STATE OF CONNECTICUT
CONNECTICUT MEDICAL EXAMINING BOARD

Charles R. Jones, M.D.
License No. 012860

Petition No. 2006-0111-001-010;
Petition No. 2006-0411-001-069;
Petition No. 2006-0407-001-068

April 20, 2010

AGREEMENT OF THE PARTIES RE: DECISION DATED MARCH 16, 2010 IN FOREGOING MATTER

1) The civil penalty ordered by the Board shall be paid into an escrow account with Pullman & Comley, LLC and shall be maintained there pending the final resolution of Dr. Jones's appeal of the Board's order.

2) The imposition of the four year probationary period against Dr. Jones will be stayed pending final resolution of Dr. Jones's appeal of the Board's order.

3) Dr. Jones shall comply with the monitoring requirements in the Board's order.

4 a) In the event the monitor disagrees with any of Dr. Jones's clinical decisions following his/her record review, the monitor must discuss the issues(s) with Dr. Jones to reach a resolution. If the monitor and the Dr. Jones cannot reach a resolution, the monitor shall have the right to call the matter to the attention of the Department of Public Health in his/her quarterly report.

b) If Dr. Jones believes that any request by the monitor is not reasonable, he may file a motion with the court to challenge it.

CONNECTICUT MEDICAL EXAMINING BOARD

By _____

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CHARLES RAY JONES, M.D.

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STATE OF CONNECTICUT
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MEMORANDUM OF DECISION

Procedural Background

On November 9, 2006, the Department of Public Health ("the Department") presented the Connecticut Medical Examining Board ("the Board") with a Statement of Charges brought against license number 012860 of Charles R. Jones, M.D. ("respondent") in Petition Nos. 2006-0111-001-010, 2006-0411-001-069, and 2006-0407-001-068. Bd Exh. E. On February 25, 2008, the Department filed a motion to present the Board with an Amended Statement of Charges ("the Charges"). Bd Exh. F. The Charges allege that respondent violated § 20-13c *et seq.* of the General Statutes ("the Statutes"). Bd Exh. F.

On January 23, 2008, a Notice of Hearing was sent via certified mail and first class mail to the respondent, scheduling several hearing dates. Bd Exh. A.

On February 19, 2008, respondent moved to disqualify hearing panelist Anne Doremus (Bd Exh. J); the Department objected to this motion on February 26, 2008 (Bd Exh. J); and the Board denied the motion on May 18, 2008. Bd Exh. J

On March 17, 2008, respondent filed an Answer with special defenses. Bd Exh. G.

On April 7 and 25, 2008, the Department filed an Answer and a Supplemental Answer to Respondent's special defenses. Bd Exhs. H and I. On May 9, 2008, the Board issued a ruling, striking respondent's special defenses, except for the third special defense to the Second Count and the third special defense to the Third Count. Bd Exh. K.

During the June 10, 2008 proceedings, the Respondent made an oral motion to dismiss the Charges. Tr. 6/10/08, p. 174. The Board deferred its decision on that motion until the close of evidence. Tr. 6/10/08, p. 184.

On January 5, 2009, respondent filed an Objection to one of the Department's witness's testimony (Dr. Krause). The Department thereafter filed an Objection to

Respondent's Objection to Dr. Krause's Testimony (Board Exh. T); and, respondent filed a Reply to the Department's Objection to Respondent's Objection to Dr. Krause's Testimony. On January 6, 2009, the Board overruled respondent's objection to Dr. Krause's testimony. Board Exh. T; Tr. 01/06/2009, p. 16.

On March 4, 2009, respondent filed a written Motion to Dismiss, to which the Department objected on March 9, 2009. Bd Exh. V. The Board again deferred adjudication of the Motion to Dismiss until the completion of evidence. Tr. 03/20/2009, p. 2.

After numerous continuances, a hearing was held regarding the allegations contained in the Charges on the following dates: May 2, and May 9, 2008; June 10, 2008; July 22, 2008; September 12, 2008; October 28, 2008; January 6, 2009; and March 20, 2009, before a duly authorized panel of the Board comprised of Richard Bridburg, MD; Anne C. Doremus; and Edward Osswalt. ("the panel").

