

- (33) Fails to cooperate with a lawful investigation conducted by the Board.

The Respondent was served with the notice of Violation of Probation and Charges Under the Maryland Medical Practice Act on or about September 15, 1999. A hearing was scheduled to begin on January 18, 2000 before the Office of Administrative Hearings. On November 10, 1999, a Case Resolution Conference ("CRC") was held before the Board's CRC Panel. As a result of negotiations entered into after the CRC, the Respondent agreed to enter into this Consent Order, consisting of Procedural Background, Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. At all times relevant to these charges, the Respondent was and is a physician licensed to practice medicine in the State of Maryland. The Respondent was originally licensed to practice medicine on December 22, 1983.
2. The Respondent maintains an office for the practice of medicine in the Baltimore area. The Respondent is a general practitioner and does not hold any hospital privileges.
3. On June 28, 1995, the Board voted to charge the Respondent under the Act, Md. Code Ann., H. O. § 14-404 (a)(22). The pertinent provisions of the Act state:
 - (a) Subject to the hearing provision of § 14-405 of this subtitle, the Board on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
 - (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State.

4. The Board based its charges on the findings of a peer review of the Respondent's practice that was conducted by the Medical and Chirurgical Faculty of Maryland ("Med-Chi") Peer Review Committee. The peer review report, dated June 20, 1995, stated that the Respondent failed to meet appropriate standards for the delivery of quality medical care for reasons which included, but were not limited to the following general deficiencies:
 - a. failure to evaluate and treat serious medical conditions;
 - b. failure to order or conduct appropriate diagnostic tests to establish, confirm or rule out possible differential diagnoses;
 - c. failure to respond to a patient's symptoms by treating the symptoms, referring the patient to a consultant or specialist or contacting the patient's primary physician;
 - d. use of chelation, vitamin and hydrogen peroxide therapies to treat medical conditions that respond to conventional medical treatment;
 - e. failure to document patients' consent and awareness that chelation, vitamin and hydrogen peroxide therapies constitute "alternative medicine" therapies;
 - f. failure to document adequately patient histories and physical examinations;
 - g. failure to document dosages of medications prescribed;
 - h. failure to interpret electrocardiograms ("EKG's") correctly; and
 - l. failure to maintain legible medical records.
5. On March 28, 1996, as a result of negotiations between the Respondent and the State, the Board issued a Consent Order whereby the Respondent's license was suspended for three (3) years beginning April 1, 1996, with the suspension to be stayed after ninety (90) days contingent upon the Respondent's attendance and successful completion of three (3) Board-approved courses including: the "Physician Refresher/Retraining Program"; an

EKG interpretation course; and a medical documentation course. The Consent Order provided that if the Respondent met the course requirements, the suspension would be stayed, the Respondent's license would be reinstated and the Respondent would be placed on probation for three (3) years beginning on April 1, 1996 with various conditions. The Consent Order further provided that the Respondent would be subject to a peer review of his medical practice during the probationary period.

6. On July 24, 1996, the Board, having determined that the Respondent had complied with the terms of the original Consent Order pertaining to the course requirements, issued an Order Staying Suspension/Order of Probation. Under the terms of this Order, the Respondent's suspension was stayed, his license was reinstated and he was placed on probation for three (3) years beginning April 1, 1996 subject to various terms and conditions. These conditions included the requirement that the Respondent's practice be monitored and that it be subject to peer review. The Order of Probation specified that the peer review would be limited to the treatment that the Respondent delivered to patients subsequent to July 24, 1996, the effective date of the Order of Probation.
7. Pursuant to the peer review provision of the Order of Probation, on or about November 7, 1997, the Board referred the matter to the Peer Review Management Committee ("PRMC") of Med-Chi for a review of the Respondent's practice. The Board requested that the Med-Chi PRMC review the "conventional" portion of the Respondent's practice in order to determine whether the Respondent was "neglecting conventional efficacious diagnostic and therapeutic means in favor of alternative treatment [and] that [the Respondent] was monitoring his patients for possible harmful side effects secondary to

alternative techniques."

