BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **THOMAS J. PETERS, M.D.** Holder of License No. **9582** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case Nos. MD-05-0581A MD-05-0084A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Decree of Censure and Probation)

The Arizona Medical Board ("Board") considered this matter at its public meeting on December 7, 2006. Thomas J. Peters, M.D., ("Respondent") appeared before the Board without legal counsel for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

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 No. 9582 for the practice of allopathic medicine in the State of Arizona.

CASE MD-05-0581A

3. The Board initiated case number MD-05-0581A after receiving a complaint regarding Respondent's care and treatment of a forty-two year-old female patient ("PB") alleging Respondent used poor judgment in prescribing narcotics and pain medications to PB resulting in her suicide. PB initially saw Respondent on March 11, 2003 and he diagnosed bilateral avascular necrosis of the hips. Respondent obtained an MRI that confirmed his diagnosis. Respondent then met with PB and recommended a total hip arthroplasty on the left hip (the more severe hip) and a core decompression of the right hip. Respondent documented discussing the pros and cons of

the proposed surgery and the reason, although the record does not contain the specifics of the discussion.

4. On May 28, 2003 Respondent performed the surgery as he described it to PB. Respondent next saw PB on June 11, 2003 and noted she was ambulating with a walker. Respondent then saw PB on June 19, 2003 and performed an open reduction internal fixation on the right hip because PB had gotten tangled in a dog leash and sustained a subtrochanteric fracture. Respondent initially managed PB's pain with Percocet. PB did physical therapy after her surgeries and in early 2004 Respondent switched to Darvocet. A September 16, 2004 chart entry documents a healed fracture and PB walking without an assistive device.

5. From June of the first surgery until January of 2004 Respondent prescribed a variety of medications to PB – she was receiving approximately five hydrocodone daily from January 2004 until November and she was taking approximately seven Darvocet daily. PB was found dead on November 25, 2004. The autopsy report documents PB committed suicide by mixing drugs and alcohol and documents lethal levels of acetaminophen and propoxyphene.

6. There are five called-in prescriptions/renewals in PB's chart authorized with the signature of Respondent's Medical Assistant ("MA"). During interviews with Board Staff, and in written correspondence with Board Staff, MA indicated she used her own judgment when refilling prescriptions and if Respondent had approved the medication it would be indicated in writing in the chart either by his initials or "per [Respondent]".

CASE MD-05-0084A

7. The Board initiated case number MD-05-0084A after receiving a complaint regarding Respondent's care and treatment of a twenty-seven year-old female patient ("LM"). LM saw Respondent one time in 1977 and next saw him January 1991 complaining of right shoulder and arm pain. Respondent diagnosed right supraspinatus tendonitis, prescribed Naprosyn, gave an injection and referred LM to physical therapy. LM saw Respondent fourteen times during 1991

and underwent numerous MRI evaluations, x-rays, and arthrograms. LM also received second orthopedic opinions and a neurology consultation for possible reflex sympathetic dystrophy. LM was treated with physical therapy, acupuncture, and medications. Respondent performed four right shoulder surgeries – July 19, 1991; April 1, 1992; February 29, 1996; and December 22, 1997.

8. Respondent began LM's medication therapy with Naprosyn in 1991, but over the fourteen-year time frame prescribed various combinations of narcotics (Vicodin, Lortab, Norco, and Darvocet), muscle relaxants (Soma and Zanaflex), anxiolytics (Xanax) and sleep aids (Ambien). Before her second surgery in 1992 LM received Darvocet #30 about every ten to fourteen days. LM continued receiving Darvocet and doing physical therapy after the second surgery. An August 14, 1992 chart entry says "per Dr. Peters no more Darvocet. Tylenol extra strength."

