

**IN THE MATTER OF** \* **BEFORE THE MARYLAND**  
**BINYAMIN C. ROTHSTEIN, D.O.** \* **STATE BOARD OF**  
**Applicant.** \* **PHYSICIANS**  
**Former License No. H30277** \* **Former Case No. 1994-0718**

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**BOARD DECISION ON PETITION FOR REINSTATEMENT**

**PROCEDURAL HISTORY**

**A. History of Prior Discipline**

**First Charges: 1995**

On June 28, 1995, the Board first charged Dr. Rothstein with violating appropriate standards of medical care within the meaning of Section 14-404 (a) (22) of the Medical Practice Act.

Dr. Rothstein was charged with: (1) failing to evaluate or treat a patient presenting with symptoms of meningitis, and instead treating the patient with intravenous hydrogen peroxide; (2) failing to evaluate, diagnose, treat or refer to another physician a two-month-old baby who was experiencing seizures, and instead performing a manipulation; (3) failing to refer to the emergency room a 67-year-old patient with an x-ray finding of pneumonia and complaints of chest pain, shortness of breath, fever and a cough with bloody production, and instead administering four intravenous hydrogen peroxide treatments and three injections of vitamins and minerals; (4) diagnosing and prescribing medication for high blood pressure for a 57-year-old patient whose blood pressure readings were all normal, failing to order a chest x-ray after that patient had a positive

tuberculosis test, failing to follow up on complaints suggestive of unstable angina, and failure to follow up on treatment administered by a covering physician for a dental abscess, and instead administering hydrogen peroxide and mineral injections without a history or physical examinations supporting their use; (5) failing, in the case of an 82-year-old patient with dyspnea, swollen ankles, rales, pitting edema, wheezing, coughing and abdominal fluid, to treat the symptoms suggestive of congestive heart failure, and instead administering hydrogen peroxide intravenously; (6) failing to adequately evaluate a patient complaining of back pain who was in fact suffering from metastatic bone cancer, and instead injecting vitamins; (7) failure to do an adequate examination of the cause of fainting accompanied by shortness of breath and chest pain in a 72-year-old patient who died shortly thereafter of a myocardial infarction and congestive heart failure, and instead administering intravenous vitamins; (8) failing to adequately examine and evaluate a 46-year-old male complaining from lower back pain who was in fact suffering from metastatic bone cancer, and instead injecting intravenous vitamins and minerals; (9) administering intravenous hydrogen peroxide and vitamins after an inadequate examination which was not detailed enough to support the diagnoses of a patient complaining of dry throat, fatigue, muscle aches and lack of coordination; and (10) diagnosing a patient and the treating that patient by intravenous hydrogen peroxide and vitamins and manipulation over eleven visits without a valid basis for that diagnosis in the physical findings.

### First Consent Order: 1996

Those charges were settled by a Consent Order of March 28, 1996. Under the terms of that Consent Order, Dr. Rothstein admitted that his care did not meet the standard of care in these cases. Dr. Rothstein's license was suspended for ninety days and he was placed on probation for a period of three years. Dr. Rothstein was also required to employ a Board-approved mentor to monitor his care of patients, to develop Board-approved consent forms for alternative medicine, to complete a Board-approved documentation course, to complete a Physician Refresher or Retraining Program, and to complete a Board-approved course in electrocardiogram interpretation. He was also subject to subsequent peer review.

### Second Charges: Consent Order II ( 2000)

On September 15, 1999, the Board charged Dr. Rothstein with violating the terms of the probation in the previous Consent Order by failing to meet appropriate standards of patient care. These charges were settled by a second Consent Order ("Consent Order II") executed on February 23, 2000. In Consent Order II, Dr. Rothstein admitted that he had violated appropriate medical standards in the treatment of nine patients whose care was reviewed by the Board subsequent to the first Consent Order.

