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

In the Matter of the Accusation Against: **ROBERT JOHN SANTELLA, M.D.** **4531 College Avenue** **San Diego, CA 92115** **Physician's and Surgeon's Certificate No. G23945,** Respondent.	Case No. 800-2014-002884 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs, and not otherwise.

2. On or about January 11, 1973, the Medical Board issued Physician's and Surgeon's Certificate No. G23945 to Robert John Santella, M.D. (respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges and allegations brought herein and will expire on December 31, 2017, unless renewed.

JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, 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 provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, be publicly reprimanded which may include a requirement that the licensee complete relevant educational courses, or have such other action taken in relation to discipline as the Board deems proper.

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:

" ...

"(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.

" ... "

6. Unprofessional conduct under section 2234 of the Code is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.).

7. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

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

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

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

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

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

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

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

8. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

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9. Section 4022 of the Code states:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only,' or words of similar import.

"(b) Any device that bears the statement: 'Caution: federal law restricts this device to sale by or on the order of a ____,' 'Rx only,' or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

10. Respondent has subjected his Physician's and Surgeon's Certificate No. G23945 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (b), of the Code, in that respondent committed gross negligence in his care and treatment of patients J.R., K.J., R.G., E.H. and C.T., as more particularly alleged hereinafter:

Patient J.R.

(a) In or around 1991, respondent began treating patient J.R. and continued seeing her as a primary care physician for more than twenty (20) years.[1]

(b) Respondent treated patient J.R. for multiple conditions including, chronic pain, myasthenia gravis, anemia and tachycardia.

(c) Respondent routinely gave patient J.R. injections of Demerol[2] and

[1] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

[2] Demerol is a brand name for meperidine, a Schedule II controlled substance pursuant to Health and Safety Code section 11056, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

fentanyl[3] at office visits, but he did not document in patient J.R.'s progress notes any reasons and/or treatment plan for administering these injections of controlled substances to her.

(d) Dosage amounts and lot numbers for controlled substances administered and/or dispensed to patient J.R. are frequently missing from the progress notes. Respondent documented in the progress notes that he had administered the "standard dose" of controlled substances to patient J.R. rather than specify an amount given. However, in many of the progress notes it is unclear whether respondent actually administered an injection to patient J.R. during these visits.

(e) Respondent rarely documented any history or physical examination findings in patient J.R.'s progress notes.

(f) Despite being a patient of respondent's for over twenty (20) years, patient J.R.'s medical records do not contain a clear medical indication documented by respondent for the use of controlled substances to treat patient J.R.'s pain.

(g) Despite being a patient of respondent's for over twenty (20) years, patient J.R.'s medical records contain only one (1) pain assessment progress note documenting some assessment of the course of treatment she was receiving from respondent.

(h) In a progress note dated April 13, 2012, it is documented that patient J.R. had chronic anemia. Laboratory tests conducted at or around the time of this progress note indicated a drop in her hemoglobin level to 7.0, which was lower than the last tested level of 11.7. Significantly, respondent did not take any action after laboratory tests showed a drop in her hemoglobin level.

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[3] Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

(i) Respondent committed gross negligence in his care and treatment of patient J.R. which included, but was not limited to, the following:

(1) Respondent failed to maintain adequate and accurate records including, but not limited to, failing to document whether controlled substances had been administered and/or dispensed to patient J.R.; failing to document the reasons why controlled substances had been administered and/or dispensed to patient J.R.; failing to document what were the dosages of the controlled substances administered and/or dispensed to patient J.R.; and rarely documenting any history or physical examination findings, treatment plan and/or periodic review during patient J.R.'s course of treatment; and

(2) Respondent failed to act on a significantly abnormal blood test result in light of patient J.R.'s diagnosed chronic anemia.

Patient K.J.

(j) In or around 2005, respondent began treating patient K.J. and continued seeing her as a primary care physician for approximately nine (9) years.[4]

(k) Respondent treated patient K.J. for multiple conditions including, lower back pain, arthritic pain in feet and knees, depression and chronic obstructive pulmonary disease.

