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

In the Matter of the Accusation Against: Lawrence Ross Rouben, M.D. Physician's and Surgeon's Certificate No. G 73813 Respondent.	Case No. 800-2021-074705

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 June 20, 2025.

IT IS SO ORDERED May 23, 2025.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, Chair
Panel B

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

In the Matter of the Accusation against:

LAWRENCE ROSS ROUBEN, M.D.

Physician's and Surgeon's Certificate No. G 73813

Respondent.

Agency Case No. 800-2021-074705

OAH No. 2024090594

PROPOSED DECISION

Cindy F. Forman, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference from March 24 through March 26, 2025.

Catherine B. Kim, Deputy Attorney General, represented complainant Reji Varghese, Executive Director of the Medical Board of California (Board), Department of Consumer Affairs.

Benjamin J. Fenton, Esq., and Henry R. Fenton, Esq., represented respondent Lawrence Ross Rouben, M.D., who was present throughout the hearing.

Oral and documentary evidence was received. After the hearing, the ALJ issued a protective order sealing documents identified by the parties and the ALJ from public disclosure. Additionally, the ALJ redacted respondent's personal identifying information from the exhibits.

The record closed and the matter was submitted for decision on March 26, 2025.

EVIDENTIARY ISSUE

At hearing, complainant sought to admit a document titled "Ethical Principles of Psychologists and Code of Conduct" prepared by the American Psychological Association, effective June 1, 2003, with 2010 Amendments, as Exhibit 30. Complainant asserted Exhibit 30, particularly paragraph 9.04, which is titled "Release of Test Data" (pp. A397–A398), was admissible and relevant to support the decision of the Board's expert psychologist to exclude respondent's psychological test scores in her psychological evaluation report. Paragraph 9.04 states a psychologist, pursuant to a patient or client release, shall provide test data to the client, patient, or other individual identified in the release. It also states a psychologist may refrain from releasing test data to "protect a client/patient or others from substantial harm or misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is governed by law." (Exhibit 30, p. A397.)

Respondent objected to the admission of Exhibit 30, contending that because respondent was neither a client nor a patient of the Board expert psychologist, paragraph 9.04 had no bearing on the expert psychologist's obligation to disclose

respondent's underlying test scores. Respondent asserted Exhibit 30 was therefore not relevant and should be excluded.

Respondent's objection is overruled. Respondent correctly notes paragraph 9.04 does not apply to his test scores because respondent was neither a client nor a patient of the expert psychologist. Additionally, any privacy interest respondent might have in such scores could be safeguarded by a protective order. Nonetheless, Exhibit 30 is admitted as evidence of the basis of the expert psychologist's assertion.

SUMMARY OF FINDINGS

The Accusation seeks to discipline respondent's medical license because respondent allegedly used alcohol to an extent dangerous to himself and others when he was arrested for driving under the influence of alcohol (DUI) on February 3, 2020, and respondent allegedly has a mental illness impairing his ability to safely practice medicine.

Complainant demonstrated by clear and convincing evidence respondent drove while intoxicated, potentially causing injury to himself and the public, and respondent's actions constituted unprofessional conduct. Complainant failed to demonstrate respondent's single DUI, in the absence of any other alcohol-related criminal history, prior license discipline, or complaints from employers, patients, and colleagues, represents an alcohol abuse problem that potentially endangers respondent's patients or the public and therefore requires Board monitoring. However, a public reproval is warranted to alert the public and others of the nature and extent of respondent's misconduct.

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Complainant demonstrated by clear and convincing evidence respondent has a mood disorder diagnosis of depression and his depression may have been affected by various psychosocial factors. Complainant failed to prove respondent's depression impairs respondent's ability to safely practice medicine. Complainant presented no evidence respondent is currently depressed, respondent has been remiss in addressing his depression, respondent's past depressive episodes adversely affected his care of patients and his interactions with others, or respondent's mental status has affected his medical practice. In the absence of proof respondent is unsafe to practice medicine, no discipline shall be imposed based on respondent's mood disorder.

FACTUAL FINDINGS

Jurisdictional Matters

1. On April 7, 1992, the Board issued Physician's and Surgeon's Certificate Number G 73813 (license) to respondent. The license is scheduled to expire on April 30, 2026.

2. On January 25, 2024, complainant, in his official capacity, filed the Accusation in this matter. The Accusation alleges respondent engaged in unprofessional conduct and used alcohol in a manner injurious to himself and others on February 3, 2020, when he was arrested for DUI. The Accusation also alleges respondent has a mental illness that impairs his ability to practice medicine safely.

3. On February 8, 2024, respondent filed a timely Notice of Defense requesting a hearing and objecting to the Accusation.

4. All jurisdictional requirements are met.

General Background

5. Respondent is 65 years old. He is married and has an adult child from a previous marriage.

6. Respondent graduated from medical school in 1987. Between 1987 and 1996, respondent completed his internship, residencies in internal medicine, respiratory, critical care and environmental medicine, and fellowships in interventional pulmonary medicine, lung transplantation, and critical care medicine. During this time, respondent also served for more than two years as a lieutenant commander in the U.S. Navy and an assistant medical director in the intensive care unit (ICU) at the Naval Hospital in San Diego. Respondent received an honorable discharge from the U.S. Navy sometime in 1996 or 1997.

7. During various times between 1996 and 2013, respondent worked as an assistant professor in the Division of Pulmonary and Critical Care Medicine, University of Louisville, in private practice, and on a locum tenens basis as an intensivist or pulmonologist at medical facilities throughout the country. In 2013, respondent moved to California and worked as an intensivist and pulmonologist at San Joaquín Hospital in Bakersfield (now known as Adventist Health Bakersfield). He then spent more than a year at Hemet Medical Center and Menifee Global Medical Center working as an intensivist and pulmonologist until early 2020.

8. Respondent started work as an intensivist at Mission Community Hospital (MCH), located in Panorama City, in February 2020, days before the COVID-19 (COVID) surge in California. Soon after the surge began, MCH became a designated COVID surge hospital, and COVID patients inundated the hospital. During the height of the pandemic, respondent lived in a trailer in MCH's parking lot so he could take care of

patients when needed. He treated up to 60 patients a day and worked 18-hour shifts under stressful conditions. Almost all of respondent's patients were on ventilators at some point in their treatment, and many died. According to the colleagues who worked at MCH with respondent during the height of COVID, MCH staff considered respondent a "hero" who was responsible for saving many patients' lives.

9. In 2022, respondent became the MCH's Director of Critical Care, and he currently heads MCH's ICU. Respondent is also the principal COVID doctor at MCH. Respondent has no private patients, and he sees between six and 10 patients a day in the ICU. Respondent supervises interns and residents who rotate through the ICU as well as two physician assistants.

10. Respondent obtained his board certification in internal medicine in 2000 and critical medicine and pulmonary medicine in 2006. Respondent's internal medicine and pulmonary medicine certifications lapsed in 2016. Respondent's critical medicine certification lapsed in 2024, and respondent intends to take the examination necessary to renew that certification.

