BEFORE THE

BOARD OF NATUROPATHIC MEDICINE

STATE OF OREGON

In the Matter of the License of:	Case No. 22-10-31
Dr. Katyna TruVal, ND,	NOTICE OF PROPOSED DISCIPLINARY ACTION
Licensee	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, pursuant to Oregon Revised Statutes (ORS) chapter 685 and Oregon Administrative Rules (OAR) chapter 850. Dr. Katyna TruVal, ND has been licensed as a naturopathic physician in the State of Oregon since October 14, 2019, and is subject to the jurisdiction of the Board.

2.

The Board hereby proposes to take disciplinary action against Licensee's license to practice naturopathic medicine, on the grounds described in the following paragraphs. For each violation, the Board may impose a civil penalty up to $5,000, a term of probation, a letter of reprimand and license limitation, suspension, or revocation.

3.

Dr. Katyna TruVal (Licensee) established care with Patient in May 2022. Patient suffered from endometriosis. Patient was on pain medication because the growths all throughout her abdomen caused constant pain. On / about September 27, 2022, Licensee wrote Patient two 30-day prescriptions; 180 Oxycodone Hcl 10 mg tablets and 60 Oxycontin ER 20mg tablets. Patient filled those prescriptions on October 1 and 2, 2022 respectively.

4.

On / about October 12, 2022, Patient sent Licensee a message through the clinic secure messaging service telling her she was admitted to the Salem Health ER. From October 28 - November 9, 2022, and Thursday November 10 – November 13, Patient and Licensee exchanged several messages through the clinic secure messaging service.

5.

On November 2, Patient sent Licensee a secure message stating "I can't leave [the hospital] until I stop throwing up blood this doctor won't give me pain medicine, she needs [sic] that's what

causing my blood in throw up." On November 4, Patient wrote to Licensee "…Hospitalist is detoxing me off all my pain meds they think it will make me stop throwing up blood once I can do that I will be allowed to go home. Just trying to push back the pain and get out of here."

6.

On November 10, at approximately 11:45am, Patient responded to a message from Licensee, writing "my new hospitalist (Hospitalist)… [wants] to discuss things with you… He also wanted to discuss with you why I'm on pain medicine and if I had any goals to come off them… Here in the hospital the pain regime has brining me down to a 7/10 and at home my baseline for pain is 6/10." Patient sent another message to Licensee at 5:20pm the same day, "just curious if you had spoken to Hospitalist today? I guess I have a blood clot on my right side. He has stopped all my pain meds, and I think we're hoping to end the tpn soon even if I go home throwing up blood still. Am I able to continue my pain/ nausea management with you when I'm home until I can get in a better comfortable place?"

7.

On Sunday, November 13, 2022, at 10:14am, Patient messaged Licensee stating, "This new doctor has been extremely harsh and has refused to manage my pain control." Licensee responded at 3:20pm, stating, "…I did call and left a message for your doctor on Friday. I have an alarm on my calendar to try calling again tomorrow at 11:30 AM. Is he thinking that the blood clot is causing the blood vomiting?" Patient responded at 335pm, stating "… He doesn't know where the blood is coming from but if I can keep a little food down, I can go home. It's been the worst experience in the hospital I've had so far. Just want to go home… I know he just wanted to talk to you about how he thinks pain medicine is causing all my issues."

8.

Licensee wrote Patient a prescription for 15 days / 90 tablets Oxycodone Hcl 10 mg on November 13, at 6:12 PM. Licensee did not check PDMP prior to prescribing the medication. Licensee did not speak with Patient's treating physicians or the Hospitalist prior to prescribing the medication to Patient. Licensee did not check with the hospital staff or physicians whether Patient was scheduled to be discharged on November 14. Licensee did not make a note regarding the subjective or objective reason for writing the prescription in Patient's chart.

9.

Licensee told Board Investigator she wrote the prescription because she believed the Patient was going to be discharged on November 14. Licensee told Board Investigator she was not aware that the treating hospital doctors were attempting to take Patient off all pain medications prior to prescribing Patient Oxycodone.

10.

Licensee submitted three written statements for Board review related to prescribing Oxycodone to Patient on November 13; a rationale for writing the prescribing while Patient was still in the hospital, a timeline of messages and actions around the date of the prescription, and a chronology of Licensees care of Patient. Licensee wrote she prescribed Oxycodone to Licensee because "on 11/10, the patient informed me through secure text messaging that her doctor was considering a trial period of discontinuing all pain medications to assess whether they might be contributing to her symptoms. The patient also mentioned that the medical team intended to discuss this plan with me. However, no contact was made. Based on the information I had; I understood that the goal was to evaluate the impact of her pain medications rather than an intent to discontinue them permanently."

11.

