The Birth of the Jemsek Specialty Clinic of SC, Emergence from Bankruptcy and Rededication to the Lyme Borreliosis Pandemic, with Related Comments on the Demise of the Corrupt US Healthcare System

A Historical and Editorial Review of Events
with Commentary on US Private Health Insurance
as the Enemy of Private Medical Enterprise

Joseph G. Jemsek, MD, FACP, The Jemsek Specialty Clinic of SC, LLC
With Published Author, PJ Langhoff

Joseph G Jemsek, MD, An Introduction to a Rich History in Medicine and Infectious Diseases; with a Legacy of Seminal Work in HIV/AIDS

Dr. Joseph G. Jemsek received his medical degree from the University of Illinois Medical School in Chicago and underwent his residency in Internal Medicine at the Medical University of South Carolina in Charleston, South Carolina. Subsequent training in an Infectious Diseases Fellowship was completed at Baylor College of Medicine in Houston, Texas in a two-year curriculum, which concluded June 1979. In the fall of 1979, Dr. Jemsek joined the now defunct Nalle Clinic in Charlotte, working as an infectious disease specialist and general internist. As documented in Dr. Jemsek's curriculum vitae included in this document, Dr. Jemsek is board certified in both the medical specialties of Internal Medicine and Infectious Diseases.

Within two years of arriving in Charlotte, Dr. Jemsek petitioned to become the first hospital epidemiologist in a private institution in North Carolina, and subsequently became one of the few epidemiologists working in a community hospital setting in the United States. He subsequently served in this capacity at Carolinas Medical Center (CMC) from 1982-1990. This era in American medicine not only ushered in the HIV/AIDS epidemic, but also presented multiple new complex issues in hospital epidemiology concerning other contagious diseases, such as Hepatitis B and the integration of new and expensive antibiotics into hospital practice. These issues concerned not only the safety of all hospitalized patients at this large institution, but also involved issues that routinely involved the contagious aspects of illness for employees at CMC who cared for these patients.

In the mid-1980s, Dr. Jemsek was invited to join the newly created Carolinas Heart Transplant program at CMC as the supervising Infectious disease physician for patients on the transplant service. This program was formed through the inspiration of Dr. Francis Robiscek, a world-renowned cardiovascular surgeon at the Sanger Clinic in Charlotte. In this highly successful program, Dr. Jemsek personally supervised the first 125 heart transplant recipients at Carolinas Medical Center, managing all Infectious disease concerns before and after surgery for these patients.

Dr. Jemsek is a nationally known authority on both HIV/AIDS and Lyme Borreliosis Complex (LBC), having participated in numerous regional and national/international conferences concerned with these topics (see curriculum vitae). For well over two decades, Dr. Jemsek was acknowledged as the region's leading care provider in HIV/AIDS. In early 1983, Dr. Jemsek diagnosed the first case of HIV/AIDS in North Carolina. This seminal event foreshadowed Dr. Jemsek's first clinical trial in HIV/AIDS research in 1989, a trial which involved AZT, the first drug approved for use in HIV/AIDS treatment. This date in 1989 marked the beginning of an uninterrupted 16-year legacy in which Dr. Jemsek and his research staff were at the forefront of FDA-approved clinical trials for new drugs for HIV/AIDS treatment. For 23 years, Dr. Jemsek and his staff provided innovative and ground breaking medical care for the largest population of HIV/AIDS patients served by the private health sector in the Carolinas, until his practice was

involuntarily halted in the spring of 2006 by the actions against him by the North Carolina Medical Board (NCMB) and Blue Cross Blue Shield of North Carolina (BCBSNC).

As an HIV/AIDS expert, Dr. Jemsek has been profiled in national media presentations featured on ABC News' 20/20, CBS 60 Minutes, Good Morning America, as well as numerous local print and TV media stories. Dr. Jemsek has been honored with a number of awards for his work in HIV/AIDS. Perhaps two of the most notable awards were granted by two different NC Governors – Governors Hunt and Easley. In 1998, by special invitation to the Governor's Mansion, Governor Hunt awarded Dr. Jemsek the Certificate of Appreciation for his pioneering work in HIV/AIDS as an example of outstanding contribution to the state by a civilian. Previous award recipients for this award include, among others, the Reverend Billy Graham.

As a noted Lyme disease specialist, Dr. Jemsek has been a featured speaker in numerous venues, both in the US and abroad. He and several of his patients with LBC are portrayed as major subjects in a recently released independent full-length documentary film about Lyme disease, entitled *Under Our Skin*. This film premiered with high praise at the *Tribeca Film Festival* in New York City on April 26, 2008. Since the premiere, the film has received similar high praise at film festivals in Boston and Washington DC (*Berkshire* and *Silverdoc*, respectively). It was recently awarded the winner of the International *Freddie Awards* for the best film in the Infectious Disease health category. It is noteworthy that the reviewers of this award are physicians and other health professionals who comprise the world stage.

A Commitment to Charitable Causes

As a natural extension of Dr. Jemsek's dedication to working in the HIV/AIDS epidemic, Dr. Jemsek takes great pride in the fact that he envisioned and created a 501(c)(3) charitable organization in the fall of 2003 for HIV/AIDS education and care, *The Jemsek CHARM Project*. This Project was the first, and is still the only charitable HIV/AIDS organization in the history of the Carolinas, which offered both medical and social services support to those with HIV/AIDS. The Jemsek CHARM Project was created for the purpose of facilitating access to care issues for those affected by HIVAIDS in the Metrolina region, and for providing education to those at risk for acquiring HIV/AIDS in the same region.

In making a personal and financial commitment to this foundation from the outset, Dr. Jemsek funded the best and most experienced talent he could locate to lead the CHARM Project, and he continued to fully fund the organization as it grew rapidly in the first three years of its history. Despite Dr. Jemsek's reluctant leave from HIV/AIDS issues in 2006, the CHARM organization had remained viable until just recently when, in May 2008, lacking his financial support, the project ended due to financial insolvency. For well over four years, this charitable work had been carried on by a devoted board of directors and project staff members who had provided benefits to hundreds of Mecklenburg County (NC) residents with HIV/AIDS, as well as providing services to those at risk for acquiring this fatal infection. Naturally, Dr. Jemsek is highly troubled by the discontinuance of the CHARM Project, which he sees as a highly undesirable consequence resulting from the unwarranted and highly injudicious actions taken against the Jemsek Clinic by the North Carolina Medical Board and Blue Cross Blue Shield of North Carolina (BCBSNC).

Once the legal and financial issues created by the current litigation are resolved, Dr. Jemsek plans to rededicate himself to continuing his charitable endeavors in both HIV/AIDS and LBC patient care issues.

The Nalle Clinic Closes in 2000 – Jemsek Clinic Begins

In the spring of 2000, the 75-year old multispecialty Nalle Clinic was forced to close its doors due to financial hardship, thereby displacing over 120 physicians. Dr. Jemsek elected to relocate to the Lake Norman, NC area where he originated the Jemsek Clinic, PA as a solo practitioner. A Physician's Assistant was hired to assist with the care of the 250 patient HIV/AIDS caseload, which followed Dr. Jemsek from the Nalle Clinic. The mission of the new Jemsek Clinic, which opened with 8 (eight) employees in June 2000, was to continue a 17-year tradition of providing high standards of care for patients with HIV/AIDS; to practice limited general medicine; and to expand the clinic's capacity for inpatient and outpatient consulting practice in Infectious diseases.

A New Awareness of Lyme Disease at Jemsek Clinic - 2001

The Clinic grew rapidly in its core specialty, HIV/AIDS, but within the first few months of operation, Dr. Jemsek began to notice a curious migration of patients to the Jemsek Clinic, arriving from outside the Charlotte area, who were seeking help with "Lyme disease". Dr. Jemsek believed he was well aware of Lyme disease at that time in 2000-2001, since he had treated approximately 30 patients while at the Nalle Clinic, beginning in 1986. Most of the patients subsequently treated at the Nalle Clinic by Dr. Jemsek required repeated courses of long-term oral antibiotics for suppression of their symptoms, and several more patients benefited from treatment with extensive intravenous antibiotic therapy. Not all patients improved with oral antibiotics.

Dr. Jemsek soon learned that he was formerly unaware of the many political and academic aspects of this chronic and debilitating illness. To wit, Dr. Jemsek had always simply assumed that chronic illness with Lyme disease was widely recognized by his peers. He had little reason to believe otherwise, as his view of the existence of a chronic form of the illness had been constantly reinforced by patient interviews and by his increasing understanding of the complex biology of the spirochetal bacterium causing Lyme disease, *Borrelia burgdorferi*. Intuitively, he drew correlations in treatment of chronic illness from other infectious disease treatment paradigms universally accepted by his Infectious disease physician colleagues, such as those illustrated in the treatment of chronic infections due to Hepatitis C, Tuberculosis, and HIV/AIDS.

Because of increasing patient awareness attained primarily through internet communication, more patients learned that Dr. Jemsek was willing to spend the necessary time to fashion customized treatment plans for patients with LBC. These patients continually challenged Dr. Jemsek and caused him to realize that there were an appreciable number of patients with LBC, and that there was absolutely no doubt that this condition was chronic and/or recurrent. *He also realized that the illness constituted levels of complexity unrecognized by the current medical system, and, most importantly, that the symptom complex or syndrome he was observing was harsh and unrelenting in its life-altering effects on his patients*. These effects were almost always worsened by the patient's sense of isolation from the medical community. Indeed, this group of patients appeared to be largely disregarded by their personal and consulting physicians (including all manner of medical specialists), and also, when referred to an academic center, were disregarded by the academic medical community at large.