(l) Respondent also treated patient K.J. for uncontrolled hypertension. Patient K.J.'s blood pressure measured at numerous visits was out of control, with systolic ranging between 185 to 196 and diastolic ranging between 110 to 132. There were multiple follow up visits with respondent where patient K.J.'s blood pressure was not recorded in the progress note. Significantly, respondent did not take any action to look for secondary causes of patient K.J.'s hypertension; nor did he refer patient K.J. to a specialist for assistance with management of her uncontrolled hypertension.

[4] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

(m) To treat patient K.J.'s pain, respondent initially prescribed her Vicodin[5]; which was then escalated to Vicodin ES and later morphine[6] plus Vicodin ES. In or around 2012, respondent began prescribing patient K.J. Dilaudid[7]; which was later changed to and varied between oxycodone[8], Percocet[9] and Norco[10]. Significantly, Patient K.J.'s "overuse of pain medications" was noted in a progress note, but respondent never referred her to a pain management specialist for further evaluation.

(n) Respondent routinely gave patient K.J. injections of Demerol and fentanyl at office visits, but he did not document in patient K.J.'s progress notes any reasons and/or treatment plan for administering these injections of controlled substances to her.

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[5] Vicodin is a brand name for acetaminophen and hydrocodone bitartrate, a Schedule II controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. Note: On or about, August 22, 2014, the Drug Enforcement Administration (DEA) rescheduled hydrocodone combination products, which include Vicodin, to Schedule II of the Controlled Substances Act (CSA). The DEA's rationale for the move was to combat prescription drug abuse. The scheduling change went into effect October 6, 2014, at which time Vicodin would be regulated as Schedule II drug under the CSA. However, prior to that date Vicodin had been regulated as a Schedule III drug.

[6] Morphine is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[7] Dilaudid is a brand name for hydromorphone, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[8] Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[9] Percocet is a brand name for oxycodone and acetaminophen, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[10] Norco is a brand name for acetaminophen and hydrocodone bitartrate, a Schedule II controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. Prior to October 6, 2014, Norco was regulated as a Schedule III drug.

(o) Dosage amounts and lot numbers for controlled substances administered and/or dispensed to patient K.J. are frequently missing from the progress notes. Respondent documented in the progress notes that he had administered the "standard dose" of controlled substances to patient K.J. rather than specify an amount given. However, in many of the progress notes it is unclear whether respondent actually administered an injection to patient K.J. during these visits.

(p) Respondent rarely documented any history or physical examination findings in patient K.J.'s progress notes.

(q) Despite being a patient of respondent's for approximately nine (9) years, patient K.J.'s medical records do not contain a clear medical indication documented by respondent for the use of controlled substances to treat patient K.J.'s pain.

(r) Despite being a patient of respondent's for approximately nine (9) years, patient K.J.'s medical records contain only one (1) pain assessment progress note documenting some assessment of the course of treatment she was receiving from respondent.

(s) Respondent committed gross negligence in his care and treatment of patient K.J. which included, but was not limited to, the following:

(1) Respondent failed to maintain adequate and accurate records including, but not limited to, failing to document whether controlled substances had been administered and/or dispensed to patient K.J.; failing to document what were the dosages of the controlled substances administered and/or dispensed to patient K.J.; failing to document the reasons why controlled substances had been prescribed to patient K.J.; and rarely documenting any history or physical examination findings, treatment plan and/or periodic review during patient K.J.'s course of treatment.

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Patient R.G.

(t) In or around 1995, respondent began treating patient R.G. and continued seeing him as a primary care physician for approximately nineteen (19) years.[11]

(u) Respondent treated patient R.G. for multiple conditions including, obesity, diabetes, hepatitis C and peripheral artery disease.

(v) Respondent prescribed monthly Percocet refills for patient R.G. due to chronic pain and surgeries. Despite several long gaps between patient visits, respondent routinely refilled patient R.G.'s monthly Percocet prescription without seeing him. Moreover, respondent never documented where patient R.G. had been even though he refilled the Percocet prescriptions without seeing respondent for long periods of time.

(w) In or around October 2013, respondent increased patient R.G.'s prescription quantity of Percocet from one (100) hundred tablets to one hundred fifty (150) tablets but did not document the reason or reasons for increasing the quantity of tablets.

(x) Respondent rarely documented any history or physical examination findings in patient R.G.'s progress notes.

(y) Despite being a patient of respondent's for approximately nineteen (19) years, patient R.G.'s medical records do not contain a clear medical indication documented by respondent for the use of controlled substances to treat patient R.G.'s pain.

