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

In the Matter of the Accusation Against: Cesar Francisco Castillo, M.D. Physician's and Surgeon's Certificate No. A 100518 Respondent.	Case No.: 800-2022-086747

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 December 4, 2025.

IT IS SO ORDERED: November 4, 2025.

MEDICAL BOARD OF CALIFORNIA

MD.

Veling Tsai, M.D., Vice Chair
Panel A

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

In the Matter of the Accusation Against:

CESAR FRANCISCO CASTILLO, M.D.,

Physician's and Surgeon's Certificate No. A 100518

Respondent.

Agency Case No. 800-2022-086747

OAH No. 2025020326

PROPOSED DECISION

Administrative Law Judge Karen Reichmann, State of California, Office of Administrative Hearings, heard this matter on September 15 through 18, 2025, in Oakland, with some witnesses appearing by videoconference.

Deputy Attorney General Karolyn M. Westfall represented complainant Reji Varghese, Executive Director of the Medical Board of California.

Attorney Jonathan A. Corr represented respondent Cesar Francisco Castillo, M.D., who was present.

The record closed and the matter was submitted for decision on September 18, 2025.

FACTUAL FINDINGS

Jurisdictional Matters

1. On June 22, 2007, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. A 100518 (Certificate) to respondent Cesar Francisco Castillo, M.D. The Certificate was in full force and effect at all times relevant to the charges in the Accusation. There has been no prior discipline against respondent's Certificate.

2. On November 13, 2024, complainant Reji Varghese, acting solely in his official capacity as the Board's Executive Director, filed the Accusation. Complainant seeks to discipline respondent for gross negligence and dishonesty, alleging that while working as a hospitalist in July 2021, respondent failed to timely respond to nursing staff calls regarding a critically ill patient, and that in November 2021, respondent made false statements on an application for reappointment of hospital privileges. Complainant also seeks cost recovery. Respondent filed a timely Notice of Defense.

Respondent's Background

3. Respondent grew up in Santa Cruz. He is the son of Mexican immigrants who worked in the fields and lumber yards. Respondent observed the challenges faced by his family and community in accessing health care, and these experiences motivated him to become a doctor.

4. Respondent went to college at UC Santa Cruz, followed by medical school at UCLA, in a program focused on underserved populations. After completing an internship and residency in hospital-based internal medicine, respondent joined what is now called Palo Alto Foundation Medical Group (PAFMG) and began working as a hospitalist at Dominican Hospital in Santa Cruz, the hospital where he was born. From about 2017 through early 2020, respondent worked primarily as a hospitalist at the Watsonville Community Hospital, in a partnership between PAFMG and Kaiser Permanente. This hospital serves a large population of underserved patients and respondent was excited to work there. When the partnership ended in 2020, he returned to working primarily at Dominican Hospital. Prior to the allegations in this matter, respondent had worked in the role of "Tier 1" at both hospitals. Tier 1 is a supervisory role, involving managing the department, scheduling staff, attending meetings, and resolving conflicts. During the Covid-19 pandemic, respondent volunteered to work on the Covid team, treating hospitalized patients with Covid, following special protocols to avoid exposure.

5. In the summer and fall of 2020, respondent experienced personal difficulties arising from the dissolution of his marriage. He was taken for surprise by his wife's adversarial and aggressive stance in their divorce proceedings. Respondent struggled to coordinate his work schedule with his child custody schedule and frequently asked colleagues to cover for him. Ultimately, issues were raised to him by PAFMG, and respondent agreed to take a six- to eight-week leave of absence from work so that he could adapt to his new situation.

November 2020 Notice from the Professional Affairs Committee

6. Prior to returning to work after this period, respondent was required to meet with the chair of the Professional Affairs Committee (PAC) and two Tier 1

physicians in the hospitalist group. After this meeting, a memo was issued to respondent dated November 20, 2020, with the subject line: "Accountability Conversation and Notice" (Notice).

7. The Notice stated that issues related to respondent's clinical performance had come to the attention of the PAC, which were similar in nature to concerns raised to him previously by Tier 1s in his group. The issues included: 1) slow response time while on duty and frequent excuses for delayed response time that invoked external forces such as phone issues; 2) failure while on shift on July 27, 2020, to respond to calls regarding a patient who was deteriorating, putting the patient at risk and causing another physician to take over care; 3) a report filed in June 2020 alleging that respondent was not available during his shifts; 4) complaints from physician specialists that respondent did not answer their calls to discuss patients in a timely manner; and 5) complaints from nurses, case managers, patients, and family members regarding respondent's lack of responsiveness. The Notice stated that respondent was not meeting his job requirements and was putting patients, himself, his colleagues, and his employer at risk.