The panel conducted the hearing in accordance with Chapter 54 of the Statutes and §§ 19a-9a-1 *et seq.* of the Regulations of Connecticut State Agencies ("the Regulations"). Respondent appeared with his attorney Elliot Pollack. Attorney David Tilles represented the Department. Both the Department and respondent presented evidence, conducted cross-examination, and provided arguments on all issues.

All panel members involved in this decision attest that they have either heard the case or read the record in its entirety. The Board reviewed the panel's proposed final decision in accordance with the provisions of § 4-179 of the Statutes. The Board considered whether respondent poses a threat, in the practice of medicine, to the health and safety of any person. This decision is based entirely on the record and the specialized professional knowledge of the Board in evaluating the evidence.

Allegations

1. In paragraphs 1, 5, and 9 of the Charges, the Department alleges that Charles R. Jones, M.D. of Hamden, Connecticut is, and has been at all times referenced in the Charges, holder of Connecticut physician and surgeon license number 012860.

Count One

2. In paragraph 2 of the Charges, the Department alleges that on August 26, 2004, respondent had an initial appointment with D.C. and M.C., sisters ages three and six, respectively. Respondent's chart contains no history or physical examination

for either child. Respondent drew blood from both children and sent the blood to IgeneX Laboratory for a Western Immunoblot for antibody reaction to Borrelia burgdorferi. Respondent also sent a urine sample from both patients to Medical Diagnostic Laboratories for a Borrelia burgdorferi DNA test by Polymerase Chain Reaction ("PCR"). Neither child had any further contact with the respondent.

3. In paragraph 3 of the Charges, the Department alleges that respondent's care for D.C. and M.C. failed to meet the applicable standard of care in one or more of the following ways:

   a. he ordered laboratory studies without having taken a history or made a physical examination for patients he did not know;
   b. he ordered laboratory studies for M.C. when she had no symptom of any illness; and/or
   c. he ordered a urine PCR test for Borrelia burgdorferi, when said test was known to be unreliable.

4. In paragraph 4 of the Charges, the Department alleges that the above described facts constitute grounds for disciplinary action pursuant to the General Statutes of Connecticut, §20-13c(4).

Count Two

5. In paragraph 6 of the Charges, the Department alleges that respondent provided care for new patient K.E., then four years old, at various times beginning on or about August 11, 2005. Based on a call from K.E.'s mother that K.E. had several non-specific complaints, respondent directed K.E.'s mother to send samples of K.E.'s blood and urine to Medical Diagnostic Laboratories and blood to IgeneX Laboratory. Respondent did not examine K.E. at that time or take a complete medical history. Medical Diagnostic Laboratory reported a positive PCR test for Borrelia burgdorferi and a positive IgG ELISA for babesia microti. The IgeneX immunoblot tests for Borrelia burgdorferi were negative. Still without examining K.E. or taking a history, respondent diagnosed Lyme disease and Babesiosis on or about August 29, 2005, and prescribed Zithromax 200mg daily and Mepron 750mg daily. On September 8, 2005, repeat antibody tests for Babesia microti, order by Dr. Sabovic and performed at Quest and IgeneX, were negative. Respondent was aware of the results and Dr. Sabovic's examination notes that K.E. showed virtually none of the symptoms that had been reported by K.E.'s mother. Respondent continued to prescribe Zithromax and Mepron. Respondent did not examine K.E. until September 25, 2005, four weeks later[1].

6. In paragraph 7 of the Charges, the Department alleges that respondent's care for K.E. deviated from the applicable standard of care in one or more of the following ways:

   a. he failed to make a differential diagnosis;

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[1] The parties stipulated that the "six weeks" was a misprint and the Charges should refer to four weeks instead of six weeks. Tr. 09/12/2008, p. 197; Tr. 01/06/2009, p. 7.

b. he failed to make an adequate differential diagnosis;
c. he ordered laboratory tests without examining the patient and/or without taking her medical history; and/or,
d. he placed a new patient on antibiotics for four weeks without examining the patient or taking her medical history.

7. In paragraph 8 of the Charges, the Department alleges that the above facts constitute grounds for disciplinary action pursuant to the General Statutes of Connecticut, § 20-13c(4).

