BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

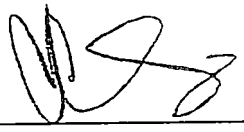
In the Matter of the First Amended Accusation Against: Criselda Calayan Abad-Santos, M.D. Physician's & Surgeon's Certificate No A 105195 Respondent.	Case No.: 800-2019-055917

ORDER DENYING PETITION FOR RECONSIDERATION

The Petition filed by Benjamin J. Fenton, attorney for Criselda Calayan Abad-Santos, for the reconsideration of the decision in the above-entitled matter having been read and considered by the Medical Board of California, is hereby denied.

This Decision remains effective at 5:00 p.m. on August 24, 2023.

IT IS SO ORDERED: August 25, 2023



Laurie Rose Lubiano, J.D., Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **Criselda Calayan Abad-Santos, M.D.** **Physician's & Surgeon's Certificate No. A 105195** **Respondent.**	**Case No. 800-2019-055917** **ORDER GRANTING STAY** **(Government Code Section 11521)**

Benjamin J. Fenton, Esq. on behalf of Respondent, Criselda Calayan Abad-Santos, M.D., has filed a Request for Stay of execution of the Decision in this matter with an effective date of August 14, 2023, at 5:00 p.m.

Execution is stayed until August 24, 2023, at 5:00 p.m.

This Stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: August 10, 2023

Reji Varghese
Executive Director
Medical Board of California

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: Criselda Calayan Abad-Santos, M.D. Physician's and Surgeon's Certificate No. A 105195 Respondent.	Case No. 800-2019-055917

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on August 14, 2023.

IT IS SO ORDERED July 13, 2023.

MEDICAL BOARD OF CALIFORNIA

Laurie Rose Lubiano, J.D., Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:

CRISELDA CALAYAN ABAD-SANTOS, M.D., Respondent.

Agency Case No. 800-2019-055917

OAH No. 2022080849

PROPOSED DECISION

Joseph D. Montoya, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter on March 20, 22, and 23, 2023, by video conference.

Complainants William Prasfika and Reji Varghese were represented by Christina Sein Goot, Deputy Attorney General. Respondent Criselda Calayan Abad-Santos, M.D., appeared each day and was represented by Benjamin Fenton, Fenton Law Group.

Prior to the hearing, Complainant moved for a protective order to seal some exhibits, to protect confidential information. There was no objection to the motion. In preparing this Proposed Decision, the ALJ determined some other exhibits should be sealed as well. Redactions were made in others. A separate protective order shall issue.

Oral and documentary evidence was received. The record closed and the matter was submitted for decision on March 23, 3023. Thereafter, the ALJ ordered the record re-opened, so that Complainant could file an amended pleading that would encompass an amendment made orally during the hearing. Complainant submitted a First Amended Accusation on May 4, 2023, as exhibit 32 which is received as a jurisdictional document.

The record again closed, and the matter was again submitted for decision on May 4, 2023. The ALJ hereby makes his factual findings, legal conclusions, and order, as follows.

FACTUAL FINDINGS

The Parties and Jurisdiction

1. Complainant William Prasfika filed and maintained the Accusation in his official capacity as Executive Director of the Medical Board of California, Department of Consumer Affairs (Board). Thereafter, Reji Varghese filed and maintained the First Amended Accusation (FAA) in his official capacity as Interim Executive Director of the Board.

2. On August 13, 2008, the Board issued Physician's and Surgeon's Certificate Number A 105195 (license) to Respondent. The license is due to expire on December 31, 2023 unless renewed. Respondent's license has previously been disciplined, as detailed below.

3. After being served with the Accusation, Respondent filed a Notice of Defense, contesting the charges and requesting a hearing. Respondent is deemed to

have controverted the FAA by operation of law. (Gov. Code, § 11507.) All jurisdictional requirements have been met.

Respondent's Background

EDUCATION AND TRAINING

4. Respondent received a bachelor's degree in psychology in 1987 from the University of the Philippines, and a medical degree from that university's College of Medicine in 1993. Between May 1992 and April 1993, she was an intern in Philippine General Hospital. From July 1995 until June 1999, Respondent was an intern and resident in psychiatry at St. Luke's-Roosevelt Hospital, Columbia University College of Physicians and Surgeons.

5. Respondent held various positions in institutional settings after her service at St. Luke's-Roosevelt Hospital. For example, she worked at St. Elizabeth's Hospital in Washington D.C. in the acute psychiatric hospital for three years. She had positions at facilities in Delaware from November 2002 to September 2009. She moved west, and beginning in 2009, Respondent held positions in Ventura County, until approximately 2012, when she began private practice in the San Fernando Valley, through the present.

PRIOR DISCIPLINE

6. Respondent has been disciplined by the Board prior to this proceeding. On March 30, 2012, in the case titled *In the Matter of the Accusation Against Criselda Calayan Abadsantos, M.D.* (Board case number 05-2010-205633), Respondent's license was revoked, but the revocation was stayed, and the license was placed on probation for three years. Among the probation conditions was a requirement that Respondent

take and pass a clinical training program, and she was barred from prescribing or furnishing controlled substances to her family members. She was obligated to maintain a record of all such drugs that she prescribed. Respondent was also required to take courses in prescribing practices, medical record keeping, and ethics.

7. In April 2014, The Board brought an action to revoke Respondent's probation in the case titled *In the Matter of the Petition to Revoke Probation Against Criselda Calayan Abadsantos, M.D.* (Board case number D1-2010-205633). On April 1, 2015, Respondent's probation period was extended for one year, and additional probation terms were imposed on her license. She was obligated to re-enroll in a clinical training program, and the bar on prescribing or furnishing controlled substances to her family members was continued. Respondent was required to continue making records of her prescriptions of controlled substances, and she was required to take a psychopharmacology course, and other courses.

8. In November 2016, another petition to revoke probation was filed against Respondent. That case, titled *In the Matter of the Petition to Revoke Probation Against Criselda Calayan Abad-Santos M.D.*, bore case number 800-2016-027627. On September 1, 2017, a decision was issued by the Board that once again extended the original probation term, for another year. Salient probation requirements ordered as part of the extension included that Respondent repeat the medical record keeping course, that her practice be monitored for at least a year, that she participate in a psychopharmacology course, and that Respondent retake the buprenorphine waiver training course. The bar on prescribing or furnishing controlled substances to family members was continued, as was Respondent's obligation to maintain a log of all controlled substances that she prescribed.

9. Respondent completed probation on September 1, 2018.

10. The facts underlying the prior discipline are summarized as follows, and are based on Respondent's admissions during the three proceedings. The original proceeding was based on Respondent's prescription of controlled substances to family members or friends. In the agreement to resolve the matter, Respondent admitted to prescribing controlled substances to five people, several of them family members, without an adequate, or sometimes any, prior examination. Thus, for example, she prescribed Adderall to an 18-year-old woman, a family friend, ostensibly for depression, without an evaluation or basic physical exam, failing to evaluate the patient's liver or cardiac functions. She did not inform the patient about potential side effects of Adderall. Later, and over a period of months, she prescribed other dangerous drugs to the patient including Phentermine (a stimulant and Schedule IV controlled substance); hydrocholorothiazide (a diuretic and dangerous drug); Trazodone (an antidepressant and dangerous drug); and Metformin (a dangerous drug used to treat diabetes). She did so without any prior exam, as the patient had moved out of state. Respondent prescribed dangerous drugs to family members who resided out of the United States, without any examination. She further admitted she failed to maintain adequate and accurate medical records for these patients.

11. To resolve the 2014 Petition to Revoke Probation, Respondent admitted to the truth and accuracy of the allegations against her. She thereby admitted she had taken the Physician Assessment and Clinical Education Program—PACE—at the University of California San Diego (UCSD) Medical School, and she admitted that during phase II of the program, the clinical education and assessment portion, she was assessed as Fail, Category 4, poor performance not compatible with overall competency and safe practice. As noted above, Respondent's probation was extended, and she was ordered to complete a Master Class in psychopharmacology offered at Harvard Medical School.

