BEFORE THE
BOARD OF NATUROPATHIC MEDICINE
STATE OF OREGON

In the Matter of the License of ROBERT J. SCHWARTZ, N.D., Licensee.	Case No. 12-08-23 NOTICE OF PROPOSED DISCIPLINARY ACTION AND OPPORTUNITY FOR HEARING

1.

The Board of Naturopathic Medicine (Board) is the state agency responsible for licensing, regulating and disciplining naturopathic physicians in the State of Oregon. Robert J. Schwartz, N.D., (Licensee) is a licensed naturopathic physician in The Dalles, Oregon, and is subject to the jurisdiction of the Board.

2.

The Board conducted an investigation based on a complaint received in regards to Licensee. Based on the results of the investigation and pursuant to ORS 685.110(8), 685.110(12) 685.110(14) and OAR 850-050-00190(3), the Board hereby proposes to revoke Licensee's license to practice naturopathic medicine, on the grounds described in the following paragraphs.

3.

In March 2008, the Board and Licensee executed a Settlement Agreement and Consent Order in Case No. N07-06-05. Licensee agreed to be assessed civil penalties, limited from prescribing for a period of six months and placed on probation for four and one half years, the terms of which included additional continuing education on patient charting. This discipline was imposed for violations related to prescribing substances that were not on the naturopathic formulary and for failing to keep adequate chart notes. Paragraph 12 of the Settlement Agreement and Consent order states:

> If Licensee commits any violation of ORS Chapter 685, OAR Chapter 850, or a term of this Settlement Agreement and Consent Order, the Board may revoke

Licensee's license, without providing Licensee the opportunity for hearing or appeal on the merits of revocation as a disciplinary action.

4.

Methadone is an opiate. Opiates are commonly prescribed for short-term, acute conditions. Long term opiate use carries a risk of patient harm due to abuse or addiction. Long term prescription of methadone requires a higher degree of assessment, screening, documentation, and record keeping to mitigate this risk. Patients should be pre-screened for risk of opioid abuse, multi-drug use, and other risk factors. The dose of opiates should be titrated safely and gradually. Pain progress should be monitored and re-assessed on a monthly scale. Periodic physical exams and blood chemistry should be performed to assess toxicity risks. Patients should be screened monthly for compliance and for multi-drug use through exam and drug screening.

5.

The general rule for prescribing methadone is to "start low and go slow." A typical starting dose for a non-cancer patient who is not frail or elderly is 2.5 milligrams (mg) every eight hours. No higher than 2.5 to 10 mg every eight to ten hours – *slowly* titrated to effect – is appropriate.

6.

Patient A Patient A sought treatment from Licensee on or about October 30, 2001. Patient A's chief complaint was back problems following surgery. On an intake form dated October 30, 2001, Patient A reported not taking any medication. There are no records from the initial visit that indicate Licensee requested any tests, used any tools for assessment of Patient A's pain, or screened Patient A for current or potential drug use. Licensee prescribed vicodin to Patient A at the initial visit.

7.

Licensee provided patient records for Patient A to the Board. The records included the intake form dated October 30, 2001. Licensee subsequently provided the Board with a second

copy of the October 30, 2001 intake form, with additional notes added, including physical examination data that were not on the initial copy provided to the Board.

8.

At some point, Licensee began prescribing methadone for Patient A.[1] This information is not in Patient A's chart, but in a September 2, 2012 letter to the Board, Licensee states that he began prescribing methadone, for Patient A on September 12, 2003, at a dose of 10 mg, four pills "tid" meaning three times a day, 360 in number, for a daily amount of 120 mg with no titration. The first date of Licensee's chart notes for Patient A, besides the 2001 intake form, is dated October 9, 2008. Licensee's chart for Patient A does contains two medication logs. One log contains seven entries between October 1, 2007 and March 17, 2008. The first entry on October 1, 2007 is a prescription for methadone 40 mg, tid, 90 in number, for a daily dose of 120 mg. The last entry, on March 17, 2008 is a prescription for methadone 10 mg, 4 pills tid, 1,080 in number. The other prescription log contains twenty-two entries between June 23, 2011 and December 31, 2012, each for 10 mg methadone, 4 pills tid, 360 pills in number, for a total dosage of 120 mg per day. Licensee's September 2, 2012 letter to the Board states that Patient A was on methadone 10 mg, 4 tid, 360 in number from October 2008 through the date of the letter.

