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**BEFORE THE ARIZONA MEDICAL BOARD**

In the Matter of

**Susan B. Fleming, M.D.**

Holder of License No. **14840**  
For the Practice of Allopathic Medicine  
In the State of Arizona.

**Case No. MD-13-0480A  
MD-13-0883A  
MD-14-0266A**

**INTERIM CONSENT AGREEMENT  
FOR PRACTICE RESTRICTION**

**INTERIM CONSENT AGREEMENT**

Susan B. Fleming, M.D. ("Respondent"), elects to permanently waive any right to a hearing and appeal with respect to this Interim Consent Agreement for Practice Restriction and consents to the entry of this Order by the Arizona Medical Board ("Board").

**INTERIM 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. 14840 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated the above referenced cases after receiving complaints as follows:

a. MD-13-0480A after receiving a complaint from a pharmacist regarding the care and treatment of 51 year-old female patient ("GM"), alleging inappropriate/excessive prescribing, and inadequate medication management.

b. MD-13-0883A after receiving a complaint regarding the care and treatment of 54 year-old male patient ("ML"), alleging inappropriate/excessive prescribing of narcotics.

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1 c. MD-14-0266A after receiving a complaint regarding the care and  
2 treatment of 54 year-old male patient ("DM") alleging inappropriate  
3 prescribing.

4 **MD-13-0480A- Patient GM**

5 4. GM's initial appointment with Respondent occurred on August 10, 2012 and  
6 she was described by Respondent as exhibiting signs of withdrawal with agitation and  
7 nausea. Respondent documented a physical exam, but did not document vital signs, or  
8 auscultation of the heart or lungs. Respondent's treatment plan included having GM sign a  
9 pain management agreement, sending urine for confirmatory testing, and continuing  
10 prescriptions for Oxycodone, lorazepam, and Zoloft, with a two week follow up.

11 5. On August 28, 2012, Respondent increased GM's Methadone, while  
12 continuing GM's Oxycodone on its regular schedule. On September 26, 2012, Respondent  
13 noted that GM continued to experience joint swelling and pain as well as facial pain from  
14 scleritis. Respondent ordered GM to continue Methadone and Oxycodone as needed.

15 6. On November 20, 2012, Respondent noted that GM was in considerable  
16 pain, and described impairment of physical activity. Respondent started GM on Oxycontin,  
17 and told her to continue her Methadone and Oxycodone.

18 7. On December 6, 2012, GM reported to Respondent that she was able to  
19 discontinue her Methadone use with the addition of Oxycontin. Respondent instructed GM  
20 to increase her Oxycodone to address GM's complaint of dizziness.

21 8. On January 4, 2013, GM reported continued pain, but stated that it was  
22 better with Oxycontin and Oxycodone. Respondent instructed her to continue these  
23 medications.

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1           9.     In March, 2013, GM reported to Respondent that the medication combination  
2 helped, but that she continued to have pain. Respondent instructed her to continue her  
3 medications, and added oxymorphone.

4           10.    On April 24, 2013, GM was seen with an acute flare of arthritis, multiple joint  
5 swelling and tenderness, and GM received an intramuscular Kenalog injection. She was  
6 instructed to continue Oxycontin with Oxycodone as needed. Respondent made an  
7 addendum to her chart note for this date stating that she received a call from a pharmacist  
8 concerned that less than thirty days elapsed between prescription refills. There were no  
9 clinical notes for review subsequent to the note of April 24, 2013. Two letters included in  
10 the records for review were noted to be from prescription review services in December of  
11 2012 and April of 2013 addressed to Respondent. The letters stated that their reviews had  
12 identified GM as having unusual medication utilization patterns with possible indication of  
13 drug over utilization. Respondent's response indicated that GM's current therapy was  
14 appropriate and medically necessary for GM to continue.

15           11.    The standard of care requires a physician to evaluate the chronic pain  
16 patient, including review of diagnostic studies and prior interventions as well as drug  
17 history. Respondent deviated from the standard of care by failing to obtain medical  
18 records from GM's prior pain management provider.