9. In July 1994 LM stopped by Respondent's office without an appointment complaining of pain and poor sleep. Respondent prescribed Darvocet and Ambien. On August 1, 1994 LM complained of right shoulder and right sided neck pain. Respondent sent her back to physical therapy, started Oruvail and continued Darvocet and Ambien. Respondent later switched the Oruvail to Naprosyn. Respondent continued the Darvocet, Ambien and Naprosyn through 1994, refilling the Darvocet #30 three to four times per month. In 1995 Respondent continued LM on the medication regimen of Darvocet, Naprosyn and Ambien, refilling the Darvocet #30 four times per month.

10. In April 1996 Respondent was refilling LM's Darvocet #60 every two weeks and giving her Lortab #30 until May 24,1996 when he refused a Lortab refill. On June 4, 1996 LM called asking for Lortab, but Respondent declined the refill. On August 27, 1996 LM said the Darvocet was not working and Respondent called in Tylenol #4 in its place. On August 29, 1996 LM reacted to the Tylenol #4 and Respondent called in Darvocet #60. On August 30, 1996

Respondent called in Lortab in place of the Tylenol #4. During the last months of 1996 Respondent was calling in LM's Darvocet approximately three times per month.

11. In 1997 LM was still on Darvocet and Ambien with Respondent refilling the Darvocet #60 two to three times per month. In June 1997 Respondent prescribed Lortab #30. Respondent refilled the Lortab in September (#30), October (#30) three times, November (#60) three times, and December (#60) four times. On October 22, 1997 Respondent reviewed an MRI, noted LM's consistent pain was her biggest problem, and recommended resection of the AC joint and removal of a cyst as an open procedure. Respondent prescribed Lortab and Soma. Respondent refilled the Soma regularly two to three times per month at #30 each time.

12. In 1998, after the fourth surgery, LM entered physical therapy and continued on Lortab and Soma. In January and February Respondent refilled these medications four times per month. In March 1998 Respondent declined LM's Lortab refill and noted he wanted to wean her off Lortab. Respondent replaced Lortab with Darvocet #120 and it was refilled approximately every two weeks. In July 1998 Respondent documented LM was using a little bit of Darvocet, had reduced her medication use significantly in the past few months, and had not been forced to use Soma or anything more powerful than Darvocet for relief of pain. On September 1, 1998 LM called Respondent's office, requested the status of her refill approval, and requested something stronger because she was waking every hour with pain. LM was instructed that, per Respondent, the Darvocet #120 should last four to six weeks. The record notes LM said "no way" and Respondent was informed of this comment. From September to December 1998 Respondent refilled LM's Darvocet #120 every two weeks.

13. In 1999 Respondent treated LM's persistent right shoulder pain with Darvocet #120 and her sleep problem with Ambien #30. Respondent refilled the Darvocet approximately twice per month. During 1999 LM saw Respondent in April, September, and December. On September 24, 1999 Respondent prescribed Lortab #30. On October 4, 1999 LM called in for a

refill and Respondent declined, telling LM the Lortab was for an exacerbation. On October 5 LM called for a refill of Darvocet and Respondent declined, telling LM the Darvocet needed to last three weeks. On October 6 Respondent refilled the Darvocet #120. On October 20 Respondent refilled LM's Darvocet #120 and then again on November 2. The November 2 refill chart entry notes "[Respondent] said no more than four per day." At no more than four per day the Darvocet should have lasted LM one month. On November 19 Respondent gave LM a prescription for Lortab 5 mg #30 because she was going to California. On November 24 LM called Respondent from California stating she used all her pain medication due to the humid weather. Respondent declined the refill. On November 30 LM called again complaining of pain. Respondent's record states "long term pain medication use was discussed" and notes LM was referred for a second opinion. However, there is no referral in the record. On December 22 Respondent noted LM was having shoulder pain and "accelerating her drug use. She has been counseled extensively about this." Respondent injected LM's subacromial space and prescribed Darvocet and Vioxx.

