



July 8, 2026

VIA EMAIL ONLY

Tanika Spidell, D.O.
1863 Kipling Dr
Dayton, OH 45406-3917
tanikaspidell@hotmail.com

RE: Case No. 25-CRF-0132

Dear Dr. Spidell:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of James T. Wakley, Esq., Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on July 8, 2026, including motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio.

Any party desiring to appeal this order shall file a notice of appeal with the State Medical Board of Ohio, located at 30 E. Broad St., 3rd Floor, Columbus, Ohio 43215, setting forth the order appealed from and stating that the agency's order is not supported by reliable, probative, and substantial evidence and is not in accordance with law. The notice of appeal may, but need not, set forth the specific grounds of the party's appeal beyond the statement that the agency's order is not supported by reliable, probative, and substantial evidence and is not in accordance with law.

The notice of appeal shall also be filed by the appellant with the court of common pleas of Franklin County or the court of common pleas in the county in which the place of business of the licensee is located or the county in which the licensee is a resident. If the party appealing is not a resident of and has no place of business in this state, the party shall appeal to the court of common pleas of Franklin County. In filing a notice of appeal with both the Medical Board and the court, the notice that is filed may be either the original notice or a copy of the original notice.

The party filing the appeal shall comply with all requirements of Ohio Revised Code section 119.12 (R.C. 119.12). The notice of appeal shall be filed within fifteen days after the service of the notice of the Medical Board order as provided in section 119.05 of the Ohio Revised Code.

THE STATE MEDICAL BOARD OF OHIO

A handwritten signature in blue ink, reading "Kim G. Rothermel M.D.", is positioned above the printed name and title.

Kim G. Rothermel, M.D.
Secretary

KGR:JTW

Enclosures

Cc: Kyle Wilcox, Assistant Attorney General
Kyle.Wilcox@OhioAGO.gov

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of James T. Wakley, Esq., State Medical Board Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on July 8, 2026, including motions approving and confirming the Findings of Fact, Conclusions and Proposed Order of the Hearing Examiner as the Findings and Order of the State Medical Board of Ohio; constitute a true and complete copy of the Findings and Order of the State Medical Board in the Tanika Sharee Spidell, D.O., Case No. 25-CRF-0132 as it appears in the Journal of the State Medical Board of Ohio.

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




Kim G. Rothermel, M.D.
Secretary

July 8, 2026
Date

IN THE MATTER OF

*

Tanika Sharee Spidell, D.O.

*

CASE NO. 25-CRF-0132

*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on July 8, 2026.

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

It is hereby ORDERED that:

1. **REVOCATION:** The license of Tanika Spidell, D.O., to practice osteopathic medicine and surgery in the State of Ohio shall be **REVOKED**.
2. **FINE:** Within thirty days of the effective date of this Order, Dr. Spidell shall remit payment in full of a fine of one thousand five hundred dollars (\$1,500). Such payment shall be made via credit card in the manner specified by the Board through its online portal, or by other manner as specified by the Board.

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




Kim G. Rothermel, M.D.
Secretary

July 8, 2026
Date



EXCERPT FROM THE DRAFT MINUTES OF JULY 8, 2026 IN THE MATTER OF TANIKA SHAREE SPIDELL, D.O.

.....

REPORTS AND RECOMMENDATIONS

Dr. Bechtel asked the Board to consider the Report and Recommendation appearing on the agenda: William Asa Seeds, M.D.; Marcus Allen; Billie Blessing; Michael A. Kobus, L.M.T.; Stephen D. Waite, M.D.; Tanika Sharee Spidell, D.O.; and Benjamin Minera, L.M.T.

Dr. Bechtel asked all Board members the following questions:

- 1.) Has each member of the Board received, read and considered the Hearing Record; the Findings of Fact, Conclusions and Proposed Orders; and any objections filed in each of the Reports and Recommendations?
- 2.) Does each member of the Board understand that the Board's 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 or Permanent Denial?
- 3.) Does each member of the Board understand that in each matter eligible for a fine, the Board's fining guidelines allow for imposition of the range of civil penalties, from no fine to the statutory maximum amount of \$20,000?