11. In addition to his California medical license, respondent has held medical licenses in Colorado, Indiana, Kentucky, Ohio, and Washington. All the licenses except for California have either expired or lapsed. Respondent's license has never been disciplined by the Board or by any other state agency where he has been licensed.

12. Respondent has never been dropped by a malpractice carrier or had any civil or malpractice case filed against him. Respondent has never been investigated by a governmental agency. There is no evidence of any patient complaint against respondent regarding his medical care.

The Initial Complaint and Investigation

13. The Accusation was triggered by respondent's February 3, 2020 DUI as well as an anonymous complaint filed with the Board on January 28, 2021. The anonymous complaint accused respondent of being temperamental, drinking heavily, appearing intoxicated at work, and showing no regard for human life. The complaint also claimed respondent had ongoing domestic violence issues in court and an extensive criminal history which caused the anonymous individual who filed the complaint to be concerned for the safety of his patients. (Exhibit 6.)

14. The Board referred both the 2020 DUI arrest and the anonymous complaint to the Division of Investigation (DOI). As part of the DOI investigation, the assigned DOI investigator obtained reports from the Department of Justice's Controlled Substance Utilization Review and Evaluation System (CURES) for respondent for the January 28, 2020, through January 28, 2021, and May 9, 2021, through May 9, 2022 periods. The CURES reports for these periods showed respondent was not prescribed controlled substances during these times. (Exhibit 7.) CURES reports of respondent's prescriptions for patients during the January 28, 2020, through January 28, 2021 period were likewise unremarkable. (Exhibit 8.)

Respondent's Arrest

15. On February 3, 2020, California Highway Patrol (CHP) Officer Chris Wymore arrested respondent for domestic violence battery in violation of Penal Code section 243, subdivision (e)(1), DUI in violation of Vehicle Code section 23152, subdivision (a), and DUI with a blood alcohol content (BAC) of 0.08 percent or above in violation of Vehicle Code section 23152, subdivision (b). Respondent was not convicted of any crimes stemming from the arrest. The District Attorney did not charge

respondent with DUI based on the arrest, and the court dismissed the domestic violence charge.

16. The facts and circumstances surrounding respondent's arrest are described in a police report (Exhibit 9) and were confirmed by Officer Wymore's testimony at hearing. On the morning of February 3, 2020, which was respondent's day off, respondent and his wife started to drive from their home in Bakersfield to Los Angeles. Respondent initially drove the vehicle, after his wife refused to do so. It was estimated respondent drove the vehicle 40 miles. After respondent complained of fatigue, respondent's wife began driving. Respondent and his wife argued while she was driving. At some point, respondent's wife stopped the car on the highway and walked away from the vehicle. A truck driver picked up respondent's wife, and at approximately 9:45 a.m., the driver reported a potential domestic violence incident to CHP.

17. After receiving the domestic violence report, Officer Wymore located respondent's vehicle, and he observed respondent exiting from the passenger side of the vehicle. After Officer Wymore requested respondent to approach the patrol vehicle, Officer Wymore observed respondent walking unsteadily. When speaking with respondent, Officer Wymore observed other signs of intoxication. Officer Wymore administered several field sobriety tests, all of which respondent failed. Respondent agreed to a breathalyzer test, which at 11:13 a.m. and 11:16 a.m., showed a BAC of 0.138 and 0.145, respectively.

18. During their interaction, Officer Wymore informed respondent of the domestic violence report CHP received. Respondent told Officer Wymore that he had been driving the vehicle earlier, but his wife then started driving. He and his wife then argued because she did not want to drive. Respondent denied engaging in any

physical fight with his wife while she drove. Respondent admitted to Officer Wymore that he drank approximately a third of a fifth of bourbon the night before, stopping at about two or three in the morning. Respondent also told Officer Wymore that he had not drunk any alcohol the morning before he and his wife left their home. He further informed Officer Wymore that he had been under the care of a psychiatrist, and he had taken Effexor and Abilify in the morning before starting driving.

19. Officer Wymore interviewed respondent's wife that same morning after another CHP Officer located her. Respondent's wife confirmed respondent initially wanted her to drive to Los Angeles, but she did not want to, and they fought about it. Respondent then drove the vehicle to a highway rest area, at which point respondent's wife started driving. Respondent's wife accused respondent of hitting her on the right side of her neck with his hand and grabbing the steering wheel at least twice while she was driving. Because of respondent's behavior, respondent's wife pulled the vehicle over to the highway shoulder and attempted to exit the car. Respondent's wife told the police that respondent tried to stop her and "inadvertently" struck her in the forehead. Respondent's wife did not want medical attention. She confirmed respondent had drunk heavily the night before.

20. Respondent's wife did not speak to the Board investigator and did not testify at hearing. Her statements to the police regarding the February 3 incident are admissible as administrative hearsay to explain and supplement respondent's testimony and the police officers' observations; however, other statements she made to the police regarding respondent and their relationship are inadmissible either as non-expert opinion or hearsay because the statements do not supplement or explain any direct testimony. (Gov. Code, § 11513.)

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Respondent's Board Interview

21. Respondent was interviewed by two DOI investigators and a District Medical Consultant (collectively, Board interviewers) on May 10, 2022. The pertinent parts of the interview are described below.

22. During his interview, respondent did not disclose he was taking any psychotropic medication. (Exhibit 11, p. A96.) He also denied ever receiving psychiatric care. (*Id.*, p. A97.)

23. During his interview, respondent explained the circumstances of his February 3, 2020 arrest. Respondent disclosed he drank half a bottle of bourbon the night before he was arrested. Respondent described himself when he left the house as drowsy, but not drunk. Respondent denied driving his vehicle the morning of his arrest. (Exhibit 11, p. A139.) Respondent further denied making physical contact with his wife or pulling the steering wheel. Respondent refused to discuss the nature of the argument he had with his wife in the vehicle based on his wife's privacy concerns. Respondent, however, reported that while his wife was driving, they had fought over the phone, and the phone had slipped and hit her head. (*Id.*, p. A142.) Respondent asserted he learned "significant lessons" from the incident, including about excessive alcohol use, and made "big changes in his life." (*Id.*, p. 152.) According to respondent, the incident "strengthened" his marriage as well as his and his wife's "love for each other." (*Ibid.*)

24. Respondent disclosed during the interview his criminal conviction in 2010 in Louisville, Kentucky for menacing, a misdemeanor. Respondent stated he did not pay any fines or serve any jail time for the criminal conviction. (Exhibit 11, pp. A90–A91.) Respondent described the incident as follows: Sometime in 2010, a utility man

came to his home to turn off the gas in his home. Respondent was in bankruptcy at the time, and he could not pay his bills. Respondent answered the door with a holstered gun. Respondent denied pointing or brandishing the gun at the utility man. He also denied verbally threatening the utility man. (*Id.*, p. A128–A129.)

