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

In the Matter of the Accusation Against: John Gilbert McNutt, M.D. Physician's and Surgeon's Certificate No. A 61636 Respondent.	Case No.: 800-2020-069903

DECISION

The attached Proposed Decision 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 September 25, 2023.

IT IS SO ORDERED: August 25, 2023.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D. , Chair
Panel B

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

In the Matter of the Accusation Against:

JOHN GILBERT McNUTT, M.D., Respondent

Agency Case No. 800-2020-069903

OAH No. 2022110148

PROPOSED DECISION

Debra D. Nye-Perkins, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference and telephone on June 20 through 23, 2023.

Christine A. Rhee, Deputy Attorney General, represented complainant, Reji Varghese,[1] Executive Director of the Medical Board of California (board), Department of Consumer Affairs, State of California.

Kathleen Brahn, Attorney at Law, Brahn Law Corporation, represented respondent, John Gilbert McNutt, M.D., who was present throughout the hearing.

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[1] Mr. Varghese was appointed Executive Director on June 23, 2023. When the accusation was filed, the Executive Director was William Prasifka.

Oral and documentary evidence was received. The record was closed, and the matter was submitted for decision on June 23, 2023.

PROTECTIVE SEALING ORDER

To protect privacy and confidential personal and medical information from inappropriate disclosure, a written Protective Order Sealing Confidential Records was issued. The order lists the exhibits ordered sealed and governs the release of documents to the public. A reviewing court, parties to this matter, their attorneys, and a government agency decision maker or designee under Government Code section 11517 may review the documents subject to the order, provided that such documents are protected from release to the public.

FACTUAL FINDINGS

Jurisdictional Matters

1. On February 14, 1997, the board issued Physician's and Surgeon's Certificate Number A 61636 to respondent. The Certificate is set to expire on October 31, 2024, unless renewed.

2. On May 13, 2022, pursuant to a stipulation of the parties, the board issued an interim order imposing license restrictions on respondent's Certificate. The basis for the interim order imposing license restrictions is that respondent is presently unable to practice medicine safely without restrictions due to a mental or physical condition. In the stipulation, respondent did not contest that, at an administrative

proceeding, complainant could establish a prima facie case with respect to the basis for the interim order imposing license restrictions.

3. On May 13, 2022, complainant filed accusation number 800-2020-069903 seeking revocation or suspension of respondent's Certificate pursuant to Business and Professions Code section 822 on the alleged basis that respondent's ability to practice medicine safely is impaired due to a mental or physical illness, specifically the results of a mental examination of respondent conducted by the board showed that respondent was diagnosed with alcohol use disorder, depressive disorder with anxiety, and post-traumatic stress disorder (PTSD) to the extent that respondent cannot practice medicine safely without certain restrictions being put in place.

The accusation specifically alleged that, on August 11, 2020, the board received notification pursuant to Business and Professions Code section 805 that respondent's privileges at Newport Beach Surgery Center (NBSC) were suspended on July 13, 2020. During an investigation by board investigators, management and co-workers of respondent at NBSC reported that respondent, an anesthesiologist, had been missing or unavailable when he was scheduled to work and was observed with slurred speech. The investigator obtained medical records showing that respondent went to the emergency department of a hospital on November 16, 2020, for treatment of alcohol use disorder and informed the hospital that he had been consuming approximately a pint of hard liquor per day for the past 18 months. During the board's mental health examination of respondent, the board learned that respondent underwent a substance abuse treatment program for alcohol use disorder in 2012, and he did not consume alcohol from 2012 to 2018. Respondent again attended another residential treatment program for alcohol use disorder from November 2020 to March 2021.

4. Respondent timely filed a notice of defense, and this hearing followed.

Interim Order Imposing License Restrictions

5. In OAH No. 2022050449, respondent and complainant entered into a stipulation whereby the board issued an Interim Order Imposing License Restrictions on respondent's license in lieu of the board filing a petition for interim suspension order. The board's interim order provides that respondent shall comply with the following license restrictions until issuance of a final decision by the board in this matter: abstain from use of alcohol and controlled substances; submit to biological fluid testing; undergo psychotherapy treatment; provide consent to respondent's employers, supervisors, and worksite monitor to communicate with the board regarding respondent's work status, performance, and monitoring; attend substance abuse support group meetings; and submit to a worksite monitor for substance abusing licensee.

Complainant's Evidence

TESTIMONY OF MOHAN NAIR, M.D.

6. Dr. Mohan Nair is a psychiatrist and pain injury medicine physician. He has been licensed to practice medicine in California since 1978 and has no disciplinary history on his license. Dr. Nair is also currently licensed to practice medicine in Hawaii, and he has previously been licensed to practice medicine in Pennsylvania, Massachusetts, and Florida. Dr. Nair has never incurred any discipline to his licenses in those other states.

Dr. Nair received his medical degree from the University of Bombay in India in 1975. He thereafter completed an internship and residency in surgery until 1977 when he moved to the United States. From 1977 to 1978, Dr. Nair attended a residency program in surgery at Lehigh Valley Medical Center in Pennsylvania. Thereafter, Dr.

Nair completed a residency in psychiatry at the University of California, Irvine, from 1978 to 1981. From 1981 to 1983, Dr. Nair completed a clinical fellowship in child psychiatry at Harvard University.

After completing his fellowship at Harvard in 1983, Dr. Nair worked for nine months as an attending psychiatrist at the outpatient psychiatry department of Martin Luther King Hospital in Orange County. Thereafter, Dr. Nair opened his own private practice in psychiatry and has worked in that capacity ever since, except for a brief nine month period in 1995 when he worked as a child psychiatrist for the County of Kauai in Hawaii. Additionally, since 1996, Dr. Nair has worked as an Assistant Clinical Professor of Psychiatry at the University of California, Los Angeles (UCLA), School of Medicine. From 1996 to 2016, he taught the child psychiatry fellowship program at UCLA. From 2000 to 2009 he taught forensic psychiatry for the forensic psychiatry fellowship program at UCLA. From 2016 to the present, he has again taught forensic psychiatry for the forensic psychiatry fellowship program at UCLA. In addition to his academic work at UCLA, Dr. Nair also was on faculty at Western University School of Health Sciences in Pomona, California, from 1986 to 2012, where he first worked as an assistant professor and later as a professor of family medicine and psychiatry. During his time at Western University School of Health Sciences, he taught medical students.

Dr. Nair is currently board certified in multiple areas of medicine. Specifically, since 1998 he has been board certified in forensic psychiatry from the American Board of Psychiatry and Neurology. He is also board certified in the three different specialties of psychiatry, child psychiatry (since 1995), and brain injury medicine, all from the American Board of Psychiatry and Neurology. Since 2000 he has been board certified in addiction medicine from the American Board of Preventative Medicine. He is also certified by the American Board of Pain Medicine (since 2013), American Society of

Clinical Psychopharmacology, and the United Council of Neurological Subspecialties in neuropsychiatric and behavioral neurology.

Dr. Nair has been involved in the medical/legal industry in the field of forensic psychiatry since the beginning of his career, but he did more work in that area after he obtained his board certification in forensic psychiatry in 1998. He explained that forensic psychiatry is the practice of looking at psychiatric and psychological information, including collateral and opposing data, for the purpose of providing opinions to triers of fact. He stated that forensic psychiatry is different from clinical psychiatry because in forensic psychiatry you have a duty to look at collateral and opposing data, and your client is not the person being examined. Since 1998, Dr. Nair has worked for the California Superior Courts in Los Angeles, Riverside, and Orange Counties in courts focusing on family, dependency, civil, and criminal matters. Dr. Nair conducts evaluations of adults and children involving issues of abuse, personal injury, and other matters. Additionally, Dr. Nair has worked for the board as an expert reviewer in the field of psychiatry for the last 10 years. He has testified in court over 50 times as an expert. He has previously testified as an expert in psychiatry on behalf of complainant approximately six or seven times. Dr. Nair characterized his private practice of psychiatry to be approximately 50 percent clinical psychiatry and 50 percent forensic psychiatry.

During his career, Dr. Nair has treated thousands of patients in clinical psychiatry for substance use disorder or alcohol use disorder. Additionally, from 1986 to 1992, he created a program for treating individuals with a history of trauma and a history of drug and alcohol problems. That program was called Adult Survivors of Child Abuse located in Bellflower, California, and Dr. Nair was its medical director. The program provided inpatient and outpatient treatment for juveniles and adults.

7. Dr. Nair's work for complainant over the past 10 years consists of the psychiatric evaluation of physicians for a determination of whether that physician is safe to practice medicine or if he or she has a mental disorder that affects his or her ability to practice medicine. Dr. Nair has conducted approximately 30 to 40 such evaluations for complainant, and the majority of those evaluations were related to substance abuse issues. Dr. Nair was asked by complainant to provide a psychiatric evaluation of respondent in this matter, which he completed and wrote a report dated October 8, 2021, a supplemental report dated March 8, 2023, and an addendum to the supplemental report dated March 14, 2023, summarizing his findings, all three of which were received in evidence. His report and supplemental report both provided answers to specific questions posed by complainant regarding his evaluation. The following factual findings are based on Dr. Nair's testimony and supporting documents received in evidence.

8. Regarding his first report dated October 8, 2021, Dr. Nair referenced an in-person examination of respondent on September 8, 2021, as well his review of multiple documents. Those documents included: certified medical records from Forrest General Hospital also known as Pine Grove Treatment Center (hereinafter "Pine Grove") and from Hoag Hospital (hereinafter "Hoag"), the report from NBSC pursuant to Business and Professions Code section 805 (hereinafter "the 805 report") advising the board of respondent's suspension from practice, and certified Medical Executive Committee (MEC) notes from NBSC. Dr. Nair also conducted various psychological testing of respondent, including the Minnesota Multiphasic Personality Inventory, second edition (MMPI-2), the Millon Clinical Multiaxial Inventory (MCMI), and the Structured Inventory of Malingered Symptomatology (SIMS). Dr. Nair noted the 805 report stated that, on several different occasions while working at NBSC, respondent was observed having slurred speech, and was unpredictably absent from the building

for extended periods of time. On June 23, 2020, respondent voluntarily submitted to a drug screening test for the MEC of NBSC and the results showed a positive test for propofol, which is a controlled substance. Additionally, the MEC received a call from respondent's wife, who was concerned that respondent was having substance abuse issues. On July 13, 2020, the MEC issued a summary suspension of respondent from NBSC based on the drug screen results.

Dr. Nair summarized respondent's history of use of alcohol and medical history in his first report and testimony. Respondent began drinking alcohol at age 12. At the age of 13 respondent was in a bicycle accident where he lost consciousness and was confused for several days due to a brain injury. When respondent was age 31, he again had another brain injury when he lost consciousness. In 2012 when he was working as an anesthesiologist at NBSC, he had his first seizure, and his co-workers were concerned about alcohol use disorder. As a result, in 2012 respondent went to a substance abuse treatment program for three months at a facility called Hazleton in Springbrook, Oregon. Thereafter, respondent attended Alcoholics Anonymous (AA) and had a sponsor in AA until 2017 when he stopped attending AA meetings. Respondent told Dr. Nair that he stopped attending AA meetings because he "had this thing beat." In 2018 respondent began drinking alcohol again and continued to do so until November 2020 when he went to the emergency room of Hoag for detox for alcohol abuse. In 2019 respondent had another seizure at a grocery store resulting in a subdural hematoma. Between 2012 and 2018, respondent did not consume alcohol at all. Respondent was a poor historian of the amount of alcohol he would consume after 2018 "because he did not keep track." During his interview with Dr Nair respondent claimed that after 2018 he only drank alcohol at home and never at bars, and he would drink beer and hard liquor and "was not picky about the type of alcohol," and he primarily only drank on the weekends and holidays and would go weeks and

months without consuming alcohol. Respondent "denied ever having any blackouts" from drinking alcohol to Dr. Nair during his in-person evaluation.

Dr. Nair noted that in the certified medical records from Pine Grove, a substance abuse treatment facility in Mississippi where respondent was treated for about two months beginning on November 30, 2020, respondent reported different information regarding his alcohol use history. Specifically, he reported to Pine Grove that he began drinking at age 12 "because his father was a heavy drinker," and started drinking on a regular basis at age 18. After completing his anesthesiology residency his drinking escalated. His drink of choice was vodka, and he was drinking five or more drinks on almost a daily basis. He also reported that in 2012 he had his first seizure at work in the morning before cases and his partners as NBSC, with the assistance of Dr. Marsha Vanover, referred him to Hazleton facility where he stayed for 90 days. Respondent informed Pine Grove that he relapsed in 2017 and started drinking alcohol again. His drinking worsened and he would start drinking at around 3:00 p.m. and would drink about a fifth of liquor every day until his mother did an intervention and he went to Hoag.

