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

In the Matter of the Second Amended Accusation Against:	)	
Robert John Santella, M.D.	)	**Case No. 800-2014-002884**
Physician's and Surgeon's Certificate No. G23945	)	
Respondent	)	

DECISION

The attached Stipulated Surrender of License and Order 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 31, 2017.

IT IS SO ORDERED August 22, 2017.

MEDICAL BOARD OF CALIFORNIA

By: _____
Kimberly Kirchmeyer
Executive Director

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Second Amended Accusation Against: **ROBERT JOHN SANTELLA, M.D.** **4531 College Avenue** **San Diego, California 92115** **Physician's and Surgeon's Certificate No. G23945,** Respondent.	Case No. 800-2014-002884 OAH No. 2016-090554 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, and by Joseph F. McKenna III, Deputy Attorney General.

2. Robert John Santella, M.D., (Respondent) is represented in this proceeding by attorney Robert W. Frank, Esq., whose address is 1010 Second Avenue, Suite 2500, San Diego, California, 92101-4959.

3. On or about January 11, 1973, the Board issued Physician's and Surgeon's Certificate No. G23945 to Respondent. The Physician's and Surgeon's Certificate No. G23945 was in full force and effect at all times relevant to the charges brought in Second Amended Accusation No. 800-2014-002884 and will expire on December 31, 2017, unless renewed.

JURISDICTION

4. On May 20, 2016, Accusation No. 800-2014-002884 was filed against Respondent before the Board. A true and correct copy of Accusation No. 800-2014-002884 and all other statutorily required documents were properly served on Respondent on May 20, 2016. Respondent timely filed his Notice of Defense contesting the Accusation.

5. On March 10, 2017, First Amended Accusation No. 800-2014-002884 was filed against Respondent before the Board. A true and correct copy of First Amended Accusation No. 800-2014-002884 and all other statutorily required documents were properly served on Respondent on March 10, 2017.

6. On July 17, 2017, Second Amended Accusation No. 800-2014-002884 was filed against Respondent before the Board, and is currently pending against Respondent. A true and correct copy of Second Amended Accusation No. 800-2014-002884 and all other statutorily required documents were properly served on Respondent on July 17, 2017. A true and correct copy of Second Amended Accusation No. 800-2014-002884 is attached hereto as Exhibit A and hereby incorporated by reference as if fully set forth herein.

ADVISEMENT AND WAIVERS

7. Respondent has carefully read, fully discussed with his counsel, and fully understands the charges and allegations in Second Amended Accusation No. 800-2014-002884. Respondent also has carefully read, fully discussed with his counsel, and fully understands the effects of this Stipulated Surrender of License and Order.

8. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in Second Amended Accusation No. 800-2014-002884; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance

of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

9. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

10. Respondent admits the truth of each and every charge and allegation in Second Amended Accusation No. 800-2014-002884, agrees that cause exists for discipline and hereby surrenders his Physician's and Surgeon's Certificate No. G23945 for the Board's formal acceptance.

11. Respondent understands that by signing this stipulation he enables the Executive Director of the Board to issue an Order, on behalf of the Board, accepting the surrender of his Physician's and Surgeon's Certificate G23945 without further notice to, or opportunity to be heard by, Respondent.

CONTINGENCY

12. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board "shall delegate to its executive director the authority to adopt a . . . stipulation for surrender of a license."

13. This Stipulated Surrender of License and Order shall be subject to approval of the Executive Director on behalf of the Medical Board. The parties agree that this Stipulated Surrender of License and Order shall be submitted to the Executive Director for her consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

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14. The parties agree that this Stipulated Surrender of License and Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Surrender of License and Order, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Executive Director on behalf of the Board does not, in her discretion, approve and adopt this Stipulated Surrender of License and Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Surrender of License and Order be rejected for any reason by the Executive Director on behalf of the Board, Respondent will assert no claim that the Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Surrender of License and Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

15. This Stipulated Surrender of License and Order is intended by the parties herein to be an integrated writing representing the complete, final, and exclusive embodiment of the agreements of the parties in the above-entitled matter.

