IN THE MATTER OF	*	**BEFORE THE MARYLAND**
PAUL VICTOR BEALS, M.D.	*	**STATE BOARD**
Respondent	*	**OF PHYSICIANS**
License No. D25922	*	**Case No. 2001-0433**

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CONSENT ORDER

PROCEDURAL BACKGROUND

On January 2, 2004, the Maryland State Board of Physicians (the "Board") charged Paul V. Beals, M.D. (the "Respondent") (D.O.B. 4/15/1943), License Number D25922, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") § 14-101 et seq. (2000 Repl. Vol., 2002 Supp.).

Specifically, the Board charged the Respondent with violating the following:

H.O. § 14-404 Denials, **reprimands, probations, suspensions and revocations – Grounds.**

(a) *In general* – 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:

(4) Is professionally, physically, or mentally incompetent, and

(18) Practices medicine with an unauthorized person or aids an unauthorized person in the practice of medicine.

On April 7, 2004, a conference with regard to this matter was held before the Case Resolution Conference (the "CRC"). 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.

SUMMARY OF PRIOR DISCIPLINARY ACTIONS

Case Number: 85-0081

A. 1988 Agreement - On June 21, 1988, in resolution of charges[1] issued against the Respondent, the Board[2] and the Respondent executed a non-public Disposition Agreement /Consent Order (the "1988 Agreement"). The 1988 Agreement required that the Respondent follow certain terms and conditions including limiting the use of non-traditional medical treatments, i.e. intravenous chelation therapy[3], Laetrile, Indican tests and xanthine oxidose analysis for patients. The Respondent was also prohibited from providing medical or psychiatric services to psychiatric patients and placing advertisements without Board approval. The Board also ordered peer review of the Respondent's medical practice. (See Exhibit 1, attached hereto and incorporated by reference herein).

B. 1993 Consent Order - On October 23, 1991, the Board voted to charge the Respondent with violation of the 1988 Agreement. The Board's vote to charge occurred prior to the Respondent's eligibility to petition for termination of probation pursuant to the 1988 Agreement. A peer review of twenty-four patients revealed that the Respondent: performed Indican tests without medical indication; provided thyroid medication without diagnostic testing; in the case of normal tests; performed cortisol

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[1] Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. (4), (11) and (18). Codified in 1987 as H.O. §14-504 (4), (11) and (18), later amended by Ch. 109 § 1, Acts 1088, effective July 1, 1998 as H.O. §15-504 (a) (4), (10) and (17), and presently codified as H.O. § 14-404 (a) (4), (10), and (17) with substantive language unchanged from the 1987 codification and the July 1998 amendment.

[2] The Commission on Medical Discipline of Maryland was the predecessor agency to the Board of Physician Quality Assurance which was created when the 1988 General Assembly, by Senate Bill No. 508 and House Bill No. 855, merged the functions of the former Commission on Medical Discipline and the former Board of Medical Examiners into the Board of Physician Quality Assurance. As of July 1, 2003 the Board is now titled the State Board of Physicians.

[3] The Respondent would be permitted to use non-traditional chelation therapy if the FDA double bind testing then in progress showed medical benefits to patients.

testing and prescribed steroids without any medical justification; instituted testosterone therapy without medication; and performed FSH testing without medical indication. The peer reviewers also noted that the Respondent's medical record documentation and record maintenance was inadequate. The charges were resolved in a November 10, 1993 Consent Order which suspended (and immediately stayed the suspension) the Respondent's license for three years, required three years probation with specific terms and conditions, including, but not limited to requirements: to not perform or order tests which were not medically indicated; and to provide complete disclosure (including Board-approved materials) to patients who seek alternative medical treatments. (See Exhibit 2 attached hereto and incorporated by reference herein). The order also contained a cease and desist provision, required appropriate documentation in and maintenance of patient medical records, and ongoing periodic peer review. [4]

C. 1996 Modified Order - On July 26, 1996, a Modified Consent Order (the "1996 Order") was executed granting the Respondent's request to perform chelation therapy provided that all patients sign a Board approved consent form. (See Exhibit 3, attached hereto and incorporated by reference herein).

D. 1999 Modification by Consent to Order - On February 24 1999, the Board again charged the Respondent with violation of probation. The new charge resulted from a December 21, 1998 peer review, which revealed that the Respondent had: inappropriately used FSH testing to assess effectiveness of plant-derived HRT (hormone replacement therapy) and that this testing was not within the standard of care for monitoring HRT. In addition, the peer reviewers found that the Respondent

[4] On June 5, 1995, the New Jersey State Board of Medical Examiners, in a reciprocal action, suspended the Respondent's medical license for three years.

overutilized FSH testing on the sixteen patients whose records were reviewed. On October 20, 1999, and prior to the issuance of a formal charging document, the February 1999 charges were resolved in a Modification By Consent to Consent Order, (the "1999 Order"). (See Exhibit 4, attached hereto and incorporated by reference herein). The 1999 Order, among other things: prohibited the Respondent from performing FSH testing in his office laboratory; required the Respondent to provide a Board-approved disclosure form to all patients for whom he prescribed plant-derived or non-prescription HRT; prohibited the Respondent from using FSH testing to test effectiveness of HRT (with the only exception being determination of the onset of menopause); mandated additional peer review or chart review by a Board designee to ascertain FSH testing ordered for patients after the effective date of the order, and probation was to continue pending successful completion of a peer review of the Respondent's practice.[5]

FINDINGS OF FACT

Case Number 2001-0433

1. At all times relevant to these charges, the Respondent was and is a licensed physician in the State of Maryland. The Respondent was initially licensed to practice in Maryland on December 19, 1980, being issued License Number D25922.