8. On or about September 25, 1998, the PRMC issued its report to the Board, finding that the Respondent breached the standard of care in his treatment of nine (9) of the ten (10) patients reviewed.
9. On or about January 27, 1999, the Board voted to charge the Respondent with a violation of the Order Staying Suspension/Order of Probation.
10. Subsequent to the referral of the case to the Office of the Attorney General for prosecution, a review of the peer review report indicated that it was likely that the Respondent had failed to transmit to the Board records that documented the Respondent's administration of chelation therapy to those patients in the peer review whom he treated with chelation therapy, despite having received the Board's February 27, 1998 subpoena that directed him to transmit a legible copy of *any and all* medical records of the patients listed in the subpoena.
11. On April 15, 1999, the Board issued a second subpoena to the Respondent directing him to deliver a copy of "all chelation therapy records" of the patients who were named on the original subpoena.
12. On or about April 23, 1999, in response to the Board's second subpoena, the Respondent transmitted to the Board additional medical records of five (5) patients (Patients B, C, D, F and I below) to whom he administered chelation therapy.¹ The additional medical records transmitted to the Board by the Respondent included not only the Respondent's

¹Some of the records that the Respondent transmitted in response to the second subpoena were duplicates of the records he had submitted in response to the first subpoena. Some of the duplicate records, however, were not identical to the first set of records and contained handwritten notations.

chelation therapy records for the five (5) patients identified above - the only category of medical records that was requested in the subpoena - but also included a variety of other types of medical records. The additional records included: office notes, results of laboratory tests, patient information sheets, chronic problems and chronic medications lists and nursing notes describing patient complaints, symptoms and reactions to chelation therapy.

13. Given the variety and substantive nature of the additional records submitted by the Respondent in response to the Board's second subpoena, it was necessary to forward the records to the peer reviewers for an additional review. The reviewers altered some of their specific findings regarding the Respondent's violations of the standard of care, but retained their general conclusions that he had violated the appropriate standard of care in his treatment of nine (9) of the ten (10) patients.

Patient-Specific Allegations

Patient A

14. Patient A² was a sixty-two (62) year old female when she initially presented to the Respondent in 1988 for treatment of musculoskeletal complaints.
15. The PRC reviewed the Respondent's treatment of Patient A, then seventy years old, for the period from May 13, 1997 through September 24, 1997. During this period of time, the Respondent treated Patient A using osteopathic manipulation for cervical strain, thoracic strain, myofascial tension and muscle strains.

²For confidentiality purposes, patient names are not set forth in this charging document. The Board maintains a list of patient names that corresponds to the alphabetical letters used in the charging document. This list is available to the Respondent upon request.

16. The Respondent failed to include a Patient Treatment Disclosure Form in Patient A's file. The Respondent consistently failed to document Patient A's vital signs and his notes of Patient A's history and physical examinations are scant. The reviewers noted that the Respondent failed to document whether he was functioning as Patient A's primary care physician or as a consultant or specialist and that it was difficult to discern the Respondent's role in Patient A's care based on a review of Patient A's record.
17. On May 13, 1997, the Respondent documented that Patient A's blood pressure was 172/66. The entry is the single instance during the review period that the Respondent recorded Patient A's blood pressure. The Respondent failed to record or monitor or document that he addressed Patient A's blood pressure subsequent to May 13, 1997.
18. On July 2, 1997, the Respondent noted that Patient A expressed concern regarding the effect that Synthroid, a thyroid medication that she had been prescribed for several years, may have on the "progression of osteoporosis." In the same note, the Respondent documented that he had reassured Patient A that her dosage of Synthroid was "too low to cause osteoporosis;" however, he did not order a study to measure Patient A's thyroid stimulating hormone level.
19. The Respondent consistently failed to document a master problem list or medications list.
20. Throughout the review period, Patient A presented with several complaints of neck pain. The Respondent did not document an upper extremity neurological examination to assess the cause of Patient A's pain.
21. The Respondent breached the appropriate standards of care for reasons including:
 - a) failure to identify and document clearly his role in Patient A's treatment;

- b) failure to perform and document adequate physical examinations and medical history;
- c) failure to document a medications list and master problem list; and
- d) failure to document that he provided conventional treatment when needed. For instance, the Respondent failed to address and monitor Patient A's hypertension, failed to document a neurological examination to assess the cause of Patient A's complaint of neck pain and failed to order a study to address Patient A's concern about the effect of Synthroid on her osteoporosis.