16. The parties agree that copies of this Stipulated Surrender of License and Order, including signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

17. In consideration of the foregoing admissions and stipulations, the parties agree the Executive Director of the Board may, without further notice to or opportunity to be heard by Respondent, issue and enter the following Order on behalf of the Board:

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ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G23945, issued to Respondent Robert John Santella, M.D., is surrendered and accepted by the Medical Board of California.

1. The effective date of this Decision and Order shall be December 31, 2017.

2. The surrender of Respondent's Physician's and Surgeon's Certificate No. G23945 and the acceptance of the surrendered license by the Medical Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Medical Board of California.

3. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Medical Board's Decision and Order.

4. Respondent shall cause to be delivered to the Medical Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Medical Board's Decision and Order.

5. If Respondent ever files an application for licensure or a petition for reinstatement of Physician's and Surgeon's Certificate No. G23945 in the State of California, the Medical Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations, and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all of the charges and allegations contained in Second Amended Accusation No. 800-2014-002884 shall be deemed to be true, correct, and admitted by Respondent when the Medical Board determines whether to grant or deny the petition.

6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Second Amended Accusation No. 800-2014-002884 shall be deemed to be true, correct, and fully admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney, Robert W. Frank, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. G23945. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 8-11-17

ROBERT JOHN SANTELLA, M.D.
Respondent

I have read and fully discussed with Respondent Robert John Santella, M.D., the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 8-14-17

ROBERT W. FRANK, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

Dated: August 15, 2017

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

JOSEPH F. MCKENNA III
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Second Amended Accusation No. 800-2014-002884

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Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO July 17 2017
BY Sara Pacion ANALYST

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

In the Matter of the Second Amended Accusation Against: **ROBERT JOHN SANTELLA, M.D.** **4531 College Avenue** **San Diego, California 92115** **Physician's and Surgeon's Certificate No. G23945,** Respondent.	Case No. 800-2014-002884 OAH No. 2016-090554 **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Second Amended 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 Second Amended 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, in pertinent part:

"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.

" ... "

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.).

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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."

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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."

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., C.T., V.A., and T.D., 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]

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

(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 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

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[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.

[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.

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.

(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

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

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.

(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

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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.

any reasons and/or treatment plan for administering these injections of controlled substances to her.

(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.

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 Second Amended 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 Second Amended 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

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

or reasons for increasing the dosage.

(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.

Patient V.A.

(tt) On or about December 6, 2012, Respondent performed surgery on patient V.A. to remove a ruptured ovarian cyst.

(uu) On or about December 11, 2012, Respondent saw patient V.A. for a post-operative office visit. Patient V.A. complained of pain and Respondent prescribed her Demerol, a controlled pain medication. Respondent failed to perform an adequate medical history and physical examination, as well as document informed consent prior to issuing a controlled prescription for opioids. Three (3) days later, Respondent prescribed the patient a second controlled pain medication, Roxicodone,[15] due to her complaints of persistent pain. Again, Respondent failed to obtain a history, perform a physical exam, and document informed consent before issuing this controlled prescription for opioids.

[15] Roxicodone 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.

(vv) On or about January 12, 2014, Respondent charted a follow-up visit with patient V.A. and documented that her pain medication, Demerol, was not working. Respondent refilled the patient's Roxicodone prescription and added naproxen and MS Contin.[16] Again, Respondent failed to obtain a history, perform a physical exam, and document informed consent before issuing this controlled prescription for opioids.

(ww) In or around January 2013, patient V.A., who was admitted into a hospital for unspecified care, provided a polysubstance abuse history to the medical provider which had included, opioids, methamphetamine, and marijuana.

(xx) In or around February 2013, Respondent, with full knowledge of patient V.A.'s polysubstance abuse history, refilled her prescription for Roxicodone and also started her on Butrans, an opioid delivered via transdermal patch. Again, Respondent failed to obtain a history, perform a physical exam, and document informed consent before issuing this controlled prescription for opioids.