Licensee wrote in the documents submitted, "During the time in which messages… from 11/10 to 11/13/2022 were sent, I was unavailable and on vacation; I was not able to review the patient's messages in detail until later in the day on 11/13/2022. At that time, I saw her request for a lower dose of oxycodone via the patient portal and based on the information available to me from messages prior to 11/10/2022— I had no knowledge of a definitive plan from the hospital to discontinue her medications, but rather an experiment to determine causation of patient symptoms."

12.

Prior to Licensee prescribing Patient Oxycodone on November 13, Licensee did not check PDMP, Licensee did not make a chart note regarding the subjective or objective reason for writing the prescription in Patient's chart. Per OHA Opioid Prescribing Guidelines, prior to prescribing opioids a physician should check the Prescription Drug Monitoring Program (PDMP) to understand the patient's prescription history before prescribing opioids. Guidelines also state a physician should evaluate the patient and document the results of this patient evaluation and the justification for prescribing an opioid. Licensee did not speak with Patient's treating physician or the Hospitalist managing her care. Licensee did not check with the hospital staff or physicians whether Patient was scheduled to be discharged on November 14. Licensees did not have hospital admission or discharge authority and may not engage inpatient care. Licensee may only prescribe opioids for Patient for outpatient care. While in the hospital, Patient is under the care of, and treatment is directed by the treating physicians and hospitalists. Treating physicians at the hospital are responsible for prescribing to patients in the hospital. Licensee prescribing Patient Oxycodone on November 13 constitutes violations of 850-050-0010(1)(c)(C): Engaging in conduct or practice contrary to the Code of Ethics of the American Association of Naturopathic Physicians as adopted by the Board (5) Obligation(e) and (f) and (6) Competence (a); and ORS 685.110 (14) Engaging in any conduct or practice contrary to a recognized standard

of ethics of the profession or any conduct or practice that does, or might, constitute a danger to the health or safety of the patient; and 850-050-0010(1)(c)(A): Negligent prescribing.

13.

Licensee prescribing Oxycodone to Patient while Patient was in the hospital, understanding "that [Patient's treating] doctor was considering a trial period of discontinuing all pain medications to assess whether they might be contributing to her symptoms…[Licensee] understood that the goal was to evaluate the impact of her pain medications rather than an intent to discontinue them permanently," constitute violations of 850-050-0010(1)(c)(C): Engaging in conduct or practice contrary to the Code of Ethics of the American Association of Naturopathic Physicians as adopted by the Board (5) Obligation(e) and (f) and (6) Competence (a); and ORS 685.110 (14) Engaging in any conduct or practice contrary to a recognized standard of ethics of the profession or any conduct or practice that does, or might, constitute a danger to the health or safety of the patient; 850-050-0010(1)(c)(A): Negligent prescribing and 850-050-0010(1)(c)(B): Negligent Treatment.

14.

Messages between Patient and Licensee from October 28-November 9, show Licensee was aware Patient's treating doctors and Hospitalist were working toward taking Patient off all pain medications. Messages exchanged between Thursday November 10 – November 13, contradict Licensees statement to Board Investigator she was not aware that the treating hospital doctors were attempting to take Patient off all pain medications prior to prescribing Patient Oxycodone on November 13. Licensee's statements to Board Investigator are violations of 850-050-0010(1)(c)(C): Engaging in conduct or practice contrary to the Code of Ethics of the American Association of Naturopathic Physicians as adopted by the Board (1) Honesty, and ORS 685.110 (14) Engaging in any conduct or practice contrary to a recognized standard of ethics of the profession * * *.

15.

In Licensee written statement submitted to the Board, Licensee stated "[t]he patient also mentioned that the medical team intended to discuss this plan with me. However, no contact was made" and "[d]uring the time in which messages… from 11/10 to 11/13/2022 were sent**,** I was unavailable and on vacation; I was not able to review the patient's messages in detail until later in the day on 11/13/2022," are contrary to the contents of the secure messages sent between Patient and Licensee from October 28-November 9, and contradicted by the messages exchanged Thursday, November 10-Sunday, November 13, and constitute violations of 850-050-0010(1)(c)(C): Engaging in conduct or practice contrary to the Code of Ethics of the American Association of Naturopathic Physicians as adopted by the Board (1) Honesty, and ORS 685.110 (14) Engaging in any conduct or practice contrary to a recognized standard of ethics of the profession * * *.

16.

In the documents submitted to the Board, Licensee wrote, "[o]n 11/17/2022, during a virtual visit with the patient, I discovered that she had not left the hospital as planned on 11/14/2022 and was still admitted." During this telemedicine visit, Licensee did not ask whether Patient filled the November 13, Oxycodone prescription, and did not discuss with Patient not taking the medication while under the care of the treating physicians at the hospital. Licensee did not notify or discuss with Patient's treating doctors at the hospital that she prescribed Oxycodone to Patient on November 13. Licensee did not subsequently check PDMP to determine whether Patient filled the prescription while she was still in the hospital.