Patient B

- 22. Patient B was a sixty-two (62) year old male when he initially presented to the Respondent on September 12, 1994 for treatment of angina, hypertension and osteoarthritis. The Respondent treated Patient B with chelation therapy, vitamins and prescription hypertensive medication.
- 23. The PRC reviewed the Respondent's treatment of Patient B for the period from March 12, 1997 through November 19, 1997.
- 24. During the review period, Patient B presented with complaints of hypertension, atherosclerotic heart disease, epigastric distress, osteoarthritis and musculoskeletal pain. The Respondent continued to treat Patient B with chelation therapy and vitamins as well as with Vasotec, a hypertensive medication, and Calan, a hypertensive medication. During the review period, the Respondent also treated Patient B with osteopathic manipulation, Lidocaine injections and flaxseed oil. On March 12, 1997, the Respondent added DHEA³ to Patient B's regime, noting that he prescribed the supplement "as a means of increasing your metabolism, decreasing your blood pressure, increasing your overall sense of well-

³ "DHEA" is the abbreviation for dehydroepiandrostone, a steroid secreted by the adrenal cortex.

being and increasing your stamina.” The Respondent failed to document that he had informed Patient B that a potential adverse side effect of DHEA is an increase of the risk of prostate cancer.

25. The Respondent’s documentation of his physical examinations of Patient B is scant and does not include an updated master problem list or a chronic medication list.
26. On September 18, 1996, the results of a lipid panel ordered by the Respondent revealed that Patient B had a high cholesterol level. The Respondent failed to document that he discussed this finding or its significance with Patient B. The Respondent did not order a repeat lipid panel during the remainder of the review period.
27. On March 12, 1997, the Respondent noted that Patient B was short of breath and began wheezing as he dressed after being examined. The Respondent failed to address Patient B’s shortness of breath.
28. On March 28, 1997, the Respondent noted that Patient B “still gets an epigastric discomfort when he begins exertion, but it subsides shortly thereafter.” The Respondent failed to conduct or order a stress test and failed to document that he monitored these symptoms subsequent to Patient B’s March 28, 1997 office visit.
29. On November 19, 1997, the Respondent conducted an EKG on Patient B and noted that the results were within normal limits, a finding he considered as “significant” because previously noted depressions of the V5 and V6 ST segments “have returned to baseline.” Depression of the ST segment of an EKG is a clinical indication of a lack of oxygen to a specific region of the heart. Patient B’s previous EKG’s did not reveal the depression of the V5 and V6 ST segments as was noted by the Respondent.

30. The Respondent wrote to Patient B on November 19, 1997, advising him that his "cardiogram has shown a significant improvement which means you have had some true healing in your heart." This statement is misleading because Patient B's EKG results had not previously indicated a significant abnormality; the "significant improvement" noted by the Respondent was merely a subtle difference in the EKG.
31. As explained in the Respondent's Consent Form for Chelation Therapy which Patient B signed, hypoglycemia⁴ and hypocalcemia⁵ are potential adverse side effects of chelation therapy. The Respondent failed to adequately monitor and document Patient C's glucose and serum calcium levels during the review period.
32. The Respondent breached the appropriate standards of care in his treatment of Patient B for reasons including:
- a) failure to perform and document adequate physical examinations of Patient B;
 - b) failure to include in Patient B's medical file a master complaint list and chronic medication list;
 - c) failure to address and monitor Patient B's hypertension, hyperlipidemia and wheezing;
 - d) failure to monitor Patient B's glucose and calcium levels for possible side effects of DHEA therapy; and

⁴Hypoglycemia is an abnormally diminished concentration of glucose in the blood, which may lead to tremulousness, cold sweat, hypothermia and headache, accompanied by irritability, confusion, hallucinations, bizarre behavior, and ultimately, convulsions and coma.