14. In 2000 LM was not seen for an office visit, but Respondent refilled her Darvocet and Ambien routinely, refilling the Darvocet #60 approximately three times per month. In February LM called requesting stronger pain medications and Respondent declined noting "this is a life long thing and she cannot take narcotics every time the weather changes." During April-June LM's scripts include four refills. Respondent prescribed Darvocet N 100 #60 with four refills in June, July and November. In July 2000 LM called Respondent to report a swollen shoulder with numbness and also reported she had a nervous breakdown and severe depression from a problem in her current job. LM asked Respondent to proceed with any surgery that would end her pain, including a previously discussed breast reduction. LM reported another physician was giving her Lortab 10 mg, she was out of those medications and that physician was out of the office. Respondent prescribed Lortab 10mg #20.

15. Respondent saw LM once in April and noted Darvocet helped reduce her pain and he recommended continued medical management. In July 2001 LM called requesting stronger pain medications and Respondent declined. In October Respondent prescribed Darvocet #60 with five refills. On November 8 Respondent prescribed Darvocet #60 with one refill. On November 14 Respondent prescribed Darvocet #60 with one refill and on November 26 prescribed Darvocet #60 with one refill. On December 7 Respondent prescribed Darvocet #60 with three refills. The refills in October, November and December were potentially toxic due to Tylenol excess. This was not addressed in Respondent's medical record.

16. On January 3, 2002 Respondent prescribed Darvocet #60 with five refills. In February 2002 LM was sent a note to make an appointment as soon as possible or no more prescriptions would be filled. On March 18 Respondent's office received a fax from a pharmacy asking for refill of Darvocet. Respondent did not authorize the refill. On March 19 LM called wanting to know why the prescription was not being filled and was told she needed an appointment. LM made an appointment for March 28 and Respondent prescribed Darvocet #60. LM was told there would be no refills before her appointment. However, LM received a refill on March 25. In April Respondent saw LM for a new industrial back injury involving the T spine. On May 31 Respondent refilled Lortab 10 mg #30 and Soma #30 because another physician no longer wanted to refill LM's pain medication and requested Respondent do so. On June 21 LM had a hysterectomy and was seen by another physician for an independent medical examination ("IME"). The IME physician noted LM's history of back pain and injury; a normal examination and normal x-rays; stated there was no identifiable injury and, at most, LM had a self-limited strain; noted LM was on Darvocet, Ambien and Norco; noted there did not seem to "be an organic basis for [LM's] complaints;" and recommended LM's discharge from active medical care. Respondent's record contains derogatory comments about the report and its findings. Respondent recommended LM continue her medications. On July 16 Respondent stated he would only fill

Darvocet and Ambien; denied the Soma refill, and said LM should get these medications from her primary care physician.

17. In January 2003 LM called saying she was having serious social and financial problems and asked for something for her nerves. Respondent gave her Xanax 0.5 mg #30 to be taken 1 po TID prn. In February Respondent continued the Xanax with four refills. On July 3 LM reported increased shoulder pain. Respondent assessed a complete rotator cuff tear and recommended an MRI. Respondent noted "some other severe issues" and his plan to manage her pain with some Zanaflex 2mg TID/QID and to continue Xanax with Darvocet for pain and Soma for muscle relaxation. On July 11 MA documents LM is getting excess Darvocet after a pharmacy notified her LM received #180 in eleven days. MA declined the refill and noted LM had an office visit scheduled in three days. On July 14 Respondent suspected RSD, instructed LM to stop Soma, and recommended a neurology consult and input from pain management. On October 6 LM was seen in the emergency room with a lesion of the right hand and was placed on antibiotics. On October 10 MA enters a note that LM is being given Darvocet #120 with five refills to "last longer," not because she is taking more in a shorter period. The pharmacy called Respondent's office and said LM had taken all #720 of Darvocet from August 20 to October 10. Assuming the same daily dose, LM would have taken 14.11 pills per day. After this phone call, Respondent's MA authorized Darvocet #120 instructing that it must last fifteen to twenty days.

