

**SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING AND REGULATION  
BEFORE THE STATE BOARD OF MEDICAL EXAMINERS FOR SOUTH CAROLINA**

**IN THE MATTER OF:**

**CONSTANCE CASEBOLT CARVER,**  
License No. MMD.14652

**Case No. 2018-236; 2018-395; 2018-657**

Respondent.

**FINAL ORDER**

Addendum: The above-referenced Final Order executed August 22, 2023 is hereby amended to correct the name of the attorney representing the State in the first paragraph of the first page, as follows:

**SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING AND REGULATION  
BEFORE THE STATE BOARD OF MEDICAL EXAMINERS FOR SOUTH CAROLINA**

**IN THE MATTER OF:**

**CONSTANCE CASEBOLT CARVER,**  
License No. MMD.14652

**Case No. 2018-236; 2018-395; 2018-657**

Respondent.

**FINAL ORDER  
SCRIVENER'S ERROR CORRECTION**

Rowland Alston, Assistant Disciplinary Counsel, represented the State.

Date of Correction: August 24, 2023

**SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING AND REGULATION  
BEFORE THE STATE BOARD OF MEDICAL EXAMINERS FOR SOUTH CAROLINA**

**IN THE MATTER OF:**

**CONSTANCE CASEBOLT CARVER, M.D.**  
License No. MMD.14652

OIE # 2018-236; 2018-395; 2018-657

Respondent.

**FINAL ORDER**  
**(PUBLIC)**

This matter was heard by the State Board of Medical Examiners for South Carolina (Board) on August 7, 2023 with a quorum present. Prentiss Shealey, Assistant Disciplinary Counsel, represented the State. Respondent was present and was represented by Alexander S. Imgrund, Esquire.

The Board considered the attached report (Panel Report) of the Medical Disciplinary Commission regarding the above-named respondent (Respondent) as well as the transcript of the Panel Hearing, including exhibits presented at the Panel Hearing.

At the conclusion of the hearing, the Board voted to adopt the Findings of Fact and Conclusions of Law of the Panel Report in their entirety.

After carefully considering the evidence, the Board concludes that sanctions are warranted in this matter. The sanctions imposed are consistent with the purpose of these proceedings and have been made after weighing the public interest and the need for the continuing services of qualified medical professionals against the countervailing concern that society be protected from professional ineptitude and misconduct. The sanctions imposed are designed not to punish the licensee, but to protect the life, health, and welfare of the people at large.

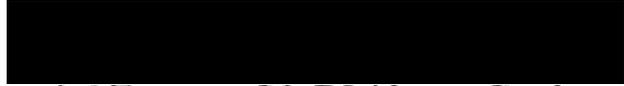
The following sanctions are hereby imposed:

1. Respondent is hereby publicly reprimanded.
2. Respondent is assessed the reasonable costs of Three Thousand Seven Hundred Fifty Dollars (\$3,750.00) incurred in the investigation of this matter, to be paid in full within six (6) months of the date of this Final Order.
3. If Respondent fails to meet any of the conditions set forth in this Order, including failure to comply with the above sanctions within the imposed deadline, Respondent's license may be immediately administratively suspended pending compliance with the terms of this Order. Proof of Respondent's noncompliance shall be presented by Board staff to the Chair, who, upon satisfaction of noncompliance, will sign an administrative suspension order on behalf of the Board.

Also, any future license law violations by Respondent shall constitute a failure to meet the conditions of this Order.

**AND IT IS SO ORDERED.**

**STATE BOARD OF MEDICAL EXAMINERS  
FOR SOUTH CAROLINA**



**ANNE G. COOK, M.D., FACP  
President of the Board**

August 22, 2023

**SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING AND REGULATION  
BEFORE THE STATE BOARD OF MEDICAL EXAMINERS FOR SOUTH CAROLINA**

**IN THE MATTER OF:**

**CONSTANCE ELAINE CASEBOLT,**  
License No.: MMD.14652

OIE Case # 2018-236; 2018-395; 2018-657  
Respondent.

**CERTIFIED REPORT OF THE  
DISCIPLINARY PANEL**  
**(Private)**

On August 10, 2022, this matter came before a Hearing Panel of the Medical Disciplinary Commission (“Panel”) as a result of the Memorandum of Agreement and Stipulation of Facts (“MOA”) signed by Respondent on August 8, 2022. In the MOA, Respondent waived formal hearing procedures and elected to dispose of the matter pursuant to S.C. Code Ann. § 1-23-320(f) (1976, as amended).