2. The Respondent's business address is 9101 Cherry Lane, Laurel Maryland, 20708. At the time of the incidents described herein, the Respondent did not have hospital privileges in Maryland.

3. The Respondent is board certified in family practice.

[5] The most recent peer review of the 1999 Order is pending.

4. The facts that led to the charges set forth herein result from, among other things; the Respondent's employment as a medical director by Innovative Medical Clinics, Inc., ("IMC") and from the medical care of certain individuals in his private medical practice.

5. IMC, a Maryland corporation, is located at its primary place of business, 19650 Clubhouse Road, Suite 106, Gaithersburg, Maryland 20886.

6. IMC was formed to provide ultraviolet blood irradiation ("UBI") treatment to the center's clients. In routine medical practice UBI is performed for certain diseases, after the patient is treated with chemotherapy. IMC provided a limited treatment; running blood through an ultraviolet light and returning the "treated" blood to the patient. The Respondent, at the time of the incidents described herein, was the contracted Medical Director of IMC.

7. As IMC's contracted Medical Director, the Respondent was assigned the following "duties and responsibilities to exercise as he sees fit:"

(a) participate as a member of the Board of directors of IMS[6];

(b) oversight of all of IMC's[7] medical operations;

(c) review written clinical procedures; approve of all protocols;

(d) review of patient records and monitor progress, as needed;

(e) determine which patients need to be examined by a physician;

(f) write physicians orders and prescriptions;

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[6] Innovative Medical Services ("IMS") was the first name of the company incorporated to provide UBI treatments to clients. The contract indicates IMS and IMC are related corporations. However, both corporations bind the Respondent by contract.

[7] IMS and IMC are used interchangeably throughout the written contract.

(g) make occasional visits to the Clinic to assure medical operations are appropriate;

(h) perform other duties as may be needed by the clinic, and

(i) to be available for telephone consultation and to authorize protocols in relationship to treatment regimes."

8. The Respondent's "optional duties", pursuant to the IMC contract, included: "participate in research grants and other programs with IMS/IMC and the Foundation for Blood Irradiation, and, may refer patients to IMC for UBI treatments."

9. The Respondent delegated his physician duties and the practice of medicine to William Eberlin[8], an unlicensed individual. Mr. Eberlin, a renal dialysis technician, was known as the "Director" at the IMC clinic by the patients seeking health care and treatment.

10. In October 1998, Mr. Eberlin, with the assistance of the Respondent and others, purchased two UBI devices (the "Devices")[9] from the Foundation for Blood Irradiation (the "Foundation") located in Silver Spring, Maryland.

11. At the time IMC purchased the Devices, the Devices were not approved by the Federal Food and Drug Administration (the "FDA") for use on humans or for investigational device exemption and were eventually seized by the FDA in August 2000.

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[8] On May 30, 2001, the Board charged with Mr. Eberlin with a violation of H.O. §14-601, practicing medicine without a license. Mr. Eberlin entered into a Consent Order with the Board on August 12, 2001 in which he admitted that he practiced medicine on patients. Mr. Eberlin was fined fifteen thousand dollars ($15, 000) for practicing medicine without a license.

[9] Precision Assembly Corporation manufactured the devices according to documentation provided by the Respondent.

12. On February 13, 1997, the federal government filed a complaint in the United States District Court for the District of Maryland for Forfeiture *in Rem* of the Knott Hemoirradiator Device (the "Federal Complaint"). [10]

13. A Device was seized on February 20, 1997 from the Foundation's offices in Silver Spring, Maryland. The parties entered into the Consent Decree of Condemnation and Permanent Injunction on January 28, 1998.

14. The Foundation Director, C.S.[11] communicated regularly with the Respondent and Mr. Eberlin about the status of the Device after the Federal Order was entered in January 1998.

15. IMC and the Respondent routinely advertised, via circulation of private offering memoranda, printed pamphlets and word of mouth advertisements, the availability of the UBI treatment and misrepresented that Mr. Eberlin was qualified to provide the treatments.

16. On May 2, 2000, the FDA Consumer Safety Officer ("FDA Officer") visited IMC at 19650 Club House Road, Suite 106, Gaithersburg, Maryland 20886.

17. Upon arrival at IMC at 2:00 p.m., the FDA officer observed two patients in a room, connected to intravenous tubing and having blood pumped from their bodies through tubing into a tabletop Device. The Device was used without FDA or other regulatory approval.

18. The patients connected to this device were monitored by a female identified as a "nurse"[12] ("Ms. G"), who is another unlicensed individual, and Mr. Eberlin.

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[10] The case, brought by the FDA on behalf of the United States is styled *United States of America vs. Knott Hemo Irradiator, Civil No. AW-97-448.* It appears that the Foundation business was transferred to IMC in the fall of 1997.

[11] Mr. S is deceased.

19. During the May 2000 inspection, a Maryland licensed physician was not present on the IMC clinic premises while the two patients underwent UBI treatment.

20. The FDA Officer issued an FDA-48 "Notice of Inspection" to Mr. Eberlin and provided his FDA identification credentials. Mr. Eberlin represented to the FDA Officer that he was not a medical doctor, but a certified hemodialysis technologist.[13]

21. Mr. Eberlin explained to the FDA Officer that UBI treatment sessions cost one hundred and twenty dollars ($120.00), were sixty minutes in duration and were given to treat patients' diagnosed disease processes.

