IN THE COURT OF COMMON PLEAS OF FRANKLIN COUNTY, OHIO, CIVIL DIVISION

Constance D. Ange, D.O.	:	
	:	Case No. 19-cv-6043
	:	
Appellant,	:	Judge O'Donnell
	:	
v.	:	
	:	
State Medical Board of Ohio	:	
	:	
Appellee	:	

NOTICE OF VOLUNTARY DISMISSAL

Plaintiff-Appellant, by and through undersigned counsel, hereby voluntary dismiss the above-captioned appeal.

Respectfully submitted,

/s/ Patrick M. Quinn
Patrick M. Quinn (0081692)
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Attorney for Plaintiff-Appellant

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on this 4th day of October, 2019, a true and accurate copy of the foregoing was filed with the Franklin County Court of Common Pleas via the electronic filing system which will send notice to all parties and counsel of record, and was also served via email upon the following:

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/s/ Patrick M. Quinn
Patrick M. Quinn (0081692)

Court Disposition

Case Number: 19CV006043

Case Style: CONSTANCE E ANGE DO -VS- STATE MEDICAL BOARD OF OHIO

Case Terminated: 08 - Dismissal with/without prejudice

IN THE COURT OF COMMON PLEAS OF FRANKLIN COUNTY, OHIO
GENERAL DIVISION

CONSTANCE E. ANGE, D.O.,	:		
Appellant,	:	**Case No.**	**19 CVF-07-6043**
v.	:	**Judge:**	**O'Donnell**
STATE MEDICAL BOARD OF OHIO,	:		
Appellee.	:		

DECISION AND ENTRY
DENYING APPELLANT'S JULY 30, 2019
MOTION TO SUSPEND ORDER PENDING APPEAL

O'DONNELL, J.

This matter is before the Court on Appellant Constance E. Ange, D.O.'s ("Appellant") July 30, 2019 Motion to Suspend Order Pending Appeal and Appellee State Medical Board of Ohio's ("Appellee") August 2, 2019 Memorandum in Opposition to Appellant's July 30, 2019 Motion for Suspension of Order Pending Appeal. On August 9, 2019, counsel for Appellant advised the Court that Appellant would not be filing a reply in support of her motion requesting a stay and the motion is now ripe for review.

BACKGROUND

On July 10, 2019, Appellee issued an order that permanently revoked Appellant's license to practice osteopathic medicine and surgery in the State of Ohio. The order's effective date is 30 days after mailing. The order was mailed to Appellant on July 11, 2019.

Appellant asks the Court to suspend or stay Appellee's order revoking her license during the pendency of this administrative appeal. Appellant argues undue hardship would result if the order is not stayed or suspended. She explains that she will turn 70 years old in September, her

daughter and five-year-old grandson live with her, and she provides care and financial support for her grandson, who is deaf. She informs the Court that she is the only psychiatrist affiliated with her practice, and unless the Court grants her request the practice will unnecessarily close before the Court has had an opportunity to consider the merits of her administrative appeal. She contends the underlying allegations against her concern her care and treatment of eight patients between September 2010 and May 2016; specifically, her selection and administration of prescription medications for these patients. Appellant argues not only will she lose income but also lose the ability to support her grandson, she will lose not only her job but also her practice, and she is too old – even if the Court ultimately reverses the revocation order – to rebuild a practice from scratch at this stage in her life.

Appellant also argues the health, safety and welfare of the public will not be threatened by a stay or suspension of Appellee's order because the proceedings below spanned more than a year and a half (from November 2017 through July 2019), and Appellee did not take any steps to suspend or restrict her license during the pendency of the proceeding. She also notes that the underlying allegations relate to conduct that last occurred in May 2016, more than three years ago, and there is nothing to suggest that suspending the revocation order would pose a danger to the health, safety or welfare of the public.

Appellee argues a stay is not appropriate because Appellant cannot establish neither unusual hardship if the stay is not granted nor that the public will not be harmed if the stay is granted. Appellee notes a permanent revocation is the harshest penalty that can be issued, and the penalty was warranted given Appellant's prior discipline for similar patient care/prescribing practices and poor record keeping. Appellee informs the Court that Appellant's license was suspended for 90 days in 2010, and she was ordered to complete training courses in prescribing

controlled substances and proper medical record keeping, yet Appellant did not change her practices after that disciplinary action and after completing the courses. Appellee argues unusual hardship requires more than the loss of income, inability to practice or damage to reputation, further noting that even the loss of an entire practice, building and equipment has been found to not constitute unusual hardship. In support of its position, Appellee directs the Court's attention to decisions issued by jurists from the Franklin County Court of Common Pleas, including *Benjamin Gill, D.O. v. State Medical Board of Ohio*, Franklin C.P. No. 07CVF09-11839 (Sept. 14, 2007), *Hazem S. Garada v. State Medical Board of Ohio*, Franklin C.P. No. 98CVF06-4873 (July 9, 1998), and *Dolce v. State Board of Chiropractic Examiners*, Franklin C.P. No. 92 CVF11-9231 (March 10, 1993).

Appellee also argues Appellant presents a significant threat to the public. Appellee notes that its review of the eight patients' charts and records revealed that Appellant prescribed controlled stimulants and benzodiazepine drugs to them without documenting the justifications for the prescriptions. For example, Patient 8 was diagnosed with anxiety, depression and insomnia, and had noted in his intake notes that he was previously treated for drug abuse and was "coming off Vicodin," yet Appellant increased his Klanopin dosage, then switched him to Xanax and switched him again to Focalin, then added the sleeping medication Ambien, all without any reasons documented for the changes in prescriptions, or medical analysis of the sleep issue or justification for the sleeping pills. Appellee argues Appellant "appears to prescribe medications based upon the whims of the patient and what drugs they are asking for," and the state's expert concluded that the medical records do not support the drug selections or administrations, there is no documentation of the patients' responses to the medications, and some of these drugs were prescribed to very young patients. Therefore, Appellee argues Appellant cannot establish that a

stay would not pose a danger to the public. Likewise, it argues Appellee cannot establish a likelihood of success on the merits given that an order based on reliable, probative and substantial evidence cannot be overturned in light of *Henry's Café, Inc. v. Board of Liquor Control*, 170 Ohio St. 233, 162 N.E.2d 223.

LAW & ANALYSIS

R.C. §119.12 provides, in pertinent part, as follows:

> Any party adversely affected by any order of an agency *** revoking or suspending a license, *** may appeal from the order of the agency to the court of common pleas of the county in which the place of business of the licensee is located or the county in which the licensee is a resident, except that appeals from decisions of the liquor control commission, the state medical board, state chiropractic board, and board of nursing shall be to the court of common pleas of Franklin county.
>
> ***
>
> The filing of a notice of appeal shall not automatically operate as a suspension of the order of an agency. If it appears to the court that an unusual hardship to the appellant will result from the execution of the agency's order pending determination of the appeal, the court *may* grant a suspension and fix its terms. *** In the case of an appeal from the state medical board or state chiropractic board, the court *may* grant a suspension and fix its terms *if it appears to the court that an unusual hardship to the appellant will result* from the execution of the agency's order pending determination of the appeal *and the health, safety, and welfare of the public will not be threatened* by suspension of the order. This provision shall not be construed to limit the factors the court may consider in determining whether to suspend an order of any other agency pending determination of an appeal.

(Emphasis added.)

As the Tenth Appellate District noted in *Bob Krihwan Pontiac-GMC Truck, Inc. v. GMC*, 141 Ohio App.3d 777, 753 N.E.2d 864 (10th Dist. 2001),

> When asked to stay an administrative order, courts give significant weight to the expertise of the administrative agency, as well as to the public interest served by the proper operation of the regulatory scheme. See *Hamlin Testing Labs, Inc. v. United States Atomic Energy Comm.* (1964), 337 F.2d 221. To that end, R.C. 119.12 allows the court to 'grant a suspension' of an agency order pending appeal if the court determines that 'unusual hardship' will result to appellant.

> Although R.C. 119.12 does not set forth or proscribe the factors the court may consider in determining whether to suspend operation of an administrative order, those factors have been refined by the courts. The Sixth Circuit, in addition to many other courts, has repeatedly relied upon the following factors as logical considerations when determining whether it is appropriate to stay an administrative order pending judicial review. Those factors are: (1) whether appellant has shown a strong or substantial likelihood or probability of success on the merits; (2) whether appellant has shown that it will suffer irreparable injury; (3) whether the issuance of a stay will cause harm to others; and (4) whether the public interest would be served by granting a stay.

Bob Krihwan Pontiac-GMC Truck, Inc., 141 Ohio App.3d at 782-783, citing *Hamlin Testing Labs, Inc. v. United States Atomic Energy Commission*, 337 F.2d 221, 222-223 (6th Cir. 1964).

As the Tenth Appellate District explained in *Maryjo Prince-Paul v. Ohio Board of Nursing*, 2015-Ohio-3984, 43 N.E.3d 13, "[c]ourts applying these factors in determining whether a stay is appropriate have stated that the factors are not prerequisites that must be met but are interrelated considerations that must be balanced together." *Prince-Paul v. Ohio Board of Nursing*, 2015-Ohio-3984, at ¶13, citing *Service Employers International Union Local 1 v. Husted*, 698 F.3d 341, 343 (6th Cir. 2012); *Michigan Coalition of Radioactive Material Users, Inc. v. Griepentrog*, 945 F.2d 150, 153 (6th Cir. 1991).

Having reviewed and considered the parties' arguments with respect to the request for a stay, the Court finds the request is not well taken. Appellant has failed to establish that unusual hardship will result if the stay is not granted. Losing one's income and even medical practice does not constitute the kind of unusual hardship that warrants a stay. As the Tenth Appellate District has noted,

> [t]hough the term "unusual hardship" is not defined in R.C. 119.12, we note that federal courts applying the concept of "undue hardship" in determining whether a stay is appropriate in bankruptcy proceedings have defined the term as being "more than mere unpleasantness or 'garden-variety' difficulty." *In re Windland*, 201 B.R. 178, 181 (Bankr.N.D.Ohio 1996), citing *In re Gammoh*, 174 B.R. 707, 709 (Bankr.N.D.Ohio

> 1994). In such cases, proof of an undue hardship "usually requires some extraordinary circumstances." *Id.*

Prince-Paul v. Ohio Board of Nursing, 2015-Ohio-3984, at ¶14.

While the Court is not unsympathetic to the financial hardship that losing a medical license may cause for Appellant and her family, especially her grandson, that financial hardship is not unusual in situations where a professional license is revoked. However, even if the Court were to assume that there would be unusual hardship, Appellant still cannot satisfy the lack of harm to others/public interest element or the substantial likelihood or probability of success on the merits element.

It is well established that, where a common pleas court finds that an agency's order is supported by reliable, probative and substantial evidence, the court can only affirm and cannot reverse, vacate or modify the order. *Henry's Café, Inc. v. Board of Liquor Control*, 170 Ohio St. 233, 236, 163 N.E.2d 678 (1959). Appellee's order is based on evidence indicating Appellant prescribed powerful stimulants and benzodiazepines without proper justifications for the same, and she did it even after having been disciplined for similar practices in the past and having been ordered to take courses about the proper prescribing of controlled substances and proper medical record keeping. Furthermore, the conduct at issue spanned a six-year period and involved the care of eight patients. While Appellee may not have taken any actions during the pendency of the proceedings before it to immediately suspend Appellant's license pursuant to R.C. §4731.22(G)(2), that does not mean that Appellant's continued medical practice, now that the proceedings have concluded and a report has been issued, would not pose a danger to the public given her practices. Furthermore, the Court is not convinced at this time that Appellant has established a substantial likelihood or probability of success on the merits in light of *Henry's Café, Inc v. Board of Liquor Control.*

In light of the foregoing, Appellant's Motion to Suspend Order Pending Appeal is hereby **DENIED**.

IT IS SO ORDERED.

Copies to:

Patrick M. Quinn (electronically)
Brunner Quinn
Counsel for Appellant

Melinda R. Snyder (both electronically)
Kyle C. Wilcox
Ohio Attorney General's Office
Counsel for Appellee

Franklin County Court of Common Pleas

Date: 08-12-2019

Case Title: CONSTANCE E ANGE DO -VS- STATE MEDICAL BOARD OF OHIO

Case Number: 19CV006043

Type: DECISION/ENTRY

It Is So Ordered.



/s/ Judge Colleen O'Donnell

Court Disposition

Case Number: 19CV006043

Case Style: CONSTANCE E ANGE DO -VS- STATE MEDICAL BOARD OF OHIO

Motion Tie Off Information:

1. Motion CMS Document Id: 19CV0060432019-07-3099980000
   Document Title: 07-30-2019-MOTION TO STAY - PLAINTIFF: CONSTANCE E. ANGE DO
   Disposition: MOTION DENIED

E768 - Y1 Franklin County Ohio Clerk of Courts of the Common Pleas- 2019 Jul 25 9:36 AM-19CV006043

BEFORE THE STATE MEDICAL BOARD OF OHIO

CONSTANCE E. ANGE, D.O. 1231-F Lyons Road Centerville, Ohio 45458	)	Case No. Judge
Appellant,	)	Category F (Administrative Appeal)
v.	)	Board Case No. 17-CRF-0146
STATE MEDICAL BOARD OF OHIO 30 E. Broad Street, 3rd Floor Columbus, Ohio 43215	)	
Appellee.	)	

NOTICE OF APPEAL

Constance E. Ange, D.O., by and through her undersigned counsel, hereby gives notice of her appeal, pursuant to R.C. 119.12, of the State Medical Board of Ohio's Entry of Order mailed on July 11, 2019. A true and accurate copy of such Entry of Order is attached hereto as Exhibit A. The grounds for this appeal are that the Board's Entry of Order is not supported by reliable, probative, and substantial evidence and is not in accordance with law.

This notice of appeal is being filed with the State Medical Board of Ohio and with the Franklin County Court of Common Pleas.

STATE MEDICAL BOARD OF OHIO
2019 JUL 22 AM 9:12

Respectfully Submitted,

/s/ Patrick M. Quinn
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Columbus, Ohio 43215
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Facsimile: (614) 241-5551
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Attorney for Appellant

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on this 25th day of July, 2019, a true and accurate copy of the foregoing was filed by hand delivery with the State Medical Board of Ohio, 30 E. Broad Street, 3rd Floor, Columbus, Ohio 43215; that a true and accurate copy of the foregoing was filed with the Franklin County Court of Common Pleas via the electronic filing system; and that a true and accurate copy of the foregoing was also served via email upon the following:

Kyle C. Wilcox
Melinda Snyder
Assistant Attorneys General
Health & Human Services
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Columbus, Ohio 43215
kyle.wilcox@ohioattorneygeneral.gov
melinda.ryanssnyder@ohioattorneygeneral.gov

/s/ Patrick M. Quinn
Patrick M. Quinn (0081692)

State Medical Board of
Ohio

July 10, 2019

Constance E. Ange, D.O.
1231-F Lyons Road
Centerville, OH 45458

RE: Case No. 17-CRF-0146

Dear Dr. Ange:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation R. Gregory Porter, Esq., Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on July 10, 2019, including motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Any such appeal must be filed in accordance with all requirements specified in Section 119.12, Ohio Revised Code, and must be filed with the State Medical Board of Ohio and the Franklin County Court of Common Pleas within (15) days after the date of mailing of this notice.

THE STATE MEDICAL BOARD OF OHIO

Kim G. Rothermel, M.D.
Secretary

KGR:jam
Enclosures

CERTIFIED MAIL NO. 91 7199 9991 7038 7174 9657
RETURN RECEIPT REQUESTED

Cc: Patrick M. Quinn, Esq.
CERTIFIED MAIL NO. 91 7199 9991 7038 7174 9664
RETURN RECEIPT REQUESTED

Mailed 7-11-19

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of R. Gregory Porter, Esq., State Medical Board Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on July 10, 2019, including motions approving and confirming the Findings of Fact, Conclusions and Proposed Order of the Hearing Examiner as the Findings and Order of the State Medical Board of Ohio; constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter Constance E. Ange, D.O., Case No. 17-CRF-0146, as it appears in the Journal of the State Medical Board of Ohio.

This certification is made by authority of the State Medical Board of Ohio and in its behalf.

Kim G. Rothermel, M.D.
Secretary

(SEAL)

July 10, 2019
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF	*	
		CASE NO. 17-CRF-0146
	*	
CONSTANCE E. ANGE, D.O.	*	

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on July 10, 2019.

Upon the Report and Recommendation of R. Gregory Porter, Esq., State Medical Board Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the approval and confirmation by vote of the Board on the above date, the following Order is hereby entered on the Journal of the State Medical Board of Ohio for the above date.

It is hereby ORDERED that:

A. **PERMANENT REVOCATION**: On the thirty-first day following the date on which this Order becomes effective, the license of Constance E. Ange, D.O., to practice osteopathic medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED. During the 30-day interim, Dr. Ange shall not undertake the care of any patient not already under her care

B. **FINE**: Within thirty days of the effective date of this Order, Dr. Ange shall remit payment in full of a fine of three thousand and five hundred dollars ($3,500.00). Such payment shall be made via credit card in the manner specified by the Board through its online portal, or by other manner as specified by the Board.

This Order shall become effective immediately upon the mailing of the notification of approval by the Board.

Kim G. Rothermel, M.D.
Secretary

(SEAL)

July 10, 2019
Date

JUN 13 2019
STATE MEDICAL BOARD OF OHIO

BEFORE THE STATE MEDICAL BOARD OF OHIO

In the Matter of	*	
		Case No. 17-CRF-0146
Constance E. Ange, D.O.,	*	
		Hearing Examiner Porter
Respondent.	*	

REPORT AND RECOMMENDATION

Basis for Hearing

In a notice of opportunity for hearing dated November 8, 2017 ("Notice"), the State Medical Board of Ohio ("Board") notified Constance E. Ange, D.O., that it had proposed to take disciplinary action against her certificate to practice osteopathic medicine and surgery in Ohio based upon her care and treatment of eight patients identified on a confidential Patient Key. The Board alleged that Dr. Ange's treatment of Patients 1 through 8 during the time period of in or around September 2010 through in or around May 2016 constitutes:

- "Failure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as that clause is used in Ohio Revised Code Section ("R.C.") 4731.22(B)(2);

- "A departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in R.C. 4731.22(B)(6);

- "[V]iolating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in R.C. 4731.22(B)(20), to wit: Ohio Administrative Code Rule ("Rule") 4731-11-02.

Accordingly, the Board advised Dr. Ange of her right to request a hearing and received her written request on December 8, 2017. (State's Exhibits ("St. Exs.") 12A, 12B)

Appearances

Dave Yost, Ohio Attorney General, and Kyle C. Wilcox and Melinda Ryans Snyder, Assistant Attorneys General, on behalf of the State of Ohio. Patrick M. Quinn, Esq., on behalf of Dr. Ange.

Hearing Date: May 14 through 16, 2018

PROCEDURAL MATTERS

1. At the close of the hearing, the record was held open to give the parties an opportunity to submit written closing arguments. The documents were timely received. The State's closing argument was marked State's Exhibit 14, and the Respondent's closing argument was marked Respondent's Exhibit A. Both exhibits were admitted to the hearing record, which closed July 17, 2018.

2. State's Exhibit 13 was paginated by the Hearing Examiner post-hearing.

SUMMARY OF THE EVIDENCE

All exhibits and the transcript of testimony, even if not specifically mentioned, were thoroughly reviewed and considered by the Hearing Examiner prior to preparing this Report and Recommendation.

Background Information

1. The educational background of Constance E. Ange, D.O., is described in detail in a Report and Recommendation from a previous hearing:

> Constance E. Ange, D.O, is a child and adult psychiatrist. She earned her undergraduate degree from the University of North Carolina, at Wake Forest. She earned her medical degree in 1974 from the Chicago College of Osteopathic Medicine. She completed a one-year "rotating" internship at Grandview Hospital in Dayton, Ohio, and completed a two-year family-practice residency in Springboro, Ohio. Between 1977 and 1981, Dr. Ange completed a two-year residency in adult psychiatry, and a two-year fellowship in child psychiatry, both at the University of Cincinnati.

(St. Ex. 13 at 11)

2. Dr. Ange was first licensed to practice osteopathic medicine and surgery in Ohio in July 1975. Her license is currently active. (Ohio eLicense Center, *<https://elicense.ohio.gov/>*, search terms "Constance," "Ange," and "Medical Board," accessed May 22, 2019)

3. Dr. Ange testified at the hearing that she is certified in both adult and child psychiatry by the American Osteopathic Association and the American Medical Association.[1] This is

[1] As noted by the Board at its August 11, 2010 meeting, the American Medical Association does not certify physicians; rather, physicians are certified by specialty boards who are members of the American Board of Medical Specialties ("ABMS"), such as the American Board of Psychiatry and Neurology. In fact, Dr. Ange is certified in both adult and child psychiatry by the American Board of Psychiatry and Neurology. (St. Ex. 13 at 39-40; ABMS website,

also reflected in Dr. Ange's letterhead. She further testified that she is exempt from having to recertify with those boards because she has been "grandfathered." (Tr. at 13, 524-525; See, e.g., St. Ex. 8 at 115)

4. Dr. Ange testified that, since completing her fellowship, she has been engaged in the private practice of psychiatry and has two offices: a main office in Centerville, Ohio, and a satellite office in Vandalia, Ohio. She practices at her Vandalia office one day per week. Dr. Ange testified that she is the only physician in her practice and that she currently has three employees. At the time of the hearing she was looking for a fourth. She testified that she sees patients Monday through Friday, from 9:30 a.m. until 4:30 or 5:00 p.m. She was reluctant to estimate her patient load but indicated that she sees an average of 10 to 15 patients per day, sometimes fewer, sometimes more. In addition, Dr. Ange testified that she does some consulting work for developmentally disabled people approximately every three months for about six hours. (Tr. at 14-16, 525-526)

5. Dr. Ange testified that her practice is cash-only and that she does not accept insurance. Dr. Ange further testified that she believes that that is becoming more common among psychiatrists. Moreover, Dr. Ange testified that she has not accepted insurance since the 1980s. (Tr. at 17, 49-50, 531)

6. Dr. Ange estimated that approximately 20 to 30 percent of her patients are children and the remainder are adults. Dr. Ange further testified that most of her patients come to her through referrals from other physician, psychologists, or counselors. (Tr. at 23-24)

7. Dr. Ange testified that she holds courtesy hospital privileges, meaning that she can send patients to the hospital but not treat them at the hospital. She did not specify which hospital(s). (Tr. at 52-53)

8. At hearing, Dr. Ange was recognized as an expert in psychiatry. (Tr. at 526)

August 2010 Board Order

9. On August 11, 2010, the Board issued an Order ("August 2010 Order"), effective September 1, 2010, that suspended Dr. Ange's license for a definite period of ninety days, based upon violations of R.C. 4731.22(B)(12) and 4731.22(B)(20) related to her prescribing practices; namely, providing pre-signed prescription blanks to her staff to complete for refills of patients' medications. The August 2010 Order further established probationary requirements, including that she complete an approved course on the subject of prescribing controlled substances and an approved course on maintaining adequate and appropriate medical records. Dr. Ange complied with the probationary requirements, and on or about November 14, 2012, the Board released Dr. Ange from probation. (St. Ex. 13)

<*https://www.certificationmatters.org/*>, search terms "Constance," "Ange," and "Psychiatry," accessed February 22, 2019)

State Expert Witnesses – Diane H. Eden, M.D., R.Ph.

10. Diane H. Eden, M.D., R.Ph., testified as an expert witness on behalf of the State. Dr. Eden testified that she had obtained a Bachelor of Science degree in pharmacy from Purdue University in 1980, and in 1985 received her medical degree from what was then called the Medical College of Ohio, and which is now known as the University of Toledo College of Medicine and Life Sciences. In 1985, she entered an internship and residency in psychiatry at University Hospitals of Cleveland which she completed in 1989. (Tr. at 214; St. Ex. 11)

    Dr. Eden was certified in psychiatry by the American Board of Psychiatry and Neurology in 1991. She testified that she was "grandfathered" in and does not have to periodically recertify. (St. Ex. 11; Tr. at 216-217)

11. Dr. Eden was licensed to practice medicine and surgery in Ohio in October 1986, and her license is currently active. She also holds active medical licensure in the states of Florida, Tennessee, and Arkansas. In addition, Dr. Eden was licensed as a registered pharmacist in Ohio in August 1980, and her pharmacy license is currently active. (St. Ex. 11; Tr. at 216; Ohio eLicense Center, *<https://elicense.ohio.gov/>*, search terms, "Diane," "Eden," "Medical Board," and "Board of Pharmacy," accessed March 26, 2019)

12. Dr. Eden testified that she entered the private practice of psychiatry in the Cleveland area in 1989, starting as a solo practitioner. In 1994, she joined some friends in a group practice. That practice ended in 2004 and Dr. Eden started a different practice of which she is the sole owner. (Tr. at 215-218) She testified that it is on the border between Cuyahoga and Lake counties, "so it's a sort of rural, sort of suburban practice." (Tr. at 218) She testified that she currently employs five psychiatrists, an advanced practice nurse, and 16 therapists. (Tr. at 218)

    In addition, Dr. Eden testified that she has also done work for the insurance industry, starting as a consultant for Cigna Behavioral Healthcare in 1992. She spent approximately 18 years as the chief medical officer for behavioral health for Medical Mutual of Ohio until 2015, and in 2016 was hired as medical director for Aetna Health Insurance Company, where she remains. She also served as the department chairperson for the psychiatric department at St. Vincent Charity Hospital. Despite all of that, Dr. Eden testified that her primary source of work and income has always been her private practice. (Tr. at 218-219)

13. Dr. Eden described her private practice of psychiatry:

    > So in my private practice I see between 20 and -- I would say 20 and 28 patients a day. I provide psychiatric diagnosis and medication management services. I do it in a group practice setting so we can offer outpatient services including psychiatric and psychological services under one roof.

> As I mentioned, I work with other psychiatrists and therapists. It's a practice that still accepts insurance, although we do have some self-pay patients as well. We offer services seven days a week.
>
> * * *
>
> * * * Most of the people are functioning in the community. They have mostly mood and anxiety disorders, attentional disorders. We have some with bipolar illnesses, mood disorders. We have some people who have psychotic disorders. They are typically the higher functioning schizophrenic patients, although we do have some people who are disabled. We do accept some of the Ohio Medicaid Plan, so some of those individuals are not working and more severely mentally ill, but it's a pretty much wide range of patients. Anybody who calls us can come see us if they want.

(Tr. at 219-220)

Dr. Eden added that she currently sees only adult patients, defined as 16 years old and up. Dr. Eden testified that she had seen patients under the age of 16 in the past but has not seen juvenile patients "for years." (Tr. at 220)

14. Dr. Eden testified that she holds consulting privileges at University Hospitals of Cleveland and at Euclid Hospital. Dr. Eden testified that consulting privileges allow her to evaluate patients at those hospitals but not admit them. She further testified that "[t]hat's by choice." (Tr. at 226)

15. Dr. Eden estimated that 95 percent of her patients are billed through insurance. (Tr. at 225)

16. Dr. Eden testified that she uses electronic medical records in her practice; however, the standard of care does not require electronic medical records. (Tr. at 355)

Dr. Ange's Care of Patients 1 through 8, In General

Testimony of Dr. Eden

17. Dr. Eden testified concerning Dr. Ange's charts that, at a patient's initial visit, "there was a fairly extensive first visit note * * *." (Tr. at 230) However, Dr. Eden further testified:

> My overall impression of the medical documentation was that it was difficult to follow, that there was not a flow that was a pattern or a flow[2] that I could follow easily. It was difficult at times to tell why a medication change was

[2] With respect to what she meant by the word "flow" when speaking of the flow of a medical record, Dr. Eden testified, "To be able to look at the chart and follow some logical pattern of thought in terms of gathering the information, coming up with an assessment, and rendering a diagnosis and treatment plan." (Tr. at 348)

made, why -- what the impact of a change in treatment was, or even the initiation of treatment.

It was difficult to understand what symptoms and information was used to create new diagnoses, and I also thought that there were a lot of controlled substance prescriptions that were prescribed outside of office appointments and long periods of time in between appointments of people taking controlled substances. I found that the OARRS report when available was reviewed in office but not when prescriptions were called in as frequently from out of office.

I also found it difficult to tell on some of the notes whether they were face-to-face visits or whether they were phone conversations. It was hard to tell what kind of service was provided because there was no documentation of the CPT code[3], although on the billing sheets there were CPT codes listed.

(Tr. at 233-234)

When asked whether Dr. Ange's accepting only cash payment affects her use of CPT codes, Dr. Eden testified:

Well, that would be a discrepancy in terms of the fact in the billing forms there are CPT codes listed, and I think if you use a medical record to relay information to the next person, in light of who might be using the records, it's important to know what kind of services were provided.

I saw some of the codes were listed as psychotherapy codes. The notes looked the same as a medication management code, so I think it's more than just charting to the insurance company. It's charting to the minimum standards of medical records.

Also I didn't see -- I saw diagnoses listed but not in an axis system which had been standard and I saw some diagnoses that were psychiatric diagnoses like panic disorder, GAD, but then I saw other things on the diagnoses like anxiety. I wouldn't know what that means because that's really a symptom or a set of disorders, not really a diagnosis itself. So there was inconsistency with diagnosis -- diagnoses made.

(Tr. at 235)

18. With respect to Dr. Ange's use of controlled substances for Patients 1 through 8, Dr. Eden testified that Dr. Ange appeared to prescribe controlled substances early in the patients'

[3] Dr. Eden testified that "[a] CPT code is the service code for the service that's provided to the patient at that visit." (Tr. at 234)

treatment "with rapid increases in doses for some of the patients and large quantities prescribed over short periods of time with increasing doses for some of the patients." (Tr. at 236)

19. With respect to Dr. Ange's use of OARRS, Dr. Eden opined:

> Well, I think OARRS was checked I think generally when Dr. Ange saw the patients but calls in between where a lot of prescribing was done, I didn't see evidence OARRS was checked.
>
> My criticism is based on the frequency, the rate of prescribing and increasing doses. It appeared that benzodiazepines were a first line choice in most of the charting that I saw and that the doses were increased rapidly based -- sometimes without documentation and sometimes with a rapid catalyzer or a poor absorber but no documentation of that.
>
> In addition, on the OARRS report there was evidence of use of opiates in some of the patients, multiple opiates in at least one of the patients that I'm recalling, and there was no documentation that there was any communication with the prescriber of the opiates. There was no documentation that education was provided about the risks of taking opiates and benzodiazepines together. There was no documentation of contact with other prescribing physicians, especially those pain medications where there might have been a pain contract where the addition of Dr. Ange's prescriptions could have violated that pain contract.

(Tr. at 237-238)

When asked why it is important for a psychiatrist to communicate with a patient's pain medicine physician or other physician providing similar medications, Dr. Eden replied:

> So coordinated care for any patient, regardless of specialty, is important when it's clinically appropriate, particularly with pain medications and pain management doctors. First of all, many of the pain doctors have contracts with the patient that they are not to take any other controlled substance unless it's run through that prescriber first.
>
> Second of all, there are well known risks in combining benzodiazepines and opiates including respiratory depression and potential death, unexpected and avoidable. So it just makes good clinical sense to make sure that everybody is on the same page in terms of prescribing for that individual.

(Tr. at 238) Dr. Eden testified that the standard of care requires the psychiatrist to at least attempt to contact the other prescribing physician. (Tr. at 239) Dr. Eden further testified, "As a matter of routine as a specialist, if there is a primary care doctor or another physician

that a patient would like notified of their treatment with me, I ask the patient if they would like me to send a letter, and they either confirm or deny that request." (Tr. at 354) Moreover, Dr. Eden testified that, if the patient declines, she documents "that the patient declined coordination of care letter." (Tr. at 355)

20. Dr. Eden testified that it is her understanding that a psychiatrist prescribing a benzodiazepine must consult an OARRS report at every prescription. (Tr. at 348-349) However, when advised that Rule 4731-11-11(E) requires follow-up OARRS review every 90 days, Dr. Eden acknowledged that Dr. Ange had not been required to check OARRS every time she issued a prescription for a benzodiazepine.[4] (Tr. at 350-351)

21. When asked what the standard of care requires for a psychiatrist to render a diagnosis, Dr. Eden described in detail the process she uses during her initial evaluation of the patient, which involves, first, asking the patient for his or her chief complaint. She then obtains a full history "including precipitating events, past treatments, stressors, symptoms for sure, things that may have helped them feel better, things that haven't in the past." (Tr. at 239) She obtains a full medical history and psychosocial history, as well as a family medical and psychiatric history. In addition, she obtains the patient's chemical dependency history, occupational history, socio-marital-family history, and past psychiatric history and treatment. (Tr. at 239-240)

    She then performs a formal mental status examination, which she described as "basically the psychiatric physical exam, looks at mood, cognition, psychotic processing, anxiety symptoms, suicidal thinking, and cognitive functioning * * * [a]nd then I draw a conclusion based on the set of symptoms that the patient provides, discuss that with the patient in terms of diagnostic impressions, and set up a treatment plan with the patient." (Tr. at 240-241)

22. As an example, Dr. Eden applied her discussion to a full workup for a diagnosis of generalized anxiety disorder ("GAD"):

> So typically the patient would not come in and say I think I have generalized anxiety disorder. They would come in with a set of symptoms. So in the course of my documentation when they describe symptoms, I would document those symptoms.
>
> And what I do is I look for sets of symptoms because the way I view this is psychiatry is a set of symptoms that form syndromes that we label as psychiatric diagnoses because of the symptoms and because of their severity and their effect on functioning. And if I have -- and I use the criteria, although I can't say that I've memorized all the DSM-5 criteria, but I know the sort of standards of what's required; for instance, for generalized anxiety disorder, a period of at least six months where you have things like excessive

[4] Note that the Board did not allege that Dr. Ange violated Rule 4731-11-11(E).