19           12.    The standard of care requires a physician to obtain complete vital signs of  
20 the patient, including checking the patient's' blood pressure, heart rate or oxygen  
21 saturation in addition to recording height and weight. Respondent deviated from the  
22 standard of care by failing to check GM's blood pressure, heart rate or oxygen saturation.

23           13.    The standard of care requires a physician to monitor (and address as  
24 indicated) the frequency of the patient's opioid prescription fills. Respondent deviated  
25

1 from the standard of care by failing to monitor the frequency of opioid prescription fills by  
2 patient GM.

3 14. The standard of care requires a physician to consider treatment modalities  
4 other than opioids and steroid injections. Respondent deviated from the standard of care  
5 by failing to consider treatment modalities other than opioids and steroid injections for GM.

6 15. The standard of care requires a physician to adequately work up or consider  
7 factors contributing to the patient's reported lack of pain control, and to avoid providing  
8 significant opioid dose escalation. Respondent deviated from the standard of care by  
9 providing significant opioid dose escalation for patient GM without adequate workup or  
10 consideration of factors contributing to GM's reported lack of pain control.

11 16. The standard of care requires a physician to monitor, recognize, and  
12 evaluate problems associated with opioid-related disorders. Respondent deviated from  
13 the standard of care by failing to monitor, recognize, and evaluate problems associated  
14 with opioid-related disorders for patient GM.

15 17. As a result of Respondent's actions, GM is at increased risk of harm from  
16 drug toxicity, drug overdose, respiratory depression, aspiration, sleep apnea, endocrine  
17 dysfunction, neurologic impairment, and death from the levels of prescribed opioids. GM  
18 did not receive any other forms of treatment to help with pain management such as pool  
19 therapy, other forms of physical therapy or occupational therapy to assist with adaptive  
20 equipment, edema management and body mechanics training, or psychological pain  
21 management training to help with quality of life issues and self-care techniques.

22 **MD-13-0883A- Patient ML**

23 18. In 2002, patient ML sustained a 30-40 foot fall at work and subsequently  
24 developed chronic pain symptoms in his lower back radiating to his left thigh. He failed a  
25 series of steroid injections for his symptoms and over several years, had built up a

1 tolerance to a fairly high-dose narcotic regimen from his pain doctor. During ML's five  
2 years with his pain doctor, he was able to work full-time without any deleterious side  
3 effects. In 2007, ML transferred his care to Respondent's clinic. Prior to that transfer, ML's  
4 pain doctor noted that the narcotic dosage had reached a very high level and he wished to  
5 titrate ML off the high prescription.

6 19. Respondent assumed care of ML and continued his high-dose treatment  
7 regimen of the long acting narcotic Oxycontin and a breakthrough prescription for  
8 Oxycodone. Per Respondent's notes, it appeared to be working satisfactorily, and ML  
9 continued to hold a full-time job. Over the next six years, Respondent continued to treat  
10 ML with a relatively similar dose of Oxycontin while significantly increasing his use of the  
11 breakthrough medications Oxycodone and oral morphine ("MSIR"). ML's doses under  
12 Respondent's care reached the levels of 1,440mg of Oxycontin per day, 660mg of  
13 Oxycodone per day, and 360mg of MSIR per day.

14 20. The standard of care when the dose of a drug becomes uncommonly high  
15 requires a physician to begin a taper where the patient is slowly weaned off the drug in  
16 order to attenuate the built-up tolerance, or to switch to other narcotic formulations to  
17 minimize a growing dependency on one substance. Respondent deviated from the  
18 standard of care by failing to suggest a narcotic taper and by failing to document an opioid  
19 rotation.

20 21. As a result of Respondent's actions, ML was at risk for opioid hyperalgesia  
21 and low testosterone levels, which could lead to osteoporosis and muscle pain. ML was  
22 treated with hormone replacement to minimize this effect.