ROLL CALL:

Dr. Rothermel	- aye
Dr. Kakarala	- aye
Dr. Feibel	- aye
Ms. Brumby	- aye
Dr. Boyle	- aye
Mr. Gonidakis	- aye
Dr. Lewis	- aye
Ms. Montgomery	- aye
Dr. Johnson	- aye
Dr. Reddy	- aye
Dr. Bechtel	- aye

In accordance with the provision in Ohio Revised Code 4731.22(F)(2), specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of any disciplinary matters. In the disciplinary matters before the Board today, Dr. Rothermel served as Secretary and Dr. Kakarala served as Supervising Member.

During these proceedings, no oral motions may be made by either party.

.....

Tanika Sharee Spidell, D.O.

.....

Dr. Johnson moved to approve and confirm the Proposed Findings of Fact, Conclusions of Law, and Proposed Order in the matter of Dr. Spidell. Dr. Boyle seconded the motion.

.....

A vote was taken on Dr. Johnson's motion to approve:

ROLL CALL:	Dr. Rothermel	- abstain
	Dr. Kakarala	- abstain
	Dr. Feibel	- aye
	Ms. Brumby	- aye
	Dr. Boyle	- aye
	Mr. Gonidakis	- aye
	Dr. Lewis	- aye
	Ms. Montgomery	- aye
	Dr. Johnson	- aye
	Dr. Reddy	- aye
	Dr. Bechtel	- aye

The motion to approve carried.

RECEIVED:
JUNE 16, 2026

BEFORE THE STATE MEDICAL BOARD OF OHIO

In the Matter of

*

Case No. 25-CRF-0132

Tanika Sharee Spidell, D.O.

*

Hearing Examiner Wakley

Respondent.

*

REPORT AND RECOMMENDATION

Appearances:

Dave Yost, Attorney General of Ohio, and Kyle Wilcox, Assistant Attorney General, for the State of Ohio.

Hearing Date: May 4 and 6, 2026. May 6, 2026 by videoconference.

I. PROCEDURAL HISTORY

By letter dated August 13, 2025, the State Medical Board of Ohio notified Tanika Spidell, D.O., that it intended to determine whether to take disciplinary action against her license to practice osteopathic medicine in Ohio. See Ex. 8a. On September 10, 2025, Dr. Spidell requested a hearing to address the charges brought by the Board. See Ex. 8b. A hearing was thereafter set for May 4-6, 2026. See November 21, 2025 Scheduling Entry.

II. PROCEDURAL MATTER

Page 14 of the transcript will be sealed to protect the identities of Patients 1-4. Lines 17, 20, and 21 on page 72 and line 14 on page 78 will also be sealed for the same reason.

III. SUMMARY OF THE EVIDENCE¹

A. Background

Dr. Tanika Spidell is a 2009 graduate of the Ohio University Heritage College of Osteopathic Medicine. Transcript (“T.”) at 20; Ex. A at 1. She began, but did not successfully complete, a general psychiatry residency at the University of Louisville.² T. at 21; Ex. A at 1. Since she left her residency, Dr. Spidell has worked as a clinical consultant, a clinical observer, a peer community health navigator, the director of a Women’s Center, and a “Medical Liaison in telehealth psychiatry.” T. at 23-24, 29-30; Ex. A at 1. At one point, Dr. Spidell held licenses to practice medicine in Ohio and Virginia. She was first licensed in Ohio in 2023, however her license expired in July 2025. T. at 17. Her Virginia license expired in March 2026. T. at 18. As of the date of this hearing, Dr. Spidell was not actively licensed to practice medicine anywhere in the United States. T. at 18.

Since November 2020, she has owned and operated Spidell Consulting Solutions, LLC. T. at 17; Ex. A at 1. According to Dr. Spidell, Spidell Consulting Solutions once offered medical services – “general H&Ps or history and physicals, recommendations, referrals to specialists” and “general preventative healthcare, psychiatric or mental healthcare, and healthcare advocacy” – and educational liaison services. At its peak, Dr. Spidell testified that she treated 20 patients as part of Spidell Consulting Solutions. T. at 128. She no longer offers medical services because she no longer holds an active medical license. T. at 126-27.

Dr. Spidell met with Board investigators in April 2025 to discuss the care she rendered to four family members. T. at 32, 64. She subsequently provided medical records for Patients 1-4 to the Board. Amongst those records was a document listing prescriptions made to Patients 1-4. See Ex. 5.