25. Respondent provided his employment history to the Board interviewers. Respondent disclosed to the Board interviewers that in 2010 he chose to resign his hospital privileges at Jewish Hospital in Louisville Kentucky, after the hospital administrators reported him to the National Practitioner Data Bank as a "disruptive" doctor and indicated they were not going to renew his privileges. Respondent explained the hospital had limited its ICU to only two ICU providers, and excluded three other ICU providers, including him. To access his patients in the ICU, respondent worked around the hospital's policy. Respondent began working as a hospitalist so he could follow his patients into the ICU as a consultant for another intensivist. The hospital administrators were upset when they learned of the practice, and according to respondent, the situation became "nasty." (Exhibit 11, p. A126.)

26. During the interview, respondent described his temperament and demeanor at work. Respondent noted there had been times when he engaged in "heated" discussions with other physicians over critical care decisions in the ICU and he involved the chief of staff to assist in a resolution. (Exhibit 11, p. A114.) Respondent explained he felt "very strongly" about his medical practice, the quality of his practice, and running the ICU, and when there was a conflict over care, he was "strong-worded and very determined in [his] decision-making process." (*Id.*, p. A115.) Respondent further explained that when he disagreed with another physician, he would usually text them, and if that was not sufficient, he would have a conversation, and if they could

not resolve the issue, he would invite the chief of medical staff to settle the conflict. (*Id.*, p. A.117.)

27. Respondent described his interactions with patients and their families as "very pleasant." (Exhibit 11, p. A119.) Respondent told the Board interviewers he was truthful with his patients and was also careful to make sure he and his nurses were consistent with what they told families. Respondent stated he showed empathy, sympathy, and compassion to his patients while being honest about their condition. Respondent noted one instance during the first peak of the COVID pandemic in which someone at the hospital reported he had not provided ACLS care to a COVID patient who arrested. Respondent explained he did not do so because he considered further care futile and the additional COVID exposure a danger to his staff. (*Id.*, p. A131.) After that incident, respondent allowed the emergency department physician to tell hospital staff to cease resuscitation efforts for an arrested COVID patient.

28. Respondent told the interviewers that he drank alcohol socially approximately once a week, during which time he had two drinks of bourbon or vodka. Respondent also stated he had never been treated for an alcohol-related problem, participated in an addiction program, or received treatment for drug dependency. (Exhibit 11, p. A98–A99.) Respondent denied ever being under the influence of any alcohol, drug, or medication while working or when on-call. (*Id.*, pp. A120, A122.) Respondent also denied being told he drinks heavily. (*Id.*, p. A129.) Respondent denied using alcohol to relieve stress. (*Id.*, p. A149.)

29. At the end of his interview, respondent refused to participate in a voluntary mental or physical examination. On September 11, 2023, the Board issued an order under Business and Professions Code section 820 compelling respondent to submit to biological testing to determine the presence of alcohol, or scheduled or

illicit drugs, a mental examination and psychological testing, and a physical examination. (Exhibit 16.) (All further statutory references are to the Business and Professions Code unless otherwise stated.)

Evaluations of Respondent

URINE SAMPLE

30. Pursuant to the section 820 order, respondent submitted a urine sample on Wednesday, October 18, 2023, for analysis by Phamatech Laboratories. The urine sample tested positive for ethyl glucuronide (ETG), ethyl sulfate (ETS), and marijuana metabolites. The sample was negative for ethanol, amphetamines, MDMA, barbiturates, benzodiazepines, cocaine, methadone, methaqualone, opiates, PCP, propoxyphene, and dextromethorphan. (Exhibit 18.) According to the Board's expert Timothy Botello, M.D., M.P.H., who is board-certified in addiction psychiatry, the presence of ETG and ETS indicate respondent ingested alcohol sometime in the 3.5 days before the test. Dr. Botello also stated a positive test result for marijuana metabolites does not indicate when respondent used marijuana because marijuana can be detected in the urine one to three days after casual use. A positive marijuana result from passive exposure could also be observed following extremely high passive exposure. (Exhibit 20, p. A203.) It therefore was not known from the test results when respondent last used alcohol, or last used or was exposed to marijuana, before submitting the sample.

PHYSICAL EXAMINATION

31. Respondent submitted to a physical examination by Dr. Aric Gregson on October 26, 2023. The parties did not offer the findings of that physical examination into evidence. However, according to the DOI's Supplemental Investigation Report 2,

Dr. Gregson found respondent was physically capable of practicing medicine safely, and he did not find any evidence of physical impairment. (Exhibit 15, pp. A163, A165.)

PSYCHIATRIC EVALUATION

32. Respondent submitted to a psychiatric evaluation by Timothy Botello, M.D., M.P.H., on October 18, 2023. Dr. Botello obtained his medical degree in 1979, was licensed to practice in California in 1980, and has been board certified in psychiatry since 1985. Dr. Botello also has specialty certifications in forensic psychiatry since 1994, geriatric psychiatry since 1995, and addiction psychiatry since 1997. Dr. Botello is currently the Emeritus Professor of Psychiatry at the Keck School of Medicine Department of Psychiatry. Dr. Botello previously was an attending psychiatrist at the LAC+USC Psychiatric Hospital for 38 years and was the Medical Director of the USC Institute of Psychiatry and Law for 37 years. Dr. Botello still sees patients and has been a Board expert since 1988.

33. Dr. Botello conducted his examination of respondent remotely via Zoom. The examination lasted approximately two hours. Additionally, as part of his evaluation, Dr. Botello reviewed and considered the 2021 anonymous complaint against respondent, the CURES reports, police reports of respondent's February 3, 2020 arrest, the transcript of respondent's interview with the Board on May 10, 2022, the DOI investigation reports, and respondent's urine test results. Dr. Botello memorialized his findings in a report dated November 1, 2023. (Exhibit 20.) Dr. Botello's testimony was consistent with his report.

34. Dr. Botello reviewed respondent's mental health history in his interview with respondent. Respondent was treated for Attention Deficit Hyperactivity Disorder and prescribed Adderall while in medical school. In 2002, while experiencing marital

difficulties, respondent sought treatment with a psychiatrist, who respondent continued to see every two months for about 10 years until 2012 or 2013. The psychiatrist prescribed Wellbutrin and other antidepressant medications.

35. In 2019, respondent sought treatment from a new psychiatrist in California who prescribed him Abilify and Effexor. Respondent stopped seeing that psychiatrist when he moved to Los Angeles. Currently, respondent's primary care physician continues to prescribe Abilify and Effexor to respondent. According to Dr. Botello, Effexor is an antidepressant medication and Abilify is an antipsychotic medication used to treat schizophrenia and bipolar disorder, and is also an add-on medication, along with an antidepressant medication, to treat Major Depression. (Exhibit 20, p. A194.) Respondent does not participate in psychotherapy.

36. Respondent reported to Dr. Botello that he has done well with Effexor and Abilify, which at the time of Dr. Botello's interview, respondent had taken for at least five years. Respondent told Dr. Botello that he becomes more irritable and less patient when he fails to take his psychotropic medication. However, respondent also noted the last time he had lost his temper was two and a half years ago. Respondent also reported the positive effect exercise has on his mood.