The Jemsek Clinic's pattern as a destination practice began to emerge as an ever-increasing number of new patients with LBC were arriving from outside the Metrolina region. After many years at the forefront of the HIV/AIDS epidemic, Dr. Jemsek had gained a great deal of experience in the increasingly sophisticated medical research associated with the study of the HIV/AIDS pandemic. In comparing many factors about the twin epidemics, HIV/AIDS and LBC, Dr. Jemsek observed a profound dichotomy in many areas, none the least of which were,*1) an uncomfortable contrast in patient care issues and 2) an appalling gap in research between HIV/AIDS and LBC.*

Given similarities in the pervasiveness and widespread epidemiologic implications of these epidemics, he found these dramatic contrasts to be utterly puzzling. Dr. Jemsek constantly sought to share his experience and treatment successes in LBC, and so presented a number of lectures on this subject, which often occurred simply because he solicited opportunities to share information by lecturing in different venues. He also wrote an extensive website on this subject, which attracted considerable attention and interest. In the period 2004-2005, by invitation after solicitation, he made two separate presentations to the NC Dept. of Public Health in Raleigh, and in April 2005, he received an invitation and subsequently delivered a grand rounds presentation on this topic to the Infectious disease department at Duke University Medical Center (Power Point presentation available on request).

Prelude to Rosedale Medical Center – the Rapid Growth of the Twin Epidemics

Over the next three years, the twin epidemics of HIV/AIDS and Lyme Borreliosis Complex (LBC), fueled Jemsek Clinic growth such that by late 2005 and into early 2006 (Rosedale Medical Center era), Dr. Jemsek employed two Infectious disease Physicians proficient in HIV/AIDS care, two Physician Assistants, and five Family Nurse Practitioners. There were by then a total of 65 full-time employees and several part-time consultants at Jemsek Clinic. By 2005, new patient demographics showed that patients who had attended the Jemsek Clinic since 2001 had traveled from a total of 45 states, as well as from several foreign countries. The clinic was at this time treating an average of 80 new patients per month for possible tick-borne illnesses (TBIs) and the HIV growth was burgeoning.

In the fall of 2005, the Clinic had a waiting list of 150 patients scheduled for new patient appointments for evaluation of possible TBIs*. The HIV/AIDS practice had expanded to more than 1,000 individuals and was adding an average of 20 patients monthly to what was already by far the largest private clinic for HIV/AIDS in the Carolinas, and one of the largest private clinics in the country. Projections for growth of the HIV/AIDS practice were for 2,000 patients by the year 2011, which would easily qualify the Clinic as one of the world's largest private facilities for HIV/AIDS care.* ***At the same time, the Jemsek Clinic had also arguably become the most active medical center in the world for treating TBIs associated with chronic illness, and specifically, LBC****. Accordingly, the Clinic based its plans for employees and space needs at the Rosedale Medical Center on these projections.*

Rosedale Medical Center: Feb 2006 – Sept 2007

In 2004, recognizing the extraordinary and ever-expanding demands for clinic services in LBC and HIV/AIDS, Dr. Jemsek committed to a vision for a world-class practice for emerging illnesses and began preparations to create an appropriate facility to accommodate this growth. The clinic was to be called Rosedale Medical Center, since the site of the commercial subdivision for the future location of the Clinic was named Rosedale. Thousands of man-hours (mostly those volunteered by Jemsek staff) went into the preparation for the Rosedale facility in Huntersville, just 20 minutes north of Charlotte, NC. In the fall of 2005, bids from financial institutions were well underway for the financing of the new medical facility. *This project attracted the eager interest of several prominent lending institutions, including SunTrust, Wachovia, and First Citizens Bank, all of which were avidly competing and promoting 100% funding packages in the $9-10MM range*.

In February 2006, after 24 months of intensive planning and preparation, Dr. Jemsek and his staff opened an $11MM state-of-the-art clinic at Rosedale Medical Center in Huntersville, NC. The Jemsek Clinic was envisioned to grow as a prototypical clinical model for the care of emerging chronic infectious diseases. With the creation of Rosedale Medical Center, there was now a world-class facility in which to accomplish these goals. As the opening day for the new Medical Center grew near, Dr. Jemsek sent a letter to each Chief of Infectious diseases at the six medical centers in North and South Carolina, (including Duke University), extending an offer for collaboration in the study of HIV/AIDS and LBC **(see reference #1).**

Dr. Jemsek was aware that he had achieved an excellent and perhaps unique community model for the study of these disease states, and wished to share this opportunity with the regional academic centers, as he assumed they would be exceptionally interested in this academic community and wish to collaborate in this unique North Carolina setting. Dr. Jemsek and his colleagues envisioned that such a center would provide a strong bridge to traditional academic centers, ultimately resulting in research efforts that would reap both immediate and long-term benefits for those suffering from these chronic illnesses. ***This collaboration, had it been incorporated by health care insurers, would in turn have led to a substantial reduction in health care costs assigned to chronic care insurers by resolving, or favorably impacting, the ongoing health maintenance costs associated with these illnesses***.

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<u>The Unexpected and Sudden Reversal of BCBSNC Support</u>

Just a few weeks prior to moving the Jemsek Clinic into the new Rosedale Medical Center facility, a series of adverse actions ensued in a sequence of events familiar to the court. In short order, after the NCMB actions became public, Dr. Jemsek proceeded to witness the rapid disintegration of his practice. Most dramatically, this disintegration was ushered in by the chilling effect that the abrupt and unexpected withdrawal of insurance reimbursement by Blue Cross Blue Shield of North Carolina (BCBSNC) had on his patient volume and on the income stream required for clinic operations. Given this devastating shortfall in reimbursement, the next several months brought severe Clinic contraction, including the involuntary attrition and release/loss of almost 80% of Dr. Jemsek's 65-70 employee base staff.

BCBSNC, which dominated the health insurance market in NC at the time; and which continues to dominate the market with more than 3.4 million premium payers at the time of this communication, was previously responsible for collecting and distributing well over 50% of the money earned by the Clinic for HIV/AIDS and LBC care during this time in the Jemsek Clinic history. Without warning or communication with the Jemsek Clinic, BCBSNC refused to pay for the vast majority of clinical services that Jemsek Clinic rendered from the period late 2005 forward, including services for HIV/AIDS care. While BCBSNC had never previously held a formal written policy for therapy for Lyme disease, suddenly, in a January 2006 bulletin, BCBSNC stated that by the first of February 2006, the insurer would announce its first policy on Lyme disease. This policy would go into effect May 2006, consistent with a regulatory-enforced, obligatory 90-day waiting period.

Insurance payments now withheld had a devastating effect on the Clinic, which of course had just taken on a great deal of debt. The sudden refusal by BCBSNC to pay for services rendered for both HIV/AIDS and LBC care stood in stark contrast to a previous pattern of reimbursement, which had been paid to Jemsek Clinic for years without dispute. In addition, services for Lyme disease care had been authorized by BCBS on numerous occasions, and these services had also been subjected to BCBSNC audits of the Jemsek Clinic, without comment.

Patient outrage at the BCBSNC actions translated into numerous letters of complaint sent to the NC DOI (Department of Insurance) and AG (Attorney General's) office in early 2006, with more than 150 letters of complaint registered. Out of respect for the patient dilemma brought on by these circumstances, the Jemsek Clinic never demanded payment or otherwise pressured patients to pay their medical bills. However, during this period, there are on record, requests made by BCBSNC in which they contacted patients, (including those of modest means such as school teachers), in unannounced phone communications, asking these patients to reimburse BCBSNC for thousands of dollars in payments the company made to Jemsek Clinic for their LBC care. Our documentation confirms that this $5BB company, NCBCNC, with up to $1BB in surplus revenues over each of the past 3 years, was asking school teachers and others of modest means to reimburse them for monies they had distributed to the Jemsek Clinic months before.

In March 2006, as the Jemsek Clinic moved into its new facility at Rosedale Medical Center, Dr. Jemsek and the Jemsek Clinic were mysteriously placed in a "special assets" category by one of their primary lenders, the same lender which four months earlier had strenuously pleaded that they be considered as the sole lender for the Jemsek Clinic's financial needs for the aforementioned multi-million-dollar loan packages. This particular lender had repeatedly emphasized that they were the preferred lender for medical enterprises in North Carolina. In fact, the President of this bank, (with headquarters in Raleigh, NC), made a personal 90-minute visit to the Jemsek Clinic at its 16630 Northcross Huntersville location in the fall of 2005. This President and CEO of one of America's largest institutions proceeded to laud the Clinic's operation and constantly reiterated the bank's interest in securing all of the necessary financing through their institution. As stated earlier, but now restated for emphasis, *only four months later* this lending institution (which subsequently had been awarded a minority fraction of the developmental loan costs, but which controlled the Clinic's line of credit) proceeded to place the Jemsek Clinic into the special assets category in their bank. *No satisfactory explanation for this action was ever given to Dr. Jemsek, either verbally or in writing*.

In effect, the Jemsek Clinic was now in **financial "jail,"** even though the Clinic had remained current on all interest and principal payments to the lending institution in question. The line of credit agreed upon by this bank, which at this time was several hundreds of thousands below their limit, was immediately frozen. This "shut down" on the line of credit was particularly devastating at a time when BCBSNC had withheld funding for services rendered for this critical period. There is much more to this story which cannot be revealed at this time, but which will be revealed in future publications.

The Devastating Results of the Actions by BCBSNC to Our Patients, Our HIV/AIDS Practice, and to the JSC Practice Model

The litigious action by BCBSNC against Dr. Jemsek clearly played an essential role in his decision to broadly abandon traditional insurance contracts because it essentially left Dr. Jemsek and the Clinic with no choice in the matter. In the "fee-for-service" model, patients pay when services are rendered and then file claims for "out-of-network" reimbursement with their insurers, assuming their policy contains such benefits. In this situation, patients generally face another deductible fee column, as if beginning anew with the deductible aspect of the insurance paradigm. Further, reimbursement is typically provided at a lower rate to the patient. As is the pattern in today's US health care insurance paradigm the insured (aka premium payers) are placed at a direct economic disadvantage by their insurance company.

Nonetheless, Dr. Jemsek's experience over the past 24 months is such that many patients with "chronic" Lyme disease continue to make significant financial sacrifices, some at the expense of basic needs, in order to obtain life-altering medical care through the Clinic. In contrast, Dr. Jemsek found that only rarely could an HIV/AIDS patient meet this financial challenge.