22. According to Mr. Eberlin, the UBI treatment procedure consisted of removing 200 cubic centimeters (200 cc)[14] of the patient's blood into tubing, passing the blood through the Device; the blood was then re-transfused into the patient. Heparin, a prescription blood anticoagulant, was injected to prevent the blood from clotting in the tubing during this process.

23. Mr. Eberlin provided a copy of the operating procedure for the Devices, yet refused to provide the Device's shipping records and product labeling.

24. The FDA Officer reported his findings to the Board Compliance Unit.

25. On June 15, 2000, Board staff met with and interviewed Mr. Eberlin. The Board staff found Mr. Eberlin at the IMC address. The IMC office and treatment area lacked signage markings on all doors and areas inside and outside of the main building.

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[12] The "nurse" is not a practical or registered nurse licensed in Maryland.

[13] According to Maryland law, hemodialysis technicians are licensed as certified nursing *assistants* ("CNA's") by the Maryland Board of Nursing. Hemodialysis is a medical treatment delegated to licensed nurses acting under the supervision of a physician. The hemodialysis technician (a nursing assistant) acts under the supervision of a registered nurse.

[14] The amount of blood removed and reinfused into the patient is approximately a one-cup volume.

26. During the June 15, 2000 meeting, Mr. Eberlin stated he was a dialysis technician. that he learned how to use the Device on the job, and, was assisted by Ms. G.

27. Mr. Eberlin explained to Board staff that he met with each patient before the UBI treatment to take a medical history, vital signs and perform a physical assessment.[15]

28. Mr. Eberlin represented that IMC's patient population included patients diagnosed with HIV, Hepatitis C and Non-Hodgkin's lymphoma. The UBI treatment, according to Mr. Eberlin, removed or destroyed any viruses or bacteria in the blood.

29. Mr. Eberlin represented that a physician was not employed by IMC to provide the UBI treatments, as it was "not necessary".

30. On August 3, 2000, the Board issued, via certified mail, return receipt requested, a Cease and Desist Order commanding Mr. Eberlin to cease and desist the operations of IMC for violating § 14-601 of the Maryland Medical Practice Act because he and the clinic employees were practicing medicine without a license. Mr. Eberlin signed the return card for the certified mailing on August 16, 2000. The Order included an opportunity for Mr. Eberlin to show cause why the order should not be entered.

31. Neither Mr. Eberlin nor the Respondent appeared on August 23, 2000, to show cause as to why the Cease and Desist Order should not be entered.

32. On May 30, 2001, the Board charged Mr. Eberlin with violating of H.O. §14-601 for practicing medicine without a license for reasons including, but not limited to, his provision of UBI treatments to patients.

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[15] CNA' s and other unlicensed persons are not authorized to take medical histories or to perform physical examinations for patients.

33. On August 12, 2001, Mr. Eberlin entered into a Consent Order with the Board in which he admitted that he practiced medicine without a license in connection with his interactions with patients at the IMC clinic.

34. The Respondent, through regular telephone, mail, facsimile and personal contact with Mr. Eberlin, referred at least twelve of his private practice patients to Mr. Eberlin for UBI treatment.

35. The Respondent had personal knowledge that Mr. Eberlin was not a physician and not competent to practice any delegated duties from a physician.

PATIENT SPECIFIC ALLEGATONS

Patient A

36. Patient A, a 47-year-old female, was self-referred to the Respondent on October 9, 1997. Patient A indicated, on a Patient History Sheet, that her chief complaints at the time were fatigue, fibromyalgia, headaches, and "sinuses". Patient A also indicated that her past medical history included: stomach problems, urinary tract infection, a thirty-five pound weight gain, hypoglycemia, insomnia, jaw surgery, breast biopsy, "tonsils", sinus surgery, depression, strep throat, back problems, arthritis, ear problems, chest pain and anxiety.

37. On October 15, 1997, the Respondent's assessment of Patient A included: CFS [chronic fatigue syndrome], fibromyalgia, migraine headaches, back pain and plantar fascitis. From October 17, 1997 through March 23, 2000, the Respondent treated Patient A for these and other medical conditions.

IMC Treatment

38. On May 12, 2000, Patient A completed an IMC Medical History Form (also the "history form"). The history form indicated that the Respondent referred Patient A to IMC.

39. On May 12, 2000 Patient A indicated on the history form that her medical history included allergies, frequent headaches, anxiety, sinus trouble, chest pain and past surgery.

40. Also on May 12, 2000, Patient A signed a consent form for photoluminescence[16]; the signature lines for the physician and nurse were left blank. The form reads as follows[17]:

Informed Consent for Photoluminescence

> I, [Patient A] wish to undergo Photoluminescence treatments and hereby grant authorization to Innovative Medical Clinics, Inc. to perform this treatment upon me [sic]
> I understand that these procedures will be formally explained to me. The treatment begins with a clinician inserting a needle into an arm vein (the gauge/size of the needle used will depend on the patency of the veins in my arm). Approximately 1.5 cc's of blood per pound of my body weight, but never more than 250 cc will be removed for irradiation. My blood will flow into a transfusion flask where it will be mixed with heparin[18], to prevent it from clotting; it will then pass through an irradiation chamber where it will be exposed to a controlled amount of ultraviolet energy. Once 250 cc of blood has been withdrawn the procedure is reversed and the blood is then returned to me, in a closed loop system, passing once more through the irradiation chamber and back into my vein. This procedure will take approximately one hour.
>
> I understand that there is a possibility of side effects, though infrequent and remote, that may be associated with these procedures. The side effects are usually, bleeding and/or bruising or a hematoma at the needle puncture site,

[16] The Respondent and others also refer to UBI as photoluminescence.
[17] The form is presented its entirety for Patient A. For the remaining patients it will be referred to as the Informed Consent for Photoluminescence.
[18] Heparin, a prescription medication, is an anticoagulant; an agent that thins blood.

low grade fever, clotting of the blood in the needle, cuvette and lines. There may be other side effects that I or the clinicians are unaware of.