37. Respondent's statements to Dr. Botello about his 2020 arrest and 2010 conviction were similar to those he made in the Board interview. When asked about his February 2020 arrest, respondent told Dr. Botello "he was not driving," (Exhibit 20, p. A197), although it was unclear whether respondent was referring to the time he was arrested or any time that morning. Respondent added more detail to his 2010 arrest in Kentucky, disclosing he answered the door with a holstered gun the second time the utility man came to the door; the first time respondent answered the door, he told the utility man he had the wrong house. (*Ibid.*)

38. Respondent discussed with Dr. Botello the incident at Jewish Hospital in 2010, which he disclosed to the Board interviewers, and another incident at San Joaquin Community Hospital in 2018, which was not discussed in his Board interview. Regarding the Jewish Hospital incident, respondent told Dr. Botello he engaged in "heated" arguments with the Chief Medical Officer, and he was referred to the Hospital's Physician Well-Being Committee, which found no adverse behavior. Regarding the San Joaquin Hospital incident, respondent explained after he worked there for five years, a nurse accused him of making inappropriate sexual innuendoes. The Medical Executive Committee cleared him, but he decided to leave the hospital because it was no longer a good working environment.

39. Respondent shared his history of alcohol and marijuana use with Dr. Botello. Respondent told Dr. Botella that he drank alcohol about one to two times a week consisting of wine or mixed drinks. He also told Dr. Botella he drank the quantity of alcohol leading to his DUI about once every three months. Respondent denied regular use of marijuana.

40. Dr. Botello's mental status examination found respondent to be appropriately groomed, alert and oriented to time, person, and circumstances, and with a calm and relaxed demeanor. Respondent was cooperative with the examination. Respondent's short-term memory was intact, and his long-term memory appeared normal. His thought process was rational and coherent. Respondent denied any symptoms of psychosis, denied any suicide attempts and suicidal ideation, and denied thoughts of wanting to harm anyone. Dr. Botello found respondent's insight into his mental health problems was fair.

41. Based on his interview and record review, Dr. Botello concluded respondent was impaired due to his diagnosis of Major Depression, Recurrent, which

was exacerbated by psychosocial factors. Those psychosocial factors included intermittent binge drinking of alcohol particularly when done in combination with taking Abilify, the stress of the COVID pandemic and respondent's intensive care treatment of many COVID ICU patients; financial stressors; marital difficulties with his current wife as outlined in the February 2, 2020 police report; and interpersonal difficulties while respondent was working at Jewish Hospital in 2010 and at San Joaquin Hospital in 2018.

42. Dr. Botello opined respondent's depression required monitoring because it could flare up intermittently and impact respondent's medical practice by adversely affecting his relationships with his colleagues. Dr. Botello testified respondent had a way of interacting with other health professionals that made them feel uncomfortable and often engaged in fights and arguments with those colleagues.

43. Dr. Botello cited a Joint Commission Sentinel Event Alert 40 (Alert) issued in 2008 to support his opinion. (Exhibit 21.) According to that Alert, intimidating and disruptive behaviors by healthcare professionals can foster medical errors, contribute to poor patient satisfaction and preventable adverse outcomes, increase the cost of care, and cause qualified healthcare personnel to seek new positions in more professional environments. The Alert identified intimidating and disruptive behaviors as overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities, as evidenced by reluctantly or refusing to answer questions, return phone calls or pages; using condescending language or voice intonation; and exhibiting impatience with questions. The Alert maintained such behaviors undermined team effectiveness and could compromise patient safety. (*Id.*, p. A209.)

44. Dr. Botello also noted respondent's intermittent binge drinking made respondent's depression worse. He did not conclude respondent suffered from an alcohol use disorder.

PSYCHOLOGICAL EVALUATION

45. On November 23, 2023, Lorainne E. Cuadra, Ph.D., performed a psychological evaluation of respondent. She memorialized her findings in a report to the Board dated December 11, 2023. (Exhibit 24.) Her testimony at hearing was consistent with the findings in her report.

46. Dr. Cuadra has been a Board-licensed psychologist since 2012. She is currently the Director of the Institute of Psychiatry, Law, and Behavioral Science at LA Hospital and a clinical assistant professor in the University of Southern California psychology department. Dr. Cuadra also has been a forensic evaluator since 2017. Dr. Cuadra maintains a separate independent clinical practice in which she conducts psychological assessments. Dr. Cuadra has provided expert services and performed fitness for duty evaluations for the Board since July 2017.

47. Dr. Cuadra evaluated respondent on November 11, 2023, for a total of approximately 3.5 hours. Her report does not indicate whether the evaluation was in person or done remotely. The purpose of Dr. Cuadra's evaluation was to determine whether respondent had a psychological condition that could interfere with his ability to safely practice medicine.

48. Dr. Cuadra reviewed respondent's social history, educational and employment history, legal history, medical history, and mental health history during her evaluation. Respondent's answers to Dr. Cuadra's inquiries were generally consistent with his statements in his Board interview except concerning his psychiatric

history. As he disclosed to Dr. Botello, respondent told Dr. Cuadra that he had a history of receiving psychiatric treatment, and had been prescribed and was then taking Abilify and Effexor for his "mood" based on his psychiatrist's belief he was depressed. (Exhibit 24, p. A245.) Respondent likewise reported he becomes irritable when is he not on the medications and that is why he does not stop taking them. (*Id.*, p. A247.) He told Dr. Cuadra there had been occasions when he ran out of medication for a day to two, but that the last time he had not taken his psychotropic medications was a year before the interview. (*Id.*, p. A246.)

49. Regarding respondent's substance use history, respondent told Dr. Cuadra, that he did not drink alcohol regularly, but he had his "binge moments," with the last time being at least a year before the interview. (Exhibit 24, p. 245.) Respondent indicated his past instances of binge drinking consisted of having "four to five . . . standard drinks" of bourbon or vodka. (*Ibid.*) Respondent also told Dr. Cuadra he last smoked marijuana around mid-October 2023. (*Ibid.*)

50. Respondent told Dr. Cuadra about his 2010 criminal conviction, the 2010 incident at Jewish Hospital, and the 2018 incident at San Joaquin Hospital, consistent with what he told Dr. Botello. Respondent also told Dr. Cuadra that since his experience with Jewish Hospital, respondent has learned to not engage with difficult people. Respondent has a support network at work that he relies on to help guide him and to keep matters calm and rational. Respondent denied having many problems working with his staff and acknowledged that when he did, he learned to admit his wrongs and make amends. Respondent further told Dr. Cuadra that he is polite to his colleagues even if they do not agree on everything because they must work together. (Exhibit 24, p. A127.)

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51. Dr. Cuadra noted in her report respondent denied experiencing symptoms of clinical depression. Respondent told Dr. Cuadra he felt good, he enjoyed the medicine he practiced, and his relationships with his wife and work colleagues were going well. Respondent also acknowledged that during the beginning of the COVID-19 pandemic, he felt numb given the traumatic events he witnessed, and was "very direct and very blunt" about his patients' prognoses. (Exhibit 24, p. A246.)