9.

Licensee's records for Patient A do not support the prescription of methadone, prescription at a high dose with no titration, or its continued chronic use. Licensee did not evaluate Patient A's current symptoms or changes in medical condition while he continued to refill prescriptions for daily methadone use. Licensee prescribed methadone for chronic pain management to Patient A without urine drug monitoring consistent with the standard of care in chronic pain management.

[1] Licensee generally prescribes "Methadose". This Notice uses the generic "methadone" throughout the Notice, which includes reference to the brand name Methadose and all other forms of the controlled substance, methadone.

10.

The Oregon Health Authority maintains a Prescription Drug Monitoring Program (PDMP) for monitoring and reporting prescription drugs dispensed by pharmacies in Oregon that are classified in schedules II through IV under the federal Controlled Substances Act, 21 USC §§ 811, 812, as modified under ORS 475.035. ORS 431.962. The PDMP became fully operative and accessible to naturopathic practitioners in September 2011 and contains prescription records dating back to June 2011.

11.

Licensee did not obtain PDMP records for Patient A prior to prescribing methadone for Patient A as detailed in this Notice.

12.

PDMP records Patient A indicate that various medical doctors on many occasions prescribed alprazolam (Xanax) and amphetamine tablets to Patient A while Patient A was taking methadone prescribed by Licensee. For example, between June 2011 and November 2012, Patient A obtained and filled prescriptions for 1948 benzodiazepine tablets. Xanax is a benzodiazepine. Patient A obtained and filled prescriptions for 436 amphetamine tablets from June 2011 to October 2011.

13.

On or about July 29, 2012, Patient A requested Xanax from a medical doctor. The doctor performed a urine drug screen, which was positive for cocaine, oxycodone, benzodiazepines, and methadone. Patient A had previously disclosed alcohol use to Licensee.

14.

Benzodiazepines act synergistically with methadone, enhancing the risks of respiratory collapse or death when used in combination with methadone. Benzodiazepines, amphetamines, alcohol and cocaine are contraindications for prescribing methadone.

15.

Licensee's chart notes have one entry, on June 23, 2011, acknowledging prescribed benzodiazepine use by Patient A. Licensee did not stop prescribing methadone for this patient at the same high dose, nor did he contact the prescribing doctor. Licensee's chart does not contain documentation of laboratory testing or the use of other objective assessment tools to rule out the use or abuse of prescription or non-prescription drugs and alcohol. Failure to screen and failure to detect or address concomitant drug use constitutes a risk of harm to the patient.

16.

Licensee did not use conventional, scientific or otherwise established methods to diagnose or treat Patient A's condition. Except for the initial intake form, Licensee's chart contains no analysis of Patient A for pain assessment, or current or potential substance abuse. Licensee's chart notes contain no documentation of laboratory tests, including urine drug monitoring tests. Additionally there is no documentation for laboratory or metabolic testing profiles, including liver and kidney function, performed on Patient A. There are several standardized and validated tools available and in common use to streamline and quantify the assessment of pain and the assessment of opioid abuse risk, including but not limited to the Opiod Risk Tool, the Screener and Opioid Assessment for Patients with Pain-Revised, the Screening Tool for Addiction Risk and the Screening. There are no chart notes indicating that Licensee used any such tools.

17.

Licensee's conduct in treating Patient A was below the standard of care; he was negligent in the treatment (including his prescribing practices) of Patient A, in violation of ORS 685.110(8). Licensee's diagnosis and treatment of Patient A was gross or repeated malpractice in violation of ORS 685.110(12).

18.

