

IN THE MATTER OF	*	BEFORE THE
	*	
BINYAMIN (FORMERLY "BRIAN")	*	
ROTHSTEIN, D.O.	*	STATE BOARD OF PHYSICIAN
	*	
Respondent	*	QUALITY ASSURANCE
	*	
License Number: H30277	*	Case Number: 94-0718
	*	
* * * * *		* * * * *

CONSENT ORDER

PROCEDURAL BACKGROUND

The State Board of Physician Quality Assurance (the "Board"), on June 28, 1995, voted to charge Binyamin (formerly "Brian") Rothstein, D.O. (the "Respondent") (D.O.B. 08/15/55), License Number H30277, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. §14-404(a)(22).

Specifically, the Board charged that the Respondent:

(a) Subject to the hearing provisions 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.

On February 21, 1996, a conference with regard to this matter was held before the Case Resolution Conference (the "CRC"). As a

result of negotiations entered into before and during the CRC, the Respondent agreed to enter into this Consent Order, consisting of a Procedural Background, Findings of Fact, Conclusions of Law and an Order.

INTRODUCTION

Based upon complaints received from two concurrently and/or subsequently treating physicians, the Board requested that the Medical and Chirurgical Faculty of Maryland ("Med-Chi") conduct a review of Respondent's practice. The peer reviewers found that Respondent failed to meet appropriate standards of care in his treatment of ten patients.

The Med-Chi report stated that Respondent failed to meet appropriate standards for the delivery of quality medical care which included, but were not limited to, the following:

- a. Failure to evaluate symptoms of meningitis, a potentially life-threatening infection of the brain and its coverings;
- b. Failure to properly manage and evaluate seizure activity in a two month old infant;
- c. Failure to immediately refer to an emergency room or to treat with intravenous antibiotics a sixty-seven (67) year old man with a history of cardiac disease and symptoms of pneumonia (cough, hemoptysis and fever);
- d. Failure to properly manage and evaluate a sixty-one (61) year old man with symptoms of unstable angina, pitting edema and a strongly positive PPD test (a

potential indication of active or inadequately treated tuberculosis); and

e. Failure to evaluate and treat symptoms and findings of shortness of breath, dyspnea on exertion, rales in the lungs and ankle and pretibial edema in an eighty-two (82) year old female.

FINDINGS OF FACT

The Board bases its charges on the following facts that the Board has cause to believe are true:

1. At all times relevant to these charges, Respondent was and is licensed to practice medicine in Maryland.

2. Based upon a review of Respondent's medical records, peer reviewers made the following findings:

PATIENT A

Patient A,¹ a fifty-five (55) year old male, presented to Respondent on September 14, 1993 with complaints of back pain, weakness, headache, a history of back pain which had been treated by another physician seven (7) years prior with codeine and ibuprophen, and a prior urinary tract infection with arthralgia.

On physical examination, Respondent documented that the patient was "stiff," and had a positive Kerning's sign and deep tendon reflexes. He diagnosed the patient's condition as "meningismus."

¹Patient names are confidential and are not used in Consent Orders. A list of patient names which correspond to the alphabetical letters used in the Charges was made available to the Respondent.

Respondent treated Patient A with an intravenous infusion of hydrogen peroxide.

Respondent's office notes indicate that nine (9) days later, on September 25, 1993, Patient A reported in a telephone conversation that the patient had a "significant improvement in symptoms." (The notation "phone conversation" and Respondent's name did not appear in the original chart but did appear in a subsequent copy of the chart.)

In fact, several days after the September 14, 1993 visit, Patient A developed generalized weakness, malaise, low grade fever and continued to experience neck aches. He presented to another physician who determined that Patient A had an erythrocyte sedimentation rate in excess of 140 mm.

Respondent departed from the standard of the care in his treatment of Patient A by:

- a. failing to address the potentially life-threatening diagnosis of meningitis;
- b. failing to perform or document an adequate physical examination to evaluate the complaints in the history;
- c. failing to adequately document the Kerning's sign to rule out meningitis;
- d. failing to adequately diagnose the patient's current condition;
- e. treating the patient with hydrogen peroxide absent a documented rationale or consent of the patient; and
- f. documenting illegibly.

