BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **THOMAS J. GROVES, M.D.** Holder of License No. 5104 For the Practice of Allopathic Medicine In the State of Arizona	Case No. MD-07-0035A **CONSENT AGREEMENT FOR LETTER OF REPRIMAND**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Thomas J. Groves, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. The Board may adopt this Consent Agreement of any part thereof. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.

5. This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any waiver,

express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. The acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this State from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.

6. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

8. If the Board does not adopt this Consent Agreement, Respondent will not assert as a defense that the Board's consideration of this Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.

9. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

10. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

11. Any violation of this Consent Agreement constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

THOMAS J. GROVES, M.D.

DATED: 2-29-07

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 5104 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-07-0035A after receiving a complaint regarding Respondent's treatment and care of a thirty-four year-old male patient ("WC").

4. On September 21, 2005 WC presented to Respondent for ongoing pain management. This is confirmed in the WC's referring physician's medical records, but Respondent had no record of this visit. The records from WC's referring physician indicated WC had been prescribed Oxycontin and Duragesic 75 mcg patches, which WC allegedly discarded in August 2005 because they were not effective.

5. Respondent's medical records for WC indicated he started treating WC on March 8, 2006. However, pharmacy surveys showed Respondent wrote five prescriptions for at least 180 tablets of 10 mg of Methadone, which is equivalent to 100 mg of Methadone per day, from November 4, 2005; through February 16, 2006. Respondent also wrote a prescription for 24 tablets of 10 mg of Methadone on November 15, 2005. The pharmacy surveys indicate Respondent prescribed Methadone to WC during that period, in the absence of any medical records or documentation of a physician-patient relationship, which includes an initial evaluation, an individualized treatment plan for WC, verification of WC's current prescriptions and continued monitoring of WC's progress.

6. Respondent did not covert WC's prescription for a Duragesic patch to Methadone in a manner consistent with accepted pharmacologic principles. Specifically, the recommended equianalgesic conversion from a Duragesic 75 mcg patch to Methadone

is 10 mg of Methadone per day. Respondent was prescribing an excessive amount of Methadone per day (approximately 100 mg of Methadone per day).

7. In addition to prescribing Methadone, Respondent also provided WC with cervical epidural steroid injections. On January 18, 2006 and February 1, 2006, Respondent performed the second and third in a series of multilevel interlaminar cervical epidural steroid injunctions at the C5-6 and C6-7 levels. There is no procedure note for the first injection in the series. It is recommended that interlaminar cervical injections be performed at a single level instead of at adjacent levels.

8. On October 3, 2006 Respondent provided WC with three prescriptions of Methadone and two of those prescriptions were pre-dated for future use. Additionally, on December 19, 2006, Respondent provided WC with a prescription for 120 tablets of Methadone 20 mg. Respondent also provided WC with an identical prescription pre-dated for the following month.

9. When prescribing long term opioid medications for chronic non-malignant pain, the standard of care requires a physician to perform an appropriate initial evaluation, verify current prescriptions being used and devise an individualized treatment plan.

10. Respondent deviated from the standard of care because he did not perform an initial evaluation prior to prescribing Methadone to WC, he did not verify WC's current prescriptions and dosages and he did not devise an individualized treatment plan for WC.

11. As a result, a subsequent treating physician would not have any knowledge of the treatment plan or ongoing medication management of WC.

12. When replacing another opioid with Methadone, the standard of care requires a physician to verify the current opioid dosage, calculate the equianalgesic dose of Methadone and then decrease the calculation by 25-50%.

13. Respondent deviated from the standard of care because he did not verify WC's current opioid dosage and he did not appropriately convert WC's Duragesic patch prescription to Methadone. Respondent started the Methadone at approximately ten times the equianalgesic dose of WC's current opioid dosage.

14. WC could have overdosed on Methadone and developed cardiac dysrhythmia, respiratory depression, aspiration, brain damage or death.

15. When treating a patient with long term opioid medication for chronic non-malignant pain, the standard of care requires a physician to regularly evaluate and re-evaluate a patient's progress.

16. Respondent deviated from the standard of care because he failed to adequately follow up on WC's progress and re-evaluate him for a six month period.

17. As a result, Respondent could have perpetuated WC's drug seeking behavior.

18. The standard of care requires a physician performing interlaminar cervical epidural steroid injections to perform them at a single level.

19. Respondent deviated from the standard of care because he did not perform the injections at a single level on WC. Respondent performed the injections at two adjacent levels.

20. Each of Respondent's unnecessary cervical epidural steroid injections put WC at risk of infection, hematoma and spinal cord injury with the potential for irreversible neurologic damage.

21. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another

practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because they did not include an initial evaluation, an individualized treatment plan for WC, verification of WC's current prescriptions and continued monitoring of WC's progress. Additionally, there are no procedure notes for the first injection in the series of interlaminar cervical epidural steroid injunctions.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient."); A.R.S. § 32-1401(27)(k) ("[s]igning a blank, undated, or predated prescription form."); A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.") and A.R.S. §32-1401(27)(ss) ("[p]rescribing, dispensing or furnishing a prescription medication or a prescription-only device as defined in section 32-1901 to a person unless the licensee first conducts a physical examination of that person or has previously established a doctor-patient relationship. . . .").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand for mismanagement of a chronic pain patient, predating prescriptions for narcotics, for prescribing narcotics without first conducting an evaluation and for failure to maintain adequate records.

2. This Order is the final disposition of case number MD-07-0035A.

DATED AND EFFECTIVE this 10th day of August, 2007.

(SEAL)

ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 10th day of August, 2007 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed this 10th day of August, 2007 to:

Thomas J. Groves, M.D.
Address of Record

_____
Investigational Review