I also understand that the efficacy of Photoluminescence has not been proven in controlled clinical tests as yet. I further understand that no one can guarantee me beneficial results in any manner; Furthermore, because this procedure is being offered to me under the condition that I release *Innovative Medical Clinics Inc.* from any legal responsibility for harm resulting from the use of this treatment my signature on this agreement will constitute a full and final release of legal responsibility resulting form the administration of Photoluminescence and/or and other medical treatment which may be necessary as a result thereof.
[Signed Patient A 5/12/00 – Physician and Nurse Signature lines are blank]

41. Patient A received six UBI treatments from May 12, 2000 through June 29, 2000 from Mr. Eberlin. Patient A was charged a total of $750.00 for the treatments.[19]

PATIENT B

42. Patient B, a 52-year-old female from Virginia Beach, Virginia, was referred to the Respondent by one of his other patients.

43. On July 18, 1995, Patient B completed the Patient History Sheet and indicated that her chief complaint was "severe chronic asthma". Patient B also indicated that her past medical history included: lung problems, stomach problems, [questionable] hiatal hernia, upper respiratory tract infections, weight gain, thyroid problems, high cholesterol, shortness of breath, past surgery (tonsillectomy, appendectomy, rectal fissure, and benign breast biopsy), depression, arthritis and sinus problems.

44. On July 18, 1995, the Respondent's note concerning his medical assessment of Patient B indicated that she had developed a chronic asthma/bronchitis condition, menopause, and depression. The Respondent also indicated Patient A had a thyroid problem since 1988 and a diagnosis of depression that was apparently due to side effects of Prednisone prescribed for the asthmatic/bronchitis condition.

[19] Not all the patient medical records contain billing information.

45. The Respondent's medical assessment of Patient B on that date included: chronic asthma and chronic obstructive pulmonary disease ("COPD"), FEV1 (measure of lung volume) last year was only 65%, hypothryoidism; postmenopausal, and suspected candidiasis (a fungal infection). The Respondent treated Patient B for these and other medical conditions from July 18, 1995 through June 4, 1996.

IMC Treatment

46. In April 1998, the Respondent referred Patient B to "IMC/Bill Eberlin" for UBI treatment.

47. On April 20, 1998, Patient B completed the IMC Medical History form. The history form indicated that the Respondent referred Patient B to IMC.

48. Patient B indicated on the IMC history form that she had multiple allergies, asthma, shortness of breath, chronic sinus trouble, swelling of neck muscles from Prednisone,[20] prolapsed bladder, wheezing and hypothyroidism.

49. Patient B signed the Informed Consent for Photoluminescence on April 20, 1998; the physician and nurse signature lines were left blank.

50. Patient B received two UBI treatments from Mr. Eberlin; on April 20, 1998 and June 1, 1998.

Patient C

51. Patient C, a 78-year-old female, was first seen by the Respondent on July 16, 1996. The Patient History Sheet indicated that Patient C's past medical history included "lung problems".

[20] Prednisone is a steroid; it is not clear from the history form or the medical records why Patient B was taking this medication.

52. On July 16, 1996, the Respondent's medical assessment of Patient C included: bronchiectasis, limitation of motion of the neck from a neck fracture, cold intolerance, rule out low thyroid, postmenopausal, and status post-hysterectomy since 1965. The Respondent treated Patient C for these and other medical conditions from July 16, 1996 through December 30, 1998.

IMC Treatment

53. On January 22, 1999, Patient C completed the IMC Medical History Form. The history form indicated that the Respondent referred Patient C to IMC.

54. Patient C indicated on the IMC history form that medical history included allergies, shortness of breath, sinus trouble, night urination and wheezing.

55. Patient C signed the Informed Consent for Photoluminescence on January 22, 1999; the doctor and nurse signature lines were left blank.

56. Patient C received 17 UBI treatments between January 22, 1999 and March 9, 2000 from Mr. Eberlin and Ms. K. G., another unlicensed individual.

57. Patient C's IMC/UBI treatment records include, in part, the following comments: January 22, 1999 treatment form indicates "heavy cough with thick yellowish, tenacious secretions...patient has difficulty breathing, very difficult vein to stick, cough heavily at times": July 1, 1999 "Rubber thing [sic] on NSS side was expulsed.[sic] Changed entire system, cuvette cleaned. Pt cannulated in the same spot right hand without problem"; March 9, 2000 Pt. fell at [illegible] hit head recommend she see Dr. for head exam."

58. There is no indication in the Respondent's medical records or the IMC records for Patient C that any physician was contacted for the symptomatology listed in paragraph 57 above.

Patient D

59. Patient D is a 30-year-old female who was first seen by the Respondent on January 27, 1999. The Patient History Sheet indicates that Patient D's chief complaints were: sore throat, sore neck, headaches, joint and muscular pain and a rash. Her past medical history included: stomach problems, urinary tract infection, upper respiratory tract infection, weight loss/gain, shortness of breath, sleeping problems, strep throat, fractures, headaches and past surgery.

