IN THE MATTER OF	*	**BEFORE THE MARYLAND**
STEVEN A. POLAKOFF, M.D.	*	**STATE BOARD OF**
RESPONDENT	*	**PHYSICIANS**
License Number: D35104	*	**Case Number: 2218-0136 A**

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CONSENT ORDER

On February 20, 2019, Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board"), charged **Steven A. Polakoff, M.D.** (the "Respondent"), License Number D35104, under the Maryland Medical Practice Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") § 14-404 (2014 Repl. Vol. and 2018 Supp.).

The pertinent provisions of the Act provide the following:

Health Occ. § 14-404. Denials, reprimands, suspensions, and revocations -- Grounds.

(a) 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:

(3) Is guilty of:

. . .

(ii) Unprofessional conduct in the practice of medicine;

(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;

(40) Fails to keep adequate medical records as determined by appropriate peer review[.]

Further, the American Medical Association ("AMA") Code of Medical Ethics provides in pertinent part:

> **Opinion 8.19 – Self-Treatment or Treatment of Immediate Family Members**
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> Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member. . . . When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.
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> Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. . . . Likewise, physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.
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> . . . In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short term, minor problems. Except in emergencies, it is not appropriate for physicians

to write prescriptions for controlled substances for themselves or immediate family members.

On May 8, 2019, Panel A was convened as a Disciplinary Committee for Case Resolution ("DCCR") in this matter. Based on negotiations occurring because of the DCCR, Respondent agreed to enter this Consent Order, consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

Panel A makes the following findings of fact.

I. Background

1. At all times relevant to the charges, Respondent was and is a physician licensed to practice medicine in the State of Maryland. Respondent was initially licensed in Maryland on May 8, 1987. Respondent last renewed his license on or about July 18, 2017, which will expire on September 30, 2019.

2. On March 31, 1994, Respondent was board-certified by the American Board of Psychiatry and Neurology in Psychiatry, which expired on December 31, 2004. On April 11, 2005, Respondent was re-certified in Psychiatry, which expired on December 31, 2015.

3. Respondent also holds an active license to practice medicine in Washington, D.C. Respondent maintains an office-based solo practice of Psychiatry and Geriatric Psychiatry in Montgomery County, Maryland.

II. Complaint

4. On December 4, 2017, the Board received a written complaint from

the father of one of Respondent's patients ("Patient 9[1]"). The Complainant alleged that Respondent had been overprescribing amphetamines, a controlled dangerous substance ("CDS"), to Patient 9, who resided out-of- state, without "meaningful contact", resulting in a psychotic episode with suicidal ideation. Patient 9 overdosed on amphetamines and was hospitalized.

III. Investigation

5. On January 12, 2018, the Board sent a subpoena to the Prescription Drug Monitoring Program ("PDMP") for a computer-generated printout of all CDS written by Respondent from July 1, 2016 to January 10, 2018 (the "drug surveys").

6. Based on the drug surveys received from the PDMP, Board investigative staff selected the names of ten (10) patients, which included Patient 9.

7. On February 1, 2018, the Board sent a letter to Respondent, notifying Respondent of the Board's full investigation and requesting a written response to the complaint. The Board enclosed subpoenas for complete medical records of the ten patients and requested that Respondent provide summaries of the care he provided to each patient.

8. On February 7, 2018, Respondent submitted correspondence to the Board stating that he has no patient file or records for one of the ten patients, who is a family member ("Family Member A"). Respondent stated that Family

[1] The names of patients are confidential and are not provided in the Consent Order. Respondent was provided with a Confidential Patient Identification List.

Member A has a brain tumor that was diagnosed in 2014, adding, "Due to the complexities of [Family Member A's] treatment and the multiple changes in medication, [Family Member A's] prescriptions expire at various times. Over time I have filled the prescriptions that were originated by the providers at [Hospital A[2]], mainly at [Pharmacy A]." Respondent denied initiating any new medications and stated that the prescriptions provided were with the knowledge of and in consultation with Family Member A's primary care providers at Hospital A and that documentation of prescriptions and related consultations should be in Family Member A's records at Hospital A.

9. On February 26, 2018, the Board received Respondent's written response wherein he responded to the allegations of the complaint, stating among other things, that he has treated Patient 9 intermittently over 15 years and he had no reason to suspect that she misunderstood the way the medications should be taken or that she may have been abusing them.