Dr. Nair's reviewed the certified medical records from Hoag from respondent's November 15, 2020, admission. He noted that respondent again provided a different version of his alcohol use history to Hoag than he did to Dr. Nair during their in-person evaluation. Specifically, the Hoag medical records show that respondent reported upon admission to the hospital that he "has been drinking approximately a pint of hard liquor per day for the past 18 months," and respondent weighed only 121 pounds at the time of his hospital admission (respondent testified at hearing that he is five feet nine inches tall). Other notes within the Hoag records show that respondent reported consuming one liter of vodka every four days, and that respondent reported

"drinking about a pint of hard liquor daily for 'several years'." Additionally, the Hoag records show that respondent reported the following regarding his history of blackouts from alcohol use: "[p]atient admits to history of blackouts. Pt. states last known blackout was 11/14. Pt. states he blacks out once a week."

Dr. Nair testified that he was concerned by the markedly different representation of respondent's pattern and volume of drinking alcohol to Dr. Nair during his evaluation than what respondent reported to both Hoag and Pine Grove. Dr. Nair explained that alcohol abuse behavior typically involves a lot of denial, which can be unconscious denial or conscious misrepresentation and it is not always possible to know which. Furthermore, respondent provided inconsistent representations with regard to his history of blackouts to Hoag versus to Dr. Nair. Another inconsistency of respondent's reporting was an incident of sexual abuse as a child reported to Hoag but not to Dr. Nair. Dr. Nair testified that respondent was not a reliable narrator of his history during Dr. Nair's evaluation of him on September 8, 2021.

9. Dr. Nair noted during his in-person evaluation of respondent that respondent had been depressed in 2006 and was taking Zoloft, but it gave him tremors and he only took the drug for a few weeks. In August 2018 respondent had increasing depression following his father's diagnosis of colon cancer and eventual death and began to see a psychiatrist, Dr. Monisha Vasa, who prescribed Zoloft to respondent. Since his treatment at Pine Grove in late 2020-early 2021, respondent has been taking another drug to increase his appetite. Prior to going to Pine Grove, respondent saw Dr. Vasa once every three months, but after his treatment at Pine Grove, he saw her once every three weeks. Dr. Vasa suggested that respondent take Naltrexone to reduce his cravings for alcohol, but respondent refused to take it. Since

his treatment at Pine Grove, respondent also attends a recovering physician's meeting twice a week with Dr. Vanover.

10. Dr. Nair testified that he used the *Diagnostic and Statistical Manual, Fifth Edition* (DSM-5) criteria to diagnose respondent with alcohol use disorder, depressive disorder not otherwise specified with anxiety, and PTSD. Dr. Nair explained that he typically relies on the DSM-5 as a reference guide, but not as much in forensic psychiatry cases because the DSM-5 is made for clinicians relying on information provided by the individual being evaluated. However, in forensic psychiatry cases you cannot necessarily rely on the information given to you by the individual being evaluated. Specifically, in this case Dr. Nair is privy to the information from the medical records from Hoag and Pine Grove regarding respondent's history, frequency and intensity of alcohol consumption, whereas clinicians are not often privy to such collateral information. Forensic psychiatry differs from clinical psychiatry because forensic psychiatry considers collateral data not available to a clinical psychiatrist. Dr. Nair noted that the DSM-5 warns that the clinical diagnoses should not be used for legal purposes.

Dr. Nair testified that in diagnosing respondent's PTSD, he relied on respondent's representations that he was disturbed by his earlier sexual abuse as a child and did not want to talk about it, and the fact that there were medical records indicating that respondent had been treated for PTSD. Dr. Nair also explained that having a diagnosis of PTSD can increase the likelihood of relapse for an individual with alcohol use disorder. He stated that PTSD can "wax and wane" throughout life, but triggers can cause symptoms to resurface and cause relapse. Dr. Nair noted that in one part of his first report he listed PTSD as a diagnosis for respondent, and in another portion of his report he listed it only as a concern.

Dr. Nair also testified and noted in his first report that he lists other concerns he has for respondent based on his evaluation, but those concerns did not reach the level of a formal diagnosis. Specifically, Dr. Nair noted in his first report that he was concerned about persistent post concussive disorder or traumatic brain injury, PTSD, sedative hypnotic or anxiolytic (drugs that reduce anxiety) use disorder, and opioid use disorder. He stated that with regard to the opioid use disorder, the basis for this concern was exclusively respondent's single positive test for propofol in 2020. Dr. Nair testified that he later learned that the positive propofol test result was unreliable and could have been the result of environmental contamination instead of ingestion of propofol. As a result of this additional information obtained after Dr. Nair wrote his first report, Dr. Nair wrote his second report, which will be addressed below.

Regarding persistent post concussive disorder or traumatic brain injury, Dr. Nair opined that because respondent had significant brain trauma at age 13 and again at age 31, he was pre-disposed to seizure disorders. Also, the use of alcohol or sedatives also increases the risk of seizures in these patients. Dr. Nair explained that at the time he wrote his first report, he had no medical records regarding respondent's treatment for seizures but was aware that respondent was receiving treatment for seizures. Dr. Nair testified and wrote in his first report that part of his recommendation to the board was that respondent should be required to have a neurological examination to assess his seizure disorders in order to practice safely. However, at hearing, Dr. Nair admitted that he has since reviewed a report from a neurologist who examined respondent and that report alleviated his concerns about respondent's neurological state. However, he also noted that he recommends a further neurological and medical evaluation of respondent in order to know his current status to be safe to practice.

Dr. Nair was also concerned about sedative hypnotic or anxiolytic use disorder because, based on his review of medical records, respondent reported that he would obtain Xanax and sleeping pills from his wife, and on one occasion his wife reported that respondent brought Ketamine home from work.

In his first report, Dr. Nair answered six specific questions asked by the board regarding respondent's ability to practice medicine safely. Dr. Nair opined that respondent does have a mental illness or condition that impacts his ability to safely engage in the practice of medicine based on his diagnoses listed above. He further opined that respondent needed a neurological examination to assess his issues related to seizure disorder, but testified at hearing that since this first report was completed, Dr. Nair has reviewed a report from a neurologist who examined respondent that alleviated his concerns. Accordingly, he stated that his opinion is that respondent no longer has a need for a neurological evaluation to practice safely. Regarding mental illness, Dr. Nair testified and wrote in his report that respondent was not safe to practice medicine without restrictions or conditions including random drug testing, being on probation, and being under psychiatric care by a psychiatrist board certified in addiction medicine. He opined that "it is well known that physicians with substance abuse disorders often tend to appear more solidly in recovery then [*sic*] they may actually be." Furthermore, he opined that respondent's job as an anesthesiologist is a concern because he has access to controlled substances, and anesthesiologists have a well-known increased risk of substance abuse.

In his first report, Dr. Nair answered question number four from complainant by writing that respondent "is safe to practice medicine since his Alcohol Use Disorder is in remission and he appears to have been abstinent since 11/15/2020." Also, in response to question number five, Dr. Nair wrote: "Dr. McNutt's continued practice of

medicine does not pose a present danger or threat to the public health, welfare or safety." However, at hearing Dr. Nair stated that his answers to these two questions in his first report were incorrect, not accurate, and inconsistent with his other answers. Dr. Nair definitively testified that he believes respondent is not safe to practice medicine without restrictions because of respondent's alcohol use disorder. Notably, in response to question six in his first report, Dr. Nair wrote "Dr. McNutt's Alcohol Use Disorder requires ongoing monitoring, treatment, oversight, and the results of a comprehensive neurological exam in order to practice medicine safely."

Dr. Nair also testified that at the time of his first report, respondent was not attending a fellowship program in Addiction Medicine at Loma Linda University. Respondent later attended that program.

11. After receiving additional documents regarding respondent, on March 8, 2023, Dr. Nair wrote his second report, titled "Mental Examination Supplemental Report" regarding his review and evaluation of respondent. Dr. Nair testified that the primary reason he wrote the second report was because new information came to light that respondent's test showing a positive result for propofol in 2020 was not valid at a forensic level. Accordingly, Dr. Nair wrote in his report and testified that his concerns regarding respondent's abuse of propofol were not valid. Dr. Nair also wrote in his second report that he reviewed medical records from Kaiser Permanente regarding respondent's treatment for depression and management of his seizure disorder. Dr. Nair noted that those medications should not interfere with respondent's capacity to function as a physician. Dr. Nair also noted that respondent "is currently employed at Loma Linda University in a fellowship program of Preventative Medicine."

With regard to respondent's alcohol abuse, in his second report Dr. Nair wrote as follows:

> Dr. McNutt has an acknowledged problem with alcohol abuse. He has been abstinent as of 2020 and has maintained consistently negative tests on a regular basis and on random testing. Alcohol Abuse Disorder and depressive disorder can be conditions that are chronic and/or episodic which means individuals have to have adequate levels of insight, compliance with treatment and self-monitoring for internal and external factors that may precipitate relapse of substance use disorder, recurrence of severe depression or recurrence of seizures. Dr. McNutt has demonstrated this between 2020 to the present. There is no meaningful data to suggest that another year, 2 years or 3 years of monitoring is going to decrease risk. Based on the above data, there is no basis for Dr. McNutt to be on continued monitoring. Dr. McNutt is able to practice medicine without restriction.

During his testimony, Dr. Nair stated that the focus of his second report was the propofol test because he had major concerns about the positive propofol test because respondent is an anesthesiologist, and in his experience, anesthesiologists are prone to issues with propofol and other controlled substances. However, once Dr. Nair learned that the positive propofol test was not reliable, then he issued this second report, which was inconsistent with his first report, because he was "distracted by the propofol issue." Dr. Nair testified that he relied exclusively on information from the board's investigator for his conclusions that respondent had no positive test results for alcohol since November 2020. However, his opinion would be different if there was evidence of positive tests from 2021 to 2023, and such information would be of great

concern to Dr. Nair. Dr. Nair also stated that his second report was "an error of judgment on his part" because he was distracted by the propofol issue and not focused on the intensity of respondent's alcohol abuse, "was swayed" by the fact that respondent was working in a fellowship in Addiction Medicine at Loma Linda and no longer practicing anesthesiology (which is not accurate information), and respondent was in treatment. Dr. Nair stated that all those factors contributed to his error in judgment that resulted in his second report. Dr. Nair testified that his conclusions in the second report are simply wrong.

12. Only six days after his second report, Dr. Nair drafted his third report dated March 14, 2023, after he had a conversation with counsel for complainant. After that conversation, Dr. Nair realized that his second report was completely inconsistent with his first report and failed to take into consideration the intensity of respondent's alcohol abuse because he was simply not focused on the alcohol abuse issue and was instead focused on the positive propofol test, which was later found to be not reliable. After recognizing his error in judgment, Dr. Nair drafted the third report titled "Addendum Mental Examination Supplemental Report." Dr. Nair's third report provides as follows:

> This report represents an addendum to my supplemental report of 3/8/3032 to reflect a change of opinion: After re-reviewing the data I came to the conclusion that my supplemental report primarily considered the issue of propofol, but did not address Dr. McNutts [*sic*] long-standing alcohol abuse problems adequately. Dr. McNutt's Alcohol Abuse Disorder is complicated by Major Depression, multiple traumatic brain injuries between age

13 and June 2019, (the last resulting in findings of subdural hematoma) and seizure disorder all of which can contribute towards medical and psychiatric stressors with increased risk of relapse into alcohol abuse disorder.

Given these factors, it is my opinion, that Dr. McNutt should continue to be monitored by the Medical Board for a period of three years with random drug testing, continued participation in 12-step meetings, have a sponsor and maintain regular follow-up with his neurologist and his addiction medicine psychiatrist.

During his testimony, Dr. Nair explained that the combination of alcohol use disorder, depression, multiple brain injuries, and seizure disorder together leave respondent with a much higher risk of relapse as compared to others. He stated that depressive disorder is co-morbid with alcohol use disorder, and a large percentage of people with alcohol use disorder also suffer from depression. In respondent's case, respondent told Dr. Nair that he has used alcohol as a coping mechanism. Medical records also show that respondent has previously reported suicidal ideation and how he wanted to kill himself using carbon monoxide poisoning. There have been instances in respondent's life that demonstrate that emotional stressors cause him to use alcohol, and the active presence of depression leaves him at higher risk of relapse independent of the brain injury and seizure issues. The traumatic brain injuries and seizure disorder can also affect his sobriety in the future because people with a history of brain injury are more likely to have unstable moods, which can cause depression, anger, sleep problems, which all contribute to risk of relapse. Additionally, people with a history of traumatic brain injury can descend into cognitive impairment, which can

make them vulnerable to poor impulse control resulting in bad decisions. Also, medications used to treat seizure disorder can cause depression thereby increasing the risk of relapse. Respondent has demonstrated poor impulse control in 2017 or 2018 when he relapsed into drinking alcohol after years of sobriety.