12. In resolving the second Petition to Revoke Probation, Respondent admitted that after failing PACE the first time, she again participated in the program and passed, but with significant deficiencies. The PACE program recommended several remedial measures, which were incorporated into the order extending probation. These measures included a year of practice monitoring or enrollment in the PACE Professional Enhancement Program (PEP); repetition of a records keeping course; that Respondent take another psychopharmacology course, either through the Massachusetts General Hospital or the 2016 Neuroscience Education Institute; repetition of one of the buprenorphine waiver training courses; and submit to a toxicology screening.

The Expert Witnesses

13. Complainant's expert witness was Peter M. Ferren, M.D., M.P.H. Dr. Ferren holds a bachelor's degree in Anthropology from Harvard University, a master's degree in Public Health from Emory University, and a medical degree from Yale University's School of Medicine. He was an intern and resident in psychiatry at Emory University's medical school between 1997 and 2000. Between 2000 and 2002 he was a fellow in child psychiatry at Yale Child Study Center. He is licensed in California, Georgia, and Connecticut, and he is board certified in general psychiatry and child and adolescent psychiatry. Since 2002 Dr. Ferren has been a professor at the University of California, San Francisco (UCSF), advancing from Assistant Clinical Professor to Associate Clinical Professor, to Clinical Professor beginning in 2014. He has been an Attending Psychiatrist at Zuckerburg San Francisco General Hospital since 2002, and he also has private practice patients. He has received numerous awards and recognitions by UCSF, and groups such as the American Psychiatric Association; Dr. Ferran was elected to Distinguished Fellow status by that organization in 2019.

14. Samuel I. Miles, M.D., Ph.D., served as Respondent's expert witness. Dr. Miles is a graduate of New York Medical College. He interned at Georgetown Medical Service D.C. General Hospital. His residency was performed at Cedars-Sinai Medical Center in Los Angeles, where he served as Chief Resident. Thereafter, he obtained his Ph.D. from the Southern California Psychoanalytic Institute in Beverly Hills. Dr. Miles is board certified in general psychiatry, addiction psychiatry, and forensic psychiatry. He is a Distinguished Life Fellow of the American Psychiatric Association. Dr. Miles has served as an Assistant Clinical Professor of Psychiatry at the UCLA School of Medicine, and he has served in various leadership positions at Cedars-Sinai Medical Center, including a three-year stint as Clinical Chief of the Department of Psychiatry and Behavioral Neuroscience. About two-thirds of Dr. Miles' practice is devoted to treating outpatients, age 17 and older.

The Two Subject Patients, Generally

PATIENT 1

15. Patient 1 was first seen by Respondent on January 4, 2018. Patient 1 was then 28-years old, a woman of Korean descent. During the first visit, Patient 1 reported she had recently moved to the Los Angeles area from Alabama, she had been diagnosed with Borderline Personality Disorder, and she had been treated by a psychiatrist in Alabama for approximately 10 years.

16. Patient 1 reported 15 symptoms on her New Patient Evaluation Form, checking off boxes for problems such as depressed or sad mood, impulsive behavior, panic attacks, racing thoughts, or problems with sleeping. Patient 1 identified her psychiatrist in Alabama, who reportedly saw her every three months. She identified several medications she had previously used, including Vyvanse, 60 mg. daily;

Lamotrigine, 200 mg. twice per day; Lexapro 10 mg. daily; and, Seroquel, 100 mg. at bedtime.

17. Patient 1 reported medical issues including thyroid disease, nose bleeds and easy bruising, sinus or nasal problems, and sleep problems. She reported taking Levothyroxine to treat the thyroid disease and noted that she was allergic to Wellbutrin. She reported sparse alcohol intake and denied using recreational drugs.

PATIENT 2

18. Patient 2 is a woman who was 69 years old when she first saw Respondent, in early 2016. According to a Medical History form signed by Patient 2 on February 29, 2016, she took medication for high blood pressure, had type 2 diabetes in the past, and suffered from arthritis and problems with her digestion, which she related to stress. She indicated she was then taking herbs for constipation, Cardizem (Diltiazem) 240 mg.; Atacand (Candesartan) 16 mg.; Hydrocodone; Opana ER; and Celebrex (Celecoxib)240 mg. Diltiazem and Candesartan are medications for high blood pressure, while the Celebrex is a non-steroidal anti-inflammatory drug often used to treat arthritis. Hydrocodone and Opana are opioids used to treat pain.

19. On her Patient Information Form, generated on March 9, 2016, Patient 2 indicated her psychotherapist recommended treatment with Respondent "to help me with medication." (Ex. 18, p. A622.) The patient indicated she had been treated on an out-patient basis for depression, denying hospitalization for any psychiatric disorder.

20. Patient 2 disclosed she suffered from chronic arthritis, vertigo since 2014, and nausea, vomiting, diarrhea and abdominal pain when anxious. She wrote she "had" type 2 diabetes, from 2004. In a separate document in the chart, apparently generated by the patient, she stated she had heart palpitations and sometimes chest pain. (Ex. 18,

p. A630.) Patient 2 also wrote she suffered from PTSD from multiple physical and psychological traumas from childhood to adult years. (*Id.* at p. A631.)

21. Patient 2 identified her primary care physician and she authorized Respondent to communicate with him. (Ex. 18, p. A623.) She indicated that she had last had a check-up or physical exam with that physician in 2015. (*Id.* at p. A632.) Patient 2 was also under the care and treatment of a cardiologist. At some point she disclosed she was being treated by a specialist in pain management.

22. Respondent diagnosed Patient 2 with major depressive disorder, recurrent, severe without psychotic features; posttraumatic stress disorder, chronic, with dissociative symptoms; panic disorder; and, generalized anxiety disorder.

TREATMENT OF PATIENT 1

23. Respondent continued three of the four medications that Patient 1 had been prescribed by her former psychiatrist: Vyvance (lisdexamfetamine), 60 mg. capsule in the morning; Lamictal (Lamotrigine), 200 mg. tablet orally twice per day; Lexapro (escitalopram), 10 mg. tablet orally in the morning. She did not continue to prescribe Seroquel to Patient 1, instead starting a new drug, Xanax (alprazolam), .25 mg. daily as needed for anxiety, 30 tablets, no refills.

24. Respondent documented a discussion with Patient 1 regarding the drugs she was prescribing; this is found on a psychiatric evaluation generated January 4, 2018, as the first entry under the heading "Treatment Plan." (Ex. 15, p. A523.) According to the entry in the chart, Respondent discussed side effects, risks, benefits, interactions with alcohol and other drugs, documenting that the patient verbalized her understanding. Such is documented in subsequent progress notes. (I.e., Ex. 15, pp. A542, A543.)

25. Generally, Respondent saw Patient 1 during monthly visits. During visits between February 28 and May 16, 2018, Patient 1 showed stability. Respondent increased the Vyvanse dosage up to 70 mg. in February 2018, and later reduced it to 60 mg. Respondent continued to prescribe Xanax, but CURES and pharmacy records indicate that the Xanax prescriptions were not filled during the time of the physician-patient relationship.

26. During later visits, the amount of Vyvance prescribed for Patient 1 varied. The patient reported that Xanax was alleviating her panic attacks. Again, this does not jibe with the CURES report indicating that no Xanax was dispensed to the patient.

27. As noted by Dr. Ferren, the relationship between Respondent and Patient 1 became strained. On January 31, 2019, Respondent wrote Patient 1, informing her that Respondent would no longer treat her, primarily because the patient failed to cooperate with the treatment plan, and because of her poor treatment of Respondent's staff. (Ex. 15, p. A516.)