PATIENT B

Patient B, a two (2) month old male, first presented to Respondent on April 11, 1994. Respondent documented a "bad cold," a history of pneumonia, and wrote "pediatrician feels is asthma." Although not legibly documented in the medical records, the billing record for that date indicates that Respondent treated Patient B with "manipulation" in an undetermined location.

On April 25, 1994, Respondent treated Patient B with an undetermined manipulation, medications that were illegibly documented and with Vitamin B12, and noted that "the child appears to be seizing."

Respondent's notes for a May 3, 1994 visit are largely illegible. Respondent documented that the patient was "better," made an undeterminable note about "seizures," and that he administered Vitamin B6 and another undeterminable substance. Respondent's billing records for that date indicate that he performed two "manipulations."

Again on June 7, 1994, Respondent saw Patient B and documented that the patient was "better . . . no longer constipated . . . wheezing." Documented treatment was illegible in Respondent's notes; however, he again billed for two "manipulations."

Respondent departed from the standard of care in his treatment of Patient B by:

- a. failing to aggressively treat and evaluate a condition involving potentially serious seizure activity or to refer the patient out;

- b. failing to document the details of Patient B's manifested behavior which led Respondent to write "appears to be seizing;"
- c. failing to communicate with Patient B's pediatrician concerning the seizure activity;
- d. treating an asthmatic condition in a two month old infant with unspecified osteopathic manipulations for unspecified reasons and without documentation;
- e. failing to obtain and document appropriate history, symptoms, physical examination and vital signs; and
- f. failing to provide or document that he provided appropriate instructions to the patient's mother for management of asthma and seizures.

PATIENT C

Patient C, a sixty-seven (67) year old male with a history of cardiac disease, was treated by Respondent from 1986 through 1993. Respondent's medical records for Patient C include a January 28, 1993 echocardiogram report from Patient C's cardiologist stating that Patient C had severe aortic stenosis, left ventricular hypertrophy, and mitral annular calcification. Patient C also had a history of dizziness.

Patient C next presented to Respondent on January 9, 1994 with complaints of chest pain and shortness of breath. Respondent ordered an electroencephalogram ("EKG") to rule out a myocardial infarction, referred Patient C for a carotid artery evaluation, and administered an EDTA chelation treatment.

On March 4, 1994, and again on March 8, 1994, Respondent administered hydrogen peroxide intravenously to Patient C. After determining that Patient C had a grade IV/V heart murmur, Respondent referred Patient C to a cardiologist who prescribed sublingual nitroglycerine spray.

Patient C next presented to Respondent on April 6, 1994 with a chief complaint of "fever, cough -- bloody production." Respondent ordered an x-ray which revealed pneumonia but failed to document his response to those findings. On April 11, 1994, Respondent administered another intravenous infusion of hydrogen peroxide. Two days later, on April 13, 1994, Respondent examined Patient C, documented that he was coughing, and administered intravenous vitamins and minerals. Respondent continued to administer intravenous hydrogen peroxide treatments on April 15, 22, and 27, 1994 and vitamin and mineral infusions on April 18 and 20, 1994. During this period, Respondent documented that Patient C continued to "cough" and that he was sweating at night.

Respondent also administered intravenous hydrogen peroxide treatment to Patient C on May 4, 1994 and again on October 31, 1994. Respondent also continued to render osteopathic manipulations.

Respondent departed from the standard of care in his treatment of Patient C by:

- a. failing to refer him to an emergency room in April, 1994 when Patient C presented with symptoms of potentially life

threatening pneumonia and cardiac problems or failing to prescribe an aggressive therapy with antibiotics and close follow-up;

b. failing to order a follow up x-ray to document clearing of the infiltrate;

c. failing to refer to a cardiologist or pulmonologist for closer follow up; and

d. failing to document consent to "alternative methods of treatment" and instructions to the patient.