B. Patient 1

Patient 1 is related to Dr. Spidell. T. at 14. Dr. Spidell testified that Patient 1’s medical issues began when he suffered multiple gunshot wounds. T. at 54. Five months after his discharge from the hospital, Patient 1 began experiencing “serious complications with shortness of breath and abdominal pain.” T. at 57. Dr. Spidell recommended that Patient

¹ All exhibits and the transcript of testimony, even if not specifically mentioned, were thoroughly reviewed and considered by the Hearing Examiner prior to preparing this Report and Recommendation.

² Dr. Spidell completed the first two years of her residency, but was dismissed from the program after she failed the third step of the COMLEX exam. T. at 21. She eventually passed the third step on her fifth attempt. T. at 22.

1 go to the hospital. Patient 1 was seen at the hospital but was quickly discharged. A few hours later, Patient 1 returned to the same hospital, this time with Dr. Spidell in tow. T. at 57. Despite still suffering from pain and Dr. Spidell offering her input, the hospital again discharged Patient 1 quickly. T. at 58. Patient 1 then went to another hospital, where he was diagnosed with an 8.4cm enlarging abscess and gastrophrenic fistula. T. at 58. His surgeons declined to refer him to pain management. T. at 56, 58, 130-31.

i. Pain management

Dr. Spidell decided to take over Patient 1's pain management when she saw how his needs were not being met by his local medical community:

So we had been denied care three different times and that's just that day. I'm not talking about all the times before where we asked for help and said, hey, can you tell us what to do, where do we go? And doctor after doctor saying, oh, you got to do that on your own, oh, you got to do that on your own. A 22-year-old, I'm not sure how much he's going to do on his own.

As a physician I said, hey, this is what you need to do, this is what you need to do. And at that point again that's when I decided, December of 2023, this was a year after that initial -- that three -- excuse me -- let me back up.

Three visits to the ER in 2023 led to the abscess. At that point he had to have a lobectomy, a thoracotomy, a couple of different revision surgeries, and that was I think the 30-day stay. I may have misspoke earlier. The first gunshot wound he had a several-day stay. This one was a 30-day stay for complications of an abscess that had been a complication from the gunshot wound earlier in the year 2022.

T. at 58-59. See also T. at 138-43.

Dr. Spidell provided pain management to Patient 1 from December 2023 until April 2025. T. at 40. See also Exs. 1; B. Prior to initiating pain management with Patient 1, Dr. Spidell had him sign a pain management agreement. Ex. 1 at 2-3. On December 11, 2023, Dr. Spidell prescribed Patient 1 Percocet (oxycodone-acetaminophen) 7.5-325mg. Ex. 5 at 14. On December 17, 2023, Dr. Spidell again prescribed Percocet as well as gabapentin 300mg. T. at 43; Ex. 5 at 14. In January 2024, Dr. Spidell prescribed Patient 1 Percocet, tramadol, and a stronger dose of gabapentin. Ex. 5 at 13. In March 2024, Dr. Spidell began prescribing Patient 1 a stronger dose of Percocet (10-325mg). Ex. 5 at 13. Dr. Spidell continued to prescribe Patient 1 Percocet and gabapentin roughly monthly until March 2025. See Ex. 5; T. at 43-48.

Dr. Spidell testified at hearing that she was aware of the Board's rules against prescribing controlled substances to family members. T. at 48-50. At hearing, Dr. Spidell was remarkably candid about violating that rule, explaining that she did so because her

relative needed care. T. at 63. She only stopped prescribing controlled substances to Patient 1 because she was visited by a Board investigator. T. at 64, 131.

ii. Patient records

In the Notice, Dr. Spidell was alleged to have inadequately documented her care of Patient 1. See Ex. 8a at ¶3(a). At hearing, however, Dr. Spidell testified that she properly documented her care of Patient 1 and that the Board did not have the entire record. T. at 64. She claimed that she sent the Board her complete patient file, which she had brought with her to the hearing on this matter. T. at 64, 157. Dr. Spidell then offered her original file, which was admitted as Exhibit B. T. at 65-66.

Exhibit 1 is 35 pages.³ Exhibit B is 81 pages. It is readily apparent that Exhibit 1 is missing some pages. For instance, page 6 of Exhibit 1 is what appears to be an excerpt from a longer medical record. That same document is found at page 48 of Exhibit B. There, the document is shown in proper context as page 2 of a CT scan report. It appears that Exhibit 1 is missing those records included at pages 5-47 of Exhibit B.