In summary, the actions by BCBSNC are directly tied to the termination of Dr. Jemsek's participation in HIV/AIDS care after a 23-year career, and have resulted in the scattering of more than 1,000 patients with HIV/AIDS into the Charlotte area health care system (more details below). Further, it would appear that these heinous actions have severely compromised access to care for LBC patients for the entire United States.

Declaration of Bankruptcy

After painstaking review of the situation in the fall of 2006 and in spite of liquidating a large portion of his personal assets in an effort to salvage the clinic's HIV/AIDS and LBC practices, Dr. Jemsek complied with the advice of a group of attorneys and consultants by entering into both professional and personal bankruptcy. *By then (September 2006), a lawsuit filed by BCBSNC against Dr. Jemsek had arrived. When coupled with BCBSNC's deliberate decision for non-*

payment of considerable funds due to the clinic, this crushing litigation, brought on by the $5BB BCBSNC Company against Jemsek Clinic, essentially ended any realistic opportunity for Dr. Jemsek to salvage either his clinic operation, or the dream that was Rosedale Medical Center. As a culminating humiliation, in August 2007, Dr. Jemsek witnessed the foreclosure of his Rosedale Medical Center, which included the ignoble auction of all assets in the medical center by legal representatives of the aforementioned lending institution.

Please note that in the period immediately prior to declaring bankruptcy, Dr. Jemsek met with BCBSNC representatives (April 2006) for an in-depth discussion designed to clarify putative disagreements between the entities. Legal representation was contracted to the Jemsek Clinic by attorney David Chilman of Raleigh, (former BCBSNC counsel), who was practicing law as a solo private practitioner. An extensively referenced and detailed summary binder on the issues was prepared for BCBSNC. *Of note, the argument that major health care savings would ensue if chronically ill patients were restored to health by care from the Jemsek Clinic was advanced to the BCBSNC representatives*. This argument was fully displayed without ambiguity (multiple documents related to this meeting available on request). Dr. Jemsek and Mr. Chilman were given token time at their meeting in April 2006 by BCBSNC "fraud investigators" who (judging by ensuing actions) had presumably already made an unfavorable and uncompromising determination against Dr. Jemsek prior to this meeting.

Immediately prior to the meeting, because of non-payment issues by BCBSNC, Dr. Jemsek filed a letter of complaint with the NC Attorney General's office in April 2006 detailing many of the arguments already listed herein (letter to the NC AG with attachments available on request).

Leaving North Carolina

Dr. Jemsek has always based his career decisions on his oath of responsibility toward patients, and upon the freedom to practice medicine with the patient's welfare as the leading precept. At the start of his private practice career in North Carolina, Dr. Jemsek's experience with the early cases of HIV/AIDS were entirely new to the medical field and interpretation and care of patients with this new syndrome required departure from standard dogma and also required the use of creative measures in both treatment and clinical evaluations. In a 23-year career leading to the NC Medical Board hearing and actions in 2006, Dr. Jemsek had provided outstanding HIV/AIDS and LBC care to the overwhelming benefit of both North Carolina citizens, as well as to those patients from out of state or foreign soil suffering with these conditions.

In the opinion of many observers, the NC Medical Board's unwarranted actions against Dr. Jemsek, (i.e. to suspend his license with immediate stay [license never surrendered]), appeared as little more than a deliberate campaign to cripple both his practice and reputation at the hands of a private agenda, by implementing a host of restrictions which would directly conflict with his desire to serve patients to the best of his ability. Even though Dr. Jemsek never lost his license as a result of this brutal action, the actions taken by the NC medical board and BCBSNC forced him to completely reevaluate his interests in practicing medicine in North Carolina.

Dr. Jemsek feels that the NC Medical Board's actions (in conjunction with BCBSNC refusals of payment) appear deliberately aligned with the IDSA (Infectious Disease Society of America) philosophy and medical guidelines. But since Dr. Jemsek's hearing, the IDSA medical guidelines, on which the BCBSNC and NCMB actions were predicated, have been questioned in compelling legal action by the Connecticut Attorney General (Ct AG) Richard Blumenthal. As noted in a May 1, 2008 declaration, the IDSA Guidelines for Lyme Disease and the intent of its authors were described as having "serious flaws".

Connecticut Attorney General Richard Blumenthal's anti-trust investigation of the IDSA is a seminal event in American history, representing the first time that a federal or state judicial authority has brought charges against a medical society. The IDSA has "blinked" in response. A

synopsis of the CT AG's charges against, and settlement with the IDSA, is fully described elsewhere in this document ***(see the section on Findings of Corruption in the IDSA in Lyme Guidelines below. Reference #3 regarding Ct AG Press Release is also provided****).*

As so powerfully stated in the Ct AG Blumenthal Press Release of May 1, 2008, the IDSA guidelines are by no means the only "standards" of care; indeed there is another "standard" of care set forth by ILADS (International Lyme and Associated Diseases Society), which are published in the National Guidance Clearinghouse (a governmental clearance house for published medical guidelines, including the IDSA guidelines). Dr. Jemsek chooses to follow the ILADS guidelines because these guidelines offer long-term, open-ended beneficial treatment options to patients that make better sense for complex LBC cases. Naturally, the ILADS treatment guidelines are not perceived as more beneficial to insurance companies, who may then be required to pay for these long-term treatments in order to effect patient wellness; whereas the IDSA medical guidelines appear more insurance "bottom-line" friendly because they seem to reflect the idea that LBC is a short-term, "easy to treat" illness. *The subject of greed as the motivating factor in the health insurance industry is discussed below****.***

The resulting choice by Dr. Jemsek to close his North Carolina practice was made, in short, because of the attitudes and actions by the NC Medical Board against him, against his practice, and against his patients; and the likelihood that under unchecked Medical Board authority, those attitudes would likely never change. For those and other reasons, in the fall of 2007, Dr. Jemsek made the request that his license in NC be made inactive.

Establishing Practice in South Carolina

In the summer of 2007, Dr. Jemsek incorporated a new clinic, **JSC of SC** (Jemsek Specialty Clinic of South Carolina), in anticipation of moving his infectious disease practice to nearby South Carolina. In September 2007, he was invited to meet and make a formal presentation to high-level officials in the SC Attorney General's office, including Attorney General Henry McMaster and his entire staff. He did so with the intent of providing education on LBC, particularly with regard to how LBC impacted citizens of the Carolinas. At the same time he hoped to secure his goal of establishing a new clinic in SC, inasmuch as he already had a long-standing active SC license in hand. *He was warmly received by Mr. Henry McMaster and was impressed by the sophisticated understanding of the issues by these prominent officials, several of whom have personal experience with LBC****.***

After discussions with Mr. McMaster and other SC officials, Dr. Jemsek proceeded to establish a SC practice. In September 2007, after foreclosure of the Rosedale Medical Center, the Clinic moved from the location in Huntersville, North Carolina and set up a temporary business office in Charlotte, NC (a few weeks prior to Jemsek's request for inactive status of his NC license). During this time his staff made copies of medical records for patients who requested them, handled triage calls from existing patients, and made plans for renewal of the practice in South Carolina.

One of the clinic's patients, James Finkel, DDS in Blythewood, SC (just north of Columbia), offered to lease temporary space at his private dental clinic in order to facilitate Dr. Jemsek's transition to a SC location. On October 11, 2007, Dr. Jemsek began to work extended weekends in Dr. James Finkel's office in Blythewood, SC. This required a daily 150-mile commute for a total of three months, during which time Dr. Jemsek logged approximately 50 days of office operation, while performing both administrative and clinical tasks outside the office on non-clinic days.

During this time, even though JSC of SC faced daunting organizational and logistical challenges, the patient response was remarkable. In addition to providing follow-up care for many loyal patients from around the country who traveled to this Blythewood location, Dr. Jemsek accepted approximately 70 new patients who traveled from 10 different states during the period October

11, 2007 through December 29, 2007. The success of this transition in Blythewood, SC has led to the establishment of JC of SC in Baxter Village in Fort Mill, SC, where rebirth and growth continues at this time. *There are no words which Dr. Jemsek can express which give justice to this patient loyalty which he and the Clinic experienced at this critical time.*

The Clinic opened for business at its Baxter neighborhood location in Fort Mill on January 3, 2008. The response from patients rapidly exceeded the Clinic's capacity and additional skilled medical assistants were hired. This process and this pattern continue to date, even as the clinic moves (for a 3rd time since Rosedale) to a slightly larger facility in the same Baxter Village commercial complex, occurring late September 2008.

Research History at Jemsek Clinic and Future Emphasis at JSC of SC

Dr. Jemsek understands the importance of validated research in all aspects of medicine. But as a practicing physician who has dealt with real and complex patient needs on a daily basis for over 25 years, he also understands the preeminent importance of placing patient care outcomes as the essential measure of professional accomplishment. The goal as a physician, after all, is to heal the patient where this is possible. Where this is not possible with the tools available, the goal then becomes to comfort the patient with all of the profession skills and common sense that the practitioner can impart to the patient and/or family in their time of need. It is the quintessential goal of a skilled and experienced practitioner to call on all of their experiential and empirically derived resources to accomplish this end. And the most important components of these resources are derived from the experience of the *listening physician* in his/her ability to understand the patient's story; i.e. the ability to take the patients' picture of their story and integrate these stories into the physician's consciousness, and then connect these pictures to the physician skill set, as if weaving a cloth from the fabric of that story. This process ideally results in a garment that cloaks and nurtures the patient (for more on Jemsek philosophy of medicine, see his prepared statements to the NC Medical Board listed on the Jemsek Specialty Clinic website under the *Knowledge Base* tab).

The real goal of medical research, simply stated, should be to assist the treating physician in better performing his/her task for optimal patient benefit. *Somewhere along the way, this mission has become terribly polluted and confused within the current health care system.*

As reflected in this document under the Curriculum Vitae section, Dr. Jemsek has published approximately 40 articles and abstracts, most dealing with his experience in HIV/AIDS. This may be but a small fraction of the number of publications attributed to esteemed medical academicians, but it is only a rare academician who has the clinical experience that Dr. Jemsek and other like-minded medical clinicians possess.