52. Dr. Cuadra observed respondent maintained adequate eye contact, had clear speech, and spoke at a normative rate. She further observed respondent readily answered questions she posed, although at times he was a vague historian. Dr. Cuadra found respondent to be calm, polite, cooperative, attentive, and coherent. According to Dr. Cuadra, respondent did not present with or endorse past or current symptoms indicative of a thought disorder or endorse a history of thoughts of harming himself or others, suicide attempts, or engaging in self-injurious behaviors. (Exhibit 24, p. A246.)

53. Dr. Cuadra administered the Minnesota Multiphasic Personality Inventory – 2 Restructured Form (MMPI-2 RF) and the Personality Assessment Inventory (PAI) tests to respondent. Dr. Cuadra did not report respondent's scores for these tests because she believed it was contrary to ethical principles for her to do so. (Exhibit 30.) Dr. Cuadra found, "Overall [respondent's] responses on the MMPI-2 RF suggest that he is not experiencing clinically significant somatic, cognitive, emotional, thought, behavioral, or interpersonal problems." (Exhibit 24, p. A247.) Regarding the PAI, Dr. Cuadra found that the results likely reflect a minimization of difficulties in certain areas. However, respondent's PAI clinical profile results suggested "no indications of psychopathology across the clinical scales." (*Id.*, p. A248.)

54. Based on her review of the records, her interview with respondent, and her review of respondent's test scores, Dr. Cuadra concluded respondent exhibited

narcissistic personality disorder traits based on his grandiose sense of self and arrogance, his appearance of getting easily frustrated when he did not receive expected praise, and his display of an entitled attitude. Dr. Cuadra also opined respondent has a mood disorder, such as depressive disorder based on his depression diagnosis, his taking of antidepressants, and his experience of irritability and hypersomnia when he does not take his antidepressant medication. Dr. Cuadra concluded respondent was at risk for a depressive episode given the many years he was treated for depression and his continued care for acutely and/or chronically ill patients in the ICU. (Exhibit 24, p. A249.)

55. Dr. Cuadra did not find respondent had a substance use disorder. However, she did not rule it out because of respondent's DUI, the anonymous complaint regarding respondent's drinking, and his history of marijuana use. She also noted respondent did not "appear to be experiencing clinically significant mental health symptoms, which is likely due to him taking his prescribed psychotropic medications and possibly limiting his use of alcohol and/or marijuana." (Exhibit 24, pp. A249-A250.)

56. Dr. Cuadra found respondent did not have a physical illness that would impair his ability to safely practice medicine. However, Dr. Cuadra opined respondent was unable to safely practice without monitoring and supervision because of his depressive mood disorder. Dr. Cuadra asserted respondent's DUI and 2010 criminal conviction, his personality disorders negatively affecting his occupational functioning, and instances of noncompliance with prescribed psychotropic medications, could impact his decision making in his practice of medicine. For the same reasons, Dr. Cuadra found if respondent's practice of medicine was not monitored or supervised, there was "a risk he may pose a potential danger or threat to the public health,

welfare, and safety of others." (Exhibit 24, p. A250.) Dr. Cuadra also found respondent's personality and mental conditions required monitoring, treatment, oversight, or other terms as recommended by the Board to ensure respondent's safe medical practice because respondent appeared to minimize or censor some information. (*Id.*, pp. A250–A251.)

Respondent's Case

RESPONDENT'S TESTIMONY

57. Respondent's testimony at hearing largely mirrored his statements to the Board interviewers, Dr. Cuadra, and Dr. Botello. However, at hearing, respondent admitted he drove his vehicle the morning of February 3, 2020, and that his denial to the Board interviewers of driving the vehicle on that date while intoxicated was false. Respondent acknowledged it was wrong to lie to the Board interviewers, but he could not explain why he had done so. According to respondent, he had drunk late into the early morning of February 3. Respondent agreed to drive because his wife refused to do so. Respondent initially did not feel drunk when he started to drive, but soon realized "he was not in a good position to continue driving" and asked his wife to take over. Although his wife did not want to do so, they eventually switched positions so she could drive. However, soon thereafter, he and his wife started arguing, and his wife pulled off the road and left the vehicle.

58. Respondent testified he changed his drinking habits after his February 2020 arrest. Respondent asserted he no longer binge drinks because it is unhealthy to do so. Respondent has limited his alcohol intake to one or two drinks on the weekend when he is not on call. He uses marijuana approximately once a month. As of the date

of the hearing, respondent last drank alcohol two to three weeks earlier, and last used marijuana six weeks earlier.

59. Respondent also acknowledged he was not fully candid with the Board examiners when he failed to disclose his use of psychotropic medications and his past psychiatric treatment. He again was unable to explain his omissions. Respondent still takes Abilify and Effexor daily for his depression and his primary care physician, who sees respondent approximately every two months, is responsible for prescribing the medication. Respondent acknowledged being diagnosed with depression, but he asserted he was not currently depressed, and he functioned well because of the medication.

60. Respondent did not know who filed the anonymous complaint with the Board. He was aware his hiring at MCH displaced several pulmonologists who were unhappy with their loss of income and knew of at least one pulmonologist who complained to the MCH Chief Medical Officer regarding the impact of respondent's hiring on the pulmonologist's finances. Respondent was also aware of a false rumor that he was intoxicated at the hospital. According to respondent, he offered to get tested, but MCH decided not to do so.

61. Respondent expressed remorse for his lack of candor with the Board, his use of a handgun, and his decision to drive after drinking. He acknowledged these decisions reflected poor judgment. Respondent maintained, however, that he has made changes in his interactions with others. Although respondent may have "heated" discussions with doctors regarding disagreements over patient care, the discussions are in normal tones, and when they cannot be resolved, respondent contacts the Chief Medical Officer to help resolve the issue. Outside a few instances, respondent reported he has a pleasant and collegial relationship with his colleagues.

62. Respondent enjoys working at MCH. He described his experience as "wonderful" and believes MCH has been "very supportive" of his practice. Respondent is proud of the significant improvements he has made in MCH's critical care delivery and protocols.

TESTIMONY BY MCH COLLEAGUES

Glenn Marshak, M.D.

63. Glenn Marshak, M.D., has been a licensed physician in California for more than 20 years. He is board-certified in internal medicine, a member of the faculty of the University of Southern California, and president of hospital operations and medical affairs at MCH. As MCH president, Dr. Marshak oversees the executive team and is also a member of the MCH Board of Governors. Dr. Marshak does not socialize with respondent outside of work. Dr. Marshak considers respondent to be an "active and integral part" (his words) of MCH's ICU and pulmonary practice. Dr. Marshak praised respondent's work ethic, which Dr. Marshak believed was unparalleled to anyone at the hospital during the COVID pandemic.

64. Although Dr. Marshak does not practice at MCH or work directly with respondent, Dr. Marshak has direct knowledge of respondent's practice and bedside manner because respondent has taken care of Dr. Marshak's mother, his niece, his sister-in-law, and multiple other family members. Dr. Marshak testified respondent provided "great care" to each member of his family.