60. On January 27, 1999, the Respondent's medical assessment of Patient D included: chronic rash; history compatible with Chronic Fatigue Syndrome; cold intolerance; rule out a low thyroid; history of constipation and suspected parasites. The Respondent treated Patient D for these and other medical conditions from January 27, 1999 through September 18, 2000.

61. On October 19, 1999, as documented in Patient D's medical record, the Respondent recommended "UBI four to six treatments for its antibacterial and yeast effect and to stimulate the immune system." The Respondent referred Patient D to IMC/William Eberlin for UBI treatments.

IMC Treatment

62. On November 6, 1999, Patient D completed the IMC Medical History Form. Patient D indicated that the Respondent referred her to IMC.

63. Patient D indicated in the IMC history form that her medical history included allergies, chest pain, and thyroid problems.

64. Also on November 6, 1999, Patient D completed the Informed Consent for Photoluminescence; the physician and nurse signature lines were left blank.

65. Patient D received approximately six UBI treatments from November 6, 1999 through February 12, 2000 from Mr. Eberlin.

66. During the February 5, 2000 UBI treatment, Patient D experienced a drop in blood pressure and dizziness. During the February 12, 2000 UBI treatment, Mr. Eberlin documented that Patient D felt faint when the "blood was being returned". The IMC notes do not indicate that a physician was contacted concerning the symptoms of hypotension and dizziness.

67. The Respondent's medical practice notes for Patient D indicate, on February 15, 2000, to "d/c UBI at this point." The Respondent's medical practice notes do not indicate, however, the patient's cardiovascular complications during the February 5, and 12, 2000 UBI treatments.

Patient E

68. Patient E, a 50-year-old female, was first seen by the Respondent on August 23, 1995. The Patient History sheet indicates that her chief complaint was a breast lump. Her past medical history included an upper respiratory tract infection.

According to the Respondent, Patient E was aware of the probable diagnosis of breast cancer and wanted an opinion from a physician specializing in "alternative" therapies.

69. Patient E was treated by the Respondent from August 1995 through July 24, 2002 for alternative nutritional and other non-conventional therapies for breast cancer and other medical conditions.

70. The Respondent noted in Patient E's medical practice record on October 22, 1999, to "consider UBI to help stimulate the immune system". On January 18, 2002, the Respondent noted in Patient E's medical record, "She is getting some UBI treatments which has also been giving her a little more energy."

IMC Treatment

71. On November 3, 1999, Patient E completed the IMC Medical History Form. Patient E indicated that the Respondent referred her to IMC and documented her medical history consisted of breast cancer.

72. On November 3, 1999, Patient E completed the IMC Informed Consent for Photoluminescence; the physician and nurse signature lines were left blank.

73. From November 3, 1999 through March 22, 2000, Patient E received approximately six UBI treatments from Mr. Eberlin.

Patient F

74. Patient F, a 73-year-old male, was first seen by the Respondent on July 29, 1999. Patient F's History Sheet indicates that his past medical history included: weight loss/gain, diabetes, history of drug/alcohol abuse, hypertension, chronic diarrhea, arthritis, recurrent muscle spasm, numbness in his right index toe area and a hip replacement.

75. On July 29, 1999, the Respondent's medical practice notes concerning Patient F indicate that he is interested in UBI treatments. The Respondent's medical practice notes for Patient F on July 29, 1999, do not contain a medical assessment, or any other indication for the treatment.

76. Patient F returned to the Respondent's medical practice on September 15, 1999. At that time, the Respondent included in his medical assessment of Patient F: mild peripheral neuropathy, rule out radiculopathy of the right leg, macrocytic anemia, chronic diarrhea and low back pain. The Respondent treated Patient F for these and other medical conditions from September 15, 1999 through October 9, 2002.

IMC Treatment

77. Patient F completed the IMC Medical History form on October 4, 1999. Patient F indicated that the Respondent referred him to IMC.

78. On October 4, 1999, Patient F's medical history included: high blood pressure, swelling of the ankles, trouble with urination and diabetes.

79. Also on October 4, 1999, Patient F completed the IMC Informed Consent for Photoluminescence form; the physician and nurse signature lines were left blank.

80. From October 4, 1999 through November 8, 1999, Patient F received four UBI treatments from Mr. Eberlin.[21]

81. Patient F was charged a total of $570.00 for the four UBI treatments. Patient F's IMC record includes a letter from a third party insurer requesting additional

[21] Patient F returned again to the Respondent's medical practice on October 6, 1999 complaining of, among other things, persistent diarrhea. With regard to the complaint, the Respondent recommended trying UBI treatments. Patient F already had a UBI treatment on October 4, 1999.

information concerning the "surgical services"[22] provided to Patient F from October 4, 1999 through November 8, 1999.

Patient G

82. Patient G, a 42-year-old female, was first seen by the Respondent on March 6, 1996. Patient G's Patient History Sheet indicates that her chief complaints were fatigue and weight gain. Her past medical history included: kidney problems, stomach problems, upper respiratory infection, weight loss/gain, sleeping problems, depression, strep throat, back problems, headaches, sinus problems, chest pains, anxiety and past nasal surgery.

83. On that date, the Respondent's medical assessment of Patient G included: low back pain, anxiety-depression, history of allergic rhinitis, rule out low adrenal [sic], cold intolerance, weight gain and rule out low thyroid levels. The Respondent treated Patient G for these and other medical conditions from March 6, 1998 through August 25, 2000.

