State Medical Board of Ohio

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Richard A. Whitehouse, Esq.
Executive Director

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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 MD RW

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 MD

Lance A. Talmage, M.D. RW
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 MD

Lance A. Talmage, M.D.
Secretary

(SEAL)

August 11, 2010
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

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

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.

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[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.

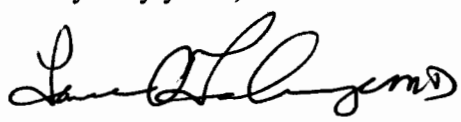
You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at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