The hearing was held pursuant to S.C. Code Ann. § 40-47-117 and the provisions of the Administrative Procedures Act, S.C. Code Ann. § 1-23-10 *et seq.*, to hear the charges alleged in the MOA, to determine whether the charges are supported by the evidence or if they do not merit taking disciplinary action, to make findings of fact and conclusions of law accordingly, and if the charges are supported by the evidence, to identify mitigating and aggravating circumstances for consideration by the Board.

Arthur E. Jordan, Jr., M.D., Marcelo Hochman, M.D., and Wade C. Arnette comprised the Hearing Panel. Arthur E. Jordan, Jr., M.D. chaired the proceeding. Rowland Alston, Assistant Disciplinary Counsel, represented the State. Respondent appeared and was represented by Alexander S. Imgrund, Esquire.

**Witnesses:**

State’s Witness 1: Laura Lupton, MD

**Exhibits:**

State’s Exhibit 1: Memorandum of Agreement with Exhibits  
State’s Exhibit 2: Affidavits of Cost for all 3 cases  
State’s Exhibit 3: CV of State’s Expert Reviewer, Dr. Laura Lupton  
State’s Exhibit 4: Expert Reviewer Packet furnished to Dr. Lupton  
State’s Exhibit 5: Copy of Informed Consent Form

Respondent’s Exhibit 1: Letter of Reference from Forum Health, Respondent’s employer

Respondent’s Exhibit 2: Patient’s affidavit in support of Respondent for case 2018-657

## **FINDINGS OF FACT**

In the MOA, Respondent admitted the following facts for all (3) cases:

1. Respondent is a physician duly licensed by the State Board of Medical Examiners (hereinafter “the Board”) to act as a physician in South Carolina, has been licensed since 1989, and was so licensed at all times relevant to this matter.

2. Respondent was Board Certified in Family Medicine until recently. Respondent practices at and operates the clinic of: "Greenville Functional Medicine DBA Wellness By Design (now DBA Forum Health Greenville" since being purchased by Forum Health October 1 2020) in Greenville, South Carolina. Respondent is a practitioner of Functional and Integrative Medicine, whereby alternative methods of treatment for various maladies are offered in conjunction with conventional. These alternative methods involve (may include among others) intravenous injections of Ozone, and vitamin C. Respondent uses these adjunctive therapies to treat-improve the immune system and quality of life for-patients afflicted with cancer.

3. In prior Case No. 2013-235, Respondent was issued a Letter of Caution, which advised Respondent to be mindful of making relevant information available to patients. This letter is relevant to the misconduct alleged herein.

4. In prior Case No. 2015-438, Respondent was issued a Letter of Caution, which advised Respondent to be mindful in recordkeeping. This letter is relevant to the misconduct alleged herein.

## **CURRENT CASES WITH THE BOARD**

5. Upon information and belief, Respondent has engaged in certain conduct that violates provisions of the South Carolina Code of Laws (S.C. Code Ann. § 40-47-5 *et seq.* (1976, as amended)), including the commission of the following acts set forth herein. The Board has jurisdiction over the subject matter herein.

### **Case No. 2018-236**

In the MOA, Respondent admitted the following facts. No additional testimony or evidence was offered during the hearing.

6. An initial complaint was filed with the Board alleging that Respondent was improperly prescribing controlled substances, and improperly prescribing to Respondent’s husband. The Board investigated this complaint, and obtained the relevant records of care.

7. On September 17, 2018, an expert, board certified in Family Medicine and appointed by the Board, reviewed the records of care and issued a report. The expert concluded Respondent failed to meet the required standard of care in recordkeeping, specifically including,

but not limited to, the following:

- a. The records of psychiatric examinations were inadequate. Suicidality was not addressed. Follow ups were not planned quickly enough. Prescriptions were written with too many refills.
- b. Respondent cared for employees, writing prescriptions without record of SOAP note, and had inadequate notes of history and physical exam. Notes did not establish a proper physician/patient relationship.
- c. Respondent cared for Respondent's husband, writing Schedule IV controlled substances. Respondent's notes were inadequate as to reflecting the need for these prescriptions.

8. The Respondent committed misconduct in failing to maintain an adequate record of care in the treatment of patients, employees, and family members.

#### **Case No. 2018-395**

In the MOA, Respondent admitted the following facts:

9. An initial complaint was filed with the Board alleging that Respondent improperly administered intravenous Ozone treatment to patient, resulting in an ICU visit at Bon Secours Hospital. The Board investigated this complaint, and obtained the relevant records of care.