23 **MD14-0266A- Patient DM**

24 22. Patient DM established care with Respondent on February 14, 2003 with a  
25 subjective complaint of chronic neck and right upper extremity pain. Treatment up to

1 March 2007, included continuous prescriptions of Oxycodone and Methadone in increasing  
2 amounts. Respondent also treated DM with Valium.

3 23. In May 2007, Respondent's records show that DM was taking Oxycodone at  
4 30mg up to six times a day and Methadone at 120mg per day (60mg twice daily). During  
5 DM's visits in May, July and November 2007, Respondent observed that DM had normal  
6 posture and gait, otherwise there was no physical examination relevant to DM's chronic  
7 neck pain. In September 2007, DM complained of constipation and Respondent provided  
8 him with samples of Miralax.

9 24. In 2008, Respondent continued to treat DM. In January 2008, DM  
10 complained of acute strain of the left mid back region that was almost completely resolved  
11 with use of Valium and heat. Respondent's records show a physical examination  
12 revealing minimal tenderness and no spasm in the thoracolumbar junction. In November  
13 2008, Respondent introduced a new patient questionnaire for DM to complete at each  
14 visit. At that time, DM stated that he was being treated for pain conditions of the low back,  
15 occasional sciatica, nerve damage and trapezius. At no time in 2008 did Respondent's  
16 records show a physical examination that supported ongoing opioid management of  
17 subjective discomforts related to the neck. None of the previous records for DM  
18 demonstrate a history, physical examination, or diagnostic work obtained by Respondent  
19 for chronic lumbar pain. Respondent's records for DM in 2008 reference continued  
20 prescriptions for Methadone at 120mg per day and unspecified continued doses of  
21 Oxycodone.

22 25. In 2009, Respondent's records reflect treatment of DM for lower back pain;  
23 however, Respondent failed to document a pain history, physical examination or  
24 diagnostic work up regarding DM's complaint. Respondent's records reference continued  
25 Methadone treatment at 120mg per day and Oxycodone at unspecified amounts.

1 Pharmacy records show that DM was taking an average of six 30mg Oxycodone daily as  
2 prescribed by Respondent. Also, while Respondent's records do not reflect any  
3 prescriptions for Diazepam, pharmacy records show that DM received seven prescriptions  
4 for #100 Diazepam 5mg tablets in 2009.

5 26. Respondent continued to prescribe DM Methadone 120mg per day,  
6 Oxycodone at unspecified doses, and Valium as needed for muscle spasms throughout  
7 2010. DM reported occasional sleepiness and constipation. Respondent's records show  
8 repeated normal physical examinations, but no objective findings to support ongoing  
9 opioid management of subjective neck and low back pain.

10 27. On November 10, 2010, Respondent provided DM with an "extra prescription  
11 for Oxycodone to cover the expected pain from the planned dental work," but did not  
12 indicate what dental work was planned, or why it would require an additional prescription.  
13 Pharmacy records show that Respondent provided DM with two prescriptions for 30mg  
14 Oxycodone at #240 each on November 3 and 10, 2010, both of which were dispensed.

15 28. In 2011, Respondent's documentation shows consistent physical  
16 examinations with normal gait and posture, and no abnormal findings providing an  
17 objective basis for ongoing opioid management of DM's subjective complaints of neck and  
18 low back pain. DM continued to report occasional constipation that was controlled with  
19 diet and Miralax. Respondent continued to prescribe Methadone at 120mg per day and  
20 Oxycodone at unspecified doses. Pharmacy records show that DM obtained monthly  
21 prescriptions of #260 Oxycodone 30mg. In 2011, Respondent's records do not show  
22 prescriptions for Diazepam; however, pharmacy records show that DM obtained ten  
23 prescriptions for 100 pills of 10mg Diazepam.