PATIENT D

Patient D, a fifty-seven (57) year old male, first presented to Respondent on March 18, 1987 for a physical examination to determine that he was "free of communicable diseases." Respondent noted the blood pressure as 120/78 and that the patient had a "large PPD reax on L forearm, no apparent contagious diseases."

Patient D returned to Respondent for nine (9) office visits from January through December of 1991. Much of Respondent's documentation is illegible; however his notes do indicate that throughout four (4) visits in January and February, he treated the patient with osteopathic manipulations for back pain, with hydrochlorothiazide ("HCTZ") for "edema," noted blood pressures of 122/72 and 118/72, and an elevated blood cholesterol of 300 mg/dr. Respondent failed to record blood pressures during May, June, July, September or December visits. On September 7, 1991, Patient D presented to the George Washington University Medical Center Emergency Department complaining of "pain with walking." House

staff diagnosed "bilateral lower leg swelling" and "plantar fasciitis."

During 1992, Respondent treated Patient D nine times for back pain and plantar fasciitis but failed to record his blood pressure on any of those visits. On November 11, 1992, Respondent noted "mild swelling." An illegible note appears to refer to "edema," yet the Respondent abruptly discontinued the HCTZ.

Respondent's office chart for Patient D does not reflect visits from November 11, 1992 until this patient returned on October 11, 1993 with complaints that the "right ankle will swell with prolonged standing and will swell and ache with prolonged walking; nonetheless, Respondent had written to an attorney in March, 1993 that Patient D's swelling of the lower extremities was "not as a result of anything at all relating to plantar fasciitis rather it was peripheral edema relating more to hypertension than anything else." He also stated that this patient was using crutches. In contrast, in an August 9, 1993 letter, Respondent wrote that the edema was caused by "prolonged standing."

In his documentation of the October 11, 1993 office visit, Respondent also noted the blood pressure as 130/90 and that this patient's chest ached. Respondent ordered an EKG and performed osteopathic manipulations.

Again, on October 17, 1993, Respondent wrote a "To Whom It May Concern" letter describing further problems caused by the plantar fasciitis: inactivity, gait change, weight gain, a mild increase in

blood pressure, an increase in cholesterol², a "decrease in his cardiovascular system" and symptoms of angina. Despite a normal EKG, Respondent wrote that more tests were necessary and that angina be treated with EDTA chelation therapy.

Patient D next presented to Respondent's office on November 15, 1993 for swollen ankles. Respondent's notes for that visit are illegible. In November and December, 1993, Respondent treated Patient D with intravenous vitamin and mineral therapy, osteopathic manipulations, and ultimately with intravenous hydrogen peroxide. Patient D's complaints during those visits were of pain in his chest, leg, shoulder and throat. His blood pressure was recorded as 120/72 and 118/76. A complete blood count ("CBC") and blood chemistry profile revealed no abnormal findings except for an elevated cholesterol level.

On January 3, 1994, Patient D presented to a physician who was "covering" for Respondent. He complained of sore throat, cough, fatigue, aches for three days and an absence of chills or fever. The physician's impression was "dental abscess" and he prescribed penicillin.

Two days later, on January 5, 1994, Respondent examined Patient D, noted an upper respiratory infection and complaints concerning this patient's feet but did not address the abscessed tooth. On that visit, Respondent treated this patient with a

²Respondent's chart on Patient D contains laboratory reports of blood cholesterol levels of 300 mg./dl. dated February 12, 1991 and 269 mg./dl. dated August 17, 1993.

hydrogen peroxide intravenous drip. On that same date, Respondent wrote to an insurance representative attributing pain in Patient D's hands, arms, back, neck and upper body to the use of crutches necessitated by the plantar fasciitis. Respondent also attributed weight gain, high blood pressure, cardiovascular problems and "ischemic heart disease" to the plantar fasciitis. At the end of January, 1994, Respondent examined this patient and concluded in his office notes that the hydrogen peroxide infusions had made the patient "much better."

