jemsek to submit a proposal in support of his treatment for Lyme disease. *PX* 100. The proposal submitted by Dr. Jemsek describes in detail his treatment for Lyme disease, including the long-term use of antibiotics. There is no direct evidence as to why the DC Board initially requested the proposal but after the first submission, Dr. Jemsek was asked to make changes to his plan to treat Lyme disease. Dr. Jemsek made the changes and in 2009, Dr. Jemsek received an unrestricted license to treat Lyme disease in D.C. *PX* 101

In 2019, Dr. Jemsek requested that the NC Board relieve him of the special terms and conditions imposed on his license. The NC Board granted the request. *PX* 105. There is no indication that Dr. Jemsek's license to practice medicine in NC was reinstated.

In 2020, the DC Board issued a Notice of Intent to Take Disciplinary Action to Revoke Dr. Jemsek's license to practice medicine after several complaints were filed with the Board from 2011 to 2016.

From 2011 to 2016, four complaints were filed with the D.C. Board referencing Dr. Jemsek's treatment of Lyme disease. Two of the complaints were filed by Dr. Karp and Dr. Prior, doctors that treated patients JKM and WP, who were under Dr. Jemsek's care. The two additional complaints were filed by JSA and PV, Dr. Jemsek patients who experienced serious medical complications while receiving Dr. Jemsek's treatment for Lyme.

4. Consent Form

Four patients signed the same "Informed Consent for Treatment for Chronic Lyme Disease" (consent forms). Joint Exhibit (JX) JX 300 pgs. 59-64. JKM's consent form included an additional page for their parents to sign giving Dr. Jemsek permission to treat a child. The consent forms include a general description of the complexities of treating Lyme disease. It also describes short and long-term antibiotic treatment, the potential side effects of long-term antibiotic treatment, the efficacy of the treatments, the possibility that additional medications may be prescribed to counter the side effects of the antibiotics, and other information related to treatment for Lyme disease. PX 110.

The consent forms communicated to patients the four possible outcomes of treatment with Dr. Jemsek. In three of these outcomes, the patients were expected to improve. In the fourth outcome, a patient's failure to improve was downplayed as unexplained. Taken together, these outcomes lead a patient to perceive the treatment as inherently valuable in treating Lyme disease. By emphasizing favorable results and minimizing the possibility of failure as an anomaly, the consent forms created an unrealistic sense of certainty that Dr. Jemsek's treatment for Lyme disease would be effective in treating patients' symptoms.

The consent forms also communicated that the medications prescribed by Dr. Jemsek would be appropriate for the treatment of Lyme disease. Even though Dr. Jemsek had no basis to diagnose these patients with Lyme disease, the fact that this diagnosis occurred entitled the patients to the belief that the medications prescribed would be valuable in treating the disease. Moreover, the consent forms do not include any indication that some of the medications used by Dr. Jemsek to treat Lyme disease are not widely accepted by the medical community or generally used for such treatment. In fact, the forms state that patients "will be treated with antibiotics selected to

address the bacteria causing Lyme disease.” A statement which itself implies that the selected medications are recognized as appropriate for treatment of the disease.

Although the tests for Lyme disease are not foolproof, they provide a potential basis for confirming the diagnoses to a degree of certainty far beyond the information that Dr. Jemsek possesses when diagnosis of these patients occurred. Upon negative tests for Lyme disease, Dr. Jemsek could have additionally tested for alternative causes of the patients’ symptoms to provide further assurance that these diagnoses were correct. Instead, Dr. Jemsek conducted no testing and relied in some cases on years old diagnoses of Lyme disease and in others only on clinical observations of non-specific symptoms. Dr. Jemsek had no basis to assume that the four patients had Lyme disease and thus no basis to make statements that a medication regimen designed to treat persistent Lyme disease would hold any value for these patients. This is also true for Dr. Jemsek’s diagnosing and treating Babesiosis without establishing that the patient was infected with the disease.

5. Complaints

Dr. Jemsek testified that he does not follow the standard Lyme treatment protocol because: 1) his clinical experience with infectious diseases informs him that the bacteria which causes Lyme can remain in the body after the completion of the standard Lyme treatment; 2) that the long term use of a combination antibiotics and other medications is the more effective treatment for patients who exhibit symptoms after receiving the standard treatment; and 3) that he does not limit the medications he prescribes to the standard medications because it does not in his opinion eradicate all the infections in a patient with Lyme disease.