24 29. On DM's March 1, 2011 visit, DM disclosed to Respondent that he had  
25 obtained Percocet from an oral surgeon for an urgent dental procedure. At that same visit,

1 Respondent prescribed an "extra" Oxycodone prescription "to cover future dental work."  
2 There is no reference in Respondent's records regarding contact with the dentist to  
3 coordinate care regarding the dental work and additional prescription. Pharmacy records  
4 show that DM filled an additional 360 pill prescription for Oxycodone 15mg and a 360 pill  
5 prescription for Oxycodone 30mg in March. In April 2011, Respondent provided DM with  
6 samples of Testim followed by a monthly prescription for compound testosterone cream  
7 for hypogonadism for a subjective complaint of daytime drowsiness. Respondent did not  
8 obtain initial laboratory values for DM's testosterone.

9         30. Pharmacy records for DM in 2012 show that he continued to receive monthly  
10 prescriptions for #360 Oxycodone 30mg, #360 Methadone 10mg, and #100 Diazepam  
11 5mg. Respondent's records consistently reflected limited physical assessments with  
12 normal posture and gate noted. Respondent's records do not reference the prescriptions  
13 for Diazepam that were being filled by DM. At DM's May 9, 2012 visit, Respondent  
14 prescribed DM an "extra" #360 Oxycodone 30mg prescription for unspecified anticipated  
15 dental surgery and a subjective complaint of exacerbation of lower back pain. In October  
16 2012, Respondent prescribed DM Adderall 5 to 10mg per day for excessive daytime  
17 sleepiness attributed to pain medication based on DM's self-report that he had used it in  
18 the past with good results. Respondent's records do not show that baseline blood  
19 pressure and heart rate were obtained at the time Adderall treatment was initiated by  
20 Respondent.

21         31. Pharmacy records show that DM obtained prescriptions from Respondent for  
22 Adderall 10mg daily on November 14, 2012 and January 31, 2013. At DM's April 2013  
23 visit, Respondent noted that DM "uses Adderall for ADHD symptoms. He uses this  
24 intermittently due to cost issues." Respondent increased DM's Adderall prescription that  
25 same month to 30mg daily and pharmacy records show that the prescription was provided

1 on a monthly basis thereafter. Respondent did not obtain relevant vital signs for blood  
2 pressure or pulse from the date Adderall treatment was initiated through February 2014.

3 32. In 2013, Respondent's limited physical examination reflected normal gait and  
4 posture and no abnormal findings to support DM's ongoing opioid medication prescriptions  
5 for subjective complaints of neck and low back pain. Respondent's records show that DM  
6 continued to utilize Miralax for constipation. In 2013, Respondent's records do not  
7 reference any Diazepam prescriptions; however, pharmacy records show that DM filled  
8 prescriptions on six occasions for #100 Diazepam 5mg from Respondent.

9 33. At DM's July 2013 visit with Respondent, she prescribed DM Dilaudid 4mg  
10 12 tablets daily, apparently related to DM's difficulty in obtaining an adequate supply of  
11 Oxycodone from pharmacies. Respondent ultimately transitioned DM to a combination of  
12 Methadone 120mg per day, Oxycodone 30mg six times a day and Dilaudid 4mg, 12  
13 tablets daily. At DM's December 2013 visit, Respondent provided DM with an extra  
14 prescription for #180 Oxycodone 15mg tablets for a recent wrist fracture that DM had  
15 already received treatment and a prescription for Ibuprofen from the VA. There is no  
16 reference in Respondent's records regarding whether she attempted to coordinate care  
17 with the VA provider.

18 34. At DM's February 2014 visit with Respondent, records show DM continued to  
19 use the extra Oxycodone 15 mg, six times daily prescription for pain from his healed wrist  
20 fracture. Pharmacy records show that DM also continued to fill prescriptions for #360  
21 Methadone 10 mg, #180 Oxycodone 30 mg and #360 Dilaudid 4 mg.

