COMMONWEALTH OF MASSACHUSETTS

Middlesex, ss.

Board of Registration in Medicine
Adjudicatory Case No. 2025-033

In the Matter of

KATHERINE LANTSMAN, M.D.

CONSENT ORDER

Pursuant to G.L. c. 30A, § 10, Katherine Lantsman, M.D. (Respondent) and the Board of Registration in Medicine (Board) (hereinafter referred to jointly as the "Parties") agree that the Board may issue this Consent Order to resolve the above-captioned adjudicatory proceeding. The Parties further agree that this Consent Order will have all the force and effect of a Final Decision within the meaning of 801 CMR 1.01(11)(d). The Respondent admits to the findings of fact specified below and agrees that the Board may make the conclusions of law and impose the sanction set forth below in resolution of investigative Dockets Nos. 20-271, 20-503, and 21-287.

Findings of Fact

Background

1. The Respondent graduated from the St. Georges University School of Medicine, Grenada, West Indies in 2001. She has been licensed to practice medicine in Massachusetts under license number 237724 since 2008. She practices internal medicine and is board-certified in internal medicine. She is not affiliated with any hospital and practices at a private office located at 1330 Beacon Street, Brookline, Massachusetts.

2. The Respondent's practice encompassed treatment of patients for Lyme Disease and other tick borne illnesses.

Patient A

3. The Respondent treated Patient A from October 2012 to at least September 2020.

4. On repeated occasions during the period of October 2012 to September 2020, the Respondent ordered [redacted] for Patient A that were conducted by labs that did not follow CDC criteria for the diagnosis of [redacted]. These labs reported results as positive for diagnosis of [redacted] that were negative by CDC criteria.

5. On [redacted], 2020 and [redacted], 2020, the Respondent treated Patient A with [redacted] and high doses of [redacted] for [redacted] after she reported possible exposure to [redacted] even though she did not have a confirmed [redacted].

6. On repeated occasions during the period of October 2012 to September 2020, the Respondent prescribed multiple [redacted] for Patient A at higher than usual doses, without maintaining [redacted] in the patient's medical record, potentially exposing the patient to possible drug-drug interactions, drug toxicities, and adverse side effects.

7. In January 2020, the Respondent recommended that Patient A take [redacted] – a medication approved by the U.S. Food and Drug Administration for treatment of [redacted] – for treatment of [redacted] for which it had not been approved.

8. Throughout her care of Patient A during the period of October 2012 to September 2020, the Respondent practiced outside the scope of a general internist and outside of the standard of care by:

a. using laboratories whose tests did not follow CDC criteria for the diagnosis of [redacted];

b. prescribing multiple [redacted] and [redacted] at higher than usual doses without documenting appropriate monitoring testing, potentially exposing the patient to the possibility of adverse side effects;

c. recommending [redacted] regimens or [redacted] without adequately documenting the rationale for recommending same.

Patient B

9. The Respondent treated Patient B from May 2018 to December 2018.

10. Patient B began treatment with the Respondent for [redacted].

11. On repeated occasions during the period of May 2018 to December 2018, the Respondent recommended numerous [redacted] without adequately documenting the rationale for recommending such [redacted].

12. On at least one occasion during the period of May 2018 to December 2018, the Respondent recommended [redacted] medications for [redacted] with no documentation of [redacted] and very low risk for acquiring various [redacted]. If the Respondent ordered [redacted], the results were not included in the medical records.

13. On at least one occasion during the period of May 2018 to December 2018, the Respondent prescribed [redacted] for Patient B at higher than usual doses, without maintaining [redacted] in the patient's medical record, potentially exposing the patient to possible drug-drug interactions, drug toxicities, and adverse side effects.

14. On [redacted], 2018, Patient B reported that he had been having [redacted] since starting [redacted], and a few other [redacted] that he got from the Respondent. The Respondent told Patient B that the [redacted] is not a side effect of [redacted], but suggested that he stop then restart [redacted].

15. On [redacted], 2018, Patient B questioned the pros and cons of [redacted], "especially given my continued lack of symptoms" and said he was opposed to further testing for things like [redacted] and [redacted], as he had concerns about the sensitivity of the tests and he was still asymptomatic.

16. On [redacted], 2018, Patient B reported that he had stopped [redacted] due to side effects of [redacted] and that when he stopped all supplements and medications, the [redacted]. Patient B also reported that the [redacted] caused [redacted], [redacted], which stopped when he stopped taking the [redacted].

17. In November 2018, emails note that Patient B was taking [redacted]; however, the Respondent did not document why this supplement was started.

18. In November 2018, the Respondent also started Patient B on [redacted] to support [redacted], which is an off label use for [redacted]. The Respondent did not consult an [redacted] prior to prescribing this medication

19. In December 2018, Patient B discontinued treatment with the Respondent because he questioned the Respondent's diagnosis of [redacted] and had become dissatisfied with her care.

20. Throughout her care of Patient B, the Respondent practiced outside the scope of a general internist and outside of the standard of care by:

a. prescribing multiple [redacted] and [redacted] at higher than usual doses, potentially exposing the patient to the possibility of adverse side effects;

b. prescribing [redacted] medication without a clear diagnosis of [redacted]; and

c. recommending [redacted] regimens or [redacted] without adequately documenting the rationale for recommending such [redacted] and

d. recommending second-line, off-label [redacted] without consulting an [redacted].