> worry, lack of pleasure, people complain their mind may go blank, fatigue, and I probably have to look up the rest of the symptoms.
>
> But, you know, I look for that set of symptoms that form the syndrome, and then I look for other complaints that the -- I have difficulty focusing, so I look at did this condition start in childhood? Do you have problems with -- you know, have the symptoms been present for at least six months? Is there something else that could be causing these symptoms?
>
> Also with generalized anxiety, is there a medical condition that could be causing these symptoms? Because every psychiatric condition basically says can't be caused by a medical problem. Is there medical problems that can look like psychiatry conditions?
>
> So that's why the medical part of the evaluation is important. And I look again for a set of symptoms that form that syndrome and discuss it with a patient, the functioning. I look at symptoms, and I look at length of symptoms and other contributing factors.

(Tr. at 241-243)

Dr. Eden added that "psychiatric diagnoses are always working diagnoses because sometimes the way the patient presents is not the way their condition actually ends up and providing treatment for." (Tr. at 243)

23. Dr. Eden was asked what the standard of care requires in terms of documentation for increasing a patient's dose of medication. She replied:

> Well, I think you have to document the symptom that you're addressing with that treatment change, and then you need to document the outcome of that treatment change at the next visit. So if –
>
> * * *
>
> If you're treating somebody for depression, you might say still complaining of poor concentration, inability to sleep, lack of energy, so I'm going to take medication A and raise it from this dose to that dose to try to get some partial improvement, to try to gain more improvement.

(Tr. at 244)

24. Dr. Eden testified that approximately eight to ten years ago she completed a medical recordkeeping course at Case Western Reserve University ("CWRU") to ensure that the medical documentation at her practice met or exceeded the minimal standard of care. (Tr. at 226-227) Dr. Eden described the CWRU course and what she learned from it:

> Well, it basically went detail by detail about what's expected in charting, the purpose of charting, who owns the charts, and then there was about a half a day of horror stories about people who didn't chart properly, who used wrong CPT codes, who made determinations that were not able to be reviewed by other physicians. So, you know, it was partly educational and partly scare tactic to make sure that we were documenting appropriately. And I think in that class most of the people there actually were ordered by the State Board to take that -- that course.
>
> * * *
>
> My understanding of patient records is that they're a legal document that are technically owned by the patient and to be released to the patient at their request. And they document as accurately as possible the interaction with the patient, the information the patient provides, the both subjective and objective findings by me and my assessment and how I derive that assessment in my plan for initial assessment and ongoing, legible documentation that another physician could pick up and follow behind me in the course of treatment if I was not available to determine ongoing diagnostic changes, considerations, treatment, and how I arrived at that treatment and what the plan would be moving forward.

(Tr. at 227-228)

25. When asked to comment on testimony offered by Dr. Ange that she documents her patient charts in a manner that *she* can understand,[5] Dr. Eden testified:

> That's not my understanding of medical records. I mean, I do have to understand what I've done and document in a way that I can follow, but equally as important, if not more important, I have to document in a way that another physician could follow if I'm not available and that it's understandable to anybody with a basic knowledge who could read the chart to get a picture of what the treatment has been.

(Tr. at 229)

26. When asked whether she charted thoroughly to ensure that insurance companies pay her patients' bills, Dr. Eden testified that she did so based on what is appropriate for the standard of care, but also testified that "[d]ocumentation that insurance companies require are part of the minimum standards." (Tr. at 342-343)

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[5] Tr. at 204

27. Dr. Eden testified the proper use of the appropriate CPT code is included in the minimal standard of care. (Tr. at 343)

Testimony of Dr. Ange

28. Dr. Ange disagreed with Dr. Eden's conclusion that Dr. Ange's care of Patients 1 through 8 fell below the minimal standard of care in the selection of medications:

> I disagree with her opinion because it was my understanding from her testimony that she believed that I used benzos or Adderall as a first line of choice, and all these patients were on antidepressants or other medicines or had had other medicines prior, and so the benzo is definitely not a first line of choice. It is my opinion it's a second line and maybe a third or fourth line even with some and was an augmentation to the -- usually it was an antidepressant because of the, in my opinion, the severity of the presentation.

(Tr. at 533-534)

Dr. Ange further disagreed with Dr. Eden that Dr. Ange's charting does not meet the minimal standard of care. Dr. Ange testified that "there are diagnoses that are available in the chart as well as complaints, impressions, which is diagnoses, and then a treatment plan [comes forward.]" (Tr. at 534-535) However, Dr. Ange acknowledged that her recordkeeping is not perfect and could be better. (Tr. at 535)

29. Dr. Ange testified that around 2010 she attended a course on medical recordkeeping offered by Case Western Reserve University that she found to be very helpful. Dr. Ange testified that she can recall no discussion during that course concerning the use of specific numerical coding as a requirement for maintaining patient medical records. (Tr. at 41-42, 532)

30. Dr. Ange testified that, throughout her practice, she has on many occasions had patients leave her practice and see other practitioners, and very frequently they request to have their chart forwarded to the new practitioner. Dr. Ange testified that she has never received a communication from a subsequent treating provider indicating that they could not understand Dr. Ange's chart. (Tr. at 537-538)

31. Dr. Ange testified that she documents prescriptions in her chart by using carbon paper to copy the prescription information directly onto a sheet of paper and places it into her chart. Dr. Ange further testified that that is why some of prescriptions in the State's exhibits appear light and are hard to read. (Tr. at 539-540)

32. Dr. Ange testified that, over the course of her practice, she has developed some standard language that she recites to patients regarding various concerns, such as risks and potential side effects for medication she prescribes. Dr. Ange testified that she documents such

discussions on short hand, such as "ed" for education, "supp" for support, "re" and a checkmark for recheck. (Tr. at 541-542)

33. Dr. Ange testified that she or a designated staff person regularly checks OARRS and that she finds the reports helpful. (Tr. at 20-21)

34. Dr. Ange testified that she disagrees that she insufficiently adjusted her treatment plan based on information obtained in OARRS. Dr. Ange testified:

> I believe the OARRS was taken into consideration. It perhaps was not interpreted in the way she would have interpreted it, but I do believe the OARRS was taken into consideration. If you're going to pull the information, you should certainly use it. We've gotten better at milling it (*sic*).[6] The State has added additional information to the OARRS to make it so much easier to understand and interpret it, so that's a lot easier. That's only been, you know, recently, but I think the OARRS is important. It should be done. It is up for interpretation how one might use it in practice.
>
> Q [By Mr. Quinn] Now, when you say it's up for interpretation as to how one -- as to how one might use it in the practice, what exactly do you mean by that?
>
> A Well, it was my impression – for example, yesterday it was simply red flags for Dr. Eden. It may be. I may be wrong on saying that, but that was my impression, and I saw like in one case a patient who had, just as an example, who had opiate issues, he was still getting opiates. While that can be a red flag in terms of management, but it also said well, they must be trusting him to do that; otherwise, why would they do it. Of course -- well, again, it's just information you use. You try to check it out with the patient. About that, and can certainly see that there's his history, and you try to take that into consideration, keep it in the back of your mind that you might have a potential problem, but I don't think it has to be always read as a red flag.

(Tr. at 536-537)

35. Dr. Ange testified that when she reviews an OARRS report and finds a potential red flag, she usually circles the information and documents the discussion with the patient by writing "discussed" in her notes. (Tr. at 544)

36. Dr. Ange testified that she prescribes controlled substances to patients if warranted. She testified that her most commonly prescribed controlled substances are ADD medications such as Adderall and Ritalin, benzodiazepines such as Klonopin and Ativan, and sleep aids such as Ambien and Lunesta. (Tr. at 21-22)

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[6] This appears to be a typographical error in the transcript. The Hearing Examiner cannot recall with any certainty what Dr. Ange actually said.

37. Dr. Ange testified that both Adderall and Vyvanse are dextroamphetamines. Dr. Ange testified that the version that "all the kids want in college" is Adderall IR, immediate release, the effects of which last about four hours. (Tr. at 24) She testified that she mainly prescribes either Adderall XR, extended release, which is released into the patient's system over the course of six to eight hours, and Vyvanse, which is released in the patient's system over the course of 10 to 12 hours. Dr. Ange further testified that college students use Adderall IR believing, rightly or wrongly, that it improves their performance on tests. (Tr. at 24-25)

    Dr. Ange testified that Adderall and Vyvanse are schedule II controlled substances. (Tr. at 26) When asked if she knows what the schedule of a medication indicates about the medication, Dr. Ange replied, "Actually, that's a good question. I never thought about that. I just assumed perhaps -- I never thought about it, about why." (Tr. at 26) She at first testified that the higher the controlled substance schedule number the more cautious a physician has to be with the drug but quickly corrected herself. (Tr. at 26) Dr. Ange stated that she treats all controlled substance medications with caution. (Tr. at 27)

38. Dr. Ange testified that benzodiazepines are used to treat anxiety, panic disorder, and agoraphobia, although the first line treatment for generalized anxiety disorder is an antidepressant. (Tr. at 32-34)]

39. Dr. Ange described the possible complications and/or side effects of benzodiazepines include sedation, increased risk of falling, and reversible short-term memory loss. She further testified that patients can suffer dangerous seizures if they are weaned too quickly from a benzodiazepine. Dr. Ange further testified that the older a patient is the more cautious the physician must be when prescribing benzodiazepines. (Tr. at 35-37)

40. Dr. Ange testified that when she increases or decreases a patient's dose of medication, she marks the chart with an up or down arrow. When asked if she notes in the charts the reason for increasing or decreasing a patient's dose of medication, she replied,

    > Well, I think you're supposed to, and I do try to put enough in the database, when you're gathering information, to substantiate the reason up or down.

    Q. [By Mr. Wilcox] What do you mean? You lost me there. "In the database" –

    A. Well, like subjective, objective, you know, it has the SOAP. These are kind of SOAP notes, sort of, and so you have subjective, objective, and then impression and plan and treatment, et cetera, and I try to put enough information of -- you know, the patient comes in, tells me what's going on. Like I'm having trouble at school, focus is good, but it seems to wear out around noon, that might be a common kind of thing, or with the benzo it might be anxiety. If I'm going to increase it, I might have in the note the anxiety is no better or it's worse. So what I'm saying is I have, you know, the

> subjectives, and then I ask them -- and then the objective is a little bit more insight to do, objective obviously, and then impression.

(Tr. at 44-45)

41. Dr. Ange testified that what she considers to be red flags that a patient might be abusing prescriptions include slurred speech, being demanding and difficult, and losing their script or medication, asserting that a neighbor stole it, the dog ate it, or that it went down the toilet. Dr. Ange further testified that OARRS also helps identify patients who physician-hop or pharmacy-hop. (Tr. at 47-48)

    Moreover, Dr. Ange testified that, in her experience, patients who are truly misusing their prescribed drugs never admit to taking too many. Dr. Ange further testified that she has also learned to be suspicious if the patient brings in a police report of the patient's claim the drugs were stolen, because the police report is usually based solely on the word of the patient. (Tr. at 547-548)

    Dr. Ange indicated how she reacts when a patient who was prescribed a benzodiazepine tells her that he or she has taken the pills more frequently than they were prescribed:

> Well, I want them mostly to tell me, you know, why they did it. You can either say, you know, they're not following instructions or they're red flags and they're drug addicts out of the gate, or you might say -- you know, from my viewpoint, I always ask well, what did you take and how much and what seemed to be work, so I have some idea of where we might be going. You have to take that in the context of the patient and their history and so forth and so on. It has been my experience over the years that most of the people are usually somewhat accurate about the dosage that they use, and then you may run into problems if that dosage is incompatible with other drugs that they're on.

(Tr. at 546-547)

42. Dr. Ange readily agreed that, going back in her charts to 2010 – 2012, she was not as savvy about reviewing OARRS as she is today. (Tr. at 49)

Patient 1 (Patient KA)

43. Patient 1 is a female born in 1975. She first saw Dr. Ange on March 11, 2015. The patient's chief complaints were anxiety, depression, and chronic pain for which she was receiving treatment from another physician. (St. Ex. 1 at 118-124) A March 11, 2015 OARRS report indicates that Patient 1 was at that time being prescribed Butrans patches and zolpidem.[7] She had also received oxycodone/APAP on one occasion in July 2014.

[7] Zolpidem is the generic name for Ambien. (Tr. at 114)

(St. Ex. 1 at 112-114) Dr. Ange continued to treat Patient 1 through at least April 14, 2016, the last visit documented in State's Exhibit 1. (St. Ex. 1 at 9-11)

44. Dr. Ange testified that Patient 1 came to her with a history of gastric bypass surgery and was seeing a pain medicine physician for chronic pain. (Tr. at 56)

45. At her initial visit, Patient 1 identified her current medications as fluoxetine (Prozac), Ambien, tizanidine, Topamax, Imitrex, Butrans patch (buprenorphine), and Ativan. (St. Ex. 1 at 119; Tr. at 56-58)

46. Dr. Ange testified that, at Patient 1's initial visit, she gave Patient 1 the Axis I diagnoses of general anxiety disorder ("GAD"), attention-deficit disorder ("ADD"), pervasive dysthymic disorder ("PDD"),[8] and panic disorder – moderate. On Axis III she identified chronic pain, overweight, headache, previous GI surgery, and fibromyalgia. At that visit, Dr. Ange prescribed Adderall 5 mg #60 with instructions to take one tablet twice per day. (Tr. at 60; St. Ex. 1 at 107)

Dr. Eden's Report

47. In her written report, Dr. Eden stated as follows concerning Dr. Ange's treatment of Patient 1 (identified as Patient KA in her report):

> Dr. Ange's medical records were reviewed. Her medical records were mostly hand written and included some notes on blank sheets of paper and some notes on pre-printed forms, and in some situations there were notes for the same date of service on blank paper duplicated on a pre-printed form. Initial patient information paperwork was provided and there were several rating scales administered at the time of intake.
>
> The patient was first seen on March 11, 2015 and the last visit was April 14, 2016 (last date on the billing sheet was March 15, 2016.) There were notes for nine (9) appointments. Three billing codes were used; 90863(6), 90791(1) and 90792(1), and the code used on the DOS 4/14/16 is not known since the type of service provided is not included on the note.
>
> The intake note dated 12/14/14 [*sic*] was legible but a diagnosis was not listed; however the billing sheet listed F90.2. The note followed an anecdotal pattern and KA was described as tearful and she reported depression, anxiety and poor sleep (p 119-123; p 122).[9] She described racing thinking, poor boundaries, felt abandoned and poor motivation. Her MSE [mental status examination] described her as normal build and appropriate appearance, focused and easily distracted, cooperative, normal and coherent speech, sad,

[8] Dr. Ange testified that PDD is "a longer type of depressive disorder." (Tr. at 60)
[9] All page references refer to State's Exhibit 1.

irritable, crying and guilty, full and appropriate affect with logical and goal directed thinking. There was no documentation of SI/HI. She reported the use of Ambien 10 mg for sleep indicating, "I am not sleeping" (p 122). Dr. Ange's diagnostic impression was GAD, anxiety, ADD, PDD, Panic Attacks, chronic pain, fibromyalgia, and GI surgery, but no ICD9/DSM codes were documented (p.122). Multiple self-reporting tools were completed, and Adderall 5 mg bid[10] was started.

On intake KA reported she was taking Fluoxetine 60 mg, Ambien 10 mg, Tizanidine tid,[11] Topamax 100 mg and 1 or 2 other medications for migraine, Butrans patch for chronic pain, and she reported Seroquel was helpful but stopped by Dr Martin in 2013.[12] KA reported Ativan had helped her but her pain doctor did not want her on Ativan because of her use of Butrans calling him "a control freak," and Dr Ange documented "Ativan helps with panic attacks" (p 119). KA reported she had gastric bypass in 2000 and said she had "poor absorption" (p 121). On 3/24/15 (p 104), Dr Ange documented that the "only thing that helped was Suboxone - has migraine pain."

The OARRS report dated 3/11/15 (p 112-114) shows KA was taking Buprenorphine, Butrans, Zolpidem and Oxycodone and the report from 4/6/2015 (p. 108) shows the addition of Adderall 5 mg #60 prescribed by Dr Ange filled on 3/11/15 and Adderall 20 mg #60 filled on 3/24/15. The note dated 3/24/15 corresponds to the request KA had to increase Adderall to 20 mg tablets (p.103-104). On 4/21/15 (p 95) KA reported that "Dr. Gupta upset her with pain meds ... nothing wrong with me ... chronic pain in my head ... need addiction specialist." Dr. Ange further documented, (p 94) "Pt is so angry with Dr. Gupta who discontinued her she believes unfounded." On 4/22/15 (p89), KA filled a prescription for Lorazepam 1 mg #15 from Dr. Ange and Buprenorphine #60 from Dr. Gupta. On 5/19/15 (p 88), KA reported Dr Gupta dismissed her for taking Ativan ... "cannot takes Benzo with pain mgmt." Dr. Ange documented that KA was not in withdrawal (p. 87). Dr Ange prescribed Adderall 20 mg bid (p. 85) and there was some documentation that implied this medication was also against her pain contract. On 7/21/15 (p 67) the patient asked for ''more Adderall" but there was no change in the prescription noted. Dr. Ange continued to prescribe Ativan 1 mg #30 (p 59.) On 1/16/16 (p 49-50), KA signed a *Controlled Substance Prescription Statement.* [Emphasis in original] The OARRS report dated 11/20/16 (p 43-44) showed a prescription for Buprenorphine 8 mg filled on 12/29/15 and 12/15/15, and six (6) Hydrocodone prescriptions filled from 11/6/2015 to 12/9/2015 totaling 108 tablets. There were no office visits with Dr. Ange during that time, but two prescriptions for Adderall were provided,

[10] Twice per day.
[11] Three times per day.
[12] Patient 1 reported at her first visit with Dr. Ange that Dr. Martin had been her family physician but had left the area. (St. Ex. 1 at 123)

> and KA was still taking Ativan. On 3/6/16, Butrans was filled (p 37). The note dated 3/15/16 (p 36) said, "In pain management currently ... pt told that OARRS shows issues (rest not legible) ... Ativan needs to be decreased," however the same dose of Ativan 1 mg #30 was filled on 4/2/2016 as documented on the OARRS report dated 4/6/2016 (p 29). On 4/13/16 (p 19), Dr. Ange's office "canceled an Adderall Rx due to a missed appointment." On 4/14/16 (p 12), a request for Adderall and Ativan was made and Dr. Ange's note (p 11) approved Ativan 1 mg #26 "but can tell she is not due Adderall."

(St. Ex. 10 at 1-2)

Testimony of Dr. Eden

48. Dr. Eden testified that Dr. Ange documented a diagnosis of ADD at Patient 1's first visit on March 11, 2015, and prescribed Adderall 5 mg twice per day. Approximately 13 days later on March 24, 2015, Dr. Ange increased Patient 1's dose of Adderall to 20 mg twice per day. (Tr. at 249; St. Ex. 1 at 104, 107) Dr. Eden further testified that she did not see any documentation in the patient record of an appropriate workup to reach that diagnosis, which should include "[a] list of symptoms that would support the diagnosis * * * in terms of time frame, symptoms, and no other contributing factors." (Tr. at 250) When asked whether Dr. Ange's documentation of symptoms such as "tearful, depressed, [and] anxiety" had been sufficient to support a diagnosis of ADD, Dr. Eden replied:

> So those are symptoms. It's not clear if those were reported by the patient or observed by Dr. Ange, but it's -- and those are symptoms that can cross over to several different psychiatric diagnoses but what's not listed here is time frame, severity, and effect on functioning. And they're not listed in a way that would fit to a particular diagnosis or not or two.

(Tr. at 251)

Dr. Eden added that, according to the DSM, at least six of the nine listed symptoms of ADD must have lasted for a period of at least six months and not have resulted from some other medical or psychiatric condition. For example, depression, anxiety, and bipolar disorder can all cause poor concentration. (Tr. at 251)

Dr. Eden further testified that, by itself, a listing of symptoms and the duration they have persisted is not enough; the physician must also note the effect of the symptoms on daily functioning. (Tr. at 251-252) However, Dr. Eden testified, "The only thing that I saw that reflected some functional problems was [that the patient] used to be able to manage [her workload], now she has to stay after work off the clock but, again, that can be related to a number of different situations, some of which are not even psychiatric diagnoses." (Tr. at 252)

49. At Patient 1's second visit on March 24, 2015, she told Dr. Ange that 5 milligrams of Adderall was "too little," that she had increased the dose to 10 milligrams but got "nothing," then increased the dose to 15 milligrams. (St. Ex. 1 at 104) In response, Dr. Ange prescribed Adderall 20 mg twice per day. (St. Ex. 1 at 103) Dr. Eden testified that such behavior is concerning so early in a treatment relationship with a patient who takes multiple controlled substances, and "it is unusual for a patient to change their dose unless they've been instructed so." (Tr. at 253)

50. Dr. Eden testified that if a patient diagnosed with ADD does not respond to Adderall 5 mg, "before you increase the dosage you have to reassess the diagnosis but, yes, if the diagnosis is accurate, increasing the medicine would be a reasonable intervention." (Tr. at 363-364)

51. On April 21, 2015, Dr. Ange prescribed Ativan 1 mg #15[13] to Patient 1 in addition to Adderall. Dr. Ange continued prescribing Ativan 1 mg to Patient 1 thereafter with instructions to take one per day. (St. Ex. 1 at 13-16, 37-40, 96)

    Patient 1 reported in April 2015 that her pain physician became upset with her for taking controlled substances prescribed by Dr. Ange, and in May 2015 she reported that the pain physician terminated her from the practice "thinking the patient's report of symptoms didn't match her actual symptoms." (Tr. at 246, 249; St. Ex. 1 at 88, 94-96)

52. At Patient 1's July 21, 2015 visit, she requested yet another Adderall dosage increase. Dr. Ange's note indicates that the patient had had gastrointestinal ("GI") surgery. (St. Ex. 1 at 67) Dr. Eden testified that patients who have had GI bypass surgery have reduced time to absorb medications and cannot use extended-release medications "because there's not enough transient time in the GI tract for the medication." (Tr. at 255) She added that such patients sometimes also have difficulty absorbing nutrients. Dr. Eden further testified that there needs to be documentation concerning nutrient deficiencies or problems with absorption. Dr. Eden noted that it appears that Dr. Ange determined that Patient 1 had difficulty absorbing Adderall but there is no documentation to medically support that determination. Also, if there are absorption issues with Adderall, the physician also needs to know if that extends to other medications, not just Adderall. (Tr. at 255-256)

53. Dr. Ange's progress note dated March 15, 2016, states, among other things, that Dr. Ange told Patient 1 that OARRS revealed some issues and that Dr. Ange must "keep tabs," that Patient 1 was currently in pain management, that Ativan needed to be reduced, and that "Adderall seems to help c̄ work."[14] (St. Ex. 1 at 36) Dr. Eden testified concerning Adderall:

    > The issue is if you give a stimulant to any adult, whether they have attention deficit or not, they are going to function better, but it's really meant for a medicinal reason to treat a medical condition. It's not meant to help people do

[13] The generic name for Ativan is lorazepam. (Tr. at 66)
[14] c̄ is a common medical abbreviation that means "with."

> better at work. It's meant to treat ADHD so this is a puzzling note because I don't know really what she's treating other than work, and work is not a medical condition.

(Tr. at 258)

54. Dr. Eden testified that Patient 1's chart indicates that Dr. Ange became concerned about the Ativan Patient 1 was receiving and noted that it needed to be decreased; however, as documented in the OARRS reports, she continued prescribing it at the same dose. (Tr. at 247) Dr. Eden further testified:

> So, I mean, the summary is that in spite of some concerns by the pain doctor, Dr. Ange didn't alter [Patient 1's] treatment, and in spite of some concerns that Dr. Ange had about the patient, both in terms of the Ativan and the Adderall, not only was the Adderall increased it was continued without appointments and even when there was a concern of some dependency.

(Tr. at 247-248)

When asked whether the standard of care required Dr. Ange to discuss Patient 1 with Dr. Gupta, Dr. Eden replied:

> Well, I think -- I mean, I think initially, yes, when you are prescribing controlled substances to somebody who's got a pain doctor and I think especially when there's concerns about that. However, you could make a case that Dr. Gupta also should have made the same effort to reach out to Dr. Ange but that does not relieve Dr. Ange of her responsibility. She actually is the one who added the treatment, so I think it would be her primary responsibility.

(Tr. at 249)

55. In addition to the Adderall and Ativan prescribed to Patient 1 by Dr. Ange, an OARRS report dated January 11, 2016, indicates that Patient 1 had also received buprenorphine tablets and Butrans patch from another physician, hydrocodone/acetaminophen 5/325 mg tablets from two different dentists, and zolpidem from another physician provider, all during the month of December 2015. (St. Ex. 1 at 44) Dr. Eden testified that that raises a red flag. She testified that she would require the patient to "document very well what is going on with that" because "there might be some doctor shopping going on." (Tr. at 257)

56. Dr. Eden testified that, in her opinion, Dr. Ange did not adequately document the basis for prescribing multiple controlled substances to Patient 1:

> Because there's poor, limited, to no documentation of symptoms that led to the diagnoses that led to the prescribing of the medications that she selected and there's limited documentation to the reason for changing those doses and

> there's lack of documentation that care was coordinated with physicians prescribing other controlled substances that had potential side effects.

(Tr. at 260)

Specifically with respect to Ativan, Dr. Eden testified that it was not clear from the patient record why that medication had been prescribed:

> There was a diagnosis initially of panic attack. There was a comment about anxiety which I mentioned is not a DSM-5 diagnosis or anxiety disorder that includes a number of other conditions. But there was no documentation of continued panic attacks in the chart, so I'm not quite sure why that was prescribed.

(Tr. at 261)

Moreover, Dr. Eden testified that she found no symptoms documented that would justify the use of Ativan. (Tr. at 262)

57. Dr. Eden testified that, if a physician has a standard discussion with patients concerning the risks and benefits of medication, then it is sufficient to simply circle "yes" next to a printed statement, "Risk/Benefit," as Dr. Ange did on her progress note for Patient 1's March 24, 2015 visit. However, Dr. Eden also noted that, on the same note, Dr. Ange underlined a printed statement "Focused Symptom Reduction" without specifying the symptoms and how they were reduced. (Tr. at 259)

58. Dr. Eden testified on cross-examination that an OARRS report should have been part of the routine evaluation of Patient 1 given that she was on multiple controlled substances and had been fired by her pain management physician. Dr. Eden further testified "that there is no documentation that she addressed the issues that the OARRS brought up and documented that she was continuing treatment as it was for whatever reason she was." (Tr. at 375)

When asked what she meant by "part of the routine," Dr. Eden testified:

> That means that in a patient you already know has been fired by a pain doctor, has taken multiple pain medications and other types of controlled substances, the best clinical judgment would be to make sure you are aware what was going on with the OARRS report. So you can say every time, but I don't know that I would want to stick firmly to every time but most times at least and not necessarily the minimum standard.
>
> Q. [By Mr. Quinn] So is pulling -- so is pulling it as a routine, to use your word, is it your opinion that's part of the minimum standard of care --

A. [By Dr. Eden] I think --

Q. -- with respect to this patient?

A. I think with respect to this patient, it would have been prudent to pull an OARRS report with each visit.

Q. Doesn't the State Medical Board of Ohio get to prescribe rules requiring essentially whatever they want and if they want to make it more frequent, they are free to do so, right?

A. Their minimum standards I think you have to use best practice standards, best standards for that patient and this is an arguable note but somebody with this kind of history I want to be very closely monitoring their controlled substance use.

Q. We're not here because Dr. Ange has been accused of violating best practices or the idea we're here because Dr. Ange in part has been accused of violating the minimum standard of care. Do you understand that? Right?

A. Yes, I do.

Q. Okay.

A. So in that case it's pulled within every 90 days.

(Tr. at 375-377)

Dr. Eden's Conclusions

59. With respect to violation of R.C. 4731.22(B)(2), Dr. Eden wrote in her report:

> In my opinion to a reasonable degree of medical probability, I believe Dr Ange failed to meet minimal standards applicable to the selection or administration of drugs, or failed to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease. Dr. Ange prescribed Ativan and Adderall knowing that the patient was on a pain contract and without communication with the pain specialist, and the use of Ativan caused the pain specialist Dr Gupta to terminate care and recommended she see a chemical dependency specialist. There was no documentation that KA was educated about the risks of using benzodiazepines and opiates at the same time, and there was no documentation of corroboration with Dr. Gupta or her second pain doctor.

(St. Ex. 10 at 2)

60. With respect to violation of R.C. 4731.22(B)(6), Dr. Eden wrote:

> In my opinion to a reasonable degree of medical probability, I believe Dr Ange's treatment or care constituted a departure from or failure to conform to minimal standards under the same or similar circumstances, whether or not actual injury to a patient was established. The documentation of KA's diagnosis was vague and difficult to follow, and there did not appear to be the rationale for medication changes and there was no documentation related to the impact of treatment changes. Dr. Ange continued to prescribe benzodiazepines without discussing their risks in combination with opiates, and despite mentioned concerns about KA's use [of] controlled substances, Dr. Ange continued to prescribe them.

(St. Ex. 10 at 3)

61. Dr. Eden concluded that Dr. Ange violated Rule 4731-11-02(C):[15]

> In my opinion to a reasonable degree of medical probability, I believe Dr Ange did not comply with 4731-11-02(C) as she prescribed benzodiazepines to KA who was on a pain contract and that violated the pain contract leading to the pain doctor terminating care. She did not coordinate care with the pain specialist. KA's formal diagnoses were difficult to determine, therefore the appropriateness of Dr. Ange's medication choices are called into question. Medications were increased with vague, if any, explanation and there was no documentation about the impact of medication changes.

(St. Ex. 10 at 3-4)

Testimony of Dr. Ange

62. When asked for the DSM criteria for diagnosing GAD, Dr. Ange responded, "I believe it's three out of -- three criteria for six months. It includes certain signs and symptoms." (Tr. at 61) When asked if she had documented an analysis of that in the chart, Dr. Ange testified, "Well, let me look at this. I have to look. On Page 122, you'll see there's, like, tearful, depressed, anxious, racing thoughts, feels abandoned. These meet the criteria." (Tr. at 61; St. Ex. 1 at 122)

63. Dr. Ange acknowledged that she did not document the specific DSM criteria for ADD in Patient 1's chart. (Tr. at 61-62) Dr. Ange further acknowledged that she did not

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[15] Rule 4731-11-02(C) provides, "A physician shall complete and maintain accurate medical records reflecting the physician's examination, evaluation, and treatment of all the physician's patients. Patient medical records shall accurately reflect the utilization of any controlled substances in the treatment of a patient and shall indicate the diagnosis and purpose for which the controlled substance is utilized, and any additional information upon which the diagnosis is based."

specifically state that she had prescribed Adderall to treat ADD, but testified, "I don't know why you would give Adderall otherwise." (Tr. at 62)

64. At Patient 1's May 19, 2015 visit, she reported that Dr. Gupta had dismissed her from his practice for taking Ativan, and that she cannot take benzodiazepines while in pain management. She also reported that "[h]e did not like Adderall." (St. Ex. 1 at 88) A May 18, 2015 OARRS report in Dr. Ange's chart shows that Patient 1 had filled a prescription for lorazepam on April 22, 2015—which was prescribed to Patient 1 by Dr. Ange at Patient 1's April 21, 2015 visit—as well as three prescriptions for Adderall since March 11, 2015. (St. Ex. 1 at 89-90, 96)

A note in Dr. Ange's chart for the May 19, 2015 visit states, according to Dr. Ange's testimony,

> "Patient has a plausible study. Evidence suggests Adderall helps her with work. She is almost off pain. Benzo is every day. Decrease Adderall to see if can" -- I think avoid another weekend, is what that means. "Risk is less than benefit. Sounds as if she" is -- "sounds as if she violated his rules and he [did] not offer her help with pain and dismissed her."

(Tr. at 67-68)

Following that testimony, the following exchange took place:

Q. [By Mr. Wilcox] When a patient is in pain management -- and this patient, I believe, was receiving the Butrans patch. That's an opioid; correct?

A. [by Dr. Ange] Correct.

Q. And other medications. Is it important to, if you're going to prescribe controlled substances yourself, to coordinate that prescribing with another physician who is -- in this case Dr. Gupta, the pain management physician?

A. Well, now it is. Back then I wouldn't have thought so, but now we try to do a letter for all of it and –

Q. So this was in 2014, 2015?

A. Correct.

Q. You don't believe it was important then and you believe it's important now?

A. Well, yes, with all the history on, you know, drug abuse in general and the red flags that people see. We have to educate ourselves. I had, in all the years, very seldom either received or sent letters to pain management doctors, but I

> think with times being what they are, we have to -- we have to coordinate better, but this would have been prior to that, that thinking.
>
> Q. In March of 2015?
>
> A. Correct.

