HE MATTER OF	*	**BEFORE THE**
JAMES P. MATTHEWS, M.D.	*	**MARYLAND BOARD OF**
Respondent	*	**PHYSICIANS**
License Number: D59665	*	**Case Number: 2006-0767**

* * * * * * * * * * * *

CONSENT ORDER

On April 23, 2008, the Maryland Board of Physicians (the "Board") charged James P. Matthews, M.D. (the "Respondent") (D.O.B. 02/05/1969), License Number D59665, under the Maryland Medical Practice Act (the "Act"), Md. Health Occ. Code Ann. ("H.O.") §§ 14-101 *et seq.* (2005 Repl. Vol.).

The pertinent provisions of the Act under H.O. § 14-404(a) provide as follow:

> **§ 14-404. Denials, reprimands, probations, suspensions, and revocations – Grounds.**
>
> Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of the quorum, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> (3) Is guilty of:
> (i) Immoral conduct in the practice of medicine; or
> (ii) Unprofessional conduct in the practice of medicine;
>
> (11) Willfully makes or files a false report 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;
>
> (27) Sells, prescribes, gives away, or administers drugs for illegal or illegitimate medical purposes; and

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

On September 2, 2009, a conference with regard to this matter was held before the Board's Case Resolution Conference ("CRC") Panel. As a result of the CRC, the Respondent agreed to enter into this Consent Order, consisting of Findings of Fact, Conclusions of Law and Order.

GENERAL FINDINGS OF FACT

1. On or about May 9, 2006, the Board received a complaint from a parent of a former patient of the Respondent alleging that the Respondent prescribed multiple narcotics to his son to which his son had become addicted.

2. Thereafter, the Board initiated an investigation of the Respondent's medical practice, the results of which are set forth below.

3. Until approximately December 2007, the Respondent, who is board-certified in family medicine, maintained an office for the practice of family medicine located at 981 Russell Avenue, Gaithersburg, Maryland. During the course of the Board's investigation, the Respondent notified Board staff in writing that he had sold his practice and would be traveling for several months. The Respondent further advised that, "for the immediate future, I will be working on a project for the U.S. Department of Defense involving brainwave reprogramming for soldiers with PTSD [Post-Traumatic Stress Disorder]."

Patient-Specific Findings of Fact

Patient A[1]

4. Patient A, a female born in 1974, initially presented to the Respondent on July 6, 2005, complaining of severe anxiety attacks. The Respondent prescribed Zoloft 25 mg (#30), an antidepressant, and Klonopin .5 mg (#60), a benzodiazepine, with three refills of each medication.

5. The Respondent failed to document a complete and adequate initial physical examination of Patient A.

6. Patient A returned two days later, on July 8, 2005, complaining that the Klonopin "seems to have no effect, despite taking three at once." The Respondent prescribed a different benzodiazepine, lorazepam (Ativan) 1 mg (#30), with three refills.

7. On August 26, 2005, the Respondent doubled Patient A's dosage of lorazepam from 1 mg to 2 mg (#50), with one refill, after she continued to complain that she was having multiple anxiety attacks. The Respondent also prescribed Vicodin (#30), an opioid Schedule III Controlled Dangerous Substance ("CDS"), to treat Patient A's complaint of severe and painful menses.

8. On August 30, 2005, the Respondent documented that Patient A presented with increased anxiety and that she requested Valium (diazepam), another benzodiazepine, rather than lorazepam. The

[1] To ensure confidentiality, the patients' names are not used in this document.

Respondent discontinued the lorazepam and prescribed diazepam 5 mg (#30) with three refills.

9. On September 23, 2005, Patient A presented for wound care after having been assaulted. The Respondent failed to document any details regarding her injury except that it was to her upper extremity.

10. On May 2, 2006, the Respondent documented that Patient A "can't sleep at all without benzos[,]" and prescribed diazepam 10 mg (#45) with three refills.

11. Throughout the period of review, July 2005 through January 2007, Patient A continued to complain of anxiety, depression and painful menses. Although the Respondent warned Patient A of the risks of overuse of benzodiazepines and narcotics and placed her on a "Pain Management Contract" on June 27, 2006, he offered her no alternative medications and continued to prescribe benzodiazepines and CDS regularly to her.

12. The Respondent failed to conduct any laboratory studies to address Patient A's severe menorrhagia, nor did he document that he conducted a pelvic examination, pelvic ultrasound and/or endometrial biopsy. The Respondent also failed to refer Patient A to a gynecologist for evaluation.