⁵Hypocalcemia is a reduction of blood calcium below normal; manifestations include hyperactive deep tendon reflexes, muscle and abdominal cramps and carpopedal spasm.

- d) failure to interpret the results of Patient B's EKG correctly.

Patient C

33. Patient C, an 82 year old female with a history of breast cancer, initially presented to the Respondent on June 9, 1997 for chelation therapy to treat conditions including peripheral vascular disease, macular degeneration, atherosclerotic heart disease, asthma and fatigue with profound exercise intolerance. Patient C also presented with end-stage Chronic Obstructive Pulmonary Disease ("COPD").
34. The PRC reviewed the Respondent's treatment of Patient C for the period of June 9, 1997 through July 25, 1997. During this period the Respondent treated Patient C with chelation therapy, vitamin and flaxseed oil therapy, and a series of lidocaine injections.
35. On June 9, 1997 the Respondent noted that Patient C was wheezing. Subsequently, on June 17, 1997 the Respondent instructed Patient C to use her inhalers "only when absolutely necessary" without documenting the medical rationale for this instruction.
36. On June 9, 1997, the Respondent conducted an EKG on Patient C. The Respondent incorrectly interpreted the EKG results as indicating that Patient C had "IRBBB" [incomplete right bundle branch block].
37. The Respondent failed to conduct baseline pulmonary function tests prior to and after a number of treatment sessions to determine whether Patient C was responding to the Respondent's regimen of treatment.
38. The Respondent failed to conduct or order pulmonary function tests, including oxygen saturation on room air, to evaluate Patient C's profound exercise intolerance.
39. Hypoglycemia and hypocalcemia are potential adverse side effects of chelation therapy, as

explained in the Respondent's Consent Form for Chelation Therapy that Patient C signed.

The Respondent failed to monitor and document Patient C's glucose and serum calcium levels during the review period.

40. The Respondent breached the appropriate standards of care in his treatment of Patient C for reasons including:
 - a) failure to treat Patient C's COPD and symptoms of wheezing with conventional medical treatment;
 - b) failure to determine or objectively assess whether treating Patient C with chelation therapy was efficacious;
 - c) failure to interpret Patient C's EKG correctly; and
 - d) failure to document that he monitored Patient C's glucose and calcium levels for possible adverse side effects of chelation therapy.

Patient D

41. Patient D, a fifty-six (56) year old male, initially presented to the Respondent on June 4, 1997 for "preventative" chelation therapy. The Respondent documented that Patient D had a family history of diabetes, heart disease and hypertension.
42. The PRC reviewed the Respondent's treatment of Patient D from June 4, 1997 through December 3, 1997.
43. The Respondent failed to document in Patient D's record whether he was functioning as Patient D's primary care physician or a specialist.
44. The Respondent failed to monitor Patient D's glucose and serum calcium for potential adverse side effects of chelation therapy such as hypoglycemia and hypocalcemia during the review period.

45. The Respondent breached the appropriate standards of care in his treatment of Patient D for reasons including:
- a) failure to document his role in Patient D's treatment clearly in the record;
and
 - b) failure to monitor Patient D's glucose and serum calcium for potential adverse side effects of chelation therapy.

Patient E

46. Patient E was a 53 year old female when she initially presented to the Respondent on April 15, 1997 with complaints of fatigue, vertigo and multiple musculoskeletal complaints. The Respondent treated Patient E with manipulation, "vitamin cocktails" and DHEA therapy.
47. The PRC reviewed the Respondent's treatment of Patient E from April 15, 1997 through June 27, 1997.
48. On April 15, 1997, the Respondent ordered a variety of blood chemistry studies of Patient E, the results of one of which indicated that she had elevated overall cholesterol and LDL cholesterol levels. The Respondent failed to document that he discussed with Patient E her elevated cholesterol values.
49. The results of Patient E's April 15, 1997 blood chemistry study indicated that she had a normal DHEA level. The Respondent nonetheless prescribed 10 mg of DHEA per day to Patient E. The Respondent did not document that he advised Patient E of the potential side effects of taking DHEA which include the exacerbation of her already elevated LDL cholesterol level.
50. The Respondent failed to document a master problem list or chronic medication list in

Patient E's medical record.