8. The Notice included a list of expectations. These included being available for patient care duties during his entire shift; being easily reachable by phone during his shift and able to be at a patient's bedside within 30 minutes; responding to texts and phone messages from staff in a timely manner, including answering all calls about changes in clinical status within 15 minutes; and choosing one phone to use for work communications, informing his answering service and colleagues of that number, and confirming the preferred phone number's listing in the hospital's records. The Notice advised respondent that, "There shall be no further complaints from your colleagues

regarding phone number confusion or excuses on your part regarding the wrong phone." Respondent returned to work shortly after this Notice was issued.

Patient A

9. Patient A, a 31-year-old man with a history of intravenous drug use, sought treatment at the Dominican Hospital emergency room at around 5:00 p.m. on July 3, 2021, complaining of left shoulder pain, left shoulder skin abscess, shortness of breath, mild chest soreness, and fever. He had experienced these symptoms for several days. He was examined in the emergency department and lab work was performed. Patient A had a very high heart rate, and elevated levels of white blood cells, creatine kinase (CK), and procalcitonin, indicating that he had a severe infection.

10. CT scans were taken of the patient's left upper extremity and chest. Because it was night, the hospital did not have a radiologist on site. The CT scans were sent to an off-site radiology service, NightHawk, which provided a preliminary or "wet" read. In this circumstance, an on-site radiologist is expected to provide a final report of the CT scans the following day.

11. The emergency department physician spoke with the NightHawk radiologist and documented the radiologist's preliminary findings in her emergency department note in Patient A's chart. The note was identical for both the upper extremity and chest readings and stated that the imaging showed: anasarca (soft tissue swelling); suspicion of mild swelling and myositis of the left pectoralis major muscle; and a few tiny gas bubbles in the glenohumeral joint and slight gas in the right glenohumeral joint. Also included in the emergency department physician's note

memorializing the "wet reads" was the following statement: "No evidence of necrotizing fasciitis[1] or obvious frank compartment syndrome.[2]"

12. Patient A was admitted to the hospital with diagnoses of sepsis[3] and left upper extremity cellulitis.[4] A hospitalist took over care of the patient. Patient A was treated with intravenous antibiotics and fluids. Morphine and acetaminophen were given for pain.

13. Respondent worked a shift as a hospitalist at Dominican Hospital on July 4, 2021. His shift went from 7:00 a.m. to 5:00 p.m. He was assigned as the hospitalist overseeing Patient A when his shift started that morning. Generally, a hospitalist is assigned 10 to 12 patients per shift. Respondent reviewed Patient A's chart and visited the patient's bedside before 10:00 a.m. The patient reported severe left shoulder pain and drug withdrawal. Lab tests from that morning showed that the patient's white

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[1] Necrotizing fasciitis is a severe infection under the skin. Its symptoms include fever and severe pain. It can only be definitively diagnosed intraoperatively. It spreads rapidly and is fatal if not treated promptly with surgery and antibiotics.

[2] Compartment syndrome is a serious condition that occurs when excess pressure builds in a compartment of the body. It can be fatal. Surgical intervention is needed to reduce the pressure.

[3] Sepsis is a life-threatening condition. It arises in response to an infection. It is treated with antibiotics and IV fluids, but can progress and require surgery.

[4] Cellulitis is an infection of the skin and soft tissue. Cellulitis can cause sepsis and can be fatal.

blood cell count, CK, and procalcitonin were still elevated, although the white blood cell count was lower than the previous night. Respondent continued antibiotic treatment and prescribed methadone to address the patient's withdrawal symptoms. Respondent documented a diagnosis of severe sepsis with a plan to "follow up on imaging."

14. Respondent left the hospital after lunch and went to his home, about a 10-minute drive away. He never returned to the hospital that day.

15. Gloria Lacasandile, R.N., was assigned to care for Patient A during the day shift on July 4, 2021. Lacasandile documented in Patient A's chart that when she rounded on him at 2:40 p.m., his left fingers had turned purple and were more swollen than before, that his left shoulder had reddened and was swollen, and that the skin of the whole arm was tight. She wrote that she had paged respondent twice and left a voicemail message on his cellphone, and that she had notified her charge nurse about the situation.