28. During her treatment of Patient 1, Respondent failed to obtain a baseline measure of the patient's blood pressure, and she did not periodically monitor the patient's blood pressure. Nor did she measure and monitor the patient's blood pressure, pulse, and serum creatine levels when she prescribed Vyvance and Cymbalta to Patient 1.

TREATMENT OF PATIENT 2

29. During the patient's initial visit, Respondent prescribed Lexapro, an anti-depressant and anti-anxiety medication; Adderall, a stimulant; Klonopin, a benzodiazepine, and Xanax, another benzodiazepine, on an as-needed basis. Respondent continued to prescribe Lexapro, Adderall, and Xanax during the next

several months. (It should be noted that as of the hearing date, Patient 2 was still treating with Respondent.) By the fall of 2017, Respondent was prescribing Wellbutrin SR 100 mg. once per day; Lamictal, 25 mg. twice per day; Lexapro, 20 mg. once per day; Adderall, 30 mg. twice per day; Xanax .25 mg once per day was often prescribed as well. (See Ex. 18, p. A639.) Diazapam made its way into the mix beginning in March 2018. (Id. at p. A640.)

30. Despite being on notice that Patient 2 had co-morbidities, and was under the care and treatment of other physicians, and despite the fact Patient 2 identified her primary care physician and consented to Respondent contacting that physician, nothing in the patient's chart indicates Respondent contacted or attempted to contact the primary care physician. Respondent did not obtain records or information from the other physicians, such as Patient 2's cardiologist or pain management doctor. Respondent did not conduct her own exams, did not measure vital signs or obtain baselines, even though the patient had cardiac problems. She prescribed Adderall, a stimulant, to a patient being treated for cardiovascular issues without consulting, or attempting to consult, with the patient's cardiologist. At one point, Respondent told the patient to communicate with the cardiologist regarding that physician's prescribing of medication for high blood pressure.

31. During a visit on February 7, 2019, Patient 2 reported her cardiologist suggested a change from Adderall, which Respondent had prescribed to treat Patient 2's ADHD, to Provigil (modafinil), as the latter would not affect the patient's heart or cause high blood pressure. (Ex.15, p. A700.) During the visit when Patient 2 reported the change to Provigil, she also reported that she was already started on "blood pressure lowering medication." (*Id.*) The treatment plan set out in the chart stated that she would discontinue Adderall and start Provigil 200 mg. tablet orally, daily.

32. When the patient's medical insurance would not pay for Provigil, not deeming it proper for treating ADHD, Respondent went back to prescribing Adderall, without any consultation with Patient 2's cardiologist, renewing that medication with 30 mg. tablets twice per day.

33. In November and December 2019, Patient 2 reported she had a new pain management doctor who was detoxing her from Opana, which she had taken for 11 years. Patient 2's new pain management doctor intended to take her off opioid pain medications entirely and was going to utilize a transdermal patch to manage the patient's arthritis pain. Patient 2 reported that she would be treated with Buprenorphine to take her off of the opiates.

34. Respondent did not take steps to consult with Patient 2's then-new pain management physician regarding the new course of treatment, and how Respondent's treatment course might be affected, and whether she should make any modifications to her prescribing medications to Patient 2.

35. Respondent, as found above, prescribed two benzodiazepines, one short acting and one long acting, to an elderly patient who was taking opioids. She did so without consulting or attempting to consult Patient 2's other doctors. It is known that prescribing benzodiazepines in such circumstances raises the risk of respiratory suppression.

Expert Opinions

DR. FERREN'S OPINIONS

36. Dr. Ferren opined, in his testimony and his report, that Respondent committed some acts of simple negligence, mainly in her care and treatment of Patient

1, and acts of gross negligence in her care and treatment of Patient 2. His opinions are summarized as follow:

(A) That Respondent committed a simple departure from the standard of care when she prescribed Vyvance and Cymbalta to Patient 1, without obtaining a baseline pulse and blood pressure, and by failing to monitor those vital signs during the course of treatment. He further opined that it was simple negligence to fail to check the patient's creatine levels when prescribing Cymbalta.

(B) Dr. Ferren opined that Respondent, in treating Patient 1, failed to obtain informed consent to the risk of dependence on Xanax, in his opinion an act of simple negligence. In Dr. Ferren's opinion, a separate written informed consent was required as to this issue of possible dependance.

(C) Dr. Ferren opined that relying solely on Patient 2's report regarding her medications and co-morbidities without attempting to obtain records, or consult directly with the patient's other treating physicians was an extreme departure from the standard of care.

(D) Dr. Ferren opined Respondent's prescription of psychotropic medications to Patient 2, without conducting baseline examinations or obtaining medical records from other providers, and the failure to periodically monitor for changes in physical health related to a known co-morbid cardiovascular condition, amounted to an extreme departure from the standard of care.

(E) It is Dr. Ferren's opinion that Respondent failed to conduct baseline and ongoing medication reconciliation in her care and treatment of Patient 2, which amounted to an extreme departure from the standard of care. During his testimony he explained that simply listing the medications prescribed by Respondent was not an

adequate medication reconciliation; there should have been information about any other drugs the patient might be taking.

(F) In Dr. Ferren's opinion Respondent's prescription of a stimulant—Adderall—to a patient with a cardiovascular co-morbidity without considering safety issues represented a lack of knowledge.

(G) Respondent's prescription of a short-acting benzodiazepine and a long-acting benzodiazepine to Patient 2 was a simple departure from the standard of care. Dr. Ferren's opinion was that the prescription of the benzodiazepines to a patient taking opioids, without collaborating with her other physicians, amounted to an extreme departure from the standard of care. Dr. Ferren opined that while the benzodiazepine doses for Patient 2 may have been low, one of those drugs was long acting, which increases the risks to the patient when prescribed with opioids, as there is increased risk of suppression of breathing.

(H) Dr. Ferren noted that despite Respondent's departures from the standard of care, there was no evidence of harm to either patient.

DR. MILES' OPINIONS

37. Dr. Miles opined, in his report and testimony, as follows:

(A) That if Respondent prescribed Xanax to Patient 1 without informing the patient of the risk of developing dependance, she would not have met the standard of care. However, he believed Respondent did so, based on a conversation he had with Respondent in February 2023.

(B) Dr. Miles agreed that the standard of care required periodic monitoring of pulse and blood pressure when prescribing lisdexamfetamine and duloxetine

(Vyvance and Cymbalta). Dr. Miles disagreed with Dr. Ferren's opinion that the failure to obtain baseline serum creatine, and periodically monitoring it, was required when prescribing Cymbalta. He pointed out that several sources of medical information did not call for such monitoring, and the manufacturer's package insert did not call for monitoring serum creatine.

(C) Dr. Miles stated his agreement with the proposition that prescription of psychotropic medication requires periodic monitoring of changes in a patient's physical and mental condition. He noted, "optimally, this can occur with communication with other physicians treating one's patient." (Ex. B, p. B5.) He further noted that such rarely occurs in private practice.

(D) Dr. Miles disagreed with Dr. Ferren's assertion that reliance on a patient's reports regarding medications and medical co-morbidities was a departure from the standard of care, noting that patient reports are often the only source of information. He went on to say "in an ideal world, a treating psychiatrist would be able to communicate with other physician's treating one's patient. Unfortunately, this is not always possible." (Ex. B, p. B5.)

(E) On the issue of prescribing benzodiazepines to a patient taking opioids, Dr. Miles believes Respondent used adequate restraint in her prescribing, such as to bring her within the standard of care. He also believed she adequately educated Patient 2 about the risks of using both medication types. Again, he noted that collaboration with other treating physicians, here pain management physicians, is often difficult.

(F) Dr. Miles opined in testimony that the chart indicates adequate informed consent regarding the prescription of Xanax to Patient 1. He is of the opinion that a

separate written consent is not required outside of institutional settings; that those working in the outpatient setting do not need to use separate informed consent documents to meet the standard of care. Notwithstanding this opinion, he acknowledged that the medical records did not have a specific note about the risk of dependance on Xanax.

