BEFORE THE

OREGON MEDICAL BOARD

STATE OF OREGON

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| In the Matter of:<br><br>JAMES FRANCIS CALVERT, JR., MD<br>LICENSE NO. MD18000 | )<br>)<br>)<br>)<br>) | STIPULATED ORDER |

1.

The Oregon Medical Board (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the state of Oregon. James Francis Calvert, Jr., MD (Licensee) is a licensed physician in the state of Oregon.

2.

In a Complaint and Notice of Proposed Disciplinary Action issued on April 5, 2012, the Board proposed taking disciplinary action by imposing up to the maximum range of potential sanctions identified in ORS 677.205(2), to include the revocation of license, a $10,000 fine, and assessment of costs, pursuant to ORS 677.205 against Licensee for violations of the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined by ORS 677.188(4)(a), (b) and (c); ORS 677.190(13) gross or repeated negligence in the practice of medicine; and ORS 677.190(24) prescribing a controlled substance without a legitimate medical purpose or following accepted procedures.

3.

Licensee is board certified in family practice and practices medicine in Klamath Falls, Oregon. Licensee's acts and conduct that violated the Medical Practice Act are:

3.1 Patient A, a 45 year old female, presented to Licensee in 2008 with complaints of chronic pain associated with a shoulder injury that required multiple surgeries. Patient A had a history of alcoholism, methamphetamine abuse and depression. In November, 2008, Licensee

started Patient A on morphine sulfate (Schedule II), 30 mg twice a day (bid), and oxycodone (Schedule II) 5 mg bid. In December, 2008, Licensee tentatively diagnosed rheumatoid arthritis and increased Patient A's prescription of morphine sulfate to 30 mgs three times a day (tid) and started her on hydroxychloroquine (Plaquenil). Subsequent laboratory studies did not support an inflammatory condition. In February, 2009, Licensee diagnosed seronegative rheumatoid arthritis and started Patient A on methotrexate and low dose prednisone. In March of 2009, Licensee authorized a medical marijuana card. In October of 2010, a consulting rheumatologist saw Patient A but did not agree with the diagnosis of rheumatoid arthritis. In November, 2010, Patient A was stopped by the police for careless driving due to driver's impairment. Licensee signed and attested on January 20, 2011 that: "There is no impairing condition" on a driver medical report for the Oregon Division of Motor Vehicles (DMV). This report also reflected Patient A's self-report of "severe arthritis in hips, back and knees, inability to control muscle movements and use of prescribed medications including morphine, marijuana and hydrocodone caused dangerous driving 11/03/10." In January, 2011, a urine drug screen was positive for methamphetamine, marijuana and benzodiazepines, as well as her prescribed narcotics. Licensee's approach was to require her to submit a "clean" urine drug sample before he would reauthorize scheduled medications. Licensee ceased prescribing for Patient A on September 9, 2011, after Patient A refused to produce a urine drug screening sample. Review of the chart reveals that Licensee failed to establish a diagnosis of rheumatoid arthritis, yet persisted in treating this condition without supporting medical indications. In addition, Licensee persisted in prescribing narcotic medications in the face of substantial evidence of impairment and substance abuse, and certified that Patient A was not impaired to the DMV in the face of strong evidence to the contrary. Licensee also authorized marijuana without medical justification when Patient A was on a course of narcotic medication.

3.2 The Board conducted a review of Licensee's charts for Patients B - E, which revealed the following pattern of substandard practice: Poor patient selection for chronic pain medications; being too willing to accept his patients' attribution of pain to medical conditions

amenable to prescribing as opposed to complex life circumstances and deficient coping skills; prescribing multiple medications with co-morbidities and high potential for abuse to satisfy patient demands for increased medications; readily prescribing opioid medication to address complaints of migraine headaches for patients with a history of substance abuse; failing to recognize and address "red flags" that indicate patient addiction, to include requests for early refills and increased dosages, missed appointments, or complaints of medication losses; failing to take appropriate action when presented with evidence of abuse or dependence; failing to effectively monitor patient compliance with the treatment plan; and failing to support his diagnoses with clinical findings, failing to obtain appropriate consultations when patients do not progress; and failing to hold his patients accountable for noncompliance with the treatment plan. Specific patient care concerns follow:

a. Patient B, a 47 year old female, was seen by Licensee on a recurrent basis over a period of multiple years. Between August 8, 2007, and May 19, 2011, Licensee treated Patient B's complaints of chronic migraine headaches with a series of IM injections of meperidine (Demerol, Schedule II) 150 - 200 mg, with phenergan (Promethazine) 25 mg, varying in frequency from twice to four times a month. Patient B also used "medical marijuana" for the ostensible purpose of treating her migraine headaches. Licensee diagnosed Patient B with migraine headaches, bipolar disorder and "possibly some parkinsonian side effects." Over the course of time, Licensee also prescribed a combination of narcotics and benzodiazepines to address Patient B's complaints, to include methadone (Schedule II) 5 mg qid, hydrocodone/acetaminophen (Schedule III), 10/325mg tid, Xanax (alprazolam, Schedule IV), 1 mg, tid, Effexor XR 75 mg, and clonazepam (Klonopin, Schedule IV) 1 mg, tid. Patient B developed a dependence on prescribed opioid medication. On March 3, 2010, Patient B suffered an overdose on narcotics and benzodiazepines and was hospitalized. On April 22, 2010, Licensee counseled Patient B that she "is probably still really in withdrawal" and increased her prescription of Effexor XR from 75 to 150 mg. Licensee also prescribed clonazepam (Klonopin, Schedule IV) 1 – 3 mg, tid, and Clonidine, and noted that "the patient's headaches have

