IN THE MATTER OF	*	**BEFORE THE MARYLAND**
JORGE C. SRABSTEIN, M.D.	*	**STATE BOARD OF**
Respondent	*	**PHYSICIANS**
License Number: D27082	*	**Case Number: 2015-0298B**

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CONSENT ORDER

On January 14, 2016, Disciplinary Panel B of the Maryland State Board of Physicians (the "Board") charged Jorge C. Srabstein, M.D. (the "Respondent"), License Number D27082, with violating the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") § 14-404(a) (2014 Repl. Vol.).

The pertinent provision of the Act provides:

> (a) *In general.* -- Subject to the hearing provisions of § 14-405 of this subtitle, a disciplinary panel, on the affirmative vote of a majority of the quorum of the disciplinary panel, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
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> ...
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> (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;
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> ...
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review[.]

On February 24, 2016, Disciplinary Panel B was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations

occurring as a result of this DCCR, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law, and Order.

I. FINDINGS OF FACT

Disciplinary Panel B finds:

BACKGROUND

1. At all times relevant to these charges, the Respondent was a physician licensed to practice medicine in the State of Maryland. The Respondent was initially licensed in Maryland on or about September 10, 1981, and he is presently licensed through September 30, 2017.

2. The Respondent is board-certified in psychiatry, child psychiatry and pediatric medicine. At all times relevant to these charges he maintained a private practice in Germantown, Maryland.

3. The Respondent holds active medical licenses in the District of Columbia (through December 2016) and Virginia (through October 2016).

4. On or about October 22, 2014, the Board received a complaint from a former patient of the Respondent ("Patient A") who alleged the Respondent had breached confidentiality by seeing four family members for "family therapy," failed to maintain adequate records and inflated his billing by seeing each patient subsequent to the other.[1]

5. After receiving the complaint, the Board initiated an investigation of the Respondent's practice.

[1] The Board's investigation did not support the allegations as specifically cited in the complaint, but did support recordkeeping deficiencies, as set forth below.

6. On or about November 14, 2014, Board staff provided the Respondent with a copy of Patient A's complaint, and notified the Respondent of its investigation, providing the opportunity for the Respondent to respond to the allegations.

7. On or about December 1, 2014, the Respondent submitted a written response to Patient A's allegations.

8. In furtherance of its investigation, Board staff transmitted four patient records (the records of Patient A and three family members) and relevant investigative documents to two peer reviewers board-certified in psychiatry (one reviewer is also board-certified in child and adolescent psychiatry), for the purpose of conducting a peer review. The results of the peer review are set forth below.

9. On or about September 8, 2015, the peer reviewers submitted their peer review reports to the Board.

10. On or about September 9, 2015, Board staff sent the Respondent copies of redacted peer review reports, providing him with an opportunity to file a supplemental response to the allegations.

11. On or about September 25, 2015, the Respondent filed a supplemental response to the peer review reports in which he disagreed with the peer reviewers' opinions relating to substandard quality care and inadequate recordkeeping.

PATIENT-RELATED FINDINGS

Patients A through C are members of the same family:

PATIENT A

12. Patient A was a male in his 40s when he was initially evaluated by the Respondent in September 2002 for symptoms of a mood disorder. Prior to seeing the

Respondent, Patient A had been treated by a previous psychiatrist, and had been diagnosed with bipolar disorder II. He had a history of substance abuse. Additionally, he had two family members with documented psychiatric issues (Patients B and C).

13. During Patient A's intake appointment with the Respondent, he had just been discharged from an 8-day inpatient hospitalization for suicidal ideation, acute depression, anhedonia, hopelessness, racing thoughts and poor focus. His medications included Effexor,[2] Wellbutrin SR,[3] and subsequently Seroquel.[4]

14. Shortly after he began seeing the Respondent, Patient A's Seroquel was discontinued after he experienced "dizziness and confusion" in September 2002, that led to an emergency room visit.

15. The Respondent diagnosed Patient A with a mood disorder, not otherwise specified. The standard of quality care for treatment of a mood disorder not otherwise specified ("NOS") as opposed to bipolar II disorder differs with regard to therapy and medications.

16. Patient A saw the Respondent for medication management and family therapy through 2010.[5] Initially, the Respondent saw Patient A for medication management weekly[6] and gradually over time, he saw Patient A every one to two months.

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[2] An antidepressant.
[3] A sustained release antidepressant.
[4] An antipsychotic used in the treatment of bipolar disorder and depression.
[5] The Respondent did not conduct individual psychotherapy with Patient A and did not document any communication with any therapists Patient A might have seen. In his December 1, 2014 written response to the Board he stated that Patient A received individual therapy through an outpatient facility that was not part of the Respondent's practice, but he had failed to note this in Patient A's record.
[6] According to the Respondent's December 1, 2014 written response to the Board, the length of the medication management visits were approximately 15 to 20 minutes in length.