At hearing, the State called Krista Tackett, the Board's Quality Intervention Program administrator, to testify about the records received from Dr. Spidell. T. at 181. Ms. Tackett testified that Dr. Spidell uploaded Patient 1's records – along with the other documents that were admitted at hearing – to the Board's secure document handling site on May 18, 2025. T. at 182-83. According to Ms. Tackett, the version of Patient 1's medical record that was uploaded by Dr. Spidell was only 35 pages. T. at 185; Rebuttal Ex. 2. The State separated out the omitted records and submitted those documents as Rebuttal Exhibit 1. T. at 197.

Amongst the records offered by Dr. Spidell at hearing are SOAP notes from office visits,⁴ prescription records,⁵ and handwritten clinic notes.⁶ Those records show that Dr. Spidell documented Patient 1's condition and pain levels, as well as checked OARRS. See, e.g., Rebuttal Ex. 1 at 8, 11, 18.

C. Patient 2

Patient 2 is a close family member of Dr. Spidell's. T. at 14. Dr. Spidell treated Patient 2 from April 2024 until April 2025. T. at 67-68. Patient 2 suffered from liver cancer. T. at 71, 74. And, in June 2024, Patient 2 had a serious fall and broke her leg. She suffered

³ Not including the certification page.

⁴ See, e.g., Rebuttal Ex. 1 at 5-8.

⁵ See Rebuttal Ex. 1 at 21-25.

⁶ See Rebuttal Ex. 1 at 34-41

a hematoma of the head and fractured both “main bones in the left leg.” T. at 89. At that point, Patient 2 was under the care of a “cancer doctor,” an orthopedic surgeon, a family medicine physician, and a pain management practice. T. at 78-79. According to Dr. Spidell, Patient 2 had been seeing a regular pain management specialist until she began developing “some abnormal discomfort that her pain management specialist was not comfortable treating.” T. at 74. At that point, Dr. Spidell recommended that Patient 2 switch from traditional pain management to palliative care. T. at 74-75.

Patient 2 began having problems virtually from the start with the palliative care provider. Patient 2 was placed on a medication regimen of Dilaudid (hydromorphone) and long-acting OxyContin. Dr. Spidell testified that the providing nurse practitioner began by prescribing too low a dose for Patient 2 (who had been dependent on long-term opioid treatment) and she eventually began delaying prescriptions for the OxyContin due to shortages of the drug. T. at 73-76. Everything came to a head when Patient 2 had been without the OxyContin for about two weeks. All she had was the Dilaudid that was intended for breakthrough pain. Patient 2 disclosed to her palliative care provider that she had taken more Dilaudid than was prescribed. At that point, Patient 2 was discharged from the practice. T. at 76-78, 143. Dr. Spidell testified that Patient 2 was referred to another palliative care provider, but that practice never called her or responded to her enquiries. T. at 78, 134. And Patient 2’s regular family physician was not comfortable prescribing pain medication. T. at 79. After several weeks of Patient 2 having no luck in seeing a new provider, Dr. Spidell elected to take over her pain management. T. at 79, 91-92. As she put it at hearing:

[Patient 2] was in a period of where there’s no insurance, you have these pain medications. The provider had -- the palliative care provider had just discharged her, so she didn’t have a provider for that. So it was a perfect storm for me at that point and that’s again why I made the decision to prescribe the medication.

T. at 93.

Dr. Spidell took over pain management for Patient 2 in August 2024. T. at 80; Ex. 2 at 112. In a note dated August 31, 2024, Dr. Spidell wrote “Due to emergent nature of pt condition with acute on chronic pain hx and recent fall, glenoid fracture of shoulder, and tib/fib fx and multiple other injuries it is necessary to provide some pain alleviation via this provider.” Ex. 2 at 114. Prior to prescribing Patient 2 controlled substances, Dr. Spidell had her sign a pain management agreement. T. at 70-71; Ex. 2 at 3-5. Over the course of treatment, Dr. Spidell prescribed OxyContin and hydromorphone, as well as Zanaflex and gabapentin, to Patient 2. T. at 73. Ultimately, Dr. Spidell prescribed controlled substances to Patient 2 for a period of nine months. T. at 94. At hearing, she readily admitted that she violated the Board’s rules:

Should it have been seven days? Yes. Should I have stopped after that?
According to the Ohio Revised Code, yes. But again, I’ll say the same thing,

for me, ethically, the oath that I took was to not harm and to help, and that's why I chose to prescribe them.

