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, M.D.,** **Respondent.**	**Case No. 21-11729-1** FILED JUL 16 2021 NEVADA STATE BOARD OF MEDICAL EXAMINERS By: CW

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Aaron B. Fricke, Esq., General Counsel and attorney for the IC, having a reasonable basis to believe that Crispino Santos, M.D., (Respondent) violated the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's charges and allegations as follows:

1. Respondent was at all times relevant to this Complaint a medical doctor holding an active license to practice medicine in the State of Nevada (License No. 8198). Respondent was originally licensed by the Board on June 9, 1997.

2. Patient A[2] was a healthy, thirty (30) year-old female of normal height and weight at the time of the events at issue.

3. At all times relevant to this Complaint, Respondent maintained a medical office at Interventional Pain Medicine, 7190 Smoke Ranch Road, Suite 150, Las Vegas, NV 89128 (IPM).

4. IPM was at all times relevant to this Complaint an "office of a physician or a facility that provides health care, other than a medical facility." Neither Respondent nor IPM held

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[1] The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing, was composed of Board members Bret W. Frey, M.D., Chair, Aury Nagy, M.D., and Col. Eric D. Wade, USAF (Ret.).

[2] 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.

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the requisite permit issued by the Nevada State Board of Health, pursuant to NRS 449.442, to provide "conscious sedation" at IPM. Further, neither IPM nor Respondent held a current accreditation by a nationally recognized organization approved by the Nevada State Board of Health.

5. On or about November 17, 2015, Patient A presented to Respondent for an initial evaluation for breast augmentation. Respondent diagnosed Patient A with hypoplasia of the breast. No description or measurement of Patient A's breasts nor a breast examination are documented in Respondent's medical records.

6. On or about November 17, 2015, Patient A agreed to have an augmentation mastopexy, with submuscular saline implants. Respondent's medical records indicate that Respondent described the procedure, consent, pre-op and post-op care to Patient A, and the plan to proceed with bilateral breast augmentation in February, however, no specific discussion of a surgical plan, the correction of deformities, or breast exam are documented in Respondent's medical records.

7. Respondent did not discuss with Patient A, on November 17, 2015, the method of anesthesia planned to be used for the operation. Patient A reasonably assumed that the surgery would be done under general anesthesia or deep sedation in a properly permitted and accredited surgical facility approved by the Nevada State Board of Health pursuant to NRS 449.442.

8. On February 9, 2016, Patient A presented to Respondent at IPM for a preoperative evaluation. The only physical exam related to Patient A's breasts that Respondent documented was the exam of axillary lymph nodes; no examination of the breast for masses, size, measurements of nipple position or breast width, no surgical plan, discussion of incision, breast implant pocket or placement are documented. At this visit, Respondent scheduled the breast augmentation procedure for the morning of February 25, 2016.

9. Respondent still had not discussed with Patient A on February 9, 2016, or previously, the method and type of anesthesia to be used for the operation. Patient A still reasonably assumed that the surgery would be done under general anesthesia or deep sedation in a

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properly permitted and accredited surgical facility approved by the Nevada State Board of Health pursuant to NRS 449.442.

10. On February 9, 2016, at this preoperative evaluation, Respondent provided hand-written prescriptions to Patient A as follows: Diazepam 10 mg tablet, 6 ct., for six (6) days supply; Hydrocodone-acetaminophen 10-325 mg tablet, 42 ct. for a fourteen (14) day supply, which constitutes a milligram morphine equivalent (MME) of 30 mg per day; Ciprofloxacin 250 mg, 28 ct., twice per day for fourteen (14) days. Respondent instructed Patient A to begin taking the prescribed Ciprofloxacin on February 19, 2016.

11. Respondent did not document in his medical record of February 9, 2016, any justification for prescribing 30 MME per day of opioid analgesics to a healthy thirty (30) year-old female of normal height and weight.

12. Respondent instructed Patient A to take Schedule IV controlled substances that he prescribed in a manner that materially deviated from the written prescriptions; Respondent instructed Patient A to take two (2) Diazepam and at least one (1) Hydrocodone-acetaminophen upon arrival at IPM for surgery. Respondent did not document the prescriptions or the reasons for the Diazepam or Hydrocodone-acetaminophen, nor did he document his instructions that contravened the written prescriptions anywhere in his medical records.