(z) Despite being a patient of respondent's for approximately nineteen (19) years, patient R.G.'s medical records contain only one (1) pain assessment progress note documenting some assessment of the course of treatment he was receiving from respondent.

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[11] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

(aa) Respondent committed gross negligence in his care and treatment of patient R.G. which included, but was not limited to, the following:

(1) Respondent failed to maintain adequate and accurate records including, but not limited to, failing to document whether controlled substances had been administered and/or dispensed to patient R.G.; failing to document the reasons why controlled substances had been prescribed to patient R.G.; failing to document why the dosages of controlled substances prescribed to patient R.G. were adjusted; and rarely documenting any history or physical examination findings, treatment plan and/or periodic review during patient R.G.'s course of treatment.

Patient E.H.

(bb) In or around 2004, respondent began treating patient E.H. and continued seeing her as a primary care physician for approximately ten (10) years.[12]

(cc) Respondent treated patient E.H. for multiple conditions including, knee pain, lumbar degenerative disc disease and depression.

(dd) Respondent regularly prescribed Percocet on a monthly basis to patient E.H. due to chronic pain.

(ee) In or around November 2012, respondent increased patient E.H.'s prescription quantity of Percocet from one (100) hundred tablets to one hundred fifty (150) tablets, but did not document the reason or reasons for increasing the quantity of tablets.

(ff) Respondent rarely documented any history or physical examination findings in patient E.H.'s progress notes.

(gg) Despite being a patient of respondent's for approximately ten (10) years, patient E.H.'s medical records do not contain a clear medical indication documented by respondent for the use of controlled substances to treat patient E.H.'s pain.

[12] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

(hh) Despite being a patient of respondent's for approximately ten (10) years, patient E.H.'s medical records contain only one (1) pain assessment progress note documenting some assessment of the course of treatment she was receiving from respondent.

(ii) Respondent committed gross negligence in his care and treatment of patient E.H. which included, but was not limited to, the following:

(1) Respondent failed to maintain adequate and accurate records including, but not limited to, failing to document whether controlled substances had been administered and/or dispensed to patient E.H.; failing to document the reasons why controlled substances had been prescribed to patient E.H.; failing to document why the dosages of controlled substances prescribed to patient E.H. were adjusted; and rarely documenting any history or physical examination findings, treatment plan and/or periodic review during patient E.H.'s course of treatment.

Patient C.T.

(jj) In or around 2005, respondent began treating patient C.T. and continued seeing him as a primary care physician for approximately nine (9) years.[13] Patient C.T.'s progress notes and medical records prior to 2010 were accidentally destroyed by respondent's office.

(kk) Respondent treated patient C.T. for multiple conditions including, obesity, diabetes mellitus and pain management. Respondent had suffered a crush injury which resulted in a leg amputation and had left him confined to a wheel chair.

(ll) In or around February 2010, respondent was prescribing Percocet 5-325 mg tablets to patient C.T. for pain management. However, according to prescription records, the Percocet dosage was later increased to 10-325 mg tablets, but with no corresponding documentation in patient C.T.'s progress notes explaining the reason or reasons for increasing the dosage.

[13] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

(mm) In or around August 2012, respondent prescribed OxyContin[14] 20 mg tablets to patient C.T. In or around April 2013, respondent increased patient C.T.'s OxyContin dosage to 40 mg tablets, but with no corresponding documentation in the progress notes explaining the reason or reasons for increasing the dosage. In or around May 2013, according to prescription records respondent increased patient C.T.'s OxyContin dosage to 80 mg tablets, and again, there is no corresponding documentation in the progress notes explaining the reason or reasons for increasing the dosage. Significantly, in light of factors indicating that patient C.T.'s pain was not being adequately treated with escalating dosages of OxyContin, respondent never referred him to a pain management specialist for further evaluation.

(nn) In or around June 2014, respondent was still prescribing both Percocet 5-325 mg tablets and OxyContin 80 mg tablets to patient C.T.

(oo) Despite being a patient of respondent's for approximately nine (9) years, patient C.T.'s medical records do not contain a clear medical indication documented by respondent for the use of controlled substances.