13. Dr. Nair testified that he reviewed the expert report of Dr. Christy Waters, respondent's expert witness in this matter. Dr. Nair opined that Dr. Waters's report is not a medical/legal report at all, but simply takes respondent's representations to her when she interviewed him and completely disregards all collateral data, such as medical records. Dr. Nair stated that Dr. Waters "makes speculative claims about events in 2012 when respondent's own words shown in certified medical records directly contradict" what respondent told Dr. Waters. Dr. Nair stated that the certified medical records from Hoag and from Pine Grove carry more weight regarding the events of 2012 than respondent's representations to Dr. Waters for his evaluation regarding this matter. Dr. Nair stated, "you don't go to treatment and have other doctors falsify records for three months." The medical records show that respondent admitted he had a serious problem with alcohol in 2012, but Dr. Waters "makes excuses" for respondent in her report by saying he did not have an alcohol problem in 2012. Dr. Nair also noted that Dr. Waters stated she is not a neurologist, but she still speculated that respondent's seizures were not related to alcohol because that is what respondent told her. Dr. Nair testified that he did not make an opinion at all regarding the cause of respondent's seizures or whether they were alcohol related or not. Dr. Waters also failed to consider the frequency and intensity of respondent's alcohol consumption when she made her diagnoses of respondent.

Dr. Nair strongly disagreed with Dr. Waters's diagnosis of respondent of alcohol use disorder in full sustained remission. He stated that Dr. Waters is basing that

diagnosis exclusively on representations of respondent and not based on collateral data such as the medical records. Furthermore, Dr. Nair noted that the diagnosis of alcohol use disorder in full sustained remission is based exclusively on the DSM-5 which has no application in the forensic psychiatry realm and instead is simply for clinical purposes. A simple clinical classification from the DSM-5 is not appropriate for use in forensic psychiatry for determination and for legal decisions about a person's risk of relapse. He also noted that DSM-5 classifications have a poor correlation with treatment decisions and outcomes, which is well established in psychiatry.

COMPLAINANT'S DOCUMENTARY EVIDENCE

14. Complainant provided multiple certified medical records for respondent, which were received in evidence. Those records were from respondent's 2020 alcohol use disorder treatment at Pine Grove and from Hoag in 2020. Additionally, complainant provided certified medical records from Hoag for respondent's admission to that hospital in 2012 when he suffered a seizure. Complainant provided certified medical records regarding respondent's treatment for seizure disorder in 2019 from Dr. Vikas Y. Rao, M.D., a neurologist, and from Dr. Valerie Acevedo, D.O., a neurologist. Complainant also provided certified medical records from MemorialCare Saddleback Medical Center (hereinafter "Saddleback") related to respondent's admission to that hospital in 2019 for a seizure. Complainant further provided certified medical records from Kaiser Permanente regarding care respondent received from that facility from January 5, 2022, to July 29, 2022.

15. Complainant also provided a copy of a transcript of the board's interview of respondent on February 25, 2022, which was received in evidence.

Respondent's Evidence

TESTIMONY OF CHRISTY SUE WATERS, M.D.

16. Christy Sue Waters, M.D. has been licensed to practice medicine in California since July 1, 1984. She received her medical degree from the University of California Davis (UC Davis) in 1983. Thereafter, she completed an internship in medicine in 1984 at White Memorial Hospital in Los Angeles. Thereafter, she "needed to pay the Air Force back for the cost of her education" and was a member of the U.S. Air Force for three years. She worked for the U.S. Air Force from 1984 to 1987 as a general medical officer where she was in charge of an emergency room and full medical clinic. Thereafter, she left the Air Force and worked at an urgent care center in Sacramento for a year and-one-half. She next completed a three year psychiatry residency at UC Davis in 1991. Dr. Waters has been board certified in psychiatry since 1993. She received a certificate in addiction psychiatry in 1998, which required her to take an exam, but which also expired in 2008 when she chose not to recertify. She received a certificate in addiction medicine in 1998. She has been a member of the American Society of Addiction Medicine since 1985 but became a distinguished fellow in that organization in 2020 based on her work. Dr. Waters admitted during her testimony that she has had no training in forensic psychiatry and has had no work experience in forensic psychiatry.

Dr. Waters first worked in private practice as a psychiatrist from 1991 to 1993 in an outpatient psychiatry center primarily treating patients suffering from Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS), but she also saw general adult psychiatry patients. From 1993 to 1995 Dr. Waters worked at Kaiser Permanente Medical Group in Sacramento providing general adult psychiatry to patients ages 18 to 80 years old. In June 1995 Dr. Waters became the Director of

Psychiatric Services at Chemical Dependency Recovery Program (CDRP), part of the Kaiser Permanente Group, where she provided addiction psychiatry services for both inpatient and outpatient care. Dr. Waters worked full-time as the Director at CDRP from 1995 to 2008, and thereafter from 2008 to 2011 she worked as the Director there on a part-time basis. During her time at CDRP, she also was a member of the Physician Well-Being Committee for Kaiser Permanente Medical Group and volunteer clinical faculty with UC Davis, Department of Psychiatry. From 2008 to 2011 Dr. Waters also worked part-time providing general adult psychiatry services at Kaiser Permanente Medical Group in San Francisco. From 2011 to 2015 she worked full-time in that position until her retirement from Kaiser Permanente Medical Group in 2015.

In 2017 Dr. Waters worked as a Senior Physician and Shareholder of Bright Heart Health where she provided addiction psychiatry and general psychiatry services by telemedicine for patients in California struggling with opioid dependency. All of her treatment of those patients was conducted over Zoom videoconference. She left this position in March 2020. In June 2021 Dr. Waters worked at Heritage Clinic with Centers of Aging Resources in Los Angeles County providing general adult psychiatry services to patients by telemedicine, primarily for medically fragile elderly patients, many of whom have been chronically mentally ill for most of their lives, and many of whom were homeless. No information was provided regarding when Dr. Waters stopped working at Heritage Clinic, but she is currently not working as a psychiatrist. Dr. Waters testified that she is "currently going through a transition and considering private practice again."

17. Dr. Waters testified that she has conducted psychiatric evaluations to determine if a person is fit for duty for private employers and some state agencies in California since 1992. However, she admitted that other than this case, she has never

provided psychiatric evaluations to determine fitness for duty for a licensee of the board. Dr. Water's testified she has performed fitness for duty psychiatric evaluations for physicians approximately five to ten times. Dr. Waters has provided a psychiatric assessment of a dental hygienist because the Dental Board of California required the dental hygienist to be assessed and the dental hygienist picked Dr. Waters from a list of providers to do so. Dr. Waters has also provided psychiatric evaluations for fitness for duty for some nurses. Dr. Waters admitted that other than this case, she has not worked as an expert witness or previously testified as an expert witness in a licensing proceeding such as this one. Dr. Waters was hired by respondent to provide a psychiatric evaluation to determine if he is safe to practice medicine, and she wrote a report summarizing her findings. The following factual findings are based on Dr. Waters's testimony, expert report, and related documents received in evidence.

18. As part of her evaluation of respondent, Dr. Waters reviewed various documents, which were listed in her report, including the 805 report, MEC notes from NBSC, certified medical records from Hoag related to respondent's November 2020 admission, certified medical records from Pine Grove, respondent's contract with Pacific Assistance Group Professional Monitoring and Support Program (PAG), investigative reports from the board, Dr. Nair's three reports, the accusation in this matter, the Interim Order Imposing License Restrictions on respondent's license, certified medical records from neurologists treating respondent, and letters of recommendation for respondent.

19. Dr. Waters wrote in her report dated March 17, 2023, that "[t]his is a case where a physician is accused of unprofessional conduct, gross negligence, impairment and excessive use of drugs or alcohol who may have been mis-using alcohol periodically but became the "elephant" quoted in the parable of *The Blind Men and*

The Elephant." As an initial matter, Dr. Water's characterization of the accusation in this matter is simply wrong. The accusation does not allege gross negligence, unprofessional conduct, or excessive use of alcohol as a basis for discipline. To the contrary, the accusation in this matter only asserts that respondent is not safe to practice medicine due to a physical or mental impairment pursuant to Business and Professions Code section 822.

20. Dr. Waters conducted an interview with respondent on March 1, 2023, using a telemedicine platform to meet virtually. Dr. Waters wrote in her report, and testified at hearing consistent with her report, that [emphasis in original]:

> It is my opinion after reviewing all documents listed and interviewing Dr. J. McNutt that he does **NOT** currently have a physical illness or condition that impacts his ability to safely engage in the practice of medicine. . . .
>
> It is my opinion after reviewing all documents and interviewing Dr. J. McNutt that he does **NOT** have a mental illness which requires mental examination. He has not demonstrated any new or unusual symptoms in the past 11 years. There was an exacerbation of symptoms in 2019 into 2020 but these have been treated, stabilized, and in remission since late 2020/early 2021. . . .
>
> Doctor McNutt has been practicing medicine safely for all of his adult life beginning with his education in medical school and continuing recently with exceptional skills as a Fellow at Loma Linda University Medical Center. He does

> have conditions in his life which need to be monitored for his own over-all well-being and health just the same as the majority of other people do. He has five years of documented abstinence from alcohol and drugs 2012-2017. He also has another two years and four months of documented abstinence from alcohol and drugs November 2020 until present/ March 2023. The diagnostic criteria from DSM-5 define "sustained remission" for anyone who previously met the full diagnostic criteria for Alcohol Use Disorder at some point and then none of the criteria for Alcohol Use Disorder have been met at any time during a period of 12 months or longer outside of a controlled environment. He has not had any of the 11 diagnostic criteria for Alcohol Use Disorder since December 2020 . . . Based on national guidelines of DSM-5 the current and correct diagnosis for Dr. J. McNutt is Alcohol Use Disorder in sustained remission. **It is my opinion that he has already had more than enough monitoring and oversight with 7 ¼ years with Pacific Assistance Group** Physician Support and Monitoring and no documented evidence of a problem in the workplace.

During her testimony, as well as in her report, Dr. Waters stressed the fact that there is no evidence that respondent's "care of patients was ever less than very good to excellent." Dr. Waters also spent a significant amount of time testifying and a significant portion of her report providing her opinion about the cause of respondent's seizures in 2012 and 2019. Specifically, she wrote that respondent had a single seizure

in 2012 and "[h]is partners/colleagues at Newport Beach Surgery Center thought the seizure was due to alcohol withdrawal despite no evidence to support that."[2] Dr. Waters then wrote extensively about possible causes for seizures and opined in her report: [emphasis in original] "**It is my firm opinion that the seizure in 2012 suffered by Dr. McNutt was NOT due to alcohol.**" Dr. Waters noted that respondent was never provided with a diagnosis of seizure disorder until 2021 when he saw an epilepsy specialist at Loma Linda University Medical Center where he was diagnosed with a seizure disorder.

Regarding respondent's alcohol use in 2012, Dr. Waters relied exclusively on the report from respondent during her interview with him for that information. She wrote in her report:

> This writer cannot find any evidence or any documentation that any of this was done in 2012 when unnamed people with unknown experience and training pronounced the single seizure was certainly due to alcohol withdrawal. The history Dr. McNutt provides of having 4-5 drinks two nights of the week but not every week does **not** meet the criteria for regular or heavy use of alcohol. It certainly does not meet both criteria - daily and more than seven drinks in a day – which is what is needed to precipitate a withdrawal

[2] It is not clear where Dr. Waters got this information or how she had any knowledge regarding what respondent's colleagues thought regarding the cause of respondent's seizure.

> seizure. He does not describe any symptoms of withdrawal at any time or in any situation in 2012. . . .
>
> The history provided by Dr. McNutt indicates that during 2012, he demonstrated two symptoms/behaviors related to his use of alcohol and only two of the 11 symptoms that are considered for a diagnosis. Using national guidelines found in DSM-5 for the specific criteria of Alcohol Use Disorder, Dr. McNutt should have been diagnosed with Alcohol Use Disorder, mild . . . He only met . . . two criteria for Alcohol Use Disorder in 2012. There was no evidence that he had any impairment at work. There also was not any specific evidence of tolerance or withdrawal. This should have been treated on an outpatient basis. . . .

Dr. Waters testified that, regarding respondent's three-month long treatment at Hazelton in 2012 for alcohol use disorder, that he "was given a firm suggestion by multiple people at work" to undergo that treatment and that is why he went. Dr. Waters was told by respondent that Dr. Vanover, the administrator at PAG, was involved with discussions with respondent and the MEC of NBSC for the decision to send respondent to Hazelton for treatment. Dr. Waters wrote in her report that respondent self-reported to Hazelton for inpatient alcohol treatment services "to avoid any charges or reports to the Medical Board of California." After his treatment at Hazelton, respondent was committed to a five-year contract with the PAG program committing him to undergo random biological fluid testing for alcohol and drugs, attend group therapy, attend 12-step meetings, and counseling. From 2012 to 2017 respondent was subject to the PAG program and never tested positive for alcohol.

Respondent told Dr. Waters he was abstinent from alcohol during the 2012 to 2017 time period. After 2017 respondent was no longer regularly attending 12-step meetings and did not have a sponsor.

21. Dr. Waters noted that after the five-year PAG contract was completed in 2017, respondent first returned to drinking alcohol in 2017 while at dinner when he was in Nebraska interviewing for a critical care fellowship. He ordered a beer with dinner "without much thought." Respondent told Dr. Waters that he was surprised that it seemed fairly normal for him to do so and that the following day he entertained the thought that he can now "drink like a regular person." Respondent reported to Dr. Waters that he did not return to drinking alcohol regularly "for a while," but he was unable to tell her exactly when he did so. Respondent reported that he was "not a daily .drinker," but following his father's diagnosis of colon cancer in 2016 and his father's death in 2017, he would drink "periodically – one or two nights a week after work." Respondent denied drinking daily or even weekly to Dr. Waters during this time, and he reported to Dr. Waters that he did not drink on days when he was working at NBSC, never went to work under the influence of alcohol, impaired or hungover. Respondent denied to Dr. Waters that he did not have withdrawal from alcohol symptoms during that time, such as agitation, nausea, vomiting or tremors. In 2018 after the death of his father, respondent began to see a psychiatrist, Dr. Vasa, for depression.