84. On December 8, 1998, the Respondent's medical assessment of Patient G included: fibromyalgia, back pain, insomnia, CFS, and suspected mixed connective tissue disease. At that time, the Respondent's proposed treatment, among other things, was to consider UBI.

85. On January 12, 1999, the Respondent's medical assessment of Patient G included: joint pain, muscle pain, insomnia and chronic fatigue symptoms. The Respondent's proposed treatment, among other things, was to recommend UBI.

[22] Apparently this communication is in reference to a claim submission for UBI.

86. On October 18, 1999[23], the Respondent's medical assessment of Patient G was: connective tissue disease, low back pain, anxiety-depression, insomnia, symptoms of chronic fatigue syndrome [purportedly] diagnosed by an [unnamed rheumatologist]. His treatment plan included, among other things, "recommend UBI which may be helpful for her many symptoms". The Respondent had previously noted, on April 16, 1999, that Patient G had one UBI treatment and "felt worse the next day".

87. On November 5, 1999, the Respondent assessed Patient G and noted that she had one UBI treatment and would receive the second UBI treatment that day.

IMC Treatment

88. On March 13, 1999, Patient G completed the IMC Medical History Form. Patient G indicated that the Respondent referred her to IMC.

89. On that date, Patient G indicated that her medical history included: allergies, frequent sinus headaches, depression, rubella, sinus trouble, kidney/bladder infections, febrile seizures, hypothyroidism, stomach problems and past surgery.

90. Also on that date, Patient G signed the IMC Informed Consent for Photoluminescence; the physician and nurse signature lines were left blank.

91. Patient G received three UBI treatments from March 13, 1999 through January 6, 2000 from Mr. Eberlin.

Patient H

92. Patient H, a 52-year-old male, was first seen by the Respondent on April 11, 1995. Patient H's Patient History Sheet indicated that his past medical history included: stomach problems, venereal disease, thyroid problems, hypoglycemia, high

[23] Patient G had other visits with the Respondent in the interim from January 1999 until October 1999.

cholesterol problems, shortness of breath, sleeping problems, liver disease, depression, back problems, arthritis, ear problems, chest pains, colitis, and anxiety.

93. On April 11, 1995, the Respondent's medical assessment of Patient H included: hearing impaired, depression and that patient wanted to rule out lupus [an autoimmune disorder]. The Respondent treated Patient H for these and other medical conditions from April 11, 1995 until May 14, 2000.

94. On October 17, 1999, the Respondent noted in Patient H's medical record that he would "consider UBI treatment for history of hepatitis and also lethargy". Patient H had been recently diagnosed with Hepatitis B and Hepatitis C.

95. On March 3, 2000, the Respondent completed a prescription referral for Patient H to be treated by Mr. Eberlin at IMC.

96. On April 17, 2000, the Respondent noted in Patient H's medical record "[h]e's had [thirteen] UBI treatments which [have] improved his energy quite a bit and his mood."

IMC Treatment

97. On February 24, 2000, Patient H completed the IMC Patient History form. Patient H indicated that the Respondent referred him to IMC.

98. At that time, Patient H's medical history included: terrible feet pain, chronic fatigue syndrome, fibromyalgia, hepatitis, anxiety, allergies, nervous/emotional problems, shortness of breath, swelling of the ankles, trouble with urination, left side chest pain, kidney or bladder infections and past surgery.

99. Also on February 24, 2000, Patient H completed the IMC Informed Consent for Photoluminescence; the physician and nurse signature lines were left blank.

100. From February 24, 2000 through April 20, 2000, Patient H received fourteen UBI treatments from Mr. Eberlin.

101. IMC records revealed that Patient H was charged a total of $480.00 for six of the UBI treatments given from February 21, 2000 through March 16, 2000.

Patient I

102. Patient I, a 71-year-old female, was first seen by the Respondent on March 19, 1997. Patient I's History Sheet indicated that her chief complaints at that time were sinus and ear problems.

103. On March 19, 1997, the Respondent's medical assessment of Patient I included: mild sinusitis, cold extremities, rule out low thyroid [levels], hypolipidemia and post-menopausal. The Respondent treated Patient I for these and other medical conditions from March 19, 1997 through October 23, 2000.

IMC Treatment

104. On June 11, 2000, Patient I completed the IMC Medical history form. Patient I indicated that the Respondent referred her to IMC.

105. At that time, Patient I placed a question mark in the history form next to nervous or emotional problems and sinus trouble and did not indicate that she any other medical complaints or history.

106. Also on June 11, 2000, Patient I completed the IMC Informed Consent for Photoluminescence; the physician and nurse signature lines were left blank.

107. From June 11, 2000 through August 18, 2000, Patient I received three UBI treatments from Mr. Eberlin.

Patient J

108. Patient J, a 71-year-old male, was first seen by the Respondent on March 2, 1998. At that time Patient J's chief complaint was burning during urination.

109. On March 2, 1998, the Respondent's medical assessment of Patient J included: dysuria, weight gain, Benign Prostatic Hypertrophy, hearing loss and urinary tract infection. The Respondent treated Patient J for these and other medical conditions from March 2, 1998 through October 23, 2000.

IMC Treatment

110. On July 2, 2000, Patient J completed the IMC Medical History Form. Patient J indicated that the Respondent referred him to IMC.

111. At that time Patient J's noted his past medical history included: sinus trouble and urinating at night.

112. Also on July 2, 2000, Patient J completed the IMC Informed Consent for Photoluminescence the physician and nurse's signature lines were left blank.