Early in his career, Dr. Jemsek was the lead author in an article on Herpes Zoster Associated Encephalitis published in *Medicine* (reference No. 14 in the Jemsek bibliography); this publication is still regarded by current authorities as a seminal and landmark contribution to this subject.

Most of Jemsek's published work reflects his commitment to HIV/AIDS, beginning in the period from 1983-2006. Since 1989, Jemsek has participated in over 100 HIV/AIDS clinical trials, many of which are seminal works in the advancement of HIV/AIDS treatment. During this time, Jemsek obviously established himself as a major contributor in the effort to find and validate new and evolving therapies in HIV/AIDS. However, during this time, Jemsek always concentrated on his private practice and the rigors of patient care for HIV/AIDS, working in a difficult and often unpopular field of medicine, while at the same time working with a wide range of new pharmaceutical products in early HIV treatment research. In this process, he engaged with a host of academic entities, including all of those academic institutions working with HIV/AIDS in the Carolinas during the period 1989-2005.

As he became more sophisticated in his chosen field, Dr. Jemsek used the research area to explore investigator-initiated trials. *One of his trials (see Abstract #1 at end of this document), became a leading story in HIV research in 2004, and Jemsek personally presented the Jemsek Clinic data to a group of 5,000 attendees at the San Francisco Infectious Disease Society Association meeting in 2004 (***see reference #2***). This Jemsek Clinic initiated project made world news. A*s important as this contribution to the expansive HIV/AIDS database may have been at this time, Dr. Jemsek's literary contributions to HIV/AIDS will always be just a footnote to his contribution to patient lives saved and lives vindicated; as has always been his purpose and motivation.

As LBC became an increasing focus for his work, by 2003, Dr. Jemsek began to accrue a research team dedicated to LBC issues, assembling a world class Java derived, custom designed database for LBC literature. Dr. Jemsek also became active in delivering lectures and writing opinions on "Lyme Disease", as time permitted. Before his work was effectively destroyed by the actions of the NC Medical Board and BCBSNC, Dr. Jemsek had assembled a research group composed of one full-time, and one part time PhD, both with degrees in Molecular Biology, as well as three support staff with degrees in the Life Sciences. All research positions in HIV/AIDS and LBC were fully funded by Dr. Jemsek at all times. As the groups moved into Rosedale Medical Center, there were 12 projects on track in LBC related issues, including both clinical and basic science topics, and there were 15 ongoing trials in HIV/AIDS. Sadly, these were all abruptly terminated commensurate with the cataclysmic decline of the Jemsek Clinic in early 2006.

Just as JSC of SC is a rebirth of dedication and focus, Dr. Jemsek also understands the importance of resurrecting a research focus. He understands quite well that precious time has been lost and that, regardless of the political obstacles he may face, participation in mainstream research publications, however flawed in process, are essential to the process of change. And so he is committed to putting pen to paper as soon as this becomes feasible, and hopes that the editors and reviewers he encounters are magnanimous and progressive in nature, and seek the truth, as he does.

The Predicted Collapse of US Health Care, as foreshadowed by the Jemsek Clinic Story at Rosedale Medical Center ; A Story of Greed Without Consequence, A Story of US Health Care Insurance

According to the National Coalition on Health Care in a recent focus article on "Health Insurance Costs", the following statement was offered: "*Experts agree that our healthcare system is riddled with inefficiencies, excessive administrative expenses, inflated prices, poor management, and inappropriate care, waste, and fraud. These problems significantly increase the cost of medical care and health insurance for employers and workers and affect the security of families."*

Dr. Jemsek feels that the medical profession itself is adrift, and has lost ownership of its profession by its own hand and/or had it wrested away by health insurance power brokers and hospital systems that were never intended to possess such influence in health care. He believes that the focus of the insurance industry and hospital systems suffers from *"mission drift"*, in which the brokers of entrusted private funds manipulate the system for their own benefit. He ascribes a considerable portion of the blame for our health care crisis on the health care insurance industry**, *which has succeeded in controlling medicine through financial domination on every level*.** He feels that our government and those assigned with regulation of industry, and that our society in general, tolerates unconscionable benefits to the insurance industry, an industry in which accountability is either lacking or is easily circumvented.

Based on annual CMA (Center for Medicare Advocacy) reports, as well as recent well-referenced reports by the National Coalition for Health Care, the health care allocation of the GDP in the US is roughly 16% of the total budget, or $2.3 trillion (2007 figure). The percent of the GNP for health care has quadrupled in the past 30 years, easily outstripping GDP growth during this time. As a

reference, health care spending is currently an alarming 4.3 times the amount spent on national defense. According to the experts, this expansionary trend is expected to continue so that by 2020, health care costs will be $4.2 trillion and consume 20% of the GNP.

Currently, private payers account for 55% of the payments of today's $2.3 trillion health care bill, or roughly $1.3 trillion per annum. If the health care industry pays out $1.3 trillion, one can assume that it takes in substantially more. Precise figures are, of course, not readily available, but given certain published facts and a few modest assumptions, one can make these estimates with ease. It is public information that the private health care industry manages to generate up to a 10% profit, not including money for a bloated, inefficient cost of doing business, estimated at 25-30% of their overhead. Once one does the math, one realizes that this leaves our health care industry, originally employed as little more than "bean counters" or "collection agencies", with hundreds of billions in annual profits, with their inflated administrative costs of around 25-30% an integral feature of this morbid excess.

Estimating the administrative costs of running a large health care business is difficult at best.
One can attempt to gain insight by understanding the Medicare model, which pays surrogate administrators like *Well Path* (a BCBS Association publicly traded group of 19 or so companies), *Cigna*, and *Aetna,* approximately 2% of the revenue stream to administer their programs. *The Council for Affordable Health Insurance*, an association of insurance carriers, argues that Medicare's administrative overhead may be up to 5% of revenues, because it doesn't factor marketing costs, etc. Whatever the case may be, it is clear that the US government offers a much lower rate for administering their programs; that health care companies compete for this business, and that the rates offered characterize the prevailing market for these services. In our opinion, the difference in these rates and the real or "declared" cost of doing business by private insurers speaks volumes about inefficiency, waste, and deception in the private health insurance sector. According to the reference quoted by the National Coalition for Health Care in this year's report, to paraphrase: *the United States has $480 Billion in excess spending compared to their European counterparts, where the excess costs are mainly associated with excessive administrative charges and poorer quality in care*.

Dr. Jemsek understands that voluntary change by the health care industry will never occur without forceful action, such as dramatic state and/or federal legislation designed to bring about much needed oversight and regulation. Nevertheless, he believes this change is inevitable and will occur sooner, rather than later. He believes that the current US health care paradigm functions in a **"patch-and-pay" model**, which fuels profits for certain corporate interests, all working in an ***anti-patient model***. In this model, insurers simply *pay what they cannot avoid paying* (see reference to business practice below). This insurance model does little or nothing to affect real change for many in America's patient population, particularly those suffering from chronic illnesses, and meanwhile the insurance industry steadily gains more control of how health care is dispensed in this country. Dr. Jemsek recognizes that profound changes in this model of greed and waste will create far-flung angst amongst those who profit in the billions of dollars from the current health care system paradigm, but he also believes that the perpetrators of this flawed and overreaching system are delusional in their hopes for perpetuity in such a self-indulgent model.

An Example of "Pseudo Speak" by BCBSNC

Dr. Jemsek believes the extent to which the system is rotting is characterized in microcosm by the attitude of BCBSNC in refusing to credential and contract with Dr. Jemsek's two HIV-credentialed physician employees in the summer of 2006 — physicians Drs. Fred Cruickshank and Octavian Cieza, referenced below.

In the time of the Jemsek Clinic's financial crisis in early 2006, consultants to the clinic recommended that Drs. Cruickshank and Cieza, Infectious Disease and HIV/AIDS trained

physicians hired by Dr. Jemsek in 2005, separate from the Jemsek Clinic to form an entirely different clinic. This business-motivated action was designed to preserve the HIV/AIDS practice Dr. Jemsek had built over two decades. Accordingly, a decision was made to form a new HIV clinic completely separate from Dr. Jemsek, and this clinic would be called Rosedale Infectious Diseases (**see reference #3**). This newly formed Rosedale Infectious Disease Clinic would be comprised of veteran Jemsek Clinic employees who would support Drs. Cruikshank and Cieza. With these physicians operating their own clinic, supported by a wealth of experienced former Jemsek Clinic employees, it was projected that the new Rosedale Infectious Diseases Clinic would be capable of following all Jemsek HIV/AIDS patients, therefore continuing, without interruption, the Jemsek Clinic tradition of excellence for the medical care of hundreds of Metrolina individuals suffering with HIV/AIDS.

Regrettably, for most of the thousand HIV/AIDS patients under the care of Dr. Jemsek in early 2006, this would not happen. BCBSNC refused to sign contracts with Drs. Cruickshank and Cieza after the separation. This meant that insured patients with BCBSNC insurance, (roughly 35% of the practice and most of the privately insured HIV population), did not have an Infectious Diseases doctor in-network at the new Rosedale Infectious Diseases Clinic. The comment made by BCBSNC to Dr. Jemsek's former colleagues was, "*We have enough HIV doctors and don't need any more… we can't contract with you"*...

This appalling statement is made even more absurd when one understands that not only does the HIV/AIDS epidemic continue to grow, but that experienced HIV/AIDS physicians are at a premium in any system. *Furthermore, since the dissolution of Jemsek Clinic, access to care for HIV/AIDS patients is far more difficult in the Charlotte area, according to a recently aired report by* CNN *in late summer of 2008.*

The Predicted Collapse of the US Health Care Insurance Industry

Dr. Jemsek recognizes that in today's health care environment, US health insurers dictate inordinate influence in health care access through their implicit control of reimbursement issues, which leads to control of financial matters in health care issues; in turn absolutely influencing behavior by both contracted providers and premium payers.

The "private" health insurance industry's original purpose was to simply collect premiums and distribute this money to physicians and hospitals. In addition, these companies functioned, and continue to function in the public domain as administrators for the benefit of government-sponsored health care plans like Medicare and Medicaid, thereby authenticating their ongoing role in the public sector. The "private" health care industry was never intended to function as it does today.