13. On February 9, 2016, Respondent instructed Patient A to deviate from the written prescriptions and take Diazepam and Hydrocodone-acetaminophen for the purpose of conscious sedation for the invasive, surgical procedure he planned to perform on Patient A.

14. Patient A took the prescribed medications as instructed, two (2) 10 mg Diazepam tablets and at least one (1) Hydrocodone-acetaminophen tablet, upon arrival at IPM for surgery on February 25, 2016. Respondent noted in Patient A's medical records that the medications were taken as instructed.

15. Respondent did not inform Patient A at any time at or before she presented to Respondent at IPM on February 25, 2016, that she would not receive general anesthesia or deep sedation prior to the commencement of the surgery on February 25, 2016. Additionally, Respondent did not inform Patient A that IPM was a facility that was not properly permitted and

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accredited by the Nevada State Board of Health pursuant to NRS 449.442, and did not obtain consent from Patient A for the performance of the procedure in the unpermitted and unaccredited facility.

16. Upon arrival at IPM, after having taken two (2) Diazepam 10 mg tablets, and at least one (1) Hydrocodone-acetaminophen 10-325 mg tablet, Respondent informed Patient A that the surgery would not be done under general anesthesia or deep sedation.

17. On February 25, 2016, Respondent attempted to perform an "Awake Breast Augmentation with Tumescent Anesthesia" (First Surgery), that is, Respondent attempted to perform a surgical operation to insert breast implants into Patient A's subpectoral muscle space under tumescent local anesthesia at the surgical site, and while Patient A was consciously sedated with a combination of Diazepam and Hydrocodone-acetaminophen.

18. Respondent commenced the First Surgery at approximately 8:55 a.m., and concluded at approximately 11:00 a.m., during which time only 10 cc of 1% Lidocaine was used for the entire procedure.

19. During the First Surgery, Respondent placed the left breast implant in a superior malposition in a sub-muscular pocket, and the right breast implant subglandular and prepectoral.

20. Patient A did not receive intravenous sedation and was awake throughout the First Surgery.

21. Patient A felt pain throughout the procedure, consciously experienced Respondent cutting open her breast skin and tissue, inserting surgical instruments and implants into her body, removing tissue from her body, stitching of her skin, and other traumas, for over two (2) hours.

22. Patient A was substantially traumatized, physically and psychologically, by the First Surgery performed by Respondent.

23. On February 25, 2016, Respondent provided a hand-written prescription to Patient A as follows: Oxycodone-acetaminophen 10-325 mg tablet, 60 ct. for thirty (30) days supply, which constitutes thirty (30) MME per day.

24. On March 1, 2016, Patient A presented to Respondent at IPM for a "post-operative visit." Respondent's record of his physical exam does not describe anything with respect to

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Patient A's breasts, implant position, erythema, or sensibility of nipple areolar position. Respondent did not document the presence or absence of seroma, hematoma, implant position, sensibility of nipples or wound appearance, except that Respondent noted a "blister" over the right breast, for which Respondent applied antibiotic ointment.

25. On March 3, 2016, Patient A presented to Respondent at IPM for another "post-operative visit." Again, Respondent's records reflect no relevant physical examination or findings of any kind.

26. On March 3, 2016, Respondent provided a hand-written prescription to Patient A as follows: Oxycodone-acetaminophen 10-325 mg tablet, 120 ct. for thirty (30) days supply, which alone amounts to sixty (60) MME per day, but combined with the thirty-day prescription for Oxycodone-acetaminophen that Respondent wrote on February 25, 2021, just eight (8) days prior, amounts to ninety (90) MME per day, and constitutes high-dose opioid therapy. If the Oxycodone-acetaminophen were taken as directed, Patient A would have had more than one hundred sixty (160) tablets of Oxycodone-acetaminophen at this time.

27. Respondent did not document in his medical record of March 3, 2016, any explanation or justification for prescribing an additional sixty (60) MME per day or the combined ninety (90) MME per day of opioid analgesics to a healthy thirty-year-old female of normal height and weight.

