

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **STEPHEN P. SUTTON, M.D.**

4 Holder of License No. **28812**
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Board Case No. MD-06-0062A

**FINDINGS OF FACT,
CONCLUSIONS OF LAW AND ORDER**

(Letter of Reprimand)

7 The Arizona Medical Board ("Board") considered this matter at its public meeting on May
8 18, 2007. Stephen P. Sutton, M.D., ("Respondent") appeared before the Board without legal
9 counsel for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-
10 1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order
11 after due consideration of the facts and law applicable to this matter.

12 **FINDINGS OF FACT**

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

15 2. Respondent is the holder of License No. 28812 for the practice of allopathic
16 medicine in the State of Arizona.

17 3. The Board initiated case number MD-06-0062A after receiving notification of a
18 malpractice settlement regarding Respondent's care and treatment of a fifty-four year-old male
19 patient ("JS") and a forty-four year-old female patient ("HS").

20 **Patient JS**

21 4. JS presented to Respondent on June 7, 2001 with a left renal stone. On June 19,
22 2001 Respondent placed a stent and performed an Extracorporeal Shock Wave Lithotripsy
23 ("ESWL"). On July 5, 2001 Respondent attempted to remove the stent, but could not because of
24 encrustation/calcification. Respondent obtained a urine culture and prescribed prophylactic
25 antibiotics (Cipro). Respondent removed the stent on July 10, 2001. A urine culture revealed

1 Pseudomonas aeruginosa. Respondent prescribed oral tetracycline, although the bacteria was
2 not sensitive.

3 5. JS consulted with another physician ("Dr. S") on August 16, 2001 who diagnosed
4 epididymitis and abscessed testicle. On August 20, 2001 Dr. S performed a left orchiectomy
5 complicated by persistent pain and infection requiring excision of the remaining spermatic cord
6 tissue on October 2, 2001. JS continued to having voiding dysfunction and recurrent urinary track
7 infections and Dr. S diagnosed Pseudomonas prostatitis. Dr. S then performed a TransUrethral
8 Resection of the Prostate on March 28, 2002 and diagnosed JS with prostate cancer.

9 6. Respondent believed his use of tetracycline to initially treat JS's uncomplicated
10 urinary tract infection ("UTI") was appropriate. Respondent noted JS was non-compliant and did
11 not obtain the repeat urine culture until ten days after Respondent instructed him to and, by that
12 time, the UTI had spread to cause systemic problems. Respondent believed his medical plan for
13 JS was medically and urologically sound and JS was non-compliant leading directly to his
14 problems.

15 7. A medical text does list Pseudomonas aeruginosa as having sensitivity to
16 tetracycline for oral therapy. Respondent initiated tetracycline at 500 milligrams four times a day,
17 yet got subsequent cultures showing a persistence of Pseudomonas and failed to act on this
18 information by either changing the course of antibiotic therapy or going to intravenous therapy.
19 Respondent maintained he was out of town with his family when JS finally got the second culture
20 and, when his office got the culture back, they immediately referred JS to a family doctor who
21 then enlisted the help of Dr. S. Pseudomonas is a very virulent organism and not particularly
22 common. Respondent noted as recently as a review class he took in 2003 for renewal of his
23 board certification, he was taught that tetracycline can be very useful in eradicating a UTI.
24 Respondent believed JS's calcified stent was the nidus for the infection and, since his active
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1 phase was asymptomatic and he had no other systemic symptoms, he was a perfect candidate
2 for tetracycline.

3 8. If a patient becomes truly septic from Pseudomonas, a gram negative bacteria,
4 failure to eradicate it in the urine and run the risk of a full-blown septic picture carries with it a very
5 high mortality rate – approximately seventy-five percent. After Respondent's treatment of JS and
6 shortly after he obtained another urinary culture in August, JS was seen by Dr. S, another
7 urologist, and underwent treatment (left orchiectomy) for ongoing sequelae from the
8 Pseudomonas itself and thereafter underwent a transurethral resection of the prostate because of
9 prostatic abscesses likewise related to the Pseudomonas. Yet, Respondent disagreed he
10 inadequately or improperly treated the Pseudomonas and noted if JS had come back sooner and
11 dropped off his culture a week and a half earlier as he was supposed to, he would have dealt with
12 the problem as he had planned and it would not have had a chance to reach a systemic level.

13 9. Having been sued Respondent would now take a more aggressive route in dealing
14 with a positive Pseudomonas culture, but he sees a lot of patients with similar problems and he
15 gives them the option of treating intravenously or with oral medications. Respondent believes if a
16 patient has an uncomplicated UTI with no other systemic symptoms and the patient understands
17 the situation and does the plan he asks them to, it is a safe way to process a UTI.

18 10. Respondent's routine for repeating the culture once he has initiated therapy for a
19 Pseudomonas culture is to give ten days worth of antibiotics and have the patient drop a urine
20 culture off. Within five days after the patient stops taking the antibiotic the culture should be back
21 and he should have an answer as to sensitivities. Since JS's case, Respondent has been more
22 proactive in contacting patients to make sure they get the repeat urine culture and tries to
23 emphasize at the beginning of treatment how important it is that the patient follow through with
24 the treatment plan.