(pp) Despite being a patient of respondent's for approximately nine (9) years, patient C.T.'s medical records contain only one (1) pain assessment progress note documenting some assessment of the course of treatment he was receiving from respondent.

(qq) Regarding respondent's care and treatment of patient C.T.'s diabetes mellitus, in April 2011, and June 2011, two (2) laboratory tests were performed, which looked at his hemoglobin and creatinine levels and a lipid panel was performed. These tests performed in 2011 are the last laboratory tests found in patient C.T.'s medical records, even though he continued to see respondent for

[14] OxyContin is a brand name for oxycodone, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

another three (3) years. Nor does there appear to be any documentation in his medical records of an ophthalmology evaluation to screen for diabetic retinal disease.

(rr) Respondent rarely documented any history or physical examination findings in patient C.T.'s progress notes.

(ss) Respondent committed gross negligence in his care and treatment of patient C.T.. which included, but was not limited to, the following:

(1) Respondent failed to maintain adequate and accurate records including, but not limited to, failing to document whether controlled substances had been administered and/or dispensed to patient C.T.; failing to document the reasons why controlled substances had been prescribed to patient C.T.; failing to document why the dosages of controlled substances prescribed to patient C.T. were adjusted; and rarely documenting any history or physical examination findings, treatment plan and/or periodic review during patient C.T.'s course of treatment.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

11. Respondent has further subjected his Physician's and Surgeon's Certificate No. G23945 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (c), of the Code, in that respondent committed repeated negligent acts in his care and treatment of patients J.R., K.J., R.G., E.H. and C.T., as more particularly alleged hereinafter:

Patient J.R.

(a) Paragraphs 10(a) through 10(i), above, are incorporated by reference and realleged as if fully set forth herein.

(b) Respondent committed repeated negligent acts in his care and treatment of patient J.R., which included, but was not limited to, the following:

(1) Respondent failed to properly document a satisfactory history and physical examination including, failing to clearly document a recognized medical indication for the use of controlled substances in treating patient J.R.'s chronic pain;

(2) Respondent failed to properly document a treatment plan including, failing to develop and record a treatment plan for the use of controlled substances in treating patient J.R.'s chronic pain;

(3) Respondent used a "standard dose" of medications when treating patient J.R.'s chronic pain with controlled substances rather than individualizing pharmacological therapy to meet her medical needs; and

(4) Respondent failed to perform periodic review of patient J.R.'s pain and treatment status.

Patient K.J.

(c) Paragraphs 10(j) through 10(s), above, are incorporated by reference and realleged as if fully set forth herein.

(d) Respondent committed repeated negligent acts in his care and treatment of patient K.J., which included, but was not limited to, the following:

(1) Respondent failed to properly document a satisfactory history and physical examination including, failing to clearly document a recognized medical indication for the use of controlled substances in treating patient K.J.'s chronic pain;

(2) Respondent failed to properly document a treatment plan including, failing to develop and record a treatment plan for the use of controlled substances in treating patient K.J.'s chronic pain;

(3) Respondent used a "standard dose" of medications when treating patient K.J.'s chronic pain with controlled substances rather than individualizing pharmacological therapy to meet her medical needs;

(4) Respondent failed to perform periodic review of patient K.J.'s pain and treatment status;

(5) Respondent failed to adjust Patient K.J.'s medications and/or make a referral to a pain management specialist in light of the concern over her "overuse of pain medications"; and

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(6) Respondent failed to adequately work up and manage patient K.J.'s severe hypertension.

Patient R.G.

(e) Paragraphs 10(t) through 10(aa), above, are incorporated by reference and realleged as if fully set forth herein.

(f) Respondent committed repeated negligent acts in his care and treatment of patient R.G., which included, but was not limited to, the following:

(1) Respondent failed to properly document a satisfactory history and physical examination including, failing to clearly document a recognized medical indication for the use of controlled substances in treating patient R.G.'s chronic pain;

(2) Respondent failed to properly document a treatment plan including, failing to develop and record a treatment plan for the use of controlled substances in treating patient R.G.'s chronic pain;

(3) Respondent failed to perform periodic review of patient R.G.'s pain and treatment status.

Patient E.H.

(g) Paragraphs 10(bb) through 10(ii), above, are incorporated by reference and realleged as if fully set forth herein.