13. The Respondent failed to document Patient A's vital signs on all of his notes of her office visits.

14. The Respondent's conduct as set forth above constitutes, in whole or in part, the failure to meet the appropriate standard of quality medical care,

in violation of H.O. § 14-404(a)(22) and/or failure to maintain adequate medical records, in violation of H.O. § 14-404(a)(40).

Finding of Facts Pertaining to Violations of H.O. § 14-404(a)(3)(i), (3)(ii), (11), (27) and/or (40)

15. Patient B, a male born in 1957, and Patient C, a male born in 1954, are brothers.

16. According to Patient B's chart and the Respondent's written summary of care that he provided to the Board, Patient B initially presented March 1, 2006 after he fell from a boat and injured his ribs.[2] The Respondent prescribed Percocet (#30), a Schedule II CDS, and lorazepam (#30).

17. Although the Respondent did not treat Patient B until March 2006, pharmacy runs obtained by the Board reveal that the Respondent wrote numerous prescriptions for Schedule II CDS, including hydromorphone, oxycodone and methadone, and benzodiazepines under Patient B's name beginning as of June 17, 2005. Investigation by the Board, which included obtaining written explanations from the Respondent, revealed that the Respondent had knowingly written prescriptions for CDS for Patient B's brother ("Patient C") under Patient B's name.

18. By letter dated September 16, 2006, the Respondent explained that Patient C was:

> ...a former contractor for the U.S. government who's been badly wounded in retaliation for some of the 'Special Services' he performed for this country....After returning from Foreign Service

[2] A pharmacy run obtained by the Board reveals that on February 3, 2005, the Respondent prescribed to Patient B a supply of insulin delivery pens. The Respondent did not document this visit or prescription.

about twelve years ago, enemy combatants rammed his car while he was in Washington, DC....

Upon presentation on 6/17/05, [Patient C] initially used his brother's name, [Patient B], and received a few prescriptions under this name. He later explained his reason for doing this was twofold: firstly, he states that he was a little paranoid because the last time he was in the U.S. someone tried to kill him and he didn't want anyone knowing his real name until he was sure he could trust them; and secondly, while he had an agreement with his former doctor about his management he'd lost faith in that team and needed to be sure I was willing to take over his care, including giving him all the narcotics he needed before he left his current pain management doctor in Baltimore.

While this was highly irregular, I didn't believe he was abusing or diverting the medications so accepted his explanation, asked him for a government issued photo ID, asked him to sign a pain management contract, and continued to treat him.

19. By letter of April 14, 2008, in response to Board staff's additional questions regarding the situation, the Respondent provided the following explanation:

There is no Health (sic) insurance or any other ID card, in the medical record of [Patient C] where he is identified as [Patient B]. As best as I can recall, [Patient C] had only presented himself as [Patient B], and not having insurance, for the first 2 – 3 visits. After that time, some physician-patient trust was developed and he presented his insurance card with his real name.

...

Given that the name on each page of [Patient C]'s record was changed when I changed his name from [Patient B] to [Patient C] in the demographics section of the electronic medical record, a fact unrecognized by me at the time, I do not have an exact record of when his name change occurred, however, may I suggest how this could be determined:

-simply look at prescriptions written for [Patient B] for which there is no supporting medical record for [Patient B], but there is a record for [Patient C]. Again, this would be approximately the first 2 – 3 visits of [Patient C] seeing me, dating 6/17, 7/6 and

> 7/12/05, about four months before the real [Patient B] had ever come in. In this way, the exact dates of [Patient C] receiving a few CDS prescriptions using his brother's name can be determined.

20. Review of the pharmacy runs obtained by the Board fails to support the Respondent's assertions that he wrote prescriptions for Patient C under Patient B's name for Patient C's first two to three visits only. Indeed, the Respondent wrote numerous prescriptions for CDS and benzodiazepines for Patient C under Patient B's name over the course of at least thirty-three office visits from June 2005 through March 2006, at which time the Respondent began treating the real Patient B.

21. The Respondent failed to document in either Patient B or Patient C's chart that he had written prescriptions for Patient C under Patient B's name, although he was aware of Patient C's deception, by the Respondent's own account, after Patient C's second or third visit. The Respondent continued to treat Patient C despite Patient C's deception.

22. The Respondent's conduct as set forth above, in whole or in part, constitutes immoral conduct in the practice of medicine, in violation of H.O. § 14-404(a)(3)(i); unprofessional conduct in the practice of medicine; in violation of H.O. § 14-404(a)(3)(ii), willfully making or filing a false report in the practice of medicine, in violation of H.O. § 14-404(a)(11), prescribing or administering drugs for illegitimate medical purposes, in violation of H.O. § 14-404(a)(27) and failing to maintain adequate medical records, in violation of H.O. § 14-404(a)(40).