65. Dr. Marshak has never observed respondent intoxicated while working at MCH. Dr. Marshak also was not aware of any patient complaints about respondent's care or bedside manner. Respondent never had an adverse finding from any MCH medical committee regarding his practice. Dr. Marshak and MCH were aware of

respondent's Kentucky criminal conviction, but MCH hired respondent because it deemed the conviction insignificant.

James Emory Burrows, M.D.

66. James Emory Burrows, M.D. has practiced internal and pulmonary medicine since July 1999, and he has been respondent's supervisor at MCH since March or April 2020. Dr. Burrows does not have a social relationship with respondent.

67. Dr. Burrows sees respondent at MCH every day. He described respondent as "delightful" and a "hero of the medical staff since COVID." According to Dr. Burrows, MCH would not have survived COVID without respondent's help. He explained respondent came into MCH every day for more than a year to treat COVID patients.

68. Dr. Burrows reviews respondent's work as a supervisor, but Dr. Burrows is also directly involved with respondent's patients after they leave the ICU and move to a hospital floor as an MCH pulmonologist and internal medicine physician. Dr. Burrows described respondent's care, both clinically and qualitatively, as "excellent" and maintained respondent is functioning at the "highest level." Dr. Burrows has never observed respondent be rude to or yell at MCH staff. According to Dr. Burrows, respondent has an "even temperament." Dr. Burrows described respondent's communication style as "a straight arrow approach" and found respondent to be "intensely connected" to his patients. Dr. Burrows has never seen respondent come to work intoxicated and never observed respondent exhibit any psychological issues. As a member of the MCH Peer Review Committee and the vice chief of staff, Dr. Burrows would be aware of any problem with respondent, and none has come to his attention.

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Dianna Cook, R.N.

69. Dianna Cook, R.N., has been a nurse for more than 20 years and currently works as the Director of the MCH ICU. RN Cook and respondent have worked in the ICU together for five years. RN Cook sees respondent every day, and they interact while taking care of patients, at bedside, and in working with the ICU nurses. RN Cook does not socialize with respondent.

70. RN Cook described respondent as "very professional." RN Cook has never seen respondent intoxicated or impaired at work. RN Cook has not observed respondent to be rude or lose his temper. RN Cook was unaware of anyone lodging complaints against respondent. RN Cook has also never seen respondent have strong disagreements with hospital staff.

Christopher Ng, M.D.

71. Christopher Ng, M.D., has been practicing medicine for 40 years. He has been on the medical staff at MCH since 2008. He is board certified in internal medicine, and he is the site director for the MCH Emergency Department. Dr. Ng has worked on almost a daily basis with respondent since March of 2020. Dr. Ng has been at bedside with respondent, involved in patient transfers between the Emergency Department and ICU, and he and respondent have supported each other in critical care cases. He does not socialize with respondent.

72. According to Dr. Ng, without respondent's presence, expertise, and medical interventions over the last five years at MCH, a "lot more people would have died." Dr. Ng has the "greatest trust and respect" for respondent and considers him to be an "exceptional physician." He has never observed respondent intoxicated or mentally impaired at work. Dr. Ng described respondent as "diligent, competent, and

attentive" and characterized respondent's bedside manner as "caring." As Chair of the MCH Peer Review Committee, Dr. Ng is not aware of any peer review cases involving respondent or any complaints lodged against respondent.

EXPERT TESTIMONY

73. Samuel I. Miles, M.D., Ph.D., testified as an expert on respondent's behalf. Dr. Miles is board-certified by the American Board of Psychiatry and Neurology in general psychiatry, forensic psychiatry, and addiction psychiatry. He has practiced medicine for over 50 years. Dr. Miles has had a private psychiatry practice since 1978 and has been an associate clinical professor of psychiatry at the David Geffen School of Medicine at UCLA since 1998. Dr. Miles also is an attending psychiatrist at Cedars-Sinai Medical Center, where he has served on the Committee on Well Being of Physicians since 1996.

74. Dr. Miles did not personally examine respondent, but he reviewed the evaluations by Dr. Botello, Dr. Cuadra, and Dr. Gregson as well as the CHP report, the transcript of respondent's interview with the Board, the Phamatech Laboratory drug test report, and various investigation reports and emails relating to the case. Dr. Miles prepared a report of his findings dated December 21, 2024 (exhibit A), and his testimony at the hearing was consistent with his report.

75. Dr. Miles agreed with Dr. Botello's assessment respondent most probably suffers from recurrent major depression, which at times, has been exacerbated by intermittent binge drinking of alcohol, his ICU responsibilities during the COVID pandemic, financial stressors, and interpersonal difficulties. However, Dr. Miles did not find any evidence respondent's depression affected respondent's competency to

practice medicine. Dr. Miles asserted respondent's steady doses of Abilify and Effexor have alleviated respondent's depression symptoms.

76. Dr. Miles criticized Dr. Cuadra's report as incomplete because it did not include the test scores underlying Dr. Cuadra's opinions. Accordingly, Dr. Miles had no means to assess Dr. Cuadra's conclusions regarding the quality of respondent's answers and his personality traits. In any event, Dr. Miles found Dr. Cuadra's assertion that respondent exhibits narcissistic personality traits unremarkable since such traits are common in hospital-based physicians. He agreed with Dr. Cuadra's opinion that respondent had a mood disorder but believed respondent appropriately treated the disorder. Dr. Miles disagreed with Dr. Cuadra's opinion that respondent should submit to monitoring or supervision of his practice because there was no evidence that respondent's functioning as a physician was impaired.

Analysis

RESPONDENT'S ALLEGED EXCESSIVE DRINKING

77. Respondent admitted at hearing that he drove his vehicle while intoxicated. However, respondent denied having an alcohol abuse problem. He denied drinking alcohol or being inebriated at work. He testified he no longer binge drinks and has limited his alcohol intake since his arrest. Respondent further testified he has limited his alcohol intake to one or two drinks on the weekend when he is not on call.

78. Complainant questioned the truthfulness of respondent's testimony regarding his drinking habits, asserting respondent's credibility was undermined by his misrepresentations and omissions at his Board interview, specifically his denial of driving on the day of his arrest and his failure to disclose his past psychiatric treatment

and his use of psychotropic medication. Complainant also asserted respondent would testify to anything to save himself from Board monitoring.

79. Respondent presented at hearing as a respectful, non-defensive, and candid physician dedicated to his work and the welfare of his patients. However, respondent's prior refusal to acknowledge to Board investigators he drove his vehicle while intoxicated on February 3 undermined his credibility. Respondent offered no explanation for his misrepresentation, although he acknowledged his failure to be truthful. Respondent also failed to explain his omissions regarding his past psychiatric care, although respondent was fully cooperative and candid about such care in the two subsequent interviews by Dr. Botello and Dr. Cuadra and at hearing.