10. On February 26, 2018, the Board received nine medical records and Respondent's summaries of care for the nine patients.

11. On May 15, 2018, Respondent was interviewed, under oath, by Board investigative staff and stated the following:

a. He has been prescribing to Family member A since at least 2015 and perhaps in 2014 when the first operation was performed. Since he has received this notice of the complaint, he has not prescribed any CDS for Family Member A, who is very ill with a brain tumor;

[2] The names of institutions and facilities are not disclosed in the Consent Order. Respondent is aware of the identity of the hospital and the pharmacy.

b. He named two doctors at Hospital A who serve as Family Member A's PCP. Family Member A sees them monthly or bimonthly and he would go with Family Member A to these visits, "and it was explicitly stated that I was refilling the ongoing prescriptions in [Pharmacy A];"

c. He confirmed that he has never initiated a new prescription. He noted that Family Member A takes benzodiazepines for anxiety (rather than seizures). He said that he did not maintain office records on Family Member A because he was not Family Member A's treating doctor. He referenced refilling prescriptions "rather than chase after the people at Hospital A;"

d. He did not state who diagnosed Family Member A with anxiety and whether Family Member A is under the care of a psychiatrist other than Respondent; and

e. He denied issuing prescriptions for CDS for himself or other family members, aside from Family Member A.

12. On June 21, 2018, the Board transmitted the complaint, Respondent's response, the drug surveys, nine summaries of care, nine medical records, and the transcript of the interview of Respondent to an independent peer review entity, requesting that a peer review be conducted by two physicians who are board-certified in psychiatry.

13. On August 15, 2018, the Board received the peer review reports. The peer reviewers concurred that in eight of the nine cases reviewed, Respondent failed to meet the appropriate standards for the delivery of quality medical care; and in nine of the nine cases, Respondent failed to keep adequate medical records.

14. On August 16, 2018, the Board sent correspondence to Respondent with redacted copies of the peer review reports, requesting a Supplemental Response.

15. On September 5, 2018, the Board received Respondent's Supplemental Response wherein he acknowledged that he has implemented the following changes in his practice:

a. He is using standardized templates to include the required elements;

b. He is using a medication log to record prescriptions, instructions at time of visit, and for refills between visits; and

c. He now requires office visits every three months for patients whose care involves the regular use of stimulants or benzodiazepines.

16. Respondent also discussed his treatment of anxiety disorders and his use of benzodiazepines, in general, and also responded to the comments of the reviewers in regard to each of the nine patients.

17. The Respondent's supplemental response was subsequently reviewed by the two peer reviewers, prior to the issuance of Charges.

IV. Summary of Allegations of Failure to Meet Standards of Quality Care and Inadequate Documentation[3]

18. Respondent failed to meet standards of quality care in his care and treatment of eight of the nine patients reviewed and failed to maintain adequate documentation regarding nine of the patients reviewed for the following reasons:

a. Documentation Deficiencies

i. Respondent's medical records, which are handwritten, are

[3] Both of the peer reviewers wrote a synopsis of care that Respondent provided to each of the nine patients, based on their review of Respondent's medical records. The peer reviewers also provided specific examples of failure to meet appropriate standards and failure to keep adequate records for each patient. This was set forth in the two peer review reports which had previously been provided to Respondent. The peer review reports constituted additional documentary and testimonial evidence, to be offered against Respondent in connection with the charges.

only approximately 80% legible;

ii. Respondent did not indicate the type of patient encounter (i.e. Initial assessment, follow-up visit, telephone contact, refill called in)

iii. Respondent did not provide patients' identifying information on individual pages of the record;

iv. Respondent often omits the year in documenting the date of appointment;

v. Respondent did not document the amount of time spent in appointments;

vi. Respondent did not document when the next follow-up visit should occur; and

vii. Respondent did not sign his notes.