22. On June 21, 2019, respondent was at a grocery store after work when he suffered a seizure resulting in him striking his head and he was taken to Saddleback for treatment of the seizure. Dr. Waters reviewed those medical records and noted that respondent was diagnosed with a subdural hematoma with a recurrent seizure with his last seizure being seven years prior. Dr. Waters noted that nothing in the Saddleback

records suggested alcohol withdrawal symptoms and there was no indication that the seizure was alcohol induced.

23. Dr. Waters noted that respondent reported to her that he did not have a "big change" in his alcohol drinking pattern until after his suspension from NBSC in July 2020. Thereafter, his drinking pattern changed significantly, and his drinking escalated with more volume of drinking and more often. Dr. Waters asked respondent how much he was drinking, and respondent failed to provide her with a clear answer but admitted that "it was excessive," and Dr. Waters "did not press him on it." Respondent "guessed" that it could be about eight drinks per day but he was not sure. Dr. Waters then discussed extensively the 11 criteria as set forth in the DSM-5 for a clinical diagnosis of alcohol use disorder. Respondent reported to Dr. Waters that prior to his July 2020 suspension from NBSC, he suffered a bout of Legionnaires' disease causing pneumonia, depression, and the seizure in 2019. Dr. Waters opined that in July 2020 respondent escalated from mild alcohol use disorder to "fairly severe" alcohol use disorder and was in need of effective, comprehensive, integrated treatment. Dr. Waters noted in her report that after his July 2020 suspension, respondent became "distraught, depressed, increased his use of alcohol and stopped eating." She also noted that he weighed 120 pounds when he self-admitted to Hoag for medical management of his alcohol withdrawal on November 15, 2020. During her testimony and in her report Dr. Waters neglected to mention that respondent only self-reported to Hoag after an "intervention" was conducted by Dr. Vanover and others for the purpose of saving his life. Dr. Waters admitted that respondent "was pretty sick" when he was admitted to Hoag for treatment. Respondent was in Hoag from November 15, 2020, to November 30, 2020, and was thereafter escorted "door-to-door" by others directly from Hoag to Pine Grove in Mississippi for further treatment.

24. Dr. Waters testified that she reviewed the Pine Grove medical records and specifically testified about the treatment respondent received there. However, it is noted that she did not address the discrepancies between the information reported by respondent to Pine Grove regarding his history of drinking alcohol and what he reported to her. Dr. Waters stated that respondent was at Pine Grove for three months and upon his discharge from Pine Grove, she opined that he was in early remission from his alcohol use disorder because he had been sober for less than 12 months but more than a week. The last date he used alcohol was November 15, 2020.

25. Upon his discharge from Pine Grove, respondent continued to see his psychiatrist, Dr. Vasa; take his antidepressants; get established with a neurologist; take his anticonvulsive medications; met with a nutritionist; attended a 12-step program; and he entered into another contract with PAG for biological fluid testing, counseling, and group therapy. When Dr. Waters interviewed respondent, he was continuing with all those steps. Also, Dr. Waters learned, at some point, that respondent applied for, was accepted, and successfully completed a one-year fellowship program in Addiction Medicine at Loma Linda University Medical Center. Respondent indicated to her that he learned a tremendous amount and enjoyed the experience and work.

Dr. Waters opined that respondent is currently diagnosed with alcohol use disorder in full sustained remission. She stated that he is considered to be in full sustained remission because he has more than 12 months of sobriety. He last consumed alcohol on November 15, 2020. Dr. Waters noted that when Dr. Nair interviewed respondent on September 8, 2021, respondent was not yet in full sustained remission of his alcohol use disorder because he only had 10 months of sobriety at that time and would still have been in early remission.

26. Dr. Waters stated that she was not aware from medical records or otherwise that respondent had any history of suicidal ideation or that he intended to commit suicide by any particular method. She noted that respondent has never had opioid use disorder. In 2022, respondent was evaluated by a neurologist at Loma Linda University Medical Center and was diagnosed with juvenile myoclonic epilepsy (JME).[3] Dr. Waters noted that alcohol does lower a person's seizure threshold regardless of the type of seizure disorder. Dr. Waters also testified that she disagrees with Dr. Nair's conclusions regarding respondent and specifically stated that "the flavor of Dr. Nair's [opinion] is that Dr. Nair still considers that respondent has some risk of remission, but I don't." Dr. Waters stated that she believes there is no basis to continue monitoring respondent and his practicing medicine without restrictions would pose no harm to the public. She stated that if respondent continues to see his therapist and "if he becomes unstable, he can be treated like anyone else" and would be safe to practice. Dr. Waters testified that respondent currently has no mental or physical condition that would render him unable to practice medicine safely.

27. On cross-examination, Dr. Waters testified that she considered the information in the Hoag medical records regarding respondent's 2012 hospital admission for his seizure regarding the amount and intensity of his alcohol use. Specifically, those records show that respondent's wife told caregivers that respondent "drinks too much. He usually drinks 750 ml of vodka daily, but he hides it. He won't admit that he has a problem with alcohol." Another note in that medical record from another caregiver states that "wife states patient drinks ETOH -vodka- heavily –

[3] Respondent testified that his treating neurologist diagnosed him with seizure disorder and had a concern for JME, but did not give him a formal diagnosis of JME.

doesn't want me to tell patient she told us." Notably, that information from the 2012 Hoag records was not contained in Dr. Waters's report or her earlier testimony. Dr. Waters testified that respondent was given an ultimatum by his colleagues at NBSC in 2012 to have treatment at Hazelton, and she admitted that "it is possible" that respondent had alcohol use disorder at that time, "but he was one of many people in the community having several drinks in the evenings." She stated she reviewed the Hoag medical records from his November 15, 2020, admission where in his initial psychiatric evaluation respondent reported "drinking about a pint of hard liquor daily for 'several years.'" She admitted that statement must mean at least two years, but she stated that it is not unusual for a caregiver to record the interview incorrectly. Dr. Waters admitted that there were discrepancies between the medical records she reviewed and respondent's report to her regarding his alcohol use history. However, she testified that she believed that respondent "was a reliable narrator" to her about the amount and frequency of his alcohol use.

28. Dr. Waters also admitted that she reviewed the Pine Grove medical records that show respondent admitted to caregivers at Pine Grove that "he is not certain that the two seizures he has had in his life were related to alcohol or not – 2012- most likely alcohol related and 2019, which is unclear." Dr. Waters stated that she does not expect her patients to make their own diagnoses on what caused those seizures.

29. On cross-examination Dr. Waters testified that she believes that respondent also meets the diagnostic criteria for PTSD. She also testified that she reviewed the biological fluid testing results from April 2021 to mid-2022 from PAG. Those records show that on December 18, 2021, respondent had a "positive" urine test and another "confirmed positive" blood test on February 2, 2022. Dr. Waters testified

that the document is unclear about what was being tested for in these biological fluid tests. She stated that she asked respondent about the December 18, 2021, positive test and he told her that he used hand sanitizer multiple times per day containing ethanol in clinical situations during his fellowship and that caused the positive test. Respondent denied consuming alcohol. She did not ask him about the confirming February 2, 2022, test results. Dr. Waters admitted that a single positive urine test for alcohol may indicate relapse "in a legal world" and it does warrant attention and discussion. However, she stated that "there is no standard definition of relapse" and "in the treatment world" you are looking for a change in behavior, which is a different situation than a single positive urine test. She stated that even assuming as a hypothetical that respondent consumed alcohol causing the single positive urine test, she would not consider that to be a relapse and it would not change her opinion in this case. She did not mention this positive test in her report. During her testimony Dr. Waters also compared alcohol use disorder to a diabetic and stated, "you don't expect a diabetic to never have dessert again, but the world sets out this perfection standard that physicians will never test positive again for alcohol in a urine test."

30. On cross-examination Dr. Waters also admitted that there is nothing in respondent's contract with PAG regarding biological fluid testing requiring PAG or respondent to report his status to the board. Also, PAG is expressly forbidden from providing information to the board without respondent's consent. Dr. Waters stated that this does not concern her or change her opinion.

TESTIMONY OF RESPONDENT

31. Respondent is 53 years old and has been licensed to practice medicine in California since 1997. Respondent was licensed to practice medicine in Indiana in 1995, but that license has since expired. He was also licensed to practice medicine in

Nebraska in 2018, and that license is active and pending renewal. He testified that he has previously held licenses to practice medicine in North Carolina and in Georgia, but both of those licenses have since expired. Respondent is married and has two daughters, ages 15 and 13, as well as one adult stepson.

He received his medical degree in 1995 from the Indiana University School of Medicine. He completed a surgical/medical internship in 1996 at St. Vincent's Hospital in Indianapolis. He completed his residency in anesthesiology in 1999 at Stanford University School of Medicine. After completing his anesthesiology residency, he worked from 1999 to 2000 as a staff anesthesiologist at the Veteran Affairs (VA) Hospital in Palo Alto, California, which is a teaching hospital associated with Stanford Medical Center. In 2000, respondent joined a private practice group providing anesthesiology services called El Camino Hospital in Mountain View, California, and did so until 2005. From 2004 to 2007 he worked as a staff anesthesiologist at Washington Hospital in Fremont, California. In 2007 respondent moved to Indianapolis, Indiana, because his parents lived there, and his father had been diagnosed with cancer. From 2007 to 2009 respondent worked as a staff anesthesiologist at Community Hospitals in Indianapolis, Indiana. In 2009 respondent began work as a staff anesthesiologist at NBSC in Newport Beach, California and stayed in that position until he was suspended in July 2020. He testified that his privileges with NBSC were still in effect after his suspension until he resigned in 2021. During his time at NBSC, he served as Medical Director of the facility from 2010 to 2012 and from 2018 to 2020.

Respondent is currently employed as a per diem anesthesiologist at Allied Anesthesia located in Upland, California, providing anesthesia services two to three days per week at different surgical centers. He has held that position since 2023 and interfaces with a work site monitor at that facility to comply with the conditions of his

interim order for the board. From 2016 to 2021, respondent worked as a staff anesthesiologist at CCRM located in Newport Beach, California. CCRM is a stand-alone fertility treatment facility and he provided anesthetics for patients undergoing fertility procedures. From 2022 to 2023, he worked as a staff anesthesiologist at Gen5 SC, a fertility center located in San Diego, California, on a part-time basis. He has also worked on a part-time basis from 2022 to May 2023 at Labryo Fertility Center in Newport Beach, California providing anesthesia services.

32. In June 2021, respondent applied for a fellowship program in Addiction Medicine at Loma Linda University Medical Center. He was accepted into the fellowship in August 2021 and started the fellowship program in February 2022. Respondent had to wait for approval of his credentials from Loma Linda University Medical Center in order to start the fellowship. He received those credentials in December 2021. Respondent explained that Addiction Medicine falls under the umbrella of Preventative Medicine. Respondent stated that during his time in the fellowship there were a total of six fellows, including himself, in the program. Respondent testified that at the time he applied for and was interviewed for the fellowship position, he disclosed to Dr. Lori D. Karan, the Program Director, and others that he had been suspended from NBSC, the 805 report was made to the board, and his prior hospitalizations for alcohol use disorder.

When the Interim Order Imposing License Restrictions on respondent's license was issued in May 2022, respondent was on his fifth month of the one-year fellowship. Respondent completed his fellowship in Addiction Medicine in February 2023. After the Interim Order Imposing License Restrictions on respondent's license was issued, respondent was required to have a work site monitor during his fellowship, and Dr. Karan, the Program Director for the Addiction Medicine Fellowship at Loma Linda

University Medical Center, served that role. During his fellowship, respondent completed clinical rotations at the VA hospital for inpatient rehabilitation, inpatient addiction at Loma Linda University Medical Center, behavioral medicine at a psychiatric hospital, outpatient clinics at the VA for addiction and mental health, methadone clinic, outpatient mental health in San Bernardino, the Orange County jail, and adolescent mental health at the Behavioral Health Institute.

33. Respondent testified that when Dr. Nair issued his first report in October 2021, Dr. Nair recommended that respondent have a neurological examination. Respondent underwent that neurological examination as required by the board in December 2022, two months before his fellowship was completed. Another requirement of the Interim Order issued by the board in May 2022 was that respondent undergo psychotherapy and have reports sent to the board on a quarterly basis. Dr. Vasa, respondent's psychiatrist since August 2018, provides that service and submits those quarterly reports to the board. In addition to undergoing the mental examination from Dr. Nair as required by the board, respondent also completed a physical examination as required by the board from Dr. Felix Y. Horng in September 2021.

