BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

SUSAN D. SCARLA, M.D.,

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

Case No.17A-13951-MDX

FINDINGS OF FACT,
CONCLUSIONS OF LAW AND ORDER
(License Revocation)

On December 6, 2017, this matter came before the Arizona Medical Board ("Board") for consideration of Administrative Law Judge (ALJ) Tammy L. Eigenheer's proposed Findings of Fact, Conclusions of Law and Recommended Order. Susan D. Scarla, M.D., ("Respondent") appeared on her own behalf; Assistant Attorney General Mary Delaat Williams, represented the State. Elizabeth A. Campbell with the Licensing Enforcement Section of the Attorney General's Office, was available to provide independent legal advice to the Board.

The Board, having considered the ALJ’s decision and the entire record in this matter, hereby issues the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. The Arizona Medical Board (Board) is the authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Susan D. Scarla, M.D., (Respondent) is the holder of License No. 13951 for the practice of allopathic medicine in Arizona.

3. On May 11, 2017, the Board issued a Complaint and Notice of Hearing to Respondent alleging Respondent had engaged in 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)(j) ("[p]rescribing, dispensing or administering any controlled substance or prescription-only drug for other than accepted therapeutic purposes"); and A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public"); A.R.S. § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the
board or its executive director under this chapter”); A.R.S. § 32-1401(27)(t) ("[k]nowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution"); A.R.S. § 32-1401(27)(dd) ("[f]ailing to furnish information in a timely manner to the board or the board's investigators or representatives if legally requested by the board"); A.R.S. § 32-1401(27)(jj) ("[k]nowingly making a false or misleading statement to the board or on a form required by the board or in a written correspondence, including attachments, with the board"); and A.R.S. § 32-1401(27)(ss) ("[p]rescribing, dispensing or furnishing a prescription medication or a prescription-only device as defined in section 32-1901 to a person unless the licensee first conducts a physical or mental health status examination of that person or has previously established a doctor-patient relationship").

4. On July 27, 2015, the Board received a complaint from the Drug Enforcement Administration (DEA) alleging that Respondent was prescribing controlled substances to family members. The complaint detailed that on July 15, 2015, Respondent wrote a prescription for a male patient, BD, and attempted to fill the prescription herself at a Walmart pharmacy informing the pharmacist that it was for her nephew. The pharmacist determined that the address for BD was the same as the address listed for one of Respondent’s DEA numbers and refused to fill the script. Further investigation showed that a female patient, KN, was also listed with the same address as Respondent and was receiving prescriptions from Respondent. The pharmacist reported the incident to the DEA as possible prescribing of controlled substances to family members. The DEA then forwarded the allegation to the Board for further investigation.

5. The Board opened an investigation regarding Respondent’s care and treatment of the patients.

6. On or about July 27, 2015, the Board notified Respondent of the complaint.

7. On or about July 30, 2015, the Board requested that Respondent submit a narrative response and complete copies of BD’s and KN’s medical records to the Board on or before August 13, 2015.
8. Respondent provided an initial narrative response to the Board on August 17, 2015, but did not include any medical records for BD or KN with the response.

9. In the narrative, Respondent stated that the Board’s letter was sent to her former address of 4133 E. Edgewood Circle, Mesa, Arizona. Respondent reported that DB and KN were not family members, but that they had used the same residential address on Edgewood Circle where Respondent used to live before her divorce. Upon her divorce, Respondent moved out and her ex-husband stayed in the home, but Respondent periodically used the Edgewood Circle address for mailing purposes to ensure she received important mail. Respondent acknowledged that her DEA number was associated with the Edgewood Circle address that BD and KN used as their residential address. Respondent asserted that her son, who had substance abuse issues, moved into the Edgewood Circle home after her ex-husband died the previous year and that BD was a roommate and KN was his girlfriend. Respondent characterized her statement to the pharmacist that BD was her nephew as a “social lie” to avoid a long explanation as to her relationship with the parties. Respondent asserted that had she known the pharmacist would file a complaint based on the addresses on record, she would have clarified the situation.

10. On or about January 15, 2016, Respondent provided some medical records for BD and KN. Upon review of the records, Board staff noted the forms were from a basic word document with different headers and contained minimal and/or redundant information. BD’s medical records included a gap of nearly one year and KN’s medical records included a gap of two years during which they were no records of any office visits even though Respondent continued to prescribe controlled substances to both patients during those time periods.

