

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **SUSAN D. SCARLA, M.D.**

4 Holder of License No. 13951
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Case No. MD-15-0916A

**INTERIM CONSENT AGREEMENT
FOR PRACTICE RESTRICTION**

7 **INTERIM CONSENT AGREEMENT**

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

11 **INTERIM FINDINGS OF FACT**

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

14 2. Respondent is the holder of License No. 13951 for the practice of allopathic
15 medicine in the State of Arizona.

16 3. The Board initiated case number MD-15-0916A after receiving a complaint
17 from the DEA alleging that Respondent was prescribing controlled substances to family
18 members.

19 4. On July 15, 2015, Respondent wrote a prescription for a male patient ("BD")
20 and then attempted to have the prescription filled herself at a pharmacy stating that it was
21 for her nephew. The pharmacist noted that the address for BD was the same as the
22 address listed for one of Respondent's DEA numbers and refused to fill the script. Further
23 investigation showed that a female patient ("KN") was also listed with the same address as
24 Respondent and was receiving prescriptions from Respondent. The pharmacist reported
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1 the incident to the DEA as possible prescribing of controlled substances to family
2 members. The allegation was then forwarded to the Board's attention.

3 5. Respondent provided an initial narrative response to the Board's
4 investigation on August 17, 2015; however, no medical records for BD or KN were
5 included in the response. Respondent stated in her narrative that BD was not actually her
6 nephew, but was in a relationship with her adult daughter, SS. Respondent further stated
7 that she informed the pharmacist that BD was her nephew as a "social lie" to avoid
8 embarrassment. Respondent also noted that KN was her son NS's girlfriend. Respondent
9 stated that the treatment relationship with KN and BD was ongoing.

10 6. Respondent attended an investigation interview with Board staff on January
11 22, 2016. Respondent stated that she was employed as an Emergency Department
12 ("ED") physician at a Hospital through a practice group and also owns a small private pain
13 management practice called Preferred Pain Management ("PPM"). Respondent stated
14 that PPM did not have a fixed location for practice, but rather stated that PPM patients
15 were seen in the "S-Bed" area at the Hospital. Respondent asserted during the interview
16 that she had been given permission to see PPM patients at the Hospital by the owner of
17 the practice group who was also the founder of the Hospital. Respondent stated that
18 current Hospital administration would not be aware of the arrangement. Respondent
19 further stated that she does not pay rent to the Hospital, and her patients are all cash-pay.

20 7. Respondent failed to provide the medical records for patients BD and KN
21 until January 15, 2016. Board staff reviewed the records and noted that they were created
22 from a basic word document, with different headers and contained very scant and
23 redundant information. During the January 22, 2016 interview, Board staff questioned
24 Respondent about the adequacy of the records. Respondent reported that she did not
25 review the records before providing them to the Board and would provide a complete set

1 of records the following week. On January 26, 2016, Respondent provided some amended
2 records and a complete patient list. Board staff reviewed the amended records, which
3 showed lined out text and new information added well after their dates of service.

4 8. Respondent interviewed the owner of the practice group as well as Hospital
5 administration. None of those interviewed confirmed that Respondent had permission to
6 see PPM patients on Hospital grounds.

7 9. A review of Respondent's patient lists and records from the Controlled
8 Substance Prescription Monitoring Program ("CSPMP") showed that the patient list
9 provided by Respondent during her January 22, 2016 interview omitted several patients,
10 all of whom were prescribed controlled substances by Respondent.

11 10. A review of pharmacy records relating to BD and KN as well as four
12 additional patients to whom Respondent prescribed controlled substances ("BH" "ML" "TY"
13 and "JW") indicates that Respondent picked up prescriptions for BD and KN identifying
14 herself as a family member. Additionally, pharmacy records identify patient JW as picking
15 up prescriptions for BH, ML and TY. Records show that when contacted, Respondent
16 informed pharmacists that JW was authorized to pick up the prescriptions.

17 11. A Medical Consultant ("MC") review of Respondent's records for BD and KN
18 identified deviations from the standard of care as well as documentation concerns.

19 12. According to Respondent's records, BD established care with Respondent
20 on March 5, 2013. During that time, Respondent prescribed Suboxone, Xanax and
21 amphetamines to BD. At each of his visits, Respondent notes that BD is consuming one
22 half pint of vodka a day and Respondent's notes identify concerns regarding abuse of
23 alcohol and heroin. According to the MC, documentation of BD's assessment, plan and
24 history of present illness are repeated verbatim in multiple visits. Respondent documented
25 that BD was concerned about the interaction of Suboxone and Xanax on one occasion,

1 and that she counseled him at that time not to take the two medications at the same time.
2 Respondent's note of May 31, 2013 indicates a past history that was "possible" for ADHD
3 and identified past medications including Xanax, Prozac, Celexa and Adderall. The note
4 of August 13, 2013 states that BD mentioned a previous diagnosis of ADHD and that BD
5 stated that Adderall had been helpful in the past.