(yy) Respondent maintained patient V.A. on controlled pain medications for over the next two (2) years, up to in or around April 2015. During this period of time, Respondent never obtained a history, performed a physical exam, and/or documented informed consent before issuing these controlled prescriptions for opioids. During this same period of time, Respondent, despite the lack of improvement in this patient's pain, never documented a review of the course of pain treatment and/or considered changes in therapy other than to increase the quantity of pain medications already prescribed to the patient. Lastly, during this same period of time, Respondent never referred patient V.A. to a pain management specialist, ordered a drug screen, and/or ran a Controlled Substance Utilization

[16] MS Contin a brand name for morphine, 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. Respondent, in a narrative drafted on or about January 12, 2014, documented that he had prescribed morphine to patient V.A.

Review and Evaluation System (CURES)[17] report to determine if she was using or abusing her controlled prescriptions.

(zz) On or about April 20, 2017, Respondent was interviewed at the California Medical Board's San Diego District Office, with his attorney present, regarding the care and treatment he had provided to patient V.A. During the subject interview, Respondent was asked about the patient's persistent pain and why he had continued to prescribe her opioids, to which he replied "[I]n desperation I would refill her medications somehow just to get rid of her."

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

(1) Respondent failed to perform periodic review of patient V.A.'s pain and treatment status; and

(2) Respondent, with full knowledge of patient V.A.'s polysubstance abuse history, increased the prescription quantity and number of different controlled prescriptions issued to her.

Patient T.D.

(bbb) On or about September 14, 2015, Respondent performed a second trimester abortion on patient T.D. The procedure was performed at an abortion clinic, Family Planning Associates (FPA), where Respondent had worked performing abortions. Regarding the procedure, FPA's post-operative note indicated that all "products of conception" had been observed and accounted for, and that the patient had tolerated the procedure well. However, during the

[17] The Controlled Substance Utilization Review and Evaluation System (CURES) is a program operated by the California Department of Justice (DOJ) to assist health care practitioners in their efforts to ensure appropriate prescribing of controlled substances, and law enforcement and regulatory agencies in their efforts to control diversion and abuse of controlled substances. (Health & Saf. Code, § 11165.) California law requires dispensing pharmacies to report to the DOJ the dispensing of Schedule II, III, and IV controlled substances as soon as reasonably possible after the prescriptions are filled. (Health & Saf. Code, § 11165, subd. (d).) It is important to note that the history of controlled substances dispensed to a specific patient based on the data contained in CURES is available to a health care practitioner who is treating that patient. (Health & Saf. Code, § 11165.1, subd. (a).)

procedure itself, the patient had suffered significant blood loss of approximately 2000 ml and had to be treated with a medication combination of tocolytics to stop the hemorrhaging. In fact, Respondent documented that the patient had suffered significant hemorrhaging during the procedure. However, despite a loss of approximately 2000 ml of blood during the surgical abortion, Respondent believed patient T.D. was stable enough to be moved into a recovery room at FPA. Initially, the patient's condition was documented as stable. However, Respondent was soon notified that excessive bleeding had begun and the patient was then returned to an operating room at FPA and a Foley catheter balloon was used to tamponade the uterine cavity.

(ccc) Patient T.D.'s family called 911 and an ambulance arrived to transfer her from FPA to Scripps La Jolla Hospital (Scripps) emergency room. Patient T.D. arrived at Scripps in hemorrhagic shock. She was later stabilized and then taken to an operating room where she underwent a supercervical hysterectomy and left salpingo-oopherectomy for uterine perforation, and injury to the left uterine vessels and the left adnexal vessels in the retroperitoneal space. Significantly, a pathology report later documented that "products of conception" were still in patient T.D.'s uterus.

(ddd) Dr. A.S. was the physician who had handled patient T.D.'s case when she first arrived to the Emergency Room at Scripps. Dr. A.S. later informed Medical Board investigators that Respondent had never contacted him to provide any information about patient T.D.'s abortion procedure and/or the complications she had experienced during and after the procedure at FPA.[18] In fact, Respondent failed to document that he had ever contacted Dr. A.S. to follow up on his patient's condition following her transfer in an ambulance under emergent conditions.

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[18] Dr. A.S. indicated that the only information that he received about the procedure came from the patient's family, and not Respondent and/or FPA.