16. At 3:00 p.m., Lacasandile called for assistance from the rapid response team (RRT), a team consisting of nurses with critical care experience who rapidly intervene in emergency situations such as a Code Blue. RRT nurse Tara Loosbrock, R.N., arrived at the patient's bedside within one minute. Lacasandile told her that she had tried to contact respondent multiple times using his pager, answering service, cell phone, and a hospital messaging app, but that respondent had not responded. Loosbrock was concerned that Patient A "didn't look good" and possibly had compartment syndrome. She checked the chart and saw that there was no final CT report, so she called radiology and asked for it. Patient A looked ill, in pain, and possibly in drug withdrawal. She believed he needed consultation with a surgeon, but as a nurse she was not able to make this request. She ordered the patient on NPO (no

food or drink) status in anticipation that he would need surgery. Loosbrock was also concerned because there were no orders for any additional pain medications for the patient, who was suffering. Nurses do not have the authority to order pain medications and do not have the authority to initiate new antibiotics without a physician order.

17. The final radiology report for the chest CT scan was entered into the patient's medical record at 3:37 p.m., and the final report for the left upper extremity was entered in the medical record at 3:48 p.m., shortly after Loosbrock called the radiology department. The radiologist reported anasarca in the chest extending to the left shoulder and upper extremity, severe edema and cellulitis, and gas in both shoulder joints of uncertain etiology. There was no longer language regarding the absence of evidence of necrotizing fasciitis or compartment syndrome.

18. Nurses continued trying to contact respondent. At 4:30 p.m., a nurse documented that the charge nurse was aware that respondent had still not returned calls and that two more calls to him were made. Loosbrock also tried to contact respondent. At 4:51 p.m., in a "last ditch effort" she texted respondent on his personal cell phone, "Please call me RRT 7801." Respondent replied "who is this?" Loosbrock responded, "Tara," and respondent texted her, "tara hunt?" and did not call her. Loosbrock credibly testified that nurses typically reach a hospitalist within 15 minutes, and that a two-hour wait for a response "is really long." She also credibly testified that this was an urgent situation and that it "wasn't the first time" that nursing staff could not reach respondent in a timely manner.

19. Amy Louden, R.N., was the nursing supervisor (also called house supervisor) on duty on July 4, 2021, from 6:00 a.m. to 6:30 p.m. She testified that on that day at around 4:45 p.m., a member of the nursing staff called her for help reaching respondent. Louden's office was very close to Patient A's room and she went

to see the patient to determine the urgency of the situation. She observed that Patient A's arm was very swollen and that he needed an urgent response from a physician. Louden called respondent at around 5:00 p.m., and he called her back "fairly quickly." Respondent called nursing staff by 5:15 p.m. He ordered an additional antibiotic and lactic acid for Patient A. Respondent stated that his shift was over and that another doctor was taking over for him. Respondent made no notes in Patient's A's medical records for July 4, 2021, other than the note he made after his morning rounds.

20. Hospitalist Rema Hanna, M.D. worked a 1:00 p.m. to 11:00 p.m. shift at Dominican Hospital on July 4, 2021. Sometime between 4:30 and 5:00 p.m., Loosbrock saw Dr. Hanna in the hallway and told her she was concerned about Patient A. Dr. Hanna came to the patient's bedside. No physician had seen the patient since respondent had done his morning rounds. When Dr. Hanna arrived, Patient A appeared ill, was unable to move his arm, and was in pain. Dr. Hanna reviewed the lab results and CT reports. She was concerned that the patient had a deep infection, including possible necrotizing fasciitis or compartment syndrome. She ordered Dilaudid, a strong pain medication, increased his antibiotics, and transferred him to the ICU for more intensive monitoring. Dr. Hanna spoke with respondent sometime between 5:00 p.m. and 6:00 p.m., and he told her he was in the process of securing surgical consultations. Dr. Hanna took over care of Patient A, as she was scheduled to do when respondent's shift ended, and respondent continued to reach out to surgeons.

21. The initial surgical consultation took place at around 6:00 p.m. Surgical procedures were performed on Patient A beginning at 8:00 p.m. Patient A was diagnosed intraoperatively with necrotizing fasciitis. Patient A did not recover and died on July 6, 2021.

22. Dr. Hanna sent an email about the July 4, 2021, incident to PAFMG management, reporting that she had been told by nursing staff that they had tried to contact respondent for "a few hours" by phone, pager, and messaging app, and did not reach him until Louden called his answering service and threatened to call his boss if he did not call back. Dr. Hanna added that other nurses and hospitalists told her that respondent had a pattern of not being reachable, especially towards the end of his shift at 5:00 p.m.

23. The PAC initiated an investigation into the allegations. The PAC became aware that respondent was well-liked and that his colleagues had covered for him in order to support and protect him, and that these colleagues were reluctant to go on the record to document respondent's lapses due to "loyalties."