Count Three

8. In paragraph 10 of the Charges, the Department alleges that respondent has been J.S.'s pediatrician since April 29, 1999, when J.S. was five weeks old. J.S. has had seven documented episodes of strep, one each year, and two in 2000. In June 2004, respondent diagnosed Lyme disease based on an unconfirmed report of a "new Ioxides (sic) scapularis attachment" and equivocal serum antibody tests by IgeneX Laboratory. Respondent placed J.S. on Amoxil from June 4 until August 17, 2004, on Zithromax from June 4 until December, 2004, and on Cedax from August 17 until December, 2004. Until December 19, 2005, J.S. had a normal medical and educational progress for a child of his age. On December 19, 2005, respondent charted that J.S. suffers from gestational Lyme disease and has numerous non-specific symptoms, none of which had ever been previously noted in his charts, including various medical forms for camp attendance. During the next several months, respondent wrote and called J.S.'s school principal repeatedly to excuse his numerous absences; respondent reported numerous strep infections to J.S.'s school principal and to otolaryngologists to whom he referred J.S., which were not documented in respondent's chart and in spite of documented negative strep tests; and, respondent asserted in his charts and his correspondence that J.S. suffers a wide variety of symptoms, even though these were reported by his mother and contradicted by his father, not observed directly by respondent, and contradicted by other observers. Respondent also charted that J.S. has suffered a hearing loss from his Lyme disease, even though respondent performed two normal hearing examinations, a school audiologist performed a normal exam, and two otolaryngologists performed two normal exams.

9. In paragraph 11 of the Charges, the Department alleges that respondent's care for J.S. failed to meet the standard of care in one or more ways:

a. after December 19, 2005, he attributed multiple non-specific symptoms to Lyme disease without performing any differential diagnosis, or without performing adequate differential diagnosis;
b. on various occasions after December 19, 2005, he provided false and/or unconfirmed information to consulting physicians;
c. on various occasions after December 19, 2005, he provided false and/or misleading information to school officials;
d. on or about February 27, 2006, he advised twelve days absence of school because of a strep infection, when the cultures were normal;

e. after December 19, 2005, he diagnosed gestational transmission of Lyme disease when he knew that J.S. had no Lyme disease until he was five years old;

f. he recommended and/or excused J.S.'s absence from school so many times between December 19, 2005, and the end of the school year in 2006 that the school retained J.S. in first grade.

10. In paragraph 12 of the Charges, the Department alleges that the above described facts constitute grounds for disciplinary action pursuant to the General Statutes of Connecticut, §20-13c(4).

Findings Of Fact

1. Respondent of New Haven, Connecticut is, and has been at all times referenced in the Charges, the holder of Connecticut physician and surgeon license number 012860. Board Exh. G; Tr. 09/12/2008, p. 18.

Count One

2. On August 26, 2004, respondent had an initial appointment with D.C. and M.C., sisters ages three and six, respectively. The children's grandmother brought them to respondent's office and provided respondent with a series of non-specific symptoms, irritability, fatigue, low grade fever, intermittent joint pain. Respondent's chart contains no history or physical examination for either child. Dept. Exhs. 1 and 2; Resp. Exh. G.

3. Without having made a physical examination or taken a medical history, respondent drew blood from both children and sent the blood to IgeneX laboratory for a Western Immunoblot for antibody reaction to Borrelia burgdorferi. Respondent also sent a urine sample from both patients to Medical Diagnostic Laboratories for a Borrelia burgdorferi DNA test by PCR. Neither child had any further contact with respondent. Bd Exh. G; Dept. Exh. 2, pp. 13, 15; Dept. Exh. 1, pp. 1-6; Tr. 09/12/2008, p. 33; Tr. 1/6/09 pp. 62; 09/12/08, p. 33.

4. The evidence is insufficient to establish that respondent ordered laboratory studies for M.C. when she had no symptom of any illness. Dept. Exh. 1.

5. Respondent ordered a urine PCR test for Borrelia burgdorferi. The evidence, however, is insufficient to establish such test is unreliable. Bd Exh. G.; Dept. Exh. 1, pp. 1-6; Tr. 01/06/2009, pp. 76-77; Tr. 03/20/2009, p. 48.

Count Two

6. At various times beginning on or about August 11, 2005, respondent provided care for a four-year old female patient, K.E. At the time, respondent did not examine her or take a complete medical history. Rt. Exh. G; Dept. Exh. 2.

