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4	BEFORE THE
5	BOARD OF NATUROPATHIC MEDICINE STATE OF OREGON
6	In the Matter of the License of: Case No. N16-10-32
7	Susan Allen, N.D., SETTLEMENT AGREEMENT AND CONSENT ORDER
8) CONSENT ORDER Licensee)
9	1,
10	The Board of Naturopath Medicine (Board) is the state agency responsible for
11	licensing, regulating and disciplining naturopathic physicians in the State of Oregon. Susan
12	Allen, N.D., (Licensee) is a licensed naturopathic physician in the State of Oregon and is
13	subject to the jurisdiction of the Board.
14	Licensee was provided the Board's proposed discipline through correspondence
15	between the Executive Director and her attorney on or about November 8, 2017. The parties
16	desire to settle this matter without hearing, appeal or judicial review, by entering into this
17	Settlement Agreement and Consent Order, pursuant to ORS 183.417(3) on the terms set forth
18	below.
19	2.
20	In 2017, the Board adopted Oregon Opioid Prescribing Guidelines. The Board finds
21	opiates are commonly prescribed for short-term, acute conditions. Long term opiate use
22	carries a risk of abuse or addiction. Long term prescription of opiates requires a higher
23	degree of assessment, screening, documentation and record keeping to mitigate this risk.
24	Patients should be pre-screened for risk of opioid abuse, multi-drug use, and other risk
25	factors. Pain progress should be monitored and re-assessed on a monthly basis. Periodic
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physical exams, blood and/or urine chemistry should be performed to assess toxicity risks and screen for compliance and multi-drug use.

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FINDINGS

The Board reviewed Licensee's records for six patients between the years 2008 and 2016. Review of these records revealed instances of improper opioid and/or benzodiazepine management, and inadequate charting, including but not limited to:

- A. Patient A. Licensee did provide a timely responses and did not adequately chart her responses to Portland Metro Treatment Center (Center) regarding their concerns Licensee was prescribing Patient A benzodiazepines in combination with their Methadone prescriptions. Licensee told the Center she would reduce Patient A's dosage, but did not adequately monitor the patient's withdrawal with drug screens or chart her tapering process with the patient.
- B. The above conduct regarding Patient A, constitutes a violations of ORS 685.110(8), committing negligence related to the practice of naturopathic medicine, 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 a patient or the public or any conduct, practice or condition that does or might adversely affect a physician's ability [to] safely and skillfully to practice naturopathic medicine. This conduct also constitutes a violation of OAR 850-050-0010(1)(c)(A) Negligent Prescribing, OAR 850-050-0010(c)(B) Negligent Treatment, OAR 850-050-0010(1)(c)(C) Conduct contrary to the recognized standards of ethics.
- C. Patient B. Licensee prescribed opioids to Patient B while Patient B was concurrently using marijuana and/or benzodiazepines. During Patient B's treatment, Licensee did not screen for drug abuse potential or multi-drug use. Licensee prescribed

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- medications without routine urine drug monitoring and without properly documenting her review of the PDMP.
- D. The aforementioned conduct involving Patient B constitutes a violation of ORS 685.110(8)- Committing negligence related to the practice of naturopathic medicine and OAR 850-050-0010(1)(c)(B) Negligent Treatment.
- E. Patient C: Licensee increased the dosage of Patient C's medication, resulting in a MED increase from 180 to 240. There is no record of Licensee making objective findings for pain for Patient C to support the increase in dosage, nor is there any other supporting documentation, constituting a violation of OAR 850-050-0010(1)(c)(A) – Negligent Prescribing.
- F. Patient D. Between 2010 and 2016, Licensee made inadequate chart notes to document objective findings prior to writing multiple prescriptions to Patient D, constituting violations of OAR 850-050-0010(1)(a)(B) Inadequate Charting, and OAR 850-050-0010(1)(c)(A) Negligent Prescribing.
- G. Patient F. Licensee prescribed Patient F Hydrocodone-Acetaminophen related to Patient F's knee pain and subsequent double knee replacement surgery, but failed to indicate in her chart the correlation for the prescription, constituting a violation of OAR 850-050-0010(1)(a)(B) – Inadequate Charting.

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SETTLEMENT AGREEMENT

- A. The Board finds the violations based on the findings above, and the Licensee denies the allegations and proposed violations, but Licensee agrees that the Board may enter the Consent Order.
- B. Licensee enters into this Settlement Agreement and the following Consent Order voluntarily and without any force or duress. Licensee acknowledges the Board

and its staff have not made promises or representations not stated herein to induce

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