113. From July 2, 2000 through July 15, 2000, Patient J received two UBI treatments from Mr. Eberlin.

Patient K

114. Patient K, a 40-year-old male, was first seen by the Respondent on October 18, 1995. At that time, Patient K indicated in the History Sheet that his chief complaints included: multiple sclerosis, sleeping problems and headaches.

115. On October 18, 1995, the Respondent's medical assessment of Patient K included: multiple sclerosis, headaches, cold intolerance and rule out low thyroid [levels]. The Respondent treated Patient K for these and other medical conditions from October 18, 1995 through October 24, 2000.

116. On October 5, 1999, the Respondent documented in Patient K's medical record, to "consider UBI".

117. On July 20, 2000, the Respondent noted in the medical record that Patient K had eight UBI treatments in April and May of that year. "He [the patient] claims it helped his eyesight and urination symptoms as well as cleared up some of the toenail fungus. It also gave him an increase in appetite. The only side effect was a slight rise in body temperature."

IMC TREATMENT

118. On March 29, 2000, Patient K completed the IMC Medical History form. Patient K indicated that the Respondent referred him to IMC.

119. At that time Patient K's medical history included: allergies, multiple sclerosis, migraines, trouble with urination and urinating at night.

120. Also on March 29, 2000, Patient K completed the IMC Informed Consent for Photoluminescence; the physician and nurse signature lines were left blank.

121. From March 29, 2000 through August 2, 2000, Patient K received nine UBI treatments from Mr. Eberlin.

Patient L

122. Patient L, a 56-year-old male, was first seen by the Respondent on June 19, 1992.

123. At that time, Patient L's chief complaint was arteriosclerosis. Patient L completed the Patient History Sheet and documented the following: heart disease, stomach problems, hiatal hernia, weight loss/gain, thyroid problems, diabetes, high cholesterol problems, shortness of breath, vascular disease, high blood pressure, arthritis, ear problems, anxiety and past surgery.

124. On June 19, 1992, the Respondent's medical assessment of Patient L is not apparent from the medical practice record. The Respondent saw Patient L on September 11, 1992, and February 5, 1993 and the medical assessments for these dates are not apparent in the medical practice record.

125. The Respondent saw Patient L on December 15, 1993 and his medical assessment of Patient L included: history of coronary artery disease, poor exercise [tolerance], rule out angina and history of hypothryoidism. The Respondent treated Patient L for these and other medical conditions from December 15, 1993 through May 24, 2000.

IMC Treatment

126. On July 5, 1999, Patient L completed the IMC Medical History Form. The form indicated that the Respondent referred Patient L to IMC.

127. On that date, Patient L listed the following medical history: allergies, nervous/emotional problems, shortness of breath, heart condition, thyroid problems and past surgery.

128. Also on July 5, 1999, Patient L completed the IMC Informed Consent for Photoluminescence form; the physician and nurse signature lines were left blank.

129. From July 5, 1999 through June 28, 2000, Patient L received seventeen UBI treatments from Mr. Eberlin.

130. As set forth herein in paragraphs 1 through 132, the Respondent practiced medicine with an unauthorized person and/or aided an unauthorized person in the practice of medicine in that, including, but not limited to, as the employed Medical Director of IMC he:

a) Directly or indirectly authorized Mr. Eberlin, a layperson, to perform UBI treatment on medically compromised individuals, with the knowledge that such treatment was the practice of medicine;

b) Directly or indirectly authorized Mr. Eberlin, a lay person, to perform on medically compromised individuals, physical examinations, take medical histories, and other such acts solely within the scope of the practice of medicine;

c) Directly or indirectly authorized Ms. G., a layperson, to assist with UBI treatments to medically compromised individuals.

131. As set forth herein, in paragraphs 1 through 133, the Respondent practiced medicine with an unauthorized person and/or aided and unauthorized person in the practice of medicine, in that he:

a) Knowingly referred medically compromised patients from his private medical practice to Mr. Eberlin, a lay person, for medical treatment with an illegal medical device;

b) Knowingly referred medically compromised patients from his private medical practice to Mr. Eberlin, a lay person, aware that Mr. Eberlin was not competent or certified in the performance of physical medical examinations, taking of medical histories and other actions within the scope of the practice of medicine.

132. As set forth herein in paragraphs 1 through 134 the Respondent's actions in their entirety constitute the incompetent practice of medicine.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes, as a matter of law, that the Respondent violated §§ H.O. 14-404(a) (4) and (18).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 26th day of April, 2004, by a quorum of the Board considering this case, hereby:

ORDERED, that the Respondent's license to practice medicine in the State of Maryland be and is hereby **SUSPENDED FOR TWO (2) YEARS** from the date of this Consent Order; and be it further

ORDERED that on the Respondent shall be on **PROBATION for a MINIMUM OF FIVE (5) YEARS, beginning the date the SUSPENSION is terminated and** shall continue until all of the following terms and conditions are met:

1. The Respondent shall submit to supervision of his medical practice as follows:

a. The Respondent's practice shall be subject to, at a minimum, annual peer review by an appropriate peer review entity, 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 of the Respondent's medical practice. The medical records to be reviewed in the chart or peer review shall consist of records documenting patient care provided.