Respondent administered vitamins, minerals, and colchicine intravenously to Patient D on January 31, February 2, and February 7, 1994 and recorded normal blood pressures.

On February 21, 1994, Patient D reported stiffness but no low back pain. Respondent performed a manipulation.

On March 14, 1994, Patient D reported no pain and Respondent recorded a normal blood pressure. The back pain returned in April and Respondent performed another manipulation.

Patient D remained pain free for the balance of his visits to Respondent during the months of April, May and June. Respondent continued to treat Patient D during some of those visits with intravenous vitamins, minerals and colchicine and with manipulations.

Respondent departed from the standard of care in his treatment of Patient D by:

- a. writing letters to an attorney and an insurance company representative describing

conditions inconsistent with those documented in his chart;

- b. diagnosing and treating hypertension despite normal blood pressure readings;
- c. attributing Patient D's high cholesterol levels to plantar fasciitis inactivity;
- d. recommending EDTA chelation as first-line treatment for elevated cholesterol;
- e. failing to adequately document histories and physical examination findings to support his use of intravenous hydrogen peroxide, colchicine, vitamins and minerals;
- f. failing to document legibly;
- g. failing to perform an appropriate work-up, including documentation of a cardiovascular examination, an EKG, and to adequately follow up Patient D's complaints which were suggestive of unstable angina or to refer this patient to a cardiologist or to document an offer to refer this patient to a cardiologist; and
- h. failing to order a chest x-ray in response to a positive PPD test.

PATIENT E

Patient E, an eighty-two (82) year old female, first presented to Respondent in August, 1991 with a chief complaint of pain in her

lower back, legs and ankles. Respondent diagnosed Patient E with lumbar strain and "LS spondylosis" and treated her with osteopathic manipulations and electric stimulation. On subsequent visits, Respondent treated Patient E with osteopathic manipulations and monitored her blood pressure which ranged from 200/78 to 174/70.

In September, 1991, Respondent ordered a chest x-ray with was interpreted as "normal" except for "mild cardiomegaly."

On October 16, 1991, Respondent noted that Patient E's lower back pain was better but that her dyspnea continued on exertion and that her ankles remained swollen. Furthermore, Respondent noted that Patient E had rales in her lungs and documented a "+2 pretibial nonpitting edema." He prescribed the diuretic Lasix, traction and manipulation. One week later, Respondent administered Vitamin B12. On that visit, the patient's legs were noted as "less swollen" but her breathing had not improved. On November 6, 1991, Patient E was still "wheezing." Patient E next visited Respondent in September 1992. Her chief complaints were coughing since the previous night and becoming hoarse. Respondent diagnosed a viral infection and prescribed erythromycin.

On subsequent visits to Respondent in May and June, 1992 (for which much of his documentation is illegible), Respondent did note that he felt "fluid filled" in the patient's abdomen and that her jugular veins were distended to 45 degrees. Respondent ordered a complete blood count, a blood chemistry profile, and an abdominal

sonogram which were all interpreted as normal. Respondent treated the patient with manipulations.

Respondent next treated this for several visits in June and July, 1994 for back pain. He did order an x-ray which was negative for spinal compression and treated the patient with a hydrogen peroxide infusion and noted that she was taking Soma. On July 9, 1994 the patient's blood pressure was recorded as was 190/90.

Respondent departed from the standard of care in his treatment of Patient E by:

- a. failing to treat her symptoms of congestive heart failure which were potentially life threatening, including but not limited to failing to administer an electrocardiogram to evaluate the patient's left ventricular function;
- b. failing to adequately evaluate or treat her symptoms of pulmonary complaints which could have represented a potentially life threatening cardiac or pulmonary disease;
- c. failing to follow up on the "fluid filled" abdomen;
- d. failing to perform adequate physical examinations; and
- e. failing to provide documentation in the chart that the patient consented to "alternative" medicine.

PATIENT F

Patient F, a seventy-two (72) year old female, first presented to Respondent on September 23, 1993. She was complaining of lower back pain of two or three days duration, that originated when she bent forward. The patient complained that the pain worsened when she was walking or standing.