T. at 93. See *also* T. at 100-01.

D. Patient 3

Like Patient 2, Patient 3 is a close family member of Dr. Spidell's. T. at 14. She began treating Patient 3 in October 2023 and continued until March or April of 2025. T. at 101. Dr. Spidell prescribed lorazepam 0.5mg to Patient 3 in December 2024 and March 2025. T. at 101-02, 106-07, 108-09; Ex. 3 at 6, 10, 12. In August, October, and November 2024, Dr. Spidell prescribed Patient 3 Trulicity. Ex. 5 at 6-7, 9. Patient 3 was being seen at the time by a primary care nurse practitioner. T. at 105. Dr. Spidell chose to prescribe controlled substances to this family member because:

[W]e were in a state where two family members, you know, parents, her family members were in the hospital, her son was even in the hospital at this time, and she's a caretaker.

And it was one of those moments where it's like we've got to do something. And I -- and I chose to do something as a physician at that point to prescribe her the low dose of lorazepam.

T. at 105-06.

When asked at hearing whether her treatment of Patient 2 was an emergency, Dr. Spidell testified that she believed that the December prescription for lorazepam was to deal with an emergency situation, but that the March occasion was not. T. at 109. However, Dr. Spidell's records from that December visit do not reflect an emergency, only that Patient 2 was "feeling overwhelmed." Ex. 3 at 12.

E. Patient 4

Patient 4 is also related to Dr. Spidell. Dr. Spidell only treated Patient 4 in July 2024. T. at 110; Ex. 4. Dr. Spidell elected to treat Patient 4 for weight loss after she lost her insurance. T. at 111; Ex. 4 at 4. In a note dated July 4, 2024, Dr. Spidell wrote that she would continue Patient 4 on a daily regimen of 15mg of phentermine. T. at 113; Ex. 4 at 4. Later that same month, Dr. Spidell prescribed buspirone, dicyclomine, fluoxetine, hydroxyzine, Omeprazole, and warfarin to Patient 4. Ex. 4 at 5-6. She discontinued Patient 4's phentermine prescription 18 days later after Patient 4 was seen and discharged from the hospital after suffering a pulmonary embolism. T. at 114-15; Ex. 4 at 9.

III. BOARD ALLEGATIONS

In the August 2025 Notice of Opportunity for Hearing, the Board alleged the following:

- (1) From in or around October 2023, to in or around April 2025, [Dr. Spidell] treated, provided care and/or prescribed medications, including controlled substances, to Patients 1 through 4.
- (2) In or around April 2025, [Dr. Spidell was] interviewed by Board Investigators. [Dr. Spidell] informed the Board Investigators that [she] practice[d] psychiatry and general medicine, and that Patients 1 through 4 were all family members. [Dr. Spidell's] prescribing of controlled substances to those patients was not in an emergency situation, as shown, in part, by the quantity of medications [she] prescribed along with the number of prescriptions that [she] wrote and/or authorized.
- (3) The specific treatment [Dr. Spidell] provided, and medications that [she] prescribed, to Patients 1 through 4 include, but is not limited to, the following:

- (a) [Dr. Spidell] provided treatment to Patient 1 from in or around December 2023 until at least in or around March 2025. On or about December 5, 2023, Patient 1 signed a pain management agreement. While the records that [Dr. Spidell] provided to the Board for Patient 1 included imaging and lab reports, there were no office visit or progress notes.

One of the documents that [Dr. Spidell] provided to the Board was a multi-page list of medications that [she] provided to Patients 1 through 5.⁷ For Patient 1, [Dr. Spidell] prescribed dangerous drugs and controlled substances, including gabapentin and oxycodone-acetaminophen, during the time frame of in or around December 2023 through March 2025. [Dr. Spidell] increased the dose of oxycodone-acetaminophen that [she] prescribed to Patient 1 from 7.5-325 mg to 10-325 mg, and the quantities [she] prescribed ranged from seven days to thirty days. In addition, [Dr. Spidell] failed to complete and maintain medical records that accurately reflected the utilization of controlled substances in connection with your treatment (and any documented diagnosis) of Patient 1, as required under Board rules.

- (b) [Dr. Spidell] provided treatment to Patient 2 from in or around April 2024 to April 2025. On or about August 31, 2024, Patient 2 signed a pain management agreement. The diagnoses listed in the records included chronic pain syndrome. [Dr. Spidell] prescribed dangerous drugs and controlled substances

⁷ No allegations regarding Patient 5 were made in the Board's Notice of Opportunity for Hearing.

to this patient on a regular basis from in or around August 2024 to April 2025, which medications included gabapentin, hydromorphone (8 mg tab, one every four hours), and oxycontin (20 mg ER twice a day). Most of the prescriptions for controlled substances were for either fifteen or thirty days.