(G) Regarding medication reconciliation, Dr. Miles testified that the process is needed when you first see the patient, and thereafter should be followed up from time to time.

(H) Dr. Miles testified that Respondent was making adequate assessment and monitoring of Patient 2's condition, and that she could essentially rely on the patient's other doctors to treat her other conditions.

(I) Dr. Miles acknowledged that use of benzodiazepines and opioids can be problematic.

Respondent's Testimony

38. Respondent testified to her education and training. She testified that her current practice has her treating patients 18 and older, eight to twelve patients per day, three days per week. She has had no malpractice claims, and no hospital discipline.

39. Regarding Patient 1, Respondent testified that she tried to call the patient's prior treating psychiatrist, but got no response. She testified that she explained to the patient the side effects and risks of the various medications she prescribed, including addiction risk for Xanax. Respondent noted she gave the lowest dose of Xanax, 2.5 mg. where the maximum dose is 8 mg. Respondent pointed to the

part of the treatment plan that documented the discussion with the patient of medication issues. She is not aware of a requirement of a separate informed consent document. Respondent understood that Patient 1 was not routinely taking Xanax, which indicated a lack of addiction to that drug. On cross-examination, Respondent acknowledged that she never checked Patient 1's blood pressure, pulse, or serum creatine level.

40. Regarding Patient 2, Respondent testified that it is her practice to obtain authorization forms from a patient so that Respondent could communicate with other doctors. She claimed to have done so with Patient 2, but despite a fax and call to the primary treating physician there was no communication from that doctor. She testified that she attempted to get information from Patient 2's other doctors, and even enlisted the help of the patient's husband, but to no avail.

41. Respondent believed that the patient's other physicians were managing the patient's blood pressure, pointing to a July 24, 2019 progress note where Patient 2 reported her blood pressure was well controlled by medication, and ranged from 115/70 to 120/75 mm daily. (Ex. 18, p. A706.) Respondent also pointed to a March 2019 progress note where she documented her advice to Patient 2 to continue taking her blood pressure medication. (*Id.* at p. A702.)

42. Respondent does not believe that she was obligated to perform a medication reconciliation at every patient visit, but attested if a patient disclosed a new medication, she would take note of it.

43. Respondent noted instances where Patient 2's records show Respondent was advising the patient about potential medicine complications. The May 22, 2018, progress note states: "[Patient 2] reports she's very careful about taking all her

medications because of all the possible drug-drug interactions." (Ex. 18, p. A694.) During an earlier visit, the patient reported she was not taking "narcotic pain medications for her severe arthritis prescribed by her pain management doctor when she's taking Diazepam." (*Id.* at p. A692 [April 20, 2018].) This followed a conversation during the prior month's meeting; the progress note for March 9, 2018, notes a discussion of bringing Diazepam into the prescription mix, followed by the statement "she [Patient 2] was warned and advised to be careful taking Diazepam with her narcotic pain medications that she's getting from her pain management doctor due to the additive effect of CNS [presumably Central Nervous System] depression with both medications. She acknowledges her understanding about drug-drug interactions." (*Id.* at p. A690.)

44. Respondent defended her prescription practice with Patient 2. As to the issue of prescribing both a long acting and short acting benzodiazepine, she spoke to the different methods of action of the various drugs. She testified that she considered the safety issue of prescribing Adderall to an older patient with cardiovascular issues, and relied on her understanding that the patient was seeing a cardiologist. Respondent indicated that the 16 mg. doses of Adderall were manageable amounts. As to the claim by Complainant that she did not prescribe benzodiazepines with restraint, she asserted she started with the lowest dose, two times per day, where other patients might get three or four times that amount.

45. On cross-examination Respondent acknowledged she did not document consent to call Patient 1's former psychiatrist, and despite her testimony to having called him, that call is not documented in the patient's records. She admitted there is no documentation in Patient 2's charts of an effort to contact that patient's primary treating physician.

46. Respondent acknowledged she didn't consult with Patient 2's cardiologist before prescribing Adderall and did not perform an EKG or other tests. She does not believe she needed to perform an EKG before prescribing stimulants such as Adderall. Respondent asserted she started Patient 2 with a low dose of Adderall—5 mg.—but acknowledged that within two months, she had increased the dosage to 30 mg., asserting that the increase was justified because there were no side effects. She described some of the side effects to look for to include increased blood pressure and heart palpitations. However, there is no evidence Respondent ever took Patient 2's blood pressure.

47. Respondent was told by Patient 2 that she had obtained some Provigil from her husband, and she told Respondent her cardiologist said that was okay. Respondent admitted that this sort of sent up a "red flag," and she admitted that ideally, she should have contacted the cardiologist, but did not do so. (See Ex. F, p. B99.) In a text from Patient 2, the latter discussed the Provigil and stated that her therapist thought the patient should tell Respondent about it. Patient 2 wrote "please call or email . . . my therapist, for any further input from him. He told me he would be more than happy to assist you in helping me." (*Id.*) Although Patient 2 provided the therapist's phone number and e-mail address, there is no evidence Respondent reached out to the therapist.

48. Respondent testified that she checks Patient 2's CURES report before every visit by the patient.

Other Findings

49. Respondent testified that at some point she wanted to obtain Patient 2's medical records, to verify that the patient was stable with the Adderall prescription,

which the patient and her husband asserted was a beneficial treatment. She testified she told the patient and patient's husband she wanted the records and claimed she was raising the issue of the records every time the prescription was refilled; she testified she told the couple she was getting uncomfortable with the Adderall prescription when she could not obtain the patient's medical records. She also testified she was concerned with drug interactions. However, Exhibit H indicates that Respondent was pressing the issue of the records after this proceeding was initiated. The patient's medical records (Exhibit 18) do not support the testimony described above.

50. Respondent offered in evidence copies of emails or text messages from Patient 2; they were admitted as Exhibits E and F. Respondent acknowledged that the documents should have been placed in the patient's records, but they were not.

51. In four years of treatment with Patient 2, Respondent did not obtain any vital signs from the patient.

52. According to Respondent's CV, she "collaborates with the primary care physicians and psychotherapists." (Ex. A, p. B115.) There is no credible evidence of any such collaboration in this case.

Findings Regarding the Expert Opinions

53. In the main, Dr. Ferren's opinions are credited. This is not a criticism of Dr. Miles' qualifications, but is based on an examination of the evidence underlying Dr. Ferren's opinions.

54. Dr. Ferren's opinion that Respondent committed a simple departure from the standard of care when she prescribed Vyvance and Cymbalta to Patient 1, without

obtaining a baseline pulse and blood pressure, and by failing to monitor those vital signs during the course of treatment, is credited. This opinion was shared by Dr. Miles. However, it was not established that Respondent departed from the standard of care by failing to monitor creatine; on this point Dr. Miles' opinion is credited.

55. Dr. Ferren's opinion that Respondent committed a simple departure from the standard of care by failing to have a separate written informed consent regarding the warning to Patient 1 about the risk of dependence when taking Xanax is not credited. Dr. Miles' opinion that a separate document is not necessary in outpatient treatment is credited. Nonetheless, it was established that such advice, if given, was not documented in the patient's chart. This was a simple departure from the standard of care and a failure to maintain adequate records.

56. Dr. Ferren's opinion that Respondent's reliance solely on Patient 2's report regarding her medications and co-morbidities without attempting to obtain records, or consult directly with the patient's other treating physicians was an extreme departure from the standard of care, is credited; this is mainly as to Respondent's failure to verify the information that Patient 2 had provided. Dr. Miles never quite said the failure to obtain records or to consult with other physicians was within the standard of care; he stated, essentially, that such may not be feasible in daily practice, where cooperation with other treaters may not be attainable. However, the documentation supports a finding that Respondent never made an effort to consult with the other medical professionals. And, if Respondent made such efforts, she did not chart them, a failure to maintain adequate records.