(Tr. at 68-69)

65. Dr. Ange testified that she has never received a communication from a pain clinic or pain management physician concerning one of her patients to whom she was prescribing benzodiazepines. (Tr. at 550-551)

66. Dr. Ange noted that an April 6, 2016 OARRS report indicates that Patient 1 had been prescribed opiates by several providers, including dentists and pain management physicians. Dr. Ange testified that they continued to prescribe opiates to Patient 1 after Dr. Ange started prescribing benzodiazepines. (Tr. at 551-553; St. Ex. 1 at 29-33)

67. Dr. Ange testified that in her note dated April 21, 2015, when she began prescribing Ativan, she wrote, among other things, "Rec std dis – ed – support," which Dr. Ange testified means "Recheck, standard discussion, educate, and support." (Tr. at 77; St. Ex. 1 at 96) Dr. Ange further testified, "That is my shorthand for we have discussed the medications, benefits, risk/benefit. That's my way of putting that, putting that down." (Tr. at 77-78) Moreover, Dr. Ange testified that she believes that to be adequate documentation for another physician who reviews Patient 1's record to know what that meant. (Tr. at 78)

68. Dr. Ange acknowledged that by April 2016 she was still prescribing lorazepam 1 mg #30, the same dose of lorazepam as she had previously. Dr. Ange testified that, by April 1, 2016, Patient 1 had found a new pain management physician and was once again receiving buprenorphine. However, Dr. Ange testified that she did not consult with Patient 1's new pain management physician. (Tr. at 74-76)

69. Dr. Ange testified that she documented telling the patient that the Ativan dose needed to be decreased; however, Dr. Ange did not actually decrease the dose of Ativan that she prescribed to Patient 1. (Tr. at 72-73) When asked why she had a discussion with the patient to decrease the drug but then did not decrease the prescribed dose, Dr. Ange replied:

> Well, I -- I haven't followed through, so I don't know if I, in fact, did decrease that. I know I would have had a discussion about the red flag on the OARRS report, and that would be my way of saying, you know, we need to just keep a better hand on this, we've got two controlled substances, and the OARRS report is saying the numbers are, you know, above -- above 90.

(Tr. at 73-74)

Patient 2 (Patient JB)

70. Patient 2 was a male born in 1978 who first visited Dr. Ange on November 20, 2014. Patient 2's last visit with Dr. Ange occurred on December 11, 2014. (St. Ex. 2)

71. The chart for Patient 2's first visit on November 20, 2014, includes a list of Patient 2's then-current medications: Coumadin,[16] lisinopril, Prevacid, Norco, Soma, low-dose aspirin, Lexapro, and Benadryl. Patient 2 wrote on a patient information questionnaire his reason for seeing Dr. Ange as "stress level through the roof, building last few month[s]. My mind races all day I'm getting lack of sleep." (St. Ex. 2 at 84) Dr. Ange's initial impression on Axis I was "Insomnia" and what appears to be "MMDNOS." (St. Ex. 2 at 103) In addition to open-heart surgery, Patient 2 had a history of two back surgeries and sleep apnea. (St. Ex. 2 at 106) His last back surgery had occurred in August 2014. (St. Ex. 2 at 108) He worked as a lineman for a utility company. It appears that he had recently been demoted and lost his bucket truck. (St. Ex. 2 at 102, 108) His neurosurgeon had recommended light duty, no lifting or bending. (St. Ex. 2 at 109) Dr. Ange documented symptoms such as stress, overwhelmed, poor sleep, distracted, and upset. She prescribed Lamictal. (St. Ex. 2 at 105, 108)

Testimony of Dr. Ange

72. Dr. Ange testified that she diagnosed insomnia, sleep apnea, and possible "major mood disorder, not otherwise specified" at Patient 2's first visit. (Tr. at 81; St. Ex. 2 at 103) She prescribed Lamictal, which she described as an anti-seizure medication that is also used for mood stabilization. Dr. Ange testified that she did not treat him for sleep apnea. (Tr. at 81-82)

73. Dr. Ange testified that she had obtained an OARRS report at Patient 2's first visit on November 20, 2014. She acknowledged that the OARRS report indicated that Patient 2 had been receiving prescriptions for oxycodone, Soma, and Xanax. (Tr. at 79-80, 554-557; St. Ex. 2 at 110-114) A considerable amount of testimony concerned whether Patient 2 had informed Dr. Ange that he had been taking oxycodone or hydrocodone and Soma, and from Dr. Ange's progress note it appeared that he had not.[17] However, on his written patient questionnaire, Patient 2 included Norco and Soma on his list of current medications. Accordingly, it appears that Patient 2 did not try to hide his use of opiates and Soma from Dr. Ange. (Tr. at 80-81, 557; St. Ex. 2 at 84)

74. Dr. Ange acknowledged that she did not consult with Patient 2's other treating physicians who were treating him at that time because she had reviewed the OARRS report. (Tr. at 82)

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[16] The chart indicates that Patient 2 had had open-heart surgery when he was 20 years old to repair or replace the aortic valve. (St. Ex. 2 at 106)
[17] See, St. Ex. 2 at 106.

75. Patient 2's second visit to Dr. Ange took place December 2, 2014. The note states that Patient 2 was going back to full work duty the following week, that he was "on edge – anxious – 'calm down' at job. uptight * * * angry & frustrated c̄ job/marriage." (St. Ex. 2 at 102) Further, the note states, "pleasant but still feels overwhelmed but less so" and "Feels better c̄ wife and job in place." (St. Ex. 2 at 101) Dr. Ange testified that she had noted anxiety. (Tr. at 85; St. Ex. 2 at 101) According to Dr. Ange—the note on State's Exhibit 2 at the bottom half of page 101 is very light and impossible to read—she prescribed Klonopin 0.5 mg #30, in addition to Lamictal, because Patient 2 had reported being on edge and anxious. (Tr. at 83; St. Ex. 2 at 101)

76. A note concerning a December 3, 2014 telephone call states that Patient 2 was to take one Klonopin 0.5 mg tablet every four to six hours as needed. (St. Ex. 2 at 99) It further states, "[T]ook 2 yesterday. [T]his question—how many can he SAFELY take?" (St. Ex. 2 at 99) (Emphasis in original) Finally, the notes states that an appointment had been made for the following day, December 4, 2014. (St. Ex. 2 at 99)

When asked whether she was concerned about Patient 2 requesting additional medication, Dr. Ange replied, "Not necessarily with the level of severity he had. He was off the chart in severity. He's one of those patients who comes in and makes you anxious because he's anxious." (Tr. at 87)

77. At Patient 2's December 4, 2014 visit, Patient 2 reported sleeping better. Dr. Ange noted that the Klonopin worked well but only lasted two hours. She further documented that she needed to increase Patient 2's Klonopin prescription secondary "to metabolism." (St. Ex. 2 at 99) She prescribed Klonopin 1 mg #90. (St. Ex. 2 at 98)

78. When asked if she considered the possibility that Patient 2 had been abusing his Klonopin, Dr. Ange replied:

> Well, that's the first thing you actually sort of think, and then you try to get the -- gather the facts, and the facts are he told me he went through it in two [days], that it worked well, and then behind that is the fact that I saw him, you know, two days previously, if you will, and this is a very -- this man had the weight of the world on him. He was -- as you can see, his list of problems were astronomical in every facet of his life, so you have to take that into consideration. You can't just -- you have to figure out well, what does this mean. That's what I'm trying to figure out, and he wants to stay at work.

(Tr. at 563)

79. Subsequently, at another visit on December 9, 2014—five days after his last visit—Dr. Ange documented that Patient 2 had taken 2 Klonopin at a time four times per day "and went through in [illegible] days." (St. Ex. 2 at 67) She also documented, "His history suggests he metabolizes benzodiazepines extremely quickly [remainder illegible]." (St. Ex.

2 at 67) She more than doubled his prescription to Klonopin 2 mg #120 and added Risperdal "to augment the Klonopin." (St. Ex. 2 at 67)

Dr. Ange believes that the note states that Patient 2 told her that he had gone through his Klonopin in eight days (although only five days had transpired since his December 4, 2014 visit). (Tr. at 88) Whereupon the following exchange took place:

Q. Is that a red flag as far as someone not taking the medications as indicated and taking them in eight days?

A. In my practice this would not normally -- it may be a red flag because I would see this differently than maybe some others. He's coming in. He's calling me. He's telling me he's going through the medicine, and he's actually keeping me posted on this. He's a very anxious man. The notes are not conveying just how severe this is, although it becomes -- he's very anxious, and he's -- the most important thing to me is he's telling me that he's having a problem. He actually comes in, we discussed it, and his anxiety is off the wall, and I'm trying to figure out some way -- because this man is still functional. He's still going to work. He's blowing through the meds. Most people that I'm aware of -- and I may need to be corrected by people who do addictions, which I don't. If they're blowing through the meds like this, they don't call you, they say they're in ER, they're going to have a seizure if you don't give me medicine, the dog ate it, they lost their scripts. This man, I felt, was very truthful with me. I just simply believed him.

Q. So in eight days did he use all the medications that he was supposed to use in a month? Is that how you –

A. Yes, he did. What he really did is he had figured out -- and if you do the math, and I did do the math here, when you do the math on this, he actually blew through 30 pills, .5, in two days, which made a dosage of 7.5, and so I was, like, wow. And that's when I began to think if you and I did that, we'd be on our butt asleep, and so I'm thinking well, maybe he's not absorbing correctly, maybe because of all these other medicines he's having trouble with absorption. And so he told me that it was about 8 milligrams a day. So what I did next is I gave him 90 pills of one milligram, which was an attempt to give him one milligram three times a day instead of 8 milligrams a day and spread it -- do the one milligram, spread it over time, so he's not taking pills all day long, and maybe that would decrease the dosage to -- so now we're at 3 milligrams, not 8 milligrams.

What he did in time is he blew through that. He actually went back to the 2 milligrams, as you can see. He went through the -- and 2 milligrams was his dosage, and he -- well, you know, I lost him to follow up, but 2 milligrams was his dosage, and he told me all these times he checked in with me on this.

> He went to work. He was very functional, and I simply thought this man must have issues with absorption. A man like that in the office today, I'd probably do the DNA on him to see if -- why isn't he absorbing this medicine, going through this medicine very quickly, and so he actually ended up at 2 milligrams, four a day, which is what he told me was his dosage, and then I ended up augmenting to that.

(Tr. at 88-90)

Dr. Ange further testified that Patient 2 was a very anxious man and felt humiliated by his demotion:

> His identity was tied up in the truck. So when you think about this, I have a man who has come in. His wife has gone through his credit cards. She pulled out his 401(k). He's having trouble with chronic back pain and so forth. He's having trouble at work, if I didn't already say that. He's having trouble at work, and he's not feeling very good, and also, at the same time, he's going through the medication.

(Tr. at 567)

80. A series of notes of telephone conversations dated December 10, 2014, between Dr. Ange and/or her staff and Patient 2 and/or his wife and/or his mother indicate that his wife was "livid" and that she, or his mother, believed he was abusing Klonopin and was suicidal. His wife took his pills away. His wife advised that he is an addict and his mother indicated that he had been through drug rehab four years prior. Either the wife or mom said that "you told him to 'tweak' pills he is taking 6 – 8 x day 1 mg Klonopin." (St. Ex. 2 at 63) In a subsequent note also dated December 10, 2014, Dr. Ange documented:

> Called [Patient 2] to see if he and his wife can come in for a visit. He declined. He states his wife is controlling.
>
> He said he had gone to Rehab 6 yrs ago after back surgery for pain pills but now takes ibuprofen only for pain.[18]
>
> * He stated he will ask wife re – appt and call back.
>
> Called @ 330 to make appt on Tuesday 1030 am.

(St. Ex. 2 at 64) (Emphasis in original)

[18] Every OARRS report in Patient 2's chart indicates that he was filling prescriptions for hydrocodone/APAP and/or oxycodone/APAP.

81. Dr. Ange testified that the information conveyed to her by Patient 2's family did not match what he had told her, and that she wanted to see Patient 2 and Patient 2's wife. (Tr. at 568)

82. On December 11, 2014, Patient 2 again visited Dr. Ange. (St. Ex. 2 at 61) Dr. Ange testified that Patient 2 came alone and that "[t]he wife wouldn't come in." (Tr. at 93) Dr. Ange further testified:

> I told him he needs to have his mom and wife come in since they have other info, and then he told me that sometimes in the past there wasn't even enough Valium. He needs to be helped. He denied suicide with me, and I actually augmented the Klonopin with Risperdal, trying to -- this is not working. We gotta do something else, and we can back off the -- hopefully in time.

(Tr. at 93)

Dr. Ange testified that, at the December 11, 2014 visit, she prescribed Risperdal 1 mg #30 as "an augmentation to Klonopin 8 milligrams." (Tr. at 93; St. Ex. 2 at 61) When asked if she had documented a reason for prescribing Risperdal, Dr. Ange testified that the progress note says "increase in anxiety and most of the psychs who receive Risperdal would say that's an augmentation to the * * * Klonopin." (Tr. at 94-95)

Later in the hearing, Dr. Ange testified that on December 11, 2014, she prescribed Risperdal, an antipsychotic that can also be prescribed for severe anxiety and severe depression. Dr. Ange testified that did not prescribe any more Klonopin. Dr. Ange further testified that that had been her final visit with Patient 2. (Tr. at 568-570; St. Ex. 2 at 61-62)

83. On December 15, 2014, Dr. Ange received a message from Patient 2's wife:

> Patient's wife called and stated that she found the patient's bottle of Klonopin that was filled on December 9th. It was originally filled with 120 pills and she counted them and their (*sic*) were only 70 left. She also found his bottles of Norco and Soma and stated that these were filled on November 25th, but she is unsure of how many were in each and they were empty.

(St. Ex. 2 at 58)

Dr. Ange testified that Patient 2 was already out of her care when she received this note. (Tr. at 95)

Subsequent notes indicate that Patient 2 had gone to drug rehabilitation at Beckett Springs around December 13, 2014. (St. Ex. 2 at 49, 56) A memo to file dated December 29, 2014, indicates that Dr. Ange felt that the Klonopin had not helped much with Patient 2's anxiety but he continued to take it. (St. Ex. 2 at 47; Tr. at 97)

Additional Information from Patient 2's Chart

84. A December 26, 2014 fax to Dr. Ange from CVS/Caremark states "Possible Therapeutic Duplication" in that he was being prescribed both eszopiclone (Lunesta) and temazepam (Restoril). A handwritten note on the fax instructs "Terry: call and discontinue Temazepam and all refills if any [illegible]." Another handwritten note on the fax states "12/31/14 called – left msg on automated system to discontinue any refills." (St. Ex. 2 at 42)

85. A CVS/Caremark prescription report in the chart indicates among other things that on January 21, 2015, Patient 2 refilled his prescription for Klonopin 2 mg #120. (St. Ex. 2 at 15)

86. Finally, a note dated January 23, 2015, states that the Miami County Coroner had called to report Patient 2's death from a self-inflicted gunshot wound. (St. Ex. 2 at 36)

Testimony of Dr. Eden

87. Dr. Eden testified that she found that Dr. Ange's documentation for Patient 2 failed to support the diagnoses of insomnia, sleep apnea, and major depressive disorder NOS. (Tr. at 264-265)

88. When asked if it was clear why Klonopin had been prescribed to Patient 2, Dr. Eden replied:

> It's not clear why it was prescribed nor was it clear why it was increased. But from December 4 to December 10, the Klonopin was increased significantly to on the 9th the patient took 2 milligrams four times a day for what described was "increased anxiety, so angry about the job that led to increased anxiety." So it appears that the medicine was increased, maybe offered an increase because of job stress.
>
> The next day after the Klonopin was reported at 8 milligrams a day of use, there was a notation that the wife was an RN and needs verification he is an addict. There was a report that he was in drug rehab four years prior, and they felt that he was abusing the Klonopin. Dr. Ange asked for the wife to come into the appointment, but it didn't appear to happen according to the notes.
>
> And then a few days after that, there was another note by Dr. Ange. It was a telephone note that his wife had called and she had found a bottle of Klonopin that was filled on 12-9 for 120 tablets. There were only 70 left so it looks like he took 50 tablets over that period of time.
>
> She also found Soma and Norco. Those are muscle relaxants and opiates that were empty but the initial quantities were not known but she must have

> mentioned it because she had significant concern that he might have misused it.
>
> And a few days later there was a note that the patient was in rehab, that he had been given 90 Klonopin tablets on 12-4 and 120 tablets on 12-9. He took 100 pills in a week in addition to the pain meds that he had as well as the Soma.

(Tr. at 266-268)

Moreover, Dr. Eden testified that she calculated that Dr. Ange had prescribed a total of 345 milligrams of Klonopin to Patient 2 between December 2, and December 8, 2014. (Tr. at 268) Dr. Eden further testified that she considered that to be a high dose "[b]ecause it's the high range of dosing on recommendations for that medication and that dosing was achieved very rapidly without documentation of symptoms other than angry and anxiety about work." (Tr. at 268) Moreover, Dr. Eden testified:

> I didn't find anything documented about the level of his anxiety or the specific anxiety symptoms he had. The only indication for increasing the dose was Dr. Ange mentioned that the patient had me -- was a -- probably a rapid metabolizer. She said it was related to metabolism. Of course, that also could be related to overuse and a tolerance built requiring higher doses of medicines to get benefit.

(Tr. at 268-269)

89. Dr. Eden acknowledged that when a physician receives messages from a patient's family members, the physician must balance the trust and care of the patient with the concerns of family members who could have other motives. (Tr. at 269-270) She explained:

> The initial assumption is that the patient is being honest with you and give you their true symptoms, and you believe that until you learn otherwise. If you have something, a red flag or some other information that comes up, then you have to take that all into consideration, especially with controlled substances and patient safety is involved.
>
> So in this case it would have been prudent to have the family in, to not continue to prescribe the medications, and if there becomes a concern about withdrawal, to send the person to a detox for a detox eval because whatever is happening it seems to be going bad very fast with rapidly increasing doses of Klonopin, family concerns about dependence, addiction, and misuse, so you have to stop at that point and look at patient safety first.

(Tr. at 270) If the family will not cooperate, Dr. Eden testified the physician would have to deal directly with the patient, and possibly send him to a chemical dependency expert. In any case, the standard of care requires some action other than continuing to prescribe medication. (Tr. at 270-271)

90. In her report, Dr. Eden had identified December 29, 2014 as Patient 2's final visit; however, she acknowledged that the December 29, 2014 note did not reflect a visit, just Dr. Ange's review of the chart. (Tr. at 385-387; St. Ex. 2 at 47) Also, elsewhere in her report, Dr. Eden had identified December 18, 2014, as the date of Patient 2's final visit. However, Dr. Eden acknowledged that that was also an incorrect date, possibly derived from a billing record and/or from a notice of returned check. (Tr. at 387-388; St. Ex. 2 at 4, 55) Dr. Eden acknowledged that the correct date for Patient 2's last visit with Dr. Ange had been December 11, 2014. (Tr. at 391; St. Ex. 2 at 61-62)

91. Dr. Eden was questioned concerning a statement in her written report that Dr. Ange had prescribed Klonopin to Patient 2 on January 21, 2015. Following review of the CVS report, she acknowledged that the prescription filled by Patient 2 on January 21, 2015, had been a refill of the prescription issued by Dr. Ange on December 9, 2014, and not a new prescription. (Tr. at 404-406; St. Ex. 2 at 15) However, she testified that "the refill wasn't canceled." (Tr. at 406) When directed to the handwritten note dated December 31, 2014, stating, "Called – left msg on automated system to discontinue any refills," Dr. Eden replied, "Refills of what?" (Tr. at 407; St. Ex. 2 at 42) However, Dr. Eden acknowledged that Dr. Ange may have canceled the refills for clonazepam and that CVS refilled it by mistake on January 21, 2015. (Tr. at 407-408)

Dr. Eden's Conclusions

92. With respect to violation of R.C. 4731.22(B)(2), Dr. Eden stated in her report:

> In my opinion to a reasonable degree of medical probability, I believe Dr Ange failed to meet minimal standards applicable to the selection or administration of drugs, or failed to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease. It is not clear from the notes why Dr Ange gave Klonopin 90 tablets on 12/4 and then 120 tablets on 12/9 or why Dr. Ange increased the dose of Klonopin. Despite concerns of misuse of the benzodiazepines, Dr. Ange continued to prescribe these medications at increasing doses until she noted (p 42) on 12/31/14 to "discontinue any refills" when she learned the patient was receiving Temazepam from another doctor. She did not recommend psychotherapy and did not recommend chemical dependency assessment despite her documented concerns. Toxicology screens were not ordered and there was no corroboration with other clinicians.

(St. Ex. 10 at 6)

93. With respect to violation of R.C. 4731.22(B)(6), Dr. Eden wrote:

> In my opinion to a reasonable degree of medical probability, I believe Dr Ange's treatment or care constituted a departure from or failure to conform to

> minimal standards under the same or similar circumstances, whether or not actual injury to a patient was established. High dose benzodiazepines were prescribed and the frequency was alarming with #30 Klonopin 0.5 mg on 12/2/14, #90 Klonopin 1 mg tablets on 12/4/14 and #120 x 2 mg tablets on 12/9/14. After the patient was admitted to Beckett Springs for Chemical Dependency treatment, Dr. Ange provided a Rx for Klonopin 2 mg # 120 without an office visit.[19] In addition, there is no mention of education or coordinated care with the prescriber of opiates for this patient after opiates appeared [on] the OARRS report. There was limited documentation on the clinical decision making and the outcome of increased doses other than the patient was a "rapid metabolizer."

(St. Ex. 10 at 6)

94. Dr. Eden concluded that Dr. Ange violated Rule 4731-11-02(C), and stated in her report:

> In my opinion to a reasonable degree of medical probability, I believe Dr Ange did not comply with 4731-11-02(C) as she prescribed high dose benzodiazepines in an alarming quantity over a short period of time and with the knowledge that the patient had taken extra benzodiazepines as well as other controlled substances (p.58). This information did not appear to change her prescribing habits until December 31, 2014 when she canceled available refills.

(St. Ex. 10 at 7)

Patient 3 (Patient AG)

95. Patient 3 is a male born in 1985. He first visited Dr. Ange on February 17, 2000, and continued seeing her until at least February 22, 2016, the last visit documented in State's Exhibit 3. (St. Ex. 3) Pursuant to the Notice, the time period relevant to this matter is from around September 2010 through around May 2016. (St. Ex. 12A) This summary focuses on that time period.

96. According to Dr. Eden's report, during the early years of treating Patient 3, Dr. Ange diagnosed him with anxiety, OCD, and later GAD. In 2003, Dr. Ange diagnosed ADD. Also in 2003, Patient 3 underwent a sleep study that Dr. Ange had ordered, following which he was diagnosed with sleep phase delay syndrome. (St. Ex. 10 at 8) By February 22, 2016, Dr. Ange listed diagnoses of insomnia, depression, OCD, and reduced GAD. (St. Ex. 3 at 3)

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[19] Dr. Eden retracted this statement at the hearing and acknowledged that the January 21, 2015 fill had been a refill and not a new prescription. (Tr. at 404-408)

97. Much of Dr. Eden's report concerns treatment that predated the relevant time period but provides background for more recent treatment. The last paragraph of her report before her discussion of the individual statutory allegations states:

> There were several notes coordinating care with the pediatrician. A sleep study was ordered on 7/14/13[20] (p.302),[21] and the letter with the results was included dated 8/1/2003 (p. 298-299.) The impression was "consistent with sleep phase delay syndrome ... common in teenagers ... not usually managed effectively with sleep medications." Despite this recommendation, Dr. Ange prescribed continuous and ongoing sleep medications including Ambien, Sonata and Lunesta as well as Trazodone. Ativan, Valium and Klonopin were also prescribed. At one point, AG was receiving Ambien from Dr. Ange and Lunesta from another doctor (OARRS report dated 3/15/2013 p.185-187). Then Dr Ange prescribed both medications. (e.g. OARRS report 6/5/2014 p 104 to 106). Benzodiazepines were prescribed throughout treatment.

(St. Ex. 10 at 8)

98. By December 10, 2010, OARRS reports indicate that Dr. Ange was prescribing lorazepam 1 mg #60 and zolpidem 10 mg #30 to Patient 3 on a regular basis. In May 2011 she added Lunesta 3 mg #30 as well. This prescribing continued through at least March 2013. (St. Ex. 3 at 185-186, 207-208) There is a break in the time periods covered by OARRS reports until June 2013, at which time Dr. Ange was prescribing clonazepam 1 mg #45, zolpidem 10 mg #30, and Lunesta 3 mg #30. (St. Ex. 3 at 105) In August 2013 she discontinued clonazepam and added diazepam 5 mg #45. (St. Ex. 3 at 105) In or around March 2014, she reduced Patient 3's dose of diazepam to 5 mg #30. Additionally, Lunesta no longer appears on OARRS after March 2014. (St. Ex. 3 at 104-105) In or around October 2014, Dr. Ange doubled Patient 3's dose of diazepam to 5 mg #60. (St. Ex. 3 at 67) In or around March 2015, Dr. Ange again doubled Patient 3's dose of diazepam to 10 mg #60. Dr. Ange continued to prescribe diazepam 10 mg #60 and zolpidem 10 mg #30 through at least December 2015. (St. Ex. 3 at 9, 37)

Testimony of Dr. Eden

99. The bulk of Dr. Eden's criticism centers around Dr. Ange's treatment of Patient 3 while he was a teenager, including prescribing benzodiazepines to a patient that age, and continuing to prescribe controlled substance sleep aids following a 2003 sleep study that recommended otherwise. However, in light of the relevant time period beginning in or around September 2010, it would be unfair to Dr. Ange to base adverse judgments against her for her treatment of Patient 3 prior to that time, except to the extent that the older information is relevant to demonstrate, for example, that Dr. Ange did not document

[20] Dr. Eden acknowledged that this date is incorrect. (Tr. at 417) The actual date was 7/14/03. (St. Ex. 3 at 302)
[21] All page references refer to State's Exhibit 3.

sufficiently to support diagnoses and treatment rendered that continued after the relevant time period began. (Tr. at 275-283; St. Ex. 10 at 8-10)

Dr. Eden also criticized Dr. Ange's prescribing of Adderall to Patient 3; however, she discontinued prescribing Adderall well before September 2010. Accordingly, those criticisms are not relevant. (Tr. at 281; St. Ex. 3 at 208-313; St. Ex. 10 at 8-9)

100. With respect to Patient 3's complaint of insomnia, Dr. Eden noted that a 2003 sleep study found that he suffered from sleep phase delay syndrome, a common affliction among teenagers. Dr. Eden further testified that "it was a normal teenage sleep cycle that should not have been treated with sleep medications." (Tr. at 282-283) However, by September 2010 when the relevant time period began, Patient 3 was 25 years old and thus well past his teen years. (St. Ex. 3 at 410)

101. A March 15, 2013 OARRS report in Patient 3's chart indicates that from March 2012 through March 2013 Dr. Ange had prescribed a combination of zolpidem (Ambien), Lunesta, and lorazepam to Patient 3. (St. Ex. 3 at 185-186)

102. With respect to Dr. Eden's criticism that Dr. Ange had utilized two different sleep medications simultaneously, Dr. Eden was asked whether she is familiar with the concept of rotating medications to avoid a patient becoming acclimated to one of them. She replied, "There are reasons that you sometimes use medications of the same class but usually you document why." (Tr. at 423)

103. Dr. Eden testified that, in her opinion, Dr. Ange's treatment of Patient 3 fell below the standard of care overall and in the selection and/or administration of drugs: "I thought the care was difficult to follow and understand the reason for prescribing different medications, and I thought that it was reckless to not utilize the sleep study report and continue prescribing sleeping medications." (Tr. at 287-288) In her report, Dr. Eden stated that Dr. Ange's care of Patient 4 violated R.C. 4731.22(B)(2), R.C. 4731.22(B)(6), and Rule 4731-11-02. (St. Ex. 10 at 12-13)

Testimony of Dr. Ange

104. Dr. Ange testified that she first saw Patient 3 on February 17, 2000. At that time he was 15 years old and in high school. She testified that she initially suspected "Panic adjustment disorder, rule out OCD, rule out PTSD." (Tr. at 103-105, 574; St. Ex. 3 at 388) She further testified that the patient also stuttered badly but she did not document that. (Tr. at 105-106)

105. Dr. Ange testified that on August 21, 2001, she started Patient 3 on Ativan. Dr. Ange testified that she had noted that Patient 3 was anxious and nervous about school, crying, had increased heart rate and shortness of breath, and foot shakes. Dr. Ange testified that she prescribed Ativan 1 mg #30. Dr. Ange testified that he had trouble going to school and she thought that the Ativan might help him get through it. (Tr. at 107; St. Ex. 3 at 348-349)

Dr. Ange acknowledged that she continued to prescribe Ativan off and on to Patient 3 for many years. (Tr. at 107-108)

Patient 4 (Patient KG)

106. Patient 4, a female born in 1995, first visited Dr. Ange on April 21, 2014. She saw Dr. Ange on a regular basis through August 18, 2015, the last visit documented in the exhibit. (St. Ex. 4)

Dr. Eden's Written Report

107. In her written report, Dr. Eden stated as follows concerning Dr. Ange's treatment of Patient 4 (identified as Patient KG in her report):

> The intake note was dated 4/21/14 and documented anxiety attacks for 1 week and Zoloft 50 mg prescribed by the pediatrician. KG was sleeping well but losing weight and was anxious. There was "OCD about school" and no reports of SI/HI/AVH/del. Dr. Ange ordered Ativan 0.5 mg q 4-6 hrs prn for anxiety,[22] continued Zoloft and Dr. diagnosed Generalized Anxiety Disorder (GAD.) On 4/29/14 Ativan was increased to 0.5 mg tid (no reason provided), Celexa 20 mg was added (p.80)[23] and the diagnosis Depression was added. In a phone call on 5/19/14 (p. 77), KG's mother said KG was doubling the dose of Ativan on some days and they were running out of medication early ... "she needs 2 ½ - 3 x day stressful days panic." Dr. Ange increased the dose of Ativan 0.5 mg to tid to Ativan 0.5 mg qid[24] (p. 77) There were several OARRS reports included. The oldest one dated 11/24/14 (p. 30) shows that from 4/21/14 to 5/19/14, the patient received a quantity of 240 Ativan 0.5 mg tablets and from 6/3/14 to 7/15/14 the patient received a quantity of 480 Ativan 1 mg tablets. Dr. Ange did try several SSRI antidepressant medications. Ativan doses were 1 mg qid on 7/14/14 (p 69) then 1 mg bid on 7/15/14 (p.68) with no explanation offered for the different doses 1 day apart. Then, on 9/15/14 (p. 44), Ativan was listed as 4 mg a day. There was no documentation supporting the clinical decision-making and response related to dosage changes.

(St. Ex. 10 at 11)

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[22] On the progress note it states Ativan 0,5 mg #30 with instructions to take one tablet daily, but below that it states, "q 4-6 hrs prn for anxiety." The instructions conflict. (St. Ex. 4 at 86)

[23] All page references refer to State's Exhibit 4.

[24] Four times per day.

Testimony of Dr. Eden

108. Dr. Eden criticized Dr. Ange for having limited documentation to support increasing Patient 4's dose of Ativan. (Tr. at 289-290) Dr. Eden noted that the diagnosis was GAD, "[b]ut when she's treating, she's talking about panic attacks, but the diagnosis is generalized anxiety and actually panic attacks are not a feature of generalized anxiety, so if she thought she had a panic disorder, that's one thing, but the diagnosis is generalized anxiety." (Tr. at 290) When asked whether the diagnosis of GAD was supported by the documentation, Dr. Eden replied:

> I am reading from page 90 [of State's Exhibit 4], "anxiety, uptight, worries, thinks too much." Those could be -- depending on time frame I suppose you could point to a GAD diagnosis with that, but then she says "OCD about school work," and I am not quite sure what that means because obsessive compulsive disorder is a diagnosis. If she's having obsessive thoughts about school work, that's one thing but that wouldn't necessarily be OCD.
>
> And then "okay in school, no trouble with grades. No psychosis here" is what she's saying. So she has some anxiety-type symptoms, but she doesn't have the time frame established to make it generalized anxiety disorder. Otherwise, people can get anxious, they can even get anxious without cause, but it doesn't necessarily mean it's an anxiety disorder.

(Tr. at 291; See, also, Tr. at 431)

109. Dr. Eden testified that when treating a young person such as Patient 4 for GAD, "you want to refer them to psychotherapy, ways of managing their anxiety rather than going to a medication that's going to blunt them and blunt their symptoms to get them through school." (Tr. at 292-293) When asked if she frequently sees high school age patients on benzodiazepines, Dr. Eden replied:

> Not in my experience and not -- that would not be the practice of psychiatrists in our group as well. They try everything to avoid benzodiazepines, especially if the diagnosis is general anxiety disorder. They would try SSRIs or other antidepressants and buspirone and BuSpar first and only reserve benzodiazepines for the most severe symptoms that affect functioning. And it would not probably be scheduled unless -- have to look at the use of the schedule and why people are taking the medicine.