22 35. Respondent's records contain results of urine drug screening performed on  
23 April 27, 2007, May 15, 2008, February 24, 2009, April 8, 2010 and June 16, 2011. A  
24 handwritten notation in the record references urine drug screens performed on October  
25 23, 2012 and May 31, 2013 but the results are not contained in the record.

1           36. The standard of care requires that in addition to initial assessment, ongoing  
2 opioid prescribing should be accompanied by intermittent reassessment of the underlying  
3 pain problem to determine if ongoing opioid prescribing is warranted, and/or if there has  
4 been interval development of new or progressive pathology. This includes targeted  
5 physical re-examination, updated diagnostic testing and specialist consultation as  
6 indicated. Given the strong evidence for serious risks of long term opioids – many of  
7 which significantly increase with long term use, the standard of care requires a physician  
8 to periodically reassess and determine if there continues to be clinical evidence of an  
9 objective pain generator which warrants continued opioid prescribing. Respondent  
10 deviated from the standard of care by failing to perform a reassessment at any time to  
11 identify objective clinical evidence of a pain generator warranting continued high dose  
12 opioid management of DM's subjective complaints.

13           37. The standard of care requires a physician to have an individualized chronic  
14 pain management treatment plan and include consideration not only of opioid medication,  
15 but also noninvasive techniques, behavioral strategies, physical therapy, non-opioid  
16 medications, and specialist consultations as indicated. Respondent deviated from the  
17 standard of care for patient DM by relying heavily on high dose opioids and unjustified  
18 dose escalations for subjective discomforts in the absence of a coordinated  
19 multidisciplinary treatment plan, and without adequate attention to alternative treatments.

20           38. The standard of care requires a physician to investigate increasing or new  
21 pain complaints for potentially treatable disease progression or new pathology prior to  
22 significant dose escalations in excess of expected development of physiologic tolerance.  
23 Respondent deviated from the standard of care for patient DM by providing significant  
24 dose escalations in excess of that expected for physiologic tolerance, in the absence of  
25 investigation or identification of any pathology to warrant such increases, and by providing

1 unjustified dose escalations in the absence of any diagnostic work up or specialty  
2 consultation to determine if there is treatable or objective pathology associated with DM's  
3 escalating subjective complaints.

4 39. The standard of care requires a physician to properly inform the patient of  
5 the cardiac risk associated with Methadone prescribing, obtain a detailed personal and  
6 family history related to cardiac risk factors, and to perform ECG screening. Respondent  
7 deviated from the standard of care for patient DM by prescribing significant doses of  
8 Methadone for eleven years, the past seven of which were after an FDA safety alert, and  
9 the past five years were after wide dissemination of Methadone prescribing guidelines  
10 related to the cardiac risks associated with such treatment. Despite this, at no time is there  
11 documentation that Respondent informed DM of the cardiac risk, obtained a detailed  
12 personal and family history related to cardiac risk factors, or performed ECG screening.

13 40. The standard of care requires a physician to base the decision to  
14 concurrently prescribe opioid and benzodiazepine on well documented and reasonable  
15 medical rationale, as this combination is well known to significantly increase the risk of  
16 respiratory depression, accidental overdose and death. Respondent deviated from the  
17 standard of care for patient DM by failing to document a rationale to warrant the risks of  
18 long term prescribing of Diazepam in combination with high dose Methadone and  
19 Oxycodone.

20 41. The standard of care requires a physician to coordinate care with the  
21 patient's other treating physicians. Respondent deviated from the standard of care by  
22 providing large quantity Oxycodone prescriptions for patient DM's anticipated post-dental  
23 procedure pain on three separate occasions; and for DM's complaint of persistent wrist  
24 pain without contacting the dentist or the patient's treating physician.

25

1           42. The standard of care requires a physician to establish the criteria for  
2 diagnosing adult ADHD and/or determining appropriateness of a stimulant prior to  
3 prescribing the medication. Respondent deviated from the standard of care for patient DM  
4 by prescribing monthly stimulant medication for one year, having failed to establish even  
5 the absolute minimum criteria for diagnosing adult ADHD and/or determining the  
6 appropriateness of stimulant medication.