28. Respondent prescribed to Patient A ninety (90) MME per day without establishing the medical necessity of high-dose opioid therapy.

29. On March 7, 2016, Patient A presented to Respondent at IPM for another "post-operative visit." Again, Respondent's records reflect no relevant physical examination or findings of any kind.

30. On March 22, 2016, Patient A presented to Respondent at IPM for another "post-operative visit." Again, Respondent's records reflect no relevant physical examination or findings of any kind, do not describe breast appearance, operative site, etc. The only notation Respondent made in reference to the First Surgery was, "The patient is doing well. Surgical site has healed. No signs of infection."

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31. On March 22, 2016, Respondent provided hand-written prescriptions to Patient A as follows: Diazepam 5 mg tablet, 5 ct., for 5 days supply; Oxycodone-acetaminophen 10-325 mg tablet, 120 ct. for a thirty (30) day supply, which alone amounts to sixty (60) MME per day, but combined with the thirty (30) day prescription for Oxycodone-acetaminophen that Respondent wrote on March 3, 2021, just eighteen (18) days prior, amounts to one hundred twenty (120) MME per day, which is high-dose opioid therapy and an unsafe dosage.

32. Respondent did not document in his medical record of March 22, 2016, any explanation or justification for prescribing either sixty (60) MME per day or one hundred twenty (120) MME per day of opioid analgesics to a healthy thirty (30) year-old female of normal height and weight.

33. Respondent prescribed to Patient A one hundred twenty (120) MME per day without establishing the medical necessity of high-dose opioid therapy.

34. On March 30, 2016, Respondent attempted to perform a "Left Breast Revision of saline implants," as stated in his records (Second Surgery), that is, Respondent attempted to perform a surgical operation to insert breast implants into Patient A's subpectoral muscle space under tumescent local anesthesia at the surgical site, and while Patient A was, again, consciously sedated with a combination of Diazepam and Hydrocodone-acetaminophen.

35. On March 30, 2016, at IPM, Respondent performed the Second Surgery for, apparently, a revision of Patient A's left breast, again, under local anesthesia with 75 cc of 1% Lidocaine. The Second Surgery took place at IPM from 3:05 p.m. to 4:35 p.m., during which time Patient A's blood pressure was taken only twice.

36. During the Second Surgery, Respondent did not correct for the prior misplacement of the implants from the First Surgery, and did not address any of the cosmetic issues, rather, Respondent merely exchanged the left breast implant for a larger one in the same position.

37. On March 30, 2016, Respondent provided a hand-written prescription to Patient A as follows: Hydromorphone 4 mg tablet, 56 ct. for a fourteen (14) day supply, which alone constitutes sixty-four (64) MME per day, but combined with the thirty (30) day prescription for sixty (60) MME per day of Oxycodone-acetaminophen that Respondent wrote on March 3, 2021,

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just twenty-seven (27) days prior, and combined with the thirty (30) day prescription for sixty (60) MME of Oxycodone-acetaminophen that Respondent wrote on March 22, 2021, just seven (7) days prior, amounts to one hundred eighty-four (184) MME per day, which is high-dose opioid therapy and an unsafe dosage.

38. Respondent did not document in his medical record of March 22, 2016, any explanation or justification for prescribing either sixty (60) MME, one hundred twenty (120) MME or one hundred eighty-four (184) MME per day of opioid analgesics to a healthy thirty-year-old female of normal height and weight.

39. Respondent prescribed to Patient A one hundred eighty-four (184) MME per day of opioid analgesics without establishing the medical necessity of high-dose opioid therapy.

40. Following the First Surgery and Second Surgery, Patient A was left with a left implant in a superior malposition in a sub-muscular pocket, sub-glandular right implant placement, asymmetry of nipple areolar complexes, with the left areolar complex being inferior. Also, Patient A had some skin dehiscence in the right compared to left mammary crease incisions.