A) Dr. Evan Karp the primary care physician for Dr. Jemsek’s patient JMK, who filed the complaint after reviewing Dr. Jemsek’s treatment plan for JKM. *DOH 202*

JKM was a 6-year-old autistic boy suffering from severe headaches after hitting his head sometime in 2009. After several doctors’ visits without any relief, JKM’s mother convinced Dr. Karp, JKM’s primary care physician, to test JKM for Lyme disease in December 2011 even though JKM did not report a tick bite or have the EM rash associated with being infected with Lyme. Dr. Karp tested JKM for Lyme with negative results for ELISA and a positive IgM and

IgG, which should have been interpreted as a negative for Lyme. However, Dr. Karp diagnosed JKM with Lyme and prescribed a 30-day treatment of doxycycline.

On January 17, 2012, JKM was taken to Dr. Jemsek's clinic complaining of a severe headache, joint pain, mood changes, and other symptoms non-specific to Lyme. *JX* 300 pgs. 76-77. After a comprehensive medical examination, Dr. Jemsek diagnosed JKM with persistent Lyme and recommended a treatment plan to first stabilize the JMK's overall health and then treat the Lyme disease and any co-infections. Dr. Jemsek did not independently test JKM for Lyme or coinfections. The plan included a combination of antibiotics, other medications, and supplements administered by pulse dosing over a period of 11 weeks. *JX Ex.* 300 pg. 78. Not all the antibiotics prescribed by Dr. Jemsek were traditionally prescribed to treat Lyme. Some of the antibiotics were prescribed to address co-infections and the supplements prescribed to address the overall side effects of the treatment. Two months into the treatment, JKM experienced mild symptom improvement.

On March 26, 2012, JKM had a second appointment with Dr. Jemsek where it was recommended that JMK continue treatment for 14 weeks. *JX* 300 pg. 107 and 108. After receiving a copy of Dr. Jemsek's treatment plan, Dr. Karp advised the family to discontinue treatment with Dr. Jemsek and filed a complaint with the D.C. Board asserting that he never saw a treatment plan like the one prescribed by Dr. Jemsek for the treatment of Lyme. However, the family continued treatment with Dr. Jemsek. *DOH Ex.* 202

B) PV Patient treated by Dr. Jemsek *DOH Ex.* 206.

In 2009, PV was diagnosed with Lyme disease by the ELISA test. There was no history of a tick bite or EM rash. PV's doctors prescribed a 10-week course of antibiotics and received no further treatment.

In November 2013, PV was seen at Dr. Jemsek's clinic for overwhelming fatigue, joint pain, and brain fog, symptoms non-specific for Lyme disease. *JX* 300 pg.213 After taking a comprehensive medical history, Dr. Jemsek diagnosed PV with persistent Lyme without additional testing. *JX* 300 at 138. Dr. Jemsek prescribed a 12-to-18-month treatment plan to first stabilize PV's overall health and then treat the Lyme disease and co-infections. The treatment

included a long-term protocol of medications that included a combination of medications and supplements. *Id.* at 139. Not all the prescribed medications were standard for treating Lyme. The treatment was modified in March 2014 to treat babesiosis without any testing to confirm the babesiosis diagnosis. *Id.* at 147 During the course of the treatment PV experiences some overall symptom improvement.

After experiencing stomach pain and sudden hearing loss in April 2014, PV was diagnosed by a different physician with Sudden Hearing Loss Syndrome resulting from the large volume of medications being administered by Dr. Jemsek. Despite the diagnosis, in June PV continued treatment with Dr. Jemsek. *JX* 300 pg. 149

PV was admitted into the hospital in July 2014, after exhibiting multiple cognitive impairments, some severe, and was diagnosed with Aseptic Meningitis, the inflammation of the tissue that covers the brain and spinal cord. The hospital tested PV for Lyme with a negative result. The doctors concluded that the meningitis was the result of the treatment for Lyme and recommended that PV stop treatment with Dr. Jemsek. After PV was released from the hospital, Dr. Jemsek recommended that PV complete his antibiotic treatment. PV did not return to treatment by Dr. Jemsek. *DOH Ex.*206

C) Patient JSA Patient treated by Dr. Jemsek *DOH Ex.* 209

In March 2016, JSA was diagnosed with Lyme by her family physician after reporting pain in her teeth and body as well as overwhelming fatigue. The doctor administered a 30-day course of doxycycline. JSA continued to experience symptoms and in April 2016, JSA was seen at Dr. Jemsek's clinic. In her initial consultation she described several symptoms non-specific to having Lyme. *JX* 300 pgs. 2313-2314. After a comprehensive medical examination, JSA was diagnosed with persistent Lyme without any further laboratory testing and directed to finish the course of antibiotics prescribed by her doctor.