(h) Respondent committed repeated negligent acts in his care and treatment of patient E.H., which included, but was not limited to, the following:

(1) Respondent failed to properly document a satisfactory history and physical examination including, failing to clearly document a recognized medical indication for the use of controlled substances in treating patient E.H.'s chronic pain;

(2) Respondent failed to properly document a treatment plan including, failing to develop and record a treatment plan for the use of controlled substances in treating patient E.H.'s chronic pain; and

(3) Respondent failed to perform periodic review of patient E.H.'s pain and treatment status.

Patient C.T.

(i) Paragraphs 10(jj) through 10(ss), above, are incorporated by reference and realleged as if fully set forth herein.

(j) Respondent committed repeated negligent acts in his care and treatment of patient C.T., which included, but was not limited to, the following:

(1) Respondent failed to properly document a satisfactory history and physical examination including, failing to clearly document a recognized medical indication for the use of controlled substances in treating patient C.T.'s chronic pain;

(2) Respondent failed to properly document a treatment plan including, failing to develop and record a treatment plan for the use of controlled substances in treating patient C.T.'s chronic pain;

(3) Respondent failed to perform periodic review of patient C.T.'s pain and treatment status;

(4) Respondent failed to make a referral to a pain management specialist; and

(5) Respondent failed to adequately monitor patient C.T.'s diabetes mellitus.

THIRD CAUSE FOR DISCIPLINE

(Prescribing Without an Appropriate Prior Examination)

12. Respondent has further subjected his Physician's and Surgeon's Certificate No. G23945 to disciplinary action under sections 2227 and 2234, as defined in sections 2242 and 4022, of the Code, in that respondent prescribed, dispensed, or furnished dangerous drugs to patients J.R., K.J., R.G., E.H. and C.T. without an appropriate prior examination and a medical indication, as more particularly alleged hereinafter:

13. Paragraphs 10 and 11, above, are hereby incorporated by reference and realleged as if fully set forth herein.

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FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

14. Respondent has further subjected his Physician's and Surgeon's Certificate No. G23945 to disciplinary action under sections 2227 and 2234, as defined in section 2266, of the Code, in that respondent failed to maintain adequate and accurate records in connection with his care and treatment of patients J.R., K.J., R.G., E.H. and C.T., as more particularly alleged hereinafter:

15. Paragraphs 10 and 11, above, are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

16. Respondent has further subjected his Physician's and Surgeon's Certificate No. G23945 to disciplinary action under sections 2227 and 2234 of the Code, in that respondent has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged hereinafter:

17. Paragraphs 10, 11, 12, 13, 14 and 15, above, are hereby incorporated by reference and realleged as if fully set forth herein.

DISCIPLINARY CONSIDERATIONS

18. To determine the degree of discipline, if any, to be imposed on respondent, Complainant alleges that on or about May 30, 2000, in a prior disciplinary action entitled "In the Matter of the Accusation Against Robert John Santella, M.D.," Case No. 10-1996-61463, the Medical Board of California (Board) issued a decision revoking respondent's Physician's and Surgeon's Certificate No. G23945, staying that revocation, and placing respondent on probation for four (4) years on various terms and conditions. The Board imposed discipline on respondent in this matter based on findings that respondent admitted he failed to maintain adequate records as alleged in paragraph eight (8) of the Accusation. That decision is now final and is incorporated by reference as if fully set forth herein.

19. To determine the degree of discipline, if any, to be imposed on respondent, Complainant alleges that on or about December 10, 1983, in a prior disciplinary action entitled "In the Matter of the Accusation Against Robert Santella, M.D.," Case No. 07-1981-702851, the Board of Medical Quality Assurance of California (Board) issued a decision revoking respondent's Physician's and Surgeon's Certificate No. G23945, staying that revocation, and placing respondent on probation for five (5) years on various terms and conditions. The Board imposed discipline on respondent in this matter based on findings that respondent committed acts of gross negligence and/or incompetence. That decision is now final and is incorporated by reference as if fully set forth herein.

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 No. G23945, issued to respondent Robert John Santella, M.D.;

2. Revoking, suspending or denying approval of respondent Robert John Santella, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering respondent Robert John Santella, M.D., to pay the Medical Board of California the costs of probation monitoring, if placed on probation; and

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

DATED: May 20, 2016

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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