(eee) On or about January 21, 2016, Respondent saw patient T.D. at his office. She was complaining of "pain" and "hot flashes." Respondent, without performing a medical examination and/or obtaining and documenting informed consent, prescribed patient T.D. one hundred forty (140) tablets of narcotics and ninety (90) tablets of Lexapro. On or about the following day, Respondent mailed a letter to patient T.D. indicating that he was refusing to care for her in the future, and that she needed to see the surgeon who did her hysterectomy for ongoing care.

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

(1) Respondent failed to recognize and react to the severity of patient T.D.'s emergent condition;

(2) Respondent failed to seek tertiary care for patient T.D. in a timely manner given her emergent condition;

(3) Respondent failed to adequately and correctly document the procedure and related events that transpired on or about September 14, 2015; and

(4) Respondent failed to communicate with patient T.D. the details of her procedure and the serious complications that occurred afterwards; rather, he just prescribed her controlled pain medications, without performing a medical examination and/or obtaining informed consent, and simply discharged her from his practice.

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., C.T., V.A., and T.D., as more particularly alleged hereinafter:

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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;

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(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

(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.

Patient V.A.

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

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

(1) Respondent failed to perform periodic review of patient V.A.'s pain and treatment status;

(2) Respondent, with full knowledge of patient V.A.'s polysubstance abuse history, increased the prescription quantity and number of different controlled prescriptions issued to her;

(3) Respondent failed to obtain a substance abuse history before prescribing controlled medications to patient V.A.;

(4) Respondent failed to obtain and document informed consent; and

(5) Respondent failed to refer patient V.A., with her complex pain issues outside of Respondent's scope of practice, to a pain management specialist.

Patient T.D.

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

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

(1) Respondent failed to recognize and react to the severity of patient T.D.'s emergent condition;

(2) Respondent failed to seek tertiary care for patient T.D. in a timely manner given her emergent condition;

(3) Respondent failed to adequately and correctly document the procedure and related events that transpired on or about September 14, 2015; and

(4) Respondent failed to communicate with patient T.D. the details of her procedure and the serious complications that occurred afterwards; rather, he just prescribed her controlled pain medications, without performing a medical examination and/or obtaining informed consent, and simply discharged her from his practice.

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., C.T., V.A., and T.D., 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.

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., C.T., V.A., and T.D., 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.

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18. On or about June 11, 2016, an incident was captured on video[19] involving Respondent and another individual (M.Z.) in front of a clinic, wherein Respondent engaged in outrageous conduct and made physically threatening gestures towards M.Z. The clinic, Family Planning Associates, is an abortion clinic located in San Diego where Respondent was working on that date.[20] M.Z. was present outside of the clinic that day to read from the Bible and essentially protest abortion. The video showed Respondent exiting the clinic's front entrance with a large pair of scissors in his hand and walking directly over to M.Z., who was standing approximately ten to twelve (10 to 12) feet away from the clinic's front entrance with his back towards the second floor railing. Respondent quickly approached M.Z. after M.Z. had stated that he needed to repent for "murdering babies." Respondent aggressively pressed his face to within inches of M.Z.'s face and angrily replied "Why?" During the exchange, Respondent obnoxiously exhaled several times directly into M.Z.'s face while speaking in a guttural tone of voice. When asked if he did that to babies, Respondent replied in a guttural tone "Yeah, I love it!" At one point, Respondent raised the large pair of scissors still in his hands to chest level and aggressively leaned his body forward causing physical contact with M.Z., who then turned away and took a step back towards the railing to avoid Respondent. Respondent, still holding the scissors only inches away from M.Z., continued making guttural sounds and aggressively exhaling right into M.Z.'s face. When told about all of the babies that he had "killed" Respondent continued to repeat "I love it, I love it!" in a guttural tone of voice; remarkably, he said this and still continued his outrageous conduct even as patients, including a young child, are seen entering the clinic's front entrance.

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[19] The video clip is approximately one (1) minute in duration.

[20] Although the exact time of day when the incident occurred is uncertain, it appeared to have occurred during the clinic's regular business hours because the video footage showed patients entering the clinic in broad daylight.

DISCIPLINARY CONSIDERATIONS

19. 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.

20. 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 had committed acts of gross negligence and/or incompetence. 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 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 and/or advanced practice nurses;

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: July 17, 2017

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

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