34. Prior to the issuance of the Interim Order in May 2022, respondent had already entered into a two-year contract with PAG on April 5, 2021, to provide drug and alcohol testing, psychiatric and psychological counseling, a 12-step program, and other oversight. Respondent testified that he entered into this contract "for accountability as part of [his] recovery." He was not required to do so at the time by the board. Pursuant to the contract respondent attended three to four 12-step meetings per week and has a sponsor, he attended group counseling meetings twice a week for one-and-a-half hours each and never missed any of those meetings. During

this two-year agreement, respondent saw Dr. Vasa for treatment about once per month. The PAG contract required him to call-in daily to approved lab facilities to learn if he had been selected to provide a random biological fluid sample for alcohol and drug testing. If selected, he had to provide a sample within 24 hours. Respondent has never been discharged from PAG for failure to comply with the contract requirements.

From 2012 to 2015, after he was discharged from Hazelton for treatment of alcohol use disorder, respondent had a similar five-year contract with PAG as that described above. During that five-year time period, he complied with all terms of the PAG contract and never had a positive biological fluid test result. Respondent admitted that all of his contracts with PAG require that he provide his consent before PAG can disclose any information regarding his monitoring and test results to any outside entity, including the board. He also admitted that he may revoke his consent for that disclosure at any time.

On March 11, 2023, respondent entered into another two-year agreement with PAG at his own expense. The March 11, 2023, agreement is similar to the other agreements with PAG but without the terms related to biological fluid testing and monitoring because those functions are now done through the board as part of the Interim Order of May 2022. The March 11, 2023, PAG contract still includes the terms requiring group therapy meetings, and support group meetings. Dr. Vanover, the Director of PAG, facilitates all of the group therapy and support group meetings as she has done since 2012. Respondent admitted that his contract with PAG requires that he provide his consent before PAG can disclose any information regarding his monitoring.

35. Respondent testified that in 2012 he had his first seizure while at work and at the front desk of NBSC. He was not treating a patient at the time of the seizure. The paramedics were called, and respondent was transported to Hoag and was at the

hospital only for a few hours. He was discharged from the emergency room and never admitted to Hoag for that incident. After he was discharged from the emergency room, NBSC required respondent to have a "work-up" to determine the cause of the seizure before he could return to work. Respondent had that work-up from Valerie Acevedo, D.O., who determined that the cause of the seizure was idiopathic, meaning having an unknown cause.[4] Additionally, NBSC required respondent to have a meeting with three other physicians, including another anesthesiologist and a surgeon, from NBSC prior to returning to work. At that meeting the physicians told respondent they wanted him to meet Dr. Vanover and to comply with her recommendations as a requirement for him returning to work at NBSC. Dr. Vanover arrived at that same meeting only a few minutes after respondent was given this information. At the meeting, Dr. Vanover recommended that respondent get treatment and evaluation at Hazelton in Oregon for substance abuse disorder. Respondent complied with that recommendation because he was told by the physicians at NBSC that if he failed to undergo that treatment, he would be suspended from NBSC and not allowed to return. Respondent admitted that he was resistant to going to Hazelton but did so because he felt he was forced to do so to keep his job. NBSC did not file an 805 report as a result of the 2012 seizure or their suspicion that respondent had a substance use disorder. Respondent denied drinking alcohol on the day of his 2012 seizure, or in the two days prior to that seizure. He stated that he did not recall the last time he drank alcohol prior to that 2012 seizure.

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[4] Medical records received into evidence show that Dr. Acevedo treated respondent for a seizure in 2019, not 2012. There were no medical records offered regarding any other treatment of respondent by Dr. Acevedo.

36. After respondent completed his substance use disorder treatment at Hazelton, he entered into the five-year contract with PAG, for which Dr. Vanover is the director. Respondent testified that as a result of the 2012 seizure he was never treated with anticonvulsive medications. Before the 2012 seizure, respondent had never been requested by NBSC to take a biological fluid test to screen for alcohol or drugs. Respondent denied ever going to work under the influence of alcohol or other substances, denied ever driving a vehicle under the influence of alcohol or other substances, and denied ever being arrested for any reason.

37. After his 2012 seizure and before his 2019 seizure, respondent had never been asked to take a drug or alcohol test by NBSC. During that time frame respondent never had "any issues" with the staff or physicians of NBSC. He stated that when he provided anesthesia services at NBSC it was almost always in the presence of other health care professionals.

38. On June 22, 2019, respondent suffered his second seizure while grocery shopping at Ralph's supermarket after work. The paramedics were called, and respondent was transferred to the emergency room of Saddleback for treatment. He was diagnosed with an intracranial subdural hematoma and seizure disorder. Respondent testified that at discharge from Saddleback, there was no known cause for his seizure that day. Notably, the medical records from Saddleback show that respondent told his treating physicians that he used alcohol "rarely" and at another portion of the records denied alcohol use at all.

39. In May 2020, the MEC of NBSC required respondent to take a drug screening test of his hair. He complied and gave a hair sample. The results of that test showed a positive result for propofol, which was the basis for NBSC suspending respondent from his job. Respondent testified that he used propofol regularly as an

anesthesiologist but has never ingested propofol himself. Later information showed that the positive propofol test was not reliable and could have been the result of environmental contamination in respondent's hair because of his frequent use of the drug on his patients.

40. Respondent testified that after he was suspended from NBSC in July 2020 and before he self-admitted to Hoag on November 15, 2020, his drinking of alcohol was at its heaviest. In response to how much he was drinking during that time respondent stated, "it was enough to interfere with my health, but I did not quantify it." At hearing respondent denied that he was drinking on a daily basis at that point and denied that he drank a pint of alcohol per day. Respondent also testified that from July 2020 to November 15, 2020, there were periods of time where he did not drink at all. However, medical records from respondent's admission at Hoag show as follows: "The patient has been drinking approximately a pint of hard liquor per day for the past 18 months. He reportedly last drank on the day of admission."

41. Regarding to his self-admission to Hoag on November 15, 2020, for treatment of alcohol use disorder, initially respondent testified that he self-admitted to Hoag because he "felt he was unhealthy, and alcohol was interfering with his life." However, on cross-examination respondent admitted that he only went to Hoag on November 15, 2020, because three family members (his mother, wife, and sister) as well as two physicians and Dr. Vanover conducted an intervention or "paid him a visit to make [him] go to the hospital." Respondent admitted that those individuals were concerned about his well-being and told him that admission to the hospital was in his best interest. On cross-examination respondent denied that he told health care workers at Hoag in November 2020 that his friends who conducted the intervention told him he would not live another two months if he continued drinking. However,

medical records from Hoag show in a nursing admission note as follows: "His 2 MD friends and family had an intervention yesterday encouraging him to go get help. Pt.'s MD friends told him he looked as if he wouldn't live another 2 months if he continued drinking."

42. During his testimony, respondent denied making many statements that were recorded in the medical records of both Hoag and Pine Grove regarding his historical use of alcohol and his physical state at the time of admission. Specifically, the Hoag medical records show as follows: "Patient admits to history of blackouts. Pt states last known blackout was 11/14. Pt. states he blacks out once a week." During hearing, respondent testified that he does not have a history of blackouts because he "does not consume alcohol like that and that is not why I sought treatment." At hearing, respondent denied making the statement regarding blackouts, denied that he suffered blackouts once a week, and denied having a blackout on November 14, 2020.

The Hoag medical records also show a quote presumably from respondent in response to a question asking him to describe any previous falls. The notation states, "I fall when I try to get up, almost every day, last fall was yesterday." At hearing respondent denied making this statement and denied falling every day. He did admit that he needed help walking at that time. He admitted that while at Hoag he had difficulty walking and used a walker with a gait belt with an attendant with him around the clock. Respondent admitted that he fell while at Hoag when he went to the bathroom and no attendant was present. At hearing, respondent also testified that he did not recall telling any health care providers at Hoag after his admission on November 15, 2020, that it was a combination of alcohol and the drugs he was taking that were causing him to have falls. The medical record from Hoag provides: "He

reported the combination of medication with alcohol has resulted in him experiencing a high frequency of significant falls that have been 'really scary.'"

The Hoag medical records also show in the nursing admission notes as follows:

> Pt's skin has many scattered cuts, scrapes, and bruises. Pt has scrape to L flank, L rib area, L posterior axilla, left thumb and hand scrape, left fourth finger scab. Bruises to bilateral arms, forearms, legs and thighs all in different stages of healing. No open wounds, all are scabbed and healing. Pt states that he fell at home and dragged himself to his bed and that he has hard floors at home that are rough.

At hearing respondent denied ever falling and dragging himself to his bed.

The Hoag medical records also state, "Pt. had a 5150[5] in 2006 related to being intoxicated and unresponsive, he was not held for the full 72 hours." At hearing respondent denied ever being held on a 5150 hold, but he admitted that he was evaluated in the emergency room but never admitted to the hospital. Respondent explained that in 2006 he was out with friends and had taken diphenhydramine (Benadryl) and was drinking alcohol. He did not admit to becoming unconscious but stated that he thinks he fell asleep. He did not recall how many drinks he had but stated his wife took him to the emergency room. He said he does not believe it was a

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[5] Welfare and Institutions Code section 5150 allows an adult who is experiencing a mental health crisis to be involuntarily detained for a 72-hour psychiatric hospitalization when determined to be a danger to others, to himself or herself, or gravely disabled.

5150 hold because he was allowed to leave when he wanted to instead of the required hold for 72 hours. Respondent admitted that he did not recall telling Dr. Nair about this incident.

His medical records at Pine Grove also contradict his previous testimony regarding his historical alcohol use and whether he ever went to work hung over. Specifically, respondent denied in his reports to Dr. Nair, Dr. Waters, and this hearing that he ever went to work hungover. However, medical records from Pine Grove provide: "He denied ever diverting drugs from work and denied ever going to work intoxicated or drinking at work. Pt. did report going to work feeling hung over."

Additionally, the Hoag records show in multiple places that respondent had a significant weight loss prior to his admission on November 15, 2020. Specifically, the records show, "weight loss of 30 pounds over the past 6 months. He just reports not eating." Another portion of the medical record shows, "PT has had a 30lb wt loss in the last 3 months . . ." At hearing respondent admitted that he had lost weight prior to his admission to Hoag, but stated that he did not believe it was 30 pounds. He argued at hearing that while that number may be accurate, "a lot of that is from dehydration," and "most of that is fluid balance." Hoag medical records show that respondent's weight at the time of admission was 121 pounds. Respondent testified that he did not recall his weight being that low. He admitted that his is five feet nine inches tall.

43. Respondent was discharged from Hoag on November 30, 2020, and he was admitted to Pine Grove in Mississippi on December 1, 2020. He stated it was "door-to-door," meaning he was placed on an airplane with an escort. Respondent admitted on cross-examination that he was reluctant to get treatment at Pine Grove because it was so far away from his family. Pine Grove was the recommended facility of Dr. Vanover. Pine Grove specializes in treatment of licensed professionals, such as

physicians, dentists, pharmacists, nurses, and attorneys, for treatment of use disorders, such as alcohol use disorder and substance use disorder. Respondent was treated at Pine Grove for four months and discharged in March 2021. Upon discharge from Pine Grove, respondent returned to California and within a few days signed another contract with PAG.

44. Respondent was interviewed by Dr. Nair on September 8, 2021, as part of his mental health evaluation required by the board. Respondent reviewed the three reports provided by Dr. Nair in this case. During his testimony respondent denied ever telling Dr. Nair or anyone else that he was suicidal in 2018 and denied he ever contemplated suicide by carbon monoxide. Notably, nursing admission notes from respondent's November 15, 2020, admission to Hoag provide as follows:

> Pt. had suicidal thoughts in 2018 related to making a big job change and move and was apprehensive when the time came to move so he made a plan to hook up the exhaust to the inside of his car, but never bought the supplies or went through with the plan.

45. Respondent testified that during the time he underwent random urine tests for drugs and alcohol from June 2022 to June 2023, he never tested positive for alcohol. However, on cross-examination, respondent was shown documentation regarding his urine test results from PAG from April 2021 to June 2022, showing the December 18, 2021, positive urine test result and a follow-up confirmation blood test of February 2, 2022, showing a positive result. Respondent explained that "it was told [to him] that it was a low abnormal result for alcohol." Respondent believes that these are "false positive" results based on his constant use of hand sanitizer at Loma Linda University Medical Center as required by the hospital policy. Respondent admitted that

his PAG contract requires him to immediately cease practice if he has a positive test for alcohol, but that did not happen with these positive tests.

46. Respondent stated that he was sober from 2012 to 2017 while being monitored with PAG. In 2017 respondent "parted ways" with is 12-step sponsor because his sponsor thought he was not taking his recovery seriously, and he and the sponsor had different ideas on the importance of the 12-steps. In 2017 respondent parted ways with his sponsor, respondent's father died, and respondent and his wife were having marital problems. Respondent admitted that he started drinking again in 2017, but he stated that from 2017 to 2019 his drinking was "occasionally" and not excessive. Additionally, respondent stated that he believes that his consumption of alcohol first became a problem in his life when it "interfered with my wife and I," but he does not recall what year that was. He stated that he believes that happened when he moved back to Indiana in 2009. Respondent admitted that "there were unhealthy times here and there after that."