11. On or about January 22, 2016, Respondent attended an investigative interview with Board staff. Respondent stated she was employed as an Emergency Department (ED) physician at Gilbert Hospital (Hospital) through a practice group and also owns a small private pain management practice called Preferred Pain Management (PPM). Respondent reported that PPM did not have a fixed location for practice, but that PPM patients were seen in the “S-Bed” area at the Hospital. Respondent asserted during the
interview that she had been given permission to see PPM patients at the Hospital by the owner of the practice group who was also the founder of the Hospital. Respondent acknowledged that the current Hospital administration was not aware of the arrangement, that she did not pay rent for the use of Hospital space, and her patients were all cash pay. Respondent was also asked about the adequacy of BD's and KN's medical records; Respondent indicated she had not reviewed the records before submitting them, but would provide the Board with a more complete set of records the following week.

12. Board staff also interviewed the owner of the practice group and Hospital administration. No one interviewed established that Respondent had permission to see PPM patients on Hospital property.

13. On or about January 26, 2017, Respondent provided amended medical records for BD and KN and included a patient list. Board staff reviewed the amended records, which included lined out text and new information added long after the dates of service. The amended medical records documented uninterrupted on-going office visits.

14. On or about March 29, 2016, the Board issued Respondent an Order to Appear at Investigative Interview on April 1, 2016, to discuss her treatment of four additional patients and requested Respondent provide copies of her medical records for those patients.

15. On April 1, 2016, Respondent did not appear for the Investigative Interview.

16. On or about April 7, 2016, Respondent entered into an Interim Consent Agreement for Practice Restriction (Practice Restriction) that prohibited her from practicing any form of medicine in the State of Arizona until receiving the Board's permission to do so.

17. Following the Practice Restriction, Respondent failed to respond to requests for patient medical records required to complete the Board's investigation and failed to appear for another investigational interview on May 13, 2016.

18. On or about April 7, 2016, April 9, 2016, and April 19, 2016, Respondent accessed and amended patient records at Hospital.

19. Upon review of the Controlled Substance Prescription Monitoring Program (CSPMP), the Board determined that Respondent failed to include on her patient list several individuals to whom Respondent had prescribed controlled substances.
20. Board staff also reviewed the pharmacy records of multiple patients identified on Respondent's patient list including BD, KN, BH, ML, TY, and JW. Those records show that at various times, Respondent picked up prescriptions for BD and KN while identifying herself as a family member and that JW picked up prescriptions for BH, ML, and TY.

21. A Medical Consultant reviewed Respondent's medical records for BD and KN and identified numerous deviations from the standard of care and medical record documentation concerns.

**Patient BD**

22. According to the records supplied, Respondent first saw BD for treatment on March 5, 2013, for polysubstance abuse, including alcohol and heroin addiction, Percocet abuse and anxiety. BD reported to Respondent that he had undergone detoxification treatment recently and had been using Suboxone.

23. Respondent did not obtain prior medical records for BD and did not review the CSPMP to confirm BD’s reported medical history. At the initial visit, Respondent prescribed BD Suboxone for addiction maintenance treatment. Nothing in the medical records established that Respondent obtained written informed consent from BD, provided him detailed instructions regarding the use of Suboxone, or set up timely follow-up appointments.

24. BD did not attend a follow-up appointment with Respondent until May 31, 2013. A urine drug screen at that appointment was positive for Suboxone only. Respondent prescribed BD Suboxone at that appointment.

25. Respondent saw BD for follow-up visits on July 12, 2013, August 13, 2013, August 27, 2013, and September 20, 2013. At each of those visits, urine drug screens were negative for Suboxone, indicating that BD was not using the medication on a regular basis for addiction maintenance treatment.

26. At the August 13, 2013 appointment, BD requested that Respondent prescribe him Adderall for a self-reported prior diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD). Respondent provided BD a prescription for Adderall. Nothing in BD's medical records indicate that Respondent evaluated BD for or confirmed a diagnosis of ADHD prior to prescribing Adderall.
27. The amended medical records Respondent provided to the Board document office visits by BD from October 2013 through December 2016. During that time, Respondent prescribed Suboxone, Xanax, Adderall, and Ambien to BD while consistently documenting that BD was consuming half a pint of vodka a day and identifying concerns regarding abuse of alcohol and heroin.