Fitness For Duty Evaluation

24. On August 2, 2021, as a result of the July 4, 2021, incident, PAFMG notified respondent that he had been relieved of his clinical duties. PAFMG placed respondent on paid administrative leave and directed him to undergo a fitness for duty evaluation. Respondent was directed to contact the fitness for duty evaluator, John Rosenberg, M.D., but did not do so, and he was placed on unpaid leave and ordered to attend the evaluation on August 17, 2021, or be terminated.

25. Respondent attended the fitness for duty evaluation. Dr. Rosenberg sent a report to PAFMG. He found that respondent was not fit for duty due to anxiety, PTSD, and mild alcohol abuse, and made recommendations including remaining abstinent from alcohol and undergoing alcohol monitoring, taking a three- to four-month leave of absence, receiving treatment from a psychiatrist and psychotherapist, and having a second fitness for duty evaluation prior to returning to

work. PAFMG notified respondent of Dr. Rosenberg's recommendations on September 20, 2021. Specifically, respondent was notified that Dr. Rosenberg had concluded that, "you are not currently fit for duty due to medical conditions that prohibit you from completing the essential job duties of a hospitalist physician." Respondent was advised that he would be transitioned to medical leave and was expected to follow Dr. Rosenberg's recommendations.

November 2021 Application for Reappointment

26. On November 5, 2021, respondent submitted an application to Dominican Hospital for reappointment of his hospital privileges. The application form asked whether the applicant's employment in any medical group ever been denied, suspended, restricted, reduced, relinquished, subject to probationary conditions, revoked, or not renewed for possible incompetence, improper professional conduct, breach of contract, or whether any such action was pending. Respondent falsely checked the "No" box in response to this question. To the question, "Have you ever been the subject of an investigation at any medical/Other Healthcare Organization?" respondent also falsely checked the "No" box. And to the question, "Do you have any physical or mental condition . . . which would prevent or limit your ability to perform the essential functions of the position and/or privileges for which your qualifications are being evaluated?" respondent also falsely checked the "No" box. Respondent submitted the application with a signed certification agreeing that the information on the application is true and correct.

Fitness For Duty Re-Assessment and Plans for Returning to Work

27. Dr. Rosenberg reassessed respondent in February to March, 2022. Dr. Rosenberg found respondent fit to return to duty. Dr. Rosenberg made specific

recommendations for his return to work, which included continuing alcohol abstinence monitoring for three to six months; continuing weekly psychotherapy for at least six months; and ongoing feedback from his department leadership to allow for clear communication of the expectations for his performance improvement.

28. On March 14, 2022, PAFMG met with respondent regarding steps he would need to take in order to return to work. This conversation was documented in a letter to respondent. Respondent was required to enroll in the UC San Diego Physician Assessment and Clinical Education competency assessment program (PACE), enroll in the Pacific Assistance Group and continue alcohol testing for five years, and be placed on a 12-month performance improvement plan upon return to work.

805 Report and Investigation

29. On March 14, 2022, PAFMG submitted a report to the Board pursuant to Business and Professions Code section 805 (805 report), reporting that respondent had been on a voluntary medical leave of absence since September 14, 2021. PAFMG further explained that respondent had been evaluated and found not fit for duty, but had recently been reassessed and medically cleared to return to work. PAFMG added that because of performance and quality of care issues, respondent would remain on administrative leave.

30. Included with the 805 report was a letter from PAFMG's attorney acknowledging that the report should have been filed in September 2021 and apologizing for the oversight in failing to file the report sooner.

31. As a result of the 805 report, an investigation was conducted on behalf of the Board by Division of Investigations investigator Michelle Metcalf.

32. As part of this investigation, respondent agreed to submit to a mental health examination, which was conducted by psychiatrist Barbara Weissman, M.D., in early August 2022. Dr. Weissman wrote a report after her examination, diagnosing respondent with panic disorder, currently largely in remission; PTSD, currently largely resolved; and no active substance use disorder. Dr. Weissman concluded that respondent does not have a mental health condition that currently impacts his ability to safely engage in the practice of medicine, is able to practice medicine safely without restrictions or conditions, does not pose a danger or threat to the public, and does not have a mental health condition requiring monitoring, treatment, or oversight in order for him to practice medicine safely.

PACE Program and Performance Improvement Plan

33. PAFMG required that respondent attend the clinical competency assessment program at UC San Diego (PACE) prior to being allowed to return to work. Respondent attended the program in May 2022, and PACE staff issued a report dated June 21, 2022.

Respondent received a final score of "Pass with Recommendations - Category 2." A Category 2 score is given when minor deficiencies are noted. Respondent's performance on a hospital medicine oral examination was superior and demonstrated his strong medical knowledge and clinical decision making.