In a notation dated on or about August 31, 2024, [Dr. Spidell] indicated that “[d]ue to emergent nature of pt condition with acute . . . chronic pain history and recent fall,” it was necessary for [her] to provide some pain alleviation. However, [Dr. Spidell] prescribed controlled substances to Patient 2 for several months. In addition, the records indicated that Patient 2 already had a primary care physician and she treated with multiple specialists.

- (c) [Dr. Spidell] provided treatment to Patient 3 from in or around October 2023 until at least April 2025. [Dr. Spidell] ordered and/or prescribed dangerous drugs and controlled substances to Patient 3, which included Trulicity and lorazepam (0.5 mg tid as needed). [Dr. Spidell] prescribed lorazepam to this patient in or around December 2024 and March 2025, with a quantity of 90 pills.
- (d) In or around July 2024, [Dr. Spidell] provided treatment to Patient 4. On or about July 4, 2024, [Dr. Spidell] ordered and/or prescribed dangerous drugs and controlled substances to Patient 4, which included buspirone, fluoxetine, warfarin, and Phentermine (15 mg daily, with a quantity of 30). On or about July 22, 2024, the patient reported that she had been in an emergency room for a blood clot in her lung, and [Dr. Spidell] discontinued Phentermine.

Ex. 8a at 1-2.

IV. FINDINGS OF FACT

- (1) From in or around October 2023 to in or around April 2025, Dr. Spidell treated, provided care and/or prescribed medications, including controlled substances, to Patients 1 through 4.
- (2) In or around April 2025, Dr. Spidell was interviewed by Board Investigators.
- (3) Dr. Spidell provided treatment to Patient 1 from in or around December 2023 until at least in or around March 2025. On or about December 5, 2023, Patient 1 signed a pain management agreement. While the records that Dr. Spidell provided to the Board for Patient 1 included imaging and lab reports, there were no office visit or progress notes. At hearing, Dr. Spidell supplemented the records that she originally provided to the Board with additional records.
- (4) One of the documents that Dr. Spidell provided to the Board was a multi-page list of medications that she provided to Patients 1 through 4. For Patient 1, Dr. Spidell

prescribed dangerous drugs and controlled substances, including gabapentin and oxycodone-acetaminophen, during the time frame of in or around December 2023 through March 2025. Dr. Spidell increased the dose of oxycodone-acetaminophen that she prescribed to Patient 1 from 7.5-325 mg to 10-325 mg.

- (5) Dr. Spidell provided treatment to Patient 2 from in or around April 2024 to April 2025. On or about August 31, 2024, Patient 2 signed a pain management agreement. The diagnoses listed in the records included chronic pain syndrome. Dr. Spidell prescribed dangerous drugs and controlled substances to this patient on a regular basis from in or around August 2024 to April 2025, which medications included gabapentin, hydromorphone, and OxyContin.
- (6) In a notation dated on or about August 31, 2024, Dr. Spidell indicated that “due to emergent nature of pt condition with acute . . . chronic pain history and recent fall,” it was necessary for her to provide some pain alleviation. However, Dr. Spidell prescribed controlled substances to Patient 2 for several months. In addition, the records indicated that Patient 2 already had a primary care physician and she treated with multiple specialists.
- (7) Dr. Spidell provided treatment to Patient 3 from in or around October 2023 until at least April 2025. Dr. Spidell ordered and/or prescribed dangerous drugs and controlled substances to Patient 3, which included Trulicity and lorazepam. Dr. Spidell prescribed lorazepam to this patient in or around December 2024 and March 2025. Neither occasion was an emergency.
- (8) In or around July 2024, Dr. Spidell provided treatment to Patient 4. On or about July 4, 2024, Dr. Spidell ordered and/or prescribed dangerous drugs and controlled substances to Patient 4, which included buspirone, fluoxetine, warfarin, and phentermine. On or about July 22, 2024, the patient reported that she had been in an emergency room for a blood clot in her lung, and Dr. Spidell discontinued phentermine.

V. CONCLUSIONS OF LAW

Dr. Spidell's acts, conduct, and/or omissions, as stated in Findings of Fact(1) through (8) 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: Rule 4731-11-08, Ohio Administrative Code.