28. Respondent treated BD with office-based Suboxone treatment. Nothing in BD’s medical records justify the suitability of BD for the treatment, based upon the recognized diagnostic criteria.

29. Over the course of Respondent’s treatment of BD, BD had several relapses with recurrent use of heroin. Each time, Respondent failed to appropriately address, manage, and treat BD’s relapses. Respondent did not recognize that her attempts at treating BD’s substance abuse failed and that he should be referred to a physician with specialized training and expertise in addiction medicine.

30. Respondent did not refer BD to a psychiatrist for evaluation or treatment of BD’s self-reported anxiety, panic disorders, or ADHD. Rather, Respondent continued prescribing BD highly addictive medications with knowledge that BD had significant alcohol use and chronic heroin abuse.

Patient KN

31. According to the records supplied, Respondent first saw KN for treatment on May 24, 2013. KN reported a history of prescription opioid abuse with a progression to heroin in the previous year. KN also reported past treatment with Suboxone, although Respondent did not record any specific details regarding the prior treatment.

32. Respondent did not obtain prior medical records for KN and did not review the CSPMP to confirm KN’s reported medical history. At the initial visit and on September 9, 2013, KN tested positive for cocaine. Despite the positive cocaine results, Respondent subscribed KN Xanax for her self-reported anxiety. Respondent also prescribed KN Adderall with no clinical evaluation or documented criteria supporting a diagnosis of ADHD. According to the amended medical records for KN, Respondent continued to prescribe these controlled substances to KN, in addition to Soma and Vicodin, for approximately two-years.
33. According to Respondent’s medical records for KN, Respondent initially prescribed KN Suboxone on June 6, 2013, with instructions to self-administer the initial doses at home, unsupervised, and return to see Respondent in two to three weeks. Respondent noted in KN’s records that she was “close to relapsing and using heroin again.”

34. According to Respondent’s amended medical records for KN, KN experienced three heroin relapses during her treatment with Respondent, which Respondent treated with Suboxone. Respondent’s medical records did not include adequate documentation supporting the use of Suboxone or the suitability of Suboxone treatment for KN based on recognized diagnostic criteria.

35. According to the amended medical records for KN, Respondent prescribed Suboxone on February 17, 2015, on the day that KN reported a heroin relapse. The amended records also indicated that on February 19, 2015, KN called Respondent and requested a prescription for Adderall to help her energy levels during the Suboxone detoxification. According to the amended records, KN reported at that time that she had not started the Suboxone protocol and there was nothing in the records to indicate that KN was in active withdrawal. Respondent prescribed KN Adderall at that time.

36. According to the amended records, Respondent saw KN on March 6, 2015, for a sprained ankle. Respondent’s notes for that visit indicate that KN had not used drugs for several months and had been using Suboxone to prevent relapses. This entry was inconsistent with the prior records indicating three heroin relapses since October 2014 including the most recent relapse in February 2015.

**Standard of Care**

37. The medical consultant reviewing the instant matter identified numerous deviations from the standard of care with respect to Respondent’s practice of medicine.

38. The standard of care requires that a physician be trained, qualified, and competent before engaging in a particular practice or field of medicine. Respondent did not have any formal training or education in addiction medicine. Respondent received only eight hours of on-line continuing medical education in prescribing and dispensing Suboxone to receive a waiver from the DEA that allowed her to prescribe and dispense the medication.
39. The standard of care requires that a physician who is evaluating a patient for opioid assisted treatment of addiction in an office setting to document in the patient's medical record a recent, complete medical history and physical examination. The medical record should document the nature of the patient's addiction(s) and any history of substance abuse and previous treatments, the evaluation of any underlying or coexisting diseases or conditions, and the effect on physical and psychological function. Additionally, the physician should obtain past medical records if the patient was previously treated for addiction.

40. With respect to BD, Respondent deviated from the standard of care by failing to document adequate medical, addiction, and substance abuse histories prior to initiating office-based opioid assisted treatment of addiction.

41. With respect to BD and KN, Respondent deviated from the standard of care by failing to obtain BD's and KN's medical records regarding reported previous addiction treatment with Suboxone.

