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

In the Matter of the First Amended Accusation Against:	
Nathan Brian Kuemmerle, M.D.	**Case No. 800-2019-051542**
Physician's and Surgeon's Certificate No. A 89368	
Respondent.	

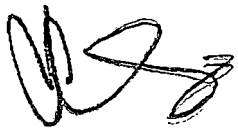
DECISION

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 29, 2022.

IT IS SO ORDERED August 30, 2022.

MEDICAL BOARD OF CALIFORNIA



Laurie Rose Lubiano, J.D., Chair
Panel A

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

In the Matter of the First Amended Accusation Against:

NATHAN BRIAN KUEMMERLE, M.D., Respondent

Physician's and Surgeon's Certificate No. A 89368

Case No. 800-2019-051542

OAH No. 2021100490

PROPOSED DECISION

Adam L. Berg, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter by telephone/videoconference on May 11, 2022.

Karolyn M. Westfall, Deputy Attorney General, Department of Justice, State of California, represented complainant, William Prasifka, Executive Director, Medical Board of California, Department of Consumer Affairs, State of California (board).

Kevin C. Murphy, Murphy Jones APC, represented respondent Nathan Brian Kuemmerle, M.D.

Oral and documentary evidence was received, and the matter was submitted for decision on May 11, 2022.

FACTUAL FINDINGS

Background

LICENSE, DISCIPLINARY, AND CITATION HISTORY

1. On November 17, 2004, the board issued Physician's and Surgeon's Certificate No. A 89368 to respondent. The license will expire on June 30, 2022, unless renewed.

2. On July 24, 2012, complainant's predecessor filed an accusation against respondent in Case No. 17-2009-197899 alleging the following: On January 27, 2011, in the United States District Court, Central District of California, respondent pled guilty and was convicted of a felony violation of 21 U.S.C. § 841(a)(1), unlawful distribution of a controlled substance. The circumstances leading to the conviction were that the Drug Enforcement Administration began investigating respondent after receiving information from two informants, who had been arrested for selling Adderall, that respondent sold them numerous controlled substance prescriptions for non-legitimate purposes. During undercover operations, on multiple dates, respondent issued non-legitimate (including multiple backdated) prescriptions for Adderall, Xanax, and Norco to the undercover agents.[1] In 2009, respondent wrote 2,382 prescriptions for 30 mg (the highest dose) of Adderall, more than any other doctor in California (approximately

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[1] Adderall, a stimulant, is a combination of amphetamine salts and dextroamphetamine, and is a Schedule II controlled substance. Xanax, a benzodiazepine, is a Schedule IV controlled substance. Norco, a combination of hydrocodone and acetaminophen, was a Schedule III controlled substance.

3.5 times more than the amount of the second highest prescriber and 43 percent of all prescriptions by the top-10 prescribers combined).

3. In a decision effective February 1, 2013, the board adopted a Stipulated Settlement and Disciplinary Order in which respondent admitted the truth of each and every charge in the accusation. The board placed respondent's license on probation for seven years with terms and conditions including a one-year suspension, total restriction on controlled substance prescribing, abstinence from controlled substance use, biological fluid testing, completion of an ethics course, completion of a clinical training program, a psychiatric evaluation, psychotherapy, solo-practice prohibition, and a practice/billing monitor.

4. On February 27, 2015, respondent filed a petition for early termination of probation, or alternatively, reduction of drug testing, cessation of the practice monitor requirement, and being allowed to engage in solo practice. At the administrative hearing, respondent admitted to prior drug use, claimed sobriety since April 2010, and discussed his rehabilitative efforts. The psychiatrist who performed the board-ordered psychiatric evaluation testified at the hearing that respondent was evasive during the evaluation, minimized his criminal history, and blamed his use of methamphetamine as the reason he sold false prescriptions to people.

5. In a decision after reconsideration dated June 13, 2016, the board denied respondent's request for penalty reduction except for limiting the number of biological fluid tests to an average of four times per month. The board made factual findings that respondent minimized his criminal history at the hearing when he described his conviction as the result of having written a prescription outside the usual course of practice and without a legitimate medical purpose, which resulted in a single felony count of writing a Xanax prescription without a medical purpose.

6. On January 20, 2017, the board issued respondent a citation for failing to submit a biological fluid sample within the required timeframe, in violation of his probation. Respondent appealed, and during an administrative hearing, admitted he failed to check-in for drug testing on multiple occasions across multiple years of his probation but was critical of the testing requirements and the vigorous enforcement of his probation; he believed that the board was too harsh on physicians. In a decision effective September 6, 2017, the board affirmed the citation and $350 fine.

7. On May 25, 2018, the board again issued respondent a citation for failing to submit to biological fluid testing and fined him $350, which respondent satisfied.