Respondent's notes indicate that he performed a very brief physical examination, that the patient was unable to bear weight, and that a vitamin injection was administered or ordered. Respondent alleges that he performed an osteopathic manipulation on that single visit; however, there is no legible documentation of such. Respondent also alleges receiving several telephone calls from Patient F; however, these calls are not documented in his chart.

Subsequently, Patient F consulted another physician, who diagnosed her as having metastatic bone cancer.

Respondent departed from the standard of care in his treatment of Patient F by:

- a. failing to document legibly;
- b. failing to order x-rays or conduct other diagnostic tests in order to make an accurate diagnosis;
- c. failing to document a diagnosis;
- d. failing to conduct or document a history and physical examination adequate to develop a reasonable set of differential diagnoses; and

- e. failing to document telephone conversations with the patient.

PATIENT G

Respondent's documentation on Patient G, a seventy-six (76) year old male, begins with an undated note that this patient was "status post CVA [cardiovascular accident] and speech defect."

Patient G presented to Respondent on April 22, 1990 with a history of fainting two days prior to the visit and that he "had not felt the same" since the incident. Respondent documented the blood pressure as 148/70. Respondent did not document a physical examination; however, he did treat the patient with intravenous vitamins.

Patient G next presented to Respondent for a series of four (4) visits from April 7 through April 12, 1991. On April 7, 1991, the patient's chief complaint was that he fell on his right knee and sprained his left ankle after feeling dizzy and experienced pain with weight bearing. Respondent documented a blood pressure of 132/56 but did not document a physical examination. Patient G returned on April 8, 1991, but Respondent did not document either a blood pressure or a physical examination. When this patient returned again the next day, on April 9, 1991, Respondent prescribed support stockings and hydrochlorothiazide; however, Respondent did not document a blood pressure or any legible physical examination. Three days later, on April 12, 1991, Respondent documented that this patient was "better, but still

hurts" and "swollen, wearing support socks;" again, Respondent did not record a blood pressure.

Finally, Patient G presented to Respondent on July 22, 1991 complaining of a persistent cough, malaise, and thigh pain with ambulation. Respondent documented a blood pressure of 184/90 but did not document a physical examination. Respondent's chart indicates that he prescribed intravenous vitamins. This is the final entry that Respondent documented concerning Patient G.

Nonetheless, in a letter dated April 27, 1994, directed to the Board, Respondent admits that in August, 1991, Respondent visited Patient G "socially" and observed that this patient was experiencing "some shortness of breath and short-lived chest pains . . ." and expressed the opinion that emergency hospitalization was not necessary.

Four days after Respondent's visit, Patient G was admitted to the hospital with an acute myocardial infarction and congestive heart failure. He died one month later.

Respondent departed from the standard of care in his care of Patient G by:

- a. documenting illegibly;
- b. failing to record adequate information regarding this patient's medical condition;
- c. failing to conduct any laboratory tests to determine the cause of this patient's fainting;

-
- d. failing to record diagnoses to support his prescriptions for hydrochlorothiazide and vitamins;
 - e. failing to order an x-ray of this patient's leg on April 7, 1991;
 - f. failing to order blood chemistry profiles prior to or after prescribing hydrochlorothiazide;
 - g. failing to document whether this patient was taking other medications; and
 - h. failing to evaluate this patient for possible pulmonary embolism in July, 1991.

PATIENT H

Patient H, a forty-six (46) year old male, first presented to Respondent on November 23, 1993 complaining of lower back pain. An MRI (magnetic resonance imaging), ordered one month prior to the visit by another physician, revealed a mild loss of height of the L5-S1 disc space with mild facet sclerosis and hypertrophy at that level. Peer reviewers found Respondent's documentation for this initial visit to be almost completely illegible; however, they were able to determine that Respondent documented a history of Patient H's back pain, a limited physical examination, a blood pressure of 134/100, and that he administered vitamins, minerals and colchicine intravenously. Respondent also ordered a blood chemistry profile which revealed normal ranges for all tests except for an elevated cholesterol level.