51. The Respondent breached the appropriate standards of care in his treatment of Patient E for reasons including:
- a) failure to document that he discussed with Patient E her elevated cholesterol levels;
 - b) failure to document that he discussed with Patient E potential adverse side effects of taking DHEA, including an exacerbation of her cholesterol levels.

Patient F

52. Patient F was a seventy-two (72) year old female when she presented to the Respondent on April 30, 1997 with hypertension, hyperlipidemia and complaints of pain in her upper extremities. Patient F, who was also being treated by an internist at another health care facility, received chelation therapy and vitamin and flaxseed oil therapy from the Respondent.
53. The PRC reviewed the Respondent's treatment of Patient F for the period from April 30, 1997 through August 18, 1997.
54. In the Respondent's note of the April 30, 1997 office visit, he noted Patient F's daughter has the same symptoms of upper extremity pain as her mother and that the daughter has been diagnosed with carpal tunnel syndrome. The Respondent failed to document that he examined or evaluated Patient F to confirm a diagnosis of carpal tunnel syndrome.
55. The Respondent noted on August 18, 1997 that, "her [Patient F's] carpal tunnel syndrome has resolved" but failed to document the clinical indications that led him to that conclusion.
56. On May 5, 1997, the Respondent conducted a carotid Doppler evaluation of Patient F but

did not document the signs or symptoms that warranted this study.

57. On July 2, 1997, the Respondent noted in the "Assessment" section that Patient F had "reactive hypertension" and that driving to his office from her home in Annapolis "gets her nervous and her blood pressure goes up." On August 18, 1997, the Respondent noted that Patient F's hypertension was "well-controlled." The Respondent failed to make an objective assessment as to whether Patient F's elevated blood pressure was caused by driving to his office, as he suggested in his July 2, 1997 note, or whether Patient F actually had hypertension.
58. As with the other patients in this charging document to whom he administered chelation therapy, the Respondent failed to monitor Patient F's glucose or serum calcium for potential adverse side effects.
59. The Respondent breached the appropriate standards of care in his treatment of Patient F for reasons including:
 - a) failure to assess or evaluate Patient F to confirm or rule out a diagnosis of carpal tunnel syndrome;
 - b) noted that Patient F's "carpal tunnel syndrome" had resolved in the absence of objective confirmation of that diagnosis and objective confirmation of its resolution;
 - c) failure to assess or evaluate whether Patient F's hypertension was "reactive," resulting from her increased tension occasioned by driving to the Respondent's office or whether she had actual hypertension;
 - d) failure to monitor Patient F's glucose or serum calcium for potential adverse side effects of chelation therapy; and
 - e) failure to document the clinical indications that warranted conducting a carotid Doppler evaluation of Patient F.

Patient G

60. Patient G was a seventy (70) year old male when he first presented to the Respondent in June 1991 for evaluation and treatment of arthritis, skin conditions and pain from a right fibular fracture. Patient G also had a history of prostate cancer that had been treated by physicians other than the Respondent with a prostatectomy and radiation. The Respondent treated Patient G with hydrogen peroxide drip therapy and osteopathic manipulations.
61. The PRC reviewed the Respondent's treatment of Patient G for the period from July 1996 through May 27, 1997.
62. On May 6, 1997, the Respondent noted that Patient G had fractured his fibula about fourteen (14) weeks prior to the office visit and sought hydrogen peroxide therapy to alleviate the swelling and tenderness in the area of the fracture. On May 27, 1997, the Respondent noted that Patient G had a "non-healing fracture of the right fibula."
63. The Respondent failed to document that he conducted or ordered a follow-up x-ray to evaluate the bone callus and to check for possible metastatic disease. A follow-up x-ray would have been appropriate conventional diagnostic care for a patient with a history of cancer.
64. The Respondent failed to document a master problem list or chronic medication list in Patient G's record.
65. The Respondent breached appropriate standards of care in his treatment of Patient G for reasons including:
 - a) failure to address the "non-healing fracture" to determine if there was a recurrence of cancer; and

