



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

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

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

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

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

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

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

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Reginald M Sutton  
REGINALD M. SUTTON, M.D.

DATED: 11/3/08

1 **FINDINGS OF FACT**

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

4 2. Respondent is the holder of license number 29166 for the practice of  
5 allopathic medicine in the State of Arizona.

6 3. The Board initiated case number MD-07-0917A after receiving a complaint  
7 regarding Respondent's care and treatment of a fifty-four year-old female patient ("NT").

8 4. On June 29, 2007, NT re-established care with Respondent and complained  
9 of lower back and left wrist pain. NT had a medical history that included a hysterectomy,  
10 salpingo-oophorectomy, irritable bowel syndrome (IBS), and constipation. Respondent  
11 examined NT and diagnosed her with chronic lower back pain with paravertebral spasm,  
12 left wrist pain and IBS. Respondent prescribed Vicodin. Respondent noted that NT's lower  
13 back pain had previously been treated at a hospital with Demerol and Lortab and that she  
14 had no history of drug abuse. However, there was no indication that Respondent obtained  
15 NT's previous treating physician's records to determine her prior narcotic use.

16 5. On October 5, 2007, NT presented for a visit and reported lower back and  
17 wrist pain. Respondent examined NT's left wrist and back and diagnosed her with left  
18 chronic recurrent lower back pain with spasm and left wrist fracture with spasm.  
19 Respondent prescribed Vicodin and again noted that NT had no history of drug abuse.

20 6. During an investigational interview with Board Staff on February 22, 2008,  
21 Respondent stated that he had not heard from NT until just prior to her June 29, 2007  
22 appointment. However, during the Board's investigation Board Staff reviewed several  
23 pharmacy surveys that showed NT filled several prescriptions on multiple occasions  
24 written by Respondent from January 1, 2007 through June 10, 2007. The prescriptions  
25 included narcotics, Prempro (an estrogen/progestin containing compound), and Zelnorm

1 for her IBS and constipation. Respondent prescribed Prempro even though he was aware  
2 that NT had undergone a hysterectomy. The surveys also showed that on several  
3 occasions NT refilled the narcotic prescriptions early. Respondent acknowledged that he  
4 may have written prescriptions for NT prior to the June 29, 2007 appointment.

5 7. Additionally, NT's medical record contained notes from visits on June 29,  
6 2007 and October 5, 2007, but it did not contain any documentation prior to June 29, 2007.  
7 Specifically, there was no documentation of NT's multiple visits; no documentation that  
8 Respondent performed a history of present illnesses that includes a directed examination,  
9 assessment and plan prior to prescribing the medications; no documented rationale for the  
10 narcotic prescriptions; no documented progress notes to substantiate the prescriptions;  
11 and no documented discussion of the possible side effects or indications for the use of  
12 Zelnorm. In response to the Board's investigation, Respondent stated that he was unable  
13 to locate the associated progress notes for NT's visits prior to June 29, 2007.

14 8. The standard of care requires a physician to document patient visits and  
15 progress including examinations directed to the patient's chief complaint.

16 9. Respondent deviated from the standard of care because he did not  
17 document NT's multiple visits and progress prior to the June 29, 2007 appointment.

18 10. The standard of care requires a physician to document a history of present  
19 illnesses that includes a directed examination, assessment, and plan when writing a  
20 prescription for controlled substances.

21 11. Respondent deviated from the standard of care because he did not  
22 document a history of present illnesses prior to June 29, 2007 when he wrote prescriptions  
23 for NT.

24 12. The standard of care requires a physician to obtain a patient's previous  
25 treatment records to determine prior narcotic use.

1           13.    Respondent deviated from the standard of care because he did not obtain  
2 NT's previous treatment records to determine her prior narcotic use.

3           14.    The standard of care requires a physician to refrain from treating the patient  
4 with progestin containing compounds when a patient has undergone a hysterectomy,

5           15.    Respondent deviated from the standard of care because he prescribed  
6 progestin containing compounds to NT.

7           16.    The standard of care requires a physician to discuss the possible side effects  
8 and indications for the use of Zelnorm.

9           17.    Respondent deviated from the standard of care because he did not  
10 document discussing the possible side effects and indications for the use of Zelnorm for  
11 NT.

12           18.    There was potential for Respondent to miss NT's drug seeking behavior and  
13 for NT to overdose on narcotics. There was an increased risk for NT to develop breast  
14 cancer from the Prempro and an increased risk that Respondent would have missed that  
15 diagnosis due to a lack of documentation of a breast examination or mammography. There  
16 was also an increased risk of diarrhea and hypotension as a result of NT using Zelnorm.

17           19.    A physician is required to maintain adequate legible medical records  
18 containing, at a minimum, sufficient information to identify the patient, support the  
19 diagnosis, justify the treatment, accurately document the results, indicate advice and  
20 cautionary warnings provided to the patient and provide sufficient information for another  
21 practitioner to assume continuity of the patient's care at any point in the course of  
22 treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because they did  
23 not contain any documentation prior to June 29, 2007.

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1 CONCLUSIONS OF LAW

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

4 2. The conduct and circumstances described above constitute unprofessional  
5 conduct pursuant to A.R.S. § 32-1401 (27)(e) (“[f]ailing or refusing to maintain adequate  
6 records on a patient.”); A.R.S. § 32-1401(27)(q) (“[a]ny conduct or practice that is or might  
7 be harmful or dangerous to the health of the patient or the public.”); A.R.S. § 32-1401  
8 (27)(jj) (“[k]nowingly making a false or misleading statement to the board or on a form  
9 required by the board or in a written correspondence, including attachments, with the  
10 board.”) and A.R.S. § 32-1401 (27)(ss) (“[p]rescribing, dispensing or furnishing a  
11 prescription medication or a prescription-only device as defined in section 32-1901 to a  
12 person unless the licensee first conducts a physical examination of that person or has  
13 previously established a doctor-patient relationship.”).

14 ORDER

15 IT IS HEREBY ORDERED THAT:

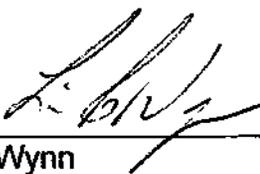
16 1. Respondent is issued a Letter of Reprimand for failure to document multiple  
17 patient visits, for failure to document rationale for narcotic prescriptions on multiple  
18 occasions, for prescribing a progestin containing compound for a patient who has  
19 undergone a hysterectomy and for failure to maintain adequate records.

20 2. This Order is the final disposition of case number MD-07-0917A.

21 DATED AND EFFECTIVE this 4th day of December, 2008.



ARIZONA MEDICAL BOARD

By   
Lisa S. Wynn  
Executive Director

ORIGINAL of the foregoing filed  
this 4th day of December 2008 with:

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

EXECUTED COPY of the foregoing mailed  
this 4th day of December 2008 to:

Stephen Myers  
Myers & Jenkins  
One East Camelback Road, Suite 500  
Phoenix, Arizona 85012

EXECUTED COPY of the foregoing mailed  
this 4th day of December, 2008 to:

Reginald M. Sutton, M.D.  
Address of Record

  
Investigational Review