Patient H next presented to Respondent on November 29, 1993. Respondent's documentation for this visit was minimal and illegible except for a notation that the blood pressure was 130/90 and that Respondent administered vitamins, minerals and colchicine intravenously. Respondent repeated this treatment on a subsequent visit, on an undeterminable date, and recorded a blood pressure of 140/104.

Respondent recorded blood pressures of 144/100 and 150/100 on December 3 and December 6, 1993 respectively. Respondent's documentation for these visits was illegible except for a final notation that this patient felt "better" and could "walk better."

Patient H presented to another physician and was diagnosed in January, 1994 as having metastatic bone cancer.

Respondent failed to meet the standard of care in his treatment of Patient H by:

- a. failing to perform and/or document adequate physical examination to render an accurate diagnosis;
- b. documenting illegibly;
- c. failing to correspond with concurrently treating physicians; and
- d. failing to document that this patient consented to Respondent's non-traditional treatments.

PATIENT I

Patient I, a twenty-two year old male, first presented to Respondent on June 28, 1994 complaining of a dry throat, fatigue, muscle aches, and loss of coordination. Respondent's brief notations concerning this patient's history and physical examination were largely illegible; however, Respondent did note that the onset of symptoms had been one year prior following a "strep throat." Respondent also noted "CMV" [Cytomegalo Virus].

Respondent made a diagnosis of "post viral syndrome" and prescribed three (3) hydrogen peroxide treatments which were administered to this patient on June 28, June 29 and July 5, 1994.

On June 29, 1994, Respondent documented that Patient I's head felt "less heavier" and that this patient was feeling more "awake" in the mornings. On July 5, 1994, Respondent documented that this patient continued to "feel tired," that he experienced occasional dizziness, and that he was "waking up in the morning much better."

Respondent prescribed intravenous infusions of vitamins and minerals on July 6, July 11, July 12, July 13, August 2 and August 3, 1994. For each visit, Respondent documented that this patient was "feeling better" than the previous visit and that he was gaining more energy.

Respondent departed from the standard of care in his treatment of Patient I by:

- a. failing to take or document an adequate history to make a diagnosis of "post viral syndrome;"

- b. failing to rule out other potential diagnose;
- c. failing to document a rationale for giving treatments with the hydrogen peroxide interstice with vitamin and mineral infusions; and
- d. failing to document that the patient consented to "alternative" treatments.

PATIENT J

Patient J, a forty-two (42) year old male, first presented to Respondent on June 17, 1994 with a history of chronic prostatitis and fatigue. On that initial visit, Respondent noted that this patient had been under the care of a urologist and performed a physical examination. Respondent prescribed a series of three hydrogen peroxide treatments and ordered a blood chemistry profile and a complete blood count.

Patient J received hydrogen peroxide infusions on June 17, June 20 and June 27, 1994. Respondent documented that there were "no changes" except that the patient "feels relaxed."

On July 5, 1994, Patient J complained of abdominal soreness. Other than a notation that the patient's prostatitis was "improved," Respondent's notes for that visit are illegible; however, Respondent's billing records for that date indicate that he made a diagnosis of "abdominal pain" and charged for two "manipulations" and the use of a traction table.

Patient J next presented to Respondent on July 18, 1994. Respondent did not document a physical examination, but merely noted that this patient was "feeling better" and administered vitamins and minerals intravenously. Again, the only recorded diagnosis for this visit, "myositis," is found on the bill.

On July 24, 1994, Respondent documented that this patient had one episode of abdominal pain the week prior but was "feeling fine" at the time of the visit. He diagnosed abdominal pain and performed two manipulations.

On August 22, 1994, Patient J complained of a "gastrointestinal upset" but of no prostate or abdominal symptoms. Respondent did not follow up on the gastrointestinal symptoms; he performed two manipulations.