After completing the initial treatment Dr. Jemsek developed a 12-to-18-month treatment plan to stabilize JSA's overall health and treat Lyme, Babesia and Bartonella co-infections. Dr. Jemsek did no testing to confirm his diagnosis. The treatment plan included the long-term

administration of a combination of medications, some of which are not generally prescribed to treat Lyme disease or co-infections. *JX* 300 pg. 2340-2342

By July 2016, JSA was taking several different medications. *RX* 300 pg. 2338-2341. JSA's symptoms worsened and on July 18, 2016, she was admitted to the Johns Hopkins Hospital with an elevated bilirubin¹ level. JSA was diagnosed with drug induced liver failure due to the long-term treatment protocol administered by Dr. Jemsek. JSA was advised not to continue treatment with Dr. Jemsek. *DOH Ex.* 209 She did not continue treatment.

Dr. Jason Prior Dr. Prior treated Dr. Jemsek's patient WP in the Intensive Care Unit after being hospitalized from complications with treatment. *DOH Ex.* 212

In 2004, WP was diagnosed with Lyme after receiving a tick bite and developing the EM rash. WP was treated and received a 30-day course of antibiotics and eventually returned to good health.

In 2013, WP received a second tick bite and developed the EM rash. He also experienced progressive neck soreness and occipital² and inflammatory cephalgia. His doctor administered 30 days of doxycycline. WP continued to experience a host of symptoms including joint pain, cognitive issues, facial nerve pain, and inflammation of the optic nerve, symptoms none of which are specific for Lyme.

In August 2015, WP traveled from Florida to Washington, DC to be seen at Dr. Jemsek's clinic for migratory myalgia, arthralgias, headaches and cognitive issues. After taking a comprehensive medical history, Dr. Jemsek diagnosed WP with Lyme. *JX* 300 pgs. 3540-3553. As with the other patients of Dr. Jemsek, he prescribed a treatment plan to stabilize WP's general health through medications and supplements. *Id* at 3564-3565.

¹ Bilirubin is tested as part of liver function test designed to determine whether the liver is properly functioning.

²Occipital neuralgia is a type of headache disorder. The condition occurs when your occipital nerves become inflamed. Your occipital nerves carry messages from your brain through your scalp. Nerve inflammation is irritation or swelling around your nerve. <https://my.clevelandclinic.org/health/diseases/23072-occipital-neuralgia> October 2, 2024.

A month later, Dr. Jemsek began a long-term treatment plan for WP that included several oral medications and supplements. WP saw Dr. Jemsek again on October 26, 2015, and was prescribed additional medications. *JX* 300 pgs. 3472-3478. In January 2016, WP's treatment was modified to provide intravenous administration of medications so that WP could better tolerate them. WP was responsible for maintaining the venous catheter used to administer the intravenous medications and would periodically travel from Florida to Washington DC to see Dr. Jemsek for follow-up.

On October 26, 2016, during a visit with Dr. Jemsek, WP was taken to George Washington Medical Center Emergency Room after experiencing excruciating pain and muscle cramping. WP was admitted into the Intensive Care Unit and treated by Dr. Prior for septic shock. Septic shock is a dramatic drop in blood pressure that can damage the lungs, kidneys, liver and other organs caused by the body's improper response to an infection or sepsis. The sepsis originated from the catheter used by Dr. Jemsek to administer the medications. After hospitalization, WP returned to treatment with Dr. Jemsek. *DOH Ex. 212*

IV. CONCLUSIONS OF LAW

Dr. Jemsek is charged with violating the following: D.C. Code § 3-1504.14(a) (26) failing to conform to standards of acceptable conduct and prevailing practice³; (28) demonstrates a willful or careless disregard for the health welfare or safety of the patient regardless of whether the patient sustains actual injury⁴; and (40) makes a false or misleading statement regarding his skill or efficacy of a medical treatment⁵. The charges arise from Dr. Jemsek's treatment of JKM, PV, JSA and WP, for persistent Lyme disease from 2012 to 2016.

According to OAH Rule 2822.2(b)⁶, the DOH has the burden of proof, "whenever the Government suspends, revokes or terminates a license, the Government has the burden of producing sufficient evidence to establish the reason for its action." Substantial evidence is evidence that exceeds a mere scintilla of proof; it means "such relevant evidence as a reasonable

³ D.C. Code 3-1504.14(a)(26).

⁴ D.C. Code 3-1504.14(a)(28).

⁵ D.C. Code 3-1504.14(a)(40).

⁶ OAH Rule 2822.2(b).

mind might accept as adequate to support a conclusion." *Children's Defense Fund v. District of Columbia Department of Employment Servs.*, 726 A.2d 1242 at 1247 (D.C. 1999).

