

**BEFORE THE VIRGINIA BOARD OF MEDICINE**

**IN RE:        COURTNEY ROCHELLE CARTER SPAGNOLO, D.O.**  
**License Number:    0102-205390**  
**Case Number:        195479**

---

**ORDER**

---

**JURISDICTION AND PROCEDURAL HISTORY**

Pursuant to Virginia Code §§ 2.2-4019 and 54.1-2400(10), a Special Conference Committee of the Virginia Board of Medicine (“Board”) held an informal conference on April 22, 2021, in Henrico County, Virginia, to inquire into evidence that Courtney Rochelle Carter Spagnolo, D.O, may have violated certain laws and regulations governing the practice of osteopathy in the Commonwealth of Virginia.

Courtney Rochelle Carter Spagnolo, D.O. appeared at this proceeding and was represented by Michael T. Pritchard, Esquire.

**NOTICE**

By letter dated October 5, 2020, the Board sent a Notice of Informal Conference (“Notice”) to Dr. Carter Spagnolo notifying her that an informal conference would be held on December 10, 2021. The Notice was sent by certified and first class mail to the legal address of record on file with the Board. The informal conference was continued at Dr. Carter Spagnolo’s request.

Upon consideration of the evidence, the Board adopts the following Findings of Fact and Conclusions of Law and issues the Order contained herein.

**FINDINGS OF FACT AND CONCLUSIONS OF LAW**

1. Courtney Rochelle Carter Spagnolo, D.O. was issued License Number 0102-205390 to practice osteopathy on August 3, 2018, which is scheduled to expire on March 31, 2022. At all times relevant to the findings contained herein, said license was current and active.

2. Dr. Carter Spagnolo violated Virginia Code § 54.1-2915(A)(3) in that while employed as a locum tenens at a Virginia state psychiatric hospital, she engaged in the following behaviors:

a. During a treatment team meeting on February 26, 2019 with Patient A, a 51-year-old cognitively limited male diagnosed with schizophrenia, she made the following harsh and belittling statements to the patient, which caused the patient to become upset and sad:

- i. That he was very sick and that he could be confined for 20 or more years;
- ii. That he was too sick to have family members visit him;
- iii. After Patient A reported crying after dreaming that his mother had died, that he cried all the time;
- iv. That his joking and laughter were inappropriate.

b. During a treatment team meeting on February 26, 2019, with Patient B, a 34-year-old male diagnosed with bipolar disorder and/or major depressive disorder, she made the following harsh statements to the patient, which caused the patient to become tearful:

- i. That his diagnosis would make him different than the rest of the world;
- ii. That his diagnosis would follow him and people would know about it;
- iii. That his quality of life would be negatively impacted for the rest of his life;
- iv. That his prognosis was poor.

c. During a treatment team meeting on January 31, 2019 with Patient C, a 55-year-old female who had been admitted following a psychotic episode, Dr. Carter Spagnolo repeatedly shook a sand timer and interrupted the patient mid-sentence to tell the patient that she was running out of time.

d. During two separate treatment team meetings with Patient D, an 18-year-old female diagnosed with major depressive disorder, Dr. Carter Spagnolo lectured the patient about the

dangers of inappropriate boundaries with therapists, suggested that the patient was having an inappropriate relationship with her therapist, which caused the patient to become upset and tearful, declared that counseling was not a valid form of therapy, and stated that going to a counselor repeatedly without progress was “the definition of insanity.”

e. During a treatment team meeting on February 5, 2019 with Patient E, a 57-year-old male who had been admitted due to unspecified psychosis not due to a substance or known physiological condition, when the patient was unable to give sufficient details regarding his psychosis and paranoid thoughts, Dr. Carter Spagnolo stated that she would be more inclined to give him a “harsher” or more serious diagnosis, such as schizophrenia, if she continued to hear that he was psychotic or paranoid. At subsequent treatment team meetings, Patient E was quick to deny any psychosis.

f. During a treatment team meeting on March 14, 2019 with Patient F, a 27-year-old male diagnosed with bipolar personality disorder who had been admitted subsequent to threatening suicide after his wife left him, Dr. Carter Spagnolo repeatedly accused the patient of being a “stalker” in an aggressive and angry manner. This caused the patient to become so upset that security was called to escort him from the room. Following the incident, another treatment provider on staff noted in the patient’s record, “staff should avoid calling him a stalker.”

3. The facility’s internal investigation of Dr. Carter Spagnolo’s treatment of Patient A concluded that Dr. Carter Spagnolo had committed verbal and psychological abuse against the patient and, as such, had violated the patient’s rights. Following the investigation, the facility terminated Dr. Carter Spagnolo’s locum tenens contract.