TESTIMONY OF MARSHA VANOVER, PH.D.

47. Marsha Vanover is currently the Administrator of PAG in Orange County, California and has been in that position for the past 25 years. Her duties at PAG include: facilitation of health support groups twice a week; enrolling physicians in urine testing with PAG's outside laboratory, which is currently Vault Laboratories; providing all written correspondence from PAG on behalf of the enrolled physicians when requested by their attorneys or insurance companies; and providing quarterly reports for those physicians being monitored by the board regarding compliance. Dr. Vanover has a Ph.D. degree in clinical psychology and a master's degree in counseling psychology.

48. Dr. Vanover first met respondent in 2012 because respondent's medical group, NBSC, contacted her and requested that she attend a meeting with members of the MEC of NBSC and respondent, as well as respondent's wife, because NBSC was concerned that respondent may have an alcohol or drug problem. Dr. Vanover testified that she recalled respondent's wife telling her that respondent had a problem with alcohol consumption. As a result, Dr. Vanover recommended that respondent attend a 90-day inpatient rehabilitation program at Hazelton, which he did. She noted that respondent was resistant to that treatment at the time.

49. After respondent's discharge from Hazelton in 2012, respondent entered into a contract with PAG for five years and Dr. Vanover signed that contract on behalf of PAG. Dr. Vanover stated that during this PAG contract from 2012 to 2017, respondent underwent random biological fluid testing and never had any positive tests for alcohol. Dr. Vanover stated that this contract, as well as the next two contracts with respondent, with the exception of after the May 2022 Interim Order took effect, are essentially identical.

50. Dr. Vanover participated in the intervention in November 2020 that resulted in respondent's self-admission into Hoag on November 15, 2020. Notably, Dr. Vanover testified that she organized that intervention. She stated that respondent "got on her radar" as a result of email communication and phone calls she had with him beginning in September 2020. She stated respondent told her that he was worried about his consumption of alcohol.

51. Dr. Vanover testified that she recalled writing a letter to respondent's caregivers at Hoag on November 16, 2020, which was received in evidence. In that letter, Dr. Vanover wrote as follows:

> He has not worked for 6 months, myself and 2 other Docs did intervention on him Sunday. His family in Texas we had on Zoom.....He will not be real happy about Pinegrove as did 90 day Spring brook 7/8 yrs. ago, hated it, denial whole time. His Medical Group made him go.....He is a very bright, introverted stubborn bad bad [*sic*] alcoholic. Both Docs Sunday told him and others they did not think he would live more than 2 more months. . . .

Dr. Vanover admitted that she made those statements to both Hoag and Pine Grove caregivers. Dr. Vanover testified that she specifically recalled telling caregivers at Pine Grove that at the time respondent was in the PAG program, he was in denial about the severity of his alcohol use.

52. After respondent's discharge from Pine Grove, on April 5, 2021, respondent entered into another contract with PAG for a term of two years. Dr. Vanover signed that contract on behalf of PAG. During that contract term respondent was tested for drugs and alcohol. Dr. Vanover obtained the testing results for that contract which spanned dates from April 23, 2021, to May 22, 2022. She testified that the board took over biological fluid testing of respondent on May 22, 2022, because of the Interim Order. These testing results showed the positive test for alcohol on December 18, 2021. Dr. Vanover was notified of any positive results from the testing facility and would have thereafter notified respondent of that result within a few days. Dr. Vanover recalled discussing this positive result with respondent and he explained that it was because of hand sanitizer. She also understood that there was a follow-up confirmation test on February 2, 2022, that was a blood test and it was also positive for alcohol.

53. Dr. Vanover testified, and the PAG contracts at issue show, that if a physician tests positive for alcohol, pursuant to the PAG contract, the physician must cease the practice of medicine. She stated that no such cease practice order happened in respondent's case because of the December 18, 2021, and February 2, 2022, positive tests because she "was fearful of respondent's well-being and fearful that respondent would have dropped out of PAG all together." Dr. Vanover stated that this concern was specific to respondent because she did the intervention on him in November 2020 and she "was told by those physicians that they believed respondent would be dead within seven days if he did not detox" from alcohol. If PAG told respondent to cease practice and he decided to "drop out" of PAG all together, PAG would have no recourse other than to inform his employer, wife, or psychiatrist of what respondent had done. However, she noted that she would only be able to inform those individuals if respondent had a signed release to allow PAG to release that confidential information. While it is a requirement for a person to sign such a release to participate in PAG, the person can also retract that authorization at any time. Dr. Vanover stated that a monitored physician with PAG who decides to quit PAG can revoke all consents to notify employers or others. She has specifically had physicians in the PAG program do just that and even put that revocation in writing. If that happens, PAG has no authority to notify any person or entity.

TESTIMONY OF MONISHA VASA, M.D.

54. Dr. Vasa has been licensed to practice medicine in California since 2008. Dr. Vasa is board certified in general adult psychiatry and has completed a fellowship in addiction psychiatry. Dr. Vasa is in private practice and specializes in general and addiction psychiatry. Respondent has been Dr. Vasa's patient since July 2018.

55. Dr. Vasa initially saw respondent in 2018 about once every four to six weeks. However, over the past two to three years, she has seen respondent about every three weeks. Dr. Vasa testified that she has diagnosed respondent with major depressive disorder in remission, generalized anxiety in remission, and alcohol use disorder in remission. Dr. Vasa stated that in the past she may have ruled out PTSD for respondent, but she does not believe that he currently meets the diagnostic criteria for a diagnosis of PTSD. Dr. Vasa stated that she also has interacted with Dr. Vanover regarding respondent, and it was Dr. Vanover who referred respondent to Dr. Vasa. From time-to-time Dr. Vanover will "reach out" to Dr. Vasa if she has a concern regarding respondent.

56. Since the May 2022 Interim Order restricting respondent's license was issued by the board, Dr. Vasa has acted as his psychotherapist pursuant to that Interim Order and submits quarterly reports to the board regarding that psychotherapy. Dr. Vasa testified that respondent has complied with her treatment and has not missed any appointments with her. Dr. Vasa wrote a letter, which was received in evidence, confirming this information. Dr. Vasa testified that every time she meets with respondent, she checks in on him and asks if he has any cravings for alcohol. For a brief period of time after respondent was discharged from Pine Grove, respondent took Naltrexone, a drug to curb cravings for alcohol, as prescribed by Dr. Vasa. However, Dr. Vasa discontinued the Naltrexone prescription because respondent did not have any cravings and the drug was not needed.

57. Dr. Vasa testified that she learned from Dr. Vanover and respondent that he tested positive for alcohol on December 18, 2021, and on February 2, 2022. The February 2, 2022, test was during respondent's fellowship at Loma Linda University Medical Center. The December 18, 2021, result was prior to that fellowship. Dr. Vasa

stated that she "thinks it was a false positive" test, and she did not have any concerns at that time of respondent relapsing because he had no clinical indicators of relapse.

TESTIMONY OF LORI D. KARAN, M.D.

58. Dr. Karan is currently employed as the Program Director of the Addiction Medicine Fellowship at Loma Linda University Medical Center, a position she has held since 2018. Additionally, since 2018, she has worked as a professor of internal medicine and preventative medicine at Loma Linda University Medical Center, and as a physician in the Addiction Medicine Section of the Department of Behavioral Health at the VA Loma Linda Healthcare System. Dr. Karan is board certified in internal medicine and in addiction medicine. Dr. Karan explained that the Addiction Medicine Fellowship at Loma Linda University Medical Center was created in 2018 by her. She stated that the fellowship became accredited in 2019 by the Accreditation Council for Graduate Medical Education (ACGME). The ACGME was first established in 2016 and the Addiction Medicine Fellowship at Loma Linda University Medical Center was the first applicant accepted for accreditation by ACGME. As of July 31, 2023, the program graduated 17 fellows. Dr. Karan explained that Addiction Medicine is a "multispecialty subspecialty" meaning that you can come into Addiction Medicine from all different medical backgrounds, such as anesthesiology, psychiatry, internal medicine, or any other specialty. Dr. Karan has presented nationally and internationally on topics related to Addiction Medicine. She is very active in many national organizations, and she is most active in the American Society of Addiction Medicine (ASAM), where she has been a board member for many years.

59. Dr. Karan first met respondent by telephone in June 2021 when he contacted her to inquire about the fellowship program. Dr. Karan stated that she knew he was very bright and she "was trying to recruit him" into the fellowship. Dr. Karan

testified that the fellowship program "did a lot of vetting [of respondent] before accepting him into the program because of the unique circumstances related to his recovery and his [medical] license." As a result, respondent attended the fellowship program "off-cycle" meaning outside of the normal time frame of July 1 to June 30 for the fellowship program every year. Respondent began the one-year fellowship program on February 1, 2022, and ended it on January 31, 2023. Dr. Karan described the fellowship program as an intense program because the fellows rotate in different health systems with different patients, different electronic records systems, with patients ranging from adolescent to geriatric. She stated that the program tries to cover "all drugs, all age groups, and all medical record systems in one year."

Dr. Karan stated that respondent underwent a lengthy interview with three faculty members and four current fellows of the program as part of his application process to be accepted into the fellowship program. After Dr. Karan "got the OK" from those seven individuals, she then had to get respondent's approved for admission into the fellowship program by the Graduate Medical Education (GME) department of Loma Linda University Medical Center. Dr. Karan stated that the GME was "very hesitant" to admit respondent, and she tried to get him accepted by August 2021 and believed she could do so by September 2021, but it did not happen until February 2022. She stated that in order to get him accepted to do clinical work in the fellowship program, respondent needed to be cleared by the Designated Institution Official (DIO), who is like a Dean or Associate Dean of the university, which required correspondence with lawyers for the university.

60. Dr. Karan testified that during the application process, respondent was forthcoming to her about his alcohol use disorder. She stated that she got letters of recommendation from individuals and Dr. Vanover wrote to her regarding his alcohol

use disorder, and she may have seen a hospital discharge summary. Dr. Karan stated that she was not his treating physician, but she did ask respondent some questions about his alcohol use disorder, but she "was not being a lawyer about it." Dr. Karan stated that after he was accepted into the fellowship program, she did not think respondent was trying to minimize his own alcohol use disorder, but "it was not an issue," and "we did not talk about his history," and "most people in the program have someone in their family with an addiction."

61. Dr. Karan described respondent as very uplifting, bright, and he thinks critically. She stated that he interacted with other fellows in the program "from a kind and gentle heart." Because he is an anesthesiologist, he knows pharmacology well, and "that helps." Dr. Karan explained that respondent, and all fellows in the program, are evaluated by a clinical competency committee (CCC), which consists of herself and other faculty members. The CCC meets twice a year and evaluates fellows on whether they meet milestones in the program. She stated that fellows are ranked on a scale of one to five with five corresponding to someone who is "nationally renowned and can teach all of us." Most people start out at a 3 because they are already specialists. She explained that you must be able to safely practice Addiction Medicine in order to complete the fellowship, with most graduates being a 4 or 4.5 on the scale at completion of the program. Respondent's scores ranged from 4.5 to 5, which she stated was "really unheard of" and that was from all evaluators including herself. Dr. Karan feels that respondent has a very good understanding of addiction medicine and how to practice in a variety of environments. She stated that he also has maturity and a keen sense of critical thinking "that pushes all of us." She stated that the rotations can be very stressful situations, but respondent handled that well, was always on time, and exhibited a gentleness and kindness to patients. She said he has a wonderful patient and bedside demeanor.

62. Dr. Karan testified that the current faculty of the Addiction Medicine Department of Loma Linda University Medical Center is "completely overloaded with 50 consults per day," which is "inhumane." During the time respondent was in the program, the faculty "could give him half of that load and could trust him to handle it without any supervision because he had proven himself." Dr. Karan stated that she has never seen respondent look as though he was impaired in any fashion or exhibit any degree of mental illness.

63. After the May 2022 Interim Order, Dr. Karan became respondent's work site monitor for his work in the fellowship program and reported quarterly to the board. Respondent was several months into the fellowship at the time of the Interim Order. Dr. Karan observed no issues that needed to be addressed, and her reports to the board reflected that. After respondent completed the fellowship, Dr. Karan has remained in contact with respondent and has tried to recruit him as part of the faculty for the program.

64. Dr. Karan wrote a letter dated January 11, 2023, to the Loma Linda Faculty Medical Group, which was received into evidence, wherein Dr. Karan was advocating for hiring respondent as a faculty member, and noted that respondent "also wants to continue his work in Anesthesiology." The letter was signed by other fellows in the program, Dr. Karan, and other faculty members. Dr. Karan praised respondent in this letter writing "[o]ne cannot easily find another Addiction Medicine practitioner who is as astute, qualified, considerate, and impassioned as Dr. McNutt," and further wrote:

> Dr. McNutt would not have a 'restricted' medical license if he were in a State other than California. .....In states other than California, problems with Dr. McNutt's medical license

would only occur if he was non-compliant with the Physicians Health Program. California is one of only five states that does not have a Physicians Health Program. As a result, the responsibility for oversight and disciplinary action falls upon an already overwhelmed medical board. Because of the delays involved, it is conceivable that the above said restrictions could persist for years.