A) D.C. Official Code § 3-1205.14(a)(26)

D.C. Official Code § 3-1205.14(a)(26) provides for the DC Board to take disciplinary action against a person who fails to conform to standards of acceptable conduct and prevailing practice within a health profession.

B) D.C. Official Code § 3-1205(a)(28)

D.C. Official Code § 3-1205(a)(28) provides for the DC Board to take disciplinary action against a medical professional who, “demonstrates a willful or careless disregard for the health, welfare, or safety of a patient...” The statute does not define “willful disregard.” When a statute does not define a term in question, it is appropriate to look at dictionary definitions to determine its ordinary meaning. [OBJ] Willful disregard is defined as, “conduct committed with an intentional or reckless disregard for the safety of the actor or others”. [OBJ]

There is substantial evidence to support the charge that Dr. Jemsek failed to conform to standards of acceptable conduct and prevailing practice within a health profession and demonstrated a disregard for the safety of his patients violating D.C. Code § 3-1205.14(a) (26) and (28). Despite evidence that diagnosing Lyme can be a challenge, Dr. Jemsek failed to conduct any diagnostic testing beyond an oral medical history to diagnose persistent Lyme.

Dr. Jemsek subjected each of the complainants to a treatment for persistent Lyme and co-infections that was known to have adverse side effects, some severe, without confirming that the patients had Lyme or co-infections. And, despite the patients experiencing adverse side effects, many life threatening, Dr. Jemsek continued treating the patients.

C. D.C. Official Code § 3-1504.14(a)(40)

D.C. Official Code § 3-1205.14(a)(40) prohibits any person permitted to practice medicine in the District from making “a false or misleading statement regarding . . . [the] value of a medicine,

treatment, or remedy prescribed or recommended by him or her.”⁷ To mislead is to “cause (another person) to believe something that is not so, whether by words or silence, action or inaction.”⁸

DOH has proven by substantial evidence that Dr. Jemsek demonstrated a willful or careless disregard for the health, welfare and safety of his patients in violation of DC Official Code § 3-1205(a)(28) and (40) by making “a false or misleading statement regarding . . . [the] value of a medicine, treatment, or remedy prescribed or recommended by him or her.” justifying the Board of Medicine in taking disciplinary action against Dr. Jemsek.^{9,10}

Dr. Jemsek had no basis for communicating to the patients in question that his treatment would be valuable in treating Lyme. The record evidence shows that Dr. Jemsek diagnosed each of the patients with Lyme disease based on insufficient evidence that any of those patients were suffering from the disease at the time treatment began. Each patient suffered from symptoms which were non-specific to Lyme disease. Dr. Jemsek did not engage in additional testing which could have provided sufficient evidence to confirm or deny the diagnoses before starting treatment.

The words of the consent forms were statements that caused these patients to believe Dr. Jemsek’s prescribed treatment would be valuable in alleviating their symptoms and that the prescribed medication would be valuable in treating Lyme disease. However, there was no value in pursuing treatment for Lyme disease for which Dr. Jemsek had insufficient bases for diagnosing. Nor was there value in taking medications not recommended for the treatment of Lyme disease. By causing the patients to believe in the value of his prescribed treatment and medication when there was no such value, Dr. Jemsek’s misled the patients. Therefore, the statements in the consent form concerning the value of Dr. Jemsek’s prescribed treatment and medication constitute violations of D.C. Official Code § 3-1205.14(a)(40).

V. RECOMMENDED ORDER

⁷ D.C. Official Code § 3-1205.14(a)(40).

⁸ *Black’s Law Dictionary* 1197 (11th ed. 2019).

⁹ D.C. Official Code § 3-1205.14(a)(40).

¹⁰ D.C. Official Code § 3-1205.14(c).

Based on the above findings of fact, conclusions of law, and the entire record in this matter, it is:

RECOMMENDED, that the District of Columbia Board of Medicine **AFFIRM** the Notice of Intent to Take Disciplinary Action and **TAKE DISCIPLINARY ACTION** against Petitioner pursuant to D.C. Official Code § 3-1205.14(c).

Dated: March 11, 2025

This Order is being transmitted to the District of Columbia Board of Medicine in accordance with 17 DCMR 4114 for a decision in which the District Columbia Board of Medicine may accept or reject the Recommended Decision, in whole or in part.

Claudia A. Crichlow /s/
Claudia A. Crichlow
Administrative Law Judge

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I hereby certify that on March 12, 2025, this document was served upon the parties named on this page at the address(es) and by the means stated.

/s/ Tyrone Williams

Clerk / Deputy Clerk

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