Naturopathic medicine is governed by six principles: the healing power of nature, identifying and treating the cause of disease, first do no harm, treating the whole person, the

physician as teacher and prevention. Licensee engaged in conduct with respect to Patient A contrary to the standard of ethics or conduct that does or might constitute a danger to the health or safety of a patient in violation of ORS 685.110(14), and OAR 850-050-0190(3). In addition, alteration of Patient A's chart is contrary to the standard of ethics. Violation of an administrative rule is grounds for discipline. ORS 685.110(25).

19.

Patient B. Patient B was seen by Licensee on or about August 4, 1997 for a complaint of neck pain after lifting a heavy gate. Patient B also reported he has hepatitis C. Licensee prescribed hydrocodone and acupuncture for treatment. Chart notes indicate that in June 1999, Patient B sought treatment for a complaint of left shoulder pain. Licensee diagnosed bursitis with a minimal exam and prescribed hydrocodone and acupuncture. An additional intake form dated December 08, 2001 shows Patient B's chief complaint was back pain. Licensee prescribed vicodin and acupuncture after minimal physical examination. In 2002, Licensee referred the Patient for an MRI. Licensee has no chart notes for Patient B between 2003 and 2008. From 2008, Licensee continued to see Patient B through 2012, but made few chart notes and none that contain significant medical information. Chart notes that exist are very brief and difficult to read, mostly consisting of a statement that patient was returning for refills and a blood pressure measurement, along with a statement that patient was doing well, or had no side effects.

20.

Licensee's chart for Patient B indicates that he prescribed methadone for Patient B as early as August or September 2003 with no clear indication of the prescribed amount. Licensee's patient chart contains three prescription logs for Patient B. One is from 2003. One has seven entries between October 1, 2007 and March 17, 2008. Between October 1, 2007 and January 20, 2008, Licensee prescribed 40 mg tid. On February 28, 2008, Licensee prescribed 5 mg methadone 8 tablets tid. On March 17, 2008, Licensee prescribed 1080 pills of 10 mg methadone, 4 tablets tid, for a daily dose during the time of the second medication log of 120 mg

without titration. And the third log has monthly entries from May 23, 2011 to December 31, 2012, showing regular monthly prescriptions of methadone 10 mg, 4 tablets tid, 360 in number. In Licensee's September 2, 2012 letter to the Board, he states he prescribed methadone for Patient B the same prescription from October 2008 and continuing to the date of the letter: 10 mg methadone, 360 in number, 4 tablets tid, i.e. 120 mg per day, with no titration.

21.

Licensee's chart notes contain a Controlled Substance Agreement dated December 5, 2008.

22

Licensee prescribed methadone for chronic pain management to Patient B without urine drug monitoring consistent with the standard of care in chronic pain management.

23.

Hepatitis C is strongly associated with intravenous drug use. Licensee did not test to establish baseline liver and kidney function. Licensee did not order any standard laboratory tests, including urine drug monitoring, nor is there any documentation showing such tests were performed or received from any other medical clinic or source. Additionally, there is no documentation to indicate that standardized written assessment tools were used to quantify the assessment of pain and the assessment of opioid abuse risk. Failure to screen and detect concomitant drug use constitutes a risk of harm to the patient.

24.

Licensee did not use conventional, scientific or otherwise established methods to diagnose or treat patient's condition. Licensee's chart contains no documentation supporting the use of pain questionnaires, pain assessment tools, opioid risk assessment tools or regular drug screening.

25.

Licensee's records for Patient B do not support the prescription of methadone, prescription at a high dose, or its continued chronic use. Licensee did not evaluate Patient B's current symptoms or changes in medical condition while he continued to refill prescriptions for daily methadone use.

26.

Licensee's conduct in treating Patient B was below the standard of care; he was negligent in the treatment (including his prescribing practices) of Patient B, in violation of ORS 685.110(8). Licensee's diagnosis and treatment of Patient B was gross or repeated malpractice in violation of ORS 685.110(12).

27.