(Tr. at 293)

110. Dr. Eden testified that Patient 4 came to Dr. Ange on a minimal dose of Zoloft 50 mg prescribed by her pediatrician. At Patient 4's first visit on April 21, 2014, Dr. Ange prescribed Ativan 0.5 mg for anxiety. Dr. Eden testified that she was unsure how long the

patient had been taking Zoloft, and that her pediatrician may have been uncomfortable providing more than a minimal dose of Zoloft; however, as a specialist, a psychiatrist could have increased Patient 4's dose of Zoloft to see how the patient responded prior to considering a benzodiazepine. (Tr. at 435)

111. Dr. Eden testified that at Patient 4's next visit on April 29, 2014, Dr. Ange documented that Patient 4 was an incomplete responder and continued to experience symptoms. (Tr. at 437-438; St. Ex. 4 at 78) However, Dr. Eden added that she did not know what symptoms Patient 4 had continued to experience. (Tr. at 439)

112. Dr. Eden testified, "[M]y overall conclusions is that the documentation and the standard of care as well as the prescribing of controlled substances fell below minimum standards." (Tr. at 296) In her report, Dr. Eden stated that Dr. Ange's care of Patient 4 violated R.C. 4731.22(B)(2), R.C. 4731.22(B)(6), and Rule 4731-11-02. (St. Ex. 10 at 12-13)

Testimony of Dr. Ange

113. Dr. Ange testified that when Patient 4 came to her she had been taking Zoloft prescribed by her family physician. (Tr. at 116-117)

At Patient 4's initial visit, Dr. Ange diagnosed GAD "severe" and noted "graduates in [one] month." (St. Ex. 4 at 84) Dr. Ange also documented "School refusal" which she testified means that she "[w]on't go to school, but yet she's got to graduate." (St. Ex. 4 at 84; Tr. at 115) Dr. Ange prescribed Ativan 0.5 mg #30 with instructions to take one tablet every 4-6 hours for anxiety. She continued Patient 4 on Zoloft 50 mg. (St. Ex. 4 at 84)

114. A note dated April 23, 2014 states that Patient 4's mother called and advised that Patient 4 had thrown up lunch and dinner and felt nauseated. The note further indicates that Dr. Ange advised her to stop Zoloft, let her stomach settle, and call her on Friday. (St. Ex. 4 at 83)

115. At Patient 4's next visit on April 29, 2014, she discontinued Zoloft and added Celexa 20 mg, and increased Patient 4's Ativan dose to 0.5 mg #90 with instructions to take one tablet three times per day. She also added "depression watch" to Axis II.[25] (St. Ex. 4 at 78-80) Dr. Ange testified that she had substituted Celexa for Zoloft because the Zoloft was giving her nausea. She further testified that she tripled Patient 4's dose of Ativan because she thought that Patient 4 was an "incomplete responder" and had continued to experience anxiety. (Tr. at 119-120; St. Ex. 4 at 78, 80)

116. A note dated May 19, 2014 states that Patient 4 had doubled her Ativan usage on certain days and will run out before her next refill is available on May 29, 2014. Dr. Ange increased the dosing frequency from one tablet three times per day to one table four times per day, and the pharmacy advised she could pick them up on May 21, 2014. (St. Ex. 4 at

[25] Dr. Ange testified that she noted that because Patient 4 was increasing her medication. (Tr. at 122-123)

77) Dr. Ange testified that she had increased the dosing frequency to see "if we can stabilize it." (Tr. at 121)

117. At Patient 4's next visit, June 3, 2014, Dr. Ange increased Patient 4's dose to Ativan 1 mg #120 with instructions to take one tablet four times per day. She also discontinued Patient 4's Celexa and started her on Paxil 20 mg. (St. Ex. 4 at 72-74)

118. An OARRS report dated November 24, 2014, indicates that Patient 4 filled the following prescriptions for lorazepam issued by Dr. Ange:

Date	Drug and Dose	Quantity	Days
04/21/14	lorazepam 0.5 mg	30	30
04/29/14	lorazepam 0.5 mg	90	30
05/19/14	lorazepam 0.5 mg	120	30
06/03/14	lorazepam 1 mg	120	30
07/15/14	lorazepam 1 mg	360	90

(St. Ex. 4 at 30)

119. The following exchange took place with respect to Dr. Ange increasing Patient 4's Ativan dose:

Q. [By Mr. Wilcox] Did you ever consider that maybe this person wasn't a good candidate to take Ativan if they were increasing their dosage without your, I guess, authorization? Do you consider that a red flag?

A. [By Dr. Ange] I didn't consider that a red flag because her mother and she are in tandem about this. The mother is telling me what's going on. I'm not getting phone calls that she can't work, can't go to school, except she has kind of a school phobia-like. I don't -- I read that differently, that they're telling me what's going on. What I'm doing is not working, and before you come in can we do some things that might work better, and then when she did come in, say to her, you know, this is a problem, it may not be working better. I'm certainly not going to give a kid, a high school -- I'm not going to give her Xanax.

(Tr. at 123)

120. Referring to a November 24, 2014 OARRS report, Dr. Ange was asked why she had prescribed lorazepam 0.5 mg #30 to Patient 4 on April 21, 2014, then prescribed lorazepam 0.5 mg #90 to Patient 4 on April 29, 2014, eight days later. (St. Ex. 4 at 30; Tr. at 585-586) She responded:

> Because again she was going through the medications and she had found that the higher dosages were working, and I simply believed her. I didn't have a

> reason at the time not to, and so in my experience, you can either treat this as a red flag, which you do take into consideration, or is she trying to find some medication that's useful. You also have to remember in the background that we're trying to get her into school and into college, and this is sort of the background information on that. She was not -- I don't know at this time, but she didn't go to prom, and that was pretty upsetting. The most important thing was to get her through school. She was a senior.

(Tr. at 586)

When asked why she had continued to increase Patient 4's dose of lorazepam to 1 mg #120 by June 3, 2014, a little over one month later, Dr. Ange responded:

> Well, again, some of this is trying to stabilize the use of medication so people don't just keep doing what we call p.r.n., so you stabilize it, in my opinion, to make sure it's -- it's much more predictable, like four times a day, three times a day, and so we're going through the motions, in my opinion, to stabilize it, to get the dosage. If I remember correctly, she did stabilize on that dosage and we got her through. But that, in my opinion, is what I'm doing. I'm trying to find -- I don't do it on everybody because not everybody comes in this severe, so you don't have these issues with everybody, but her in particular, I'm trying to find a dosage that worked, get her through school, get her into college, and, you know, eventually she got treatment where she was, where she went to college.

(Tr. at 587-588)

Moreover, Dr. Ange testified that she increased Patient 4's prescription to #360 in July 2015 because she obtained her prescriptions from Express Scripts which offered 90-day supply of medications. Dr. Ange testified that, today, she does not routinely prescribe such a volume of benzodiazepines to patients. (Tr. at 589-590)

121. Dr. Ange testified that she lost Patient 4 as a patient when Patient 4 went to college in Indiana. (Tr. at 127)

Patient 5 (Patient KH)

122. Patient 5 is a female born in 1987. She first visited Dr. Ange on April 29, 2003, and she continued seeing Dr. Ange off and on through early 2006. Patient 5 returned to Dr. Ange's practice in January 2010 and Dr. Ange continued to treat her through at least November 18, 2015, the last visit documented in the chart. (St. Ex. 5) Pursuant to the Notice, the time period relevant to this matter is from around September 2010 through around May 2016. (St. Ex. 12A)

Dr. Eden's Report

123. In her written report, Dr. Eden stated as follows concerning Dr. Ange's treatment of Patient 5 (identified as Patient KH in her report):

> Initial patient information paperwork was provided and there were some self-reporting tools from January 2010 including an ADHD self-scale (p.152)[26] that was negative and MDQ that was borderline (p. 148). On 12/11/11 Dr Ange received a note from Steve Karnhem M.A. (p.106) saying he, "asked questions on the Adult ADHD Self-Report ... seems clinically significant. . .simply leave this information ... discuss possible medication issues." Adderall was started prior to that on 11/23/11 even though there was a notation that said "Adderall XR - had issues years ago" (p.109).
>
> * * * Most of the subjective and objective parts of the notes were legible, but there were * * * times when end of the note was illegible or too light to read. There are long lapses between appointments with many prescriptions called in or provided for pick up, (13 charges for prescriptions between 8/11/14 to 7/27/15 and 8 times between 1/9/13 to 8/11/14). Many of these were for Adderall even after documentation several times that KH should locate a physician where she lives (p. 108 and p. 100)
>
> The intake note was dated 4/29/03 and documented the diagnoses Depression, Anxiety and r/o OCD. KH originally did well on Effexor XR 37.5 mg. On 4/1/10 (p.134) there was mention of binge eating "gained 125# and mentions of "hi highs low-low .. .little in between ... believes she cycles+." On 4/5/10 (p.133) the documentation says, "Feels high for 3 days." Lamictal 25 mg is listed but it is not clear this was started, but on 4/21/10 (p.132)it say Lamictal was stopped. There is an undated copy of a "Self-Harm Inventory" (p. 153) and KH reported "frequently been experiencing anger, hitting, kicking, punching objects in fit of anger." On 4/21/10 (p. 132) Restoril 30 mg was started for sleep and then on 4/27/10 (p. 131), Xanax 0.5 mg at bedtime was provided outside of an office visit. On 5/3/10 (p. 129) KH reported feeling "high [and] weird feeling" on Effexor "like on Zoloft." The impression was Hypomania; consider Lamictal and Bulimia "lost 10#." Seroquel was started. On 1/3/11 (p. 119), Dr. Ange mentions, "full blown eating disorder." The next visit is not until 6/8/11 and Cyclothymic Disorder is considered but the intervention was to stop Topamax 25 mg (not sure when it was started) (p. 115.) Xanax 0.5 mg bid was continued on 6/7/ (p.114) but it was not clear when it was started, and the notes indicate it was stopped on 10/5/11 (p. 110.) On 11/23/11 (p.108) Adderall was started and over time the dose was increased. As previously mentioned, many Rx were approved outside of scheduled appointments with long lapses in between visits. On 9/17/14 on a

[26] All page references refer to State's Exhibit 5.

> refill request form (p. 43) there is a note that says, "Mom said you would write double but know to only take 1." Adderall 20 mg #60 was approved.

(St. Ex. 10 at 14)

Testimony of Dr. Eden

124. Dr. Eden testified that, when Patient 5 returned to Dr. Ange's practice in January 2010, her chief complaint had been severe depression. Dr. Eden testified that Dr. Ange's diagnostic considerations were adjustment disorder with depressed mood. Dr. Ange initially ordered light therapy and St. John's wort. (Tr. at 296-297; St. Ex. 5 at 135) Dr. Eden further testified:

> [I]t seems like there was a period of time between that initial visit and when the patient came back in April where Deplin and Zoloft were recommended. Deplin is a folic acid derivative that's meant to enhance the benefit of antidepressants.
>
> A few days later Dr. Ange reports that the patient felt high on the Zoloft, and she started Lamictal which we mentioned earlier was a mood stabilizer. And it's not clear if Cymbalta or Celexa were started, but it appears that the Zoloft was stopped.

Q. [By Mr. Wilcox] And that's page 133, correct?

A. [By Dr. Eden] Yes.

Q. What does that indicate to you, "feels high for three days"? That's what it says on page 133.

A. If you remember before, I said the psychiatric diagnoses are always a work in progress, that a patient can present with one set of symptoms but end up with a different diagnosis. And in my experience patients come in complaining of depression, you always have to consider whether or not there's a bipolar illness, that maybe that patient either hasn't had a manic or hypermanic response or that they haven't recognized it as symptoms they see, just as a period of better time, and so when somebody takes an antidepressant and they get activated on it or feel high, you have to consider bipolar illness then. And I think Dr. Ange did because she started a mood stabilizer, but she continued the antidepressant I think which may have fueled the high, and so it might have been more prudent to start a mood stabilizer and stop the antidepressants.

Q. What was the mood stabilizer?

A. The Lamictal.

Q. Okay. Go ahead with your summary.

A. So even with that the starting of the Lamic -- Lamictal and the reported feeling high on the antidepressants, I didn't see that there was any change in diagnostic consideration. There was also the off and on use of Effexor and another antidepressant for this patient. And I notice that that seemed to be started on April 21, 2010, and that Restoril, which is temazepam, it's one of the benzodiazepine sleeping medications, was started.

(Tr. at 297-299) Dr. Eden further testified that she could find no medical documentation of a reason why the benzodiazepine was started. (Tr. at 299)

125. Dr. Eden testified that, because Patient 5 was documented to have felt high for three days taking Effexor, an antidepressant, Dr. Ange should have considered starting a mood stabilizer and documented her reason for not discontinuing Effexor. Dr. Eden testified that an antidepressant alone can push a bipolar person into mania, and her reaction could have suggested that she had bipolar disorder. Dr. Eden further testified that she found it to be below the minimal standard of care for Dr. Ange not to recognize that Effexor may have contributed to Patient 5's symptom that she was high. (Tr. at 444-445; St. Ex. 5 at 133)

126. Dr. Eden noted that an undated Self-Harm Inventory indicates that Patient 5 engaged in some self-harming behavior and experienced fits of anger involving "hitting, kicking, [and] punching objects." (Tr. at 299; St. Ex. 5 at 153) Dr. Eden noted:

> [T]here's a number of symptoms -- of diagnoses that could be associated with that. And it could be just -- no psychiatric illness, just sort of bad behavior, but in a patient who reports depression, got high on antidepressants, and has anger, again, you have to point to a cyclical mood disorder like bipolar illness and there didn't seem like there was that clinical correlation with this individual.

(Tr. at 299)

127. An April 27, 2010 note indicates that Patient 5's mother had called stating that Patient 5 had had "a meltdown" and was having continued difficulty sleeping at night due to anxiety. The note indicates that Dr. Ange called in a prescription for Xanax 0.5 mg #15 with instructions to take one tablet at bedtime. (St. Ex. 5 at 131) Dr. Eden testified:

> So I was a little puzzled because it seems like Dr. Ange is treating the symptoms without treating the underlying conditions. So patient has anxiety, can't sleep. There is medicine to make her drowsy but it's still not addressing the underlying condition which points to some kind of mood disorder even if there is an axis II diagnosis.

(Tr. at 301)

128. Dr. Eden testified concerning a January 3, 2011 progress note that indicates Patient 5 has a "Full blown eating disorder," and that Dr. Ange referred her to the Lindner Center. However, Dr. Eden further testified:

> [I]t's not clear what kind of eating disorder. There's restricted disorders. There's binge-purge eating disorders. There's binge eating disorders. I couldn't tell what she thought the eating disorder was, but she thought it was severe enough to refer to a specialty program. It's not clear whether she was suggesting outpatient or inpatient or what level of care, residential treatment. But maybe she is referring to them to make the determination.

(Tr. at 302)

On a different page of that progress note, Dr. Ange wrote, "Binge eat at night has stopped since c̄ her parents." (St. Ex. 5 at 118) Dr. Eden testified that it may therefore have been a binge eating disorder; however, that is a newer diagnosis and she is not sure if it existed at that time. (Tr. at 302-303) Dr. Eden further testified that Dr. Ange documented, "Anxiety ↑ c̄ eating too much – feels guilty – diet vs. lifestyle." (Tr. at 303; St. Ex. 5 at 117)

129. Dr. Eden testified that Dr. Ange's June 8, 2011 progress note (or possibly telephone note) was the first time she documented suspicion of a cyclical mood disorder. Dr. Eden also testified that the note appears to indicate that Dr. Ange stopped Topamax at that time, which she found odd since Topamax is used off-label as a mood stabilizer. Dr. Eden further testified that a progress note dated the previous day indicated that Dr. Ange had decreased Patient 5's dose of Prozac, as the note states, "Prozac = 'complete high.'" (Tr. at 303-304; St. Ex. 5 at 114-115)

Dr. Eden further testified that Dr. Ange continued Patient 5's Xanax 0.5 mg with instruction to take it twice per day. Dr. Eden testified, "the only other notation that I recall was that it was 15 tablets at bedtime for sleep for that acute period. I am not sure why it was continued." (Tr. at 304) At Patient 5's visit (or telephone visit) on October 5, 2011, Dr. Ange discontinued Patient 5's Xanax. (St. Ex. 5 at 110)

130. On November 23, 2011, Dr. Ange began prescribing Adderall 10 mg #30 to Patient 5. Dr. Ange noted on the progress note that Patient 5 had a general lack of concentration, extreme fatigue, decreased focus, and was fidgety. Dr. Eden testified that that is not a sufficient workup to support a diagnosis of ADD, and that she saw no appropriate workup in the chart for that diagnosis. Dr. Eden further criticized Dr. Ange for rendering the ADD diagnosis based on a visit that was marked as a teleconference, as Patient 5 was living in Nashville at that time. A note on the chart reflects that Dr. Ange had recommended that Patient 5 find a physician in Nashville. (Tr. at 305-306; St. Ex. 5 at 108-109)

With respect to ADD and a cyclical mood disorder, Dr. Eden testified that "if you have a cyclical mood disorder, it's not you can never prescribe or treat ADD if it's properly

diagnosed, but you have to be cautious about that, whether you have a potentially cyclical mood disorder. And so there's no documentation that there's been education about that as well." (Tr. at 306)

131. Dr. Eden noted that Dr. Ange's following progress note, which is undated, states that Patient 5 felt more calm, less distracted, more organized, and more focused than before. Dr. Eden noted that that was "proper documentation of improvement of symptoms based on a medical intervention." (Tr. at 306-307; St. Ex. 5 at 107)

132. In November 2011 Dr. Ange began prescribing Adderall to Patient 5. Dr. Ange documented symptoms such as lack of concentration, decreased focus, extreme fatigue, and fidgetiness. (St. Ex. 5 at 108-109) Dr. Eden testified that these symptoms are not indicative of ADD: "General lack of concentration, focus, and fidgetiness might be, but they could be related to other conditions that aren't even represented in this chart like mood disorder." (Tr. at 452-453) Moreover, to diagnose ADD, Dr. Eden testified that "[t]echnically you need symptoms starting at an earlier age and at least six symptoms and there's three listed here." (Tr. at 453)

133. Dr. Eden noted that a number of Patient 5's encounters with Dr. Ange appear to have taken place over the telephone. (Tr. at 307-308)

134. Dr. Eden testified concerning her overall opinion of Dr. Ange's treatment of Patient 5 that diagnoses changed without clear documentation. Moreover, there were long periods of time between live visits which Dr. Eden believes "is problematic not only in terms of what's safe practice for prescribing these kinds of medications, but also with changing diagnoses." (Tr. at 309) Dr. Eden further testified:

> So it's very difficult over the phone to know what you're diagnosing. And Dr. Ange continued to provide treatment despite asking the patient to find treatment where she was living. There was also an occasion on I think it's page 43 on September 7 [2014] where the Adderall quantity was written for another 60 after most of the quantities had been 30. And the notes said "mom said you could write double, but I know to only take one." She was also told to take her off the Adderall on 7-27-15. But on 8-17-15 60 tablets were written for Adderall.

(Tr. at 309-310)

135. Dr. Eden testified that, in her opinion, Dr. Ange's selection of medications for Patient 5 was inappropriate because "it was not clear what diagnosis was being treated and that diagnoses were being changed to and medications were being changed without clear documentation and appropriate evaluation." (Tr. at 310) Moreover, Dr. Eden testified that her treatment of Patient 5 fell below the minimal standard of care. (Tr. at 310)

In addition, when asked whether she found that Dr. Ange had violated the Board's rules concerning prescribing controlled substances, Dr. Eden replied:

> I did, particularly related to prescribing the medication in a dose that Dr. Ange was aware the patient was not taking, increasing the quantity, concerns about prescribing anti -- anxiolytic and stimulant medications when there was a concern about dependency in the patient and then ultimately at the end turned out there were chemical dependency concerns with this patient as recorded by her mother at the end of the medical record.[27]

(Tr. at 311)

Testimony of Dr. Ange

136. Dr. Ange testified that Patient 5 had been a freshman in high school at her first visit on April 29, 2003. Dr. Ange further testified that she had diagnosed depression, anxiety, and to rule out OCD at her first visit. Dr. Ange prescribed Effexor 37.5 once per day. (Tr. at 128-130)

137. In a progress note dated January 3, 2011, Dr. Ange noted among other things that Patient 5 had anxiety and depression, as well as an eating disorder, and noted that Patient 5 reported "anxiety ↑ c̄ eating too much – feels guilty – Diet vs lifestyle." (St. Ex. 5 at 117) Her recommendations include "may need hospital." Dr. Ange explained what she meant by that:

> Well, I talked to her about it because it's part of her overall -- I mean, I'm not going to treat her like the eating disorder doesn't exist, so I said you "may need hospital" if you can't control it. I gave her [the number for] the Lindner Center. That's a place down south. I kept her on the Effexor. She had a meal planner. She was getting that. Her mom and dad were -- she was actually back. I'm pretty sure she -- she was mostly in Nashville, and her mom and dad were helping. My understanding of that, she probably was back home. They were helping her with the eating. Like I have down here, "someone helps," her "mom." She was no longer cheating on Sunday.

(Tr. at 138)

138. Dr. Ange acknowledged that Patient 5 was moody and did not tolerate most antidepressants well; however, she was able to tolerate Effexor, which she opined argued against a diagnosis of bipolar disorder. Dr. Ange testified that "if you're truly bipolar, theoretically you're not going to be able to tolerate Effexor," which she testified is a stimulating antidepressant. (Tr. at 595-596)

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[27] Dr. Eden testified that Dr. Ange's November 18, 2015 progress note states, in part, "Mom reports major substance abuse with alcohol. Might have old Adderall. Erratic behavior, driving under the influence, still with eating problems." (Tr. at 311; St. Ex. 5 at 3)

139. On June 2, 2011, Dr. Ange prescribed Patient 5 Xanax 0.5 mg #60 with two refills. (St. Ex. 5 at 113) Dr. Ange testified that she provided refills because Patient 5 was moving to Nashville. (Tr. at 140) Dr. Ange further testified that Patient 5 was "more stressed, more anxious. She's got a final, move. She's got Nashville. She broke up with her boyfriend. There's a lot of pressure. I don't remember if this was the one where she was robbed or not." (Tr. at 141) Whereupon the following exchange took place:

Q. [By Mr. Wilcox] The thing I don't understand is all those things you just mentioned, people, throughout life, have stress in their life; correct?

A. [By Dr. Ange] Uh-huh.

(Discussion off the record.)

A. Yes, yes.

Q. They break up with their boyfriends; correct?

A. Correct.

Q. They have stresses with their job; correct?

A. Correct.

Q. Stressors with their school; correct?

A. Correct.

Q. But they don't need Xanax or benzodiazapine. So how -- how do we know this person was -- needed Xanax?

A. Well, from my point of view, the Xanax was given her to continue to make her functional. I'm always looking at functionality and the patient getting through whatever they do. People have those issues like you just said, but if they're functional, they don't come in for treatment. You can infer that when they come in for treatment, they're not very functional, so I'm trying to get her back to school. She had a major life change. What's not -- I did note it but it's not understood, she went from being a premed college student to writing music in Nashville. That's quite a shift, and she's really good at it, so forth and so on, but it's dysregulating for her. But I'm always looking at functionality. People are not going to -- most people, at least in my office, don't come in if it's just minor, situational things. There's an inference that these people are not very functional.

Q. But if you start them on a drug like Xanax, which can become dependent or habit-forming –

A. Uh-huh.

Q. Is that correct?

A. Correct.

Q. I mean, are you kind of starting them down a road where they may become used to that, every time they have some kind of stress in their life they have to start taking Xanax? Don't they, I guess, fall into that pattern?

A. Well, if everybody buys the Kool-Aid, that's what's happening, I would agree with that, but in my practice -- she didn't get Xanax very long, as you can see, and she was off, and it was to help this -- to me it's why you would use something like that, in my opinion, to get her through, and I -- I'll have to double-check, but I don't think we ever put her back on Xanax. I'd have to check that to make double sure, but I'm looking at functionality. People are not going to come in unless they feel like they're not functional.

(Tr. at 141-143)

140. According to the chart, Patient 5 moved to Nashville around June 2011. Dr. Ange testified that Patient 5 continued school in Nashville. (St. Ex. 5 at 110-112; Tr. at 146)

141. When asked if she had ever diagnosed Patient 5 with an eating disorder, Dr. Ange replied:

> No. I had -- I -- it's referenced throughout the chart, but Patricia Hayes and then eventually some people in Nashville treated her for it. Steve Karnehm treated her some, but we were having Miss Hayes treat her mostly for that.

Q. [By Mr. Wilcox] So you never diagnosed her with an eating disorder?

A. Well, I diagnosed her on and off. You've seen notes throughout that says watch sleeping disorder -- I'm sorry, watch eating disorder, but I never nailed her if she was bulimic or anorexic. I left that to Dr. Hayes to do that.

(Tr. at 136) Dr. Ange later testified that Patient 5 suffered from an eating disorder; however, Dr. Ange did not diagnose or treat that disorder. (Tr. at 592)

142. On November 23, 2014, Dr. Ange documented among other things that Patient 5 felt terrible, and had a general lack of concentration and focus. (St. Ex. 5 at 109) Dr. Ange's

progress note further states, "Is she ADD – Has enough S/S [signs and symptoms[28]]." (St. Ex. 5 at 108) The note also states that Patient 5 had had a bad response to Strattera, and "had issues years ago" with Adderall XR. (St. Ex. 5 at 109) Dr. Ange prescribed Adderall 10 mg #30 with instruction to take one per day. (St. Ex. 5 at 108) At her next visit,[29] Dr. Ange noted improvement but stated that Patient 5 "felt hardly anything" at Adderall 10 mg. She also noted that Adderall 20 mg would be the "upper limit." (St. Ex. 5 at 107) On December 21, 2011, Dr. Ange increased Patient 5's dose to Adderall 20 mg #30 with instructions to take one tablet per day. Dr. Ange testified that she had done so because Patient 5 reported that the 10-milligram dose had not been effective. (St. Ex. 5 at 105; Tr. at 145-156) On or around August 22, 2104, Dr. Ange again increased Patient 2's dose of Adderall 20 mg to twice per day—one tablet in the morning and one tablet at noon. The only note the Hearing Examiner found was "Feels worse." (St. Ex. 5 at 45)

143. When asked whether a sufficient workup for ADD was documented in Patient 5's chart, Dr. Ange replied, "Actually, I do. Would I do it differently now, with all the mess with Adderall that may be coming, as we talked about earlier? I would probably do more formal psychometric testing, but, yes, these do meet criteria for DSM. Back then it was DSM-IV-R." (Tr. at 145) Dr. Ange added that she had received a December 1, 2011 letter from Patient 5's counselor who indicated that Patient 5's answers on the Adult ADHD Self-Report seemed clinically significant. (St. Ex. 5 at 106; Tr. at 145)

144. On a prescription form dated September 17, 2014, concerning prescriptions for Adderall 20 mg #60 and Effexor XR 75 mg #60, a note states, "Mom said you were going to write double But she knows to take only 1." (St. Ex. 5 at 43) Dr. Ange testified that she did not write that note and that the message "was wrong." (Tr. at 599-600) Dr. Ange testified that she continued to prescribe Adderall 20 mg #60 with instructions to take one tablet in the morning and one tablet at noon. (Tr. at 601-602)

145. OARRS reports dated February 26, 2014; July 17, 2015; and August 10, 2015, (which were the only OARRS reports in State's Exhibit 5), indicate that, from February 8, 2014, through June 26, 2015, the last entry in the August 10, 2015 report, Patient 5 filled the following prescriptions for Adderall 20 mg or generic equivalent prescribed by Dr. Ange:

Date Filled	Drug[30] and Dose	Quantity	Days
02/08/14	Adderall 20 mg	30	20
03/28/14	Adderall 20 mg	30	30
04/25/14	Adderall 20 mg	30	30
07/01/14	Adderall 20 mg	30	30
08/12/14	Adderall 20 mg	30	30
08/22/14	Adderall 20 mg	60	30
09/19/14	Adderall 20 mg	60	30

[28] Tr. at 144.
[29] The progress note is undated. (St. Ex. 5 at 105, 107)
[30] Brand name; all prescriptions were filled with the generic equivalent for Adderall. (St. Ex. 5 at 11)

Date Filled	Drug[30] and Dose	Quantity	Days
11/17/14	Adderall 20 mg	60	30
12/10/14	Adderall 20 mg	60	30
01/08/15	Adderall 20 mg	60	30
02/09/15	Adderall 20 mg	60	30
02/26/15	Adderall 20 mg	30	30
05/19/15	Adderall 20 mg	30	30
06/26/15	Adderall 20 mg	60	30

(St. Ex. 5 at 11, 20, 30)

146. Dr. Ange testified that she provided refills for Adderall when the patient called in, but she had to be seen every 90 days. (Tr. at 147-148)

147. Referring to her billing records, Dr. Ange testified that her charge for an office visit was typically $85.00, and that she charged $20.00 for a prescription refill without a visit. Based on that information, it appears that Dr. Ange actually saw Patient 5 on January 22, 2010; April 1, 5, and 21, 2010; May 3 and 19, 2010; June 18, 2010; January 3, 2011; April 18, 2011; October 3, 2012; August 11, 2014; and then saw her monthly on July 27, 2015 (which is an $85.00 charge but states, "Psychotherapy PHONE-SICEAE"); August 17, 2015; and September 9, 2015. (Tr. at 147-St. Ex. 5 at 201-203)

148. Dr. Ange testified that she could have seen Patient 5 "at the window" on some of the dates where the $20.00 fee was charged. (Tr. at 149) Whereupon the following exchange took place:

Q. [By Mr. Wilcox] What does that mean, "I would see her at the window"?

A. [By Dr. Ange] Well, there's a window. Like if I'm the secretary sitting here, there's a window in front, and so patients would come here, and so if I'm walking up and I saw her, then I would certainly say something and then just see what's going on, what's she about, what's happening, because I'm aware that she's traveling. I'm assuming this reflects all the traveling across the country.

Q. Okay. So she would actually come in to pick up the prescription rather than it being –

A. Sometimes she would. Sometimes her mother would because we -- the mother was allowed to -- to do that.

Q. But it's safe to say for a lot of this time frame she was on a Schedule II medication, and you weren't actually seeing her? You were just basically writing the scripts for her and she was picking it up or someone else in her family?

A. Someone else was picking it up. Obviously, we changed that. The rules are different now, and we definitely have tighter reins, although I didn't change the medication particularly.

Q. When you say, "Obviously, we changed that," what do you mean by that?

A. Well, you want to be seeing patients. My understanding the last few years is you definitely want to be seeing patients for this every 90 days, and we definitely do that. They have to come in no matter where they live, and so we made those big changes to --

Q. And why is it important to see a patient every 90 days?

A. Well, one, I think the law says so. I could be wrong on that, but I think the law says so. The standard of practice says with the -- again, with the issues in Ohio and controlled substances being an issue, you want to be -- have a tighter rein on them. The office has tried to evolve along with the tighter rein on patients, so things aren't as -- so patients come in every 90 days. They might get the script in between, but they're going to have to show their face no matter what.

Q. And it's also important just to evaluate how they're doing; right? I mean sometimes you want to see them and observe them and --

A. Oh, correct. That's obvious, yes. Your point is well taken.

Q. But this patient I guess in this time frame, which was up until 2015, basically 2012 to 2015, in that time frame she was out and about with her music career, she wasn't really living in the Dayton area, and so she would infrequently come to your office; is that --

A. Infrequently is good. She actually lived six months there and six months at her house. It was really kind of back and forth, was my understanding.

(Tr. at 149-151)

149. Dr. Ange testified that even though Patient 5 had moved to Nashville to attend school and to further her music career, she traveled a lot and her home address was always her parent's home in Ohio. (Tr. at 146-147)

150. Dr. Ange acknowledged that Patient 5's behavior had become more erratic toward the end of her treatment with Dr. Ange. Dr. Ange testified that, one of the last notes in Patient 5's chart, dated November 15, 2015, indicates that Dr. Ange had spoken with Patient 5's

mother who reported that Patient 5 had had a meltdown and was abusing alcohol, among other things. (St. Ex. 5 at 3; Tr. at 153-154)

151. Dr. Ange testified that she no longer sees Patient 5 and that Patient 5 now sees a provider in Nashville. (Tr. at 153, 603-604)

Patient 6 (Patient MJ)

152. Patient 6 is a female born in 1974. She first visited Dr. Ange on December 17, 2010, with a chief complaint of depression. At that visit, Dr. Ange diagnosed general anxiety, depression, rule out seasonal, and rule out burnout. (St. Ex. 6 at 242-268) Dr. Ange continued to see Patient 6 through at least February 17, 2016, the last visit documented in State's Exhibit 6. (St. Ex. 6 at 6-8)

Dr. Eden's Written Report

153. In her written report, Dr. Eden stated as follows concerning Dr. Ange's treatment of Patient 6 (identified as Patient MJ in her report):

> Dr. Ange's medical records were reviewed. Her medical records were mostly hand written and included some notes on blank sheets of paper and some notes on pre-printed forms, and in some situations there were notes for the same date of service on blank paper duplicated on a pre-printed form. Initial patient information paperwork was provided and there were some self-reporting tools included. There were notes from an inpatient treatment at Sierra Tucson in January and February 2013 with diagnoses MDD, anxiolytic dependency, ADHD, and borderline traits (p192-196.)[31] The record indicated that when MJ was admitted to Sierra Tucson she "endorsed substance abuse" (p. 196-196) that "the client did not view self as an addict and she was hesitant to stop benzodiazepines." She was discharged on Klonopin 1 mg tid, Vyvanse 30 mg bid, Seroquel 50 mg bid prn, Lamictal 150 mg bid and Gabapentin 600 mg tid (p.192). There was also notation that MJ had been admitted to Sierra Tucson 12/6/12, but she left treatment on 12/21/2012 after approximately 2 weeks because of the stress on her family at that time of the year (p. 160, 165.)
>
> The billing records and notes document that the patient was first seen on December 12, 2010 and the last visit was February 12, 2016 for a total of 41 billed appointments. * * * Most of the subjective and objective parts of the notes were legible, but there were several times when the end of the note was illegible or too light to read.

[31] All page references refer to State's Exhibit 6.

> The intake note was dated 12/17 /10 and the diagnoses listed were Generalized Anxiety Disorder (GAD), Depression, r/o Burnout, Gastric Bypass and Anemia. Xanax 1 mg bid was ordered on 12/17/10 (p.249) and later increased to 1 mg tid on 5/26/12 (p 233), then increased to qid on 6/17/12 (p. 220). There was no clear documentation as to why the dosage increases were made. On 12/26/12 there was documentation that MJ was "taking too many Xanax'' (p.201.) Klonopin 1 mg bid was started and dx[32] PTSD was added (p.200.) In the Sierra Tuscon note (p 184), MJ stated that she "experienced increased tolerance and would use increasing doses of her Xanax to reduce symptoms and to 'check out' ... result in running out ... withdrawal may have been a factor in her recent seizure ... met criteria for anxiolytic dependence." Dr. Ange continued to prescribe Vyvanse 30 mg bid until 6/18/14 when she documented "Vyvanse to 70 mg cheaper than #2/30" (p.86.) She also continued to prescribe Klonopin 1 mg qid (9/26/13-p.135), 1 mg tid (11/1/13-p 132) and then 2 mg tid (5/1/14-p 103.) On the OARRS report 6/6/2014 (p. 97) between 8/7 /13 and 12/1/13, Klonopin 2 mg #105 tablets and Klonopin 1 mg# 540 tablets were filled by the patient. From 12/9/13 to 7/17/14, MJ received Klonopin 2 mg #410 tablets. On 11/10/14 (p. 72), Dr. Ange noted she discussed the OARRS report with MJ who said "she believes her husband picked up the refills that were not cancelled at Kroger ... discussed that looks like double dipping." There were opiates listed on the OARRS report and there is no mention that Dr. Ange discussed the risks associated with taking opiates in combination with benzodiazepines. A controlled substance patient agreement was signed on 2/17/16 (p. 13-14). On 2/17/16 (p. 8), Dr. Ange noted Klonopin was reduced to 2 mg bid "coverage for seizure." However, on 3/18/16 (p.4), prescriptions were called in for all of her meds including Adderall 20 mg qd[33] and Klonopin 2 mg prescribed tid without documentation for the higher dose.