The Board is authorized to impose a civil penalty for this violation. The Board's guidelines provide as follows:

Maximum recommended fine:	\$20,000
Minimum recommended fine:	\$1,500

The State has not proven that Dr. Spidell violated Rule 4731-11-02(C). Because the records submitted to the Board were incomplete, however, the Board was substantially justified in bringing this charge.

RATIONALE FOR THE PROPOSED ORDER

The Board's Notice of Opportunity for Hearing alleges two classes of violations against Dr. Spidell. First, the Board has alleged that Dr. Spidell violated the Board's rules against prescribing controlled substances to family members. At hearing, Dr. Spidell readily admitted that she violated those rules. She openly admitted that she was aware of the Board's rules regarding prescribing to family members and deliberately chose to violate them. She even admitted that she would do so again if she was placed in the same situation. That violation, therefore, has been proven.

The Board also alleged that Dr. Spidell failed to adequately document her treatment of Patient 1. The Board was fully justified in bringing that charge. The record made at hearing demonstrates that, for whatever reason, Dr. Spidell did not provide the Board with the entirety of Patient 1's patient record. The records provided to the Board and included as Exhibit 1 are plainly deficient. But Dr. Spidell eventually provided the Board with the entirety of her records for Patient 1. Those records, as required by O.A.C. 4731-11-02(C), "accurately reflect the utilization of any controlled substances in the treatment of a patient and shall indicate the diagnosis and purpose for which the controlled substance is utilized, and any additional information upon which the diagnosis is based." It is only because Dr. Spidell failed to originally provide the complete records to the Board and then neglected to review the State's exhibits in advance of hearing – despite those records being timely sent to her – that this issue was not resolved earlier.

Because Dr. Spidell has been honest and forthright about her conduct, there is no reason to believe that the additional records offered at hearing were later created to avoid discipline. It appears to be nothing more than multiple simple errors on Dr. Spidell's part. Because Dr. Spidell's records now appear to be largely in compliance with the Board's laws and rules, no violation of Rule 4731-11-02(C) has been established.

Having established that Dr. Spidell has violated this Board's laws and rules, the question then turns to discipline. Dr. Spidell credibly testified that her purpose in prescribing to these family members was purely altruistic. It does not appear that she substantially profited from her treatment of these patients. And her desire to treat Patients 1 and 2 was meant to address the needs of those patients that were not being adequately met elsewhere.

It is difficult to see family in pain or in need and do nothing. But Dr. Spidell did violate the law. She did so knowingly and intentionally. Those violations are serious and warrant discipline by this Board. At hearing, however, Dr. Spidell testified that she presently holds no active licenses – in this or any other State. Her medical practice has always been very limited. Therefore, the proposed order would revoke Dr. Spidell's license to practice osteopathic medicine in Ohio. Because her motives were altruistic, and because she was honest and forthright at hearing, the minimum fine suggested by the Board's guidelines is recommended.

PROPOSED ORDER

It is hereby ORDERED that:

1. **REVOCATION:** The license of Tanika Spidell, D.O., to practice osteopathic medicine and surgery in the State of Ohio shall be **REVOKED**.
2. **FINE:** Within thirty days of the effective date of this Order, Dr. Spidell shall remit payment in full of a fine of one thousand five hundred dollars (\$1,500). Such payment shall be made via credit card in the manner specified by the Board through its online portal, or by other manner as specified by the Board.

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

/s/ James T. Wakley

Hearing Examiner



August 13, 2025

Case number: 25-CRF-0132

Tanika Sharee Spidell, D.O.
405 West Grand Ave
Dayton, OH 45405
tanikaspidell@hotmail.com

Dear Doctor Spidell:

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 or suspend your license or certificate, or refuse to grant or register or issue the license or certificate for which you have a pending application in accordance with Section 9.79 of the Ohio Revised Code, or refuse to renew or reinstate your license or certificate to practice osteopathic medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

- (1) From in or around October 2023, to in or around April 2025, you treated, provided care and/or prescribed medications, including controlled substances, to Patients 1 through 4, as identified in the attached Patient Key. (Patient Key is confidential and shall be withheld from public disclosure.)
- (2) In or around April 2025, you were interviewed by Board Investigators. You informed the Board Investigators that you practice psychiatry and general medicine, and that Patients 1 through 4 were all family members. Your prescribing of controlled substances to those patients was not in an emergency situation, as shown, in part, by the quantity of medications you prescribed along with the number of prescriptions that you wrote and/or authorized.
- (3) The specific treatment you provided, and medications that you prescribed, to Patients 1 through 4 include, but is not limited to, the following:
 - (a) You provided treatment to Patient 1 from in or around December 2023 until at least in or around March 2025. On or about December 5, 2023, Patient 1 signed a pain management agreement. While the records that you provided to the Board for Patient 1 included imaging and lab reports, there were no office visit or progress notes.