57. Dr. Ferren's opinion that Respondent committed an extreme departure from the standard of care by her prescription of psychotropic medications to Patient 2, without conducting baseline examinations or obtaining medical records from other

providers, and the failure to periodically monitor for changes in physical health related to a known co-morbid cardiovascular condition is credited. Dr. Miles stated his agreement with the proposition that prescription of psychotropic medication requires periodic monitoring of changes in a patient's physical and mental condition. It is noteworthy that Dr. Miles agreed with Dr. Ferren's opinion that failure to do basic monitoring of Patient 1 was at least simple negligence; it follows that it was an extreme departure from the standard of care to fail to conduct baseline examinations, and to monitor Patient 2, given her age and co-morbidities. And, Respondent did not document any effort to contact other treating physicians.

58. Dr. Ferren's opinion that Respondent failed to conduct baseline and ongoing medication reconciliation in her care and treatment of Patient 2, and that such was an extreme departure from the standard of care, is credited.

59. Dr. Ferren's opinion that Respondent's prescription of a short-acting benzodiazepine and a long-acting benzodiazepine to Patient 2 was a simple departure from the standard of care is credited. Further, his opinion that the prescription of the benzodiazepines to a patient taking opioids, without collaborating with her other physicians, amounted to an extreme departure from the standard of care, is also credited.

Costs

60. The Board incurred costs in the investigation and prosecution of this matter totaling $22,908.75, which costs are reasonable on their face.

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LEGAL CONCLUSIONS

Jurisdiction

1. Jurisdiction to proceed in this matter pursuant to Business and Professions Code sections 2004 and 2227 was established, based on Factual Findings 1 through 3. (Further code citations are to the Business and Professions Code unless otherwise noted.)

Rules of General Applicability

2. The standard (as opposed to the burden) of proof in this proceeding is that of clear and convincing evidence, to a reasonable certainty. (*Eittinger v. Bd. of Med. Quality Assurance* (1982) 135 Cal.App.3d 853.) Complainant was therefore obligated to adduce evidence that was clear, explicit, and unequivocal—so clear as to leave no substantial doubt and sufficiently strong as to command the unhesitating assent of every reasonable mind. (*In Re Marriage of Weaver* (1990) 224 Cal.App.3d 478.)

3. (A) The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke, Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.* at p. 67–68, quoting from *Nevarov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) The testimony of "one credible witness may constitute substantial evidence," including a single expert witness. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.)

(B) The rejection of testimony does not create evidence contrary to that which is deemed untrustworthy. Disbelief does not create affirmative evidence to the contrary of that which is discarded. "The fact that a jury may disbelieve the testimony of a witness who testifies to the negative of an issue does not of itself furnish any evidence in support of the affirmative of that issue, and does not warrant a finding in the affirmative thereof unless there is other evidence in the case to support such affirmative." (*Hutchinson v. Contractors' State License Bd. of Cal.* (1956) 143 Cal.App.2d 628, 632–633, quoting *Marovich v. Central Cal. Traction Co.* (1923) 191 Cal. 295, 304.)

(C) Discrepancies in a witness's testimony, or between that witness's testimony and that of others does not necessarily mean that the testimony should be discredited. (*Wilson v. State Personnel Bd.* (1976) 58 Cal.App.3d 865, 879.)

(D) "On the cold record a witness may be clear, concise, direct, unimpeached, uncontradicted—but on a face to face evaluation, so exude insincerity as to render his credibility factor nil. Another witness may fumble, bumble, be unsure, uncertain, contradict himself, and on the basis of a written transcript be hardly worthy of belief. But one who sees, hears and observes him may be convinced of his honesty, his integrity, his reliability." (*Wilson v. State Personnel Bd., supra*, 58 Cal.App.3d 865, 877–878, quoting *Meiner v. Ford Motor Co.* (1971) 17 Cal.App.3d 127, 140.)

(E) An expert's credibility may be evaluated by looking to his or her qualifications. (*Grimshaw v. Ford Motor Co.* (1981) 119 Cal.App.3d 757, 786.) It may also be evaluated by examining the reasons and factual data upon which the expert's opinions are based. (*Griffith v. Los Angeles County* (1968) 267 Cal.App.2d 837, 847.)

(F) The trier of fact may reject the testimony of a witness, including an expert witness even if it is uncontradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3

Cal.3d 875, 890.) The expert's opinion is no better than the facts on which it is based and, "where the facts underlying the expert's opinion are proved to be false or nonexistent, not only is the expert's opinion destroyed but the falsity permeates his entire testimony; it tends to prove his untruthfulness as a witness." (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 923–924.) The statement of this general rule here is not to be considered as a finding or conclusion that either expert was untruthful.

(G) Even when the witness qualifies as an expert, he or she does not possess a carte blanche to express any opinion within the area of expertise. For example, an expert's opinion based on assumptions of fact without evidentiary support, or on speculative or conjectural factors, has no evidentiary value and may be excluded from evidence. Similarly, when an expert's opinion is purely conclusory because unaccompanied by a reasoned explanation connecting the factual predicates to the ultimate conclusion, that opinion has no evidentiary value because an expert opinion is worth no more than the reasons upon which it rests. (*Jennings v. Palomar Pomerado Health Systems, Inc.* (2003) 114 Cal.App.4th 1108, 1116.) The bare conclusion of an expert without supporting facts is not entitled to evidentiary weight. (*Bushling v. Fremont Medical Center* (2004) 117 Cal.App.4th 493.)

(H) The presiding officer in an administrative proceeding may evaluate evidence based on his or her experience or training. (Gov. Code, § 11425.50, subd. (c).)

4. A professional is negligent if he or she fails to use that reasonable degree of skill, care, and knowledge ordinarily possessed and exercised by members of the profession under similar circumstances, at or about the time of the incidents in question. Just what that standard of care is for a given professional is a question of fact, and in most circumstances must be proven through expert witnesses. (*Flowers v.*

Torrance Memorial Hospital Medical Center (1994) 8 Cal.4th 992, 997-998, 1001; *Alef v. Alta Bates Hospital* (1992) 5 Cal.App.4th 208, 215; see 6 B. Witkin, *Summary of California Law* (9th. Ed.), Torts, sections 749, 750, and 774.)

5. The Code does not define just what "gross negligence" means in proceedings of this type. The Court of Appeal addressed this matter in *Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040. There the Second District Court of Appeal stated:

> Gross negligence is "'the want of even scant care or an extreme departure from the ordinary standard of conduct.'" (*Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 941 [123 Cal.Rptr.1053, 1063], quoting from *Van Meter v. Bent Construction Co.* (1956) 46 Cal.2d 588, 594 [297 Cal.Rptr. 644].) The use of the disjunctive in the definition indicates alternative elements of gross negligence—both need not be present before gross negligence will be found. (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 196-197 [167 Cal.Rptr. 881].)[1]

(189 Cal.App.3d at 1052-1053.)

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[1] The disjunctive definition set forth in *Gore* was also followed in *Yellen v. Bd. of Med. Quality Assurance* (1985) 174 Cal.App.3d 1040, 1058.

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6. (A) "Mere error in judgment, in absence of a want of reasonable care and skill . . . , will not render a doctor responsible for unintentional consequences in treatment of his patient." (*Hufman v. Lindquist* (1951) 37 Cal.2d 465, 475.)

(B) In selecting a method of treatment, skillful members of the medical profession may differ; however, the practitioner must keep within the "recognized and approved methods." (*Callahan v. Hahnemann Hospital* (1934) 1 Cal.2d 447.) If so, negligence is not shown by evidence that other medicines or treatment might have been employed. *(Jensen v. Findlay* (1936) 17 Cal.App.2d 536.) The mere fact there is a difference of medical opinion concerning the desirability of one particular medical procedure over another does not establish the determination to use one of the procedures was negligent. (*Clemens v. Regents of Univ. of Cal.* (1970) 8 Cal.App.3d 1, 13.)