(St. Ex. 10 at 17-18)

Testimony of Dr. Eden

154. Dr. Eden testified that Dr. Ange had diagnosed Patient 6 with GAD, depression, rule/out burnout, history of gastric bypass surgery, and anemia. At the first visit on December 17, 2010, Dr. Ange prescribed, among other things, Xanax 1 mg twice per day and Ambien was added a short time later. (Tr. at 312-313) Dr. Eden further testified that on May 26, 2011, Xanax was increased to three times per day in May 2011, possibly due to the death of Patient 6's grandfather, which Dr. Eden characterized as "normal stress * * * there was no documentation as to altered functioning that would require an increase in Xanax." (Tr. at 313, 466-467) Dr. Eden further testified:

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[32] Diagnosis.
[33] Every day.

> And then again in June [2012] on page 220, the Xanax was then increased to four times a day. This is a potential problem with Xanax which is highly addictive and people can accommodate to the medication quickly and you require increasing doses to get the same response, so I don't know if that's the reason or if Dr. Ange thought the patient was having more symptoms, and so she was increasing the dose, increasing the dose and frequency.

(Tr. at 313-314)

155. When asked if Xanax had been a reasonable first line of treatment at Patient 6's first visit for diagnoses of GAD and depression, Dr. Eden replied that she would not start with Xanax for major depressive disorder; she would start with an antidepressant. (Tr. at 464-465)

156. A report concerning a January 2013 psychometric test evaluation performed at Sierra Tucson states that Patient 6 "admitted that she experienced increased tolerance and would use increasing doses of her Xanax to reduce her symptoms and to 'check out.'" (St. Ex. 6 at 184) The Axis I discharge diagnoses for Patient 6 rendered by the physician at Sierra Tucson on or around February 5, 2013, were:

> Depressive disorder, not otherwise specified, including symptoms of dysthymia and major depression (please note, I think a lot of this may be dysthymia related to personality issues; attention deficit hyperactivity disorder, improved with medication; polysubstance abuse, in early remission (ongoing benzodiazepine prescription taken as prescribed for anxiety); anxiety disorder, not otherwise specified.

(St. Ex. 6 at 193)

Dr. Eden testified that Patient 6 had identified herself at Sierra Tucson as "using Xanax to alter her state, not to take it medicinally." (Tr. at 316) Dr. Eden further testified that they probably advised her that this could be anxiolytic dependency but that she had been unwilling to accept that, and was unwilling to taper off benzodiazepines. (Tr. at 316-317) Moreover, Dr. Eden testified:

> They discharged her on Klonopin 1 milligram three times a day which was puzzling given their concerns about her dependence, her anxiolytic misuse, and the fact she was in a residential program which would allow them a safe taper, so I can't explain why they made that decision. But they did diagnose her with polysubstance abuse, in early remission, and ongoing benzodiazepine prescription taken as prescribed for anxiety.

(Tr. at 317)

When asked to assume that Dr. Ange had testified that she had viewed Patient 6 being discharged by Sierra Tucson with a prescription for Klonopin as a sort of green light to prescribe benzodiazepines, Dr. Eden replied:

> Well, my reaction to that is as the treating psychiatrist, the attending psychiatrist, if I have concerns that somebody has anxiolytic dependence, that they have already admitted to using benzodiazepines to "check out" and to alter their mood and not for medicinal reasons, then I am uncomfortable continuing to prescribe even if somebody else isn't. And, you know, the charge is really with the person who is the ongoing treatment provider. I do think it's weak that Sierra Tucson didn't address that more vigorously but that doesn't excuse me continuing to do the same thing is the way I would view that.

(Tr. at 318)

Moreover, Dr. Eden testified that Dr. Ange had continued to prescribe Klonopin to Patient 6 for many years following her discharge from Sierra Tucson.

> Uh-huh. I'm sorry, yes. There's also if you go to page -- not only was it continued to be prescribed and even at higher doses than what she was discharged from Sierra Tucson, but on page 72 [of State's Exhibit 6],[34] and this shows up in the OARRS report, Dr. Ange discussed with the patient that multiple prescriptions had been picked up at different pharmacies for the same medication so that there were increased quantities than what was expected. And the explanation was that the patient's husband may not have been aware that he wasn't supposed to pick up those prescriptions.
>
> Q. [By Mr. Wilcox] What does that indicate to you?
>
> A. That would be another red flag that more medication than is intended to be utilized is actually being taken.

(Tr. at 318-319)

157. Dr. Eden testified that she is aware of Sierra Tucson's substance abuse program, and that, in her opinion, "it's not highly regarded." (Tr. at 468)

158. As previously noted, Patient 6 had been discharged from Sierra Tucson on Vyvanse and Klonopin. Dr. Eden testified that she presumed the Vyvanse was prescribed to treat ADHD, but it is also indicated to treat binge eating disorder. (Tr. at 469-470) Dr. Eden expressed concern with Sierra Tucson's decision to discharge Patient 6 on a

[34] This refers to a progress note dated November 10, 2014. (St. Ex. 6 at 72)

benzodiazepine and Vyvanse and that she thinks "that would be one of the reasons their reputation is not that stellar." (Tr. at 470)

Further, Dr. Eden testified that she was uncomfortable with Dr. Ange's continued prescriptions for Vyvanse and Klonopin to Patient 6. (Tr. at 472-473) Whereupon the following exchange took place:

Q. [By Mr. Quinn] Well, it's always up to any provider to make their own clinical decision before they sign their name on the prescription pad, right?

A. [By Dr. Eden] Yes.

Q. You can't delegate that to some other physician or somebody else, right?

A. Correct.

Q. But what you can perhaps conclude is that if other physicians are seeing it the same way as Dr. Ange, perhaps it's the case that you have a different philosophy from other folks within the psychiatric community, true?

A. In this case I have a different opinion from Dr. Ange and Sierra Tucson, so yes.

Q. And is it your opinion they fell below the standard of care in prescribing the benzodiazepines and stimulant for this patient given her history?

A. Well, Sierra Tucson was a short-term treatment, so the standard long-term treatment falls on the treating provider Dr. Ange so, you know, I think that Sierra Tucson could have used the opportunity to address the anxiolytic dependence in more -- with more thoroughness. They did not. I think Dr. Ange would have too, and she did not.

Q. Okay. Could have or had to?

A. I believe from a safety point of view had to. Is there a standard that said that she must? Probably not. But what's best practices? This is a legal hearing. I have been told that several times by you. Safe and best practice I think most people would question why this patient continued in the treatment that she had. Most treating psychiatrists would question that.

Q. Okay. But, again, the -- and as you mentioned, I brought up the legal nature, what we are here for, a couple of times. But, again, Dr. Ange isn't being charged with not meeting best practices. She's being accused of violating the standard of care, right? You are aware of that?

A. I think this is below the standard of care.

Q. Okay. And so Sierra Tucson is also below the standard of care?

A. I think they functioned below the standard of care by not addressing basically the condition she went there for.

(Tr. at 473-475)

159. Dr. Eden opined that the dosages of Klonopin Dr. Ange prescribed to Patient 6 "are high doses, especially for somebody who is noted to have an anxiolytic dependence and used benzodiazepines to 'check out.'" (Tr. at 320)

160. Dr. Eden testified that Dr. Ange's selection of medications for Patient 6 fell below the minimal standard of care in the selection of medications "[b]ecause Dr. Ange continued to prescribe controlled substances to a patient who was known to misuse benzodiazepines and in light of her anxiolytic dependence diagnosis that Dr. Ange did not dispute." (Tr. at 321) Dr. Eden further testified that Dr. Ange's care and treatment of Patient 6 fell below the minimal standard of care because the documentation did not support the treatment provided, and also violated the Board's rules concerning prescribing controlled substances. (Tr. at 321) Moreover, Dr. Eden testified that Dr. Ange violated the Board's rules concerning the prescribing of controlled substances "based on the patient's diagnoses and the quantity of medications prescribed." (Tr. at 321)

Testimony of Dr. Ange

161. Dr. Ange testified that she disagrees with Dr. Eden's rather low opinion of Sierra Tucson and believes it to be "a very excellent place to go." (Tr. at 605-606)

162. Dr. Ange testified regarding Sierra Tucson discharging Patient 6 on Klonopin and Vyvanse:

> Well, she went into a very good program, in my opinion. They seemed to assess her quite well, if one looks at the information, and one of their issues was they thought she had a dependence issue, and they sent her home on Klonopin, which was a difference than Xanax. So she went in on and she came out on Klonopin, and they diagnosed her with ADD and gave her Vyvanse.

(Tr. at 608) Dr. Ange further testified that they also discharged her on Lamictal, a mood stabilizer; gabapentin, which is now a controlled substance but was not at that time; and Seroquel which is an antipsychotic. (Tr. at 608-610) The record indicates that she also received propanolol, Cymbalta, and Flexeril. (St. Ex. 6 at 193)

163. Dr. Ange testified that, in her opinion, Sierra Tucson is better equipped to diagnose and treat substance abuse disorder than she is. (Tr. at 610)

164. Dr. Ange noted that a progress note dated February 17, 2016, indicates that she had planned to decrease Patient 6's dose of Klonopin. (Tr. at 611-612; St. Ex. 6 at 8) However, a note dated March 18, 2016, indicates that, among other prescriptions, a prescription was called in for Klonopin 2 mg #90 with instructions to take one tablet three times per day. (St. Ex. 6 at 4)

Patient 7 (Patient RL)

165. Patient 7 is a male born in 1982. He first saw Dr. Ange on December 16, 2010, and continued treating with her through at least March 22, 2016, the last patient contact documented in State's Exhibit 7. Dr. Ange's notes indicate that Patient 7 is a veteran. (St. Ex. 7)

Dr. Eden's Report

166. In her report, Dr. Eden stated, in part, as follows concerning Dr. Ange's treatment of Patient 7 (identified as Patient RL in her report):

> The intake note was dated 12/16/10 and the diagnoses listed were Depression, Anxiety, ADD and Post-concussive Syndrome. The documentation related to RL's past use of psycho-stimulants was not clear. Dr. Ange started Adderall 20 mg XR and 20 mg qAM[35] and Zoloft. On p. 163[36] (dated 12/21/10) there was a letter from Larry Pendley, Psychologist who said RL was "fatigued on Zoloft ... has a history with Adderall...tweaking will enliven him."[37] Dr. Ange replied to Larry Pendley on 1/21/11 (p. 149-150) and stated that RL was "using the Adderall to manipulate his feelings in order to enhance his behavior." She went on to say she would "do it [Adderall 30mg] for 1 month ... would not do a refill ... establish he's actually getting out and do something ... and even if he does something I am not going to give him 90 mg of Adderall every day." The notes from 1/6/11 (p. 159) state "Adderall: focus ... energy to get up - worse task I can do." On [her progress note dated] 1/18/11 (p.157) Dr. Ange described RL as "passive aggressive." She ordered Adderall XR 30 mg tid and wrote "will not do it again - this is a [j]ump start." Dr. Ange wrote a note to Psychologist Larry Pendley on 1/21/11 (p 149) and said, "RL is using the Adderall to manipulate his feelings in order to enhance his behavior ... did give Adderall 30 mg tid ... only for 1 month."

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[35] Every morning.
[36] All page references refer to State's Exhibit 7.
[37] The entire quote from Mr. Pendley states, "He reports fatigue with the Zoloft. I encouraged him to wait it out. He has a positive history with the Adderall and I think tweaking it will enliven him a bit." (St. Ex. 7 at 163)

> RL returned for treatment 10/22/12 (p. 148) with reports that he had been off of Adderall since May 2012. Dr. Ange prescribed Adderall and said RL "should follow up in Springboro which he had been doing." Nevertheless, Dr. Ange continued to prescribe medications including Adderall and sleeping meds. The prescriptions continued even though RL moved and was unavailable for appointments, and Dr. Ange continued to write prescriptions for controlled substances because she agreed to "get him through" his job training (pp. 5, 13, 24, 25.) There is a note on 11/25/15 (p. 21) that says, "Had agreed since move would do this one time only." This note follows a phone request from 11/6/15 (p.20) asking Dr. Ange to "date a prescription later'' because the Rx was due on 12/6/15 and he was moving to Atlanta.[38] There were many prescriptions provided outside of appointments for controlled substances and OARRS was not routinely checked.

(St. Ex. 10 at 20)

167. Dr. Eden further opined as follows:

- With respect to R.C. 4731.22(B)(2):

> In my opinion to a reasonable degree of medical probability, I believe Dr Ange did not meet minimal standards applicable to the selection or administration of drugs, or did not[39] fail to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease. Dr. Ange made a diagnosis of Attention Deficit Disorder and utilized self-screening tools twice to support her diagnosis. Despite the diagnosis, Dr. Ange's lack of regular follow up, the high doses of Adderall ordered, the many prescriptions written outside of office visits, and Dr. Ange's concerns about misuse of the stimulants, her decision to continue to prescribe is of concern. Also of concern were her comments about how RL's use was to enhance his mood perhaps indicating the medications were not being used as prescribed would commonly lead to closer follow up.
>
> (St. Ex. 10 at 21)

- With respect to R.C. 4731.22(B)(6):

> In my opinion to a reasonable degree of medical probability, I believe Dr Ange's treatment or care constituted a departure from or failure to conform to minimal standards under the same or similar circumstances,

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[38] Dr. Eden retracted this statement at the hearing. She acknowledged that there is a very light, nearly illegible note in the chart that states "11/25/15" and "not to fill [before] 12/6/15."[38] Accordingly, Dr. Eden testified that that prescription had not been postdated as she originally opined. (Tr. at 486-489; St. Ex. 7 at 21)

[39] Based on context, this appears to be a typographical error.

> whether or not actual injury to a patient was established. Dr. Ange prescribed psycho-stimulants for an ADD diagnosis, but she continued to prescribe despite documented concerns over his use of stimulants and prescribed despite allowing infrequent visits and providing multiple prescriptions while RL was living out of state.
>
> (St. Ex. 10 at 21)

Dr. Eden further opined that Dr. Ange's treatment violated Rule 4731-11-02(C) concerning prescribing controlled substances. (St. Ex. 10 at 21-22)

Testimony of Dr. Eden

168. Dr. Eden testified that she gathered from Dr. Ange's January 21, 2011 letter to the psychologist that Dr. Ange did not think that Adderall was an appropriate medication for Patient 7. However, Patient 7's chart indicates that she provided him with prescriptions for Adderall 20 mg XR #30 on December 16, 2010; what appears to be Ritalin 20 mg (but is barely legible) on January 6, 2011; and Adderall 30 mg #90 on January 18, 2011, with a note in the chart stating that she would not prescribe that quantity again. (St. Ex. 7 at 157, 160, 164; Tr. at 322-323) Patient 7 did not return to Dr. Ange until October 22, 2012. (St. Ex. 7 at 148)

169. At his October 22, 2012 visit, Dr. Ange noted that Patient 7 had told her that he had been off Adderall since May 2012. However, an OARRS report dated a few months later on January 21, 2013, indicates that Patient 7 had continued to fill prescriptions for Adderall and methylphenidate prescribed by another physician through July 10, 2012. (St. Ex. 7 at 140-141, 148) Dr. Ange prescribed Adderall 20 mg #30 and Adderall 10 mg #30. (St. Ex. 6 at 146)

    Dr. Eden noted that, although the OARRS report was inconsistent with the information Patient 7 had provided to Dr. Ange, there is no documentation that that discrepancy was discussed. (Tr. at 323-324)

170. Dr. Eden testified that Dr. Ange had initially documented that she would prescribe only one month of Adderall for Patient 7, but in fact prescribed Adderall for a long period of time, including when he was out of state for job training. Dr. Eden further testified that it was not clear whether Patient 7 had had a workup for the diagnosis of ADD. (Tr. at 324-325) According to Patient 7's chart, Dr. Ange continued to prescribe Adderall to Patient 7 through at least March 22, 2016, the last prescription record in State's Exhibit 7, at which time she prescribed Adderall XR 30 mg, Adderall 30 mg, and Ambien 10 mg; no quantities or instructions were documented. (St. Ex. 7 at 3)

171. Dr. Eden testified that she had treated veterans in her practice. When asked whether simulant usage is more prevalent in the veteran population compared to the general

population, Dr. Eden replied, "In my experience I don't see the military experience as an indicator of the use of stimulants." (Tr. at 479)

172. Dr. Eden testified that Patient 7's use of Adderall to manipulate his feelings and enhance his behavior is not a proper use of that medication, as is alluded to in Patient 7's chart. (Tr. at 480-481)

173. With respect to Patient 7's May 22, 2014 Adult ADHD Self-Report (ASRS-V1.1) Symptom Checklist, Dr. Eden testified:

> I think that the way things are checked here would support a diagnosis, so if this is on treatment, then, yes, but if you are going to do a self-check list at this point in treatment after the patient has already been treated it probably would be wise to do it on and off medicine so you could see the change, especially if it looks like there are still symptoms.

(Tr. at 485-486; St. Ex. 7 at 102)

174. Dr. Eden testified concerning her overall conclusions with regard to Dr. Ange's treatment of Patient 7:

> Well, my overall conclusions are that the diagnosis was not clear, that Dr. Ange initially reported being uncomfortable prescribing Adderall to this man. There was some discrepancies between his report of use of the medication after the initial prescribing and stating that he wasn't taking it while, in fact, the OARRS reports he was and that despite several times saying that she would only do it one time, Dr. Ange continued to prescribe Adderall without office visits over a long period of time.

(Tr. at 326-327)

Finally, Dr. Eden testified that Dr. Ange's care and treatment of Patient 7 fell below the minimal standard of care. (Tr. at 327)

Testimony of Dr. Ange

175. Dr. Ange testified that, at Patient 7's first visit on December 16, 2010, she diagnosed "[d]epression, anxiety, hypersomnia, and postconcussion syndrome." (Tr. at 171) Dr. Ange testified that she was uncertain when Patient 7 suffered a concussion and stated that she had asked him "but he's a veteran. It's hard." (Tr. at 172) She testified that he had lost a best friend in Afghanistan but was unsure if Patient 7 had been injured at that time. She testified that losing his friend was contributing to his depression. (Tr. at 172) She further testified that he was attending Wright State University "and had some trouble there." (Tr. at 172)

Dr. Ange acknowledged that she had prescribed Ambien to Patient 7 at his first visit for a diagnosis of insomnia. She stated that Patient 7 "fears going to sleep." (Tr. at 173) She also prescribed Adderall to Patient 7, and described him in the chart as poorly organized, fidgety, and messy, and stated that he had had ADD his whole life. (Tr. at 173; St. Ex. 7 at 172) She also prescribed Zoloft. (St. Ex. 7 at 166)

176. In a letter dated December 21, 2010, Dr. Pendley, a psychologist who had been seeing Patient 7 advised Dr. Ange that Patient 7 had reported fatigue with Zoloft but that the psychologist encouraged him to "wait it out." He further stated, "He has a positive history with the Adderall and I think tweaking it will enliven him a bit." Moreover, Dr. Pendley stated, "In my opinion, there may be medical issues in his mood problem i.e., post concussion issues or testosterone/thyroid problems. Maybe blood work or a workup on his post concussion." (St. Ex. 7 at 163)

Dr. Ange testified that she interpreted Dr. Pendley's comment concerning Adderall to mean that he felt the Adderall was helpful. (Tr. at 174)

177. In a letter dated January 21, 2011, Dr. Ange advised Dr. Pendley, among other things:

> In the office with me [on January 18, 2011] was his mother and helped validate the stories. [Patient 7] is using the Adderall to manipulate his feelings in order to enhance his behavior. I shared with him that that is not usually the way it works that he will have to do something before he really feels good.[40] He will not feel good then do something. It is my impression that this was a conversation he did not like. The essence of the conversation was that he needs to get up and do something. * * *
>
> * * *
>
> * * * [On January 18, 2011] I did give [Patient 7] Adderall 30 milligrams take one TID. I shared with him I would only do it for one month. I would not do a refill and that he would have to establish that he's actually getting out and do something and even if he does something I'm still not going to give him 90 milligrams every day of Adderall. It is debatable if his compliance with the antidepressants is appropriate so that will also have to be watched. But hopefully this will jump start him and at least get him in the right direction. It's my impression that his work with you will be the most valuable.

(St. Ex. 7 at 149-150)

178. Following the January 18, 2011 visit, Patient 7 did not return to Dr. Ange until nearly two years later on October 22, 2012. (St. Ex. 7 at 146-148) Dr. Ange testified that he was off

[40] Elsewhere in her letter Dr. Ange related that Patient 7 just stays in his room, uses electronics, and eats fast food. Dr. Ange encouraged him to get out and engage in some activity. (St. Ex. 7 at 149)

of Adderall at that time. Dr. Ange testified, "He had a position. He realized the Adderall made him quiet. It gave him focus, but not necessarily organization. The quality of work was better. He was less drifting, and he felt it was helpful." (Tr. at 176) However, Dr. Ange further testified that he reported that "he had been off the medicine and was having some struggles at work * * *." (Tr. at 176-177) Dr. Ange prescribed Adderall XR 20 mg #30 with instructions to take one tablet daily, and Adderall 10 mg #30, with instructions to take one tablet daily at 4:00. (St. Ex. 7 at 146)

Dr. Ange acknowledged that she continued to prescribe Adderall to Patient 7 for an extended period of time. Dr. Ange further acknowledged that he had rarely visited her office later during treatment because he had moved to Atlanta. (Tr. at 177-178)

179. Dr. Ange testified that she had diagnosed Patient 7 with ADD based on his self-report and that she did no testing. Dr. Ange further testified:

> That is something that would change today because things are different today. I would do some formal psychometric testing because Adderall is becoming an issue in the culture, according to my literature, so I would probably do more formal testing, although over time he does seem to meet the criteria.

(Tr. at 178-179)

180. Dr. Ange testified that, today, she would send a patient suspected of ADD to either Dr. Pendley, who saw Patient 7, or to the Flexman Clinic for formal testing for ADD. (Tr. at 616-617)

181. Dr. Ange testified that she still sees and treats Patient 7. She further testified that she continues to prescribe Ambien and Adderall but has somewhat decreased them. Moreover, Dr. Ange testified that she sees Patient 7 fairly regularly, about every three or four months. (Tr. at 179-180)

Patient 8 (Patient NL)

182. Patient 8 is a male born in 1966. He first visited Dr. Ange on January 6, 2011, and continued to see her through at least April 2016, the last patient contact documented in the chart. (St. Ex. 8) At Patient 8's first visit, Dr. Ange diagnosed GAD, depression, and insomnia. On Axis III she noted chronic pain from migraines, "coming off Vicodin," and hypothyroid, and on Axis IV she noted marital problems. (St. Ex. 8 at 158; Tr. at 183-184) Patient 8 further reported receiving Neurontin from his neurologist, and having taken Klonopin for six years. Dr. Ange noted that Patient 8 wakes up two or three times per night, has nightmares, and can't sleep without Klonopin. (St. Ex. 8 at 154) The notes indicate that he was receiving "Vicodin → Subutex (maintenance daily for HA)." (St. Ex. 8 at 155) The prescriptions listed are very faint and hard to read but include Klonopin [dose illegible] #90 and Elavil. (St. Ex. 8 at 158)

Written Report of Dr. Eden

183. In her written report, Dr. Eden stated as follows concerning Dr. Ange's treatment of Patient 8 (identified as Patient NL in her report):

> The intake note was dated 7/6/11 and the diagnoses listed were Generalized Anxiety Disorder (GAD), Insomnia and chronic pain, and it was mentioned NL had used Klonopin for 6 years (p. 154-156.)[41] On 8/24/11 (p.149) the documentation indicates Klonopin 0.5 mg tid ... takes 1-2 most times extra for flare," but Dr. Ange continued to write for 3 daily. On 1/26/12 (p. 144) the note says "cluster headache to Vicodin to Subutex 40 day program ... poor sleep since off Subutex ... Klonopin tid OK." On 1/29/12 (p.143) Klonopin was increased to qid with no reason cited, and on 8/24/12 (p. 136-137) Xanax was started (dose not legible) with note that says "Klonopin over 2 mg is irritating." On 9/6/12 (p. 133) Xanax was stopped and the note says "is he ADD" and Focalin is started. No additional symptoms were documented. Dr. Ange made two referrals to pain management with a referral made on 9/2/12, but the note dated 10/10/12 (p. 124) said Family doc was "more liberal" and didn't want pain management. It is not clear if NL sought treatment after the second referral since there is no documentation to say either way. Many of these notes were too light to be readable.

(St. Ex. 10 at 23)

Testimony of Dr. Eden

184. Dr. Eden testified:

> Diagnosis generalized anxiety disorder, insomnia, and chronic pain, that the patient used Klonopin for six years in that the documentation on page 149, which was August 24, 2011, indicated that the patient -- the prescription was written for Klonopin .5 milligrams three times a day, but the notation was that the patient "takes one to two times most days, extra for flare." So I didn't quite know what that meant, but Dr. Ange continued to write for quantity of three a day even though the patient mentioned generally took one to two a day. I didn't see any documentation of frequency the patient had a flare or the frequency of days that the patient had to take an extra dose. And I wasn't sure what the flare was. What was the patient taking the medicine for? What constituted a flare?
>
> I saw on page [State's Exhibit 8 at page] 143 Klonopin was increased to four a day with no reason cited. And then in August of 2012 on page 136, "Xanax was started," I couldn't tell the dose, and said "Klonopin over 2 milligrams is

[41] All page references refer to State's Exhibit 8.

> irritating." The problem is I wasn't clear when Klonopin over 2 milligrams was taken since the maximum dose was written for .5 milligram QID. And then in September of 2012, Xanax was stopped. The note says "Is he ADD" and "Focalin was started" without any documentation of why that medicine was indicated.

(Tr. at 328-329)

185. Dr. Eden testified regarding Dr. Ange's January 26, 2012 progress note:

> So they are talking about cluster headaches it looks like somehow leads to Vicodin which leads to Subutex, some kind of 40 day program. Subutex is buprenorphine without naloxone. A couple years of maintenance so maybe they were on maintenance. Bupropion I'm not sure. Now, he's off. He had withdrawal which was no fun but glad to be off. Again, I don't really know. You have to fill in a lot to understand what that -- you have to assume a lot to understand really what that means.

(Tr. at 330; St. Ex. 8 at 144)

Dr. Eden testified that buprenorphine is indicated for opiate withdrawal and maintenance as well as for pain. (Tr. at 491-493)

186. Some time later, in a September 6, 2012 progress note, Dr. Ange noted, among other things, "Is he ADD[?]" (St. Ex. 8 at 133) Dr. Eden testified

> Dr. Ange looked at his fidgetiness, disorganized, reduced focus, and energy and restlessness as being ADD. But those are symptoms that can be related to other things. Maybe disorganization could be more directly related to ADD in the right set of symptoms but that she heard those symptoms and reacted and prescribed Focalin which is another type of stimulant.

(Tr. at 331, referring to St. Ex. 8 at 133)

Dr. Eden further testified that she did not find any appropriate workup for a diagnosis of ADD, only a few words about being restless, fidgety, and having reduced focus and energy. (Tr. at 332; St. Ex. 8 at 133)

187. Dr. Eden testified that Dr. Ange made at least two attempts to get Patient 8 into pain management, but Patient 8 failed to follow Dr. Ange's recommendations. (Tr. at 332)

188. Dr. Eden testified that Dr. Ange's care and treatment of Patient 8 fell below the minimal standard of care because it was not clear what her medical rationale had been for prescribing and increasing the doses of the medications she prescribed. Moreover,

Dr. Eden testified that Patient 8's response to treatment was not documented, which fell below the minimal standard of care. (Tr. at 334-335)

Testimony of Dr. Ange

189. Dr. Ange testified that Patient 8 came to her on a referral from his neurologist. When asked if she had ever contacted his neurologist to obtain records or learn more about the patient, she replied that she did not. (Tr. at 188) When asked if she would typically want to see the patient's prior treatment records, Dr. Ange replied, "Maybe, maybe not. Obviously sometimes -- nowadays I probably would. I'd be much more vigilant about that because of this -- these issues with the benzos, et cetera, but not necessarily." (Tr. at 189)

190. Dr. Ange testified that Patient 8 came to her with a history of having received Klonopin over a period of six years prescribed to him by his neurologist. (Tr. at 621-622)

191. With respect to Patient 8's use of Vicodin, the following exchange took place:

Q. [By Mr. Wilcox] "Coming off Vicodin," what does that mean?

A. [By Dr. Ange] Well, he told me that he was coming off the -- that he was off Vicodin actually -- well, I take that back, because these notes are messed up a little bit. The next visit he was off, so he must have told me -- I've got to find it. My remembrance of this is that it didn't help much anyway, and I might have written he was coming off the next time. On 8/11 he was -- he was off, is what he said anyway.

Q. Was he -- was he addicted to Vicodin?

A. That was not my understanding, although he did have some issues, as it turned out, with some -- the pain meds, and I think he had -- he told me -- I have to get the dates and all because I don't have that right here. He had been on Suboxone earlier, but he came off of that.

Q. And the Suboxone was to treat him for addiction to Vicodin? Is that what that was for?

A. I assume that.

* * *

Q. He was in a "40-day program." He went through "withdrawal." That was "no fun," as you stated in your chart; correct?

A. Uh-huh, yes.

Q. So this person is -- I would assume someone comes to your practice with a history of taking Subutex or Suboxone and is being treated for opioid addiction with Suboxone, that is a red flag, a person that you would want to watch carefully. Is that true?

A. It's a bit of a flag. I would agree with that.

Q. I mean, if you're considering controlled substances, you have to be, I guess, more vigilant with a patient like this?

A. Correct, yes.

(Tr. at 184-186)

192. Dr. Ange testified that she had prescribed the controlled substances Klonopin and Focalin to Patient 8 during the course of his treatment. (Tr. at 189-190) When asked if she took Patient 8's history of problems with Vicodin into consideration in determining what medication she prescribed, Dr. Ange replied:

> You take it into consideration. If a patient has a problem with opiates, it's not a given they're going to have problems with the others, and so, you know, again we're looking for functionality, do the symptoms warrant being treated. In my opinion, they do warrant being treated. Is he functional, is he getting in trouble with it, you know, so forth and so on. Your point is well taken. You just want to keep it in the back of your mind.

Q. [By Mr. Wilcox] What if the patient does something like, you know, increases their own medication dose? Because I think on Page 149 [August 24, 2011] the patient was talking about taking additional Klonopin. Is that a red flag given his history?

A. Not necessarily, because the red flag was on the opiate, if you will. If a patient takes an increase in the medicine, what I appreciate is them telling me the truth, and so it's not my -- it has not been my experience so far, unless, you know, I'm totally being duped, that patients who have some of these issues, that they just don't tell you they're doing it. What they do is they call in say I've run out of pills, I need a new script, the dog ate it, et cetera, et cetera. I appreciate the fact that they tell me the truth, and then it's, like, well, okay, is this what we really need to do. In some ways it's like insulin, if you -- I'm sorry. It's a little bit like diabetes. If there's sugar issues, should we increase the insulin. I appreciate them telling me the truth and sometimes telling me well, they took an extra themselves. It's a -- functionality is an issue, and can we give the fewest amount of pills over a period of time and not take pills all the time, can we get rid of this pill taking all the time.

(Tr. at 190-191)

193. Dr. Ange testified that she had prescribed Focalin to Patient 8 on September 6, 2012. Dr. Ange testified that Focalin is methylphenidate, similar to Ritalin, that is mostly prescribed for ADD. She further testified that she had documented that Patient 8 was restless, fidgety, disorganized, had decreased focus and decreased energy. (Tr. at 623-624; St. Ex. 8 at 133) When asked what she was trying to convey, Dr. Ange replied, "I'm asking myself about the ADD, thinking mostly that he has it, and we need to follow through and see if, in fact, this is accurate." (Tr. at 624)

When asked what she would do nowadays with to diagnose a prospective ADD patient, Dr. Ange testified that she would send them to a local provider who performs the psychometric testing that is used to diagnose that condition. (Tr. at 195)

194. Dr. Ange testified that Patient 8 continued to have pain issues while she treated him and that she referred him to a pain management specialist. Dr. Ange testified that he received Suboxone and Subutex as treatment for pain. Dr. Ange agreed that such medication used in combination with a benzodiazepine requires caution. Dr. Ange further testified that she had never been contacted by Patient 8's pain specialist to discuss medication issues. (Tr. at 625-626)

195. Dr. Ange testified that, as of the date of the hearing, she continues to see Patient 8. (Tr. at 620-621)

Patients in General

Testimony of Dr. Eden

196. Dr. Eden testified that, even if a medication has very limited indications, the physician must still document the symptoms the medication is being utilized to treat and follow up with the treatment outcome. (Tr. at 501)

197. When asked whether she thought Patients 1 through 8 were complicated patients, Dr. Eden replied, "Well, they are patients who had multiple complaints, but I don't know that I can classify them as complicated or simple." (Tr. at 340)

Testimony of Dr. Ange

198. With respect to the long-term prescribing of benzodiazepines, the following exchange took place:

> Q. [By Mr. Wilcox] * * * Would you agree with me that benzodiazepines are associated with tolerance, Doctor?
>
> A. [By Dr. Ange] Correct.