One of the documents that you provided to the Board was a multi-page list of medications that you provided to Patients 1 through 5. For Patient 1, you prescribed dangerous drugs and controlled substances, including gabapentin and oxycodone-acetaminophen, during the time frame of in or around December 2023 through March 2025. You increased the dose of oxycodone-acetaminophen that you

prescribed to Patient 1 from 7.5-325 mg to 10-325 mg, and the quantities you prescribed ranged from seven days to thirty days. In addition, you failed to complete and maintain medical records that accurately reflected the utilization of controlled substances in connection with your treatment (and any documented diagnosis) of Patient 1, as required under Board rules.

- (b) You provided treatment to Patient 2 from in or around April 2024 to April 2025. On or about August 31, 2024, Patient 2 signed a pain management agreement. The diagnoses listed in the records included chronic pain syndrome. You prescribed dangerous drugs and controlled substances to this patient on a regular basis from in or around August 2024 to April 2025, which medications included gabapentin, hydromorphone (8 mg tab, one every four hours), and oxycontin (20 mg ER twice a day). Most of the prescriptions for controlled substances were for either fifteen or thirty days.

In a notation dated on or about August 31, 2024, you indicated that “[d]ue to emergent nature of pt condition with acute . . . chronic pain history and recent fall,” it was necessary for you to provide some pain alleviation. However, you prescribed controlled substances to Patient 2 for several months. In addition, the records indicated that Patient 2 already had a primary care physician and she treated with multiple specialists.

- (c) You provided treatment to Patient 3 from in or around October 2023 until at least April 2025. You ordered and/or prescribed dangerous drugs and controlled substances to Patient 3, which included Trulicity and lorazepam (0.5 mg tid as needed). You prescribed lorazepam to this patient in or around December 2024 and March 2025, with a quantity of 90 pills.
- (d) In or around July 2024, you provided treatment to Patient 4. On or about July 4, 2024, you ordered and/or prescribed dangerous drugs and controlled substances to Patient 4, which included buspirone, fluoxetine, warfarin, and Phentermine (15 mg daily, with a quantity of 30). On or about July 22, 2024, the patient reported that she had been in an emergency room for a blood clot in her lung, and you discontinued Phentermine.

Your acts, conduct, and/or omissions as alleged in paragraphs (1) through (3)(d) 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: Rule 4731-11-08, Ohio Administrative Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) through (3)(a) above, individually and/or collectively, constitute “violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board,” as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: General Provisions, Rule 4731-11-02, Ohio Administrative Code. Pursuant to Rule 4731-11-02(E), Ohio Administrative Code, a violation of Rule 4731-11-02(C), Ohio Administrative Code, also constitutes a violation of Sections 4731.22(B)(2), 4731.22(B)(3) and 4731.22(B)(6), Ohio Revised Code.

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

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of service 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 service 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 or suspend your license or certificate, or refuse to grant or register or issue the license or certificate for which you have a pending application in accordance with Section 9.79 of the Ohio Revised Code, or refuse to renew or reinstate your license or 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 or issue a license or certificate to practice to an applicant, revokes an individual's license or certificate to practice, refuses to renew an individual's license or certificate to practice, or refuses to reinstate an individual's license or certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a license or certificate to practice and the board shall not accept an application for reinstatement of the license or certificate or for issuance of a new license or certificate."

Copies of the applicable sections are enclosed for your information.

THE STATE MEDICAL BOARD OF OHIO



Kim G. Rothermel, M.D.
Secretary

KGR/MRB
Enclosures

Via Email: tanikaspidell@hotmail.com

**IN THE MATTER OF
Tanika Sharee Spidell, D.O.
25-CRF-0132**

**August 13, 2025, NOTICE OF
OPPORTUNITY FOR HEARING -
PATIENT KEY**

**SEALED TO
PROTECT PATIENT
CONFIDENTIALITY**