80. That respondent was consistently self-serving was unproven. During his Board interview and the interviews by complainant's experts, respondent willingly disclosed and discussed issues that placed him in a poor light. Those included his Kentucky criminal conviction, the disruptive doctor incident at Jewish Hospital, and the sexual harassment report at San Joaquín Hospital. Respondent also readily discussed his disputes with other doctors. Respondent further disclosed his past binge drinking and his marijuana use. Although respondent's recollections of his past drinking habits varied somewhat, he never denied such use.

81. However, even without respondent's testimony, there was insufficient evidence to establish respondent was an alcohol-abusing physician under California Code of Regulations, title 16, section 1361.5 based on his single DUI arrest. None of the physicians or the psychologist who examined respondent diagnosed him with an alcohol abuse disorder. Respondent has never been hospitalized for alcohol-related issues. Outside of his February 3 arrest, respondent has never been arrested or convicted of any alcohol-related offense. None of respondent's witnesses were aware

of any complaints regarding respondent's alcohol use. Respondent's MCH colleagues who work with him closely every day never observed him intoxicated at work or perform in a subpar manner consistent with alcohol abuse, even while respondent was working 18-hour days and seeing 60 patients a day during the height of the COVID epidemic. Such conduct is inconsistent with alcohol abuse.

RESPONDENT'S ALLEGED MENTAL IMPAIRMENT

82. Complainant failed to present sufficient evidence to establish respondent had a mental illness that impaired his ability to practice medicine safely. Dr. Miles's opinion that respondent is safe to practice medicine without monitoring was more persuasive than the contrary opinions of Dr. Botello and Dr. Cuadra.

83. Neither Dr. Botello nor Dr. Cuadra found respondent was depressed at the time of their evaluations. Nor did they find respondent presented with any thought or behavior irregularities or cognitive difficulties. Nonetheless, both Dr. Botello and Dr. Cuadra opined respondent's depression might recur without monitoring and supervision considering the presence of several psychosocial factors, and both experts further opined that if the depression did flare up again, respondent's ability to safely practice medicine would be impaired.

84. The opinions of complainant's experts were not well-founded. Most of the psychosocial factors they cited are no longer present or remote in time. For instance, respondent's sole criminal conviction occurred 15 years ago. There is no evidence the emotional trauma respondent experienced taking care of COVID patients during the surge four to five years ago has persisted. Respondent reported his relationship with his wife has become stronger since his February 2020 arrest. Respondent no longer binge drinks and has limited his social drinking. While

respondent continues to have financial stress, complainant offered no evidence such stress affected his depression or his practice of medicine.

85. Dr. Botello and Dr. Cuadra both cited respondent's purported difficulties with interpersonal relationships as a basis for requiring Board monitoring. Both experts also used the Jewish Hospital and San Joaquin Hospital incidents as examples of respondent's difficulties with colleagues. However, those incidents occurred in 2010 and 2018, respectively, and neither involved patient care. Since 2010, there is no evidence any of respondent's employers ever asked him to leave his position because of problematic behavior. There was no evidence respondent exhibited the intimidating or disruptive behaviors, i.e., engaged in verbal outbursts, made physical threats, used condescending language, or showed impatience with questions, warned about in the Alert cited by Dr. Botello. Respondent denied such conduct, and respondent's MCH colleagues, who have now known him for more than five years, reported no personnel issues. Respondent's admission that he has engaged in heated discussions about patient care is not surprising, as he is responsible for treating patients at their sickest and most vulnerable, and the decisions he makes about their care are life-altering.

86. Dr. Botello's and Dr. Cuadra's opinions about respondent's ability to safely practice were also speculative. That respondent is "at risk" of reoccurrence of his depression disorder and such risk presents "a potential danger" to the public, as Dr. Cuadra stated in her report, does not render him incapable of practicing medicine safely. This is particularly true considering respondent has been taking prescribed medication that has successfully addressed his depression for well more than five years, and respondent has not expressed any objection to continuing the medication.

87. Dr. Botello and Dr. Cuadra's concerns respondent's medical practice may suffer if he skipped his medication for a couple of days is similarly speculative. As both

experts point out, respondent's depressive symptoms include shortness of temper and irritability. Dr. Botello and Dr. Cuadra opine respondent's failure to take his medication over a couple of days may therefore affect his interpersonal relationships, which ultimately may affect patient care. However, there is no evidence to support Dr. Botello and Dr. Cuadra's fears. Although respondent acknowledged skipping medication only a couple of times when his prescription ran out, there was no evidence his lack of compliance affected his competency.

88. That respondent has suffered from recurrent depressive episodes in the past and may experience depression in the future does not demonstrate respondent is unsafe to practice. The evidence demonstrates respondent has managed his depression successfully with medication. Complainant offered no evidence respondent's depression has impaired his delivery of medical care or respondent's medication regimen interferes with his medical practice. That respondent may be a difficult person or have narcissistic tendencies does not make him unsafe to practice medicine.

Costs

89. Complainant seeks reimbursement of $84,430.25 in enforcement and investigation costs incurred in this matter. The costs consist of $50,354.75 in prosecution costs billed by the Department of Justice, $20,875.50 in investigation costs certified by the Department of Consumer Affairs and allocated to the Board in this case; $8,100 in expert costs certified by Amy Cleveland, Associate Government Program Analyst designated to certify expert costs incurred by the Board; and $5,100 in expert costs certified by the experts themselves.

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90. Respondent is unable to pay the requested expenses because of outstanding tax obligations that take precedence. Respondent financially supports himself and his wife. His only source of income is from MCH, and respondent was uncertain of his ability to pay the requested costs on a payment plan.

LEGAL CONCLUSIONS

1. Complainant bears the burden of establishing that the charges in the accusation are true by clear and convincing evidence. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.) The requirement to prove by clear and convincing evidence is a "heavy burden, far in excess of the preponderance sufficient in most civil litigation. [Citation.]" (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.) "The burden of proof by clear and convincing evidence 'requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind.' [Citation.]" (*Ibid.*)

First and Third Causes for Discipline

2. The Accusation alleges respondent is subject to disciplinary action under section 2234 and section 2239, subdivision (a), because respondent used alcoholic beverages to an extent, and in such a manner, as to be dangerous or injurious to himself or other persons, and such conduct constitutes unprofessional conduct.

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3. Section 2234 authorizes the Board to take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes the use of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the licensee, to any other person, or to the public. (§ 2239, subd. (a).)

4. Complainant proved by clear and convincing evidence respondent drank alcohol on February 3, 2020, and then drove his vehicle while intoxicated. (Factual Findings 15–20, 57, 77.) Such conduct endangered respondent, his passenger, and the public. Cause therefore exists to discipline respondent's license under sections 2234 and 2239, subdivision (a), for unprofessional conduct based on respondent's excessive drinking on February 3, 2020.

Second Cause for Discipline

5. The Accusation alleges respondent is subject to disciplinary action under sections 820 and 822 because respondent's ability to safely practice medicine is impaired due to a mental illness or disorder affecting competency.