Findings of Fact Pertaining to Violations of H.O. § 14-404(a)(22) and/or (40)

a. Patient B

23. As stated above, on Patient B's first visit on March 1, 2006, the Respondent prescribed Percocet and lorazepam to Patient B for complaints of "bitter pain" after falling in a boating accident. Patient B signed a Pain Management Contract with the Respondent on his first visit. The Contract states in pertinent part: "I understand that I will be working toward getting off of all pain medications, and or muscle relaxants."

24. Patient B returned to the Respondent on June 30, 2006 after falling from a ladder. The Respondent prescribed hydromorphone (Dilaudid) 8 mg, a Schedule II CDS. The Respondent failed to document his treatment rationale for prescribing hydromorphone to Patient B at the maximum dosage.

25. Thereafter, Patient B returned to the Respondent on eight subsequent occasions during the review period, through September 7, 2006.[3] The Respondent prescribed hydromorphone 8 mg (#30) to Patient B at each visit.

26. The Respondent failed to ascertain Patient B's pain management history prior to prescribing the maximum dosage of hydromorphone.

27. On June 30, 2006, Patient B presented after falling from a ladder with complaints of trauma and abrasion to his right antecubital fossa (the area in the hollow of the elbow joint) with "foreign body insertion." The

[3] When interviewed by Board staff, the Respondent advised that Patient B had died in mid-2007 of meningitis. The Respondent had not been involved in Patient B's care since 2006.

Respondent initiated treatment with Augmentin, an antibiotic, and continued to prescribe hydromorphone.

28. On July 27, 2006, the Respondent documented that Patient B's infection had resolved; however, thrombosis persisted in the area of injury.

29. On July 27, 2006, after several follow-up visits and an unsuccessful attempt to refer Patient B to a vascular surgeon for treatment of venous embolism and thrombosis,[4] the Respondent commenced treatment with Coumadin, an anti-coagulant. The Respondent failed to warn Patient B of the risks of this treatment, nor did he refer Patient B, who was uninsured, to an emergency room for more appropriate treatment.

30. The Respondent failed to document Patient B's vital signs on all of his notes of Patient B's office visits.

b. Patient C

31. Patient C initially presented to the Respondent on June 17, 2005 for pain management for chronic leg, back and shoulder pain. Patient C had shattered his right ankle in a motor vehicle accident in 1993 and later developed osteomyelitis, an infection of the bone. In February 2005, Patient C had undergone surgery in an attempt to salvage his ankle. On this visit, the Respondent recommended that Patient C take ibuprofen 400 mg for pain and prescribed Klonopin.

32. Patient C next returned on July 6, 2005, complaining of weakness in his left leg after falling on his coccyx. The Respondent documented that he

[4] The Respondent documented that Patient B could not afford to be seen by the vascular surgeon.

advised Patient C to get an orthopedic consultation, but that Patient C did not have insurance and requested an alternative plan. The Respondent noted that the symptoms would likely resolve in six weeks without intervention. The Respondent prescribed Klopopin #60.

33. In the treatment plan portion of the July 6, 2005 note, the Respondent documented, "refill pain meds." The Respondent had not, however, documented that he had prescribed any pain medications to Patient C in his office note for Patient C's previous visit on June 15, 2006. Review of the pharmacy runs revealed that on June 17, 2005, a prescription written by the Respondent for oxycodone with APA (Percocet) #200 under Patient B's name had been filled.

34. On July 12, 2005, Patient C next presented to the Respondent and advised him that "he was shorted 70 pills on his last rx [prescription]." The Respondent wrote a prescription for Percocet (#70), one tablet every six hours as needed. The Respondent also prescribed Ativan (#40) on this visit. The Respondent wrote both prescriptions under Patient B's name.

35. In September 2005, the Respondent began providing wound care for an open lesion on Patient C's foot. The Respondent initially noted the measurements of the lesion, but did not do so again until January 2006, despite noting at some visits that Patient C's healing progress was slow.

36. On November 8, 2005, the Respondent began prescribing hydromorphone 8 mg, one tablet every six hours, to Patient C, using Patient B's name. The Respondent failed to document the reason he discontinued Percocet

and started hydromorphone, nor did he document why he started hydromorphone at its maximum dosage.

37. On November 16, 2005, the Respondent documented that Patient C recognized that he was "using a large amount of pain medication" and that he wanted to be weaned from them, but his pain was too great to do so. The Respondent added Klonopin and Zoloft, an anti-depressant, to Patient C's medication regimen. The Respondent failed to document his treatment rationale for adding Zoloft, except to note "depression."