18. Eleven days later on October 21 MA refilled the Darvocet #120 with one refill. On November 3 LM called, told MA she was out of medication and asked MA to authorize an early refill. MA authorized a refill for November 4 because that was fifteen days from when she authorized the last prescription. On November 20 LM saw an orthopedic surgeon for a second opinion who recommended an MRI of the C spine, which was without significant abnormality. The surgeon felt LM should be referred to a pain specialist for a possible stellate block and did not feel she was a candidate for surgery at that time. On December 1 LM got another early refill because

she was going out of town and would run out. During 2003 LM received nearly monthly refills of Darvocet #60-#120 with numerous refills. LM received excessive amounts of Darvocet.

19. On January 12, 2004 Respondent saw LM in follow-up of shoulder pain and documented "she ha[d] not accelerated her drug use." Respondent noted there was no hard evidence of RSD and recommended continued medical management. Respondent refilled LM's medications, but did not note which medications he refilled. On February 23 LM was given early refills and more Darvocet because she would be working out of town. Respondent saw LM on July 13 and noted she was using Darvocet for pain, added Soma, and noted "she [was] down to about 9 a day" of Darvocet. On August 9 LM was admitted to Verde Valley Medical Center ("VVMC") with fever and weakness. On August 13 she was admitted again complaining of right shoulder pain for nausea, headaches and dizziness. On August 31 LM was admitted again after a motor vehicle accident. LM had driven into a pole after pulling quickly out of a gas station after felling threatened by some men. On September 2 she was admitted again complaining of blurred vision in her right eye after the accident. An MRI of CNS was normal. On September 13 LM received an early refill of Darvocet because she was leaving town. On November 5 she called Respondent and asked to take six Xanax per day, but Respondent declined. On November 16 Respondent's Physician Assistant saw LM for right shoulder pain and gave her refills of her medications. From December 10 through 11 LM was again admitted to VVMC for possible suicidal ideation. LM had been speaking to her sister on the phone when the call was disconnected. LM was found by paramedics on the sidewalk. LM told the paramedics she had taken "a lot" of Soma, Darvocet, and Percocet.

20. A January 8, 2005 chart notation reflects Respondent received an emergency room report that LM was brought in for right shoulder pain, had been arrested for possible driving under the influence, and that LM's emergency room diagnosis was opiate and benzodiazepine intoxication. A January 10, 2005 chart note written by MA said Respondent reviewed the

emergency room report and instructed staff not to give LM anymore medication. The note also said "[LM] should be under psychiatric care of her PCP until she gets her other problems under control." From January 10 - 12 LM was again admitted to VVMC for overdose with Ambien and Tylenol. LM admitted she thought of taking her own life and had taken the pills in front of her daughter.

21. Respondent admitted the personal information on LM should have been more carefully detailed in the record and this would have been brought to bear with the behavior problems that were developing and led to her ultimate breakdown. Respondent misplaced confidence in LM because she was a nurse. Respondent testified PB's case was an unexpected tragedy in a patient who had been taken off powerful narcotics (Percocet) and was taking Darvocet. Respondent saw no warning signs of relapse into alcohol use or change in medication use prior to her death.

22. Respondent has read the Board's Pain Management Guidelines ("Guidelines") and has used recommended materials to avoid future problems with prescribing narcotics. Respondent deviated from the Guidelines in the care of the patients at issue in his Darvocet prescriptions because the amount of acetaminophen he prescribed was in excess of what would normally be recommended. The Board asked whether Respondent believed he was engaged in acute pain management or chronic pain management with LM. Respondent testified LM had acute injuries and in between surgeries she was on a maintenance program in chronic pain with a monthly regimen for control of her medications. The Board asked Respondent to elucidate some of the items in the Guidelines. Respondent mentioned monitoring.

23. The Guidelines require, among other things, a physician to evaluate the patient; develop a treatment plan; obtain informed consent; conduct periodic review; refer for consultations as appropriate; and maintain appropriate records. Respondent did not have a treatment plan for LM or PB. Respondent did not have informed consent from LM.