10. On October 3, 2019, an expert, board certified in Family Medicine and appointed by the Board, reviewed the records of care and issued a report. The expert concluded Respondent failed to meet the required standard of care in the profession, specifically including, but not limited to, the following:

- a. Respondent's assessment and treatment of patient failed to meet the standard of care, and resulted in negative outcome.
- b. Intravenous Ozone administration has the known attendant risk of inducing air embolism, a gas bubble that can obstruct the flow of blood in an artery or vein.
- c. Respondent should have suspected air embolism in the patient, and failed to recognize and promptly act upon the patient's exhibition of clinical signs of limb ischemia and stroke; nevertheless, Respondent sent the patient home.
- d. Respondent did not provide a valid informed consent form to patient, presenting the known significant risks with treatment; specifically, the

informed consent form used by Respondent did not apprise patient of the risk of air embolism.

11. Respondent committed misconduct in failing to suspect air embolism, in failing to recognize and address the clinical signs of ischemia and stroke, and in failing to provide an informed consent form that apprised patient of the risk of air embolism.

12. Respondent makes the following averments:

- a. Air embolism is not a known risk of this type of Ozone treatment, thus there is not a requirement for informed consent to this risk.
- b. The patient's reaction to the treatment was severely atypical and not foreseeable.

During the hearing, testimony was presented by the State and Respondent:

13. On or about April 17, 2018, Patient was given ozone via DIV administration in Respondent's medical office to treat fatigue. After the procedure, medical records indicate that patient was light headed and had vision problems. Additionally, as time went along, patient's fingers turned white and patient was experiencing stomach cramps, vomiting, headaches and memory problems. Patient was described as continuing to act sleepy and confused, and at one point could not remember her own name.

14. After approximately three hours of observation at Respondent's office, Respondent sent patient home with her husband and advised that patient would need to be watched. Respondent testified she advised the husband to take the patient to the emergency room.

15. Upon patient arriving at the hospital, she was determined to have an altered mental status: alert but only oriented to person, speech was fluid, but her words did not make sense. Patient's hospital diagnosis includes: Acute embolic stroke confirmed by MRI, ozone poisoning and toxicity resulting in severe encephalopathy confirmed by MRI and EEG, acute ongoing seizure activity in brain confirmed by EEG, pulmonary infiltrates, resulting aphasia, and "moderate to severe cognitive deficit." The patient required an extended hospital stay, part of which was in the ICU.

16. The State called Dr. Laura Lupton. Dr. Lupton's testimony followed the information and opinions included in her expert review report that is summarized above and was attached as an exhibit to the stipulation. Dr. Lupton opined that the Respondent:

- a. failed to recognize and accurately diagnose a serious medical condition;
- b. failed to initiate or coordinate appropriate and timely care for a serious medical condition;
- c. failed to obtain a valid informed consent prior to administering DIV ozone to

- the patient; and
- d. that the event harmed the patient and lead to an extended hospital stay and need for rehabilitation services.

When questioned, Dr. Lupton admitted that she had no personal experience with ozone therapy, but was aware of it prior to her review.

17. Respondent testified on her own behalf that the patient's reaction was very unusual and that at the time she did not realize there could be a risk based on her training and experience. She stated that she had no reason to believe the symptoms were not transient as they had never happened before and her training never indicated this could be an issue. Respondent thought that the patient's fingers being white was Reynaud's type situation rather than an air embolism. Respondent told the patient's husband to take the patient directly to the ER as an added measure of caution. Respondent stated that she did not consider the possibility of a stroke as patient was still moving, walking, and conversing.

18. Respondent testified that if she had the ability to handle this situation again, she would act more quickly and get the patient to the hospital more quickly. Respondent additionally testified that the 2018 informed consent could have been more robust and that she has updated her consent forms. Respondent spoke of her remorse that an adverse action occurred and how that impacted the patient. Respondent testified that she is no longer performing DIV ozone therapy.

#### **Case No. 2018-657**

In the MOA, Respondent admitted the following facts. No additional testimony was offered during the hearing. One exhibit was admitted.

19. An initial complaint was filed with the Board alleging that Respondent was improperly treating advanced breast cancer in a patient with Ozone, herbs, and supplements, resulting in delayed standard care; the patient later presented to an oncologist with metastasis precluding a mastectomy, and could only receive palliative therapy. The Board investigated this complaint, and obtained the relevant records of care.

20. On May 22, 2019, an expert, board certified in Family Medicine and appointed by the Board, reviewed the records of care and issued a report. The expert concluded Respondent failed to meet the required standard of care in recordkeeping, specifically including, but not limited to, the following:

- a. While Respondent provided patient a consent form explaining that Ozone is not recognized as standard of care, there was no consent form for intravenous Vitamin C or supplements.
- b. Respondent should have documented discussions of risks and benefits of alternative treatments administered as it relates to cancer.