Naturopathic medicine is governed by six principles: the healing power of nature, identifying and treating the cause of disease, first do no harm, treating the whole person, the physician as teacher and prevention. Licensee engaged in conduct with respect to Patient B contrary to the standard of ethics or conduct that does or might constitute a danger to the health or safety of a patient in violation of ORS 685.110(14), and OAR 850-050-0190(3). Violation of an administrative rule is grounds for discipline. ORS 685.110(25).

28.

Patient C. Patient C initially sought treatment from Licensee on or about April 24, 2002 for hyperactive thyroid (Grave's Disease). Licensee's chart for Patient C contains an intake form and a controlled substances agreement dated from the year 2002. The earliest chart notes in Licensee's chart begin in March 2007.

29.

Licensee's patient chart for Patient C reflects thyroid hormone testing was performed only three times from February 2008 through December 2012 while Licensee was managing Patient C's Grave's Disease. Generally, thyroid hormone testing should be performed at least annually.

30.

Licensee provided patient records for Patient C to the Board. The records included an intake form dated April 2, 2002. Licensee subsequently provided the Board with a second copy of the April 2, 2002 intake form, with additional notes added, including previous medical history comments and undated comments regarding a thirty minute consultation that were not on the initial copy provided to the Board.

31.

Patient records indicate Patient C suffered from depression, a history of alcohol abuse, episodes of hypertension, chronic back pain and plantar fasciitis. Patient records also indicate Patient C was prescribed clonidine, and acupuncture was used for back pain.

32.

Licensee initially prescribed Patient C in July 2007 a daily dose of methadone of 200 mg without titration (40 mg five times a day). The amount was increased to 240 mg of methadone on a daily basis, without apparent titration on approximately November 17, 2007. Licensee's chart notes indicate this amount was educed to 160 mg daily (10 mg, 4 tablets, 4 times a day) on approximately February 22, 2010, a dosage that was continued through December 2012. (Licensee's September 2, 2012 letter to the Board states that he prescribed a daily dose of 200 mg from July 2007 to February 2008 and a daily dose of 120 mg from September 2010 to the date of his letter). Licensee's chart contains no documentation that Patient C was prescribed a titrating dose schedule for the prescription or the increase and later reduction in methadone.

33.

At some point prior to an emergency room visit on or about March 5, 2010, Patient C was prescribed temazepam, which is a benzodiazepine, which is reflected in the patient records for the emergency room visit. Records of this visit were provided by the hospital to Licensee. Concomitant use of benzodiazepine and alcohol, as well as methadone, placed this patient at risk for a potentially fatal drug reaction.

34.

On or about October 2, 2011, Patient C was again seen in an emergency room, for confusion, hallucinations, possible delirium tremors and chronic back pain after Patient C had stopped drinking three days before. Records of this visit were provided by the hospital to Licensee. Patient C reported to the emergency room physician that she/he took methadone. A serum toxicology screening performed during this visit showed that Patient C had ingested a benzodiazepine, but methadone was not detected. The emergency room physician advised Patient C that methadone at doses above 100 mg can cause hyperalgesia (abnormal pain sensitivity) and suggested rotating to a different opiate, and told the patient to discuss this with the patient's physician. Licensee received a copy of these records, but continued to prescribe methadone for Patient C and did so at the same high dose. Licensee did not perform urine drug screening of Patient C.

35.

Licensee's records for Patient C do not support the prescription of methadone, prescription at a high dose, or its continued chronic use, particularly given the risk factors of Patient C's benzodiazepine and alcohol use. Licensee did not evaluate Patient C's current symptoms or changes in medical condition while he continued to refill prescriptions for daily methadone use. Licensee did not perform routine urine drug screening on Patient C, which would detect the benzodiazepine use.

36.

Licensee did not use conventional, scientific or otherwise established methods to diagnose or treat patient's condition, and demonstrates a lack of reliance on objective tests. Licensee did not order sufficient standard laboratory tests, including urine drug monitoring, nor is there any documentation showing such tests were performed or received from any other medical clinic or source. Additionally, there is no documentation to indicate that standardized

written assessment tools were used to quantify the assessment of pain and the assessment of opioid abuse risk. Failure to screen and detect concomitant drug use constitutes a risk of harm to the patient.