7. "Repeated negligent acts" is defined as two or more acts of negligence. (*Zabetian v. Medical Board* (2000) 80 Cal.App.4th 462, 468; see also Code § 2234, subd. (c)(1).)

8. (A) The purpose of proceedings of this type is to protect the public, and not to punish an errant licensee. (*Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 784-786; *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d 1471, 1476.)

(B) While public protection is the highest priority of the Board and the ALJ, the Board and the ALJ "shall, whenever possible take action that is calculated to aid in the rehabilitation of the licensee, ..." (§ 2229, subd. (b).) However, that rehabilitative effort must not endanger the public. (*Id.* at subd. (c).)

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Legal Conclusions Dispositive of the Case

First Cause for Discipline—Gross Negligence

9. It was established that Respondent's license is subject to discipline for gross negligence in her treatment of Patient 2, pursuant to section 2234, subdivision (b), based on Factual Findings 13 through 59.

Second Cause For Discipline—Repeated Negligent Acts

10. It was established that Respondent's license is subject to discipline pursuant to section 2234, subdivision (c), for repeated negligent acts in connection with her care and treatment of Patient 1 and Patient 2, based on Factual Findings 13 through 59.

Third Cause for Discipline—Prescribing Without an Appropriate Prior Examination

11. It was established that Respondent's license is subject to discipline pursuant to section 2242 for her prescription of controlled substances or dangerous drugs, or both, to Patient 1 and Patient 2 without appropriate prior examinations. This Conclusion is based on Factual Findings 13 through 59.

Fourth Cause for Discipline—Failure to Maintain Adequate Records

12. It was established that Respondent's license is subject to discipline pursuant to section 2266 for failure to maintain adequate records for the two patients, based on Factual Findings 13 through 59.

Costs

13. The Board is entitled to recover its costs of enforcement pursuant to section 125.3, based on Legal Conclusions 9 through 12. The reasonable amount of those costs is $22,908.75, based on Factual Finding 60.

The Board's Disciplinary Guidelines

14. Grounds for discipline having been established, the issue becomes what discipline should be imposed. The Board has developed disciplinary guidelines, entitled "Manual of Model Disciplinary Orders and Guidelines (2016)" (Disciplinary Guidelines) which are incorporated by reference into California Code of Regulations, title 16, section 1361, subdivision (a). The Disciplinary Guidelines provide guidance, at once general and specific, for what the disciplinary response should be for violations of the Medical Practice Act. The Discipline Guidelines provide that where an ALJ would depart from those Guidelines, for reasons such as mitigating circumstances, the age of the case or evidentiary problems, such issues should be identified.

15. (A) In summary, the Disciplinary Guidelines usually recommend a maximum discipline, and a minimum, though revocation is the only remedy for some violations, such as registering as a sex offender.

(B) For gross negligence and repeated negligent acts under section 2234, for failing to maintain adequate records in violation of section 2266, or for prescribing without an appropriate prior examination, the maximum discipline is revocation of the physician's certificate, while the minimum may be summarized as revocation stayed, with five years of probation, with conditions to include various courses, such as the prescribing course, monitoring, solo practice prohibition, and prohibited practices.

Disposition

16. If this were Respondent's first brush with discipline, the ALJ would order her license be revoked, and would order probation with appropriate terms and conditions. However, the Board and Respondent have gone down that road before, and it brought the parties to this junction.

17. Respondent was on probation from March 30, 2012 until September 1, 2018, a period just shy of six and one-half years. During that six-plus years she failed PACE, a comprehensive competency evaluation, then barely passed that program on a second try, still showing a number of deficiencies. She twice took a psychopharmacology course, and she was required to retake the record keeping course after her second attendance at PACE.

18. Respondent first saw Patient 1 in early January 2018, when she had some nine months left on her probation term. Respondent first saw Patient 2 in early 2016, four years into her probation, and continuing to treat that patient through the balance of Respondent's probation term.

19. Respondent's breaches of the standard of care occurred when she was on probation, and contemporaneously with her efforts at remedial education and training, i.e., the two record keeping courses and two psychopharmacology courses. Those courses, and two PACE programs do not appear to have improved Respondent's practice significantly. She prescribed psychotropic drugs to Patient 1 without obtaining baseline vital signs, and did not monitor those vital signs, something her own expert says she should have done. She prescribed benzodiazepines to an elderly patient when that patient was taking opioids, a situation that calls for close scrutiny and monitoring of the patient, which did not occur. She prescribed a stimulant to an elderly patient

with cardiovascular issues, with no effort to obtain vital signs such as blood pressure. If her expert believes the standard of care required such basic testing with a young woman, if follows that such monitoring of vital signs was needed for an elderly patient with significant co-morbidities. The nature of Patient 2's cardiovascular issues is not disclosed in the records, because there is no reliable evidence Respondent ever reached out to Patient 2's other physicians to consult and coordinate treatment, even though Respondent's CV claims she "collaborates with the primary care physicians and psychotherapists." (Ex. A, p. B115.)

20. Complainant argued that he and the Board do not have to wait until Respondent harms a patient, a point well-taken. It does not appear that another course of probation will remedy Respondent's shortcomings. In all the circumstances, public protection requires revocation of Respondent's license.

ORDER

Certificate number A 105195, issued to Respondent Criselda Calayan Abad-Santos, M.D., is revoked.

DATE: 06/12/2023

Joseph Montoya

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Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **CRISELDA CALAYAN ABAD-SANTOS, M.D.** **21900 Burbank Blvd. #3076** **Woodland Hills, CA 91367-7418** **Physician's and Surgeon's No. A 105195,** Respondent.	Case No. 800-2019-055917 **FIRST AMENDED ACCUSATION**

PARTIES

1. **Reji Varghese (Complainant) brings this First Amended Accusation solely in his official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).**

2. On or about August 13, 2008, the Board issued Physician's and Surgeon's Certificate Number A 105195 to Criselda Calayan Abad-Santos, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2023, unless renewed.

3. **An administrative hearing took place in this matter on or about March 20, 22, and 23, 2023, during which Administrative Law Judge Joseph D. Montoya granted Complainant's motion to amend the Accusation to add an additional allegation of negligence by Respondent, pursuant to Government Code section 11507. On or about April**

26, 2023, Administrative Law Judge Montoya issued an Order Re-Opening [the] Record (ALJ Order) and ordered Complainant to submit an amended accusation alleging the additional claim of negligence because "interlineating new language in the existing document in the Case Center system is problematic[.]" Accordingly, Complainant hereby amends the Accusation as set forth in this First Amended Accusation, with new language in bold print, as required by the ALJ Order.

JURISDICTION

4. This **First Amended** Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

5. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

6. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

7. Section 2242 of the Code states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care.

(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of the patient's practitioner, but in any case no longer than 72 hours.

(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code.

8. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

COST RECOVERY

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

DEFINITIONS

10. The following medications are "dangerous drugs" within the meaning of the Business and Professions Code:

"Adderall®" is a brand name of a combination of two stimulant drugs, amphetamine and dextroamphetamine. It is generally used to treat attention deficit hyperactivity disorder (ADHD), but also has a high potential for abuse. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d)(1), and a dangerous drug as defined in Code section 4022.

"Benzodiazepines" are a class of drugs that produce central nervous system (CNS) depression. They are used therapeutically to produce sedation, induce sleep, relieve anxiety and muscle spasms, and to prevent seizures. In general, benzodiazepines act as hypnotics in high doses, anxiolytics in moderate doses, and sedatives in low doses, and are used for a limited time period. Commonly prescribed benzodiazepines include alprazolam (Xanax), lorazepam (Ativan), clonazepam (Klonopin), and diazepam (Valium). They are dangerous drugs as defined in Code section 4022.