- b) failure to document a master problem list and chronic medication list in Patient G's medical record.

Patient H

- 66. Patient H was a forty-two (42) year old female when she initially presented to the Respondent on February 28, 1997 with a history of leukopenia, hypothyroidism and chronic musculoskeletal pain. The Respondent treated Patient H with myofascial release, percussion hammer of bilateral lower extremities, a "vitamin cocktail," hydrogen peroxide drips and lidocaine injections.
- 67. The PRC reviewed the Respondent's treatment of Patient H for the period from February 28, 1997 through March 2, 1998.
- 68. On Patient H's initial office visit on February 28, 1997, the Respondent noted that she had a "questionable angina history" and had been recently seen by a cardiologist who had conducted an echocardiograph. According to the Respondent's note, the results of the echocardiograph were not available at the time and Patient H had not undergone a stress test.
- 69. The Respondent's initial plan of treatment indicates that Patient H was to be administered hydrogen peroxide drips twice a week for a total of two (2) weeks at which time she would be reevaluated. The Respondent documented the February 28, 1997 administration of hydrogen peroxide therapy to Patient H, but failed to document the remaining therapy sessions.
- 70. The Respondent failed to document the dosage of the vitamin cocktails he prescribed to Patient H.

71. On March 17 and April 1, 1997, the Respondent noted that Patient H complained of chest tightness that at times was exertional. The Respondent did not document whether Patient H had undergone a stress test nor did he document that he took any action to evaluate Patient H's chest pain.
72. The Respondent breached the appropriate standards of care in his treatment of Patient H for reasons including:
- a) failure to evaluate Patient H's complaints of chest pain;
 - b) failure to document appropriately Patient H's hydrogen peroxide drip therapy sessions and vitamin dosages; and
 - c) failure to document the dosage of vitamins that he prescribed to Patient H.

Patient I

73. Patient I was a sixty-five (65) year old male when he first presented to the Respondent on May 7, 1997 complaining of shortness of breath upon exertion and angina pains. Patient I's past medical history included a myocardial infarction in 1984, bypass surgery in 1984 and 1995 and an angioplasty in March 1997. The Respondent assessed Patient I as having arteriosclerotic heart disease, peripheral vascular disease, r/o [rule out] hypothyroidism. The Respondent did not document whether Patient I remained under the care of a cardiologist or other physician while he was being treated by the Respondent.
74. The PRC reviewed the Respondent's treatment of Patient I for the period from May 7, 1997 through September 3, 1997.
75. The Respondent treated Patient I with chelation therapy, flaxseed oil, 5-HT, coenzyme Q10, vitamin C and "Dr. Ben" vitamins.

76. Patient I continued to complain of chest pain and exercise intolerance during the course of treatment. The Respondent conducted EKG's, but did not order any other cardiac testing to address or assess Patient I's symptoms.
77. On May 6, 1997, the Respondent ordered a thyroid function study to rule out the possible diagnosis of hypothyroidism. The results of the study were abnormal, indicating hyperthyroidism. The Respondent did not document that he discussed the lab results with Patient I or planned to address the problem.
78. On August 11, 1997, the Respondent ordered a study of Patient I's cholesterol levels. The results of the study indicated that Patient I's cholesterol levels were elevated, a lipid profile that is not acceptable in a patient with coronary artery disease. The Respondent did not document that he discussed the lab results or a treatment plan with Patient I.
79. The Respondent breached the appropriate standards of care in his treatment of Patient I for reasons including:
- a) failure to address Patient I's angina,
 - b) failure to address Patient I's abnormal thyroid function test;
 - c) failure to discuss or treat Patient I's elevated cholesterol levels; and
 - d) failure to document his treatment role in Patient I's care.
80. The Respondent's actions, as described above, constitute, in whole or in part, the failure to meet appropriate standards for the delivery of quality medical care in violation of the terms and conditions of the Order of Probation in Board Case Number 94-0718 as well as H.O. § 14-404(a)(22).
81. The Respondent's failure to comply with the Board's subpoenas for medical records as