7. Respondent's care for K.E. was based on a questionnaire his assistant completed based on information provided to her by K.E.'s mother during a telephone call. The mother informed his assistant that K.E. had several non-specific complaints (stomach, leg, arm, and neck pain, mood swings, and tantrums). Based on this information, respondent directed K.E.'s mother to send samples of K.E.'s blood and urine to Medical Diagnostic Laboratories and blood to IgeneX Laboratory. Rt. Exh. G; Dept. Exh. 2.

8. Medical Diagnostic Laboratory reported a positive PCR test for Borrelia Burgdorferi and a positive IgG Elisa for Babesia microti. The evidence is insufficient to establish that the IgeneX imminoblot tests for Borrelia burgdoferi were negative since the test result for the urine was negative while the blood test result was positive. Dept. Exh. 2, pp. 9-11 ; Tr. 01/06/2009, p. 39.

9. Still without examining K.E. or considering a differential diagnosis, respondent diagnosed Lyme Disease and Babesiosis on or about August 29, 2005, and prescribed Zithromax 200 mg daily and Meptron 750mg daily. Bd Exh. G; Dept. Exh. 2, p. 13-15.

10. On September 8, 2005, Dr. Sabovic repeated the antibody tests for Babesia microti, which were performed at Quest and IgeneX, the results were negative. Dept. Exh. 2, pp. 65-66, 76.

11. The evidence is insufficient to establish that respondent was aware of the results of the tests ordered by Dr. Sabovic, or Dr. Sabovic's examination notes that K.E. showed virtually none of the symptoms that had been reported by K.E.'s mother. Dept. Exh. 2 pp. 69-70.

12. Respondent continued to prescribe Zithromax and Mepron to K.E., and did not examine K.E. until September 25, 2005, four weeks later. Bd Exh. G.

13. Respondent failed to make a differential diagnosis. Tr. 1/6/09 pp. 56-67; Dept. Exh. 2.

14. Respondent deviated from the applicable standard of care because he failed to make an adequate differential diagnosis. Tr. 1/6/09 pp. 56-68; Dept. Exh. 2.

15. Respondent ordered laboratory tests without examining K.E. and without taking a medical history. This alone, however, is insufficient to establish that respondent violated the applicable standard of care. Dept. Exh. 2, pp. 12-13; Tr. 1/6/09, pp. 62, 68.

16. Respondent placed K.E., a new patient, on antibiotics for four weeks without examining the patient and/or taking her medical history. Dept. Exh. 2, pp. 13-15; Tr. 1/6/09, p. 2.

17. Placing K.E. on antibiotics for four weeks without examining K.E. and/or taking her medical history violates the standard of care.

Count Three

The Board finds that the allegations in this Count, even if proven, are insufficient to establish any violation of the standard of care.

Discussion And Conclusions Of Law

Section 20-13c of the Statutes provides, in pertinent part, that:

> The Board is authorized to restrict, suspend or revoke the license or limit the right to practice of a physician or take any other action in accordance with section 19a-17, for any of the following reasons: . . . (4) illegal, incompetent or negligent conduct in the practice of medicine . . . .

The Department bears the burden of proof by a preponderance of the evidence in this matter. *Steadman v. Securities and Exchange Commission*, 450 U.S. 91, 101 S. Ct. 999, *reh'g denied*, 451 U.S. 933 (1981); *Swiller v. Comm'r of Public Health*, No. CV970573367, Superior Court, J.D. Hartford/New Britain at Hartford, February 19, 1998.

The Department sustained its burden of proof with regard to some of the allegations in Counts One and Two of the Charges. Respondent's conduct in those two counts constitutes grounds for disciplinary action pursuant to § 20-13c of the Statutes. The conduct that the Department proved in Count Three does not warrant disciplinary action, and the Board dismisses the allegations in Count Three.

a. Count One

With regard to the allegations contained in paragraph 2 of the Charges, Respondent admits the allegations in full. Rt. Exh. G Respondent admits that on August 26, 2004, he had an initial appointment with D.C. and M.C., sisters ages three and six respectively, who were brought to respondent's office by their grandmother. The grandmother provided respondent with a series of non-specific symptoms including low grade fever, irritability, fatigue, and intermittent joint pain. Respondent's chart contains no documentation of either a history or physical examination for either child. Respondent drew blood from both children and sent the blood to IgeneX laboratory for a Western Immunoblot for antibody reaction to Borrelia burgdorferi. Respondent also sent a urine sample from both patients to Medical Diagnostic Laboratories for a Borrelia burgdorferi DNA test by PCR. Neither child had any further contact with respondent.