7           43. The standard of care prior to prescribing testosterone requires a physician to  
8 obtain lab verification that the condition exists, and when prescribing long term, the  
9 standard requires a physician to monitor the patient with lab testing every six months.  
10 Respondent deviated from the standard of care for patient DM by prescribing testosterone  
11 replacement for one year, in the absence of initial documentation of low testosterone  
12 levels on laboratory testing and without monitoring testosterone levels during treatment.

13           44. The standard of care prior to introduction, continuation and/or escalation of  
14 long term opioids for chronic pain requires a physician to closely monitor the patient for  
15 non-compliance and/or aberrant drug seeking behavior. Respondent deviated from the  
16 standard of care by failing to closely monitor patient DM for non-compliance and/or  
17 aberrant drug seeking behavior.

18           45. Respondent's actions perpetuated an iatrogenic physical and emotional  
19 dependence on ultra-high doses of narcotics for patient DM, in the absence of any  
20 objective evidence to support the treatment. As a result, DM was unnecessarily exposed  
21 to risk of long term harms of these medications and by failing to periodically assess DM's  
22 underlying condition for associated new or progressive pathology, a potentially treatable  
23 new or progressive cause for his subjective symptoms may have been overlooked.  
24 Additionally, DM developed a motor and sensory ulnar neuropathy that took months to  
25 resolve, after falling asleep in a sitting position, leaning on his elbows. This is an unusual

1 development in an individual who is not cognitively impaired, as the ulnar pain from this  
2 sleeping position would awaken most cognitively intact patients prior to development of  
3 prolonged motor dysfunction.

4 46. Additional potential harms of Respondent's chronic high dose opioid  
5 treatment for patient DM include hypogonadism, narcotic bowel syndrome (up to and  
6 including small bowel obstruction), osteoporosis, sleep apnea, opioid induced  
7 hyperalgesia (increased sensitivity to pain) and opioid induced mood disorder (anxiety,  
8 depression and/or apathy).

9 47. Methadone related potential harm for patient DM includes a potentially fatal  
10 cardiac event due to abnormal heart rhythms associated with high dose Methadone that  
11 can occur in the absence of any ECG monitoring. Adderall related potential harm for  
12 patient DM includes stimulant abuse, addiction, and diversion, as well as insomnia,  
13 anorexia, headaches and social withdrawal. Testosterone related potential harm for  
14 patient DM in the absence of documented hypogonadism or monitoring of serum  
15 testosterone during treatment, includes unnecessary exposure to exogenous testosterone  
16 which has been implicated in increased risk of prostate disease including prostate cancer,  
17 as well as increased cardiovascular risk.

18 48. The aforementioned information was presented to the investigative staff, the  
19 medical consultant and the lead Board member. All reviewed the information and concur  
20 that the interim consent agreement to restrict Respondent's practice is appropriate.

21 49. The investigation into the above matters is pending and will be presented to  
22 the Board promptly upon completion for review and action.

#### 23 INTERIM CONCLUSIONS OF LAW

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



1           1.     The Board, through its Executive Director, may adopt this Interim Consent  
2 Agreement, or any part thereof, pursuant to A.R.S. § 32-1405(C)(25) and A.A.C. R4-16-  
3 504.

4           2.     Respondent has read and understands this Interim Consent Agreement as  
5 set forth herein, and has had the opportunity to discuss this Interim Consent Agreement  
6 with an attorney or has waived the opportunity to discuss this Interim Consent Agreement  
7 with an attorney. Respondent voluntarily enters into this Interim Consent Agreement and  
8 by doing so agrees to abide by all of its terms and conditions.

9           3.     By entering into this Interim Consent Agreement, Respondent freely and  
10 voluntarily relinquishes all rights to an administrative hearing on the matters set forth  
11 herein, as well as all rights of rehearing, review, reconsideration, appeal, judicial review or  
12 any other administrative and/or judicial action, concerning the matters related to the  
13 Interim Consent Agreement.