65. Dr. Karan also wrote another letter dated February 24, 2023, to respondent's counsel in this matter praising respondent's abilities and mirroring her testimony at hearing and other letter dated January 11, 2023, but without the comments regarding her opinion that respondent would not have restrictions on his license if he were practicing in a state other than California.

TESTIMONY OF DHARINI PATEL, M.D.

66. Dharini Patel, M.D. is licensed to practice medicine in California and is board certified in anesthesiology. She previously held a board certification in internal medicine. Dr. Patel has worked at NBSC as an anesthesiologist since 2008. She first met respondent at NBSC in 2008 when she started working there and worked with him until he left NBSC in 2020. Dr. Patel stated that she and respondent did not work on cases with each other directly because anesthesiologists don't typically do that. She stated that on less than 10 patients but more than five patients during the time they worked together, she and respondent assisted each other, primarily for consultations for patient care in anesthesia, and assisting with nerve blocks or difficult airways. Dr. Patel stated that respondent was the Medical Director of the NBSC facility and was always there and available to assist. The types of cases seen at NBSC were generally

gastroenterology, gynecology, plastic surgery, rarely orthopedic cases, and very rarely pediatric cases.

67. During the time Dr. Patel worked with respondent at NBSC, she was never asked to "step into" a case because respondent had gone missing or did not show up. Dr. Patel was not aware of any scheduled case at NBSC where respondent failed to show up for the procedure. Dr. Patel never saw respondent slur his words and never saw him impaired at work. Dr. Patel has never seen respondent intoxicated or hung over. Dr. Patel has never seen respondent in a social setting. Dr. Patel described respondent as one of the best anesthesiologists at NBSC and stated that he has a vast knowledge of anesthesiology and medicine.

68. On cross-examination Dr. Patel admitted that she had never read the accusation in this matter. She has never discussed this hearing with respondent. She was asked to testify by respondent's attorney "to assess my working relationship with" respondent and to discuss "whether [she] has ever been privy to any of those things you have been discussing." Dr. Patel has never discussed with respondent or his attorney his use of alcohol.

Evaluation

69. The sole basis for action in this matter rests upon complainant's allegations that respondent suffers from a physical or mental illness affecting his ability to safely practice medicine arising from respondent's alcohol use disorder. Accordingly, expert testimony is necessary for complainant to establish these allegations. Two experts testified in this matter, Dr. Nair on behalf of complainant, and Dr. Waters on behalf of respondent. Each had contrasting opinions regarding respondent's ability to practice medicine safely. Accordingly, an evaluation of the

opinions of each expert must be made, taking into account the evidence relied upon by each, and other evidence presented that would support or contradict the opinion of each expert.

In determining the weight of each expert's testimony, the expert's qualifications, credibility and bases for the opinions were considered. California courts repeatedly underscore that an expert's opinion is only as good as the facts and reason upon which that opinion is based: "Like a house built on sand, the expert's opinion is no better than the facts on which it is based." (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 923.) An expert's failure to consider all of the facts may make his opinions less persuasive (*People v. Coddington* (2000) 23 Cal.4th 529, 614) and the expert may be examined about whether the expert sufficiently took into account matters arguably inconsistent with the expert's conclusions. (*People v. Ledesma* (2006) 39 Cal.4th 641, 695.) An expert's opinion may be rejected if the reasons given for it are unsound. (*Kastner v. Los Angeles Metropolitan Transit Authority* (1965) 63 Cal.2d 52, 58.)

70. Both Dr. Nair and Dr. Waters have impressive credentials in psychiatry and have practiced in a clinical setting for years. However, only Dr. Nair has credentials and training in forensic psychiatry, which is directly applicable to this matter. In contrast, Dr. Waters only applied a clinical psychiatry viewpoint to her evaluation of respondent, which was based primarily on information she obtained directly from respondent, and she gave little attention or weight to information regarding respondent's history of alcohol use presented in his medical records or other collateral evidence. Dr. Waters also stressed during her testimony that respondent has never harmed a patient. However, because the main purpose of license restrictions is to protect the public, patient harm is not required before the board can impose

restrictions. It is far more desirable to impose restrictions on a physician before there is patient harm than after harm has occurred. Prevention of future harm is part of public protection. (*Griffiths v. Superior Court* (2002) 96 Cal.App.4th 757, 772-773.) Dr. Waters opined in her report that respondent "has already had enough monitoring and oversight with 7 1/4 years" with PAG. Dr. Waters's opinion completely disregards the fact that respondent relapsed in 2020 to the point where he almost drank himself to death and was consuming extreme volumes of alcohol to the point where an intervention was necessary. That happened about two and-one-half years ago demonstrating that his seven and one quarter years of monitoring is apparently not sufficient. When questioned during cross-examination about discrepancies between the medical records' evidence of respondent's volume and pattern of drinking alcohol, and what respondent reported to Dr. Waters, Dr. Waters admitted there were contradictions but simply avoided answering the question of why she trusted the information provided by respondent over that contradictory information. Dr. Waters testified, without any evidentiary support, that she believes respondent is a reliable narrator of his alcohol use history.

Dr. Waters even opined that respondent's 2012 inpatient treatment was unnecessary because he did not meet the DSM-5 criteria for alcohol use disorder, but she based that exclusively on respondent's reporting to her of his alcohol use at that time. She testified that she expressly excluded information from medical records that evidenced that respondent was drinking 750 ml of vodka per day during that time period. Dr. Waters even went so far as to opine about the cause of respondent's seizures, concluding that those seizures were not caused by alcohol use. She confidently made that conclusion despite not being a neurologist or having sufficient credentials in neurology to do so. By comparison, Dr. Nair made no conclusions or findings at all regarding the cause of respondent's seizures and stated he is not

qualified to do so. Instead, Dr. Nair credibly explained how any seizure disorder may increase the risk of a person relapsing and using alcohol.

Dr. Nair provided credible testimony regarding the evidence he considered for his evaluation, which included multiple sources of information such as medical records which gave a clearer picture of respondent's alcohol use than respondent's reporting to Dr. Nair or to Dr. Waters. While Dr. Nair's first report sets forth more specific information regarding Dr. Nair's evaluation and analysis, he testified that after he received the information that the positive test for propofol was unreliable, he issued a second report essentially reversing his opinion that respondent suffers from a mental health condition that impairs his ability to practice medicine safely. Dr. Nair also credibly testified that he did so in error and was distracted and more focused on the possibility that respondent was using propofol because he is an anesthesiologist, and he failed to properly reflect on the information regarding respondent's use of alcohol. While Dr. Nair's second report is deeply concerning, he credibly and convincingly explained why this error happened. Only a few days later, Dr. Nair corrected his errant second report by writing a third report in which he stressed that respondent's alcohol abuse disorder is complicated by his major depression, multiple traumatic brain injuries, and seizure disorder, all of which can contribute towards medical and psychiatric stressors and cause an increased risk of relapse into alcohol abuse disorder. Dr. Nair's opinions were simply more credible that those of Dr. Waters, and Dr. Nair's opinions were supported more by other evidence than were those of Dr. Waters. Dr. Nair's admission of his error also made him a more credible witness.

Notably, respondent's own testimony at this hearing regarding his history of alcohol use and other issues in many instances was directly contradicted by extensive documentation in medical records received in evidence, much of it from statements he

made to his treaters, as well as testimony from Dr. Vanover. These inconsistencies clearly established that respondent is not a reliable narrator of his alcohol use history. Respondent's testimony also demonstrated his denial of the extent of his alcohol use disorder. Furthermore, Dr. Vanover's testimony regarding her involvement in respondent's multiple attempts at sobriety further supported Dr. Nair's opinion that respondent has a very long history of alcohol use disorder, and he is at risk of relapse because of his other complications. Notably, Dr. Vanover wrote in letters and testified that respondent has a long history of denial of his alcohol use disorder and is a "bad bad alcoholic." She credibly testified about respondent's physical state in November 2020 when she organized an intervention to save his life. By comparison, respondent downplayed his physical condition during his testimony. Dr. Vanover is the only witness, other than respondent, who was present in 2012 at that MEC meeting at NBSC where Dr. Vanover recommended that respondent get treatment. Dr. Vanover was a credible witness and historian regarding respondent's alcohol use. As it is well established, the testimony of one credible witness may constitute substantial evidence. (*In re Frederick G.* (1979) 96 Cal.App.3d 353, 365 cert. den. 100 S.Ct. 2150; *Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052-1053.)

It is also notable that during the times respondent has been monitored by PAG from 2012 to 2017 and again from 2021 to May 2022 when the board took over monitoring him, respondent stayed sober. However, soon after the PAG contract ended in 2017, respondent began drinking again. This evidence suggests that without monitoring of respondent's alcohol use, he is prone to relapse. This is particularly concerning given respondent's own admission during his testimony that he has had a drinking problem since 2009, which is well over 14 years.

On balance, Dr. Nair's testimony and opinions regarding whether respondent suffers from a mental illness or physical illness that affects his ability to practice medicine safely were more credible, reliable, and persuasive than those of Dr. Waters. Complainant established by clear and convincing evidence that respondent suffers from a mental illness, namely alcohol use disorder, that affects his ability to practice medicine safely without restrictions.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. Complainant bears the burden of proof of establishing that the charges in the accusation are true. (Evid. Code, § 115; 500.) The standard of proof required is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The obligation to establish charges by clear and convincing evidence is a heavy burden. It requires a finding of high probability; it is evidence so clear as to leave no substantial doubt, or sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.).

Applicable Statutes

2. Business and Professions Code section 820 provides:

> Whenever it appears that any person holding a license, certificate or permit under this division or under any initiative act referred to in this division may be unable to practice his or her profession safely because the licentiate's

ability to practice is impaired due to mental illness, or physical illness affecting competency, the licensing agency may order the licentiate to be examined by one or more physicians and surgeons or psychologists designated by the agency. The report of the examiners shall be made available to the licentiate and may be received as direct evidence in proceedings conducted pursuant to Section 822.

3. Business and Professions Code section 822 provides:

If a licensing agency determines that its licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill, or physically ill affecting competency, the licensing agency may take action by any one of the following methods:

(a) Revoking the licentiate's certificate or license.

(b) Suspending the licentiate's right to practice.

(c) Placing the licentiate on probation.

(d) Taking such other action in relation to the licentiate as the licensing agency in its discretion deems proper.

The licensing agency shall not reinstate a revoked or suspended certificate or license until it has received competent evidence of the absence or control of the condition which caused its action and until it is satisfied that with due regard for the public health and safety the

person's right to practice his or her profession may be safely reinstated.

4. Business and Professions Code section 2227 provides:

(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

(1) Have his or her license revoked upon order of the board.

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

Disciplinary Guidelines

5. California Code of Regulations, title 16, section 1361, provides that when reaching a decision on an action pursuant to Business and Professions Code section 822, the board must consider and apply the "Manual of Model Disciplinary Orders and Disciplinary Guidelines" (12th Edition/2016). Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure. Furthermore, California Code of Regulations, title 16, section 1361, provides that the board "shall use the Uniform Standards for Substance-Abusing Licensees as provided in section 1361.5, without deviation, for each individual determined to be a substance-abusing licensee." Official Notice was taken of the board's disciplinary guidelines in this matter.

Cause for Action

6. Cause exists under Business and Professions Code section 822 to revoke, suspend, or take any action imposing restrictions upon respondent's license.

Complainant established by clear and convincing evidence that respondent's ability to practice medicine is impaired by a mental or physical illness affecting his competency.

Appropriate Action

7. As cause for action has been established, determination of the appropriate action to impose on respondent's license in order to protect the public is necessary. The evidence established that respondent has been sober since November 2020. Although there was some evidence presented regarding a positive alcohol test for respondent on December 18, 2021, and February 2, 2022, it was insufficient to establish that respondent consumed alcohol on those dates. Given that he has been sober for only about two and one-half years, and he has successfully completed a fellowship in Addiction Medicine with rave reviews from Dr. Karan, respondent is certainly on the path to recovery from his alcohol use disorder. However, recovery is a lifelong journey, and in light of his long history of alcohol abuse spanning at least 14 years, public protection requires that respondent be monitored by the board to ensure he is sufficiently rehabilitated.

There is no dispute that respondent is a stellar physician in the areas of both anesthesiology and addiction medicine. However, restrictions must be put in place to ensure that respondent remains sober for a sufficient period of time, beyond the two and one-half years of sobriety he currently has, to demonstrate his recovery. Accordingly, a probation period of three years with terms and conditions including abstaining from dangerous drugs and alcohol, as well as biological fluid testing, practice monitor, psychotherapy, psychiatric evaluation, and other conditions is appropriate in this case.

ORDER

Physician's and Surgeon's Certificate number A 61636 issued to John Gilbert McNutt, M.D. is revoked. However, revocation is stayed, and respondent is placed on probation for three (3) years upon the following terms and conditions.