Please note the obvious; that our US health care companies do not have notable commodity acquisition costs, (i.e. they are not buying airplanes or immense earth-moving machines); instead they are buying ink, paper, and telephone time.

In fiscal year 2007, BCBSNC, with $5BB in revenues, declared approximately $200MM in profit, but also claimed almost $1BB in operating expenses. Their annual reports appear loaded with accounting tricks and gimmicks designed to misinform and confound, and thereby deflect the true facts. In 2006, a short time after their efforts to become a public company were denied, the company ceased a 10-year history of making quarterly press conference reports that until then had put their executives out front to answer questions by the premium payers. The company's response to the cessation in news access was that *"we are not a public company... trying to meet the expectations of investors…"* (*Triangle Business Journal* Sept 1, 2006). However, legislators and others argued that BCBSNC, during its conversion process, blacked out major portions of the documents that it filed with the NC DOI — information it had to submit to regulators but didn't want the public to view.

BCBS reports use actuarial assumptions in their disclosures. While this is a standard accounting practice, it reduces transparency and is a means by which management may manipulate earnings figures. Since these assumptions are not required for disclosure, industry comparisons are murky at best, since it is nearly impossible to locate the ingredients for their final numbers.

BCBSNC, which is criticized by many for disingenuous behaviour and excess in many areas of their operations, discounted criticism of their $32MM marketing budget in 2004, which was formally quoted as 72% higher than the other 42 BCBS companies, and which continues to grow. They responded that these figures are *"flawed since it doesn't include our community support activities",* (*Triangle Business Journal*, March 18, 2005). But the $32MM investments for "good works" quoted by BCBSN are not verifiable in benefits to their *"community support activities",* and certainly have never been provided for public scrutiny.

BCBSNC justifies the exorbitant funds shuttled to the reserve fund (see below) as "in line" and well within the maximum six months of expenditures allowed by the NC legislature as a benchmark for a "savings account" guaranteed by the NC legislature. Most assuredly, however, clear thinking legislators in NC never intended for BCBSNC to garner such enormous profits. In "gaming the system", BCBSNC could use both claims payments and administrative costs as their basis for the RBC formula. *The key in this model is Administrative Costs* – the higher the administrative costs, the better the ratios work for BCBSNC in the allocation of surplus funds shunted to the reserve fund, and the more bloated the reserve fund becomes.

As suggested previously, careful review of publicly traded health care companies, or any review of the footnoted financial statements of private or public health care companies' financial statements, shows that these corporations routinely operate with excessive overhead, consuming up to 30% or more of the entire health care dollar in operating expenses and profits, with unstated profits routinely hidden in legally sanctioned "reserve funds." The "reserve fund" seems to be a particularly favorite tool of non-profit BCBS entities such as BCBSNC (which has vigorously tried to become "for-profit" only to be thwarted by the legislature, NC DOI, and others in NC. For-profit status would mean more benefits from shares assigned to executives; and the more in reserve funds, the more valuable the enterprise).

BCBSNC now has well over $2 BB in reserve fund assets. And they reported $90MM in "investment earnings" in a recent annual report, presumably on investment of these "reserve" funds. The destination and accounting for these surplus funds are never fully obvious, but it is reasonable to assume that they are used to reduce retained earnings by increasing liability account levels diverted to the reserve fund.

In 2005, legislators in the NC House (Faison and Jones) attempted to introduce legislation that would cap some of the BCBSNC excess earnings going into this reserve fund and divert them to a trust fund to provide health coverage for low income North Carolina citizens who didn't qualify for Medicaid and who were being squeezed by premium hikes by BCBSNC. The legislators took note that BCBS generated a $865MM surplus in 2004, an amount that equated to almost three to four times above what is considered adequate for reserves, as based on the industry standard Risk Based Capital model (RBC). This legislation was immediately and vigorously opposed by BCBSNC, which called it "poorly conceived and hastily introduced" (*Triangle Business Journal*, April 21, 2005). BCBSNC President and CEO Greczyn went on to impugn the RBC standard, calling it an *"untested standard".*

Of course, had the legislation passed, the irony is that this action would have effectively assisted BCBSNC in fulfilling their "mission" to provide affordable health care to all. Instead, Greczyn, who in recent times is reputed to have been the only individual in a list of the top 10 political contributors to NC lawmakers, a list otherwise occupied by corporations, responded as if BCBSNC premium payers would be placed in mortal danger if the bill passed. According to Greczyn, *"Our reserves protect our members in the event of unexpectedly high claims… They*

also allow us to invest in technology and improvements in customer service". (*Triangle Business Journal,* April 21, 2005).

In a recent report by the National Coalition on Health Care (NCH), the authors cite a *Wall Street Journal/NBC* survey in which 50% of those surveyed list the cost of health care as their number one concern. In a *USA Today/ABC News* survey quoted by NCH, 80% of Americans were dissatisfied (60% very dissatisfied) with nationally high health care spending. In a July, 2008 *American Medical News* magazine story, the plight of "insured Americans" who held off accessing health care because they weren't "insured enough" is discussed. It would appear that Greczyn may be confused about the quality of customer service his organization is delivering for the premium prices he is charging, at least as far as national polls are concerned.

If the choking of the health care dollar isn't adequately insulting to the consumer, in order to ensure their influence, the insurers have become brutally intrusive in the physician-patient relationship as part of their "normal course of business". This practice is so pervasive at this time that whether medical procedures are performed hinges on "what insurance says (pays)", and so this sordid phrase has sadly become part of the vernacular in our modern American culture.

The insurers, and legislators who empower them, appear to have lost sight of the primary and simple role of health insurance, which, in its essence, is to collect premiums and distribute earned income to hospitals and physicians. It is not up to insurance companies to make medical decisions, and certainly not up to them to make decisions based on their bottom line, regardless of how many medical consultants they hire to do their bidding—and yet they do these things routinely, without comment from those blithely paying into their burgeoning surplus accounts.

The insurance companies are in effect, practicing medicine and "making it pay", without consequences or accountability. Unfortunately, this is currently being tolerated by their premium payers and politicians alike. We reiterate that insurance companies undertaking these practices appear to be suffering from a serious and ultimately fatal malady which we term "mission drift".

In the grand scheme, health insurers should operate on modest margins, similar to banking and grocery chain models. It can be argued that health insurance companies, such as BCBSNC (commensurate with their mundane responsibilities and executive and employee skill sets), should have one of the lowest true profit margins of any industry in the US economy. Their margins should reflect low premiums and low Selling, General & Administrative Expense (SG&A) rather than the BCBSNC pattern of ever increasing premiums and HUGE increases in SG&A. The hundreds of billions of dollars in profits, declared and disguised, that are reaped annually by the private health care industry is money that could otherwise provide an inordinate amount of quality health care to US citizens.

This was the thinking in NC in 2005, when state representatives Faison and Jones made legislative proposals designed to cap the $865MM BCBSNC surplus and reduce it to approximately $675MM, and thereby divest about $200MM to help uninsured NC citizens for the purpose of accessing unaffordable health care insurance. To quote NC House member Faison, *"I talked to people…who were insured by Blue Cross and looking at premiums rising by 30%…We have to deal with this problem and I think this is a very deliberate first step"*. (*Triangle Business Journal*, April 21, 2005). Savings in health care premiums, afforded by using some of the BCBS surplus income, would have made health coverage affordable to a significant number of these NC citizens at that time, namely those citizens who are in the "gap" and whom earn too much to qualify for government programs like Medicare or Medicaid, but whom can't begin to afford today's escalating health care premiums.

Our health care reimbursement system, as epitomized by BCBSNC, is a system that seems to be operating totally out of control; a system without checks and balances, and one which has

become base and counterintuitive. Dr. Jemsek believes that the current domination of health care issues by insurers represents opportunistic carnage of our society's health initiatives and financial resources and, as such, is perverse and amoral. Dr. Jemsek uses the term *"Greed Induced Psychosis"* to describe the otherwise unconscionable attitude purveyed by the health care insurance industry, whose sense of entitlement seems now evermore on full display, an attitude which he feels is shamelessly helping to gut the fabric of medical care in our country.

BCBSNS and others appear to be playing a dangerous "shell game," and, as such, they are guilty of deceiving their subscribers. Clearly they are operating in "bad faith" with their premium payers and society as a whole. Concerns about the failure of the insurer's mission abound in our times, and every day brings more criticism as the American public slowly awakens to the horror of another example of deceit by corporate America on a grand scale (**see references #4-6**). At best, the deceit and suppression of these profits by some insurers is disingenuous, and at worst, these profits are outright fraud thrust upon the American public.

BCBSNC and the Jemsek Clinic

Dr. Jemsek recognizes that the forces that led to the devastating situation at Jemsek Clinic are complex, intertwined, and multi-layered and so it follows that even the inevitable major correction in the health care insurance industry will not alone resolve the issues of poor health care delivery in the current era. For example, the leaders of the medical profession in this country must regain control of the principles that members of the profession are sworn to uphold, and the profession must come together to reclaim a "mission lost" as a profession, for the sake of the patients. Inevitably, patients will demand change, and this, in fact, is the far more likely scenario for change in US medicine, since patient revolt is far more likely than medical school and physician reform.

In the Jemsek case at hand, Jemsek feels that it will be subsequently shown that the actions by BCBSNC against him were pivotal in the downfall of his clinic, essentially robbing him of any opportunity to reorganize his practice. He also believes that the litigation process will uncover that the charges brought against him reflect the foolish and ill-advised outrage and subsequent irrational directive against Jemsek by a single individual or small circle of individuals in control at BCBSNC — rather than being the result of a studied and cooperative decision made with the assistance of the Board of Directors. *In fact he considers it highly improbable that members of the Board of Directors at BCBSNC have, or have ever had, any real understanding of the Jemsek litigation, arguably the most notable ongoing litigation at BCBSNC at this time*. Dr. Jemsek would be most interested in a poll of current members of the BCBSNC BOD members done in real time, without "coaching" by the executives. We feel certain that the Bankruptcy Court would share this interest.