COUNT I

NRS 630.301(4) - Malpractice

41. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

42. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

43. NAC 630.040 defines malpractice as "the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances."

44. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when rendering medical services to Patient A by, among other failures, 1) failing to properly perform the surgery he intended by instead placing the left breast implant in a superior malposition in a sub-muscular pocket in the First Surgery; 2) failing to properly perform the surgery he intended

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by placing the right breast implant subglandular and prepectoral in the First Surgery, 3) repeating these errors in the Second Surgery; 4) failing to properly examine for, recognize and document that the breast implants had been placed in different positions in the chest wall, i.e., one subpectoral and the other subglandular; 5) repeatedly failing, both pre-operatively and post-operatively, to perform and document an appropriate examination of the chest, breasts, and surgical site, sensibility in the nipples, perfusion in the skin, presence or absence of seroma or hematoma, and the obvious malposition of the implants with respect to each other; and 6) repeatedly prescribing exceedingly high and unsafe dosages of opioid analgesics without medical necessity.

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

COUNT II

NRS 630.306(1)(o) – Administration of Conscious Sedation at an Unaccredited and Unpermitted Facility

46. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

47. Pursuant to NRS 630.306(1)(o), failure to comply with the requirements of NRS 630.373 is grounds for initiating discipline or denying licensure.

48. Pursuant to NRS 630.373(1), a physician shall not administer or supervise directly the administration of general anesthesia, conscious sedation or deep sedation to patients unless the general anesthesia, conscious sedation or deep sedation is administered: (a) in an office of a physician or osteopathic physician which holds a permit pursuant to NRS 449.435 to 449.448, inclusive; (b) in a facility which holds a permit pursuant to NRS 449.435 to 449.448, inclusive; (c) in a medical facility as that term is defined in NRS 449.0151; or (d) outside of the State of Nevada.

49. For the purposes of NRS 630.373, "conscious sedation" means a minimally depressed level of consciousness, produced by a pharmacologic or nonpharmacologic method, or a combination thereof, in which the patient retains the ability independently and continuously to

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maintain an airway and to respond appropriately to physical stimulation and verbal commands. NRS 449.436.

50. Pursuant to NRS 453.021, "administer" means the direct application of a controlled substance, whether by injection, inhalation, ingestion or any other means, to the body of a patient or research subject by: (1) a practitioner or, in the practitioner's presence, by the practitioner's authorized agent; or (2) the patient or research subject at the direction and in the presence of the practitioner.

51. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to comply with NRS 630.373 when rendering medical services to Patient A, by, among other misconduct, issuing prescriptions for controlled substances to Patient A in order to administer and/or supervise directly the administration of conscious sedation to Patient A for an invasive surgical procedure that Respondent performed on Patient A at IPM, which is not the office of a physician or osteopathic physician which holds a permit pursuant to NRS 449.435 to 449.448, inclusive, not a facility which holds a permit pursuant to NRS 449.435 to 449.448, inclusive, and not a medical facility as that term is defined in NRS 449.0151, and which is located inside the State of Nevada.

52. 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 award fees and costs for the investigation and prosecution of this case as outlined in NRS 622.400;

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5. 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

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

DATED this day of July, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: ______________________________

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Attorney for the Investigative Committee

VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Bret W. Frey, 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 16th day of July, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

BRET W. FREY, M.D.
Chairman of the Investigative Committee

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1 CERTIFICATE OF SERVICE

2 I hereby certify that I am employed by the Nevada State Board of Medical Examiners and 3 that on the 16th day of July, 2021, I served a file-stamped copy of the **COMPLAINT** and 4 **PATIENT DESIGNTION**, via U.S. Certified Mail, with a courtesty copy by electronic mail, to 5 the following parties:

6 Crispino Santos, M.D.
7 c/o John A. Hunt, Esq.
Clark Hill, LLP
8 3800 Howard Hughes Parkway
Las Vegas, NV 89169
9 jhunt@clarkhill.com

10 **Certified Mailing No.*: 9171 9690 0935 0255 6177 15

11 Additionally, Pursuant to NRS 630.342, a Fingerprint Card and Background Waiver, with 12 instructions for completing and submitting fingerprints were included in the same mailing.

13 DATED this 16th day of July, 2021.

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MERCEDES FUENTES
16 Legal Assistant
17 Nevada State Board of Medical Examiners

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