1 improved greatly since she got off her pain medicine." On April 14, 2011, Patient B complained
2 that her "pain is intolerable" and that she was: "using a lot of marijuana to try to make her pain
3 go away...." Licensee started her on hydrocodone (Norco, Schedule III) 10 mg, 1 qid, to treat
4 her complaints of generalized pain from fibromyalgia. On May 12, 2011, Licensee started
5 Patient B on methadone, 2.5 mg, qid for pain control. On May 20, 2011, Patient B was admitted
6 to a hospital with somnolence, flat affect, and depressed respirations due to her medications.
7 Licensee last saw Patient B on May 26, 2011, when she denied taking too much methadone, and
8 claimed that she was just treating her "headache." Licensee started her on seratraline (Zoloft),
9 25 mg, and continued the methadone. Patient B was found dead at home on June 19, 2011.
10 Licensee placed Patient B on a dangerous combination of narcotics and benzodiazepines and
11 resumed prescribing narcotic medication when it was not medically indicated. Licensee failed to
12 recognize that Patient B was not a safe candidate for opioid medication and failed to effectively
13 address her symptoms of dependence prior to her death.
14 b. Patient C, a 55 year old woman, presented to Licensee on September 29,
15 2008, for a routine follow up visit, with a medical history that included "failed back syndrome,"
16 fibromyalgia, fibromyositis, depression, chronic hepatitis C infection, and recurrent anemia.
17 Licensee treated her complaint of joint pain with a 40 mg IM injection of Kenalog and 6 mL of
18 Marcaine. In successive clinical visits, Patient C continued to complain of back pain. Licensee
19 diagnosed "low back syndrome" based on history, but without supporting clinical findings. A
20 review of Licensee's medication log sheet reflects that on April 30, 2009, Licensee started
21 Patient C on a course of methadone (Schedule II), 10 mg, #420, Roxicet (oxycodone &
22 acetaminophen, Schedule II) #60, and methylphenidate (Ritalin, Schedule II) #60. Licensee did
23 not establish clinical findings or diagnoses to support these medications. In his chart notes,
24 Licensee makes reference to a history of back surgeries and states that she had been on a long
25 course of chronic opioid therapy. On October 29, 2009, Licensee renewed the prescriptions even
26 though she had missed two previous appointments. She still complained that her back hurt—but
27 Licensee did not record an examination or make clinical findings. On November 17, 2009,

1 Licensee continued the prescriptions, and charted that: "Her back hurts but things go okay as
2 long as she has her pain medications." On November 18, 2010, Licensee listed Attention Deficit
3 Disorder as a diagnosis, but did not provide supporting clinical findings. On February 17, 2011,
4 Licensee authorized an early refill of methadone due to Patient C's complaint that her: "back was
5 bothering her more than it ever has." There are no clinical findings. On June 21, 2011, Licensee
6 observes that Patient C "looks pale. She is shaky. She is very tachycardiac with a heart rate of
7 about 130. Her blood pressure is 96/70." Licensee also noted that Patient C: "is in a little bit of
8 withdrawal, since she has been low on her medicine the last couple of days, so she cannot really
9 talk to me about too much." Licensee's plan was to give her "medicines for next 3 months."
10 Licensee inappropriately responded to Patient C's withdrawal symptoms and her deviations from
11 her treatment plan by prescribing a three month supply of controlled substances. Patient C was
12 admitted to the hospital in August of 2011 to reverse a possible narcotic overdose.
13 4.
14 Licensee and the Board desire to settle this matter by entry of this Stipulated Order.
15 Licensee understands that he has the right to a contested case hearing under the Administrative
16 Procedures Act (chapter 183), Oregon Revised Statutes. Licensee fully and finally waives the
17 right to a contested case hearing and any appeal therefrom by the signing of and entry of this
18 Order in the Board's records. Licensee admits that he engaged in the conduct described in
19 paragraph 3, and that this conduct violated ORS 677.190(1)(a) unprofessional or dishonorable
20 conduct, as defined by ORS 677.188(4)(a), (b) and (c); ORS 677.190(13) gross or repeated
21 negligence in the practice of medicine; and ORS 677.190(24) prescribing a controlled substance
22 without a legitimate medical purpose or following accepted procedures. Licensee understands
23 that this Order is a public record and is a disciplinary action that is reportable to the National
24 Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank and the Federation of
25 State Medical Boards.
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5.

Licensee and the Board agree to resolve this matter by the entry of this Stipulated Order subject to the following sanctions and terms and conditions of probation:

5.1 Licensee is reprimanded.

5.2 Licensee must pay a fine of $5,000, payable in full within 60 days from the signing of this Order by the Board Chair.

5.3 Licensee must promptly enroll in and successfully complete courses on the treatment of chronic pain (including prescribing) and rheumatologic disorders, which are pre-approved by the Board's Medical Director within one year of the date this Order is signed by the Board Chair.

5.4 Licensee is placed on probation for five years. Licensee must report in person to the Board at each of its quarterly meetings at the scheduled times for a probation interview, unless otherwise directed by the Board's Compliance Officer or its Investigative Committee.

5.5 Licensee stipulates and agrees that this Order becomes effective the date it is signed by the Board Chair.

5.6 Licensee stipulates and agrees that any violation of the terms of this Order shall be grounds for further disciplinary action under ORS 677.190(17).

IT IS SO STIPULATED THIS 19 day of June, 2012.

**SIGNATURE REDACTED**

JAMES FRANCIS CALVERT, JR., MD

IT IS SO ORDERED THIS 12th day of July, 2012.

OREGON MEDICAL BOARD
State of Oregon

**SIGNATURE REDACTED**

W. KENT WILLIAMSON, MD
BOARD CHAIR