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1 11. Respondent initially placed JS on Cipro after the initial lithotripsy and stent and
2 there was no sign of any infection. Respondent did not perform a culture and prophylactically
3 instituted the antibiotics because he had instrumented the urinary tract. When JS was in the office
4 for the stent removal, which was aborted because the stent was too encrusted, Respondent
5 routinely prescribed antibiotics and did not deem a culture necessary at that time. A couple of
6 days later when Respondent pulled the stent out under anesthesia he obtained a routine culture
7 that came back positive for Pseudomonas and, based on JS's lack of symptoms, he put him on
8 tetracycline.

9 12. Respondent thought the stent was infected, yet still felt comfortable putting JS on
10 oral antibiotics because he had taken the stent out and the encrustation was totally gone. The
11 culture that came back from that two days later showed there was a virulent Pseudomonas that
12 was not sensitive to any oral agent, but since JS was asymptomatic, Respondent chose to use
13 his judgment to try oral tetracycline to see if he could clear it up and, if that did not work, he would
14 go to IV medication.

15 13. The standard of care required Respondent to institute appropriate antibiotic
16 treatment of Pseudomonas according to culture results.

17 14. Respondent deviated from the standard of care by treating JS's urinary tract
18 infection with inappropriate and improper antibiotics.

19 15. JS required several surgical procedures to remove infected organs/glands.
20 Respondent's failure to provide appropriate antibiotics resulted in worsened infection, ultimately
21 causing abscess formation in the testicle resulting in surgical excision of the testicle. The infection
22 in the urinary tract involved the prostate requiring surgical resection to alleviate inflammation and
23 voiding dysfunction symptoms.

24 16. Respondent's failure to properly treat the urinary tract infection could have resulted
25 in fatal sepsis.

Patient HS

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2 17. HS presented to Respondent with a large renal stone (staghorn calculus) and
3 urinary infection. A renal scan to test for function revealed only ten percent function of the
4 affected kidney. Respondent's office notes included options of ESWL or percutaneous extraction
5 of the stone, however Respondent did not document he discussed removal of the entire kidney or
6 the possible necessity for removal with HS. HS underwent treatment with ESWL that was
7 complicated by infection and pain and required a nephrectomy to remove the nonfunctioning,
8 infected kidney.

9 18. After seeing HS's x-rays, even before Respondent saw her, he ordered a nuclear
10 scan to assess exactly how much function the kidney still had and to direct what therapy he would
11 offer her. Given what Respondent saw as 11.5 percent overall renal function, exceeding the 10
12 percent limit, he believed ESWL was appropriate. Respondent maintained he discussed the
13 options with HS, including doing nothing, and HS chose to have a series of repeat lithotripsies.
14 The last lithotripsy did not render the stone totally broken up and HS developed a perinephric
15 abscess that eventually resulted in nephrectomy. Respondent's chart does not support that he
16 discussed the options with HS. Respondent denied being negligent in not performing a
17 nephrectomy right away or in not diagnosing xanthogranulomatous pyelonephritis earlier.

18 19. The volume of stone in HS's kidney was fairly large and could not be removed in
19 one ESWL. However, Respondent believed he could remove it with three to five ESWL
20 treatments. Twenty days after the fourth lithotripsy HS underwent a procedure performed by
21 another physician to drain a perinephric abscess. This physician noted she was going to need a
22 nephrectomy due to poor function of the kidney. If presented with a similar case – a large
23 staghorn calculus, a normal contralateral kidney with normal renal function, and a 10 to 13
24 percent function of the diseased kidney - Respondent would send the patient out for a second
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1 opinion to make sure his plan was backed up by other sources and, if they agreed, he would
2 proceed the same way he did with HS.

3 20. The standard of care for treating a nonfunctioning infected kidney with
4 Xanthogranulomatous Pyelonephritis ("XGP") is to remove the kidney in its entirety.

5 21. Respondent deviated from the standard of care by not offering removal of the
6 kidney as an option and by failing to remove the kidney.

7 22. HS experienced worsening pain, underwent four ESWL procedures, developed a
8 perinephric abscess and experienced delay in obtaining the nephrectomy she required. The delay
9 in surgical resection, especially after manipulation of an infection stone in a nonfunctioning or
10 poorly functioning kidney could have resulted in sepsis or infection of other organs.

11 **CONCLUSIONS OF LAW**

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

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

17 3. The conduct and circumstances described above constitutes unprofessional
18 conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be
19 harmful or dangerous to the health of the patient of the public") and A.R.S. § 32-1401(27)(ll)
20 ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence
21 resulting in harm to or the death of a patient.").

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ORDER

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

IT IS HEREBY ORDERED:

Respondent is issued a Letter of Reprimand for failing to appropriately treat a Pseudomonas infection of the urinary tract, for failing to perform a nephrectomy and failing to discuss all the alternatives with a patient.

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 10th day of August 2007.

THE ARIZONA MEDICAL BOARD



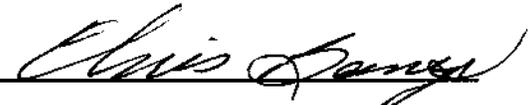
By [Signature]
TIMOTHY C. MILLER, J.D.
Executive Director

1 ORIGINAL of the foregoing filed this
2 20 day of August, 2007 with:

3 Arizona Medical Board
4 9545 East Doubletree Ranch Road
5 Scottsdale, Arizona 85258

6 Executed copy of the foregoing
7 mailed by U.S. Mail this
8 20 day of August, 2007, to:

9 Stephen P. Sutton, M.D.
10 Address of Record

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