17.

Patient was discharged from the hospital on / about December 13, 2022. Licensee wrote in her statement to the Board, that during Patient's subsequent telehealth appoint on December 22, she "…was informed that [Patient] did fill the oxycodone that was prescribed on 11/13/2022, however her mom had it in a lock box and she has not taken any. With this information, we discussed that because she was fully detoxed off the medication AND she was unable to access the medication due to it being in a lock box, I would no longer be prescribing opiate pain management." Licensee did not request or require Patient submit a urinalysis or return prescription in full to the clinic or return the prescribed medication to Licensee to perform per a pill count.

18.

When Licensee learned during a telemedicine visit on November 17, Patient was still in the hospital, Licensee did not ask whether Patient filled the November 13, Oxycodone prescription, and did not discuss with Patient not taking the medication while under the care of the treating physicians at the hospital. Licensee did not notify or discuss with Patient's treating doctors at the hospital that she prescribed Oxycodone to Patient on November 13. Licensee did not subsequently check PDMP to determine whether Patient filled the prescription while she was still in the hospital. Per OHA Opioid Prescribing Guidelines, prior to prescribing opioids a physician should check the Prescription Drug Monitoring Program (PDMP) to understand the patient's prescription history before prescribing opioids. Licensees did not have hospital admission or discharge authority and may not engage inpatient care. Licensee may only prescribe opioids for outpatient care. While in the hospital, Patient is under the care of, and treatment is directed by the treating physicians and hospitalists. Treating physicians at the hospital are responsible for prescribing to patients in the hospital. Licensee not checking PDMP to determine whether Patient filled the prescription, and not discussing the prescription with Patient and not advising the treating physicians in the hospital she prescribed Patient Oxycodone on November 13 constitutes violations of ORS 685.110 (14) Engaging in any conduct or practice contrary to a recognized standard of ethics of the profession or any conduct or practice that does, or might, constitute a danger to the health or safety of the patient and 850-050-0010(1)(c)(B) Negligent

treatment; and 850-050-0010(1)(c)(C) Engaging in conduct or practice contrary to the Code of Ethics of the American Association of Naturopathic Physicians as adopted by the Board (5) Obligation(e) and (f) and (6) Competence (a).

19.

During their December 22, telehealth appointment Patient told Licensee she filled the Oxycodone prescription, and it was in her mother's possession. Licensee was aware Patient was fully detoxed off all medication while in the hospital. Licensee did not request or require Patient to submit a urinalysis or return the prescription to the clinic in full or give the prescribed medication for Licensee to perform per a pill count. Per OHA Opioid Prescribing Guidelines, compliance monitoring, pill counts are useful tools to confirm medication adherence and help to reduce the risk of diversion. Urine drug testing is also a compliance monitoring tool that can be used to assist providers in assessing whether patients are using opioids as prescribed, using other substances or potentially diverting opioids. Per guidelines, Clinicians should advise patients about safe storage and disposal of all controlled substances. Licensee was aware Patient was fully detoxed off all medication while in the hospital, but did not confirm medication adherence by requiring Patient to submit a urinalysis or return the prescription to the clinic in full or give the prescribed medication for Licensee to perform per a pill count constitutes violations of ORS 685.110 (14) Engaging in any conduct or practice contrary to a recognized standard of ethics of the profession or any conduct or practice that does, or might, constitute a danger to the health or safety of the patient and 850-050-0010(1)(c)(B) Negligent treatment; and 850-050-0010(1)(c)(C): Engaging in conduct or practice contrary to the Code of Ethics of the American Association of Naturopathic Physicians as adopted by the Board (5) Obligation(e) and (f) and (6) Competence (a).

20.

For the violations described above; the Board proposes the following discipline:

A. Probation – 36 Months.

B. Civil Penalty: $15,000

C. Eight hours of continuing education focused on ethical prescribing of controlled substances in addition to hours required for annual renewal per OAR Section 40, to be completed within the first six (6) months of probation.

D. Quarterly review of PDMP prescribing records.

21.

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 submit request for hearing to either via email Naturopathic.Medicine@obnm.Oregon.gov or U.S. Mail 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.

22.

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.

23.

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.

24.

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 become part of the evidentiary record of this disciplinary action for the purpose of proving a prima facie case.

NOTICE TO ACTIVE DUTY SERVICEMEMBERS: Active-duty service members have a right to stay these proceedings under the federal Service members Civil Relief Act. For more

information contact the Oregon State Bar at 800-452-8260, the Oregon Military Department at 503-584-3571 or the nearest United States Armed Forces Legal Assistance Office through http://legalassistance.law.af.mil.

DATED this ___30____day of ___December_____2024.

BOARD OF NATUROPATHIC MEDICINE

State of Oregon

Mary-Beth Baptista, JD
Executive Director