42. Prior to initiating office-based opioid assisted addiction treatment, the standard of care requires a physician to document in a patient's medical record the suitability of the patient for the treatment, based upon recognized diagnostic criteria.

43. Respondent deviated from the standard of care by failing to document in BD's and KN's medical records the patients' suitability for office-based treatment of addiction based on recognized diagnostic criteria.

44. The standard of care for office-based opioid assisted treatment of addiction with Suboxone requires a physician to supervise the induction doses of the medication and examine the patient in person; the physician should see the patient in the office at a minimum of one to three day intervals, and sometimes, on a daily basis.

45. Respondent deviated from the standard of care by allowing unobserved induction of Suboxone for both BD and KN, failing to provide in-office evaluation of withdrawal and medical supervision, and by advising follow-up visits at excessively long intervals.

46. The standard of care for office-based opioid assisted treatment of addiction with Suboxone requires the physician to stabilize the patient by monitoring the patient,
through regular and frequent office visits, and making appropriate dose adjustments until the patient no longer experiences withdrawal symptoms.

47. Respondent deviated from the standard of care by failing to provide appropriate dose adjustments and monitoring BD and KN following her prescribing Suboxone to both patients.

48. The standard of care for office-based opioid assisted treatment of addiction requires a physician to have a written treatment plan and treatment goals that have been discussed with the patient, including contingencies for treatment failure.

49. Respondent deviated from the standard of care by failing to provide a written treatment plan or identify treatment goals or contingencies for treatment failure for both KN and BD.

50. The standard of care for office-based opioid assisted treatment of addiction requires a physician to obtain written informed consent and agreement for treatment prior to initiating the treatment. The informed consent and agreement should address the risks and benefits of the use of the opioid medications, alternative treatment options, regular toxicological testing for drugs, number, and frequency of prescription refills, and reasons for which drug therapy may be discontinued.

51. Respondent deviated from the standard of care by failing to obtain documented informed consent and agreement for treatment with respect to BD and KN.

52. The standard of care for office-based opioid assisted treatment of addiction requires a physician to conduct periodic assessments of the patient once a stable dosage of the Suboxone was achieved. The physician should assess continuation or modification of Suboxone therapy based on an evaluation of progress towards treatment objectives. If reasonable treatment goals are not being achieved, the standard of care requires the physician to re-evaluate the appropriateness of continued treatment.

53. Respondent deviated from the standard of care by failing to appropriately monitor BD and KN during the time she prescribed Suboxone to the patients. Respondent routinely recommended follow-up visits for both BD and KN at two to three week intervals, regardless of the acuity of the patients' situations. Additionally, Respondent
repeatedly failed to properly address abnormal drug test results, repeated heroin relapses, and repeated non-compliant use of Suboxone by both parties.

54. The standard of care when treating a patient with active or relapsing drug addiction requires that a physician prescribe controlled substances with a potential for abuse, addiction, or diversion only when there is a clear medical indication for the drug, there is adequate documented rationale to anticipate that use of that drug will provide more benefit than harm, and that there is appropriate monitoring of the patient to include urine drug testing, CSPMP review, and frequent follow-up visits. The physician must be qualified to prescribe the drug to a patient with a history of addiction.

55. Respondent deviated from the standard of care by continuously prescribing BD several highly addictive non-opioid central nervous system depressant medications including Xanax, Ambien, and Soma, and stimulant medication Adderall without a confirmed diagnosis. Additionally, BD’s reported ongoing daily use of alcohol contraindicated the frequent and rotating prescribing of these controlled substances.

56. Respondent deviated from the standard of care by prescribing KN highly addictive controlled substances including Xanax, Adderall, and Soma despite active cocaine abuse, heroin relapses, a strong history of addiction and in the absence of confirmed diagnosis justifying the need for the drugs.

57. The standard of care when treating a patient with active or relapsing drug addiction requires a physician to pursue a team approach, including referral for counseling and other ancillary services.

58. Respondent deviated from the standard of care by failing to obtain BD’s and KN’s past medical records or communicate with previous providers and refer BD and KN to a psychiatrist for presumed diagnoses of ADHD, anxiety, and panic attacks. Additionally, Respondent failed to refer BD and kN for consultations by a qualified, recognized addiction medicine specialist.