17. In July 2003, Patient A consulted with a second psychiatrist, who diagnosed him with bipolar II disorder. The second psychiatrist recommended Depakote,[7] and the Respondent started him on this medication with improvement noted.

18. For the next few years, the Respondent changed Patient A's medications frequently. The medications, besides those noted in ¶¶ 13 and 17, although not all prescribed simultaneously included: Topamax,[8] Risperdal,[9] Paxil,[10] Zoloft,[11] Tofranil,[12] trazadone,[13] Lamictal,[14] Geodon and Zyprexa.[15]

19. Until approximately 2004 or 2005, the Respondent's prescribing of medications and dosages varied frequently and often he failed to provide justification for changing Patient A's medications.

20. From approximately 2005 through 2008, the Respondent consistently continued prescribing Lamictal, Wellbutrin and trazadone.

21. Around 2008 Patient A was diagnosed with colon cancer, and in 2009, with HIV, which led to acute reactive depression and attempted suicide by overdose. The Respondent prescribed Risperdal, but Patient A did not take it.

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[7] A mood stabilizer.
[8] Used in the treatment of bipolar disorder and cluster headaches.
[9] Used in the treatment of schizophrenia, bipolar disorder, and irritability caused by autism.
[10] Selective serotonin reuptake inhibitor (SSRI) used in the treatment of depression, anxiety disorders, and obsessive-compulsive disorder ("OCD").
[11] An SSRI used in the treatment of OCD, posttraumatic stress disorder ("PTSD") anxiety and panic disorders.
[12] An antidepressant.
[13] An antidepressant and sedative/
[14] A mood stabilizer used in the treatment of bipolar disorder.
[15] Geodon and Zyprexa are antipsychotic medications most commonly used in the treatment of bipolar and schizoaffective disorders.

22. In November 2009, the Respondent briefly prescribed Ritalin[16] to Patient A for fatigue or concentration issues.

23. Patient A saw the Respondent less frequently between November 2009 and Spring of 2010, and in May 2010 he told the Respondent he had switched to another provider.

24. On May 4, 2010, the Respondent documented that Patient A would be continuing care with another provider.

25. The Respondent's documentation of his care and treatment of Patient A was largely illegible.

26. The Respondent's recordkeeping was inadequate for Patient A constituting evidence of violations of Health Occ. § 14-404(a)(40), for reasons including but not limited to the following:

a. The Respondent failed to adequately document Patient A's differential diagnoses in order to clarify Patient A as bipolar;
b. Other than the initial intake note, the Respondent failed to adequately document follow-up with Patient A's history of substance abuse;
c. The Respondent failed to adequately document issues relating to Patient A's medical status after he was diagnosed with cancer and HIV;
d. The Respondent inadequately documented Patient A's mental status exams, pertinent psychiatric review of symptoms and safety concerns;
e. The Respondent failed to document adequate justification of Patient A's frequent medication changes (especially during the first two years of treatment);
f. The Respondent treated Patient A with almost exclusively medication management, and did not provide him with individual therapy, nor did he document any communication with any therapists of Patient A; and/or
g. The Respondent's progress notes were largely illegible.

[16] Ritalin is a Schedule II CDS (stimulant) used in the treatment of ADHD.

PATIENT B

27. Patient B, a female, was a child below the age of 13 when she began seeing the Respondent for psychiatric care in August 2002. Patient B had been seen by a prior psychiatrist and had a history of ADHD, mood instability, irritability, depression, aggressive behavior and a decline in academic performance. She had been prescribed Neurontin[17] and Risperdal by her former psychiatrist.

28. The Respondent initially diagnosed Patient B with a mood disorder N.O.S. The Respondent did not document a systematic review of systems to screen for psychotic symptoms or delusions, whether there was more of an Axis II component to Patient B's behaviors,[18] whether situational stressors were exacerbating or leading to Patient B's symptoms or learning disorder issues.

29. The Respondent's documentation of Patient B's records was largely illegible.

30. The Respondent treated Patient B from 2002 through August 2004, and resumed psychiatric care again for Patient B from 2008 through 2012.

31. The Respondent failed to document adequate psychotherapeutic considerations for Patient B.

32. Initially, the Respondent changed Patient B's Neurontin to Topamax and increased her Risperdal. Subsequently, he added Adderall XR.[19]

33. In December 2002, the Respondent switched Patient B's Risperdal to Seroquel due to suicidal ideation, ongoing aggressive behavior, poor relatedness and weight gain.

