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

In the Matter of the Accusation Against: **CECELIA THERESA MADRID, M.D.** **2701 W. Alameda Avenue, Suite 500** **Burbank, CA 91505-4402** **Physician's and Surgeon's Certificate No. G 48480,** Respondent.	Case No. 800-2021-077174 **A C C U S A T I O N**

PARTIES

1. Reji Varghese (Complainant) brings this 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 2, 1982, the Medical Board issued Physician's and Surgeon's Certificate Number G 48480 to Cecelia Theresa Madrid, 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 March 31, 2024, unless renewed.

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JURISDICTION

3. This 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.

4. 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.

STATUTORY PROVISIONS

5. 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.

6. 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

7. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may 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.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to

subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

8. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that she committed repeated negligent acts in connection with the care and treatment of Patients 1 and 2.[1] The circumstances are as follows:

Patient 1

9. Patient 1 is a ninety-year-old female, who was treated by Respondent from approximately 2018 to 2019,[2] for various maladies including chronic obstructive pulmonary disease (COPD), bronchitis, osteoarthritis, hypothyroidism, and epigastric pain, among other things.

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[1] The patients are identified by number to protect their privacy.

[2] These are approximate dates based on the medical records, which were available to the Board. Patient 1 may have treated with Respondent before or after these dates.

10. Per CURES (Controlled Substance Utilization Review and Evaluation System, a drug monitoring database for Schedule II through V controlled substances dispensed in California), between September to December 2018, Respondent prescribed Patient 1 Promethazine with Codeine, as well as simultaneous benzodiazepine prescriptions for lorazepam (a sedative used to treat anxiety) and temazepam (a sedative used to treat insomnia). Respondent also prescribed Patient 1 Lyrica (a nerve pain medication) on at least two occasions.

11. During Patient 1's treatment period, Respondent maintained medical records pertaining to each of Patient 1's visits. Each of the electronic medical record entries listed Dr. R.K. as the provider, due to an apparent system defect. Respondent routinely made handwritten notes in the records, which she signed.

12. In the entries dated on or about June 14, 2018, June 19, 2018, July 16, 2018, and December 3, 2018, medication reconciliation[3] was not documented. Instead, the records stated "error message" under the medication reconciliation sections. On other occasions, the same medications were listed and the medication reconciliation was not updated from the previous visit.

13. Respondent's repeated failure to maintain clear documentation constitutes a simple departure from the standard of care.

Patient 2

14. Patient 2 is a seventy-one-year-old female, who was treated by Respondent from approximately 2017 through 2020.[4] According to the CURES Patient Activity Report, Patient 2 was on a clonazepam[5] regimen prior to being treated by Respondent. Respondent first prescribed Patient 2 clonazepam in February 2017.

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[3] Medication reconciliation is the process of identifying the most accurate list of all the medications that a patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider. Medication reconciliation is expected to ensure patient safety and quality of care.

[4] Again, these are approximate dates based on the medical records, which were available to the Board. Patient 2 may have treated with Respondent before or after these dates.

[5] Clonazepam is a Schedule IV benzodiazepine used for the acute management of panic disorders and epilepsy.

15. Patient 2 presented to Respondent in June 2018 for pre-operative clearance for a breast lumpectomy and right axillary node biopsy. Patient 2's medical concerns also included hypothyroidism, major depression, and bilateral hand pain.

16. On or about July 2, 2018, Patient 2 was diagnosed as having breast cancer. The treatment plan included radiation therapy to address the cancer.

17. On or about April 11, 2019, Patient 2 presented to Respondent for a breast cancer follow-up and to address her anxiety, which was exacerbated by the cancer diagnosis. Respondent's treatment plan included a referral to a specialist and an order to continue with Patient 2's current medications, which included clonazepam and Lexapro (an antidepressant used to treat anxiety and depression).

18. Between June 2018 and June 2019, Patient 2 was prescribed a stable dose of 1 milligram of clonazepam, to be taken three times daily.

19. On or about June 24, 2019 and July 16, 2019, Patient 2 presented to Respondent to address her anxiety and depression. Following the June 24, 2019 appointment, Respondent increased Patient 2's clonazepam dosage to 1 milligram four times daily. This increased dosage continued through December 2019.

20. In or about January 2020, Patient 2 was placed back on a 1 milligram of clonazepam, three times daily, regimen.

21. On or about February 20, 2020 and August 21, 2020, Patient 2 again presented to Respondent to address her anxiety and depression. Respondent continued Patient 2 on Lexapro and again increased her clonazepam dosage to 1 milligram four times daily.

22. Patient 2 continued on the increased clonazepam dosage until the patient-doctor relationship ended.

23. The standard of care requires routine urine toxicology screening to ensure a patient is taking long-acting benzodiazepines[6] as prescribed and to rule out diversion. Further, patients should be routinely monitored for clinical response and CURES activity should be monitored.

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[6] Benzodiazepines are a class of depressant drugs that produce sedation and hypnosis, relieve anxiety and muscle spasms, and reduce seizures.

24. Though not documented in the medical records, Respondent indicated that she reviewed Patient 2's CURES activity report. However, Respondent failed to administer routine urine toxicology screening to rule out diversion. This failure constitutes a simple departure from the standard of care.

25. During Patient 2's treatment period, Respondent maintained medical records pertaining to each of Patient 2's visits. Each of the electronic medical record entries listed Dr. R.K. as the provider, due to an apparent system defect. Respondent routinely made handwritten notes in the records, which she signed. Several of the medical record entries failed to correctly document Patient 2's medications in the medication reconciliation. Some records included an error message in the medication reconciliation section. Respondent's repeated failure to maintain clear documentation constitutes a simple departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Records)

26. By reason of the facts and allegations set forth in the First Cause for Discipline in paragraphs 9 through 25, above, Respondent is subject to disciplinary action under section 2266 of the Code in that Respondent failed to maintain accurate records of her care and treatment of Patients 1 and 2.

DISCIPLINARY CONSIDERATIONS

27. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about October 20, 2011, in a prior disciplinary action titled *In the Matter of the Accusation Against Cecelia Theresa Madrid, M.D.* before the Medical Board of California, in Case Number 06-2007-184583, Respondent's license was revoked, with the revocation stayed for a period of seven (7) years, subject to terms and conditions. This action was taken due to sustained allegations of gross negligence, repeated negligent acts, prescribing without an appropriate examination, failure to maintain adequate medical records, and excessive prescribing. That decision is now final and is incorporated by reference as if fully set forth herein.

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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 G 48480, issued to Respondent Cecelia Theresa Madrid, M.D.;

2. Revoking, suspending or denying approval of Respondent Cecelia Theresa Madrid, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Cecelia Theresa Madrid, 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: MAR 23 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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