38. Beginning in or around December 2005, the quantity of medication the Respondent prescribed to Patient C regularly exceeded the maximum Patient C would have needed had he followed the Respondent's orders regarding how often he should take the medication. For instance, on December 22, 2005, the Respondent prescribed 100 tablets of hydromorphone with instructions to take one or two tablets every six hours, or a maximum of eight tablets a day, and with a follow-up appointment in three to four days. Patient C returned to the Respondent seven days later, on December 29, 2005, and the Respondent prescribed another 100 tablets of hydromorphone with the same dosage instructions. Had Patient C followed the Respondent's instructions, he would have taken a maximum of fifty-six tablets of hydromorphone of the initial prescription up to December 29, yet the Respondent prescribed him 100 more tablets. As stated previously, all prescriptions the Respondent wrote

for Patient C from June 17, 2005 through January 13, 2006 under Patient B's name.

39. Beginning in January 2006 and continuing through July 2006, the Respondent saw Patient C frequently, every three to five days. On January 6, 2006, Patient C advised that his pain was "agonizing" but he wanted to "get off pain medications as soon as possible." The Respondent added OxyContin 80mg[5] to Patient C's medication regimen.

40. On January 17, 2006, the Respondent documented that Patient C "knowingly allowed some of his family members to take some of his benzos [benzodiazepines] so now he's out." The Respondent further noted that, "sharing CDS with his family members is unacceptable and that if they need benzos they should present for eval." According to pharmacy runs obtained by the Board, the Respondent refilled Patient C's Klonopin (#60) in Patient B's name; he did not note the refill in Patient C's chart. At this time, the Respondent was prescribing Patient C quantities of medications equivalent to 32 to 40 tablets of hydromorphone 8 mg to Patient C daily, in addition to Klonopin.

41. In January 2006, the Respondent referred Patient C to a pain management clinic because of the quantity of CDS Patient C required and "the extra benzos [Patient C] needed recently;" however, Patient C stated that the clinic did not accept his health insurance. The Respondent agreed to continue treating him.

[5] The second highest dosage of OxyContin; used for opioid-tolerant patients.

42. On January 24, 2006, Patient C entered into a Pain Management Contract with the Respondent. On this date, the Respondent added methadone, one tablet three times a day, to Patient C's medication regime.

43. On February 8, 2006, Patient C requested hydromorphone rather than methadone. The Respondent noted that he would continue to treat Patient C "as indicated despite appearances of large doses." The Respondent also indicated that he would "contact DEA [federal Drug Enforcement Administration] to proactively present patient's extraordinary needs;" there is, however, no correspondence either to or from DEA in Patient C's chart.

44. On February 21, 2006, Patient C requested a "ramp up of narcs" because of break-through pain. The Respondent prescribed hydromorphone 8 mg, two tablets every four hours (#85) and Klonopin, two tablets twice a day (#60). The Respondent continued to prescribe quantities of drugs that exceeded his dosage instructions.

45. On February 24, 2006, Patient C requested OxyContin and Valium. The Respondent noted that he refused to refill Patient C's prescriptions, "[s]adly, I know he is in pain, however I suspect he took too many of his rx and is now running low."

46. On April 11, 2006, the Respondent documented that Patient C had told him that his ophthalmologist had diagnosed him with glaucoma and that he would benefit from Marinol, a synthetic form of marijuana and Schedule III CDS. The Respondent prescribed Marinol (with three refills) at Patient

C's request and without benefit of information from the ophthalmologist (the Respondent noted that Patient C would submit documentation from the ophthalmologist at his next visit; however, there are no such notes in Patient C's chart).

47. On June 15, 2006, Patient C reported to the Respondent that the pharmacist had "shorted" him seven tablets of oxycodone on his prescription of June 13, 2006. The Respondent documented that the pharmacist denied this allegation, yet prescribed Patient C twelve tablets of OxyContin.

48. The Respondent continued to prescribe narcotics and benzodiazepines to Patient C in excessive quantities through September 2006; often changing the drugs he prescribed at Patient C's specific request and with no other treatment rationale noted. On September 11, 2006, the Respondent's last note, he prescribed Patient C 150 tablets of hydromorphone 8mg, four tablets to be taken every six hours as needed, with instructions to return in one week.

49. As of Patient C's first visit on June 17, 2005, the Respondent documented the Review of Systems ("ROS") portion of Patient C's notes using an identically worded narrative for almost every visit. As of Patient C's February 28, 2006 visit and continuing through June 13, 2006, the Respondent also documented the "Subjective" portion of Patient C's notes using an identically worded narrative for each visit. As with Patients A and

B, the Respondent failed to note Patient C's vital signs on any of his office visit notes.