With regard to the allegations contained in paragraph 3a of the Charges, the Department sustained its burden of proof that Respondent did not do a physical examination prior to ordering laboratory studies. Respondent made a diagnosis of Lyme disease without considering a differential diagnosis, and ordered laboratory tests only to confirm Lyme disease even though the symptoms relayed to respondent by the D.C.'s and M.C.'s grandmother were non-specific. This failure to consider a differential diagnosis violates the standard of care. Dept. Exh 1; Tr. 09/12/09, pp. 35,77, 86.

With regard to the allegations contained in paragraph 3b of the Charges, the Department failed to sustain its burden of proof.

With regard to the allegations contained in paragraph 3c, the Department failed to meets its burden of proof that such test was known to be unreliable.

b. Count Two

With regard to the allegations contained Count Two, paragraph 6 of the Charges, the Department sustained its burden of proof with regard to the following allegations. At various times beginning on or about August 11, 2005, respondent provided care for a four-year old patient, K.E. without examining her. Instead, he relied on a telephone questionnaire that his assistant took from K.E.'s mother that K.E. had several non-specific complaints. Respondent directed K.E.'s mother to send samples of K.E.'s blood and urine to Medical Diagnostic Laboratories and blood to IgeneX Laboratory. Medical Diagnostic Laboratory reported a positive PCR test for Borrelia Burgdorferi and a positive IgG Elisa for Babesia microti. Dept. Exhs. 2, 9.

Without examining K.E., Respondent diagnosed Lyme Disease and Babesiosis on or about August 29, 2005, and prescribed Zithromax 200mg daily and Meptron 750mg daily. Respondent continued to prescribe Zithromax and Mepron, and did not examine K.E. until September 25, 2005, four weeks later. Dept. Exhs. 2, 9

The Department failed to sustain its burden of proof with regard to the remainder of the allegations contained in paragraph 6 of the Charges. The evidence is insufficient to establish that the IgeneX imminublot tests for Borrelia burgdoferi were negative since the test result for the urine was negative while the blood test result was positive. The Department also failed to establish that the Respondent was aware of the results of the tests ordered by Dr. Sabovic, or Dr. Sabovic's examination notes that K.E. showed virtually none of the symptoms.

With regard to the allegations contained in paragraphs 7a through and including 7d, the Department sustained its burden of proof. Respondent deviated from the applicable standard of care in that he failed to make a differential diagnosis. The applicable standard of care requires that in order to make an adequate differential diagnosis an adequate medical history must be taken; a physical examination made; and any appropriate diagnostic tests be ordered based on the physical examination.

c. Count Three

A preponderance of the evidence establishes that respondent has been J.S.'s pediatrician since April 29, 1999, when J.S. was five weeks old; there was an established physician-patient relationship at the times alleged in the Charges. During that time, J.S. has had seven documented episodes of strep, and was treated by the Respondent for other complaints. In June 2004, respondent diagnosed J.S. with Lyme Disease based on a report of a "new Ioxides (sic) scapularis attachment" and equivocal serum antibody tests by IgenX Laboratory, and placed J.S. on Amoxil from June 4 until August 17, 2004, on Zithromax from June 4 until December 2004, and on Cedax from August 17, until December 2004. On December 19, 2005, respondent charted that J.S. suffers gestational Lyme Disease and had numerous non-specific symptoms.

Respondent admits that he contacted J.S.'s school and otolaryngologists to report J.S.'s strep infections. The Department failed to prove, however, that these communications were regarding infections not documented in respondent's chart, or that the communications occurred in spite of documented negative strep tests. The Department also failed to prove that (1) Respondent asserted in his charts and his correspondence that J.S. suffered a wide variety of symptoms, even though these were reported by his mother and contradicted by his father, as well as other observers, and were not observed directly by Respondent; (2) Respondent based his diagnosis on an unconfirmed laboratory test report; (3) on December 19, 2005, J.S. had a normal medical and educational progress for a child of his age; and, (4) Respondent charted that J.S. suffered hearing loss as a consequence of Lyme Disease, even though Respondent performed two normal hearing examinations, a school audiologist performed a normal exam, and two otolaryngologists performed two normal exams.