Q. Since they are, would you agree that in general you don't want to use them long term because the patient will become, I guess, tolerant or dependent on them?

A. I would agree with that with the caveat that that's new information.[42] I was trained actually otherwise, but I do agree that that is something one must consider.

Q. Your training was that long term was not, I guess, as problematic?

A. Correct.

Q. When you say new, what do you -- can you tell us what you mean by that? When you stated --

Could you read her answer back?

(Answer read back.)

Q. "New information," can you just explain that?

A. Well, I think in the last four to five years, with all the information, like the heroin, with the -- particularly the OARRS, because I think OARRS came before heroin. I could be wrong on that, but the OARRS calling attention that we've got issues here and that we've got to keep on top of it. The treatment for generalized anxiety and panic and agoraphobia is not the greatest treatment in the world. It's still an evolving kind of thing, and so like I said earlier, I was taught that chronic usage was probably not an issue. I think that's different information now. There's more price to pay than one knows. I don't know what else to say. And so in the last four or five years, the tighter the diagnosis -- in my practice do the -- well, I've always done the antidepressants first, but benzos, for the sake of conversation, is a third line of treatment, not a second line of treatment, and then if -- and they may even go down as time goes on if we get totally just horrible. I don't know how that's going to pan out, but I think the literature currently suggests, you know, we need to be very much on top of this.

Q. How long have you practiced medicine? I don't want to --

A. Well, a long time.

---

[42] Dr. Ange may have been referring to testimony by Dr. Eden that, in 2016, the Centers for Disease Control communicated a new or revised warning concerning the simultaneous usage of benzodiazepines and opiates related to respiratory depression. That testimony did not concern the issue of patients developing a tolerance to or becoming dependent on benzodiazepines. (Tr. at 498-500)

Q. '74, from 1974 to --

A. I was in family practice since '74 for about three years and then did my residency, and I think I've been out since about 1980, '81, '82, something like that. You just need to keep up. You can't just --

Q. So less than 40 years of psychiatry but getting close?

A. Yeah, just about.

(Tr. at 201-203)

199. When asked whether another physician could pick up one of Dr. Ange's patient records and understand why things were done, Dr. Ange replied:

> I think other people might have trouble. The charts are written for me, and I think I do see the diagnosis and infer from that this is what I was thinking. Perhaps it's not as clear to others. I'm not sure about that. I think any psychiatrist who is look at this, if they looked at the medications, they can see what's probably going on. There's not a lot -- there's not a horrible leeway in the way the medicines are used.

(Tr. at 204)

Dr. Ange testified that she still documents her charts in the same manner as the charts for Patients 1 through 8. (Tr. at 205-206)

200. Dr. Ange testified that, of the eight patients named in this matter, she continues to see three of them: Patient 3, Patient 7, and Patient 8. (Tr. at 526-528)

FINDINGS OF FACT

1. On August 11, 2010, the Board issued an Order ("August 2010 Order"), effective September 1, 2010, that suspended the license of Constance E., Ange, D.O., to practice osteopathic medicine and surgery in Ohio for a definite period of ninety days, based upon violations of R.C. 4731.22(B)(12) and 4731.22(B)(20) related to her prescribing practices; namely, providing pre-signed prescription blanks to her staff to complete for refills of patients' medications. The August 2010 Order further established probationary requirements, including that she complete an approved course on the subject of prescribing controlled substances and an approved course on maintaining adequate and appropriate medical records. Dr. Ange complied with the probationary requirements, and on or about November 14, 2012, the Board released Dr. Ange from probation.

2. In the routine course of her medical practice, Dr. Ange undertook the care of Patients 1 through 8, as identified on a confidential Patient Key. The evidence supports a finding that, during the time period from in or around September 2010 through in or around May 2016, Dr. Ange failed to adequately assess, examine and/or treat Patients 1 through 8 related to various psychiatric disorders and/or failed to document the same, including but not limited to not utilizing data from the Ohio Automated Rx Reporting System in a manner consistent with the minimal standards of care; failing to adequately justify the bases for specific medications prescribed and/or changes in medication prescribed; failing to corroborate with other treating physicians who were concurrently prescribing controlled substances; failing to assess prescribed controlled substances for risk/benefits in light of controlled substances being prescribed concurrently by other practitioners; and failing to adjust prescribing patterns when she became aware of red flags of misuse of controlled substances.

3. During the hearing the State's expert witness acknowledged some factual errors included in her report and direct testimony. First, with respect to Patient 2, Dr. Eden at first stated that Dr. Ange's last visit with Patient 2 was December 29, 2014, and that her last prescription for Klonopin for Patient 2 was January 21, 2015. However, she acknowledged at the hearing that, in fact, Patient 2's last visit with Dr. Ange took place on December 11, 2014, and that Dr. Ange last prescribed Klonopin to Patient 2 on December 9, 2014. Further, with respect to Patient 7, Dr. Eden initially opined that a barely legible entry for an Adderall prescription issued on November 25, 2015, had been postdated. However, she later acknowledged that, on a closer reading of the note, the prescription was appropriately dated and instructed the pharmacist "not to fill" the prescription until a later date. (Of note, in her written report, Dr. Eden did not mention a post-dated prescription in her discussions concerning violations of R.C. 4731.22(B)(2), 4731.22(B)(6), or Rule 4731-11-02.) Moreover, Dr. Eden initially opined that Dr. Ange should have checked OARRS as frequently as monthly with respect to these patients; however, she later acknowledged that Rule 4731-11-11 requires that OARRS be checked only once every 90 days.

4. Dr. Eden's testimony concerning CPT and ICD codes being required by the standard of care was disregarded inasmuch as no such allegation was included in the Board's Notice.

CONCLUSIONS OF LAW

1. The acts, conduct, and/or omissions of Constance E. Ange, D.O., as described in Findings of Fact 2, individually and/or collectively, constitute a "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as those clauses are used in R.C. 4731.22(B)(2).

1.a. Pursuant to R.C. 4731.225, the Board is authorized to impose a civil penalty for violations that occurred after September 28, 2015. The Board's fining guidelines for this violation are as follows: Minimum Fine $2,500; Maximum Fine $20,000.

2. The acts, conduct, and/or omissions of Dr. Ange as described in Findings of Fact 2, individually and/or collectively, constitute a "departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in R.C. 4731.22(B)(6).

2.a. Pursuant to R.C. 4731.225, the Board is authorized to impose a civil penalty for violations that occurred after September 28, 2015. The Board's fining guidelines for this violation are as follows: Minimum Fine $3,500; Maximum Fine $20,000.

3. The acts, conduct, and/or omissions of Dr. Ange as described in Findings of Fact 2, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in R.C. 4731.22(B)(20), to wit: Rule 4731-11-02, General Provisions.

3.a. Pursuant to R.C. 4731.225, the Board is authorized to impose a civil penalty for violations that occurred after September 28, 2015. The Board's fining guidelines for this violation are as follows: Minimum Fine $1,000; Maximum Fine $10,000.

RATIONALE FOR THE PROPOSED ORDER

The evidence established that, from around September 2010 through around May 2016, Dr. Ange treated Patients 1 through 8 with controlled substances or other dangerous drugs related to various psychiatric disorders without performing or documenting sufficient assessments to support the diagnoses for which the patients were treated. Of the various diagnoses documented in the eight patient charts, none identified specific DSM criteria necessary to support the diagnosis. Dr. Eden testified persuasively that it appeared to her that Dr. Ange was treating patient symptoms rather than diagnoses. Further, medications were prescribed and dosages changed without sufficient documentation to support the medication or changes in dosages. Dr. Ange also did not appropriately respond or document her response to red flags of possible misuse of the controlled substances she was prescribing. Additionally, Dr. Ange did not communicate with other treating physicians who were concurrently prescribing controlled substances. Although Dr. Eden acknowledged that the other physicians bear some of that responsibility as well, that did not absolve Dr. Ange from that responsibility.

Dr. Ange does not appear to be amendable to remediation inasmuch as she completed Board-approved courses on controlled substances prescribing and medical recordkeeping at about the same time that the time period relevant to this matter began. Given the seriousness of the violations, permanent revocation is recommended, as well as a fine of $3,500.00, the minimum fine for a violation of R.C. 4731.22(B)(6).

PROPOSED ORDER

It is hereby ORDERED that:

A. **PERMANENT REVOCATION**: On the thirty-first day following the date on which this Order becomes effective, the license of Constance E. Ange, D.O., to practice osteopathic medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED. During the 30-day interim, Dr. Ange shall not undertake the care of any patient not already under her care

B. **FINE**: Within thirty days of the effective date of this Order, Dr. Ange shall remit payment in full of a fine of three thousand and five hundred dollars ($3,500.00). Such payment shall be made via credit card in the manner specified by the Board through its online portal, or by other manner as specified by the Board.

This Order shall become effective immediately upon the mailing of the notification of approval by the Board.

R. Gregory Porter
Hearing Examiner

State Medical Board of Ohio

30 E. Broad St., 3rd Floor
Columbus, Ohio 43215
(614) 466-3934
www.med.ohio.gov

EXCERPT FROM THE DRAFT MINUTES OF JULY 10, 2019

REPORTS AND RECOMMENDATIONS

Dr. Schottenstein announced that the Board would now consider the Reports and Recommendations appearing on its agenda.

Dr. Schottenstein asked whether each member of the Board had received, read and considered the hearing records, the Findings of Fact, Conclusions of Law, Proposed Orders, and any objections filed in the matters of: Constance E. Ange, D.O; Franklin D. Demint, D.O.; Laura Ann Ringenbach; and John Allen Ross, M.D.

A roll call was taken:

ROLL CALL:	Dr. Rothermel	- aye
	Dr. Saferin	- aye
	Mr. Giacalone	- aye
	Dr. Edgin	- aye
	Dr. Schottentein	- aye
	Dr. Johnson	- aye
	Dr. Kakarala	- aye
	Dr. Feibel	- aye
	Dr. Bechtel	- aye

Dr. Schottenstein asked whether each member of the Board understands that the disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from dismissal to permanent revocation. A roll call was taken:

ROLL CALL:	Dr. Rothermel	- aye
	Dr. Saferin	- aye
	Mr. Giacalone	- aye
	Dr. Edgin	- aye
	Dr. Schottenstein	- aye
	Dr. Johnson	- aye
	Dr. Kalarala	- aye
	Dr. Feibel	- aye
	Dr. Bechtel	- aye

Dr. Schottenstein noted that, in accordance with the provision in section 4731.22(F)(2), Ohio Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further

participation in the adjudication of any disciplinary matters. In the matters before the Board today, Dr. Rothermel served as Secretary and Dr. Saferin served as Supervising Member. In addition, Dr. Bechtel served as Secretary and/or Supervising Member in the matters of Dr. Ange and Dr. Demint. The matter involving Dr. Ross is non-disciplinary and therefore all Board members may vote.

Dr. Schottenstein reminded all parties that no oral motions may be made during these proceedings.

The original Reports and Recommendations shall be maintained in the exhibits section of this Journal.

.....

CONSTANCE E. ANGE, D.O.

.....

Mr. Giacalone moved to approve and confirm Mr. Porter's Findings of Fact, Conclusions of Law, and Proposed Order in the matter of Constance E. Ange, D.O. Dr. Johnson seconded the motion.

.....

A vote was taken on Mr. Giacalone's motion to approve:

ROLL CALL:	Dr. Rothermel	- abstain
	Dr. Saferin	- abstain
	Mr. Giacalone	- aye
	Dr. Edgin	- aye
	Dr. Schottenstein	- aye
	Dr. Johnson	- aye
	Dr. Kakarla	- aye
	Dr. Feibel	- aye
	Dr. Bechtel	- abstain

The motion to approve carried.

State Medical Board of
Ohio

November 8, 2017

Case number: 17-CRF- 0146

Constance E. Ange, D.O.
1231 Lyons Road
Building F
Centerville, OH 45458

Dear Doctor Ange:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to grant or register or renew or reinstate your license or certificate to practice osteopathic medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

(1) On or about August 11, 2010, the Board issued an Order [August 2010 Order], effective September 1, 2010, that suspended your certificate to practice osteopathic medicine and surgery in Ohio for a definite period of ninety days, based upon your violations of Sections 4731.22(B)(12) and 4731.22(B)(20), Ohio Revised Code, related to your prescribing practices. The August 2010 Order further established certain probationary requirements, including that you complete an approved course dealing with the prescribing of controlled substances and an approved course on maintaining adequate and appropriate medical records. On or about November 14, 2012, the Board released you from probation.

(2) In the routine course of your medical practice, you undertook the care of Patients 1 through 8, as identified on the attached Patient Key. (The Patient Key is confidential and not subject to public disclosure.) During the time period of in or around September 2010 through in or around May 2016, you failed to adequately assess, examine and/or treat Patients 1 through 8 related to various psychiatric disorders and/or failed to document the same, including but not limited to not utilizing the data from the Ohio Automated Rx Reporting System consistent with minimal standards of care; failing to adequately justify the basis for specific medications prescribed and/or changes in medication prescribed; failing to corroborate with other treating physicians who were concurrently prescribing controlled substances; failing to assess prescribed controlled substances for risk/benefits in light of controlled substances being prescribed concurrently by other practitioners; and failing to adjust prescribing patterns when you became aware of red flags of misuse of controlled substances.

Your acts, conduct, and/or omissions as alleged in paragraph (2) above, individually and/or collectively, constitute "[f]ailure to maintain minimal standards applicable to the selection or

Mailed 11-9-17

administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as that clause is used in Section 4731.22(B)(2), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraph (2) above, individually and/or collectively, constitute a "departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraph (2) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: General Provisions, Rule 4731-11-02, Ohio Administrative Code.

Furthermore, for any violations that occurred on or after September 29, 2015, the board may impose a civil penalty in an amount that shall not exceed twenty thousand dollars, pursuant to Section 4731.225, Ohio Revised Code. The civil penalty may be in addition to any other action the board may take under section 4731.22, Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to grant or register or renew or reinstate your certificate or license to practice osteopathic medicine and surgery or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that "[w]hen the board refuses to grant or issue a license or certificate to practice to an applicant, revokes an individual's license or certificate to practice, refuses to renew an individual's license or certificate to practice, or refuses to reinstate an individual's license or certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a license or certificate to practice and the board shall not accept an application for reinstatement of the license or certificate or for issuance of a new license or certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,

Kim G. Rothermel, M.D.
Secretary

KGR/JBR/bjr
Enclosures

CERTIFIED MAIL #91 7199 9991 7036 6914 0734
RETURN RECEIPT REQUESTED

cc: Patrick Quinn
35 North Fourth Street
Suite 200
Columbus, Ohio 43215

CERTIFIED MAIL #91 7199 9991 7036 6914 0741
RETURN RECEIPT REQUESTED

IN THE MATTER OF CONSTANCE E. ANGE, DO

17-CRF-0146

NOVEMBER 8, 2017, NOTICE OF OPPORTUNITY FOR HEARING - PATIENT KEY

SEALED TO PROTECT PATIENT CONFIDENTIALITY AND MAINTAINED IN CASE RECORD FILE.

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

August 11, 2010

Constance E. Ange, D.O.
1255-G Lyons Road
Centerville, OH 45458

RE: Case No. 09-CRF-079

Dear Dr. Ange:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Gretchen L. Petrucci, Esq., Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on August 11, 2010, including motions approving and confirming the Findings of Fact and amending Conclusions of the Hearing Examiner, and adopting an Order.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Such an appeal must be taken to the Franklin County Court of Common Pleas.

Such an appeal setting forth the Order appealed from and the grounds of the appeal must be commenced by the filing of an original Notice of Appeal with the State Medical Board of Ohio and a copy of the Notice of Appeal with the Franklin County Court of Common Pleas. Any such appeal must be filed within fifteen (15) days after the mailing of this notice and in accordance with the requirements of Section 119.12, Ohio Revised Code.

THE STATE MEDICAL BOARD OF OHIO

Lance A. Talmage, M.D.
Secretary

LAT:baj
Enclosures

CERTIFIED MAIL NO. 91 7108 2133 3936 3070 7160
RETURN RECEIPT REQUESTED

cc: James L. Leo, Esq.
CERTIFIED MAIL NO. 91 7108 2133 3936 3124 7177
RETURN RECEIPT REQUESTED

Mailed 9-1-10

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of Gretchen L. Petrucci, Esq., State Medical Board Attorney Hearing Examiner; and excerpt of the Minutes of the State Medical Board, meeting in regular session on August 11, 2010, including motions approving and confirming the Findings of Fact and amending the Conclusions of the Hearing Examiner, and adopting an Order; constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of Constance E. Ange, D.O., Case No. 09-CRF-079, as it appears in the Journal of the State Medical Board of Ohio.

This certification is made by authority of the State Medical Board of Ohio and in its behalf.

Lance A. Talmage, M.D.
Secretary

(SEAL)

August 11, 2010
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF *

* CASE NO. 09-CRF-079

CONSTANCE E. ANGE, D.O. *

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on August 11, 2010.

Upon the Report and Recommendation of Gretchen L. Petrucci, Esq., State Medical Board Attorney Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the modification, approval and confirmation by vote of the Board on the above date, the following Order is hereby entered on the Journal of the State Medical Board of Ohio for the above date.

It is hereby ORDERED that Conclusions of Law #2 and #3 be amended as follows:

2. Dr. Ange's acts, conduct and/or omissions, as set forth in Finding of Fact 2 above, individually and/or collectively, constitute "[c]omission of an act in the course of practice that constitutes a misdemeanor in this state, regardless of the jurisdiction in which the act was committed," as set forth in Section 4731.22(B)(12), Ohio Revised Code, to wit: Section 3719.06(C), Ohio Revised Code, Authority of Licensed Health Professional.

3. Dr. Ange's acts, conduct and/or omissions, as set forth in Findings of Fact 2 above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as set forth in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-02(E), Ohio Administrative Code. Pursuant to Rule 4731-11-02(E), Ohio Administrative Code, violation of Rule 4731-11-02(E), Ohio Administrative Code, also violates Sections 4731.22(B)(2) and (6), Ohio Revised Code.

It is further ORDERED that:

A. **SUSPENSION OF CERTIFICATE**: The certificate of Constance E. Ange, D.O., to practice osteopathic medicine and surgery in the State of Oho shall be SUSPENDED for a period of 90 days.

B. **PROBATION:** Upon expiration of the 90-day suspension, Dr. Ange's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least two years:

1. **Obey the Law**: Dr. Ange shall obey all federal, state, and local laws, and all rules governing the practice of osteopathic medicine and surgery in Ohio.

2. **Declarations of Compliance**: Dr. Ange shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which this Order becomes effective. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

3. **Personal Appearances**: Dr. Ange shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which this Order becomes effective, or as otherwise directed by the Board. Subsequent personal appearances shall occur every three months thereafter, and/or as otherwise directed by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.

4. **Controlled Substances Prescribing Course(s)**: Before the end of the first year of probation, or as otherwise approved by the Board, Dr. Ange shall submit acceptable documentation of successful completion of a course or courses dealing with the prescribing of controlled substances. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

In addition, at the time Dr. Ange submits the documentation of successful completion of the course(s) dealing with the prescribing of controlled substances, she shall also submit to the Board a written report describing the course(s), setting forth what she learned from the course(s), and identifying the specificity how she will apply what she has learned to her practice of osteopathic medicine in the future.

5. **Medical Records Course(s)**: Before the end of the first year of probation, or as otherwise approved by the Board, Dr. Ange shall submit acceptable documentation of successful completion of a course or courses on maintaining adequate and appropriate medical records. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

   In addition, at the time Dr. Ange submits the documentation of successful completion of the course(s) on maintaining adequate and appropriate medical records, she shall also submit to the Board a written report describing the course(s), setting forth what she learned from the course(s), and identifying the specificity how she will apply what she has learned to her practice of osteopathic medicine in the future.

6. **Monitoring Physician**: Within 30 days of the date of Dr. Ange's reinstatement or restoration, or as otherwise determined by the Board, Dr. Ange shall submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary and Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Ange and who is engaged in the same or similar practice specialty.

   The monitoring physician shall monitor Dr. Ange and her medical practice, and shall review Dr. Ange's patient charts, including her medical recordkeeping and handling of prescriptions. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

   Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Ange and her medical practice, and on the review of Dr. Ange's patient charts, including her medical

recordkeeping and handling of prescriptions. Dr. Ange shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Ange's declarations of compliance.

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Ange shall immediately so notify the Board in writing. In addition, Dr. Ange shall make arrangements acceptable to the Board for another monitoring physician within 30 days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Dr. Ange shall further ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefore.

The Board, in its sole discretion, may disapprove any physician proposed to serve as Dr. Ange's monitoring physician, or may withdraw its approval of any physician previously approved to serve as Dr. Ange's monitoring physician, in the event that the Secretary and Supervising Member of the Board determine that any such monitoring physician has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

7. **Absences from Ohio**: Dr. Ange shall obtain permission from the Board for departures or absences from Ohio. Such periods of absence shall not reduce the probationary term, unless otherwise determined by motion of the Board for absences of three months or longer, or by the Secretary or Supervising Member of the Board of absences of less than three months, in instances where the Board can be assured that probationary monitoring is otherwise being performed. Further, the Secretary and Supervising Member of the Board shall have discretion to waive part or all of the monitoring terms set forth in this Order for occasional periods of absence of 14 days or less.

   In the event that Dr. Ange resides and/or is employed at a location that is within 50 miles of the geographic border of Ohio and a contiguous state, Dr. Ange may travel between Ohio and that contiguous state without seeking prior approval of the Secretary or Supervising Member provided that Dr. Ange is otherwise able to maintain full compliance with all other terms, conditions and limitations set for in this Order.

8. **Tolling of Probationary Period While Out of Compliance**: In the event Dr. Ange is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that

deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Order.

9. **Required Reporting of Change of Address**: Dr. Ange shall notify the Board in writing of any change of residence address and/or principal practice address within 30 days of the change.

C. **TERMINATION OF PROBATION**: Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Ange's certificate will be fully restored.

D. **REQUIRED REPORTING WITHIN 30 DAYS OF THE EFFECTIVE DATE OF THIS ORDER**:

1. **Required Reporting to Employers and Others**: Within 30 days of the effective date of this Order, Dr. Ange shall provide a copy of this Order to all employers or entities with which she is under contract to provide healthcare services (including but not limited to third-party payors), or is receiving training; and the Chief of Staff at each hospital or healthcare center where she has privileges or appointments. Further, Dr. Ange shall promptly provide a copy of this Order to all employers or entities with which she contracts in the future to provide healthcare services (including but not limited to third-party payors), or applies for or receives training, and the Chief of Staff at each hospital or healthcare where she applies for or obtains privileges or appointments. This requirement shall continue until Dr. Ange receives from the Board written notification of the successful completion of her probation.

   In the event that Dr. Ange provides any healthcare services or healthcare direction or medical oversight to any emergency medical services organization or emergency medical services provider in Ohio, within 30 days of the effective date of this Order, she shall provide a copy of this Order to the Ohio Department of Public Safety, Division of Emergency Medical Services. This requirement shall continue until Dr. Ange receives from the Board written notification of the successful completion of her probation.

2. **Required Reporting to Other State Licensing Authorities**: Within 30 days of the effective date of this Order. Dr. Ange shall provide a copy of this Order to the proper licensing authority of any state or jurisdiction in which she currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Agency, through which she currently holds any license or certificate. Also, Dr. Ange shall provide a copy of this Order at the time of application to the proper licensing authority of any state in which

she applies for any professional license or reinstatement/restoration of any professional license. This requirement shall continue until Dr. Ange receives from the Board written notification of the successful completion of her probation.

3. **Requied Documenation of the Reporting Required by Paragraph (D)**: Dr. Ange shall provide this Board with **one** of the following documents as proof of each required notification within 30 days of the date of each such notification: (1) the return receipt of certified mail within 30 days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Order was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Order to the person or entity to whom a copy of this Order was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the e-mail transmission of a copy of the Order to the person or entity to whom a copy of the Order was e-mailed.

This Order shall be effective immediately upon the mailing of the notification of approval by the Board.

Lance A. Talmage, M.D.
Secretary

(SEAL)

August 11, 2010
Date

STATE MEDICAL BOARD OF OHIO
2010 JUL 15 PM 12: 34

BEFORE THE STATE MEDICAL BOARD OF OHIO

In the Matter of	*	**Case No. 09-CRF-079**
Constance E. Ange, D.O.,	*	**Hearing Examiner Petrucci**
Respondent.	*	

REPORT AND RECOMMENDATION

Basis for Hearing

By letter dated July 8, 2009, the State Medical Board of Ohio [Board] notified Constance E. Ange, D.O., that it had proposed to take disciplinary action against her certificate to practice osteopathic medicine and surgery in Ohio. The Board based its proposed action on two allegations: (a) prior to responding to a Board subpoena, she had removed and destroyed several pages of a patient record; and (b) she had presigned otherwise blank prescription forms and permitted her staff to complete the prescriptions for dangerous drugs and/or controlled substances. Further, the Board alleged that Dr. Ange's acts, conduct, and/or omissions constitute:

- "[c]omission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed," as set forth in Section 4731.22(B)(10), Ohio Revised Code. The Board alleged that the felony was Tampering with Evidence, as set forth in Section 2921.12, Ohio Revised Code.

- "[c]omission of an act in the course of practice that constitutes a misdemeanor in this state, regardless of the jurisdiction in which the act was committed," as set forth in Section 4731.22(B)(12), Ohio Revised Code. The Board identified the misdemeanor as Authority of Licensed Health Professional, Section 3719.06(C), Ohio Revised Code.

- "violating or attempting to violate, directly or indirectly or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as set forth in Section 4731.22(B)(20), Ohio Revised Code. The Board identified Rule 4731-11-02(E), Ohio Administrative Code as the rule violated.

Accordingly, the Board advised Dr. Ange of her right to request a hearing in this matter. (State's Exhibit [St. Ex.] 1A) On July 31, 2009, Dr. Ange requested a hearing. (St. Ex. 1C)

Appearances at the Hearing

Richard Cordray, Attorney General, by Kyle C. Wilcox, Assistant Attorney General, on behalf of the State of Ohio. James J. Leo, Esq., on behalf of Dr. Ange.

Hearing Dates: December 16 and 18, 2009, and April 19, 2010

PROCEDURAL MATTER

After the hearing record closed in December 2009, Dr. Ange filed a motion to supplement the hearing record. The State filed a motion in opposition. By entry issued April 2, 2010, the Hearing Examiner reopened the hearing record in order to allow the parties to present additional testimony and evidence. An additional day of hearing was held on April 19, 2010. The record closed on April 19, 2010.

SUMMARY OF THE EVIDENCE

All exhibits and the transcript, even if not specifically mentioned, were thoroughly reviewed and considered by the Hearing Examiner prior to preparing this Report and Recommendation.

Background

1. Constance E. Ange, D.O, is a child and adult psychiatrist. She earned her undergraduate degree from the University of North Carolina, at Wake Forest. She earned her medical degree in 1974 from the Chicago College of Osteopathic Medicine. She completed a one-year "rotating" internship at Grandview Hospital in Dayton, Ohio, and completed a two-year family-practice residency in Springboro, Ohio. Between 1977 and 1981, Dr. Ange completed a two-year residency in adult psychiatry, and a two-year fellowship in child psychiatry, both at the University of Cincinnati. (Hearing Transcript [Tr.] at 340-342)

2. In 1981, Dr. Ange opened a private psychiatric practice in Dayton, Ohio. In 1984, she moved her psychiatric practice from Dayton, and opened two offices, one in Centerville and the other in Vandalia, Ohio. She continues to see patients at those two offices. She also worked for Mental Health Services of Clark and Madison Counties, where she treated children until approximately July 2006. (Tr. at 21, 25-26, 303, 332, 334, 336, 342-343)

3. Dr. Ange's letterhead reflects that she is board-certified by the American Osteopathic Association and the American Medical Association in both Adult and Child Psychiatry. (St. Ex. 7)

Dr. Ange's Medical Practice and Employees

4. Dr. Ange works four days each week at the Centerville office, and one day each week at the Vandalia office. Dr. Ange testified that, not including her husband, she generally has employed one full-time employee and one part-time employee. (Tr. at 282, 303, 343-344, 357)

5. Richard Fryman is Dr. Ange's husband. He has managed Dr. Ange's psychiatric practice since she opened her practice in 1981, and has had other business endeavors. Mr. Fryman testified that he handles the day-to-day administrative matters of Dr. Ange's practice, including office processes, marketing and advertising. He handled payroll as well until May 2009, when a contractor began handling that function. Mr. Fryman works in a separate office building, and visits the Centerville office each week. (Tr. at 20, 22-24, 82-83, 151, 184, 232-233, 236, 242-243, 246, 249-250, 253, 329, 358-359)

6. Pamela S. Keene worked full-time for Dr. Ange from May 2005 to May 2009. For most of that time, she was the office manager. Her duties included scheduling patients and employees, answering the telephone, checking charts and calling in prescriptions. (Tr. at 20-21, 67, 248-249, 358, 557)

7. Anna M. Fisher worked part-time for Dr. Ange's husband and for Dr. Ange from 2006 to March 2009. Ms. Fisher functioned as a clerk for Dr. Ange's practice. Ms. Fisher is Ms. Keene's daughter. (Tr. at 22, 150, 153, 163, 165, 181, 358)

8. Between 2006 and 2009, Dr. Ange occasionally employed temporary assistants, mostly to cover office duties when Ms. Keene and/or Ms. Fisher were out of the office. (Tr. at 21-22, 31, 125-126, 330)

9. Dr. Ange estimated that she sees approximately 20 patients each day at each of her office locations. Ms. Keene testified that, during her employment with Dr. Ange, the average number of patients each day at the Centerville office was 15 to 20, and the average number of patients each day at the Vandalia office was 25 to 40 patients. (Tr. at 26-27, 282)

10. Dr. Ange's patient charts in the Centerville office were accessible to all staff; they were not locked. At this location, Dr. Ange's patient charts were stored in file cabinets near Ms. Keene's desk and in the "lunchroom." (Tr. at 29-30)

Patient 1

(This evidence is summarized in order to give some context for the Board's investigation and the allegation of removal of pages from Dr. Ange's medical record for Patient 1. The Notice of Opportunity for Hearing does *not* contain any allegation related to Dr. Ange's care and treatment of Patient 1, and thus it is *not* an issue for Board consideration in this matter.)

11. Patient 1 first saw Dr. Ange in her Centerville office on August 6, 2008. She remained a patient for seven and one-half weeks. (St. Ex. 3; Tr. at 138, 156, 300)

12. At her first office visit with Dr. Ange, Patient 1 complained of anxiety, numbness in her fingers and toes, and her brother's suicide. Dr. Ange diagnosed generalized anxiety disorder with panic attacks and chronic pain. Dr. Ange issued a prescription for Tranxene, and she gave Patient 1 samples of Luvox and Seroquel.[1] She instructed Patient 1 to continue the previously prescribed Soma, and to discontinue her other medications, which were Ativan, Lexapro, and Limbitrol. (St. Ex. 3 at 15, 21, 23, 37)

13. On three different occasions in August 2008, Patient 1 consumed more Seroquel than prescribed, and Dr. Ange was informed. On one of those occasions, Patient 1 was taken to the hospital. (St. Ex. 3 at 29, 33, 41, 43)

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[1]Dr. Ange stated that the Luvox was for depression. Seroquel is an antipsychotic medication, which Dr. Ange stated is "good" for borderline personality disorder, and can be used for impulsivity. (Tr. at 299, 313, 315, 344, 352)

14. While Patient 1 was at Dr. Ange's office on September 24, 2010, Patient 1 received samples of Seroquel, approximately two weeks worth. Also, Dr. Ange wrote prescriptions for Seroquel, Luvox, and Tranxene on that same date. (St. Ex. 3 at 47, 49)

15. Patient 1 died on September 27, 2008, from an overdose of Seroquel. (Tr. at 51, 107, 285; St. Ex. 3 at 11)

Board Investigation, December 2008-January 2009

16. On December 22, 2008, Board Investigator Teresa L. Meyer visited Dr. Ange's Centerville office as part of an investigation into Dr. Ange's treatment of Patient 1. Dr. Ange and Ms. Meyer sat in Dr. Ange's office with Patient 1's chart. Dr. Ange reviewed the entire chart, page by page, with Ms. Meyer. Ms. Meyer did not read through the chart herself; instead, she sat on the other side of Dr. Ange's desk, as Dr. Ange explained the information contained in Patient 1's chart. Ms. Meyer took notes during the meeting. (Tr. at 284-285, 287, 380-383, 395)

17. On December 29, 2008, Ms. Meyer prepared a Report of Investigation [ROI], which reflects what she had learned in the course of the investigation from Dr. Ange. (Tr. at 383; St. Ex. 6)

18. In January 2009, Board Investigator Greg McGlaun served a subpoena *duces tecum* on Dr. Ange at her Centerville office. The subpoena requested Patient 1's medical chart. At that time, Ms. Keene, Ms. Fisher, and Dr. Ange were in the office. The medical chart was given to the Board investigator, and a copy was maintained in Dr. Ange's office. (Tr. at 33-35, 152-153, 288, 290)

19. State Exhibit 3 is a photocopy of Dr. Ange's medical chart for Patient 1, as obtained by the Board Investigator in January 2009. (St. Ex. 3; Tr. at 43)

Comparison of the Investigator Report of Investigation and the Medical Chart Obtained in January 2009

20. Ms. Meyer's ROI and the medical chart reflect that Patient 1 visited Dr. Ange on six occasions in August and September 2008. Moreover, other events took place during that time. (St. Exs. 3, 6; Tr. at 138, 305) A brief comparison of the information contained in ROI and the medical chart is as follows:

Date in 2008	Event documented in Investigator's ROI	Event documented in chart
August 6	Patient 1's first office visit.	Patient 1's first office visit.
August 11[2]	Office visit.	Office visit.
August 13	Telephone call from Patient 1.	Telephone call from Patient 1.
August 20	Office visit.	Office visit.