PACE made the following recommendations for respondent: 1) take an ECG review course to improve his ECG interpretation skills; 2) complete a medical record keeping course to improve his documentation and have a period of chart monitoring upon his return to practice; 3) improve his physical examination skills, including by reviewing deficits identified during the PACE program and reviewing an online

resource; 4) continue random substance abuse monitoring; and 5) continue receiving mental health monitoring.

34. Respondent returned to work with PAFMG at Dominican Hospital in August 2022. He was placed on a performance improvement plan in order to return. The plan's provisions included that respondent would be shadowed by another hospitalist when he first returned and that he would attend regular meetings with the PAC chair and his department chair.

35. Respondent was also required to enroll in the PACE physician enhancement program (PEP). His mentor in the program was Deepak Asudani, M.D. Dr. Asudani wrote a letter summarizing respondent's participation in the program. Dr. Asudani performed monthly chart reviews with respondent between October 2022 and August 2023. He wrote that respondent had been very receptive to feedback, incorporated recommendations in a positive manner, and demonstrated willingness to make changes. Dr. Asudani described respondent as motivated, conscientious, and focused on patient care, career advancement, and quality improvement.

36. On November 24, 2023, PAFMG notified respondent that he was released from the performance improvement plan, in light of his significant progress.

Expert Witnesses

COMPLAINANT'S EXPERT, DAVID BRODY, M.D.

37. Complainant retained David Brody, M.D., as an expert witness. Dr. Brody is a hospitalist on staff at Contra Costa County Regional Medical Center. He serves on the hospital's peer review committee. He also serves as an outside peer reviewer for

small hospitals throughout the country. Dr. Brody has been an expert reviewer for Board matters for about 10 years.

38. Dr. Brody reviewed Patient A's medical records and death certificate, interview transcripts from complainant's investigation, and records from PAFMG regarding respondent's employment. Dr. Brody wrote an expert report and testified at the hearing.

39. Dr. Brody explained that Patient A was very sick when he arrived at Dominican Hospital on July 3, 2021, and that the lab results and high heart rate were extremely concerning. Dr. Brody did not believe that the initial "wet read" statement regarding no evidence of necrotizing fasciitis would reasonably cause a prudent physician to stop being concerned about this condition. The presence of tiny gas bubbles in the joint described in the wet read should have "dramatically" raised concerns about necrotizing fasciitis, despite the other statement. Dr. Brody was critical of the emergency department physician and admitting hospitalist for not seeking surgical consultations for Patient A based on indications that the patient had a severe infection. Dr. Brody does not believe the final CT reports were significantly different than the wet reads.

40. Dr. Brody explained that the standard of care for a hospitalist is to be reachable and respond to calls from nursing staff in a timely manner. The hospitalist retains responsibility for an admitted patient until the end of his shift, and the standard of care is to respond to changes in the patient's condition in a timely manner.

41. Dr. Brody concluded that respondent committed an extreme departure from the standard of care by failing to return calls from hospital staff regarding Patient

A's change in condition in a timely manner. Dr. Brody explained that Patient A's symptoms were worsening and that he required attention from a physician, noting that when Dr. Hanna took over, she took several immediate actions to address the patient's deteriorating condition. Timing is critical as necrotizing fasciitis is fatal without immediate intervention and can be confirmed only via surgery.

42. Dr. Brody's opinions were persuasive in all respects. His opinions were consistent with the medical records and other evidence, and with common sense.

RESPONDENT'S EXPERT, BRETT HALLORAN, M.D.

43. Respondent retained Brett Halloran, M.D., as an expert witness. Dr. Halloran is a hospitalist at Adventist Health Hospital in St. Helena. He also works as a physician advisor and director of document integrity for five Adventist Health Hospitals, which involves interacting with insurance companies and reviewing patient charts for accuracy and integrity. He was previously the medical director of the hospitalist program at the St. Helena hospital and has served on its peer review committee. Dr. Halloran has been an expert reviewer for the Board and an expert witness in civil litigation.

44. Dr. Halloran reviewed Patient A's medical records and other documents. Notably, he was not provided with information regarding respondent's prior history of not responding to nursing staff and his interactions with the PAC. Dr. Halloran testified that he was not aware that there had been prior problems or that respondent had been warned and had agreed to provide a single phone and to respond within 15 minutes, although this history was discussed in Dr. Brody's report, which Dr. Halloran reviewed and criticized.

45. Dr. Halloran called the statement of the NightHawk radiologist that there was no evidence of necrotizing fasciitis, "unusual" and "bold," but also opined that it was reasonable for a hospitalist not to second guess the NightHawk radiologist and that it was reasonable not to contact a surgeon until receipt of the final radiology report. Dr. Halloran acknowledged that although rare, necrotizing fasciitis is always on the mind of a hospitalist when treating a patient with a severe infection.