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[17] Used in the treatment of nerve pain.
[18] Axis II disorders include personality and intellectual disorders.
[19] Schedule II amphetamine used in the treatment of ADHD.

34. In February 2003, Patient B's aggressiveness persisted, and the Respondent switched Patient B's Seroquel prescription to Geodon.

35. In May 2003, the Respondent added Zoloft to Patient B's medications due to ongoing aggression and irritability she exhibited.

36. In August 2003 a deterioration of Patient B's clinical condition and increased aggression led to a brief in-patient hospitalization. Patient B was discharged on Geodon, Zoloft and Topamax, and Trazadone was added for sleep.

37. Over the next few months, the Respondent increased the dosages of Geodon and Zoloft with no real change.

38. In July 2004, the Respondent documented in a letter that Patient B exhibited symptoms of a pervasive developmental disorder ("PDD"), possibly a schizoaffective disorder and an attention deficit hyperactivity disorder ("ADHD"). [20]

39. In September 2004, Patient B was admitted to a residential facility for deterioration of her clinical condition, and was treated with Abilify,[21] Adderall, Zoloft, Trazadone and individual and group therapy.

40. In May 2008, the Respondent resumed his treatment of Patient B for mood disorder N.O.S. In December 2008, the Respondent increased Patient B's Abilify when Patient B reported her nightmares had increased.

41. In February 2009, the Respondent added Topamax when Patient B reported she had trouble keeping up with her schoolwork and ongoing nightmares.

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[20] The Respondent did not address the diagnoses of PDD or schizoaffective disorder elsewhere in Patient B's record. Additionally, although the Respondent treated Patient B for ADHD, there were no standardized reports from teachers in the file to address this issue.

[21] Antipsychotic used in the treatment of bipolar and schizoaffective disorders.

42. In October 2009, Patient B reported worsening depression and deteriorating self-care. The Respondent increased the dosages of all of her medications: Topamax, Zoloft and Abilify. The Respondent did not note much change in Patient B's condition after he increased Patient B's medications.

43. In March 2010, the Respondent switched Patient B's Topamax to Lamictal and increased her Adderall.

44. The Respondent increased Patient B's Lamictal over the next few months. The Respondent did not note much change over the next few months other than Patient B's affect which moved from 'flat' to 'appropriate' to 'detached.'

45. By February 2012, Patient B's medications were Zoloft, Adderall, Abilify, Lamictal and Trazadone. Patient B complained of flashbacks and nightmares.

46. In March 2012, the Respondent increased Patient B's Lamictal from 150 to 175 mg and the next month, the Respondent closed his office and transferred Patient B to a new provider.

47. The Respondent failed to document that during Patient B's treatment she had received individual psychotherapy.

48. The Respondent provided medication management visits for Patient B of 15 to 20 minutes duration and occasional family medical psychotherapy.[22] There was no documentation that the Respondent had provided any individual therapy to Patient B, nor was there support in Patient B's record that the Respondent had communicated with Patient B's psychotherapist.

[22] The Respondent billed for family medicine sessions every one to three weeks, but they were not consistently documented in Patient B's progress notes.

49. The Respondent's recordkeeping was inadequate for Patient B constituting evidence of violations of Health Occ. § 14-404(a)(40), for reasons including but not limited to the following:

a. The Respondent failed to adequately document differential diagnoses;
b. The Respondent failed to adequately document symptom screening;
c. The Respondent failed to adequately document mental status examinations or provide adequate information for psychiatric evaluations;
d. The Respondent failed to adequately evaluate and document individual psychotherapy considerations for Patient B. The Respondent's treatment of Patient B was almost exclusively medication management, with several sessions of undocumented family therapy;
e. The Respondent failed to include documentation from Patient B's school staff regarding her ADHD symptoms;
e. The Respondent failed to adequately document the justification for changing medications frequently for Patient B;
f. The Respondent's recordkeeping was partially illegible; and/or
g. The Respondent failed to adequately document the etiology/significance of Patient B's nightmares and flashbacks.

PATIENT C

50. Patient C, a male, was under 10 when he began seeing the Respondent for psychiatric care in September 2002. He had a history of speech and language insomnia, significant temper tantrums, impulsivity, aggression, and periods of high energy intertwined with fatigue. Patient C had been previously treated by another psychiatrist, and medicated with Depakote, Zyprexa and Adderall XR, for diagnoses of a mood disorder and ADHD.

51. The Respondent documented consistently that Patient C had poor eye contact and social relatedness issues, which are symptoms of an autistic spectrum disorder.