detailed above in ¶¶ 10-13 constitutes, in whole or in part, the failure to cooperate with a lawful investigation of the Board in violation of H.O. § 14-404(a)(33).

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes that the Respondent committed prohibited acts under the Maryland Medical Act, Section 14-404(a)(22) in violation of the terms of his Order of Probation. Accordingly, the Board concludes as a matter of law that the Respondent violated his probation in that he failed to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical care.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 22 day of Feb, 2000 by a majority of the full authorized membership of the Board considering the case:

ORDERED that the Respondent be placed on **PROBATION** for a period of **THREE (3) YEARS** as of the effective date of this Consent Order, the effective date being the date that the Consent Order is executed by the Board Chair or his designee, subject to the following conditions of probation:

A) Within thirty (30) days from the effective date of this Consent Order, the Respondent shall terminate his practice of "alternative" or "complementary" medicine and shall practice only "traditional", "conventional" or osteopathic medicine for the entire period of probation. For the purpose of this Consent Order, alternative or complementary medicine shall be considered to include chelation therapy, hydrogen peroxide therapy and vitamin therapy (except for prescriptions for vitamins approved by the physician supervisor), or any treatment

not approved by the physician supervisor;

B) Within thirty (30) days of the effective date of this Consent Order, the Respondent shall obtain a Board-approved physician supervisor to review the Respondent's records of patient care in order to assess the Respondent's provision of medical services, interpretation of EKGs and other diagnostic studies and medical record keeping.

- 1) The Respondent shall supply his supervising physician with a copy of this Consent Order .
- 2) The Respondent shall make arrangements for the supervising physician to submit to the Board verification that the supervisor has received this Consent Order and understands the conditions imposed upon the Respondent.
- 3) The Board and the Respondent both acknowledge that the supervising physician shall be participating in and contributing to the Board's function as a medical review committee, and, as such, both parties acknowledge that the supervising physician shall be immune from liability in accordance with H.O. § 14-501, or any successor provision, when performing the function of a medical review committee.
- 4) The Respondent shall meet with the supervising physician on a monthly basis. The supervising physician shall determine how much time is needed for each session to review the Respondent.
- 5) The Respondent shall make arrangements for the supervising physician to submit quarterly reports to the Board in which the supervisor assesses the Respondent's attendance, participation, and medical care, including an evaluation of the Respondent's general patient care, interpretation of EKGs and other diagnostic

studies and medical record keeping. The Respondent shall be responsible for assuring that the physician supervisor sends reports to the Board as required by this Consent Order. The Respondent's failure to arrange for timely reports from the physician supervisor as outlined herein as requested by the Board shall be deemed a violation of this Consent Order.

- 6) The Board must approve and ratify any changes in supervision based upon the supervising physician's report.
- 7) The Respondent shall pay all costs, if any, associated with the supervisory arrangement described in this Consent Order. If the Respondent fails to pay the costs pursuant to the arrangement, then the supervising physician will notify the Board. Failure to pay all costs pursuant to the arrangement shall be deemed a breach of and violation of this Consent Order.
- 8) If the Respondent fails to attend the supervisory sessions, then the supervising physician shall immediately notify the Board, with the exception that in the instances of medical or other true emergencies, the Respondent shall be permitted to reschedule a session (or sessions) subject to the approval of the supervising physician. The Respondent's failure to attend shall be deemed a breach of and violation of this Consent Order.
- 9) If the supervising physician believes that the Respondent is a danger to his patients, or is not competent to practice medicine, or has violated this Consent Order, then the supervising physician shall immediately notify the Board; and be it further **ORDERED** that the Respondent may be subject to peer review by an appropriate peer