6. Section 820 provides that whenever it appears that a person holding a license may be unable to practice their profession safely due to mental illness, the licensing agency may order a psychological examination. Section 822 provides that a licensing agency may suspend or revoke a license if it determines that the "licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill." The purpose of these statutes is to protect the public from mentally incompetent healthcare professionals by allowing licensing agencies to "determine whether a licentiate's mental state is interfering with his or her competency to practice." (*Alexander D. v. State Board of Dental Examiners*, 231 Cal.App.3d 92, 99; see also *Kees v. Medical Board of California* (1992) 7 Cal.App.4th 1801, 1813 ["the

government has a compelling need in protecting the public against risk of harm by physicians who are so impaired they cannot practice medicine safely"].)

7. Complainant did not prove by clear and convincing evidence respondent's mental illness renders him incompetent to provide medical care or impairs his ability to safely practice. (Factual Findings 31–56, 59, 73–76, 82–88.) Complainant's experts' opinions were speculative and did not demonstrate respondent's depression, currently successfully managed with medication, interfered with his competency to practice. Their opinions also were contrary to the reality established by respondent's witnesses who uniformly testified respondent practiced at the highest level of medicine and exhibited the utmost dedication to his patients throughout the COVID epidemic. Cause therefore does not exist to impose monitoring, supervision, or any other disciplinary action against respondent's license under sections 820 and 822.

Disposition

8. Complainant did not establish by clear and convincing evidence respondent is an alcohol-abusing physician. (Factual Findings 77–81.) Accordingly, the Board's Uniform Standards for Substance-Abusing Licensees are not applicable in this proceeding.

9. However, respondent's excessive drinking on February 2, 2022 and unprofessional conduct, in violation of sections 2234 and 2239, subdivision (a), subjects his license to discipline. Under the Manual of Model Disciplinary Orders and Disciplinary Guidelines (12th ed. 2016) (Guidelines), the Board has recommended discipline ranging from stayed revocation and five years' probation to revocation for excessive use of alcohol and unprofessional conduct. These recommendations "are not

binding standards" but the Board expects that, absent mitigating or other appropriate circumstances, an administrative law judge will follow the Guidelines' recommendations. (Exhibit 25, p. A254.)

10. California Code of Regulations, title 16, section 1360.1, subdivision (b), lists several factors considered by the Board in determining discipline. These include the nature and gravity of the professional misconduct, the total criminal record or record of professional misconduct, the time elapsed since the commission of the professional misconduct, and rehabilitation evidence submitted by the licensee.

11. Here, the factors demonstrate a deviation from the Guidelines' recommended discipline is warranted because probation is not necessary to safeguard the public. Although driving while intoxicated is a serious act, respondent did not injure anyone or damage any property because of his intoxication. Respondent was off from work the day of his arrest, and he had stopped driving before he was arrested because he no longer could drive safely. It has been more than five years since respondent's arrest, and he has had no arrests since that time. Respondent's February 2020 DUI arrest is his only alcohol-related arrest. Respondent's single criminal conviction is not deemed an aggravating factor considering it was for a non-alcohol-related misdemeanor and occurred more than 15 years ago.

12. Although respondent initially lied to the Board regarding his role on February 3, respondent acknowledged his deception at hearing, and he testified without hesitation he was the initial driver of the vehicle on the morning of his arrest. Respondent recognized he exercised poor judgment in agreeing to drive after drinking several hours earlier. Respondent learned from his arrest, and he has now limited his drinking. He no longer engages in binge drinking. He drinks only on social occasions

when not scheduled to be on call or at work. (Factual Findings 57, 58, 61.) Considering respondent's work schedule, alcohol is not a regular part of respondent's life.

13. Respondent's conduct at MCH is also inconsistent with someone who abuses alcohol. For the past five years, respondent has been the lead COVID doctor at MCH. During the COVID surge, he treated more than 60 patients a day, worked 18-hour days, and was at MCH every day. (Factual Findings 8, 9.) Respondent subsequently became the head of MCH's ICU. His employment at MCH has been stable. MCH has had no issues with respondent's patient care or interpersonal relations. Respondent's supervisor and his colleagues uniformly laud his clinical and diagnostic skills and his compassionate patient care. None of respondent's witnesses observed respondent inebriated at work, and there was no evidence that MCH ever received any complaints accusing respondent of alcohol abuse. (Factual Findings 63–72.)

14. The evidence shows respondent made a regrettable decision on a single occasion to drive the morning after he engaged in late-night heavy drinking at home. There is no evidence respondent suffers from an alcohol abuse problem. Complainant did not prove respondent is likely to repeat his mistake considering the absence of any alcohol-related convictions or arrests before or after his 2020 arrest, respondent's dedication to his work, and the observations of his colleagues who worked with him every day under close and high-stress conditions and who consistently found no evidence respondent abused alcohol.

15. The purpose of licensing statutes and administrative proceedings enforcing licensing requirements is public protection and not to punish an errant practitioner. (*Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 784–786; *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d 1471, 1476.)

Respondent's unprofessional conduct was limited to a single incident and caused no actual harm. However, respondent's single DUI cannot be ignored altogether despite respondent's nearly 40-year history of practicing medicine without prior discipline and his laudable skills, compassion, and dedication to the profession and his patients. The public is best protected by serving notice of respondent's unprofessional conduct without imposing overly harsh or punitive discipline. A public reprimand will serve to remind respondent that the same or similar misconduct will likely result in a far more serious disciplinary action. It also provides notice to the public and others of the nature and extent of respondent's misconduct.

Costs

16. Complainant seeks reimbursement of $84,430.25 in enforcement and investigation costs incurred in this matter (Factual Finding 89.) Pursuant to section 125.3, the ALJ may order a licensee found to have violated a licensing act to pay the reasonable costs of investigation and prosecution of a case. In *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, the California Supreme Court set forth factors to be considered in determining the reasonableness of costs sought pursuant to statutory provisions like section 125.3. These factors include whether the licensee has been successful at hearing in getting charges dismissed or reduced, the licensee's subjective good faith belief in the merits of his or her position, whether the licensee has raised a colorable challenge to the proposed discipline, the financial ability of the licensee to pay, and whether the scope of the investigation was appropriate in light of the alleged misconduct.

17. Here, respondent was successful at hearing in getting one charge against him dismissed and reduced the proposed discipline for two other charges. Respondent had a subjective good faith belief in the merits of his position, and raised a colorable

challenge to the proposed discipline. Although the scope of the investigation was appropriate considering the alleged misconduct, respondent lacks the financial ability to pay the requested costs, even on a payment plan. (Factual Finding 90.)

18. Respondent therefore established a basis to reduce or eliminate the costs in this matter. As a result, respondent shall pay $8,400 to the Board, approximately 10 percent of the requested costs on a payment plan approved by the Board.

ORDER

1. Physician's and Surgeon's Certificate No. G 73813 issued to Lawrence Ross Rouben, M.D., is publicly reprimanded based on respondent's excessive use of alcohol on February 3, 2020.

2. Respondent shall pay $8,400 to the Board in reimbursement for its costs of investigation and enforcement based on a payment plan approved by the Board.

DATE: 04/25/2025

CINDY F. FORMAN
Administrative Law Judge
Office of Administrative Hearings