In this litigation, which began in the fall of 2006, BCBSNC has amply demonstrated, in defiance of court orders, that they played "keep away" with discovery documents for over one year, to the tolerance that the court would allow. As of June 2008, BCBSNC has been ordered by the court to produce discovery documents in the case of Jemsek vs BSCBNC, but, as of this writing, the majority of documents have not been delivered. The court record will show that BCBSNC filed at least two motions that they hoped would absolve them of the need to produce potentially incriminating material from their files. At the same time, Dr. Jemsek and his staff produced more than 250,000 pages of records, which are on full display for the court and BCBSNC, and which were presented in a timely and responsible manner for the court, in stark contrast to the behaviour exhibited by BCBSNC.

Jemsek's counsel is confident that the documents will reflect that powerful forces in the insurance industry did commit, in purposeful, premeditated, and wholly unnecessary actions leveled against him, aggressive and unethical actions designed to eliminate Dr. Jemsek's career in medicine. Dr. Jemsek finds it implausible that some level of collusion was not used against him. While the players involved are yet to be entirely identified, a process of collusion, a concept suggested by the Connecticut Attorney General's action against the IDSA (see below), is the logical answer that

explains the actions in this case. The insurance industry often stands to benefit by denying claims for care in complex illnesses. Insurers of health care have an unsavory history of taking action against physicians who practice medicine in a way that doesn't suit their "bottom line."

Above all, Dr. Jemsek is hopeful that the individual(s) responsible for the coldhearted and brutal action against him and the Clinic realize that they have not only brought great and indelible harm to his family, but also brought harm and suffering to *thousands of individuals under his care and influence* by their poorly conceived actions, and that no amount of money can repair the damage caused by these actions. Still, Dr. Jemsek hopes that the perpetrators' families will never have to experience firsthand the horror of an illness such as LBC and the lack of access to care.

References

1. Letter dated November 11, 2005 from Dr. Joseph Jemsek to John Hamilton, M.D. Professor of Medicine, Duke University, Chief, Div. of Infectious Diseases and International Health; and 5 other locations.

2. Feinberg, J. *Bad Nukes Come in Threes*. ACC *Journal Watch*. Top HIV Medicine Stories of 2004 – AIDS Clinical Care. 2005 Massachusetts Medical Society. [serial on the Internet] Access: http://aids-clinical-care.jwatch.org/cgi/content/full/2005/0101/1

3. Jemsek, JG. Rosedale Infectious Diseases, PLLC. Articles of Incorporation of Professional Limited Liability Company. Filed: 9/27/2006, with North Carolina Secretary of State. SOSID: 868968.

4. Eder S, McKinnon J. *Patients suffer as care, coverage limits collide. Physicians say insurers intrude on treatment.* MetroBlade.com Medical/Health [serial on the Internet] Access: http://www.toledoblade.com/assets/swf/TO53639823.swf

5. Trapp D. *Health care access problems surge among insured Americans.* Amednews.com. Government & Medicine. [serial on the Internet] Access: http://www.ama-assn.org/amednews/2008/07/21/gvl10721.htm

6. Trapp D. *Uninsured tally dips to 45.7 million, with more covered by government.* Amednews.com Government & Medicine. [serial on the Internet] Access: http://www.ama-assn.org/amednews/2008/09/15/gvl10915.htm

THE JEMSEK SPECIALTY CLINIC OF SC, LLC
ADDITIONAL HISTORICAL INFORMATION
PERTINENT TO THE CASE

Finding of corruption in the IDSA in Lyme Disease Guidelines by the CT Attorney General Part I: Jemsek and BCBSNC

On May 1, 2008, in a scheduled press conference, Connecticut Attorney General Richard Blumenthal announced the findings of his investigation of the Infectious Disease Society of America (IDSA), a national group primarily composed of academic and community-based Infectious Disease physicians, a group of which Dr. Jemsek is also a member. This powerful and scathing indictment of the IDSA's Guidelines authors on Lyme Disease by AG Blumenthal has been world news since its release (multiple media references available on request, including the *Wall Street Journal* and *New York Times Review*).

The findings concluded that there are:

1) Conflicts of interest activities of a major proportion by the IDSA Guidelines Authors of 2000 and 2006; and that,
2) Ethical concerns exist due to major guidelines creation process irregularities

The Attorney General's charges, and the subsequent settlement by the IDSA (see below), are unprecedented events in American history. The findings of Mr. Blumenthal have had an immediate and chilling effect on the validity of these formerly influential guidelines, for obvious reasons.

Please bear in mind that the entire basis on which Dr. Jemsek was brought before the NC Medical Board in June, 2006 rested entirely on the validity of the IDSA Guidelines, and more specifically on the charge that he deviated from the "standard of care" for Lyme Disease as recommended by these IDSA guidelines; and that these guidelines transpose to NC, a state which in fact did not have formal existing guidelines prior to the Jemsek hearing (i.e. there were no standards of care in NC for the treatment of LBC before Jemsek). In fact, BCBSNC had NO standards for care until they hurriedly prepared a document for such in Feb 2006, scheduled then in 90 days for implementation (May 2006) as discussed earlier.

The sources utilized in the preparation of the document prepared February 2006 for BCBSNC for the diagnosis and treatment of Lyme disease, is a matter of great interest to Dr. Jemsek's attorneys. We are entirely confident that Dr. Komives, a medical director at BCBSNC who is purported to have written these guidelines, is an individual who is entirely incapable of creating such a document without the solicitation and support of outside sources, since we believe she has no experience whatsoever in the treatment of persistent Lyme Disease. We are also confident that Dr. Komives' sources will be shown to have conflicts of interest in this matter, similar or identical to those shown to be the case for the IDSA Lyme guideline authors, as elaborated by CT AG Richard Blumenthal in his proclamation on May 1, 2008 (see below). More fundamentally, the whole notion that national guidelines somehow guide individual patient care represents a highly overstated interpretation of the intention of guidelines of any sort, a subject which Dr. Jemsek discusses in a series of letters of correspondence with the IDSA leadership in 2005 (correspondence available on request).

The Significant CT Attorney General's Findings of Corruption of the IDSA's Lyme Disease Guidelines

The following quotations are taken verbatim from the landmark CT AG press release that was issued on May 1, 2008:

Attorney General's Investigation Reveals Flawed Lyme Disease Guideline Process, IDSA Agrees to Reassess Guidelines, Install Independent Reviewer

"*Attorney General Richard Blumenthal today announced that his antitrust Investigation has uncovered serious flaws in the Infectious Diseases Society of America's (IDSA) process for writing its 2006 Lyme disease guidelines and the IDSA has agreed to reassess them with the assistance of an outside arbiter*".

The IDSA guidelines have sweeping and significant impacts on Lyme disease medical care. They are commonly applied by insurance companies in restricting coverage for long-term antibiotic treatment or other medical care and also strongly influence physician treatment decisions.

Insurance companies have denied coverage for long-term antibiotic treatment relying on these guidelines as justification. The guidelines are also widely cited for conclusions that chronic Lyme disease is nonexistent.

Blumenthal goes on to state:

"*This agreement vindicates my investigation – finding undisclosed financial interests and forcing a reassessment of the IDSA guidelines,"* Blumenthal said. *"My office uncovered undisclosed financial interests held by several of the most powerful IDSA panelists. The IDSA's guideline panel improperly ignored or minimized consideration of alternative medical opinion and evidence regarding chronic Lyme disease, potentially raising serious questions about whether the recommendations reflected all relevant science*".

"*The IDSA 's Lyme guideline process lacked important procedural safeguards requiring complete reevaluation of the 2006 Lyme disease guidelines – in effect a comprehensive reassessment through a new panel. The new panel will accept and analyze all evidence, including divergent opinion. An independent neutral ombudsman – expert in medical ethics and conflicts of interest, selected by both the IDSA and my office – will assess the new panel for conflicts of interests and ensure its integrity*".

Blumenthal's findings are significant:

1) The IDSA failed to conduct a conflicts of interest review for any of the panelists prior to their appointment to the 2006 Lyme disease guideline panel;
2) Subsequent disclosures demonstrate that several of the 2006 Lyme disease panelists had conflicts of interest;
3) The IDSA failed to follow its own procedures for appointing the 2006 panel chairman and members, enabling the chairman, who held a bias regarding the existence of chronic Lyme, to handpick a like-minded panel without scrutiny or by formal approval of the IDSA's oversight committee;
4) The IDSA's 2000 and 2006 Lyme disease panels refused to accept or meaningfully consider information regarding the existence of chronic lyme disease, once removing a panelist from the 2000 panel who dissented from the group's position on chronic Lyme disease to achieve "consensus";
5) IDSA panel members blocked appointment of scientists and physicians with divergent views on chronic Lyme who sought to serve on the 2006 guidelines panel by informing them that the panel was "fully staffed", even though it was later expanded; (this includes Dr. Jemsek)
6) The IDSA portrayed another medical association's Lyme disease guidelines as corroborating its own when it knew that the two panels shared several authors in common, including the chairmen of both groups, and were working on guidelines at

the same time. In allowing its panelists to serve on both groups at the same time, IDSA violated its own conflicts of interest policy.

SUMMARY

In summary, Dr. Jemsek has created a legacy as a pioneer in HIV/AIDS and LBC, but the events of the past several years have effectively, at least for the time being, terminated his involvement in the HIV/AIDS epidemic and has also led to the demise of his charitable HIV/AIDS organization, the *Jemsek CHARM Project.* Nevertheless, these events have served to shift his interest, and more importantly, have galvanized his commitment to the field of LBC. In his research and patient care efforts, Dr. Jemsek has made seminal contributions to the body of literature on HIV/AIDS, and hopes to do the same with LBC once the political and litigious fires die down. He has been a key figure in the provision of care and advocacy for highly marginalized groups when it has been extremely unpopular to do so. His colleagues and advocacy groups, NC office holders, and national media have recognized him for his role in the care of such individuals who are often trapped and otherwise without hope within our current health care system.