37.

Licensee's conduct was below the standard of care; he was negligent in the treatment (including his prescribing practices) of Patient C, in violation of ORS 685.110(8). Violation of ORS 685.111(8) is grounds for discipline. ORS 685.110(25)

38.

Licensee's conduct in treating Patient C was below the standard of care; he was negligent in the treatment (including his prescribing practices) of Patient C, in violation of ORS 685.110(8). Licensee's diagnosis and treatment of Patient C was gross or repeated malpractice in violation of ORS 685.110(12).

39.

Naturopathic medicine is governed by six principles: the healing power of nature, identifying and treating the cause of disease, first do no harm, treating the whole person, the physician as teacher and prevention. Licensee engaged in conduct with respect to Patient C contrary to the standard of ethics or conduct that does or might constitute a danger to the health or safety of a patient in violation of ORS 685.110(14), and OAR 850-050-0190(3). In addition, alteration of Patient C's chart is contrary to the standard of ethics. Violation of an administrative rule is grounds for discipline. ORS 685.110(25).

General Violations.

40.

Chart notes for the above-described patients are illegible and do not follow a standardized format providing subjective data, objective data, assessment and a treatment plan. Licensee's charting for Patients A, B and C is incomplete. Licensee's charts contain no documentation supporting the use of pain questionnaires, pain assessment tools, opioid risk assessment tools or

regular drug screening; in Licensee's management of Patients A, B and C all risk factors for fatal overdose were present. None of these three patients were referred to a pain practitioner. Licensee's charting practices and treatment constitute conduct that does or might constitute a danger to health or safety of a patient or the public, in violation of ORS 685.110 (14) and OAR 850-050-0190(3).

41.

Definitions that may be relevant to this Notice are contained in ORS 685.010 and OAR 850-010-0005.

NOTICE OF OPPORTUNITY FOR HEARING

Licensee is entitled to a hearing as provided by the Administrative Procedures Act (ORS Chapter 183). If you want a hearing, you must file a written request for hearing with the Board within 21 days from the date this notice was mailed. You must mail any request for hearing to Oregon Board of Naturopathic Medicine, 800 NE Oregon Street, Suite 407, Portland, OR 97232. The request for hearing must be received by the Board within 21 days from the date of mailing of this notice, and must be accompanied by a written answer to the charges contained in this Notice. If a request for hearing is not received within 21 days, the right to hearing is waived.

If you request a hearing, you will be notified of the time and place of the hearing. Before the hearing, you will receive information on the procedures, right of representation, and other rights of parties related to the conduct of the hearing. An administrative law judge from the Office of Administrative Hearings will preside at any hearing. ORS 183.635.

An answer is required to this Notice, pursuant to OAR 850-001-0015, due to the complexity of the matters alleged above. The answer shall be made in writing to the Board and shall include an admission or denial of each factual matter alleged in this Notice, and a short plain statement of each relevant affirmative defense Licensee may have. Except for good cause, factual matters alleged in this notice and not denied in the answer shall be presumed admitted;

failure to raise a particular defense in the answer will be considered a waiver of such defense; and new matters alleged in the answer (affirmative defenses) shall be presumed to be denied by the agency and evidence shall not be taken on any issue not raised in the Notice and answer.

If you fail to request a hearing within 21 days, withdraw a request for a hearing, notify the Board or administrative law judge that you will not appear or fail to appear at a scheduled hearing, the Board may issue a final order by default revoking your license. If the Board issues a default order, the contents of the Board's file automatically becomes part of the evidentiary record of this disciplinary action for the purpose of proving a prima facie case.

DATED this _____day of August 2013.

BOARD OF NATUROPATHIC MEDICINE
State of Oregon

COPY – ORIGINAL SIGNED ON / ABOUT 8/15/2013

Anne Walsh, Executive Director

Confidential Patient Key	
Patient A	Matthew Siemens
Patient B	William Siemens
Patient C	Skylar King