14           4.     Respondent understands that this Interim Consent Agreement does not  
15 constitute a dismissal or resolution of this matter or any matters that may be currently  
16 pending before the Board and does not constitute any waiver, express or implied, of the  
17 Board's statutory authority or jurisdiction regarding this or any other pending or future  
18 investigations, actions, or proceedings. Respondent also understands that acceptance of  
19 this Interim Consent Agreement does not preclude any other agency, subdivision, or  
20 officer of this State from instituting civil or criminal proceedings with respect to the conduct  
21 that is the subject of this Interim Consent Agreement. Respondent further does not  
22 relinquish her rights to an administrative hearing, rehearing, review, reconsideration,  
23 judicial review or any other administrative and/or judicial action, concerning the matters  
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1 related to a final disposition of this matter, unless she affirmatively does so as part of the  
2 final resolution of this matter.

3 5. Respondent acknowledges and agrees that upon signing this Interim  
4 Consent Agreement and returning it to the Board's Executive Director, Respondent may  
5 not revoke her acceptance of this Interim Consent Agreement or make any modifications  
6 to it. Any modification of this original document is ineffective and void unless mutually  
7 approved by the parties in writing.

8 6. Respondent understands that this Interim Consent Agreement shall not  
9 become effective unless and until it is signed by the Board's Executive Director.

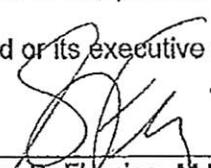
10 7. Respondent understands and agrees that if the Board's Executive Director  
11 does not adopt this Interim Consent Agreement, she will not assert in any future  
12 proceedings that the Board's consideration of this Interim Consent Agreement constitutes  
13 bias, prejudice, prejudgment, or other similar defense.

14 8. Respondent understands that this Interim Consent Agreement is a public  
15 record that may be publicly disseminated as a formal action of the Board, and that it shall  
16 be reported as required by law to the National Practitioner Data Bank.

17 9. Respondent understands that this Interim Consent Agreement does not  
18 alleviate her responsibility to comply with the applicable license-renewal statutes and  
19 rules. If this Interim Consent Agreement remains in effect at the time Respondent's  
20 allopathic medical license comes up for renewal, she must renew her license if  
21 Respondent wishes to retain her license. If Respondent elects not to renew her license as  
22 prescribed by statute and rule, Respondent's license will not expire but rather, by  
23 operation of law (A.R.S. § 32-3202), become suspended until the Board takes final action  
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1 in this matter. Once the Board takes final action, in order for Respondent to be licensed in  
2 the future, she must submit a new application for licensure and meet all of the  
3 requirements set forth in the statutes and rules at that time.

4 10. Respondent understands that any violation of this Interim Consent  
5 Agreement constitutes unprofessional conduct under A.R.S. § 32-1401(27)(r) ("[v]iolating a  
6 formal order, probation, consent agreement or stipulation issued or entered into by the  
7 board or its executive director under this chapter.").

8  
9   
Susan B. Fleming, M.D.

DATED: 11/19/14

10  
11 DATED this 20<sup>th</sup> day of November, 2014.

12 ARIZONA MEDICAL BOARD

13 By Patricia E. McSorley

14 Patricia E. McSorley  
15 Interim Acting Executive Director

16 EXECUTED COPY of the foregoing e-mailed  
17 this 20<sup>th</sup> day of November, 2014 to:

18 Stephen Myers  
19 Myers & Jenkins  
20 One East Camelback Road, Suite 500  
Phoenix AZ 85012  
Attorney for Respondent

21 ORIGINAL of the foregoing filed  
22 this 20<sup>th</sup> day of November 2014 with:

23 Arizona Medical Board  
24 9545 E. Doubletree Ranch Road  
Scottsdale, AZ 85258

25 Mary Robee  
Board Staff