4. With respect to her treatment of Patient A, Dr. Carter Spagnolo explained at the informal conference that she had always had a good rapport with Patient A. She believes that both the patient and the rest of the treatment team misinterpreted her statements. She explained that the patient wanted to

leave the hospital and had asked her how long he was going to be there. Dr. Carter Spagnolo said she told him she could not give him a specific answer but described the discharge process requirements and explained the long term unit possibilities, which could be for any amount of time, even 20 years. Dr. Carter Spagnolo said she told Patient A it was her goal to get him safe for release.

5. Dr. Carter Spagnolo also explained that Patient A kept asking during their meeting, “can I go, can I go see my family?” She stated that she denied his request at that time, and asked that they finish the meeting first. She believes that her treatment team interpreted this to mean that she did not want Patient A to have any visits. She noted that if she wanted the patient to not see family, she could have written such in an order. In addition, she said that when she first began working at the hospital in October 2018, her training had been expedited and she was not aware of the visitation schedule in general, so when she said “no” it was not forever. The Committee noted that Dr. Carter Spagnolo had been at the facility for four months at the time of the interaction with Patient A, so she should have been aware of visitation schedules. Dr. Carter Spagnolo said she did understand that Patient A was tearful about his mother, and she reflected back to him that he was the type of person who gets easily emotional. She explained that Patient A initially made jokes that they all laughed at, but he kept going, so eventually she told him they needed to stop with the jokes and move forward with the meeting.

6. Dr. Carter Spagnolo explained that her team members and she were not on the best of terms, and that this was why her team members tended to misinterpret what she said to Patient A.

7. The local Department of Social Services conducted a separate investigation of Dr. Carter Spagnolo’s behavior toward Patient A. The Adult Protective Services worker who investigated the matter concluded that a preponderance of the evidence showed that mental abuse had occurred.



8. With respect to her treatment of Patient C, Dr. Carter Spagnolo acknowledged at the informal conference that she made use of a sand timer in January 2019, but stated she stopped using the sand timer because her team members did not like it.

9. With respect to her treatment of Patient D, Dr. Carter Spagnolo explained at the informal conference that Patient D had been focused on the appearance of the therapist and his “cool tattoos,” and she advised the patient to remain aware of her boundaries and consider alternative treatments.

10. With respect to her treatment of Patient F, at the informal conference, Dr. Carter Spagnolo denied using the word “stalker” and stated she had described Patient F as having an “attachment issue.”

11. At the informal conference, Dr. Carter Spagnolo said that she had sent an email message to hospital staff regarding racial disparities in mental health treatment and believed that her team members were retaliating against her for this action by complaining of her treatment of patients. She also recalled that team members made comments about Black patients’ appearance that she found offensive. However, the Committee noted that outside staff who did not receive her email message (Community Services Board and Adult Protective Services workers) also took issue with Dr. Carter Spagnolo’s communication style and handling of patients.

12. Dr. Carter Spagnolo violated Virginia Code § 54.1-2915(A)(18) and 18 VAC 85-20-29(A)(2) of the Regulations Governing the Practice of Medicine, Osteopathy, Podiatry and Chiropractic in that she repeatedly berated her colleagues at the state psychiatric hospital when they questioned the appropriateness of her using a sand timer and telling patients that they were out of time in treatment team meetings, discounting the value of therapy, and making demeaning statements to patients.

13. At the informal conference, Dr. Carter Spagnolo said that she wished that the situation could have been resolved before getting to this point. She said that in the future, to avoid these types of misunderstandings, she would explain herself using more context so that her intentions would not be

misinterpreted by the patients or her treatment team members. In addition, in making complaints going forward, she said that she may do so in a more discreet manner. She intends to work with her team as best as she can and have people get to know her by engaging on a more personal level with co-workers.

**ORDER**

Based on the foregoing Findings of Fact and Conclusions of Law, the Virginia Board of Medicine hereby ORDERS that Courtney Rochelle Carter Spagnolo, D.O., is REPRIMANDED.

Pursuant to Virginia Code §§ 2.2-4023 and 54.1-2400.2, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

FOR THE BOARD

  
\_\_\_\_\_  
Jennifer Deschenes, J.D., M.S.  
Deputy Executive Director  
Virginia Board of Medicine

ENTERED: 5/6/2021

**NOTICE OF RIGHT TO APPEAL**

Pursuant to Virginia Code § 54.1-2400(10), you have 30 days from the date you are served with this Order in which to notify William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in writing that you desire a formal administrative hearing before the Board. Upon the filing with the Executive Director of a request for the hearing, this Order shall be vacated. The service date shall be defined as the date you actually received this decision

or the date it was mailed to you, whichever occurred first. In the event this decision is served upon you by mail, three days are added to that period.