46. Dr. Halloran concluded that respondent's treatment of Patient A was within the standard of care. He called respondent's patient care, "timely and appropriate" and "reasonable." He commended the speed with which respondent obtained a surgical consult once respondent became aware of the final CT findings. He called it a "judgment call" whether to return to the patient's bedside, and stated that the best use of respondent's time was to seek surgical consultation rather than return to the hospital.

47. Dr. Halloran does not believe that a two-hour delay in obtaining a surgical consultation would have made a difference in the outcome of this critically ill patient. He believes that too much time had already passed from the time the patient first arrived at the hospital for the patient to survive necrotizing fasciitis, which has a high mortality rate even if it is identified and treated immediately. Dr. Halloran found fault with the NightHawk radiologist for the delay in the patient's treatment.

48. Dr. Halloran wrote that it was unclear when the communications from nursing staff first reached respondent and that the nursing staff might not have used his preferred method of communication. He testified that it is "not unusual" for a hospitalist not to take a call from a nurse in order to focus on something else, and opined that "distraction" is not the same thing as "a mistake." Dr. Halloran also

speculated that the communications from nursing staff likely did not make clear the clinical details regarding the patient due to privacy laws.

49. On cross-examination, Dr. Halloran was defensive, argumentative, and evasive, diminishing his credibility and the persuasiveness of his opinions. His opinions were further diminished because they were based on incomplete information and because of his apparent efforts to provide testimony favorable to respondent.

Respondent's Evidence

50. Respondent denied any wrongdoing and expressed no remorse. He did not accept responsibility for failing to respond to phone calls and pages from nursing staff on July 4, 2021, and did not accept responsibility for the false responses on his application for reappointment with Dominican Hospital.

51. Respondent testified that he left work after lunch on July 4, 2021, because he had completed his work and his patients were stable. He has access to his patients' electronic medical records from home and also has contact information for specialists. Respondent testified that he was allowed to leave before the end of his shift, especially during the pandemic. Respondent did not feel it was necessary to call radiology for the final CT reports because he believed the patient was stable and responding to treatment. He assumed the reports would come in during his shift and he planned on reviewing them when they did. He did not think it was appropriate to contact surgeons until the final CT reports were available. Respondent was aware of the possibility of the patient developing necrotizing fasciitis and considered this a differential diagnosis, but his suspicion was low due to the rareness of that condition.

52. Respondent testified that, at some point between 4:00 p.m. and 5:00 p.m., he looked at Patient A's medical records as he was finishing up his "to do list" at

the end of his shift. He testified that once he saw the final CT reports, he became concerned because they stated "severe edema" rather than mild edema, and because there was no longer language stating that there was no evidence of necrotizing fasciitis or compartment syndrome. Respondent testified that after reviewing the CT reports, he began trying to arrange surgical consultations for Patient A.

53. Respondent testified that he "did not recall" any contact from nursing staff on July 4, 2021, prior to a call from Louden at around 4:45 p.m., at which time he asserted he was already in the process of arranging the surgical consultations. Because respondent did not document his efforts to obtain surgical consultations and did not produce other evidence establishing when these efforts started, it cannot be determined whether his testimony that he was already in the process when Louden contacted him is true.

54. Respondent does not believe that he needs monitoring to practice safely and testified that he has had no problems relating to patient care or communication with staff since he returned to work in 2022. He has been working on a project at Dominican Hospital to improve nurse to physician communication and to develop best practices for communication on the hospital's messaging app.

55. Regarding the false statements on his application to Dominican Hospital, respondent offered several inconsistent explanations. He first explained that a practice manager from PAFMG fills the application out and forwards it to him, suggesting that this individual is to blame for the false responses. Respondent then testified that he did not understand his status with PAFMG or that he had been found unfit for duty, and had a good faith belief that his answers were true and correct at the time of the application. He denied trying to hide anything from the hospital and stated that he "wasn't aware of anything other than that I'm on medical leave;" did not know his

clinical privileges were suspended or that his employment was in jeopardy; that he personally believed he was safe to practice; and that he understood that his medical leave was "private." After testifying that he now understands that his responses were incorrect, respondent subsequently testified that, based on tortured interpretations of the application questions presented by his attorney, that his answers were in fact true and correct. He also noted that the application was approved.

55. Respondent completed an "ECG Boot Camp Workshop" on July 9, 2024, and he completed an "EKG Interpretation Seminar" on November 22, 2022. Respondent completed a two-day medical record keeping course, presented by PACE, on January 27, 2023.