b. Clinical Content of Documentation:

i. Respondent failed to obtain and document a clinical history;

ii. Respondent's notes are generally quite brief, quite sketchy, and contain little detail. They usually contain little or no interim history and little or no information about social, occupational or relationship status or functioning. Some are so brief as to be essentially meaningless;

iii. Respondent failed to document a regular clinical assessment. The history section of the progress notes was largely followed by prescriptions without a notation of what Respondent thought the clinical assessment was and why the changes, or ongoing medications, were indicated;

iv. Respondent failed to perform mental status examinations other than at the initial psychiatric evaluation. Most notes, which are apparently follow-up visits, do not document the patients' mental status examination at the time of the appointment;

v. Respondent mentions diagnoses in some notes, but most notes do not indicate Respondent's diagnostic impressions or working diagnosis, which should be in every note;

vi. Respondent failed to adequately assess suicidality, an essential task of a psychiatrist;

vii. Respondent failed to assess bipolarity. This is important as the use of antidepressants can severely negatively impact the clinical course of this disease;

viii. Failed to take vital signs despite use of stimulant medications, and/or failed to document coordination with the patients' family doctor in obtaining vital signs;

ix. Failed to obtain adequate laboratory monitoring for metabolic syndrome, despite use of second-generation antipsychotics; and
x. Failed to document that he was monitoring for tardive dyskinesia in patients who were on antipsychotics.

c. Documentation of Prescriptions:

i. Respondent nearly always abbreviates the name of the medication and the medication is often not identifiable from the abbreviation (i.e., "Dex" could be any number of stimulant preparations);
ii. Respondent did not document the tablet/capsule strength or include units (i.e., mg, micrograms);
iii. Respondent did not clearly indicate the number of refills. Some medications entries include "x 2" or "x 3," which likely represent number of refills. Prescription records do not include the directions for taking the medications being prescribed; and
iv. Respondent did not adequately document patients' medication regimens. Many progress notes have lists of medications (names abbreviated) that look like records of prescriptions, but in the progress notes, it is often impossible to tell exactly what medications the patient should be taking.

d. Prescribing Practices

i. Respondent's "overall prescribing practices" fall outside of usual community practices because of the extreme frequency with which unusual combinations of controlled substances are prescribed. All but two of the nine cases reviewed exemplify this. The most common situation is prescribing a combination of a benzodiazepine (sedative) medication and an amphetamine (methylphenidate or modafinil) (stimulants) simultaneously. These drugs should only rarely be prescribed together as they have opposite physiological effects and in effect work at cross purposes. The prescription of several agents in the same class is also unusual and the more appropriate practice is to select one agent from a pharmaceutical class and increase the dose to achieve maximum efficacy;

ii. Respondent's records do not document a justification for these medication combinations, and whether patients were using controlled substances as performance enhancers. Review of the PDMP report shows that numerous other patients whose medical records were not reviewed were prescribed a combination of sedative and stimulant medications; and

iii. Respondent's records document that controlled substances were prescribed in high amounts with inadequate assessments of the patients, who were sometimes prescribed controlled substances for years without being seen. Patient 3, whose last recorded appointment with Respondent was in 2015, received 26 additional prescriptions for methyl-phenidate over the next two years with no documentation of any contact. Respondent's contact with Patient 9 were by intermittent telephone calls.

V. Findings of Unprofessional Conduct Regarding Family Member A

19. A review of the PDMP regarding Respondent's prescribing for Family Member A reveals the following:

a. Respondent prescribed Clonazepam[4], Lorazepam[5], Onfi[6] (clobazam), and Vimpat (lacosamide[7]) repeatedly;

b. Respondent prescribed Clonazepam, up to 270 tablets at a time, from at least August 5, 2016 to January 8, 2018;

c. Respondent issued a total number of 40 prescriptions for CDS, which were issued almost monthly; and

d. Respondent prescribed 30 tablets of oxycodone[8] on November 12, 2017.

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[4] Clonazepam, a Schedule IV CDS, is the generic form of the brand-name drug Klonopin, prescribed to treat seizures and panic attacks.

[5] Lorazepam, a Schedule IV CDS, is the generic form of the brand-name drug Ativan, a benzodiazepine medication. It is used to treat anxiety disorders, trouble sleeping, active seizures including status epilepticus.

[6] Onfi, a Schedule IV CDS, is indicated to treat seizures.

[7] Lacosamide, a Schedule V CDS, is indicated for the treatment of partial seizures.

[8] Oxycodone, a Schedule II CDS, is an opiate.