59. The standard of care for prescribing Suboxone to a female patient of child-bearing age requires a physician to take appropriate precautions and obtain appropriate informed consent. Prior to prescribing Suboxone, the physician should perform initial pregnancy
tests, and inquire each month thereafter whether the patient may be pregnant; the
physician should request the patient to notify the physician if they think they are pregnant.

60. Respondent deviated from the standard of care by failing to perform a pregnancy
test prior to initiating Suboxone, failed to routinely ask KN if she might be pregnant, and
failing to request KN to notify her if she might be pregnant.

61. A physician is required to maintain "adequate records" for every patient, which are
defined as legible medical records containing, at a minimum, sufficient information to
identify the patient, support the diagnosis, justify the treatment, accurately document the
results, indicate advice and cautionary warnings provided to the patient, and provide
sufficient information for another practitioner to assume continuity of the patient's care at
any point during treatment.

62. With respect to medical records specific to office-based opioid assisted addiction
treatment, the prescribing physician should keep accurate and complete records to
include 1) medical history and physical examination; 2) diagnostic, therapeutic, and
laboratory results; 3) evaluations and consultations; 4) treatment objectives; 5) discussion
of risks and benefits; 6) treatments; 7) medications prescribed or dispensed, including
date, type, dosage, and quantity; 8) a physical inventory of all Schedule III, IV, and V
controlled substances on hand that are dispensed by the physician in the course of
maintenance or detoxification treatment of an individual; 9) instructions and agreements;
and 10) periodic reviews. Medical records should remain current and be maintained in
an accessible manner and readily available for review.

63. Respondent failed to maintain adequate records for BD in that there is no
documentation in BD's medical records justifying the suitability of BD for Suboxone
treatment based upon recognized diagnostic criteria; there is no indication in the medical
records that Respondent obtained written informed consent from BD, provided him
detailed instructions on Suboxone use, or set up timely follow-up appointments;
Respondent did not adequately document BD's medical history, addiction history, or
substance abuse history; there is no indication in BD's medical records that Respondent
evaluated BD for or confirmed a diagnosis of ADHD prior to prescribing Adderall.
64. Respondent failed to maintain adequate records for KN in that there is no adequate documentation supporting the use of Suboxone and the suitability of Suboxone treatment for KN based on recognized diagnostic criteria; there is no documented criteria supporting a diagnosis of ADHD for which Respondent prescribed medication; and Respondent's treatment notes are inconsistent regarding KN's use of heroin and relapses.

65. Respondent's treatment of BD and KN caused actual harm in that both patients experienced uncontrolled, relapsing heroin addiction. The propensity for heroin relapse was dramatically increased by Respondent's substandard treatment, including the introduction and continuation of a variety of addictive controlled substances with substantial street value; inappropriate allowance for self-administration of Suboxone even while actively abusing heroin; and failure to recognize that her treatment attempts had failed and BD and KN required referral to a higher level of professional care.

66. There was a potential for additional harm to BD and KN in that perpetuating failed treatment for heroin addiction includes the risk of life threatening infections, transmissible diseases, respiratory depression, accidental overdose, brain damage, death, accidents, suicide, family stress, financial problems, employment and work-place issues, legal problems, long-term mental and physical health problems, and public health and safety issues.

Hearing Evidence

67. Respondent testified that she started seeing patients at the Hospital in an “ill-fated” attempt to transition to private practice.

68. Respondent stated that she did not receive timely notice of the April 1, 2016 interview and was unaware it had been moved to a later date. Respondent indicated she was not trying to be obstructionist and wanted to everything the Board requested, but personal matters interfered with her ability to do so. Respondent testified that her son had another overdose during this timeframe and she was not checking her mail or email regularly during that time.

69. Respondent acknowledged that she updated Hospital patient charts after she signed the Practice Restriction. Respondent asserted that she had already seen the
patients prior to the Practice Restriction and was only memorializing the impressions she made during those examinations.

70. Respondent acknowledged that the first records she submitted were incomplete, but asserted that she provided more complete records after the January 22, 2016, Board interview.

71. Respondent admitted that the patient charts for BD and KN were much less complete than she would have wished, but she believed she would be the only one to see the charts. Respondent acknowledged that as of the time of the hearing, she had not provided to the Board all of the requested medical records for the other patients. Respondent stated that she maintained patient records on different personal computers at her home, one of which her son took under the guise of fixing it and probably pawned it. Respondent acknowledged that she released a computer containing confidential patient records to her son.