The violations admitted in Consent Order II were similar to the original violations that had first caused the Board to charge Dr. Rothstein the first time. All but one patient was given chelation therapy, vitamin injections and/or hydrogen peroxide injections, and many patients were given other treatments such as flaxseed oil; but once again serious medical problems for which conventional treatments are available were not evaluated

or, if evaluated, not properly treated. In one patient, he failed to address the patient's shortness of breath, wheezing, high cholesterol and epigastric discomfort upon exertion, and he misinterpreted the patient's EKG. In another patient he also misinterpreted an EKG, failed to address the patient's Chronic Obstructive Pulmonary Disease, wheezing, and profound exercise intolerance, failed to order any pulmonary function tests, failed to monitor for the possible side effects of chelation therapy and failed to make any assessment of whether chelation therapy was effective. In another patient, he again failed to monitor for side effects of chelation therapy, failed to properly address the patient's high blood pressure and diagnosed a patient without a sufficient examination, based on the patient's word that her daughter had the disease. He prescribed a steroid to a patient whose blood levels of that steroid were normal, even though that steroid could exacerbate her already high cholesterol problem, and he did not discuss the cholesterol problem with her. He treated a patient who had a history of cancer and a non-healing fracture of the right fibula with hydrogen peroxide and manipulation, but he failed to order an x-ray to check for metastatic cancer. He failed to evaluate another patient's chest pain. In another patient with shortness of breath and angina-like pain, he failed to address the angina issue at all and also failed to address the patient's abnormal thyroid tests or to address or treat the patient's elevated cholesterol.

In Consent Order II, Dr. Rothstein agreed with the facts alleged in the charging document and agreed to a disposition of the case by the imposition of probation and numerous conditions. The Board placed Dr. Rothstein on probation for three years and imposed many conditions, including the prohibition of the practice of alternative or complimentary medicine, including specific named therapies that he had abused in the

past, and a requirement that he cooperate fully with the Board's efforts to monitor, supervise and investigate his practice.

### ORDER OF REVOCATION (2005)

The Board subsequently charged Dr. Rothstein with violating the Consent Order by: (1) providing therapies specifically prohibited by the Consent Order II; (2) providing substandard care to his patients; and (3) failing to cooperate with a lawful investigation of the Board. After a 9-day evidentiary hearing before an Administrative Law Judge and an exceptions hearing, the Board, in a Final Decision and Order issued on May 26, 2005, found that Dr. Rothstein had violated specific provisions of the Consent Order II by providing prohibited therapies, had provided substandard care to patients and had failed to cooperate with the Board's investigation. The failure to cooperate with the Board's investigation consisted of withholding, from the records submitted to the Board in response to the Board's subpoena, documents which showed that he had been knowingly violating the terms of the Consent Order.

The Administrative Law Judge found that Dr. Rothstein had "failed to diagnose cancer and other serious ailments" and that his actions "continue to make him a danger." In that Final Decision and Order, the Board revoked Dr. Rothstein's license and ordered that it would not accept any application for reinstatement for at least five years. The Board noted that after "years of probation, peer reviews and supervision, Dr. Rothstein continues to practice substandard medicine." The Board ruled that it could not allow him to continue to practice substandard medicine after two unsuccessful efforts to rehabilitate his practice. The Board also found that his failure to disclose the

incriminating medical record in response to the Board's lawful subpoena had "destroyed the trust which the Board must have in the cooperation of a physician."

### **B. Consideration of Current Application for Reinstatement**

On September 8, 2010, Dr. Rothstein filed a Petition for Reinstatement with the Board, asking the Board to exercise its discretion and grant reinstatement of his medical license.

After losing his license, Dr. Rothstein engaged in a practice which he termed "energy healing," a practice which he termed a religious practice rather than the practice of medicine. The ailments that Dr. Rothstein treated by "energy healing" in this practice included a stiff finger, hemorrhoids, a urinary tract infection and hypertension. After the Board subpoenaed and eventually obtained his treatment records, Dr. Rothstein ceased this "energy healing" practice. Because he was not a licensee at the time, Dr. Rothstein was not under the Board's jurisdiction with respect to the standard of care he provided in these instances. The Board did not charge him with practicing without a license.