6 13. According to Respondent's records, KN established care with Respondent
7 on May 24, 2013 and during her course of treatment, Respondent prescribed her
8 Suboxone, Xanax and amphetamines. Respondent's notes indicate that KN had been
9 previously prescribed amphetamines and Xanax for ADHD. KN's initial drug screen was
10 positive for cocaine and KN identified a history of heroin abuse. According to the MC,
11 notes of visits with KN appear to be duplicative of each other. An assessment on October
12 9, 2013 states that Respondent prescribed KN Adderall in order to "combat the lack of
13 energy so she will be able to perform her daily activities." Additionally, a note from
14 October 18, 2014 indicates that KN was occasionally drinking alcohol. A note dated
15 February 17, 2015 states that KN had relapsed on heroin and that Respondent prescribed
16 Suboxone to KN based on her assessment. An addendum was added on February 19,
17 2015 stating that KN wanted Adderall and that she could not afford Suboxone.
18 Respondent provided KN with a prescription for Adderall.

19 14. A review of CSPMP data for BD and KN indicated that neither BD nor KN
20 had been prescribed Adderall prior to Respondent's treatment. BD had no prior
21 prescriptions of Xanax identified on his CSPMP report and KN had only two Xanax
22 prescriptions prior to Respondent's treatment.

23 15. The standard of care for prescription of medications with the potential for
24 abuse requires the physician to provide instructions on proper usage and informed
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1 consent. Respondent deviated from the standard of care for BD and KN by failing to
2 provide instructions on proper usage or adequate informed consent.

3 16. The standard of care for providing Suboxone requires adequate informed
4 consent and discussion of the risks of treatment. Caution should be used with regard to
5 other medications with Suboxone as well as prescribing Suboxone to patients who are
6 actively abusing alcohol. Respondent deviated from the standard of care by failing to
7 obtain or provide informed consent and by failing to exercise adequate caution with
8 patients who were actively abusing alcohol. Respondent also deviated from the standard
9 of care by failing to use appropriate caution in managing BD's use of Suboxone and Xanax
10 together.

11 17. There was potential for patient harm in that it is not recommended to use
12 Xanax or any benzodiazepine with Suboxone due to increased risk of respiratory
13 depression and overdose. Additionally, patients taking narcotics with uncontrolled
14 substance abuse problems are at risk of overdose.

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

18 19. The investigation into this matter is pending and will return to the Board
19 promptly upon completion for review and action.

20 **INTERIM CONCLUSIONS OF LAW**

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

23 2. Pursuant to A.R.S. § 32-1405(C)(25) the Executive Director has authority to
24 enter into a consent agreement when there is evidence of danger to the public health and
25 safety.

RECITALS

Respondent understands and agrees that:

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

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

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

4. Respondent understands that this Interim Consent Agreement does not constitute a dismissal or resolution of this matter or any matters that may be currently pending before the Board and does not constitute any waiver, express or implied, of the Board's statutory authority or jurisdiction regarding this or any other pending or future investigations, actions, or proceedings. Respondent also understands that acceptance of this Interim Consent Agreement does not preclude any other agency, subdivision, or officer of this State from instituting civil or criminal proceedings with respect to the conduct that is the subject of this Interim Consent Agreement. Respondent further does not

1 relinquish his rights to an administrative hearing, rehearing, review, reconsideration,
2 judicial review or any other administrative and/or judicial action, concerning the matters
3 related to a final disposition of this matter, unless he affirmatively does so as part of the
4 final resolution of this matter.

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

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

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

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

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

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

10
11 Susan D. Scarla, M.D. DATED: 4/5/16
12 SUSAN D. SCARLA, M.D.

13 DATED this 7th day of April, 2016.

14 ARIZONA MEDICAL BOARD

15 By Patricia E. McSorley
16 Patricia E. McSorley
17 Executive Director

18
19 EXECUTED COPY of the foregoing e-mailed
20 this 7th day of April, 2016 to:

21 Susan D. Scarla, M.D.
22 Address of Record

23 ORIGINAL of the foregoing filed
24 this 7th day of April, 2016 with:
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1 Arizona Medical Board
2 9545 E. Doubletree Ranch Road
3 Scottsdale, AZ 85258

4 Mary Baker
5 Arizona Medical Board Staff
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