20. Respondent, by prescribing medications for Family Member A engaged in unprofessional conduct in the practice of medicine because:

a. Objectivity is compromised when Respondent is treating a member of his own family;

b. Quality of care is diminished when treating a family member;

c. Physician/patient confidentiality is impacted because family members do not have the opportunity to discuss alternative treatment and make private disclosures such as psychosocial and personal stressors, mood difficulties, substance/alcohol abuse, and dietary intake that otherwise would be made to a primary psychiatrist or primary care physician to whom they are not related;

d. Family members' ability to give meaningful informed consent is limited because family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending Respondent;

e. Family members are placed in a position of dependence on Respondent to continue to prescribe their medications;

f. Respondent may be inclined to treat problems that are beyond his expertise or training; and

g. Respondent failed to maintain documentation of the prescriptions he was writing for Family Member A and the medical indication for each.

CONCLUSIONS OF LAW

Panel A concludes that Respondent is guilty of unprofessional conduct in the practice of medicine, in violation of Health Occ. § 14-404(a)(3)(ii); failed to meet standards of quality medical care in this State, in violation of Health Occ. § 14-404(a)(22); and failed to keep adequate records, in violation of Health Occ. § 14-404(a)(40).

ORDER

It is, by Disciplinary Panel A, hereby

ORDERED that Respondent is **REPRIMANDED;** and it is further

ORDERED that Respondent shall not apply to renew his license to practice medicine in Maryland, and, after his current license to practice medicine in Maryland has expired, Respondent shall not apply for the reinstatement of his license; and it is further

ORDERED that, if Respondent allegedly fails to comply with any term or condition imposed in this Consent Order, Respondent shall be given notice and an opportunity for a hearing. If there is a genuine dispute as to a material fact, the hearing shall be before an Administrative Law Judge of the Office of Administrative Hearings followed by an exceptions process before a disciplinary panel or the Board; and if there is no genuine dispute as to a material fact, Respondent shall be given a show cause hearing before a disciplinary panel; and it is further

ORDERED that after the appropriate hearing, the disciplinary panel determines that Respondent has failed to comply with any term or condition of this Consent Order, the disciplinary panel may reprimand Respondent, place Respondent on further probation with appropriate probationary terms and conditions or suspend or revoke Respondent's license to practice medicine in Maryland. The disciplinary panel may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon Respondent; and it is further

ORDERED that the effective date of the Consent Order is the date the Consent Order is signed by the Executive Director of the Board. The Executive Director signs the Consent Order on behalf of the disciplinary panel which has imposed the terms and conditions of this Consent Order; and it is further

ORDERED that this Consent Order is a public document. *See* Health Occ. §1-607, Health Occ. § 14-411.1(b)(2), and Gen. Prov. § 4–333(b)(6).

06/06/2019
Date

Signature on File

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

CONSENT

I, Steven A. Polakoff, M.D., acknowledge that I have consulted with counsel before signing this document.

By this Consent, I agree to be bound by this Consent Order and all its terms and conditions and understand that the disciplinary panel will not entertain any request for amendments or modifications to any condition.

I assert that I am aware of my right to a formal evidentiary hearing, pursuant to Md. Code Ann., Health Occ. § 14-405 and Md. Code Ann., State Gov't §§ 10-201 *et seq*. concerning the pending charges. I waive these rights and have elected to sign this Consent Order instead.

I acknowledge the validity and enforceability 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 behalf, and to all other substantive and procedural protections as provided by law. I waive those procedural and substantive protections. I acknowledge the legal authority and the jurisdiction of the disciplinary panel to initiate these proceedings and to issue and enforce this Consent Order.

I voluntarily enter into and agree to comply with the terms and conditions set forth in the Consent Order as a resolution of the charges. I waive any right to contest the Findings of Fact and Conclusions of Law and Order set out in the Consent Order. I waive all rights to appeal this Consent Order.

I sign this Consent Order, without reservation, and fully understand the language and meaning of its terms.

5/30/19
Date

Signature on File
Steven A. Polakoff, M.D.
Respondent

NOTARY

STATE OF Maryland
CITY/COUNTY OF Montgomery

I HEREBY CERTIFY that on this 30th day of May, 2019 before me, a Notary Public of the State and County aforesaid, personally appeared Steven A. Polakoff, 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.

MBARU CEESAY
Notary Public – State of Maryland
Montgomery County
My Commission Expires Sep 25, 2021

Notary Public

My commission expires 09/25/2021

5/30/19
Date