For these reasons, the Board finds that allegations contained within Count Three, even the ones that were proven, do not constitute grounds for disciplinary actions, and

dismisses the allegations in Count Three. In dismissing Count Three, the Board emphasizes the insufficiency of the evidence presented as to the allegations noted in the preceding paragraph. The Board also considered that the Respondent was this patient's pediatrician from five weeks of age, and, therefore, this patient was known to the Respondent. The evidence also shows that in this patient's case, the Respondent considered differential diagnoses when evaluating J.S.'complaints.

Conclusion

The Board finds that the allegations proven by the Department in Counts One and Two, and the Respondent's own statements under oath, demonstrate that the respondent does not, as a matter of practice, perform differential and/or adequate differential diagnoses, particularly with new patients. Instead, Respondent tends to obtain a cursory history, often by telephone survey results and other telephone conversations between unlicensed office assistants and patients or prospective patients; orders laboratory tests; and prescribes antibiotics, often for a period of several weeks, before performing physical examinations. Dept. Exh. 4, p. 4. The respondent's own records support this conclusion: "Due to a large volume of tick-borne disease patients in my practice, and the 2-6 month waiting time in between registering, obtaining lab work, and having an office visit, it is my practice to initiate antibiotic treatment, if the history and labs tests are positive for tick-born diseases. This is done to prevent further harm resulting from a delay in treatment." Dept. Exh. 3. p. 4 (transcription of Dr. Jones' chart for K.E.)

Respondent testified that his initial contact with each patient takes a minimum of two hours for a complete medical history and physical exam. He claims that his follow up visits are one hour long, and occur approximately every three to six months. Tr. 09/12/08, pp. 56-57, 63-66.

The Board finds that this same testimony undermines the respondent's credibility. For example, respondent also testified that he sees three thousand (3,000) patients per year, ten percent of whom are referred to him by other physicians. Tr. 09/12/08, pp. 56-57, 63-66.He, therefore, claims to see two thousand seven hundred (2,700) unreferred patients per year. He also testified that he works ten hours per day, six days per week. . Even assuming that the respondent takes no vacation and no special holidays, and works 52 weeks, this leaves him with three thousand one hundred twenty-five (3,125) hours per

year to see patients. Id. It is physically impossible for him to spend the amount of time he described with each patient during the number of available hours, and, therefore his testimony describing the length of time he spends with each patient is not credible. Respondent's own testimony supports the Board's own conclusion that respondent is not generally performing adequate differential diagnosis of his patients, and, specifically, did not do so in the case of K.E.

The Board also notes that in making its findings and conclusions, it deliberately avoided considering evidence presented by both parties regarding the ongoing debate concerning the existence of chronic Lyme Disease and the propriety of the prescription of long-term antibiotics. The Board did not consider such evidence to be relevant to the actual Charges. In particular, the Board disregarded all of the testimony from the Department's expert, Dr. Zemel, due to his evident bias against those physicians who do make diagnoses of chronic Lyme Disease, and against at least some of the laboratories utilized by these physicians for testing. Instead, the Board focused on the other expert testimony presented by both parties, in particular, Dr. Peter Krause, whose testimony the Board found to be credible and more pertinent to the actual allegations in the Charges, especially to the issue of adequate differential diagnoses. The Board also gave great weight to the Respondent's own testimony and the medical records he maintained for the patients referenced in the Charges. The Board emphasizes that its findings herein that the Respondent did not meet the applicable standard of care relate to violations of general standards of care applicable to all physicians, not just those diagnosing and treating Lyme Disease. [2]

Based on the foregoing, respondent's license is subject to discipline pursuant to §20-13c(4) of the Statutes, for the allegations contained Counts One and Two that were proven by a preponderance of the evidence. The evidence was insufficient to establish violations pursuant to § 20-13c (4) of the Statutes for the allegations contained in Count Three.