[2]It is possible that this office visit took place on August 21 or August 27, not August 11. The date in the chart is not entirely clear. (Tr. at 309-310)

Date in 2008 (cont.)	Event documented in Investigator's ROI (cont.)	Event documented in chart (cont.)
August 21	Telephone call from Patient 1's landlord/roommate, reporting that Patient 1 went to the emergency room after consuming several prescription medications.	Telephone call from Patient 1's landlord/roommate, reporting that Patient 1 went to the emergency room after consuming an entire bottle of Seroquel.
August 28	Office visit.	Office visit.
September 3	Office visit.	Office visit.
September 9	Patient 1 calls the office numerous times. "Pam took some of the phone calls and let others go into voice mail. The excessive phone calls tied up the phone lines to the office. Pam's notes in the chart indicate that [Patient 1] was drug seeking and was told no more drugs would be prescribed until the next office visit."	
September 24	Office visit.	Office visit.
September 25	Patient 1 calls the office number times "advising her medications were making her feel dizzy and wanted her medications changed over the phone. She was advised this would not be done and told her she needed to come in for an office visit or to go to ER. She refused to do either and thus Pam felt that [Patient 1] was again seeking medications."	
September 27	Telephone call from Patient 1's landlord/roommate.	Telephone call from Patient 1's landlord/roommate.
October 2	Telephone call from Patient 1's landlord/roommate.	Telephone call from Patient 1's landlord/roommate and from the Coroner's office.

(St. Exs. 3, 6) The medical chart obtained in January 2009 does not include anything regarding events on September 9 and 25, 2008.

Testimony of Ms. Keene and Ms. Fisher Regarding the January 2009 Events

21. Ms. Keene and Ms. Fisher both stated that, after the Board Investigator presented the subpoena, Ms. Fisher retrieved Patient 1's medical record from the file cabinets in the lunchroom. They stated that Dr. Ange asked to look at the chart before it was turned over to the Board investigator. Ms. Keene and Ms. Fisher both testified that they were in the lunchroom as Dr. Ange looked through the chart. Ms. Keene stated that she was standing beside Dr. Ange in the lunchroom as she looked through the chart. (Tr. at 37-38, 153, 175-176)

22. Ms. Keene testified as follows regarding the next events:

Q. And what did you notice as [Dr. Ange] flipped through the chart?

A. I was standing to the right, Anna was standing to the left, okay, [Dr. Ange] was in the middle. As she flipped through the chart, okay, she licked her finger and was flipping through, because they're not – they don't have the – I don't know what you call that, you know, the little part up here at the top, the little file holder.

Q. The binder?

A. Yes. They don't have those. They're just single pieces of paper that's in the chart. So there's nothing holding them.

So she licked her finger, and she went through and she pulled out the first five papers that was on top and she laid them over to her left. She stated, "These don't look good on us," and she laid them over to the left.

Then she, you know, continued to flip through the chart. About midway back – Like I said, there wasn't a tremendous amount in the chart, which you can see from here. I'd say about midway back in the chart she took another piece of paper out and laid it over to the side. Then she said, "Okay. That should be fine, make the copy," and handed me back the chart to make the copy.

I did. I walked up to the front, I made the copy of the chart. I stuck it in an envelope like this, but it was kind of white. The gentleman had came back in, okay. I waited for him at the window. He came back in and I handed it to him.

* * *

And the originals went back into the chart. He wanted the original is what he wanted. You know, everything went back into the chart the way it was as far as the copies that we had, you know, I put them back in order.

Q. So you gave him the original?

A. Correct. That's what he asked for.

Q. And then did – What did you observe after that as far as what happened?

A. When I went, you know, to hand him, of course, this chart, she had taken – at the time I had walked out, okay, and was coming around to the window, and Anna was still in there. She took the five or six papers that was there, and she took them into her office.

Q. Okay. Did you see her do that?

A. Yes. Because that's when I walked out to take the chart to him.

* * *

She took them into her office and she shredded them. I know that just because we heard the shredder.

Q. Okay. So you didn't actually observe her shredding them?

A. I did not.

Q. But you heard?

A. The shredder.

Q. Okay. Where was the shredder located?

A. In her office. It's on a trash can. * * * She walked back into her office, and that's when we heard the shredder. Those papers never came back out to me to put back in the chart or to make a copy.

(Tr. at 38-41)

23. Ms. Keene testified as to why she provided Patient 1's file without the pages to the Board Investigator:

> You know, to be honest with you, I think I was just in awe. I think I was just shocked. I didn't understand, you know, what had happened, you know, what had taken place. I didn't know why we took them out. I was just shocked.
>
> I didn't know what to do at that point. I mean, she's my boss. You know, I couldn't say, "Hey, you know, you took those papers out and you'll lose you job over it." I had to – I didn't know what to do. I mean, I really and truly didn't know what to do at the time. So I didn't say anything. I should have, I just didn't.

(Tr. at 41-42)

24. Ms. Fisher testified as follows regarding the events:

> I then pulled the chart out, handed it to Pam. Pam had walked over. At that moment, Dr. Ange had walked out of her office, had walked into the lunchroom with her chart. There was a counter in the room, there's a counter here and there's a refrigerator here.
>
> She had walked over, sat the chart down, opened the chart up, licked her fingers, pulled the first five or six pages out. Sat them aside. Looked through the rest of the chart. Handed the chart to Pam, told her to go make a photocopy of it for herself to have her own record. Pam then took it to the front.
>
> Dr. Ange – Pam walked out, Dr. Ange and then myself. Dr. Ange walked back to her office, which then I heard the shredder run. Then I walked back up front where Pam was making a photocopy of the chart and handed it to the gentleman and he left.

(Tr. at 154-155; See, also, Tr. at 159, 176-177)

25. Ms. Fisher testified that she did not report the removal of pages from Patient 1's chart because she did not know what to do and because she was afraid of being fired. (Tr. at 181)

Descriptions of the Pages Allegedly Removed

26. Ms. Keene testified that Patient 1's chart, as admitted at the hearing, is a copy of what was provided to the Board Investigator. It is a copy of Dr. Ange's chart for Patient 1 without the several pages that Dr. Ange had removed in January 2009. Similarly, Ms. Fisher testified that Patient 1's chart, as admitted at the hearing, is a copy of Dr. Ange's chart for Patient 1 without notes regarding telephone calls from Patient 1. (Tr. at 43, 158, 194-195)

27. Ms. Keene testified that the pages removed by Dr. Ange included notes that Ms. Keene had made. She also stated that "they were pretty important." (Tr. at 42, 44) She initially described those pages as follows:

- Notes from numerous messages that Patient 1 left one day approximately three weeks prior to her death. Ms. Keene checked the answering machine and estimated that it may have been 30 times that day. Ms. Keene stated that Dr. Ange had instructed the other office personnel not to speak with Patient 1. Ms. Keene testified that, when she learned about this, she "went back to the answering machine and literally went through how many times [Patient 1] had called and counted them." (Tr. at 46-47, 49)
- Notes that Ms. Fisher and Mr. Fryman had written. (Tr. at 48-49)

28. Ms. Keene next claimed that she took notes after meeting with Patient 1 on September 24, 2008. Ms. Keene stated that she met alone with Patient 1 for more than one hour that day,

and had taken notes from that office visit. Ms. Keene stated that Patient 1 left the office with a bag of Seroquel samples "because the doctor instructed me to give them to her." Furthermore, Ms. Keene stated that she gave her notes to Dr. Ange, who took the notes, rewrote them and added only the re-written version to the chart. Ms. Keene further stated that a "sticky note" related to this event was missing from the chart. Ms. Keene stated that the "sticky note" was written by her to Dr. Ange, stating that Patient 1 had come into the office and wanted another appointment. Ms. Keene testified that Dr. Ange had written back, stating "No, just give her these and let her go." (Tr. at 67-69, 71, 97-106, 140-141; St. Ex. 3 at 47-49)

29. On a third occasion, Ms. Keene described the removed pages as follows. Ms. Keene is certain that five pages were removed from Patient 1's medical record, and she believes that a sixth page was also removed. Ms. Keene testified that the five pages were notes from phone messages and phone calls from Patient 1. She explained that the notes were written during Patient 1's final three weeks by herself, Ms. Fisher and possibly the temporary assistant. The sixth page was written by Ms. Keene around Patient 1's third office visit (August 20, 2008), and that page reflects a date when Patient 1 had an office appointment, a comment that Patient 1 was a drug seeker, and a list of medications that did not work for her. (Tr. at 135-138)

30. Ms. Fisher testified that the removed pages contained notes about phone calls from Patient 1, which were taken by Ms. Fisher and Ms. Keene, and contained notes between Dr. Ange and Mr. Fryman that referenced Patient 1. Ms. Fisher explained that she spoke with Patient 1 at least 12 to 15 times, and she took notes from those phone calls "[p]robably at least four or five times." Moreover, Ms. Fisher confirmed that, shortly before her death, Patient 1 came into the office and did not see Dr. Ange. Instead, Ms. Keene spoke with Patient 1. Ms. Fisher was aware that Ms. Keene made notes of that meeting. (Tr. at 155, 158-159, 178-180, 190, 192-193)

Dr. Ange's Testimony Regarding the January 2009 Events

31. Dr. Ange recalled that, when she learned of the subpoena, she took Patient 1's chart and reviewed it in her office in order "to make sure there were no misfilings." Dr. Ange stated that she found no misfilings, asked Ms. Keene to copy the chart (so that she would have the copy for her records), and to give the original chart to the Board investigator. (Tr. at 290-292, 316)

32. Dr. Ange denied that she had removed five or six pages from Patient 1's medical chart. Moreover, she stated that there was no reason for her to remove pages from Patient 1's chart because any notes related to telephone calls from Patient 1 would have been helpful. Dr. Ange explained why:

> Because it speaks to the state of the mind of the patient. If she's calling in that much, which I wasn't aware of, but if she was calling in that much and I had [been] privy to those notes, we might have perhaps done things differently. You know, I don't know that, but it would have helped my case.

(Tr. at 293; See, also. Tr. at 346-347, 349-350, 353)

33. Moreover, Dr. Ange denied that only Ms. Keene met with Patient 1 on September 24, and that Dr. Ange rewrote Ms. Keene's notes from that meeting. Dr. Ange testified that she was not aware that Ms. Keene had met with Patient 1 for an hour in September 2008, and she would not have approved of such action if she had known about it. Dr. Ange testified that she personally met with Patient 1 on September 24, generated progress notes from that office visit, and included them in Patient 1's chart. (Tr. at 297-299)

34. Nevertheless, Dr. Ange testified that the copy of Patient 1's medical record which is marked as State Exhibit 3 is not an accurate copy of the medical record provided to the Board investigator in January 2009. (Tr. at 316) She stated:

> Q. When you went over this chart with the investigator from the State Medical Board, Teri Meyer, on December 22nd of 2008, is it your position that there were no notes in the chart from September 25th of 2008?
>
> A. I don't know, because I don't know – I don't know if Pam messed with the chart or not. All I know is this is as close an approximation as I can or not.
>
> When she came in to talk to me, and I'm closer to the rememberance of the patient, if there are a lot of --- like, for example, right now I can tell you she says that she called in because I can remember them talking, but did she call in enough for them to document it and let me know?[3] I don't know. I'm further away from that memory.
>
> Q. Well, you heard Pam testify today that there were notes in the chart she believed which she had written down regarding phone calls that had come in, correct?
>
> A. Correct. I did hear that.
>
> Q. And you believe that those notes didn't – never existed?
>
> A. I don't remember seeing any notes from Pam. Pam's notes would be like phone calls – I'm sorry, would be like notes of phone calls. It may be with Ms. Meyer I said things like, "I'm sure the patient called in a lot," because I might have known about that, but I might not have gotten a note about that.
>
> Q. And you went over the whole chart with Ms. Meyer, correct?

[3]Dr. Ange explained that, although not all calls are noted in the patient records, if a patient calls frequently, her staff should include notes in the patient record so that she is aware of the frequent calling. (Tr. at 345-346)

A. To the best of my knowledge, yes.

(Tr. at 318-319)

35. Moreover, Dr. Ange stated that, during the time that Patient 1 was her patient, Patient 1 probably made many calls to her office. However, Dr. Ange is not aware why Patient 1 called because she did not receive notes about it. (Tr. at 345-346)

36. Dr. Ange acknowledged that she owns a shredder, and that it was probably located in her office in January 2009. At the time of the hearing, the shredder was located by the desk near the reception window. (Tr. at 328, 358)

Testimony of Ms. Meyer

37. Ms. Meyer testified that she did not see notes of any telephone calls from Patient 1 to Dr. Ange's office. However, Ms. Meyer recalled that Dr. Ange *read from* notes in the medical chart that included notes regarding telephone calls. Ms. Meyer does not know how many pages of notes from telephone calls were included in Patient 1's chart. (Tr. at 403, 407)

Discovered Notes

38. Dr. Ange testified that, on January 29, 2010, she was going through patient charts and bills on her desk. She stated that she noticed two pieces of yellow tablet paper sticking out of the pile of files. She stated that they were folded in quarters. She found, when she opened them, that they were dated September 9 and 25, 2008. Dr. Ange stated that there is no patient name on either piece of paper, but because of the dates and the content, she believes the notes relate to Patient 1. (Tr. at 468-471, 475, 507-508, 569)

39. Dr. Ange also explained that Patient 1's chart was not on her desk at the time she discovered the two pieces of paper. However, one of the charts on her desk at the time was for a patient whose last name begins with the same first letter as Patient 1's last name. (Tr. at 473, 476)

40. The first sheet of paper is dated September 9, 2008, and states:

> Doctor Ange she has called probably 20 times. Are you sure you don't want me to talk to her and get her in.
> PK
>
> Anna she said No! Get rid of her! Just let it go to voicemail.
> PK
>
> Don't call her back she is probably seeking meds. Doctor Ange said she knows the situation.
> PK

(Resp. Ex. O)

41. The second sheet of paper is dated September 25, 2008, and states:

> Doctor Ange I don't know what to tell her, she said the meds keep making her dizzy and she keep falling.
> PK
>
> Anna
> Call her back
> Come in for appointment!
> OK
>
> She said she just came in and you didn't change anything.
> ↓
> Anna,
> Doctor Ange said just let it go it is probably a med seeking situation.
> PK

(Resp. Ex. P)

42. Dr. Ange sent the two sheets to the Board in early February 2010. (Tr. at 471-472, 507; St. Ex. 7) Among other things, Dr. Ange stated the following in her cover letter:

> The handwriting on the pages is that of Pam Keene. My writing appears nowhere on the notes. Furthermore, the format of the notes is very different from the format that Ms. Keene used when she took other notes on all other occasions. Ms. Keene seldom wrote any phone messages to be filed in patient charts. If so they were brief: a line or two. One page of notes, much less two pages that reflect a summary of two separate dates all written in the same neat, evenly spaced organized handwriting is highly different. Because of this, I am inclined to believe that both pages were written on the same day – despite the fact that one page is dated September 9, 2008 and another is dated September 25, 2008.
>
> Also, please know that I have not seen these two pages until I very recently discovered them while filing and organizing charts. Please also know that there is no way that I would say some of the things purported on these pages.
>
> While, to my knowledge, these two pages were never in the medical file for the patient, and, because of their suspect nature, I am not certain that they are technically medical records. However, in the spirit of full cooperation and in the interest of erring on the side of full disclosure, I am sending them to you now.

(St. Ex. 7)

Dr. Ange's Testimony Regarding the Discovered Notes

43. Dr. Ange testified that she did not author the two pieces of paper; rather they contain Ms. Keene's handwriting. (Tr. at 480, 512)

44. Dr. Ange acknowledged that, at the time she spoke with Ms. Meyer in December 2008, there were notes in Patient 1's medical chart that addressed telephone calls from Patient 1 on September 9 and 25, 2008. Dr. Ange believes that she read those notes to Ms. Meyer. Dr. Ange reached that conclusion after comparing Patient 1's medical chart and Investigator Meyer's ROI because Ms. Meyer's ROI so closely followed the information in Patient 1's medical chart. Dr. Ange also testified that information related to telephone calls from September 9 and 25, 2008, is missing from Patient 1's medical chart. (Tr. at 489-502, 510-511)

45. Dr. Ange stated that the two discovered pages match Ms. Meyer's description of events from September 9 and 25, 2008. (Tr. at 503)

46. However, Dr. Ange stated that she does not believe that the two discovered pages, Resp. Exs. O and P, are the notes that she read to Ms. Meyer from the medical chart. Dr. Ange believes that Resp. Exs. O and P are contrived for the following reasons: (a) they are very legible, but Ms. Keene's handwriting is not always that legible; (b) the notes do not contain that patient's name or a line between entries, which is the note-taking format that Ms. Keene typically followed; (c) Dr. Ange was in her Vandalia office on September 9 and she would not have had Patient 1's chart in order to have the conversation recorded on Resp. Ex. O; and (d) there is nothing on either note that reflects that Dr. Ange reviewed them. (Tr. at 514-516, 518, 521, 523-524)

47. Later in her testimony, Dr. Ange provided conflicting testimony on this point. Dr. Ange stated that she is not completely certain whether she read Resp. Exs. O and P to Ms. Meyer. Moreover, Dr. Ange also stated that she did review Resp. Exs. O and P with Ms. Meyer, along with State's Exhibit 3. In addition, Dr. Ange stated that she believes she saw Resp. Exs. O and P previously. (Tr. at 564-568)

48. Dr. Ange does not recall her staff informing her that Patient 1 had called 20 times, or telling her staff to let Patient 1's calls go to voicemail. Dr. Ange does not recall telling her staff to "let the situation go because Patient 1 was probably med seeking." Dr. Ange does not believe that Patient 1's chart included notes from her husband or a list of medication changes. (Tr. at 569-570, 572)

49. Dr. Ange believes that Ms. Keene tampered with Patient 1's medical chart and that is the reason the chart was not complete when provided to the Board Investigator in January 2009. (Tr. at 520)

Ms. Keene's Testimony Regarding the Discovered Notes

50. Ms. Keene testified that all the handwriting on Resp. Ex. O is hers, and she wrote all on Resp. Ex. P except "OK," which was written by Ms. Fisher. Ms. Keene stated that both Resp. Exs. O and P relate to Patient 1. (Tr. at 529-530, 534-535, 554)

51. Ms. Keene testified that Resp. Exs. O and P were not placed in Patient 1's medical chart, but "formal notes" of the September 9 and 25, 2008, events were placed in Patient 1's medical chart and remained there until January 2009. Ms. Keene estimated that there was one page of notes from each of those days placed in Patient 1's chart. (Tr. at 533-534, 537-539, 544-547, 554)

52. Ms. Keene explained that the discovered notes were her "informal notes" of the events from those two dates:

> We would just kind of make this note between us, okay. Because if we took a note every single time that a patient called and stuck it in the chart, the chart would be a foot thick.
>
> So at the end of the day, we would go through and kind of, I guess concise everything, you know, at the end of the day, make a formal note and put in the chart.
>
> The way that you know it was a formal note in the chart was that it would have the patient's name at the top and a date. Everything always had the patient's name at the top and the date. That's how you know it was a formal note that went in there. You very seldom would ever see just a note tossed in without a name on it.

(Tr. at 533) She further explained that anyone in the office who created informal notes would create formal notes to be included in the patient records. (Tr. at 540-541)

53. In addition, Ms. Keene stated that she kept these "informal notes" in her desk in a folder marked "Problem Patients." She also testified that she kept the informal notes related to problem patients for a few months thereafter, in case she needed to refer to them.[4] (Tr. at 535-537, 555, 558, 559)

54. Ms. Keene stated that the "formal notes" from September 9 and 25, 2008, are not the only pages removed from Patient 1's medical chart. Ms. Keene contends that two or three other pages of formal notes "that had to do with other issues with the same patient" were removed, and one other page "that Mr. Fryman had written in his own handwriting, and Dr. Ange had

[4]Dr. Ange testified that she never knew that Ms. Keene kept notes in another file folder, and there was no informal/formal note-taking procedure. Moreover, Dr. Ange stated that, after Ms. Keene's termination, she did not find a file in Ms. Keene's desk that contained informal notes related to problem patients. (Tr. at 567, 572-573)

written in her handwriting." Ms. Keene elaborated that one of the pages contained a list of medication changes made. (Tr. at 547, 548, 560)

55. Ms. Keene acknowledged that, although she knew the Board was investigating Dr. Ange regarding Patient 1 and she had seen pages removed from Patient 1's medical chart, she did not produce to the Board any informal notes she kept regarding Patient 1. (Tr. at 561-562)

Dr. Ange's Prescriptions

56. The State presented copies of 12 completed prescriptions written for various other patients of Dr. Ange. All prescriptions were for Ritalin or Adderall,[5] and all were signed by Dr. Ange. The following is a summary of the evidence regarding who completed the other portions of those prescriptions:

Prescription	Who completed the Prescription, per Ms. Keene, and Citation to the Record	Who completed the Prescription, per Dr. Ange, and Citation to the Record
St. Ex. 2 at 2	Ms. Keene (Tr. at 56-57)	Ms. Keene (Tr. at 322)
St. Ex. 2 at 3	A temp (Tr. at 61-62)	Dr. Ange (Tr. at 322-323)
St. Ex. 2 at 4	A temp (Tr. at 62)	Maybe a temp (Tr. at 323)
St. Ex. 2 at 5	A temp (Tr. at 63)	Dr. Ange (Tr. at 323)
St. Ex. 2 at 6	Ms. Keene (Tr. at 63)	Ms. Keene (Tr. at 323)
St. Ex. 2 at 7	Ms. Keene (Tr. at 63)	Ms. Keene (Tr. at 323)
St. Ex. 2 at 8	A temp (Tr. at 64)	Dr. Ange (Tr. at 323)
St. Ex. 2 at 9	Ms. Fisher (Tr. at 64-65; See, also, Tr. at 161-162)	Ms. Fisher (Tr. at 323)
St. Ex. 2 at 10	Ms. Keene (Tr. at 65)	Ms. Keene (Tr. at 324)
St. Ex. 2 at 11	Ms. Keene (Tr. at 65)	Ms. Keene (Tr. at 324)
St. Ex. 2 at 12	Dr. Ange (Tr. at 65)	Dr. Ange (Tr. at 324; See, also, Tr. at 257)
St. Ex. 2 at 13	Ms. Keene (Tr. at 66)	Ms. Keene probably (Tr. at 324)

Testimony of Ms. Keene and Ms. Fisher Regarding Dr. Ange's Prescription-Writing Practices

57. Ms. Keene testified that, each day "whenever we asked," Dr. Ange gave the office personnel some prescription forms that she had signed, but had not otherwise filled out. Ms. Keene noted that Dr. Ange would give five, 10 and sometimes 20 otherwise blank prescription forms. Ms. Keene kept hers at her desk, and the other personnel kept theirs in a folder in the front area of the office. Ms. Keene and Ms. Fisher testified that they and the other office personnel would complete these otherwise blank prescription forms for patients who would

[5]One of the prescriptions was for Methylphenidate. Dr. Ange testified that Methylphenidate is the same as Ritalin. Also, she stated that Ritalin and Adderall are scheduled medications, under Schedule II. (Tr. at 344-345)

come into the office seeking refills of their existing medications. (Tr. at 52-55, 62, 146-147, 164, 180)

Ms. Keene testified that she and the other office personnel completed the otherwise blank prescription forms on their own, without specific instructions from Dr. Ange. Instead, they relied on the patient's chart, following the prior prescription. Ms. Keene described this as an office policy, and noted that even the temporary employees filled out prescription forms based on the patient's prior prescription. (Tr. at 57-59)

58. Ms. Keene stated that this practice began approximately one month after she began working for Dr. Ange and continued until March 2009. Ms. Keene explained that, in March 2009, several presigned, otherwise blank prescription forms were lost, and she wanted to report it to the police. Ms. Keene stated that she was told not to contact the police. Ms. Keene then refused to complete any more otherwise blank prescription forms. Ms. Keene noted that Dr. Ange then altered her procedure to sign the prescription forms and write the first initial and the last name of the patient. (Tr. at 142-144)

59. In addition, Ms. Keene stated that she kept notes on her calendar as to the number of otherwise blank prescriptions she received from Dr. Ange each day. (Tr. at 53)

Ms. Keene also testified that she also would circle a number on an otherwise blank prescription in order to remember the number of otherwise blank prescriptions that Dr. Ange had given to her. Ms. Keene identified an otherwise blank prescription that Dr. Ange had given to her, and Ms. Keene noted that she (Ms. Keene) had circled "10" on the prescription form. (Tr. at 53; St. Ex. 2 at 1) Ms. Keene explained why she had circled the "10" on that prescription:

> Then here, if you look, this was just my own note, okay, this didn't help anybody else but myself. On this prescription you'll see where I circled, there's a 75-100, that's because that day she handed me 10. That would help me remember when she handed them to me what to write on my calendar, okay. Because there's – you know, pretty much say 1 through 9 on those numbers and it would help me.
>
> Now, the old prescriptions didn't have that on there. That's why I wrote it on the calendar, because the old prescriptions never had those numbers. It was just kind of a key for me.

(Tr. at 53-54)

60. Ms. Keene acknowledged that the office personnel completed the Refill/Sample Request Form, and that Dr. Ange provided directions as to what to do when a patient called into the office seeking a refill of an existing prescription. (Tr. at 59-61)

61. Ms. Fisher testified regarding Dr. Ange's prescription-writing practices as well. Ms. Fisher explained that, if the staff knew that a patient was going to need a prescription, the staff

would ask Dr. Ange for a signed prescription form. Ms. Fisher stated that Dr. Ange might presign four or five prescription forms, and the staff was expected to fill-in the rest of the prescription. Ms. Fisher contended that Dr. Ange did not explain how the prescription form was to be completed. Ms. Fisher stated that she would look in the patient's chart and complete the otherwise blank prescription form either based on the last prescription written or based on any note from Dr. Ange regarding a different medication. Ms. Fisher stated that this procedure existed because Dr. Ange would be meeting with patients and did not allow any interruptions. (Tr. at 165, 188-189)

Testimony of Dr. Ange and Mr. Fryman Regarding Dr. Ange's Prescription-Writing Practices

62. Dr. Ange noted that, until July 2009, there were three ways in which she prescribed medications to her patients:

- She personally wrote the prescription in its entirety, and carbon copied it in the patient's progress notes.
- She authorized a refill of an existing medication directly to the pharmacy following receipt of a refill request from the pharmacy.
- She authorized a refill after a patient called in and asked for a prescription that continued an existing medication. In this circumstance, she signed the prescription form, and directed her staff to complete the remainder of the prescription form.[6]

(Tr. at 272, 280)

63. With regard to the first methodology by which Dr. Ange issued prescriptions, she explained that she would personally write the prescriptions with carbon paper while meeting with the patients. As a result of this practice, her progress notes include a carbon copy of the handwritten portions of the prescriptions. On these occasions, the prescriptions are written entirely by Dr. Ange. (Tr. at 244, 255, 259, 265-266, 280; See, also, St. Ex. 3 at 23, 25, 45, 47, 49; Resp. Ex. C)

Mr. Fryman and Dr. Ange estimated that, until July 2009, 95 percent of Dr. Ange's prescriptions were written fully by her at the time she was seeing the patient and were carbon copied on the progress notes. (Tr. at 244, 264, 325)

64. With regard to the second method by which prescriptions are issued by Dr. Ange, she explained that it is a relatively recent development for the pharmacies to send refill requests. Dr. Ange testified that, in this situation, a form is completed for the pharmacy that authorizes or does not authorize the requested medication, and it is sent by facsimile to the pharmacy. (Tr. at 271)

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[6]Dr. Ange stated that if the patient called in asking for a new medication, her policy is to require the patient to see her first. (Tr. at 270)

65. With regard to the third manner in which prescriptions were issued by Dr. Ange, Mr. Fryman and Dr. Ange explained that, for at least 10 years when a patient called the office and asked to have another prescription of an existing medication, the office policy had been to have the staff complete a Refill/Sample Request Form. Dr. Ange reviewed the form and the patient chart to determine what to prescribe. Dr. Ange stated that, if she agreed with the request, she may write "Okay" or put her initials on the form. If the prescription were called into a pharmacy, her staff would make that telephone call. If a prescription were generated for the patient to pick up, Dr. Ange would sign an otherwise blank prescription form and attach it to the patient chart. Then, her staff would *complete* the prescription form. Dr. Ange stated that she delegated that prescription-completion duties in order to save time, and she acknowledged that Ms. Keene completed the prescription forms in this circumstance. Mr. Fryman and Dr. Ange further stated that less than five percent of the prescriptions that Dr. Ange issued were generated from the Refill/Sample Request form process. (Tr. at 251-252, 254, 258, 267-276, 280, 329, 353; Resp. Exs. A, B)

Dr. Ange acknowledged that, with this procedure for handling patients who seek refills, she was not aware what occurred with the otherwise blank prescription forms. She explained that she had not considered that risk because she had been more focused on ensuring that appropriate documentation of the patients' telephone calls took place. (Tr. at 354-356)

66. When asked why she would ever sign a prescription form and not fill it out, Dr. Ange testified:

> Because I actually believed that I was doing it the correct way. I thought the way that I was doing it with the proper procedures in place and decreasing the risk of anybody being able to, like, steal a scrip and kind of stuff, I thought I had everything covered.
>
> I thought if you told me what the chart was – I'm sorry, if you told me who the patient was, if you told me what the medication was, if you hooked it up to a chart and I looked at it and I saw what was needed, I thought I was generating a progress note for the chart that day.
>
> I thought I was – You know, I've come to learn that maybe there's another way to look at that. But at the time that I did it that way, I believed I was fulfilling all the requirements and I was doing it the proper way, so there would be documentation – if a patient calls, there would be documentation and it would be in the chart.