review society, or a chart review by a Board designee, to be determined at the discretion of the Board. After a chart review, the Board may recommend a peer review. The peer review committee or chart reviewer, if assigned, shall receive a copy of this Consent Order and may receive any other materials in the Board's possession at the discretion of the Board. If the peer review or chart review indicates to the Board that the Respondent's practice fails to conform to the Act, the Board reserves the right to modify the terms and conditions of this Consent Order and may impose any *additional sanctions it deems appropriate; and be it further*

ORDERED that the Respondent shall at all times cooperate with the Board of Physician Quality Assurance and any of its agents or employees in the monitoring, supervision and investigation of the Respondent's compliance with the terms and conditions of this Consent Order, including the Respondent causing to be submitted, at his own expense, written reports, records and verifications or actions that may be required by the Board or any of its agents or employees. The Respondent's failure to cooperate fully with the Board at all times shall be deemed a breach of and violation of this Consent Order; and be it further

ORDERED that the Respondent's failure to comply fully with the terms and conditions of this Consent Order hereby imposed shall be deemed a violation of this Consent Order and the Respondent may be subject to charges by the Board of Physician Quality Assurance; and be it further

ORDERED that the Respondent shall comply with all laws governing the practice of medicine under the Act, and all rules and regulations promulgated thereto. Failure to do so shall constitute a violation of this Consent Order, as well as subject the Respondent to further disciplinary action by the Board; and be it further

ORDERED that if the Respondent violates any of the terms of this Consent Order, the Board, after notice, opportunity for a hearing and determination of violation, may impose any other disciplinary sanctions it deems appropriate, including but not limited to revocation or suspension; said violation of probation being proved by a preponderance of evidence; and be it further

ORDERED that pursuant to Md. Code Ann., State Gov't § 10-226(c) and Md. Regs. Code tit. 10, § 32.05, the Respondent is subject to summary suspension if an investigation or peer review indicates to the Board that there is a substantial likelihood of a risk of serious harm to public welfare, safety or welfare by the Respondent; and be it further


ORDERED that no sooner than **THREE (3) YEARS** after the date of this Consent Order, the Respondent may petition the Board for termination of terms, conditions and restrictions imposed by this Consent Order. If the Respondent has satisfactorily complied with all conditions of this Consent Order, and there are no outstanding complaints regarding the Respondent, the Respondent may petition the Board for termination of conditions and restrictions imposed by this Consent Order; and be it further

ORDERED that the Respondent shall be responsible for all costs incurred under this Consent Order; and be it further

ORDERED that this Consent Order is considered a public document pursuant to Md.

Code Ann., State Gov't § 10-611 *et seq.*

Date 2/23/00



Sidney B. Seidman, Chair
Maryland State Board of Physician
Quality Assurance

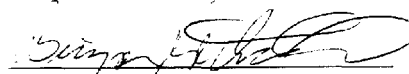
CONSENT

I, Binyamin Rothstein, D.O., acknowledge that I am represented by legal counsel, and I have had the opportunity to consult with counsel before entering into signing this document. By this consent, I hereby admit the Findings of Fact and Conclusions of Law, and submit to the foregoing Consent Order consisting of _____ pages.

I acknowledge the validity of this Consent Order as if entered after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by law. Although I am not in total agreement with all of the Findings of Fact, I acknowledge the legal authority and the jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I also affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

7 Jan 00
Date


Binyamin Rothstein, D.O.

STATE OF MARYLAND

CITY/COUNTY OF Baltimore

I HEREBY CERTIFY that on this 5th day of January, 2000, before me, Notary Public of the State and City/County aforesaid, personally appeared Binyamin Rothstein, D.O., and made oath in due form of law that the foregoing Consent was his voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

Heather McLaughlin
Notary Public

My Commission Expires: 1 Dec 2000