b. The Respondent shall obtain a Board-approved physician-supervisor (the "physician-supervisor") who is Board-certified in family practice medicine to supervise his practice. The Respondent shall obtain prior approval from the Board of the physician-supervisor before entering into this supervisory arrangement. As part of the approval process, the Respondent shall provide the Board with the curriculum vitae and any other information requested by the Board regarding the qualifications of the practitioner who is submitted for approval. The supervisory arrangement shall continue for the duration of the Respondent's probationary period, subject to the following:

i. The physician-supervisor shall have no prior or current business, personal or financial relationship with the Respondent;

ii. The physician-supervisor shall notify the Board in writing of his/her acceptance of the supervisory role with the Respondent;

iii. The Respondent shall provide to the physician-supervisor a copy of the charging document, Consent Order, and any other documents that the Board deems relevant;

c. The Respondent shall meet with the physician-supervisor once per month for the term of Probation. The physician-supervisor shall randomly select a minimum of ten (10) patient records of the Respondent's patients and review and discuss with the Respondent his treatment plan, medical decision-making, and compliance with appropriate standards of care. The physician-supervisor shall review the patient records and discuss his/her assessment of the Respondent's practice performance with the Respondent.

d. The physician-supervisor shall submit written reports to the Board on a quarterly basis stating his/her assessment of the Respondent's compliance with appropriate standards of care and his medical judgment/decision making; and

2. The Respondent shall have sole responsibility for ensuring that the physician-supervisor submits the required quarterly reports to the Board in a timely manner; and it is further

ORDERED that the Respondent is assessed a FINE in the amount of Twenty Five Thousand Dollars ($25,000.00); and be it further

ORDERED that the Respondent shall hereby pay the Twenty-Five Thousand Dollars ($25,000.00) to the Board by certified check(s), payable to the Maryland State Board of Physicians, which shall be paid in full within one hundred-eighty (180) days of this Consent Order; and be it further

ORDERED that after the conclusion of the **FIVE (5) YEAR minimum** period of PROBATION, the Respondent may file a written petition for termination of his probationary status without further conditions or restrictions, but only if: the Respondent has satisfactorily complied with all conditions of this Consent Order, including all terms

and conditions of probation, including the expiration of the **FIVE (5) YEAR** minimum period of probation; there are no pending complaints regarding the Respondent before the Board; and the peer review and physician-supervisor findings are satisfactory to the Board, including findings in all cases that there were no violations of the standard of care, and that the peer review was performed in a timely manner; and be it further

ORDERED that there shall be no early termination of the **FIVE (5) YEAR** minimum probationary period; and be it further

ORDERED that the Respondent shall notify the Board, in writing, within five (5) calendar days of any change in business or home address; and be it further

ORDERED, that if the Respondent violates any of the terms and conditions of this Consent Order, the Board, in its discretion, after notice and a hearing, and a determination of the violation, may impose any other disciplinary sanctions it deems appropriate said violation being proven by a preponderance of the evidence; and be it further

ORDERED that pursuant to Md. State Gov't Code Ann. § 10-226 (c) and COMAR 10.32.02.05, 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 health safety or welfare by the Respondent; and be it further

ORDERED that the Respondent shall practice according to the Maryland Medical Practice Act and in accordance with all applicable laws, statutes, and regulations pertaining to the practice of medicine; and be it further

ORDERED that the Respondent shall be responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and be it further

ORDERED that this Consent Order is considered a **PUBLIC DOCUMENT** pursuant to Md. State Gov't. Code Ann. § 10-611 et seq. (1999).

4/28/09
Date

C. Irving Pinder, Jr.
Executive Director,
Maryland Board of Physicians

CONSENT

I, Paul V. Beals M.D., License No. D25922 by signing this Consent Order, consisting of thirty-three (33) pages, agree to be bound by the terms and conditions of the foregoing Consent Order. I acknowledge that I have read this Consent Order and that I have been notified of my right to consult with an attorney in the course of the Board's proceedings in relation to this Consent Order and that I have consulted with my attorney Alan Dumoff, Esquire.

I further acknowledge that, by signing this Consent Order, I admit to the findings of fact and conclusions of law and submit to its terms and conditions as a resolution of the Charges against me. By signing this Consent Order, I waive my right to contest the terms and findings herein and all challenges legal or otherwise to the proceedings before the Board.

I acknowledge the enforceability of this Consent Order as if it were made after a formal evidentiary hearing in which I would have the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other procedural protections to which I am entitled by law. I also recognize that I am waiving my right to appeal any adverse ruling of the Board that might have followed any such hearing and am also waiving any other legal remedies I may have regarding resolution of this matter.

I have had the opportunity to review this Consent Order and sign it voluntarily, understanding its terms, meaning and effect.

April 13, 2004
Date

Paul V. Beals, M.D.

Reviewed by: Alan Dumoff
Alan Dumoff, Esquire

NOTARY

STATE OF MARYLAND

CITY/COUNTY OF _____

I HEREBY CERTIFY that on this _____ day of _____, 2004, before me, Notary Public of the State and City/County aforesaid, personally appeared Paul V. Beals, M.D. 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.

_____
Notary Public

My Commission Expires: _____

I have had the opportunity to review this Consent Order and sign it voluntarily, understanding its terms, meaning and effect.

4/14/04
Date

Paul V. Beals, M.D.

Reviewed by: _____
Alan Dumoff, Esquire

NOTARY

STATE OF MARYLAND

CITY/COUNTY OF Prince George's

I HEREBY CERTIFY that on this 14th day of April, 2004, before me, Notary Public of the State and City/County aforesaid, personally appeared Paul V. Beals, M.D. 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.

Lynn M Quelley
Notary Public

My Commission Expires: 5/1/2005