24. Respondent's policy for office personnel reviewing prescriptions is that he looks at and checks off every prescription being renewed. Respondent testified there are times when his MA may approve a refill if a pharmacy calls and Respondent is in surgery. The Board clarified with Respondent that only he is authorized to approve a refill. Respondent then testified his MA does not authorize any refills. The Board noted Respondent's testimony was different from the MA's testimony during an investigational interview with Board Staff; was different from what his MA submitted in writing to the Board; and was different from the MA's comments to the Board at the Call to the Public just prior to the formal interview.

25. Respondent testified that he is ninety-nine percent sure he has seen all of the prescriptions that are authorized for refills. Respondent admitted his MA authorized refills before he personally approved, but stated she did so only on refills already written by him. Respondent testified the calls from the pharmacy were to confirm it was an appropriate time and place to do the refill and his MA would give this confirmation. The Board noted if a patient has been on a drug for six months, and all refills have run out, the pharmacy will call to confirm whether the patient can get the drug and this is a new prescription, not a refill.

26. Respondent testified the activities at issue occurred over the course of fifteen years for a brief period of time and the issues before the Board are as much administrative record keeping issues and are not necessarily representative of malfeasance on his part – he was simply trying to keep and maintain patient flow.

27. The standard of care requires a physician to recognize drug seeking behavior by a patient; that a patient not be given medication with excessive doses of acetaminophen; compliance with the Board's Guidelines on the treatment of chronic pain; that a physician should only prescribe escalating doses of narcotics as part of a coherent pain control plan; and that a physician adequately supervise a medical assistant to ensure the medical assistant does not authorize refills of medications.

28. Respondent deviated from the standard of care because he did not recognize LM's drug seeking behavior; gave LM excessive doses of acetaminophen; did not follow the Board's Guidelines on treating chronic pain when treating LM; prescribed escalating doses of narcotics without a coherent pain control plan; and did not adequately supervise his medical assistant to ensure she did not authorize refills of medications.

29. LM was hospitalized several times for suicidal ideation, a motor vehicle accident, and finally a drug overdose. LM was at risk for hepatic dysfunction as a result of the Tylenol contained with the excessively prescribed Darvocet.

30. PB overdosed on the over-prescribed medications and died.

31. Respondent's past disciplinary history with the Board is an aggravating factor.

CONCLUSIONS OF LAW

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

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes 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)(q) ("[a]ny conduct or practice which is or might be harmful or dangerous to the health of the patient or the public"); A.R.S. § 32-1401(ll) ("[c]onduct that that board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient"); and A.R.S. § 32-1401(27)(ii) ("[l]ack of or inappropriate direction, collaboration or direct supervision of a medical assistant or a licensed, certified or registered health care provider employed by, supervised by or assigned to the physician.").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

1. Respondent is issued a Decree of Censure for mismanagement of a drug-seeking patient, failure to appropriately supervise a medical assistant resulting in over-prescribing to patients, and failure to maintain adequate medical records.

2. Respondent is placed on probation for two years with the following terms and conditions:

a. Within 120 days Respondent shall obtain 20 total hours of Board Staff pre-approved Category I Continuing Medical Education ("CME") in pain management and prescribing. Respondent shall provide Board Staff with satisfactory proof of attendance.. The CME hours shall be in addition to the hours required for biennial renewal of medical license.

b. Board Staff or its agents shall conduct chart reviews every six months. The Board may take additional disciplinary or remedial action based upon the chart review.

c. Respondent shall obey all federal, state, and local laws and all rules governing the practice of medicine in Arizona.

3. In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 9th day of February 2007.

ARIZONA MEDICAL BOARD 1913 STATE OF ARIZONA

THE ARIZONA MEDICAL BOARD

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

ORIGINAL of the foregoing filed this 9th day of February, 2007 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Mail this 9th day of February, 2007, to:

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

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