Dr. Jemsek has a long history of business success in the practice of medicine. He is an acknowledged philanthropist and has a noteworthy history of sharing economic success with patients, his staff, and his community. There is no reason that this pattern should not continue, provided he prevails in his litigation with BCBSNC and goes on to experience financial recovery; and provided that the medical boards in his province allow him the freedom to practice medicine as medicine was intended to be practiced, i.e. a practice designed to optimize patient welfare, patient benefit, and patient safety as the uppermost objectives of a relationship in medical care.

References for any of the information cited within this document are either provided herein or are available on request.

THE JEMSEK SPECIALTY CLINIC OF SC, LLC
Curriculum Vitae of Joseph G. Jemsek, MD, FACP

PERSONAL INFORMATION

1171 Market Street, Suite 211
Fort Mill, South Carolina 29708
Phone: (803) 396-5885
Fax: (803) 396-5887

MEDICAL TRAINING

POSTGRADUATE FELLOWSHIP	Baylor College of Medicine, Texas Medical Center, Houston, TX, 1977-1979
RESIDENCY	Medical University of South Carolina, Charleston, SC 1975-1977
INTERNSHIP	Medical University of South Carolina, Charleston, SC 1974-1975

EDUCATION

MEDICAL	Doctor of Medicine, University of Illinois, Medical Center at Chicago, 1970-1974
UNDERGRADUATE	Bachelor of Science in Psychology, University of Illinois, Champaign-Urbana, Illinois, 1966-1970

LICENSES AND CERTIFICATIONS

- State of South Carolina permanent physician's license # 7584
- State of North Carolina inactive physician's license #23386, inactive
- Fellow of the American College of Physicians (FACP)
- Infectious Disease Board Certified
- American Board of Internal Medicine – Diplomat

PROFESSIONAL EXPERIENCE

2007- Present	Jemsek Specialty Clinic of SC, LLC, Owner Infectious Disease Clinic
2000 – 2007	Jemsek Clinic, PA, Owner HIV/AIDS Specialist/Infectious Disease Lake Norman Regional Medical Center, Infectious Disease Consultant Presbyterian Hospital, Infectious Disease Consultant

PROFESSIONAL EXPERIENCE (Continued)

1979-2000	Nalle Clinic Infectious Disease/Internal Medicine
1991-1996	Medical Director, Clinical Research Department
1989-1993	Medical Director, Nalle Home IV Therapy
1986-1994	University of North Carolina at Chapel Hill, School of Medicine Clinical Associate Professor
1983-1993	Carolinas Medical Center Chairman & Originator Antibiotic Committee
1985-1991	Co-Chairman, Pharmacy & Therapeutics Comm. Infectious Disease Consultant for Cardiac Transplant Team
1982-1990	Epidemiologist, Carolinas Medical Center (first)

PROFESSIONAL AND SOCIETY MEMBERSHIPS

- ACP (American College of Physicians)
- Infectious Disease Society of America
- American Society of Microbiology
- North Carolina Medical Society Political Education & Action Community
- American Medical Association
- Mecklenburg County Medical Society
- North Carolina Medical Society
- North Carolina Society of Internal Medicine
- North Carolina Infectious Disease Society
- IAPAC (International Association of Physicians in AIDS Care)
- IAS (International AIDS Society)
- AAHIVM (American Academy of HIV Medicine)
- ILADS (International Lyme and Associated Diseases Society), Treasurer 2007-2009
- ACMPE (American College of Medical Practice Executives)

HONORS AND AWARDS

- Governor's World AIDS Day – Volunteer Service Awards (2004)
- Governor's Award (N.C.) – Certificate of Appreciation (1998)
- Honoree – Thanks for Giving Ball Award (1997) by House of Mercy

RESEARCH EXPERIENCE

- Participated in approximately 100 clinical research projects. Detailed information available upon request.

ORAL PRESENTATIONS AT INTERNATIONAL MEETINGS

- 2005 4th Annual UK Conference on Tick Borne Diseases, Keynote Speaker
- 2004 Conference on Retroviruses & Opportunistic Infections
- 2003 5th International Work Shop on Adverse Drug Reactions and Lipodystrophy in HIV
- 2003 2nd IAS Conference on HIV Pathogenesis and Treatment
- 1998 World AIDS Conference Poster Collaboration
- 1998 ICAAC Presentation of Abstract (see *Abstracts*, #8)

GRAND ROUNDS PRESENTATIONS

- Duke University Infectious Disease Department, April 2005
- Long list of other venues (available by request)

NATIONAL PRINT MEDIA CONTRIBUTIONS

- The Chronic Lyme Disease Controversy, by Angenette Rice-Figueroa, *CFIDS Chronicle*, Spring 2005
- Quoted and mentioned in numerous articles

NATIONAL BROADCAST MEDIA EXPOSURE

- Good Morning America - 2001
- 20/20 – January 1999
- 60 Minutes – January 1998
- Under Our Skin documentary - 2008

PUBLICATIONS

PEER-REVIEWED ARTICLES

1. **Jemsek JG**, Arathoon E, Arlotti M, Perez C, Sosa N, Pokrovskiy V, Thiry A, Soccadato M, Noor MA, Giordano M. Body Fat and Other Metabolic Effects of Atazanavir and Efavirenz, Each Administered in Combination with Zidovudine plus Lamivudine, in Antiretroviral-Naïve HIV-Infected Patients. Journal Clinical Infectious Diseases 2006 January 15 (42): 273-80.

2. **Jemsek JG**, Hutcherson P, Harper E. Poor Virologic Responses and Emergence of Resistance in Treatment Naïve, HIV-Infected Patients Receiving Once-Daily Didanosine, Lamivudine, and Tenofovir DF. Journal of AIDS 2006

3. Squires K, Lazzarin A, Gatell JM, Powderly WG, Pokrovskiy V, Delfraissy JF, **Jemsek JG**, Rivero A, Rozenbaum W, Schrader S, Sension M, Vibhagool A, Thiry A, Giordano M. Comparison of Once-Daily Atazanavir With Efavirenz, Each in Combination With Fixed-Dose Zidovudine and Lamivudine, As Initial Therapy for Patients Infected With HIV. J Acquir Immune Defic Syndr. 2004 Aug 15;36(5):1011-19.

PEER-REVIEWED ARTICLES (Continued)

4. Eron JJ Jr, Murphy RL, Peterson D, Pottage J, Parenti DM, **Jemsek JG**, Swindells S, Sepulveda G, Bellos N, Rashbaum BC, Esinhart J, Schoellkopf N, Grosso R, Stevens M. A comparison of stavudine, didanosine and indinavir with zidovudine, lamivudine and indinavir for the initial treatment of HIV-1 infected individuals: selection of thymidine analog regimen therapy (START II). AIDS. 2000 Jul 28;14(11):1601-10.

5. Spruance SL, Pavia AT, Mellors JW, Murphy R, Gathe J Jr, Stool E, **Jemsek JG**, Dellamonica P, Cross A, Dunkle L. Clinical efficacy of monotherapy with stavudine compared with zidovudine in HIV-infected, zidovudine-experienced patients. A randomized, double-blind, controlled trial. Bristol-Myers Squibb Stavudine/019 Study Group. Ann Intern Med. 1997 Mar 1;126(5):355-63.

6. Pierce M, Crampton S, Henry D, Heifets L, LaMarca A, Montecalvo M, Wormser GP, Jablonowski H, **Jemsek JG**, Cynamon M, Yangco BG, Notario G, Craft JC. A randomized trial of clarithromycin as prophylaxis against disseminated Mycobacterium avium complex infection in patients with advanced acquired immunodeficiency syndrome. N Engl J Med. 1996 Aug 8;335(6):384-91.

7. Holloway KL, Smith KW, Wilberger JE Jr, **Jemsek JG**, Giguere GC, Collins JJ. Antibiotic prophylaxis during clean neurosurgery: a large, multicenter study using cefuroxime. Clin Ther. 1996 Jan-Feb;18(1):84-94.

8. Eron JJ, Benoit SL, **Jemsek JG**, MacArthur RD, Santana J, Quinn JB, Kuritzkes DR, Fallon MA, Rubin M. Treatment with lamivudine, zidovudine, or both in HIV-positive patients with 200 to 500 CD4+ cells per cubic millimeter. North American HIV Working Party. N Engl J Med. 1995 Dec 21;333(25):1662-69.

9. Henry DH, **Jemsek JG**, Levin AS, Levine JD, Levine RL, Abels RI, Nelson RA, Thompson D, Rudnick SA. Recombinant human erythropoietin and the treatment of anemia in patients with AIDS or advanced ARC not receiving ZDV. J Acquir Immune Defic Syndr. 1992;5(8):847-8.

10. Geckler RW, Eng RH, Fabian TC, Echols RM, **Jemsek JG**, LeFrock JL, Mogabgab WC, Wilson SE. A multicenter comparative study of cefotetan once daily and cefoxitin thrice daily for the treatment of infections of the skin and superficial soft tissue. Am J Surg. 1988 May 31;155(5A):91-95.

11. **Jemsek JG**, Harrison F. Ampicillin/Sulbactam vs. Cefoxitin for the treatment of Pelvic inflammatory disease. Journal in Infectious Disease in Obstetrics and Gynecology. Manuscript No. CL96 1227-66 (1988).

12. Wilson SE, Boswick JA Jr, Duma RJ, Echols RM, **Jemsek JG**, Lerner R, Lewis RT, Najem AZ, Press RA, Rittenbury MS, et al. Cephalosporin therapy in intraabdominal infections. A multicenter randomized, comparative study of cefotetan, moxalactam, and cefoxitin. Am J Surg. 1988 May 31;155(5A):61-66.

13. Lewis RT, Duma RJ, Echols RM, **Jemsek JG**, Najem AZ, Press RA, Stone HH, Ton GT, Wilson SE. Comparative study of cefotetan and cefoxitin in the treatment of intra-abdominal infections. Am J Obstet Gynecol. 1988 Mar;158(3 Pt 2):728-35. Erratum in: Am J Obstet Gynecol 1989 Apr;160(4):1025.

14. **Jemsek JG**, Greenberg SB, Taber L, Harvey D, Gershon A, Couch RB. Herpes zoster-associated encephalitis: clinicopathologic report of 12 cases and review of the literature. Medicine (Baltimore). 1983 Mar;62(2):81-97.