- c. Respondent should have documented recommendations for patient to follow up with an oncologist.

21. Respondent committed misconduct in failing to provide the appropriate consent form, in failing to document the known risks of provided alternative treatments, and in failing to document recommendations of follow up with an oncologist.

22. Respondent makes the following averments:

- a. The patient in this case does not wish Respondent to be disciplined, feels that Respondent gave her excellent care, and Respondent never attempted to dissuade her from any traditional cancer treatment.
- b. Respondent's informed consent now includes language regarding cancer.

### **CONCLUSIONS OF LAW**

1. Pursuant to S.C. Code Ann. § 40-47-11(C), the Panel is empowered to hear this matter and to recommend findings of fact and conclusions of law to the Board. This Panel is required to submit this Certified Report of the proceedings, including its findings of fact, conclusions of law, and mitigating and aggravating circumstances, for consideration by the Board in rendering a final decision. The Panel has jurisdiction over Respondent and concludes that he was properly served, as described above.

#### **Case 2018-236**

In the MOA, the State alleges and Respondent admits that the aforementioned acts set forth in the Findings of Fact above present grounds that constitute misconduct, as alleged, and violate the South Carolina Code of Laws in the following particulars:

- a. S.C. Code Ann. § 40-47-110(B)(14) (2011) in that Respondent has violated a provision of this chapter or a regulation or order of the Board; specifically, S.C. Code Ann. § 40-47-113 (2011), in prescribing drugs to an individual without first establishing a proper physician-patient relationship; and,
- b. S.C. Code Ann. § 40-47-110(B)(17) (1976, as amended) in that Respondent failed to prepare or maintain an adequate patient record of care provided.

#### **Case 2018-395**

2. The Panel finds and concludes that Respondent violated the Medical Practice Act as outlined in the Stipulation of Facts. More specifically, the Panel concludes that the State proved by a preponderance of the evidence that Respondent's conduct is sanctionable as set forth

in the following provisions of the Medical Practice Act:

- a. S.C. Code Ann. § 40-47-110(B)(9) (1976, as amended) in that Respondent engaged in dishonorable, unethical, or unprofessional conduct that is likely either to deceive, defraud, or harm the public. § 40-47-20(53) defines “unprofessional conduct” as acts or behavior that fail to meet the minimally acceptable standard expected of similarly situated professionals including, but not limited to, conduct that may be harmful to the health, safety, and welfare of the public, conduct that may reflect negatively on one's fitness to practice, or conduct that may violate any provision of the code of ethics adopted by the board or a specialty.
- b. S.C. Code Ann. § 40-47-110(B)(14) (1976, as amended) in that Respondent has violated a provision of this chapter or a regulation or order of the Board; specifically, S.C. Reg. 81-60(E), which states that “A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.” (emphasis added).
- c. S.C. Code Ann. § 40-47-110(B)(17) (1976, as amended) in that Respondent failed to prepare or maintain an adequate record of care provided.

3. As to the violation of S.C. Code Ann. § 40-47-110(B)(9), the Respondent failed to recognize the acute adverse event and failed to respond to this event in an acceptably timely fashion. Respondent did not quickly assess that intervention was necessary and allowed for considerable time to elapse before patient was taken by her husband to the emergency room.

4. As to the violation of S.C. Code Ann. § 40-47-110(B)(14), the Respondent and State verbally agreed on the record that a violation occurred and the Panel concurs.

5. As to the violation of S.C. Code Ann. § 40-47-110(B)(17), the Respondent did not meet the standard of documentation of treatment and procedures. Respondent’s records did not adequately reflect the events of the day in question including times of treatments and procedures.

#### **Case 2018-657**

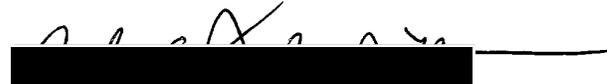
In the MOA, the State alleges and Respondent admits that the aforementioned acts set forth in the Findings of Fact above present grounds that constitute misconduct, as alleged, and violate the South Carolina Code of Laws in the following particulars:

- a. S.C. Code Ann. § 40-47-110(B)(17) (1976, as amended) in that Respondent failed to prepare or maintain an adequate record of care provided.

**MITIGATING/AGGRAVATING CIRCUMSTANCES**

The Panel finds no circumstances that mitigate or aggravate Respondent's conduct in this matter.

**RESPECTFULLY SUBMITTED,**

  
  
**Arthur E. Jordan, Jr., M.D.**  
**Chair of Hearing Panel**

January 23, 2023