Dr. Rothstein also opened an establishment in Baltimore for laser hair removal surgery, a practice that the Board had, in a Declaratory Ruling issued on October 30, 2002, had found to be the practice of medicine. After the Board began its investigation of him and of others involved, Dr. Rothstein quickly closed the practice. He stated at the time that he had been unaware of the Board's declaratory ruling on the subject. He refused, however, to comply with Board subpoenas in its investigation of himself and others involved in this practice. The Board did not bring suit to compel him to comply with the subpoenas, and it did not charge him with practicing medicine without a license.

Dr. Rothstein opened an unlicensed massage therapy practice in Pennsylvania. When the Board inquired about this, he stated that he was unaware that Pennsylvania law had been amended to require a license in order to practice massage therapy. Upon confirming for himself that it was unlawful to practice massage therapy without a license, he reached an agreement with the Pennsylvania authorities that he could continue the practice until May, 2011, when he closed it, according to his account.

Dr. Rothstein has been engaged in lecturing, in conducting various business activities related to the practice of medicine and in the promotion of his book, "Brain Fog." He has taken the required amount of Continuing Medical Education credits. With respect to the question of whether he had changed his character sufficiently so that he no longer would pose a danger to patients if permitted to practice, he stated that he has "changed, both personally and professionally." He admitted that he was wrong in some specific instances in the past. For example, he admitted that his use of intravenous vitamin cocktails (thus violating the requirements of the Consent Order) was wrong. He also admits that the use of Chelation Therapy as a treatment for heart disease was wrong and not appropriate. At the same time, he has maintained a website in which he states that the reason that the Board revoked his license "because my patients did well," and that the Board was "never able to find a misdiagnosis or mismanagement" in his care in ten years of supervising him. These statements are contradicted by his admissions in the Consent Orders as well as the findings in the Board's Final Decision and Order.

Dr. Rothstein was given the opportunity to appear at an informal meeting with a reinstatement panel of the Board. After hearing the presentations of Dr. Rothstein and

the Administrative Prosecutor in person at that informal meeting, the panel advised Dr. Rothstein that it would recommend to the full Board that he not be reinstated to the practice of medicine. The matter was brought to the full Board for consideration. This is the Board's final decision on Dr. Rothstein's Petition for Reinstatement.

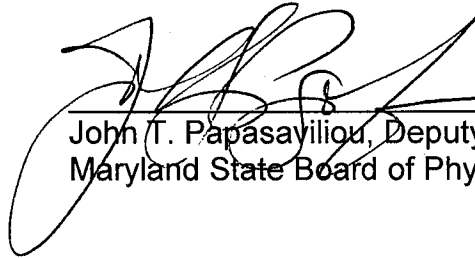
Granting or denying reinstatement to a previously revoked licensee is a discretionary act. See *Oltman v. Maryland State Board of Physicians*, 182 Md. App. 65 (2008). The Board will deny reinstatement. Although Dr. Rothstein did make a few statements in which he expressed belated agreement with a few of the Board's past findings concerning his substandard medical care, he simply has not persuaded the Board that he has changed his outlook or is any more likely to practice medicine safely at this time. Since his revocation, he has treated patients as a health occupation practitioner in two different states without making himself aware, or keeping himself aware, of the laws of either state governing the practice. He has maintained his website in which he makes false statements about the Board's past disciplinary actions against him. Altogether, despite his general statements that he has changed and seen the error of his ways, Dr. Rothstein has not persuaded the Board that his practice would be improved to the extent that he would no longer pose a danger to the patient public if given his license again. In the interest of public safety, the Board will deny reinstatement of his license.

#### **ORDER**

It is therefore **ORDERED** that the Petition for Reinstatement filed by Binyamin C. Rothstein, M.D., be, and it hereby is, **DENIED**.

It is further **ORDERED** that this order is a **PUBLIC DOCUMENT** pursuant to Md.  
State Gov't Code Ann. § 10-611 et seq. (2004 Repl. Vol.).

So ordered this 21<sup>st</sup> day of December, 2011.



John T. Papasaviliou, Deputy Director  
Maryland State Board of Physicians