72. Respondent indicated that she only prescribed Suboxone to those patients that had previously used it.

73. Respondent denied writing any prescriptions after entering into the Practice Restriction. Respondent testified that she believed one of her prescription pads had been stolen by JW, which accounted for the prescriptions that appeared to be written after the Practice Restriction, but she did not report the possible theft to the Board.

74. Respondent requested that her lack of any disciplinary history with the Board during her 37 year career be taken into account and asked that she be allowed to maintain her license to practice medicine. Respondent indicated she would be willing to engage in educational programs, obtain a practice monitor, and limit herself to emergency medicine.

**CONCLUSIONS OF LAW**

1. The Board has jurisdiction over Respondent and the subject matter in this case. The legislature created the Board to protect the public. See Laws 1992, Ch. 316, § 10.
2. Pursuant to A.R.S. § 41-1092.07(G)(2) and A.A.C. R2-19-119(B), the Board has the burden of proof in this matter. The standard of proof is by clear and convincing evidence. A.R.S. § 32-1451.04.

3. A.R.S. 32-1401(2) defines “adequate records” as follows:

   legible medical records, produced by hand or electronically, containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment.

4. The Board established by clear and convincing evidence that Respondent engaged in unprofessional conduct in violation of A.R.S. § 32-1401(27)(e) by failing or refusing to maintain adequate records for all her patients, and specifically for BD and KN.

5. The Board established by clear and convincing evidence that Respondent engaged in unprofessional conduct in violation of A.R.S. § 32-1401(27)(j) by prescribing, dispensing or administering any controlled substance or prescription-only drug for other than accepted therapeutic purposes.

6. The Board established by clear and convincing evidence that Respondent engaged in unprofessional conduct in violation of A.R.S. § 32-1401(27)(q) with respect to her conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.

7. The Board established by clear and convincing evidence that Respondent engaged in unprofessional conduct in violation of A.R.S. § 32-1401(27)(r) by violating the Practice Restriction.

8. The Board established by clear and convincing evidence that Respondent engaged in unprofessional conduct in violation of A.R.S. § 32-1401(27)(t) by knowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine when she told the pharmacist that BD was her nephew.

9. The Board established by clear and convincing evidence that Respondent engaged in unprofessional conduct in violation of A.R.S. § 32-1401(27)(dd) by failing to furnish the requested patient records in a timely manner to the Board.
10. The Board established by clear and convincing evidence that Respondent engaged in unprofessional conduct in violation of A.R.S. § 32-1401(27)(jj) by knowingly making a false or misleading statement to the Board regarding the Hospital granting her permission to see patients on the grounds.

11. The Board established by clear and convincing evidence that Respondent engaged in unprofessional conduct in violation of A.R.S. § 32-1401(27)(ss) by prescribing, dispensing or furnishing a prescription medication to BD and KN without a physical or mental health status examination of them and/or reviewing the CSPMP report.

12. The legislature created the Board to protect the public. See Laws 1992, Ch. 316, § 10. Respondent’s failure to respond to the Board’s repeated requests for information up to and including the date of the hearing, taken together with the serious practice concerns regarding Respondent’s prescribing of Suboxone and other controlled substances, indicate that she cannot be regulated at this time. Therefore, the Board should revoke Respondent’s license to practice allopathic medicine.

**ORDER**

**IT IS ORDERED** revoking License No. 13951 for the practice of allopathic medicine in Arizona previously issued to Respondent Susan D. Scarla, M.D.

**RIGHT TO PETITION FOR REHEARING OR REVIEW**

Respondent is hereby notified that she 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 ___ day of December, 2017.

THE ARIZONA MEDICAL BOARD

By: Patricia E. McSorley
Executive Director

ORIGINAL of the foregoing filed this ___ day of December, 2017 with:

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

COPY of the foregoing filed this ___ day of December, 2017 with:

Greg Hanchett, Director
Office of Administrative Hearings
1400 W. Washington, Ste 101
Phoenix, AZ 85007

Executed copy of the foregoing mailed by U.S. Mail this ___ day of December, 2017 to:

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

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# 6622459

Mary "Bobbi"
Board Staff