On October 3, 1994, Patient J presented with an upper respiratory infection and aching "hernia scars." Respondent also administered hydrogen peroxide infusions on October 10 and October 14, 1994, noted that this patient's "throat feels swollen," and made a diagnosis of "viral infection." Finally, on October 19, 1994, Respondent treated Patient J's "cough" with two manipulations.

Respondent failed to meet the standard of care in his treatment of Patient J by:

- a. failing to document physical examinations of the patient on several visits;
- b. failing to document adequate histories;

- c. rendering diagnoses not supported by physical findings; and
- d. failing to address the October 14, 1994 potentially life-threatening symptom of "throat feels swollen."

3. Respondent does not agree with all aspects of the Med-Chi peer review report; however, in the interest of providing quality patient care, Respondent agrees to the terms of this Consent Order.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes that the Respondent committed prohibited acts under the Act, H.O. §14-404(a)(22). Accordingly, the Board concludes as a matter of law that the Respondent failed to meet appropriate standards of care 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 28 day of March, 1996, by a majority of the full authorized membership of the Board considering this case:

ORDERED that the Respondent be SUSPENDED for a period of THREE (3) years, beginning April 1, 1996 such SUSPENSION to be stayed after a period of ninety (90) days contingent upon the following conditions:

- 1. Respondent shall successfully and satisfactorily

complete the "Physician Refresher/Retraining Program," an eight (8) week 320 hour intensive review course of general medicine, offered by Medical College of Pennsylvania, Division of Continuing Medical Education;

2. Respondent shall successfully and satisfactorily complete a Board approved course in electrocardiogram interpretation;

3. Respondent shall initiate a Board approved course in documentation; and be it further

ORDERED that should the Respondent meet the above conditions, he shall be placed on **PROBATION** for a period of **THREE (3)** years beginning April 1, 1996, subject to the following conditions of probation:

1. Respondent shall employ a Board approved mentor to review Respondent's patient care on a weekly basis, such time interval to be extended at the judgement of the mentor;

2. Respondent shall devise Board Approved Consent Forms fully apprising patients of the concept of alternative medicine and the risks thereof;

3. Respondent shall successfully and satisfactorily complete the Board approved documentation course, written documentation of successful completion to be submitted by the course instructor within one year of initiation of the course; and be it further

4. If the stay is lifted, Respondent shall be subject to a peer review of his current practice one year from the date of this Order. After receipt of the Peer Review Report, the Board shall determine whether further peer reviews of Respondent's medical

practice are warranted. (This determination may be delegated to the Weekly Review Panel or a Case Resolution Conference Committee.) The Respondent shall cooperate fully with the peer reviewers.

ORDERED that if the Respondent violates any of the terms of the Respondent's probation, the Board, after notice and a hearing, and a determination of violation, may impose any other disciplinary sanctions it deems appropriate, said violation of probation being proved by a preponderance of evidence; and be it further

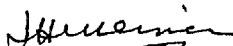
ORDERED that if Respondent presents a danger to the public health, safety, or welfare, the Board, **WITHOUT PRIOR NOTICE AND AN OPPORTUNITY FOR A PRE-DEPRIVATION HEARING**, may vacate the stay of suspension and reinstate the suspension provided that Respondent is given notice of the Board's action and an opportunity for a hearing within thirty (30) days after requesting same in accordance with Md. Code Ann., State Gov't §10-226; 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.

3/28/96

Date



Israel H. Weiner, M.D.
Chair
Maryland State Board of
Physician Quality Assurance

CONSENT

I, Binyamin (formerly "Brian") 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 27 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 procedure protection provided by law. 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.

12/29/86

Date



Binyamin (formerly "Brian")
Rothstein, D.O.

STATE OF MARYLAND

CITY/COUNTY OF Baltimore

I HEREBY CERTIFY that on this 12th day of March, 1996, before me, Notary Public of the State and City/County aforesaid, personally appeared Binyamin (formerly "Brian") 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.

Donna Faudel
Notary Public

My Commission Expires: 2/2/98

a:rothstein.com