(Tr. at 326-327)

67. Dr. Ange testified that she no longer reviews a Refill/Sample Request Form, provides a signed prescription and authorizes her staff to complete the prescription form. Beginning in July 2009, Dr. Ange now completes all prescription forms by herself. Additionally, she has updated the refill form that is completed by her staff. (Tr. at 277-279, 328, 355; Resp. Ex. D)

68. In response to Ms. Keene's claim that she kept several presigned, otherwise blank prescription forms in her desk, Dr. Ange stated that it was untrue. Dr. Ange explained that she only signed blank prescription forms in response to patient refill requests and provided them to her staff to complete the prescription form as authorized. (Tr. at 281-282)

69. Dr. Ange agreed that, among the State's Exhibits, is a prescription form that contains her signature and is otherwise blank. Dr. Ange stated that it exists because she believes that Ms. Keene was able to get extra signed prescriptions from her. (Tr. at 322, 326)

70. Mr. Fryman stated that Dr. Ange does not have a policy of providing signed, but otherwise blank prescription forms. He further stated that he has never seen her do that. (Tr. at 243-244. 252-253)

Evidence Regarding the Witnesses' Credibility

71. Ms. Keene acknowledged that she was involved in three different collection matters while she was employed with Dr. Ange. (Tr. at 108)

- One collection matter involved Ford Motor Credit Company LLC. Ms. Keene testified that it was resolved by garnishment of her husband's paycheck, and that she had spoken to Dr. Ange in full about this debt. (Tr. at 110-111, 120-121)

  However, Dr. Ange presented a January 2008 letter from the debt collector. That letter was addressed to Dr. Ange, "Attn: Payroll," seeking to garnish Ms. Keene's pay. Mr. Fryman testified that the January 2008 letter was found in Ms. Keene's desk after her employment was terminated in May 2009. (Tr. at 236; Resp. Ex. F)

- The second collection matter involved Kohler Foods Inc. Ms. Keene testified that this matter was resolved in 2007 after she paid the debt. (Tr. at 109-110)

  Dr. Ange presented a May 2007 Order and a May 2007 Citation from the Kettering Municipal Court, through which the Court scheduled a contempt hearing and cited Dr. Ange for failure to comply with a court order. Mr. Fryman testified that, in May 2007, he found the May 2007 Order and a May 2007 Citation on Ms. Keene's desk. He believes they had just been delivered. Mr. Fryman testified that neither he nor Dr. Ange knew about the Kohler Foods Inc. collection matter until that time, and that Ms. Keene initially acted as though she knew nothing about the matter. Mr. Fryman further testified that, soon thereafter, the debt was paid in full, and Dr. Ange did not need to attend the contempt hearing. (Tr. at 233-235, 239; Resp. Ex. E)

- The third collection matter involved RKL Investments. This debt developed after Ms. Keene had co-signed a property lease for Ms. Fisher and her husband. They left the property before the lease expired and left it in a damaged condition. Rodney K. Litteral, owner of RKL Investments, testified that the outstanding debt was $2,500. RKL Investments attempted to work with Ms. Keene, but Mr. Litteral contends that she used deceptive practices and repeatedly avoided payment.[7] RKL Investments turned the matter over for collection. Its collection agent filed suit, obtained a judgment against Ms. Keene, and in May 2007 began garnishment proceedings. RKL Investments' collection agent had difficulty obtaining service of the garnishment documents, and repeatedly contacted Dr. Ange's office, as Ms. Keene's employer, to complete the garnishment. Ms. Keene stated that she did not intercept any portion of RKL documentation sent to Dr. Ange's office. (Tr. at 111-112, 121-124, 199-200, 212, 216, 223-229; Resp. Ex. I)

  Sarah Jones, a paralegal with RKL Investments' collection agent, testified that she had contacted Dr. Ange's office on numerous occasions and supposedly had spoken to different employees of the office, but they all had the same, distinctive voice. Ms. Jones further explained that there were numerous excuses given as to why the garnishment could not be completed. Later, some payments on the debt were made directly by Ms. Keene, and the collection agent "backed off" the garnishments. Ms. Jones later discovered the distinctive voice was actually Ms. Keene's voice. Ms. Jones stated that, by May 2008, all payments had stopped, and the collection agent sought to hold Dr. Ange in contempt for failure to comply with the garnishment order. Ms. Keene accepted service of the contempt complaint for Dr. Ange at her Centerville office. In February 2009, the collection agent sued Dr. Ange for failure to garnish Ms. Keene's wages, seeking to hold Dr. Ange personally liable for all amounts unpaid by Ms. Keene. Because Dr. Ange did not respond to the February 2009 complaint, the Dayton Municipal Court issued a judgment against her. As of the date of Dr. Ange's Medical Board hearing, the debt was not completely paid off, but Dr. Ange had entered into a payment plan. (Tr. at 202-212, 215, 219; Resp. Exs. J-M)

72. With regard to the debts, Ms. Keene admitted that there were payment receipts that were sent to the attention of Dr. Ange's office that Ms. Keene did not give to Dr. Ange. Instead, Ms. Keene took them. She also acknowledged that she intercepted the 2007 Kettering Municipal Court Order and Citation addressed to Dr. Ange in the Kohler Foods collection matter, but did so because the debt had been paid and therefore the matter "had already been

[7]Mr. Litteral stated that Ms. Fisher and her husband were not "collectible," and he chose to collect from Ms. Keene. (Tr. at 224)

resolved." She explained that all three matters have been paid in full and are resolved. (Tr. at 114-115, 118-119, 134; Resp. Ex. E)

73. Ms. Keene acknowledged that, while employed by Dr. Ange, she had created a curriculum vitae [CV] and that it contained numerous untrue statements regarding her job responsibilities. Ms. Keene stated, however, that she had not included the untrue statements; rather Dr. Agrawal "had beefed up" her CV. Dr. Agrawal collaborated with Dr. Ange in order to involve Dr. Ange in clinical trials. Ms. Keene stated that her CV was changed in order to "make it fit what would need to be sent off to the clinical trial companies." Ms. Keene further testified that Dr. Agrawal accessed the document on her computer, and that she knew he was making changes that were untruthful. Additionally, Ms. Keene stated that she was concerned about the inaccurate information in the CV, but did not object to the changes after she learned that her CV would not need to be provided in order to obtain the clinical trial work. She did not use the CV to obtain employment either. Ms. Keene, nonetheless, left the draft document on her computer because she "didn't want him to go back and add other things to it on his computer and send it out." (Tr. at 76-94, 134; Resp. Ex. G)

74. In May 2009, Mr. Fryman gave Ms. Keene a note stating that her services were no longer needed. Ms. Keene testified that her employment with Dr. Ange ended amicably and on good terms. (Tr. at 67, 94-95)

Dr. Ange explained that she terminated Ms. Keene's employment in 2009, after learning that Ms. Keene had taken mail intended for Dr. Ange and after Dr. Ange had become responsible for the outstanding RKL debt. Dr. Ange further stated that she did not immediately terminate Ms. Keene, although she had been advised to do so, because it had been difficult for her to terminate Ms. Keene. Dr. Ange stated that Ms. Keene's employment ended in a "pretty strained" manner, and that Ms. Keene was pretty angry and did not say goodbye. Similarly, Mr. Fryman stated that, at the end of Ms. Keene's employment, their relationship with her was very strained. Moreover, a peace officer was present in the office at the time that Ms. Keene was expected to retrieve her last paycheck. (Tr. at 237-238, 304, 359-361)

75. Ms. Fisher stated that she left Dr. Ange's practice on good terms, after she had found a full-time position with benefits. She stated that she had looked for another position because she wanted to work more hours, wanted more stability, and wanted a less stressful environment. She stated that she has no bias against Dr. Ange or her husband. (Tr. at 165-166, 181-182, 185-186)

Ms. Fisher acknowledged that, shortly before leaving Dr. Ange's employ, she had written to Mr. Fryman, complaining, among other things, that she was not treated fairly and not given sufficient hours. Ms. Fisher testified that, during her entire employment with Dr. Ange and Mr. Fryman, "[w]e were always fighting battles like this, but it never changed anything." She started her new job one week after leaving Dr. Ange's employ. Ms. Fisher did not inform Dr. Ange that she had obtained new employment. (Tr. at 185-186; Resp. Ex. N)

With regard to Ms. Fisher's departure, Dr. Ange explained that she was aware that Ms. Fisher was upset, but she had been offered extra work hours. Dr. Ange stated that Ms. Fisher did not want the offered times and was looking for full-time benefits. Dr. Ange feels that Ms. Fisher's departure was not particularly contentious, however. (Tr. at 362-363)

76. Ms. Fisher testified that she spoke with Ms. Keene about the removal of documents from Patient 1's chart the day that it had happened. She stated that she also spoke with Ms. Keene about the event shortly before the hearing. (Tr. at 176-178)

77. Mr. Fryman stated that "it may be true" that he has been sued 54 times in Montgomery County. He acknowledged that the Internal Revenue Service has filed a lien alleging that Mr. Fryman and Dr. Ange owe the Internal Revenue Service over $800,000. Mr. Fryman contends that the lien is incorrect. (Tr. at 241, 245)

78. Ashesh Agrawal, M.D., testified on behalf of Dr. Ange. He explained that he earned his medical degree in India and is not practicing as a physician in the United States. Rather, Dr. Agrawal is Clinical Director at the Dayton Science Institute. He assists pharmaceutical companies establish clinical trials with various physicians. (Tr. at 416, 421-422)

Dr. Agrawal testified that he first met Ms. Keene when she was working for a physician prior to Dr. Ange. Dr. Agrawal denied that he had asked Ms. Keene to provide her CV for purposes of establishing a clinical trial for Dr. Ange. Also, Dr. Agrawal denied that he had ever told Ms. Keene to include fabrications in her CV for purposes of establishing a clinical trial. He stated that there would have been no reason for Ms. Keene to include false statements because she would not be a clinical person involved with a trial. Dr. Agrawal also testified that he never had access to Ms. Keene's computer. Dr. Agrawal further noted that he did not conduct a clinical trial with Dr. Ange because no pharmaceutical company was willing to accept Dr. Ange. (Tr. at 418-420, 423-424, 426)

RELEVANT OHIO LAW

Section 2921.12, Ohio Revised Code, states:

> (A) No person, knowing that an official proceeding or investigation is in progress, or is about to be or likely to be instituted, shall do any of the following:
>
> (1) Alter, destroy, conceal, or remove any record, document, or thing, with purpose to impair its value or availability as evidence in such proceeding or investigation;
>
> (2) Make, present, or use any record, document, or thing, knowing it to be false and with purpose to mislead a public official who is or may be engaged in such proceeding or investigation, or

with purpose to corrupt the outcome of any such proceeding or investigation.

(B) Whoever violates this section is guilty of tampering with evidence, a felony of the third degree.

Section 3719.06(C), Ohio Revised Code, states:

Each written prescription shall be properly executed, dated, and signed by the prescriber on the day when issued and shall bear the full name and address of the person for whom, or the owner of the animal for which, the controlled substance is prescribed and the full name, address and registry number under the federal drug abuse control laws of the prescriber. If the prescription is for an animal, it shall state the species of the animal for which the controlled substance is prescribed.

Pursuant to Section 3719.99(E), Ohio Revised Code, "[w]hoever violates section 3719.05, 3719.06, * * * of the Revised Code is guilty of a misdemeanor of the third degree. If the offender has been convicted of a violation of section 3719.05, 3719.06, * * * of the Revised Code or a drug abuse offense, a violation of section 3719.05, 3719.06, * * * of the Revised Code is a misdemeanor of the first degree."

Rule 4731-11-02, Ohio Administrative Code, states in relevant part:

(E) A physician shall obey all applicable provisions of sections 3719.06, * * * of the Revised Code, and all applicable provisions of federal law governing the possession, distribution, or use of controlled substances.

(F) A violation of any provision of this rule, as determined by the Board, shall constitute "failure to maintain minimal standards applicable to the selection or administration of drugs," as that clause is used in division (B)(2) of section 4731.22 of the Revised Code; and a "departure from, or the failure to conform to, minimal standards of care of similar physicians under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in division (B)(6) of section 4731.22 of the Revised Code. * * *

FINDINGS OF FACT

1. In January 2009, Constance E. Ange, D.O., was served with an investigative subpoena *duces tecum* by an investigator from the Board, requiring her to produce the complete, original patient record for the patient identified on the patient key attached to the subpoena [Patient 1].

   The evidence is insufficient to establish that, prior to producing the original patient record, Dr. Ange removed and destroyed several pages of documentation contained in Patient 1's patient record.

2. Dr. Ange presigned otherwise blank prescriptions prior to their issuance. Further, Dr. Ange has permitted members of her office staff who are not legally authorized to prescribe to complete the presigned prescriptions for patients for dangerous drugs and/or controlled substances.

CONCLUSIONS OF LAW

1. The acts, conduct and/or omissions of Constance E. Ange, D.O., as set forth in Finding of Fact 1 above, individually and/or collectively, do not constitute "[c]omission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed," as set forth in Section 4731.22(B)(10), Ohio Revised Code, to wit: Section 2921.12, Ohio Revised Code, Tampering with Evidence.

2. Dr. Ange's acts, conduct and/or omissions, as set forth in Finding of Fact 2 above, individually and/or collectively, do not constitute "[c]omission of an act in the course of practice that constitutes a misdemeanor in this state, regardless of the jurisdiction in which the act was committed," as set forth in Section 4731.22(B)(12), Ohio Revised Code, to wit: Section 3719.06(C), Ohio Revised Code, Authority of Licensed Health Professional.

3. Dr. Ange's acts, conduct and/or omissions, as set forth in Finding of Fact 2 above, individually and/or collectively, do not constitute "violating or attempting to violate, directly or indirectly or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as set forth in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-02(E), Ohio Administrative Code.

RATIONALE

The issues in this matter turn on the credibility of the State's witnesses. With regard to the removal of pages from Patient 1's medical chart, the Hearing Examiner is convinced that certain documentation was in Patient 1's chart when Dr. Ange met with Ms. Meyer in December 2008, but not provided to the Board in January 2009. Two different versions of what happened to the documentation were presented. Similarly, with regard to Dr. Ange's prescription-writing, the witnesses presented two different versions of the manner in which prescriptions were completed for current patients who sought additional prescriptions of existing medications.

In weighing the testimony, the Hearing Examiner finds that Ms. Keene and Ms. Fisher did not provide credible testimony. Ms. Keene presented inconsistent descriptions of the documentation that was removed from Patient 1's chart. She did not testify truthfully at the hearing regarding the termination of her employment with Dr. Ange or about intercepting Dr. Ange's mail. She also lied repeatedly to RKL Investments and its debt collector. She skirted her responsibilities with several debts, and allowed her CV to contain blatant lies. As a result, she was not a trustworthy witness.

Ms. Fisher, also presented inconsistent testimony about her relationship with Dr. Ange and her husband. She first described her departure from Dr. Ange's office as amicable, but a note that she wrote just prior to her departure demonstrates that she was quite unhappy with them. Then, in explaining the note, Ms. Fisher testified that she was "always fighting battles" with Dr. Ange and her husband. Their relationship was not amicable, and Ms. Fisher was not truthful at hearing on that point. Moreover, Ms. Fisher discussed the removal of documentation from Patient 1's chart with her mother shortly before the hearing. Furthermore, Ms. Fisher is personally related to Ms. Keene. Collectively, these factors convinced the Hearing Examiner that Ms. Fisher was not a trustworthy witness too.

With regard to the prescription-writing allegation, the Hearing Examiner disagrees with the State for two reasons. First, the Hearing Examiner disagrees with the State's interpretation of Section 3719.06(C), Ohio Revised Code. The State argues that Section 3719.06(C), Ohio Revised Code, requires the prescriber to complete the prescription form in its entirety. The plain language of that statute does not require all parts of the prescription form be completed exclusively by the prescriber. A reasonable reading of the statute would permit a prescriber's staff to complete portions of the prescription form, so long as the prescriber is the person who signs the prescription, and the prescription complies with the directives of the prescriber. Second, the Hearing Examiner did not find Ms. Keene and Ms. Fisher to be credible witnesses. Dr. Ange testified convincingly that, upon patient request and her concurrence for another prescription for an existing medication, she signed prescription forms and gave them to her staff for completion, consistent with that medication's prior prescription. Also, Dr. Ange presented documentation to support her contention that, if she agreed with the medication request, she would "okay" the request and her staff would carry out the prescription process for her (in that situation, by calling a pharmacy). Ms. Keene's and Ms. Fisher's testimony of receiving numerous presigned prescription forms for completion in any manner they chose was unconvincing. Also, Ms. Keene's testimony of keeping track of presigned prescriptions by circling numbers directly on the prescriptions was nonsensical.

In the end, the State did not sustain its burden of proof. The Hearing Examiner is not convinced that the State's evidence establishes by a preponderance of the evidence that the alleged violations occurred.[8] Accordingly, it is recommended that the allegations be dismissed.

[8]This statement is not intended to mean that the Hearing Examiner fully accepts Dr. Ange's version of all events, however.

PROPOSED ORDER

It is hereby ORDERED, that the allegations against Constance E. Ange, D.O., as set forth in the July 8, 2009 Notice of Opportunity for Hearing, Case No. 09-CRF-079, are DISMISSED.

This Order shall become effective immediately upon the mailing of the notification of approval by the Board.

Gretchen L. Petrucci
Hearing Examiner

State Medical Board of Ohio

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EXCERPT FROM THE DRAFT MINUTES OF AUGUST 11, 2010

REPORTS AND RECOMMENDATIONS AND PROPOSED FINDINGS AND PROPOSED ORDERS

Dr. Amato announced that the Board would now consider the Reports and Recommendations, and the Proposed Findings and Proposed Order appearing on its agenda.

Dr. Amato asked whether each member of the Board had received, read and considered the hearing records; the Findings of Fact, Conclusions of Law, Proposed Orders, and any objections filed in the matters of: Constance E. Ange, D.O.; Robert Edward Barkett, Jr., M.D.; Thomas Michael Bender; James A. Handley, L.M.T.; Roy William Harris, D.O.; Harold M. Jones, D.P.M.; Sarah Ann Lewis, M.D.; Christopher Allan Rice, M.D.; and Richard Joseph Sievers, II, D.O. A roll call was taken:

ROLL CALL:	Dr. Strafford	- aye
	Mr. Hairston	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Amato	- aye
	Mr. Albert	- aye
	Dr. Madia	- aye
	Dr. Talmage	- aye
	Dr. Suppan	- aye
	Mr. Morris	- aye
	Dr. Ramprasad	- aye

Dr. Amato asked whether each member of the Board understands that the disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from dismissal to permanent revocation. A roll call was taken:

ROLL CALL:	Dr. Strafford	- aye
	Mr. Hairston	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Amato	- aye
	Mr. Albert	- aye
	Dr. Madia	- aye
	Dr. Talmage	- aye
	Dr. Suppan	- aye
	Mr. Morris	- aye
	Dr. Ramprasad	- aye

Dr. Amato noted that, in accordance with the provision in Section 4731.22(F)(2), Ohio Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of these matters. In the matters before the Board today, Dr. Talmage served as Secretary and Mr. Albert served as Supervising Member. Additionally, in the case of Robert Edward Barkett, Jr., M.D., Dr. Amato served as Acting Supervising Member.

Dr. Amato reminded all parties that no oral motions may be made during these proceedings.

The original Reports and Recommendations shall be maintained in the exhibits section of this Journal.

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CONSTANCE E. ANGE, D.O.

Dr. Amato directed the Board's attention to the matter of Constance E. Ange, D.O. He advised that objections were filed to Hearing Examiner Petrucci's Report and Recommendation and were previously distributed to Board members.

Dr. Amato continued that a request to address the Board has been timely filed on behalf of Dr. Ange. Five minutes would be allowed for that address.

Dr. Ange was accompanied by her attorney, James Leo.

Mr. Leo stated that Dr. Ange has been practicing medicine for approximately thirty years, during which she has had no successful malpractice suits against her, nor any disciplinary actions except the one currently before the Board. Mr. Leo stated that this case concerns the method in which Dr. Ange prescribed medication. Mr. Leo noted that the Hearing Examiner recommended that this case be dismissed.

Mr. Leo explained that Dr. Ange had utilized a process by which, if a patient needed a refill of prescription medication, then a Refill/Sample Request Form was used. A staff person would write the patient's name and prescription on the form, then Dr. Ange would review the form and the patient's chart. Dr. Ange would then either approve or deny the request. If Dr. Ange approved the request, she would give a written prescription with her name signed on the bottom to the staff and the staff would copy verbatim the contents of the Refill/Sample Request Form onto the script.

Mr. Leo stated that Dr. Ange's prescribing habits were in technical compliance with Section 3719.06, Ohio Revised Code, which states that a written prescription "shall be properly executed, dated, and signed by the prescriber." Dr. Leo noted that the Section 3719.06 does not say that the prescriber shall properly execute, date, and sign the prescription. Under the statute, the prescriber is only required to sign the prescription.

Mr. Leo stated that Dr. Ange's process did not involve her simply telling her staff to fill in blank prescriptions at their own will, but to copy verbatim what was stated on the Refill/Sample Request Form. Mr. Leo noted that Mr. Wilcox had stated that such a practice would open the door to *carte blanche* fraud and staff members could write any prescription that wanted. Mr. Leo stated that, in fact, the possibility of that form of fraud exists under any process, whether or not the physician fills out the whole prescription. Mr. Leo noted that there is no law requiring a physician to keep prescription pads under lock and key, and therefore, any staff member in any physician's office could engage in such fraud.

Mr. Leo continued that Dr. Ange's case is different from other prescibing cases that have come before the Board because none of the previous cases had an authorization form process like Dr. Ange's. Dr. Leo stated that Dr. Ange's practice was vastly different from cases in which a phsycian gives signed prescritions to his or her staff to fill out without further direction.

Mr. Leo stated that in a practical sense, the case against Dr. Ange is moot because she has not used this process for about a year. Mr. Leo stated that Dr. Ange now fills out all prescriptions in their entirely, except for call-ins to pharmacies, a process which does not involve staff members.

Mr. Leo asked the Board to affirm the Hearing Examiner's Proposed Order and dismiss this case.

Dr. Amato asked if the Assistant Attorney General wished to respond. Mr. Wilcox replied that he did wish to respond.

Mr. Wilcox disagreed with Mr. Leo's argument that there is a significant difference between Dr. Ange's actions and leaving pre-signed prescription forms with staff. Mr. Wilcox stated that, if the Board believed Dr. Ange's testimony about the convoluted system she developed for prescription refills, then the fact remains that Dr. Ange pre-signed blank prescriptions. When a prescription is pre-signed by a physician, then someone of ill will can use it to obtain as many pills of any drug they wish.

Mr. Wilcox submitted that Dr. Ange's practice is in violation of the prescribing rules and of Section 3719.06, Ohio Revised Code. Mr. Wilcox stated that the language of Section 3719.06, that each written prescription "shall be properly executed, dated, and signed bythe prescriber on the date issued," is clear and concise. Mr. Wilcox continued that the Pharmacy Board rules and the Code of Federal Regulations make it clear that a prescriber must treat a prescription as they would any legal document and that the prescriber is ultimately responsible for what is written on the prescription. Mr. Wilcox stated that there is no provision in the law that allows for pre-signed blank prescriptions to be placed in the hands of untrained office staff.

Mr. Wilcox noted that in her hearing testimony, Dr. Ange stated that her staff were essentially liars and lowlifes. Dr. Ange made these statements in an effort to attack and destroy the credibilty of her office manager, who had accused Dr. Ange of destroying records and tampering with evidence. However, Dr. Ange also argues that it is perfectly acceptable to trust this office manager and other untrained staff with

pre-signed blank prescriptions on a routine basis. Mr. Wilcox noted that Dr. Ange empoyed this office manager for four years.

Mr. Wilcox stated that this case proved the state's argument that if a physician pre-signs blank prescriptions, then they are ultimately bestowing their exclusive power to prescribe onto office employees. Mr. Wilcox pointed out that Dr. Ange has admitted that she was not aware of what occurred with the otherwise blank prescriptions after she signed them.

Mr. Wilcox suggested that the Board amend the Hearing Examiner's Conclusions of Law 2 and 3 b to reflect that Dr. Ange violated Section 3719.06, Ohio Revised Code, and as a result also violated Sections 4731.22(B)(12), (B)(20), (B)(2), and (B)(6), Ohio Revised Code.

Dr. Steinbergh moved to approve and confirm Ms. Petrucci's Findings of Fact, Conclusions of Law, and Proposed Order in the matter of Constance E. Ange, D.O. Dr. Mahajan seconded the motion.

Dr. Amato stated that he would now entertain discussion in the above matter.

Dr. Steinbergh observed that, in addition to improper prescribing practices, Dr. Ange was also charged with tampering with evidence, namely a medical record prior to its being subpoenaed by the Board. Dr. Steinbergh stated that the record in question was of a patient who died of an overdose of Seroquel which had been prescribed by Dr. Ange. The hearing record included a number of people who testified to witnessing Dr. Ange removing paper from the file, then submitting the rest to the Board in response to its subpoena. Dr. Steinbergh noted that the Hearing Examiner felt there was not enough evidence to discipline Dr. Ange for tampering with evidence, due to the unreliability of the witnesses. However, Dr. Steinbergh suspected that someone had tampered with that medical record.

Dr. Steinbergh continued to the second charge, alleging improper prescribing practices. Dr. Steinbergh stated that a properly executed prescription is signed by a physician after it is written. Otherwise, the prescriber does not know what is on the completed prescription. Dr. Steinbergh stated that nothing would relieve Dr. Ange of the responsibility of signing prescriptions in an appropriate manner. Dr. Steinbergh noted that, according to Dr. Ange, she no longer handles prescriptions in this way, which suggests to Dr. Steinbergh that Dr. Ange recognizes that it was inappropriate.

Dr. Steinbergh stated that she agrees with the State's objections, and therefore is presenting an alternative order. Dr. Steinbergh stated that the alternative order amends Conclusions of Law 2 and 3 to say that Dr. Ange violated the statutes mentioned therein. The alternative order suspends Dr. Ange's medical license for 90 days, then imposes a probationary period of two years. Stipulations of the probationary period require Dr. Ange to take a substance-prescribing course and a medical record-keeping course, as well as a monitoring physician and standard reporting requirements.

Dr. Steinbergh also noted that, as part of the hearing record, Dr. Ange submitted letterhead from her office which identified Dr. Ange as AOA board-certified in adult psychiatry and child psychiatry, and AMA

board-certified in child and adult psychiatry. Dr. Steinbergh stated that, in fact, physicians are not certified by the AMA, but by the ACGME specialty boards, i.e. the American College of Psychiatry and Neurology. The AOA, through its member specialty boards, does certify osteopathic physicians, i.e. the American College of Osteopathic Psychiatry and Neurology. This caused Dr. Steinbergh concern about how Dr. Ange was presenting herself to the public through her letterhead.

Dr. Steinbergh stated that she continues to be concerned about the patient who died from an overdose of Seroquel. Dr. Steinbergh stated that, though Dr. Ange was not charged with violations of the minimal standards of care, the medical record was worrisome. Dr. Steinbergh stated that the medical record included discussions and concerns that the patient had been in the emergency department, where they were aware that the patient was overdosing. The patient subsequently did overdose and die.

Dr. Steinbergh moved to amend the Proposed Order as follows:

CONCLUSIONS OF LAW AND PROPOSED ORDER
IN THE MATTER OF CONSTANCE E. ANGE, D.O.
CASE NO. 09-CRF-079

CONCLUSIONS OF LAW

2. Dr. Ange's acts, conduct and/or omissions, as set forth in Finding of Fact 2 above, individually and/or collectively, constitute "[c]omission of an act in the course of practice that constitutes a misdemeanor in this state, regardless of the jurisdiction in which the act was committed," as set forth in Section 4731.22(B)(12), Ohio Revised Code, to wit: Section 3719.06(C), Ohio Revised Code, Authority of Licensed Health Professional.

3. Dr. Ange's acts, conduct and/or omissions, as set forth in Finding of Fact 2 above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as set forth in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-02(E), Ohio Administrative Code. Pursuant to Rule 4731-11-02(F), Ohio Administrative Code, violation of Rule 4731-11-02(E), Ohio Administrative Code, also violates Sections 4731.22(B)(2) and (6), Ohio Revised Code.

PROPOSED ORDER

It is hereby ORDERED, that:

A. **SUSPENSION OF CERTIFICATE**: The certificate of Constance E. Ange, D.O., to practice osteopathic medicine and surgery in the State of Ohio shall be SUSPENDED for a period of 90 days.

B. **PROBATION**: Upon expiration of the 90-day suspension, Dr. Ange's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least two years:

1. **Obey the Law**: Dr. Ange shall obey all federal, state and local laws, and all rules governing the practice of osteopathic medicine and surgery in Ohio.

2. **Declarations of Compliance**: Dr. Ange shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which this Order becomes effective. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

3. **Personal Appearances**: Dr. Ange shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which this Order becomes effective, or as otherwise directed by the Board. Subsequent personal appearances shall occur every six months thereafter, and/or as otherwise directed by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.

4. **Controlled Substances Prescribing Course(s)**: Before the end of the first year of probation, or as otherwise approved by the Board, Dr. Ange shall submit acceptable documentation of successful completion of a course or courses dealing with the prescribing of controlled substances. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

   In addition, at the time Dr. Ange submits the documentation of successful completion of the course(s) dealing with the prescribing of controlled substances, she shall also submit to the Board a written report describing the course(s), setting forth what she learned from the course(s), and identifying with specificity how she will apply what she has learned to her practice of osteopathic medicine in the

future.

5. **Medical Records Course(s)**: Before the end of the first year of probation, or as otherwise approved by the Board, Dr. Ange shall submit acceptable documentation of successful completion of a course or courses on maintaining adequate and appropriate medical records. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

   In addition, at the time Dr. Ange submits the documentation of successful completion of the course(s) on maintaining adequate and appropriate medical records, she shall also submit to the Board a written report describing the course(s), setting forth what she learned from the course(s), and identifying with specificity how she will apply what she has learned to her practice of osteopathic medicine in the future.

6. **Monitoring Physician**: Within 30 days of the date of Dr. Ange's reinstatement or restoration, or as otherwise determined by the Board, Dr. Ange shall submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary and Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Ange and who is engaged in the same or similar practice specialty.

   The monitoring physician shall monitor Dr. Ange and her medical practice, and shall review Dr. Ange's patient charts, including her medical recordkeeping and handling of prescriptions. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

   Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Ange and her medical practice, and on the review of Dr. Ange's patient charts, including her medical recordkeeping and handling of prescriptions. Dr. Ange shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Ange's declarations of compliance.

   In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Ange shall immediately so notify the Board in writing. In addition, Dr. Ange shall make arrangements acceptable to the Board for another monitoring physician within 30 days after the previously

designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Dr. Ange shall further ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefor.

The Board, in its sole discretion, may disapprove any physician proposed to serve as Dr. Ange's monitoring physician, or may withdraw its approval of any physician previously approved to serve as Dr. Ange's monitoring physician, in the event that the Secretary and Supervising Member of the Board determine that any such monitoring physician has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

7. **Absences from Ohio**: Dr. Ange shall obtain permission from the Board for departures or absences from Ohio. Such periods of absence shall not reduce the probationary term, unless otherwise determined by motion of the Board for absences of three months or longer, or by the Secretary or the Supervising Member of the Board for absences of less than three months, in instances where the Board can be assured that probationary monitoring is otherwise being performed. Further, the Secretary and Supervising Member of the Board shall have discretion to waive part or all of the monitoring terms set forth in this Order for occasional periods of absence of 14 days or less.

   In the event that Dr. Ange resides and/or is employed at a location that is within 50 miles of the geographic border of Ohio and a contiguous state, Dr. Ange may travel between Ohio and that contiguous state without seeking prior approval of the Secretary or Supervising Member provided that Dr. Ange is otherwise able to maintain full compliance with all other terms, conditions and limitations set forth in this Order.

8. **Tolling of Probationary Period While Out of Compliance**: In the event Dr. Ange is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Order.

9. **Required Reporting of Change of Address**: Dr. Ange shall notify the Board in writing of any change of residence address and/or principal practice address within 30 days of the change.

C. **TERMINATION OF PROBATION**: Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Ange's certificate will be fully restored.

D. **REQUIRED REPORTING WITHIN 30 DAYS OF THE EFFECTIVE DATE OF THIS ORDER:**

1. **Required Reporting to Employers and Others**: Within 30 days of the effective date of this Order, Dr. Ange shall provide a copy of this Order to all employers or entities with which she is under contract to provide healthcare services (including but not limited to third-party payors), or is receiving training; and the Chief of Staff at each hospital or healthcare center where she has privileges or appointments. Further, Dr. Ange shall promptly provide a copy of this Order to all employers or entities with which she contracts in the future to provide healthcare services (including but not limited to third-party payors), or applies for or receives training, and the Chief of Staff at each hospital or healthcare center where she applies for or obtains privileges or appointments. This requirement shall continue until Dr. Ange receives from the Board written notification of the successful completion of her probation.

   In the event that Dr. Ange provides any healthcare services or healthcare direction or medical oversight to any emergency medical services organization or emergency medical services provider in Ohio, within 30 days of the effective date of this Order, she shall provide a copy of this Order to the Ohio Department of Public Safety, Division of Emergency Medical Services. This requirement shall continue until Dr. Ange receives from the Board written notification of the successful completion of her probation.

2. **Required Reporting to Other State Licensing Authorities**: Within 30 days of the effective date of this Order, Dr. Ange shall provide a copy of this Order to the proper licensing authority of any state or jurisdiction in which she currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Agency, through which she currently holds any license or certificate. Also, Dr. Ange shall provide a copy of this Order at the time of application to the proper licensing authority of any state in which she applies for any professional license or reinstatement/restoration of any professional license. This requirement shall continue until Dr. Ange receives from the Board written notification of the successful completion of her probation.

3. **Required Documentation of the Reporting Required by Paragraph (D)**: Dr. Ange shall provide this Board with **one** of the following documents as proof of each required notification within 30 days of the date of each such notification: (1) the return receipt of certified mail within 30 days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Order was hand delivered, (3) the original

facsimile-generated report confirming successful transmission of a copy of the Order to the person or entity to whom a copy of the Order was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the e-mail transmission of a copy of the Order to the person or entity to whom a copy of the Order was e-mailed.

This Order shall be effective immediately upon the mailing of the notification of approval by the Board.

Dr. Strafford seconded the motion. A vote was taken:

ROLL CALL:	Dr. Strafford	- aye
	Mr. Hairston	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Amato	- aye
	Mr. Albert	- abstain
	Dr. Madia	- aye
	Dr. Talmage	- abstain
	Dr. Suppan	- aye
	Mr. Morris	- aye
	Dr. Ramprasad	- aye

Dr. Steinbergh moved to approve and confirm Ms. Petrucci's Findings of Fact, Conclusions of Law, and Proposed Order, as amended, in the matter of Constance E. Ange, D.O. Dr. Madia seconded the motion. A vote was taken:

ROLL CALL:	Dr. Strafford	- aye
	Mr. Hairston	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Amato	- aye
	Mr. Albert	- abstain
	Dr. Madia	- aye
	Dr. Talmage	- abstain
	Dr. Suppan	- aye
	Mr. Morris	- aye
	Dr. Ramprasad	- aye

The motion carried.

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

July 8, 2009

Case number: 09-CRF- 079

Constance E. Ange, D.O.
6936 Eastpoint
Centerville, Ohio 45459

Dear Doctor Ange:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice osteopathic medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

(1) In or about January 2009, you were served with an investigative subpoena duces tecum by an investigator from the Board, requiring you to produce the complete, original patient record for the patient identified on the patient key attached to the subpoena. Prior to producing the original patient record, you removed and destroyed several pages of documentation contained in said patient record.

(2) You have pre-signed otherwise blank prescriptions prior to their issuance. Further, you have permitted members of your office staff who are not legally authorized to prescribe to complete prescriptions for patients for dangerous drugs and/or controlled substances from a supply of pre-signed blank prescriptions.

Your acts, conduct, and/or omissions as alleged in paragraph (1) above, individually and/or collectively, constitute "[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed," as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Section 2921.12, Ohio Revised Code, Tampering with Evidence.

Further, your acts, conduct, and/or omissions as alleged in paragraph (2) above, individually and/or collectively, constitute "[c]ommission of an act in the course of practice that constitutes a misdemeanor in this state, regardless of the jurisdiction in which the act was committed," as that clause is used in Section 4731.22(B)(12), Ohio Revised Code, to wit: Section 3719.06(C), Ohio Revised Code, Authority of Licensed Health Professional. Pursuant to Section 3719.99(E), Ohio Revised Code, whoever violates Section 3719.06, Ohio Revised Code, is guilty of a misdemeanor of the third degree.

Mailed 7-9-09

Further, your acts, conduct, and/or omissions as alleged in paragraph (2) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: 4731-11-02(E), Ohio Administrative Code. Pursuant to Rule 4731-11-02(F), Ohio Administrative Code, violation of Rule 4731-11-02(E), Ohio Administrative Code, also violates Sections 4731.22(B)(2) and (6), Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice osteopathic medicine and surgery or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that "[w]hen the board refuses to grant a certificate to an applicant, revokes an individual's certificate to practice, refuses to register an applicant, or refuses to reinstate an individual's certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,

Lance A. Talmage, M.D.
Secretary

LAT/DSZ/flb
Enclosures

CERTIFIED MAIL #91 7108 2133 3936 3068 6946
RETURN RECEIPT REQUESTED