56. Dr. Hanna wrote a letter in support of respondent. She is now a Tier 1 for the hospitalist group at Dominican Hospital. She wrote that respondent is dedicated, punctual, collegial, and respectful, and has stepped forward to cover other hospitalists who are ill or having emergencies. She added that there have been no discipline or behavioral issues since he returned from leave. At hearing, Dr. Hanna testified that respondent has been working with her to review protocols for nurse messaging and to improve nurse to physician communication. She stated that she has no concerns that respondent poses any danger to patients. She acknowledged that two hours is not a typical response time for a hospitalist to respond to messages from nursing staff.

57. Rami Dakkuri, M.D., is a general surgeon who serves on PAC at PAFMG. He was involved in the committee's actions with respect to respondent following the July 4, 2021, incident through respondent's successful completion of the performance improvement plan in 2023. Dr. Dakkuri testified that since respondent returned to work, there have been no further complaints from nursing staff. Dr. Dakkuri also wrote a letter in support of respondent, stating that he has observed respondent's

"meaningful and sustained professional growth" and that he is "confident in the quality of care" respondent provides to patients.

58. Aron Mohan, M.D., wrote a letter in support of respondent. Dr. Mohan oversaw respondent's return to work in November 2023 as the hospitalist department chair at Dominican Hospital. Dr. Mohan commended respondent's strong communication and interpersonal skills, outstanding attendance, and commitment to teamwork. Dr. Mohan wrote that there have been no concerns raised by nursing staff since respondent returned to work.

59. Loosbrock testified that since respondent returned to work, he has been very responsive on the messaging app.

60. Julieann Alvarado, L.M.F.T., wrote a letter dated March 26, 2023, confirming that she had been providing mental health care to respondent since November 2021. She wrote that as of the time of her letter, respondent's symptoms were in full remission and that respondent was functioning at a high capacity across home, work, and public settings. She anticipated that he would graduate from therapy within three to six months.

Respondent testified that he gained insight from therapy and found it useful, but did not elaborate and did not demonstrate any insight regarding the misconduct that resulted in PAFMG requiring him to participate in therapy.

61. Respondent is proud of being a role model to the community in Santa Cruz where he grew up. Respondent mentors at-risk youth and coaches little league and youth soccer.

Ultimate Findings on Causes for Discipline

62. Clear and convincing evidence established that respondent committed an extreme departure from the standard of care on July 4, 2021, when – after prior counseling regarding slow response to calls from nursing staff – respondent did not make himself readily available and/or did not timely respond to urgent calls from nursing staff regarding Patient A's deteriorating condition.

This delay in treatment of the critically ill patient caused a risk of harm. It cannot be known whether the outcome would have been different if respondent responded more quickly. At a minimum, however, the delay in treatment caused discomfort for the patient, who was in need of stronger pain medication, and was stressful for nursing staff, who urgently needed to reach a physician.

63. Clear and convincing evidence established that respondent made false statements on his November 2021 application for reappointment at Dominican Hospital, and that he knew or reasonably should have known that these statements were false. Respondent's inconsistent explanations for his false responses were not credible.

Costs

64. Complainant seeks to recover $37,683 for legal services provided by the Department of Justice through September 10, 2025; $15,348.50 in investigation costs; and $2,700 in expert reviewer costs, for a total of $55,731.50. These costs are supported by declarations in compliance with the requirements of California Code of Regulations, title 1, section 1042, and are reasonable.

LEGAL CONCLUSIONS

1. It is complainant's burden to demonstrate the truth of the allegations by "clear and convincing evidence to a reasonable certainty," and that the allegations constitute cause for discipline of respondent's Certificate. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

2. Business and Professions Code section 2227 authorizes the Board to take disciplinary action against licensees who have been found to have committed violations of the Medical Practice Act.

3. Business and Professions Code section 2234, included in the Medical Practice Act, provides that a licensee may be subject to discipline for committing gross negligence. (Bus. & Prof. Code, § 2234, subd. (b).) Clear and convincing evidence established that respondent committed gross negligence in the care and treatment of Patient A. (Finding 62.) Cause for discipline was established under Business and Professions Code sections 2227 and 2234, subdivision (b).

4. Business and Professions Code section 2234, subdivision (e), provides that the Board may discipline a physician for unprofessional conduct including "[t]he commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon." Respondent's false statements on his application for reappointment at Dominican Hospital constitute cause for discipline under Business and Professions Code sections 2227 and 2234, subdivision (e). (Finding 63.)

5. In exercising its disciplinary functions, protection of the public is the Board's highest priority. (Bus. & Prof. Code, § 2229, subd. (a).) The Board is also

required to take disciplinary action that is calculated to aid the rehabilitation of the physician whenever possible, as long as the Board's action is not inconsistent with public safety. (*Id.*, subds. (b), (c).)

