OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against CRISPINO SANTOS SANTOS, M.D., Respondent.	**Case No. 18-11729-1**

FILED
JUL 2 6 2018
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board) hereby issues this formal Complaint (Complaint) against Crispino Santos Santos, M.D. (Respondent), a physician licensed in Nevada. After investigating this matter, the IC has a reasonable basis to believe that Respondent has violated provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act). The IC alleges the following facts:

1. Respondent is a physician licensed to practice medicine in the State of Nevada (License No. 8198). He has been continuously licensed by the Board since June 9, 1997.

A. Respondent's Treatment of Patient A

2. Patient A was a 52-year-old female when she presented to Respondent for medical care on or about June 4, 2013. Patient A's true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

3. On or about June 4, 2013, Patient A presented to Respondent for a routine refill of her intrathecal pain pump.

[1] The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board), at the time this formal Complaint was authorized for filing, was composed of Board members Wayne Hardwick, M.D., Chairman, Theodore B. Berndt, M.D., and Mr. M. Neil Duxbury.

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4. Respondent electronically interrogated Patient A's intrathecal pump computer, which showed the pump reservoir had 6.3 cubic centimeters (cc's) of medication volume remaining.

5. Respondent inserted a needle into Patient A's subcutaneous pump tissue pocket, rather than into the pump injection port.

6. Respondent then attempted to aspirate the medication in the pump, but noted that he aspirated only 2 cc's of medication volume, rather than 6.3 cc's; this descrepency should have provided further indication to a reasonable practitioner under the circumstances that Respondent had not positioned the needle correctly in the injection port.

7. Respondent proceeded to inject intrathecal pain medication directly into the subcutaneous tissue pocket, rather than into the pump injection port, causing Patient A to suffer a drug overdose and a stroke, with resulting neurological deficits, paralysis and a speech disorder.

8. Immediately after Respondent injected intrathecal pain medication directly into Patient A's body, Patient A began to suffer slurred speech and hypotension, and became incoherent.

9. Respondent did not call 9-1-1 or otherwise alert emergency medical services. Instead, he instructed one of his medical assistants to "wheel her down to the emergency room of Centenial Hills Hospital."

10. Respondent did not remain with Patient A; he did not accompany her to or attend to her at the emergency room; he did not contact emergency room staff and inform them of Patient A's condition; he did not support her airway, or monitor her blood pressure and vital signs; he did not administer a reversing agent, such as Narcan; Respondent was, or should have been, able and equipped to perform all the aforementioned countermeasures as a practitioner undertaking to support and care for intrathecal pain pump patients.

COUNT I

NRS 630.301(4) (Malpractice)

11. All of the allegations in the above paragraphs are hereby incorporated as if fully set forth herein.

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12. Malpractice is grounds for disciplinary action against a licensee pursuant to NRS 630.301(4).

13. NAC 630.040 defines malpractice as a practitioner's failure to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances when treating a patient.

14. As demonstrated by, but not limited to, the above-outlined facts, Respondent committed malpractice with respect to his treatment of Patient A by failing to use reasonable care, skill or knowledge ordinarily used under similar circumstance when treating Patient A by, alternatively or in combination: (1) incorrectly inserting the needle into Patient A's subcutaneous pump tissue pocket, rather than into the pump injection port; (2) failing to discover this incorrect needle position before injecting intrathecal pump medication; (3) injecting intrathecal pain medication directly into Patient A's body, causing Patient A to suffer a drug overdose and a stroke.

15. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT II

NRS 630.301(4) (Malpractice)

16. All of the allegations in the above paragraphs are hereby incorporated as if fully set forth herein.

17. As demonstrated by, but not limited to, the above-outlined facts, Respondent committed malpractice with respect to his treatment of Patient A by failing to use reasonable care, skill or knowledge ordinarily used under similar circumstance when treating Patient A by, alternatively or in combination: (1) failing to remain with Patient A to personally assure her continued care under life-threatening circumstances; (2) failing to accompany her to or attend to her at the emergency room; (3) failing to maintain her airway, monitor her blood pressure and vital signs; (4) failing to administer a reversing agent, such as Narcan.

18. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT III

NRS 630.304(7) (Terminating Care Without Making Other Arrangements for the Continued Care of the Patient)

19. All of the allegations in the above paragraphs are hereby incorporated as if fully set forth herein.

20. Terminating the medical care of a patient without making other arrangements for the continued care of the patient is grounds for disciplinary action against a licensee pursuant to NRS 630.304(7).

21. As demonstrated by, but not limited to, the above-outlined facts, Respondent terminated care of Patient A without making adequate arrangements for her continued care.

22. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

WHEREFORE, the Investigative Committee prays:

1. That the Board give Respondent notice of the charges herein against him and give him notice that he may file an answer to the Complaint herein as set forth in NRS 630.339(2) within twenty (20) days of service of the Complaint;

2. That the Board set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

3. That the Board determine what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

4. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

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5. That the Board take such other and further action as may be just and proper in these premises.

DATED this 25 day of July, 2018.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

Aaron Bart Fricke, Esq., Deputy General Counsel
Attorney for the Investigative Committee

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Wayne Hardwick, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

DATED this 25th day of July, 2018.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Wayne Hardwick

Wayne Hardwick, M.D., Chairman

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