1. **Notification** - Within seven (7) days of the effective date of this Decision, the respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the board or its designee within 15 calendar days. This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

2. **Supervision of Physician Assistants and Advanced Practice Nurses** - During **probation**, respondent is prohibited from supervising physician assistants and advanced practice nurses.

3. **Obey All Laws** - Respondent shall obey all federal, state and local laws, all **rules** governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

4. **Quarterly Declarations** - Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

5. **General** Probation Requirements –

Compliance with Probation Unit

Respondent shall comply with the board's probation unit.

Address Changes

Respondent shall, at all times, keep the board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the board or its designee in writing 30 calendar days prior to the dates of departure and return.

6. **Interview with the Board or its Designee** - Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

7. **Non-practice While on Probation** - Respondent shall notify the board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

8. **Completion of Probation** - Respondent shall comply with all financial **obligations** (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

9. **Violation of Probation** - Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed

against respondent during probation, the board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

10. **License Surrender** - Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his license. The board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

11. **Probation Monitoring Costs** - Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the board or its designee no later than January 31 of each calendar year.

12. **Substance Abuse Support Group Meetings** – Within 30 days of the effective date of his Decision, respondent shall submit to the board or its designee, for its prior approval, the name of a substance abuse support group which he shall attend for the duration of probation. Respondent shall attend substance abuse support group meetings at least once per week, or as ordered by the board or its designee. Respondent shall pay all substance abuse support group meeting costs.

The facilitator of the substance abuse support group meetings shall have a minimum of three (3) years of experience in the treatment and rehabilitation of substance abuse and shall be licensed or certified by the state or nationally certified organizations. The facilitator shall not have a current or former financial, personal, or business relationship with respondent within the last five (5) years. Respondent's previous participation in a substance abuse group support meeting led by the same facilitator does not constitute a prohibited current or former financial personal, or business relationship.

The facilitator shall provide a signed document to the board or its designee showing respondent's name, the group name, the date and location of the meeting, respondent's attendance, and respondent's level of participation and progress. The facilitator shall report any unexcused absence by respondent from any substance abuse support group meeting to the board, or its designee, within twenty-four (24) hours of the unexcused absence.

13. **Worksite Monitor** – Within thirty (30) calendar days of the effective date of this Decision, respondent shall submit to the board or its designee for prior approval as a worksite monitor, the name and qualifications of one or more licensed physician and surgeon, other licensed health care professional if no physician and surgeon is available, or, as approved by the board or its designee, a person in a position of authority who is capable of monitoring the respondent at work.

The worksite monitor shall not have a current or former financial, personal, or familial relationship with respondent, or any other relationship that could reasonably be expected to compromise the ability of the monitor to render impartial and unbiased reports to the board or its designee. If it is impractical for anyone but respondent's employer to serve as the worksite monitor, this requirement may be

waived by the board or its designee, however, under no circumstances shall respondent's worksite monitor be an employee or supervisee of the licensee.

The worksite monitor should have an active unrestricted license with no disciplinary action within the last five (5) years and shall sign an affirmation that he or she has reviewed the terms and conditions of this Decision and agrees to monitor respondent as set forth by the board or its designee.

Respondent shall pay all worksite monitoring costs.

The worksite monitor shall have face-to-face contact with respondent in the work environment on as frequent a basis as determined by the board or its designee, but not less than once per week; interview other staff in the office regarding respondent's behavior, if requested by the board or its designee; and review respondent's work attendance.

The worksite monitor shall verbally report any suspected substance abuse to the board and respondent's employer or supervisor within one (1) business day of occurrence. If the suspected substance abuse does not occur during the board's normal business hours, the verbal report shall be made to the board or its designee within one (1) hour of the next business day. A written report that includes the date, time and location the suspected abuse; respondent's actions; and any other information deemed important by the worksite monitor shall be submitted to the board or its designee within 48 hours of occurrence.

The worksite monitor shall complete and submit a written report monthly or as directed by the board or its designee which shall include the following: (1) respondent's name and Physician's and Surgeon's Certificate number; (2) the worksite monitor's name and signature; (3) the worksite monitor's license number, if applicable;

(4) the location or location(s) of the worksite; (5) the dates respondent had face-to-face contact with the worksite monitor; (6) the names of worksite staff interviewed, if applicable; (7) a report of respondent's work attendance; (8) any change in respondent's behavior and/or personal habits; and (9) any indicators that can lead to suspected substance abuse by respondent. Respondent shall complete any required consent forms and execute agreements with the approved worksite monitor and the board, or its designee, authorizing the board, or its designee, and worksite monitor to exchange information.

If the worksite monitor resigns or is no longer available, respondent shall within five (5) calendar days of such resignation or unavailability, submit to the board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within fifteen (15) calendar days. If respondent fails to obtain approval of a replacement monitor within sixty (60) calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

14. **Controlled Substances - Abstain From Use** - Respondent shall abstain completely from the personal use or possession of controlled substances as defined in the California Uniform Controlled Substances Act, dangerous drugs as defined by Business and Professions Code section 4022, and any drugs requiring a prescription. This prohibition does not apply to medications lawfully prescribed to respondent by another practitioner for a bona fide illness or condition.

Within 15 calendar days of receiving any lawfully prescribed medications, respondent shall notify the board or its designee of the: issuing practitioner's name, address, and telephone number; medication name, strength, and quantity; and issuing pharmacy name, address, and telephone number.

If respondent has a confirmed positive biological fluid test for any substance (whether or not legally prescribed) and has not reported the use to the board or its designee, respondent shall receive a notification from the board or its designee to immediately cease the practice of medicine. The respondent shall not resume the practice of medicine until the final decision on an accusation and/or a petition to revoke probation is effective. An accusation and/or petition to revoke probation shall be filed by the board within 30 days of the notification to cease practice. If the respondent requests a hearing on the accusation and/or petition to revoke probation, the board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. If the case is heard by an Administrative Law Judge alone, he or she shall forward a Proposed Decision to the board within 15 days of submission of the matter. Within 15 days of receipt by the board of the Administrative Law Judge's proposed decision, the board shall issue its Decision, unless good cause can be shown for the delay. If the case is heard by the board, the board shall issue its decision within 15 days of submission of the case, unless good cause can be shown for the delay. Good cause includes, but is not limited to, non-adoption of the proposed decision, request for reconsideration, remands and other interlocutory orders issued by the board. The cessation of practice shall not apply to the reduction of the probationary time period.

If the board does not file an accusation or petition to revoke probation within 30 days of the issuance of the notification to cease practice or does not provide

respondent with a hearing within 30 days of a such a request, the notification of cease practice shall be dissolved.

15. **Alcohol - Abstain From Use** - Respondent shall abstain completely from the use of products or beverages containing alcohol.

If respondent has a confirmed positive biological fluid test for alcohol, respondent shall receive a notification from the board or its designee to immediately cease the practice of medicine. The respondent shall not resume the practice of medicine until the final decision on an accusation and/or a petition to revoke probation is effective. An accusation and/or petition to revoke probation shall be filed by the board within 30 days of the notification to cease practice. If the respondent requests a hearing on the accusation and/or petition to revoke probation, the board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. If the case is heard by an Administrative Law Judge alone, he or she shall forward a Proposed Decision to the board within 15 days of submission of the matter. Within 15 days of receipt by the board of the Administrative Law Judge's proposed decision, the board shall issue its Decision, unless good cause can be shown for the delay. If the case is heard by the board, the board shall issue its decision within 15 days of submission of the case, unless good cause can be shown for the delay. Good cause includes, but is not limited to, non-adoption of the proposed decision, request for reconsideration, remands and other interlocutory orders issued by the board. The cessation of practice shall not apply to the reduction of the probationary time period.

If the board does not file an accusation or petition to revoke probation within 30 days of the issuance of the notification to cease practice or does not provide

respondent with a hearing within 30 days of a such a request, the notification of cease practice shall be dissolved.

16. **Biological Fluid Testing** - Respondent shall immediately submit to biological fluid testing, at respondent's expense, upon request of the board or its designee. "Biological fluid testing" may include, but is not limited to, urine, blood, breathalyzer, hair follicle testing, or similar drug screening approved by the board or its designee. Prior to practicing medicine, respondent shall contract with a laboratory or service approved in advance by the board or its designee that will conduct random, unannounced, observed, biological fluid testing. The contract shall require results of the tests to be transmitted by the laboratory or service directly to the board or its designee within four hours of the results becoming available. Respondent shall maintain this laboratory or service contract during the period of probation.

A certified copy of any laboratory test result may be received in evidence in any proceedings between the board and respondent.

If respondent fails to cooperate in a random biological fluid testing program within the specified time frame, respondent shall receive a notification from the board or its designee to immediately cease the practice of medicine. The respondent shall not resume the practice of medicine until the final decision on an accusation and/or a petition to revoke probation is effective. An accusation and/or petition to revoke probation shall be filed by the board within 30 days of the notification to cease practice. If the respondent requests a hearing on the accusation and/or petition to revoke probation, the board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. If the case is heard by an Administrative Law Judge alone, he or she shall forward a Proposed Decision to the board within 15 days of submission of the matter. Within 15 days of

receipt by the board of the Administrative Law Judge's proposed decision, the board shall issue its Decision, unless good cause can be shown for the delay. If the case is heard by the board, the board shall issue its decision within 15 days of submission of the case, unless good cause can be shown for the delay. Good cause includes, but is not limited to, non-adoption of the proposed decision, request for reconsideration, remands and other interlocutory orders issued by the board. The cessation of practice shall not apply to the reduction of the probationary time period.

If the board does not file an accusation or petition to revoke probation within 30 days of the issuance of the notification to cease practice or does not provide respondent with a hearing within 30 days of a such a request, the notification of cease practice shall be dissolved.

17. **Psychiatric Evaluation** - Within 30 calendar days of the effective date of this Decision, and on whatever periodic basis thereafter may be required by the board or its designee, respondent shall undergo and complete a psychiatric evaluation (and psychological testing, if deemed necessary) by a board-appointed board certified psychiatrist, who shall consider any information provided by the board or designee and any other information the psychiatrist deems relevant, and shall furnish a written evaluation report to the board or its designee. Psychiatric evaluations conducted prior to the effective date of the Decision shall not be accepted towards the fulfillment of this requirement. Respondent shall pay the cost of all psychiatric evaluations and psychological testing.

Respondent shall comply with all restrictions or conditions recommended by the evaluating psychiatrist within 15 calendar days after being notified by the board or its designee.

18. **Psychotherapy** - Within 60 calendar days of the effective date of this Decision, respondent shall submit to the board or its designee for prior approval the name and qualifications of a California-licensed board-certified psychiatrist or a licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders. Upon approval, respondent shall undergo and continue psychotherapy treatment, including any modifications to the frequency of psychotherapy, until the board or its designee deems that no further psychotherapy is necessary.

The psychotherapist shall consider any information provided by the board or its designee and any other information the psychotherapist deems relevant and shall furnish a written evaluation report to the board or its designee. Respondent shall cooperate in providing the psychotherapist any information and documents that the psychotherapist may deem pertinent.

Respondent shall have the treating psychotherapist submit quarterly status reports to the board or its designee. The board or its designee may require respondent to undergo psychiatric evaluations by a board-appointed board-certified psychiatrist. If, prior to the completion of probation, respondent is found to be mentally unfit to resume the practice of medicine without restrictions, the board shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the board determines that respondent is mentally fit to resume the practice of medicine without restrictions.

Respondent shall pay the cost of all psychotherapy and psychiatric evaluations.

19. **Medical Evaluation and Treatment** - Within 30 calendar days of the effective date of this Decision, and on a periodic basis thereafter as may be required

by the board or its designee, respondent shall undergo a medical evaluation by a board-appointed physician who shall consider any information provided by the board or designee and any other information the evaluating physician deems relevant and shall furnish a medical report to the board or its designee. Respondent shall provide the evaluating physician any information and documentation that the evaluating physician may deem pertinent.

Following the evaluation, respondent shall comply with all restrictions or conditions recommended by the evaluating physician within 15 calendar days after being notified by the board or its designee. If respondent is required by the board or its designee to undergo medical treatment, respondent shall within 30 calendar days of the requirement notice, submit to the board or its designee for prior approval the name and qualifications of a California licensed treating physician of respondent's choice. Upon approval of the treating physician, respondent shall within 15 calendar days undertake medical treatment and shall continue such treatment until further notice from the board or its designee.

The treating physician shall consider any information provided by the board or its designee or any other information the treating physician may deem pertinent prior to commencement of treatment. Respondent shall have the treating physician submit quarterly reports to the board or its designee indicating whether or not the respondent is capable of practicing medicine safely. Respondent shall provide the board or its designee with any and all medical records pertaining to treatment, the board or its designee deems necessary.

If, prior to the completion of probation, respondent is found to be physically incapable of resuming the practice of medicine without restrictions, the board shall retain continuing jurisdiction over respondent's license and the period of probation

shall be extended until the board determines that respondent is physically capable of resuming the practice of medicine without restrictions. Respondent shall pay the cost of the medical evaluation(s) and treatment.

DATE: July 24, 2023

Debra D. Nye-Perkins

DEBRA D.NYE-PERKINS

Administrative Law Judge

Office of Administrative Hearings