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[2] The Board notes that after the commencement of these proceedings, the Connecticut General Assembly enacted P.A. 09-12, which specifically provides that effective July 1, 2009, the Department of Public Health shall not initiate a disciplinary action against a licensed physician and such physician shall not be subject to disciplinary action by the Connecticut Medical Examining Board solely for prescribing, administering or dispensing long-term antibiotic therapy to a patient clinically diagnosed with Lyme disease . . . . . Nothing in this section shall prevent the Connecticut Medical Examining Board from taking disciplinary action for other reasons against a licensed physician."

Accordingly, the Board concludes that there is sufficient basis upon which to issue the following order.

Order

Based upon the record in this case, the above findings of fact and the conclusions of law, and pursuant to the authority vested in it by §§ 19a-17 and 20-13c of the Statutes, the Board finds that the misconduct alleged and proven in the separate paragraphs of Counts One and Two of the Charges is severable and warrants the disciplinary action imposed by this order, and hereby orders the following in the case of Charles R. Jones, M.D., who holds Connecticut physician and surgeon license number 012860, in Petition numbers 2006-0111-001-010, 2006-0411-001-069, and 2006-0407-001-068:

1. Count Three of the Charges is hereby dismissed.
2. Respondent shall pay a total civil penalty of ten thousand dollars ($10,000) by a certified or cashier's check payable to "Treasurer, State of Connecticut." The check shall reference the Petition Numbers on the face of the check, and shall be payable within 30 days of the effective date of this Decision.
3. Respondent's license shall be placed on probation, commencing on the date this Order is issued, for a period of four years under the following terms and conditions:

   a. No later than thirty (30) days from the date of this decision, respondent shall submit to the Department for its pre-approval, the name of a physician ("monitor") who will monitor respondent's practice, as further specified in this paragraph.

   b. Said monitor shall be licensed to practice as a physician and surgeon in Connecticut, shall be board certified in pediatrics, shall not have had any professional association with respondent, and shall not have served on any guideline panel relating to Lyme Disease.

   c. Respondent shall bear all expenses of monitoring, including a reasonable fee for the monitor's services.

   d. The monitor will conduct a monthly random review of twelve (12) of respondent's patient records created or updated during the preceding month. All such records shall be legible or transcribed. Within fifteen days of the Department's approval, respondent shall provide the monitor with a copy of this

Decision. Respondent shall cause the monitor to confirm receipt of this Decision within fifteen days after he has received the Decision. In the event respondent has twelve (12) or fewer patients whom he has seen in the preceding month, the monitor shall review all of respondent's patient records for patients seen in the preceding month.

(1) Respondent's monitor shall meet with respondent not less than once every month for the entire probationary period. The monitor shall discuss his findings with respondent during each such meeting.

(2) Respondent shall be responsible for providing written monitor reports directly to the Department every month for the entire probationary period. Such monitor reports shall include documentation of dates and the duration of meetings with respondent, number and a general description of the patient records and patient medication orders and prescriptions reviewed, additional monitoring techniques utilized, and statement that respondent is practicing with reasonable skill and safety, and in conformity with the standard of care enunciated in this Memorandum Of Decision, and has made and documented an adequate differential diagnosis for each patient whose chart the monitor has reviewed. The Department may provide a reporting form to the monitor that is consistent with this Order.

(3) The monitor shall have the right to monitor respondent's practice by any other reasonable means which he or she deems appropriate. Respondent shall fully cooperate with the monitor in providing such monitoring. The monitor shall give respondent a copy of his report to the Department. Within seven days of the report, respondent shall give the Department a copy of his entire chart for any patient whose care the monitor has identified as not meeting the terms of paragraph 3.d.(2). All such copies shall be legible or transcribed.

4. Respondent shall pay all costs necessary to comply with this Decision.

5. All correspondence and reports are to be addressed to:

Bonnie Pinkerton, Nurse Consultant
Department of Public Health
Division of Health Systems Regulation
410 Capitol Avenue, MS #12HSR
P.O. Box 340308
Hartford, CT 06134-0308

Ms. Pinkerton may also be contacted at the following email address: bonnie.pinkerton@ct.gov.

6. Respondent shall inform the Department in writing of his current address and any change thereto during the period of probation. All notices provided to respondent will be sent to the most current address of respondent on file with the Department.

7. This Order shall become effective upon the signature of the Board Chairperson.

Connecticut Medical Examining Board

March 16, 2010
Date

By: Anne C. Doremus, Chairperson