"Cymbalta®" is a brand name for duloxetine, an antidepressant and nerve pain medication used to treat depression, anxiety, diabetic peripheral neuropathy, fibromyalgia, and chronic muscle or bone pain. It is from a group of drugs called selective serotonin and norepinephrine reuptake inhibitors. It is a dangerous drug as defined in Code section 4022.

"Vyvanse®" is a brand name for lisdexamfetamine, a stimulant used as part of a treatment program to control symptoms of ADHD or to treat moderate or severe binge eating disorders. It is a psychostimulant and a dangerous drug as defined in Code section 4022.

FACTUAL ALLEGATIONS

11. At all times relevant to the allegations herein, Respondent practiced in the field of psychiatry.

Patient 1[1]

12. Respondent treated Patient 1 from approximately January 2018 through January 2019. Respondent first saw Patient 1 on or about January 4, 2018, then a 28-year-old female, when she presented to Respondent seeking treatment for borderline personality disorder after relocating to California from Alabama, where she reported being under the care of the same psychiatrist for ten years. At the first appointment, Respondent completed a psychiatric evaluation of Patient 1 and diagnosed her with (1) Bipolar II disorder, current episode depressed, moderate; (2) Attention deficit-hyperactivity disorder, combined type; (3) Panic disorder without agoraphobia; (4) Binge-eating disorder, mild (rule out); and (5) Borderline personality disorder by history. In the "Mental Status Examination" Respondent incorrectly documented that the "Patient is a young white female who appears her stated age . . ." In fact, Patient 1, as described by Respondent in her "History of Present Illness," is "a 28-year-old single Korean American female." Respondent prescribed the following medications to the patient at this visit, which had been prescribed by her prior psychiatrist: (1) Vyvanse (lisdexamfetamine) 60 mg capsule, orally in the morning; (2) Lamictal (lamotrigine)[2] 200 mg tablet, orally twice a day; and (3) Lexapro (escitalopram) 10 mg tablet, orally in the morning. Respondent did not prescribe Seroquel (quetiapine)[3] 100 mg at bedtime, as had been prescribed by her prior psychiatrist. Instead, she

[1] Patients are referred to by number to protect their privacy.

[2] Lamotrigine is an anticonvulsant medication used to treat epileptic seizures or in the treatment of bi-polar disorder.

[3] Quetiapine is an antipsychotic medication used in the treatment of schizophrenia, bi-polar disorder, or depression.

started Patient 1 on one new medication, Xanax (alprazolam) 0.25 mg tablet, daily as needed for anxiety. Respondent failed to document either an intent or attempt to obtain medical records from Patient 1's prior psychiatrist.

13. Respondent saw Patient 1 for regular appointments over the next several months, and during the initial five months of treatment, Respondent documented that Patient 1 was relatively stable with only minor requests to adjust her Vyvanse dosing to target both ADHD and binge eating disorder symptoms. During this period, the patient did not fill her Xanax prescription from Respondent.

14. On or about August 22, 2018, Respondent switched Patient 1 from Lexapro (escitalopram)[4] to Cymbalta (duloxetine), 30 mg orally in the morning.

15. On or about October 23, 2018, Respondent documented that "Xanax is alleviating [Patient 1's] panic attacks," however pharmacy and California Utilization, Review and Evaluation System (CURES)[5] records indicate the patient never filled her prescription for Xanax from Respondent at any time during the one-year treatment course with her.

16. Throughout her treatment of the patient, Respondent continued to prescribe Xanax, Cymbalta, and Vyvanse to Patient 1 until the termination of their patient-physician relationship in January 2019.

17. Vyvanse is a stimulant medication and Respondent should have conducted a baseline cardiac evaluation for Patient 1; her pulse and blood pressure should have been obtained at baseline and monitored periodically. During the time Respondent prescribed Vyvanse to Patient 1, she failed to obtain and monitor Patient 1's pulse and blood pressure levels, at baseline and thereafter.

18. During the time Respondent prescribed Cymbalta to Patient 1, Respondent should have obtained a baseline measure of Patient 1's blood pressure and periodically monitored her blood pressure, as well as checked her serum creatinine level at baseline and thereafter.

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[4] Escitalopram is a selective serotonin reuptake inhibitor (SSRI) used to treat depression and generalized anxiety disorder.

[5] CURES is the Department of Justice, Bureau of Narcotics Enforcement's system for the electronic monitoring of the prescribing and dispensing of Schedule II, III, IV, and V controlled substances in California pursuant to Health and Safety Code section 11165.

However, during the period when Respondent prescribed Cymbalta to Patient 1, she failed to obtain and monitor Patient 1's pulse, blood pressure, and serum creatinine levels.

Patient 2

19. Respondent treated Patient 2, an elderly woman with several co-morbidities including, abnormal blood pressure, migraine headaches, Hepatitis B, and chronic pain for several years during the time period beginning on or about March 9, 2016 through at least February 26, 2020. During the time Respondent treated Patient 2, she continuously prescribed psychotropic medications to Patient 2.

20. On or about March 9, 2016, Respondent first saw Patient 2, a sixty-nine-year-old woman with reported medical conditions, including Type 2 diabetes mellitus and arthritis in her knees, among others. She reported five current medications that she had been taking: Celebrex (celecoxib),[6] Cardizem (diltiazem),[7] Atacand (candesartan),[8] hydrocodone,[9] Opana ER (oxymorphone),[10] and an herbal stool softener. The medications reported by Patient 2 suggested additional medical conditions that were not self-reported, specifically involving the patient's cardiovascular system. Similarly, there was no medication reportedly being taken to treat the patient's Type 2 diabetes mellitus. Respondent did not follow up on these discrepancies with verification from other sources such as her concurrent medical providers or pharmacy records. Respondent improperly relied on Patient 2's report regarding medications and medical co-morbidities without attempting to obtain past medical records, direct consultation with concurrent prescribers, or consideration of other physicians' treatment plans. Respondent diagnosed Patient 2 with major depressive disorder, recurrent, severe without psychotic features; posttraumatic stress disorder, chronic, with dissociative symptoms; panic disorder; and generalized anxiety disorder. Respondent prescribed the following drugs to Patient 2 at the initial visit: Lexapro,

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[6] Celecoxib is a nonsteroidal anti-inflammatory drug (NSAID) used to treat arthritis, acute pain, and menstrual pain and discomfort.

[7] Diltiazem is a calcium channel blocker used to treat high blood pressure.

[8] Candesartan is an angiotensin II receptor blocker used to treat high blood pressure.

[9] Hydrocodone is a semi-synthetic opioid form of codeine. It is a narcotic analgesic taken orally for relief of moderate to severe pain.

[10] Oxymorphone is an opioid analgesic used to help relieve moderate to severe pain.

Adderall, Klonopin, and Xanax.

21. Prescribing psychotropic medications to a patient requires that a psychiatrist perform a psychiatric evaluation (including a review of medical records),[11] discuss the diagnoses with the patient, develop a recommended treatment plan that must also be discussed with and agreed to by the patient, and obtain an informed consent from the patient following a discussion about risks, benefits, and alternatives for each medication. However, when Respondent initiated and continued to prescribe the three scheduled medications (Lexapro, Adderall, and Xanax) throughout the course of treatment, she failed to adequately (1) seek to obtain authorization from the patient to obtain records from her primary care provider and, later, her cardiologist and two pain specialists; or (2) in lieu of obtaining records and consultung with Patient 2's other medical providers, conduct her own physical examinations, measure vital signs, obtain laboratory studies or electrocardiograms (ECG) at baseline (and periodically thereafter) to ensure the safety of the medications that she was prescribing to a patient with cardiac co-morbidities (or adequately document any of the foregoing). Respondent committed gross negligence when she prescribed psychotropic medications to Patient 2 without adequately obtaining thorough records or conducting indicated baseline examinations and periodically monitoring for changes in physical health through physical examination, vital signs, laboratory studies, and ECG for a known co-morbid cardiovascular condition; and when she prescribed stimulant medications to a patient with a co-morbid cardiovascular condition, without adequately considering and/or addressing possible safety issuesin the patient.[12]

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[11] This evaluation should include considerations for contraindications for the prescribed medications (*e.g.,* allergies or co-morbid medical conditions such as a liver impairment). A psychiatrist should collaborate with concurrent medical providers to verify self-reported medical conditions by obtaining medical records. Baseline and periodic screening examinations, including physical examination, vital signs, laboratory studies, and electrocardiogram should be appropriately performed. Prescribing these medications, requires ongoing medication reconciliation and documentation of medications from medical records and review of each medication with the patient at the time of evaluation to verify that medications are being consumed by the patient.