52. The standard of quality care for ADHD includes but is not limited to a combination of therapy along with medication management. The standard of quality

care requires that effectiveness of treatment should be monitored by both parents and teacher reports, using standardized assessments.

53. There were no reports from Patient C's school in his record monitoring the effectiveness of his treatment for ADHD.

54. The Respondent did not refer or document that he gave consideration to referring Patient C for a neuropsychological evaluation.

55. The standard of quality care for mood disorders includes but is not limited to therapy and medication management that targets specific symptoms. Medication and dosages should be the least possible to achieve therapeutic benefit. If inconsistent or limited benefits are seen despite multiple medication trials, consideration of alternate diagnoses should occur.

56. The Respondent's documented progress notes for Patient C were largely illegible.

57. The Respondent provided medication management every one to four weeks, and occasional family medical family psychotherapy for Patient C from October 2002 through July 2009. At different times during that period, the Respondent prescribed to Patient C: Prozac; Wellbutrin; Adderall XR; Concerta;[23] Depakote; risperidone (brand name Risperdal); Cogentin;[24] Ability; Zyprexa; Geodon and Topamax.

58. The Respondent frequently changed Patient C's medications as often as one to four times monthly depending on Patient C's presenting symptoms, which most commonly were sleep issues and irritability.

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[23] Schedule II CDS used in the treatment of ADHD.
[24] Used in the treatment of schizophrenia.

59. The Respondent submitted billing for family therapy sessions; however, these visits were not consistently documented in Patient C's record.

60. In 2009, Patient C was admitted to an inpatient residential facility because of his "inability to attend regular classes" according to the Respondent, and discharged from the Respondent's care.

61. The Respondent's recordkeeping was inadequate for Patient C constituting evidence of violations of Health Occ. § 14-404(a)(40), for reasons including but not limited to the following:

a. The Respondent failed to conduct an adequate diagnostic differential and symptom screening for Patient C;
b. The Respondent failed to adequately document mental status examinations, comprehensive system screening, review of systems;
c. The Respondent failed to adequately evaluate Patient C for ADHD to include but not limited to obtaining corroborative information from school staff and/or referring Patient C for a neuropsychological evaluation;
d. The Respondent inadequately documented psychosocial stressors affecting Patient C and/or therapy interventions instituted throughout his care;
e. The Respondent changed Patient C's medications and dosages frequently without documenting an adequate justification for doing so;
f. The Respondent consistently prescribed to Patient C multiple medications, and failed to wean Patient C off the medications to determine if any were exacerbating his symptoms; and/or
g. The Respondent's handwriting is partially illegible.

II. CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, Disciplinary Panel B concludes as a matter of law that the Respondent's actions and inactions constitute violations of Health Occ. § 14-404(a) (40). The Health Occ. § 14-404(a) (22) charge is dismissed.

III. ORDER

It is, on the affirmative vote of a majority of the quorum of Board Disciplinary Panel B hereby:

ORDERED that the Respondent is reprimanded; and it is further

ORDERED that within **SIX (6) MONTHS** of the date of this Consent Order, the Respondent shall successfully complete a Board-approved comprehensive course in documentation. The Respondent shall ensure that the Board through the Probation Unit receives confirmation of successful course completion. The course shall not count toward the Respondent's requirements for continuing medical education for licensure; and it is further

ORDERED that if the Respondent fails to comply with any of the terms and conditions of this Consent Order, the Board or Disciplinary Panel, in its discretion, after notice and opportunity for a show cause hearing before the Board or Disciplinary Panel if there is no genuine dispute as to material fact or an evidentiary hearing at the Office of Administrative Hearings, may impose additional sanctions authorized under the Medical Practice Act, including a reprimand, suspension, probation, revocation and/or a monetary fine; and it is further

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

ORDERED that this Consent Order shall be a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Prov. §§ 4-101-4-601 (2014).

03/07/2016
Date

Christine A. Farrelly
Christine A. Farrelly, Executive Director
Maryland State Board of Physicians

CONSENT

I, Jorge C. Srabstein, M.D., acknowledge that I am represented by counsel and have consulted with counsel before entering into this Consent Order. By this Consent and for the sole purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that I might have filed after any such hearing.

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

3/1/16
Date

Jorge C. Srabstein, M.D.

DISTRICT OF COLUMBIA

~~**STATE OF MARYLAND**~~

CITY/~~COUNTY OF~~: WASHINGTON

I HEREBY CERTIFY that on this 1st day of March, 2016, before me, a Notary Public of the State and County aforesaid, personally appeared Jorge C. Srabstein, M.D., and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

E. A. Fay

Notary Public

My commission expires:

ERIN FAY
NOTARY PUBLIC DISTRICT OF COLUMBIA
My Commission Expires August 14, 2017