Patient C

21. The Respondent treated Patient C from November 2020 to December 2021.

22. On at least one occasion during the period of November 2020 to December 2021, the Respondent attempted to diagnose Patient C with additional underlying [redacted] conditions, despite Patient C being under the care of a board-certified [redacted], as the Respondent did not believe that the [redacted] was assessing the patient's [redacted] levels.

23. In a [redacted], 2020 email, Patient C told the Respondent that his [redacted] disagreed with the Respondent's assessment of his [redacted] level because it did not take into account the time of day the [redacted] level was drawn and was not interpreted in the context of [redacted] he was taking for another medical condition. The [redacted] also disagreed with the Respondent's recommendation to start [redacted] because it can have adverse effects and was not likely to make the patient feel better. In an email response to Patient C on [redacted], 2020, the Respondent appeared to be dismissive of the [redacted] and suggested the [redacted] was "clos[ing] her eyes" on the patient's [redacted].

24. On at least one occasion during the period of November 2020 to December 2021, the Respondent arrived at the diagnosis of [redacted] by ordering numerous tests from different laboratories and combining the results to achieve the laboratory criteria of [redacted]. Some of the tests were not FDA approved, although performed by CLIA certified laboratories.

25. Patient C questioned the Respondent's diagnosis of [redacted] when he said in a [redacted], 2021 email to her, "[redacted]"

26. Throughout her care of Patient C, the Respondent practiced outside the scope of a general internist and outside of the standard of care by:

a. ordering numerous tests, some of which were not FDA approved, from different laboratories and combined the results to achieve the laboratory criteria of [redacted] to arrive at a diagnosis of [redacted];

b. prescribing multiple [redacted] and [redacted] at higher than usual doses, potentially exposing the patient to the possibility of adverse side effects; and

c. recommending [redacted] regimens or [redacted] without adequately documenting the rationale for recommending such [redacted].

Recordkeeping

27. The Respondent failed to maintain complete patient records, including but not limited to lab test results for Lyme Western blot tests and TSH levels which were not included in the medical records, making it impossible to interpret these tests.

28. The Respondent failed to clearly document her medical reasoning for treatment, including but not limited to her selection of Armour Thyroid, a desiccated animal-derived thyroid product, rather than other thyroid medications.

29. The Respondent failed to document a plan for addressing abnormalities in lab results.

30. The Respondent failed to clearly document the indication for changing medications.

31. Parasite testing results for patients for whom the Respondent ordered targeted therapy against parasites, if ordered, were not included in the medical records.

Conclusions of Law

A. The Respondent violated 243 CMR 1.03(5)(a)3 in that she has engaged in conduct which places into question her competence to practice medicine, including practicing medicine with negligence on repeated occasions.

B. The Respondent failed to maintain patient records that are complete and adequate to enable the licensee or any other health care provider to provide proper diagnosis and treatment, in violation of M.G.L. c. 112, §5, eighth par. (h) and 243 CMR 2.07(13)(a).

Sanction and Order

The Respondent's license is hereby REPRIMANDED and she is ORDERED to document successful completion of a medical education course on infectious disease (such as the one offered by the CDC Train called "Tick Borne Disease Education" or the American College of Physicians "Medical Knowledge Self-Assessment Program on infectious diseases" or other course approved by the Board); and document successful completion of a medical education course on medical record-keeping (such as the Center for Physician Education for Professionals' "CPEP" course, "Improving Patient Safety Through Effective Record Keeping" or other course approved by the Board); within six months of Board approval of this Consent Order.

This sanction is imposed for each violation of law listed in the Conclusion section and not a combination of any or all of them.

Execution of this Consent Order

Complaint Counsel and the Respondent agree that the approval of this Consent Order is left to the discretion of the Board. The signature of Complaint Counsel and the Respondent are expressly conditioned on the Board accepting this Consent Order. If the Board rejects this Consent Order in whole or in part, then the entire document shall be null and void; thereafter, neither of the parties nor anyone else may rely on these stipulations in this proceeding.

As to any matter in this Consent Order left to the discretion of the Board, neither the Respondent, nor anyone acting on her behalf, has received any promises or representations regarding the same.

The Respondent waives any right of appeal that she may have resulting from the Board's acceptance of this Consent Order.

The Respondent shall provide a complete copy of this Consent Order with all exhibits and attachments within ten (10) days by certified mail, return receipt requested, or by hand delivery to the following designated entities: any in- or out-of-state hospital, nursing home, clinic, other licensed facility, or municipal, state, or federal facility at which the Respondent practices medicine; any in- or out-of-state health maintenance organization with whom the Respondent has privileges or any other kind of association; any state agency, in- or out-of-state, with which the Respondent has a provider contract; any in- or out-of-state medical employer, whether or not the Respondent practices medicine there; the state licensing boards of all states in which the Respondent has any kind of license to practice medicine; the Drug Enforcement Administration Boston Diversion Group; and the Massachusetts Department of Public Health Drug Control Program. The Respondent shall also provide this notification to any such designated entities with which the Respondent becomes associated within one year following the

imposition of the reprimand. The Respondent is further directed to certify to the Board within ten (10) days that the Respondent has complied with this directive.

The Board expressly reserves the authority to independently notify, at any time, any of the entities designated above, or any other affected entity, of any action it has taken.

Katherine Lantsman, M.D.
Licensee

9/29/2025
Date

Megan Grew Pimentel, Esq.
Counsel for Licensee

9/29/25
Date

Sheryl M. Bourbeau, Esq.
Complaint Counsel

11/3/2025
Date

So ORDERED by the Board of Registration in Medicine this 4th day of December, 2025.

Booker T. Bush, M.D.
Board Chair