50. Throughout the entire period of review, the Respondent failed to obtain laboratory studies to address the severity of Patient C's infected wound or the effect of such high dosages of narcotics on Patient C's kidney or liver.

51. The Respondent failed to document in Patient C's chart that he had prescribed narcotics and benzodiazepines to Patient C using Patient B's name.

52. The Respondent ignored, or failed to recognize, signs of Patient C's drug abuse and/or diversion such as using his brother's name, allowing family members to take his medications, claiming that no specialists accepted his health insurance and making specific requests to change or increase his medications.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent is guilty of engaging in immoral conduct in the practice of medicine, in violation of H.O. § 14-404(a)(3)(i) and unprofessional conduct in the practice of medicine, in violation of H.O. § 14-404(a)(3)(ii); willfully making or filing a false report in the practice of medicine, in violation of H.O. § 14-404(a)(11); failing to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical care, in violation of H.O. § 14-404(a)(22); selling, prescribing, giving away, or administering drugs for illegal or illegitimate medical purposes, in violation of H.O. § 14-404(a)(27) ; and

failing to keep adequate medical records as determined by appropriate peer review, in violation of H.O. § 14-404(a)(40).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 28th day of October, 2009, by a majority of the quorum of the Board considering this case:

ORDERED that the Respondent's license to practice medicine in the State of Maryland shall be **REPRIMANDED;** and it is further

ORDERED that the Respondent shall be placed on **PROBATION** for a minimum of **THREE (3) YEARS**, beginning on the effective date of the Consent Order and continuing **UNTIL** all of the following terms and conditions are satisfied:

a. Should the Respondent relocate from Maryland, he shall notify the Board within one (1) week of relocation. The probationary period shall be tolled for the period the Respondent is not residing in Maryland. The Respondent shall notify the Board in writing if he returns to Maryland within one (1) week of his return and the probationary period shall resume;

b. Within three (3) months of the effective date of the Consent Order, the Respondent shall successfully complete at his own expense a Board-approved intensive course in CDS prescribing. The course shall be in addition to the Continuing Medical Education ("CME") credits required for licensure;

c. Within three (3) months of the effective date of the Consent Order, the Respondent shall successfully complete at his own expense a Board-

approved intensive course in medical record-keeping. The course shall be in addition to the CME credits required for licensure;

d. Within 3 months of the effective date of the Consent Order, the Respondent shall successfully complete at his own expense a Board-approved intensive course or tutorial in medical ethics. The course shall be in addition to the CME credits required for licensure; and it further

ORDERED that the Respondent shall be subject to chart or peer review at the discretion of the Board during the probationary period; and it is further

ORDERED that the Respondent shall comply with the Maryland Medical Practice Act and all laws, statutes and regulations pertaining to the practice of medicine; and it is further

ORDERED that the Respondent's failure to comply with any of the conditions of this Consent Order, shall be considered a violation of probation and a violation of this Consent Order; and 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 an opportunity for an evidentiary hearing before an Administrative Law Judge at the Office of Administrative Hearings if there is a genuine dispute as to the underlying material facts, or an opportunity for a show cause hearing before the Board, may impose any other disciplinary sanction for with the Board may have imposed, including a reprimand, probation, suspension, revocation and/or monetary fine, said violation being proven by a preponderance of the evidence; and it is further

ORDERED that the Respondent shall not petition the Board for early

termination of the terms and conditions of this Consent Order; and it is further

ORDERED that the Respondent shall be responsible for all costs under this Consent Order; and it is further

ORDERED that this Consent Order shall be a public document pursuant to Md. State Gov't Code Ann. § 10-611 (2004 Repl. Vol.).

10/28/09
Date

John T. Papavasiliou
Deputy Director
Maryland Board of Physicians

CONSENT

I, James P. Matthews, M.D., acknowledge that I am represented by counsel and have consulted with counsel before entering this Consent Order. By this Consent and for the 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 the 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.

9/24/09
Date

James P. Matthews, M.D.
Respondent

STATE OF MARYLAND
CITY/COUNTY OF Gaithersburg

I HEREBY CERTIFY that on this 24 day of September 2009, before me, a Notary Public of the foregoing State and City/County personally appeared James P. Matthews, M.D., and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

Notary Public

Notary Public
Montgomery Co., State of Maryland
Joaquin G. Correal
My Appointment Expires 10 / 24 / 2010