PEER-REVIEWED ARTICLES (Continued)

15. Gentry LO, **Jemsek JG**, Natelson EA. Effects of sodium piperacillin on platelet function in normal volunteers. Antimicrob Agents Chemother. 1981 Apr;19(4):532-33.
16. **Jemsek JG**, Martin RR, Greenberg SB, Gentry LO. Antimicrobial susceptibility testing of Haemophilus parainfluenzae by a kinetic killing-curve method. J Infect Dis. 1980 Mar;141(3):310-16.
17. **Jemsek, JG** Urinary enzyme excretion in the assessment of aminoglycoside nephrotoxicity. Current Opinions: aminoglycoside Nephrotoxicity. (Monograph), 29-31. (1980)
18. **Jemsek JG**, Gentry LO, Greenberg SB. Malignant group B streptococcal endocarditis associated with saline-induced abortion. Chest. 1979 Dec;76(6):695-97.
19. Wilson SZ, Martin RR, Putman M, Greenberg SB, Wallace RJ Jr, **Jemsek JG**. Quantitative nasal cultures from carriers of Staphylococcus aureus: effects of oral therapy with erythromycin, rosamicin, and placebo. Antimicrob Agents Chemother. 1979 Mar;15(3):379-83.
20. **Jemsek JG**, Greenberg SB, Gentry LO, Welton DE, Mattox KL. Haemophilus parainfluenzae endocarditis. Two cases and review of the literature in the past decade. Am J Med. 1979 Jan;66(1):51-57.
21. Mogabgab WJ, Pollock B, Beville RB, Gentry LO, **Jemsek JG**. Treatment of acute bacterial bronchitis and pneumonia with cefaclor. Postgrad Med J. 1979;55 Suppl 4:62-6.
22. Gentry LO, Ives RT, & **Jemsek JG.** Antibacterial of piperacillin against gram negative bacteria. Current Therapy Research 1979, 26, 175-83

NON-PEER-REVIEWED ARTICLES

1. **Jemsek JG**: Epidemic of the Ages. Pride Magazine Dec 2003 -Feb 2004
2. **Jemsek JG**: Epidemic of the Ages. Pride Magazine Sept-Nov 2003
3. **Jemsek JG**: Epidemic of the Ages. Pride Magazine Jun-Aug 2003
4. **Jemsek JG**: Hydroxyurea: An Alternative strategy? Published on website www.healthcg.com/hiv Lead article May 30, 1998
5. **Jemsek JG**: Is HIV Different in Women? Presbyterian Focus on Women Center on Women's Health 1996

ABSTRACTS

1. **Jemsek J**., Hutcherson P., Harper E.: Poor virologic responses and early emergence of resistance in treatment naïve, HIV-infected patients receiving a once daily triple nucleside regimen of didanosine, Lamivudine, and Tenofovir DR. (presented at the 11th Conference on Retroviruses and opportunistic infections February 2004).
2. **Jemsek J**., Arathoon E., Arlotti M. Perez C., Sosa N., Pokroviskiy V., Giordano M., Thiry A., Soccodato M.: Body fat effects of Atazanavir (ATV) and Efavirenz (EFV) each combined with fixed-dose Zidovudine (ZDV) and Lamivudine (3TC), have similar effects on body fat distribution in antiretroviral-naïve patients. (Presented at the 2nd IAS conference on HIV pathogenesis and treatment. July 2003).

ABSTRACTS (Continued)

3. Badaro R., DeJesus E., Lazzarin A., **Jemsek J**., Clotet B., Rightmire A., Thiry A., & Wilber R.,: Efficacy and safety of Atazanavir (ATV) with Ritonavir (RTV) or Saquinavir (SQV) versus Lopinavir/Ritonavir (LPV/RTV) in combination with Tenofovir (TFV) and one NRTI in patients who have experienced virologic failure to multiple HAART regimens. (Presented at the 5th International Workshop on Adverse Drug Reactions and Lipodystrophy in HIV July 2003).

4. Yeni P., MacGregor T., Gathe J., Arasteh K., Jayaweera D., **Jemsek J**., Hawkins T., Cameron W., Bodsworth N., McCallister S., Kohlbrenner V., Quinson A., Leith J., Sabo J., Mayers D.,: Correlation of viral load reduction and plasma levels in multiple protease inhibitor experienced patients taking Tipranavir/Ritonavir in a phase IIB 1182.52 (Presented at the 10th Conference of Retroviruses and Opportunist Infections, February 2003).

5. Yeni P., MacGregor T., Gathe J., Arasteh K., Jayaweera D., **Jemsek J**., Hawkins T., Cameron W., Bodsworth N., McCallister S., Kohlbrenner V., Auinson A., Leith J., Sabo J., Mayers D., Correlation of Viral load reduction and plasma levels in multiple protease inhibitor (PI) experience patients taking Tipranavir/Ritonavir in a phase IIB 1182.52. (Presented at the 5th International workshop on Adverse drug reactions and Lipodystrophy in HIV. July 2003).

6. Eron J., Peterson D., Murphy R., **Jemsek J**., Pottage J., Parenti D., Esinhart J., Schoellkopf N., & Stevens M.: An open-labeled, randomized, comparative study of d4t +ddl +ODV versus ZDV +3TC + IDV in treatment naïve HIV –infected patients: START II. (Presented at the 5th Conference on Retroviruses and opportunistic infections in Chicago, IL February 1998).

7. Mildvan D., Martin G., Eyster M., **Jemsek J**., Kagan S., Seekins D., Steigbigel D., Lee S.R., Manion D.J.: The Efavirenz clinical development team, and the DMP 266024 study team: Initial effectiveness and tolerability of Nelfinavir (NFV) in combination with Efavirenz (EFV, SUSTIVA™, DMP 266) in Antiretroviral therapy Naïve or nucleoside analogue experienced HIV –1 infected patients: Characterized in a phase II, open-label, multicenter study at 16 weeks (presented as an abstract at the 12th World AIDS Conference, Geneva, Switzerland July 1998).

8. Mayers D., **Jemsek J**., Eyster E., Tashima K., Thompson M., labriola D., Ruiz N. The Efavirenz Clinical Development Team and the DMP 266-004 Study Team: A Double blind, Placebo-controlled study to assess the sfety, tolerability and antiretroviral activity of Efavirenz (CEFV.SUSTIVA™ DMP 266) in combination with open-label Zidovudine (ZDV) and Lamivudine (3 TC) in HIV –1 Infected patients) Presented as an abstract at the Interscience Conference on Antimicrobial Agents and Chemotherapy, San Diego, California, July 1998).

9. Kagan S., **Jemsek J**., Mayers D., Pierone G., Manion D.J., Lee S.R., Ruiz N., DMP 266 024 Study Team: Initial Effectiveness and Tolerability of Nelfinavir (NFV) in Combination with Efavirenz (EFV.SUSTIVA™ DMP266) in Antiretroviral therapy Naïve or Nucleoside Analogue Experience HIV –1 Infected patients: Characterization in a phase II. Open-Label, Multicenter Study at > 36 weeks (1998).

10. Pierce M., Lamarca P.M., Lablonowski H., **Jemsek J**., Faetkenheuer G., Youle M., Bautzenberg B. : A placebo controlled trial of Clarithromycin Propylaxis against MAC Infections in AIDS patients (Presented as an abstract to 34th ICAAC Orlando, FL 1994).

11. Moskovitz B., Wiesinger B., **Jemsek J**.: Randomized Comparative Study of Itraconazole for Treatment of AIDS-related Cryptococcal Meningitis. (Presented as an abstract to the National Conference on Human Retroviruses and related Infections, Washington, DC December 12-16 1993).

ABSTRACTS (Continued)

12. **Jemsek J**.: Safety and efficacy of teicoplanin vs. cefazolin for the treatment of skin/soft tissue infections due to staphylococcus aureus. (Presented as an abstract to the International Congress on Chemotherapy, Stockholm, Sweden June 1993).
13. Gentry L.O., **Jemsek J**., Natelson E.A.: The effects of sodium piperacillin on platelet function in normal volunteers. (Presented as an abstract to the 20th Interscience Conference on Antimicrobial Agent and Chemotherapy, October 1980).
14. **Jemsek J**., Gentro L.O., Martin M.D.: Comparative aminoglycoside Nephrotoxicity using N-Acetyl-B_Glcosaminidase. (Presented as an abstract to the 19th Interscience Conference on Antimicrobial Agent and Chemotherapy, October 1980).
15. **Jemsek J**., Martin R.R., Greenberg S.B.: Antimicrobial sensitivity studies of Haemophilus parainfluenzae using kinetic killing curves. (Presented as an abstract to the 18th Interscience Conference on Antimicrobial Agents and Chemotherapy, October 1979).
16. **Jemsek J**., Martin R.R., Dewitz T.S., Solis R.T., McIntire L.V. : Effects of an in vitro shear stress on leukocyte morphology and function. (Presented as an abstract on the 17th Interscience Conference on Antimicrobial Agents and Chemotherapy, New York, October 1977).

ADDITIONAL

Dr. Jemsek is Treasurer of ILADS, the International Lyme and Associated Diseases Society, a collaborative group of expert physicians and academicians who specialize in the diagnosis and treatment of LBC.

Dr. Jemsek was featured as a prominent character in the full-length film documentary *"Under Our Skin"* released Spring 2008.

Dr. Jemsek wrote the foreword to a non-fiction book by published author PJ Langhoff, titled *"It's All In Your Head, Patient Stories From the Front Lines,"* Book I (2008, Allegory Press). She is working on numerous other projects at this time and publishes medical books and peer-reviewed articles on tick-borne illnesses alone and in tandem with medical experts.

Dr. Jemsek's LBC treatment protocols are featured in Dr. James Schaller's books *"The Diagnosis and Treatment of Babesia"* and *"The Health Care Professional's Guide to the Treatment and Diagnosis of Human Babesiosis: An Extensive Review of New Human Species and Advanced Treatments"* (October 2006, Hope Academic Press).