6. The Board's Manual of Disciplinary Orders and Disciplinary Guidelines (12th ed., 2016; Cal. Code Regs., tit. 16, § 1361) provide for a minimum discipline of five years' probation and a maximum discipline of revocation for licensees who have committed gross negligence or who have committed acts of dishonesty not arising from or occurring during patient care, treatment, management, or billing.

Respondent steadfastly denied the causes for discipline, but argued that should cause for discipline be found, a letter of reprimand would be sufficient discipline. Complainant recommended a five-year period of probation on standard terms and conditions, with special conditions including a solo practice prohibition, education and professionalism courses, and a practice monitor.

7. Respondent committed an act of gross negligence involving a single patient more than four years ago, by failing to return urgent communications from nursing staff for at least two hours. This gross negligence was followed by false statements on a hospital reappointment application. To his credit, respondent successfully completed all requirements imposed upon him by his employer, including addressing mental health issues, completing the PACE assessment and PEP, and completing a performance improvement plan. There have been no further complaints since respondent returned to work in 2022. Respondent has no prior history of Board discipline and is respected by colleagues who report observing improvement in his performance since his return.

Of greatest concern is respondent's failure to acknowledge that his conduct on July 4, 2021, was in any way unprofessional, despite the fact that this conduct resulted in his employer ordering him to a fitness for duty evaluation, placing him on leave for more than a year, requiring him to attend PACE, and returning him to work on a performance improvement plan. Also concerning is his failure to take any responsibility for the false statements on his application for reappointment at Dominican Hospital and the inconsistent explanations offered.

Accountability and honesty are critical attributes for health care practitioners, and respondent's deficiencies in these areas require Board monitoring. The evidence did not support deviation from the Board's guidelines. Because respondent's clinical practice was closely monitored by the PAFMG professional affairs committee for one year after he returned to work, a practice monitor is not necessary.

A five-year probationary period with all other conditions recommended by complainant (solo practice prohibition and education and professionalism courses) will adequately protect the public and is the appropriate discipline in this matter. Complainant did not argue for, and the evidence did not support, imposition of substance abuse conditions, notwithstanding the fitness for duty evaluator's diagnosis of mild alcohol abuse in 2021.

8. Business and Professions Code section 125.3 authorizes the Board to recover its reasonable costs of investigation and enforcement if the licensee is found to have committed a violation of the licensing act. In *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, the California Supreme Court set forth standards by which a licensing board must exercise its discretion to reduce or eliminate cost awards to ensure that licensees with potentially meritorious claims are not deterred from exercising their right to an administrative hearing. Those standards

include whether the licensee has been successful at hearing in getting the charges dismissed or reduced, the licensee's good faith belief in the merits of his or her position, whether the licensee has raised a colorable challenge to the proposed discipline, the financial ability of the licensee to pay, and whether the scope of the investigation was appropriate to the alleged misconduct. No basis for a reduction of costs was established. As set forth in Factual Finding 64, the reasonable costs in this matter are $55,731.50.

ORDER

Physician's and Surgeon's Certificate No. A 100518, issued to respondent Cesar Francisco Castillo, M.D., is revoked; however, revocation is stayed, and respondent is placed on probation for five years under the following terms and conditions.

1. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. Solo Practice Prohibition

Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) respondent

merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) respondent is the sole physician practitioner at that location.

If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, respondent's practice setting changes and respondent is no longer practicing in a setting in compliance with this Decision, the respondent shall notify the Board or its designee within 5 calendar days of the practice setting change. If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

4. Notification

Within seven days of the effective date of this decision, respondent shall provide a true copy of this decision and the accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies,

and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

5. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

6. Obey All Laws

Respondent shall obey all federal, state and local laws, and all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments, and other orders.

7. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

8. General Probation Requirements

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit.

Address Changes: Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice: Respondent shall not engage in the practice of medicine in respondent's or a patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal: Respondent shall maintain a current and renewed California physician's and surgeon's certificate.

Travel or Residence Outside California: Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty calendar days.

In the event respondent should leave the State of California to reside or to practice, respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

9. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

10. Non-Practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations.

11. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

12. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

13. License Surrender

Following the effective date of this decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed

appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

14. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

15. Cost Recovery

Respondent shall pay to the Board costs associated with its enforcement of this matter, pursuant to Business and Professions Code Section 125.3, in the amount of $55,731.50.

DATE: 10/13/2025

Karen Reichmann

KAREN REICHMANN
Administrative Law Judge
Office of Administrative Hearings