[12] For example, when prior authorization for Provigil (modafinil) is denied by the patient's health insurance, Respondent reverted to prescribing Adderall and deferred to the patient's wishes rather than the cardiologist's recommendation communicated indirectly through the patient. Respondent also failed to routinely complete medication reconciliation at each appointment, specifically, for example, when she documented that the patient is reporting a new unnamed antihypertensive medication on or about March 1, 2019.

22. Patient 2 reported during Respondent's initial psychiatric evaluation of her that another doctor had prescribed two opioid medications (hydrocodone and oxymorphone) to her. Despite the known risk of respiratory suppression in patients who are concurrently taking opioid medications and benzodiazepines, Respondent proceeded to prescribe Patient 2, one scheduled long-acting benzodiazepine (clonazepam), and one short-acting benzodiazepine (alprazolam).

23. Respondent did not seek authorization from Patient 2 to contact her other physicians to collaborate in her medical care, even though Patient 2 had pre-existing conditions that would impact Respondent's treatment plan for anxiety (*i.e.*, a cardiovascular condition and a pain disorder managed with opioids). Later, on or about March 9, 2018, Respondent prescribed diazepam to Patient 2 for muscle spasms and continued to prescribe alprazolam to her for anxiety. Respondent committed gross negligence (a) when she prescribed benzodiazepines to Patient 2, including in the context of Patient 2 being concurrently prescribed (i) opioid medications by another physician and soley relied on psychoeducation of the risks, rather than either exercise more restraint in prescribing or collaborate with the other physicians regarding treating Patient 2, vis-a-vis benzodiazepine versus opioid medications and alternatives; and (ii)short-acting and long-acting benzodiazepines for two separate indications; and (b) when Respondent routinely failed to complete medication reconciliations during her treatment of Patient 2.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence – Patient 2)

24. Respondent Criselda Calayan Abad-Santos, M.D. is subject to disciplinary action under section 2234, subdivision (b), of the Code in that she committed gross negligence in her care and treatment of Patient 2. The circumstances are as follows:

25. The facts and circumstances alleged in paragraphs 18 through 22 above, inclusive, are incorporated herein as if fully set forth.

26. Respondent committed gross negligence in connection with her treatment of Patient 2, as discussed above, including when Respondent:

A. Relied on Patient 2's report regarding medications and medical co-morbidities without attempting to obtain appropriate medical records, direct consultation with concurrent

prescribers, or consideration of other physicians' treatment plans;

B. Prescribed psychotropic medications to Patient 2 without obtaining thorough records or conducting indicated baseline examinations and periodically monitoring for changes in the patient's physical health through physical examinations, vital signs, laboratory studies, and ECGs for a known co-morbid cardiovascular condition;

C. Failed to complete medication reconciliations;

D. Prescribed stimulant medications to a patient with a co-morbid cardiovascular condition, without consideration of possible safety issues; and

E. Prescribed benzodiazepines to Patient 2, who was also taking opioid medication concurrently prescribed by another physician, and relied solely on psychoeducation of the risks rather than either exercising restraint in prescribing or collaborating with the other physicians regarding the importance and handling of benzodiazepine versus opioid indication and alternatives.

27. Respondent's acts and/or omissions as set forth above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

28. Respondent Criselda Calayan Abad-Santos, M.D. is subject to disciplinary action under section 2234, subdivision (c), of the Code in that she committed repeated negligent acts in her care and treatment of Patients 1 and 2. The circumstances are as follows:

29. The allegations of the First Cause for Discipline are incorporated herein by reference as if fully set forth, and represent repeated negligent acts.

Patient 1

30. In addition, Respondent committed negligence in connection with her treatment of Patient 1, as discussed above, including when Respondent:

A. Failed to adequately obtain and monitor Patient 1's pulse and blood pressure levels while prescribing her Vyvanse, at baseline and thereafter; and

B. Failed to adequately obtain and monitor Patient 1's pulse, blood pressure, and

serum creatinine levels while prescribing her Cymbalta, at baseline and thereafter.

C. Prior to prescribing Xanax (alprazolam), failed to obtain and document written informed consent regarding the risk of developing dependence.

Patient 2

31. Respondent committed negligence in connection with her treatment of Patient 2, as discussed above, including when Respondent prescribed a short-acting and long-acting benzodiazepine for two separate indications.

32. Respondent's acts and/or omissions as set forth above, whether proven individually, jointly, or in any combination thereof, constitute repeated negligent acts.

THIRD CAUSE FOR DISCIPLINE

(Prescribing Without an Appropriate Prior Examination)

33. Respondent Criselda Calayan Abad-Santos, M.D. is subject to disciplinary action under section 2242 of the Code in that she prescribed controlled substances and/or dangerous drugs to Patients 1 and 2 without an appropriate prior examination. The circumstances are as follows:

34. The allegations of the First and Second Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Records)

35. Respondent Criselda Calayan Abad-Santos, M.D. is subject to disciplinary action under section 2266 of the Code in that she failed to maintain adequate records for Patients 1 and 2. The circumstances are as follows:

36. The allegations of the First through Third Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

DISCIPLINARY CONSIDERATIONS

37. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about March 30, 2012, in a prior disciplinary action entitled, *In the Matter of the Accusation Against Criselda Calayan Abadsantos, M.D.*, before the Medical Board

of California, Case No. 05-2010-205633, Respondent's license was revoked, however, the revocation was stayed and her license was placed on probation for three years, which included requirements that she pass a clinical training program, be prohibited from prescribing or furnishing controlled substances to family members, maintain a record of all controlled substances prescribed, and take prescribing practices, medical record keeping, and ethics courses.

38. On or about April 10, 2014, a Petition to Revoke Probation was filed entitled *In the Matter of the Petition to Revoke Probation Against Criselda Calayan Abadsantos, M.D.*, before the Medical Board of California, Case No. D1-2010-205633. On or about April 1, 2015, Respondent's probation was extended one additional year to run consecutively from the time remaining on the original probation order in Case No. 05-2010-205633. Respondent's probation included additional requirements that she re-enroll in a clinical training program, continue to be prohibited from prescribing or furnishing controlled substances to family members, maintain a record of all controlled substances prescribed, and take psychopharmacology and American Psychiatric Association refresher courses.

39. On or about November 7, 2016, a Petition to Revoke Probation was filed entitled *In the Matter of the Petition to Revoke Probation Against Criselda Calayan Abad-Santos, M.D.*, before the Medical Board of California, Case No. 800-2016-027627. On or about September 1, 2017, Respondent's probation was extended one additional year, which included requirements that her practice be monitored for a minimum of one year, that she repeat the medical record keeping course, participate in a psychopharmacology course, retake a buprenorphine waiver training course, submit to a toxicology screen, continue to be prohibited from prescribing or furnishing controlled substances to family members, and maintain a record of all controlled substances prescribed.

40. On or about September 1, 2018, Respondent completed her probation.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 105195,

issued to Respondent Criselda Calayan Abad-Santos, M.D.;

2. Revoking, suspending or denying approval of Respondent Criselda Calayan Abad-Santos, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Criselda Calayan Abad-Santos, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: MAY 04 2023

Jenna Jones for
REJI VARGHESE
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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