8. Respondent completed his probation on September 29, 2020.

FIRST AMENDED ACCUSATION

9. On February 3, 2022, complainant signed the first amended accusation alleging respondent used alcoholic beverages in a manner dangerous to himself, was convicted of a substantially-related offense, committed gross negligence, committed repeated negligent acts, and engaged in unprofessional conduct.[2] In support of the causes for discipline, complainant alleged that on March 5, 2019, respondent was convicted of "wet reckless" driving after he was arrested for driving with a blood alcohol concentration (BAC) of 0.17 percent. Complainant also alleged that on December 1, 2017, respondent wrote a letter to a family court judge on behalf of his patient, G.G., in which he communicated a "strong impression" that his patient's wife, A.G., who was not respondent's patient, suffered from borderline personality disorder

[2] The only amendment to the original accusation, signed on August 25, 2021, was to request cost recovery.

(BPD). Complainant seeks the revocation or suspension of respondent's certificate and recovery of investigation and enforcement costs.

10. Respondent timely filed a notice of defense. This hearing ensued.

Respondent's Criminal Conviction

11. On March 5, 2019, in the Superior Court of California, County of San Diego, respondent was convicted on his guilty plea of violating Vehicle Code section 23103, subdivision (a), pursuant to Vehicle Code section 23103.5, subdivision (a), "wet reckless driving," a misdemeanor.[3] The court placed respondent on summary probation for three years with conditions that included completion of a first-offender and Mothers Against Drunk Driving (MADD) program, and payment of fines and fees. On October 18, 2021, the court terminated respondent's probation and dismissed the conviction pursuant to Penal Code section 1203.4.

12. The circumstances underlying the conviction, as derived from a police report admitted pursuant to *Lake v. Reed* (1997) 16 Cal.4th 448[4] are as follows: On

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[3] Vehicle Code section 23103.5 allows for a defendant charged with driving under the influence to plead guilty to reckless driving, upon finding a factual basis that the consumption of alcoholic beverages occurred while driving.

[4] In *Lake*, the California Supreme Court concluded that direct observations memorialized in a police officer's report were admissible under Evidence Code section 1280, the public employee records exception to the hearsay rule, and were sufficient to support a factual finding. The court further concluded that admissions by a party memorialized in such a report were admissible under Evidence Code section 1220 and were sufficient to support a factual finding. Citing Government Code section 11513,

December 28, 2018, shortly after midnight, a Carlsbad Police Department officer observed a vehicle stopped at a green light at the end of a freeway off-ramp. The officer contacted respondent, the driver, who was passed-out in the driver's seat with the ignition on. After awaking respondent, the officer observed signs of intoxication in addition to vomit on the outside of the car door and window. The officer administered several standardized field sobriety tests, which respondent could not complete, and arrested respondent for driving under the influence (DUI). A blood sample revealed a BAC of 0.17 percent.

13. Respondent's arrest and conviction occurred while he was on disciplinary probation and constituted a violation of the requirement of his probation that he abide by all laws. Respondent timely reported the arrest and conviction to his probation monitor. In an email to his probation monitor on January 2, 2019, respondent wrote that he was completely abstaining from alcohol "to show my earnestness no matter what the facts of the case turn out to be." Following his conviction, respondent submitted a letter reporting the conviction for "Wet and Reckless 0.09 BAC misdemeanor." In the letter, respondent admitted to driving after consuming alcoholic beverages, which he recognized as being a poor decision. He wrote that while on the freeway, he felt sick from "bad sushi" and exited the freeway. At the bottom of the off-ramp, he vomited from the "irritating sushi" and alcohol he consumed. He laid his head back to rest and was falling asleep. He had no intention of

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the court held that other hearsay statements set forth in the police officer's report could be used to supplement or explain other evidence, but they were not sufficient, by themselves, to support a factual finding, unless the hearsay evidence would be admissible over objection in civil actions.

driving any further. He was easily awoken by the police and was thankful he had the ability to get off the freeway and stop his vehicle. It was extremely cold (38 to 42 degrees) when he was asked to perform the field sobriety tests, he was shivering, and he attempted to perform the tests to the best of his ability. He concluded by expressing regret for what happened and was thankful for having the presence of mind to realize his condition in order to get off the freeway and stop his vehicle.

The December 1, 2017, Letter

14. On January 6, 2019, the board received an online complaint from A.G. alleging that following her husband's arrest for domestic violence on November 17, 2017, she was issued a temporary protective order against him. On December 1, 2017, her husband submitted to a judge a letter written by respondent, in which respondent diagnosed A.G. with BPD despite her never having been his patient. This letter was also used in child custody documents relating to their divorce. A.G. claimed that her attorney had subpoenaed respondent's records that he used to establish her diagnosis, to which respondent did not reply.

15. The letter in question, dated December 1, 2017, on Crownview Medical Group letterhead with the name Nathan Kuemmerle, M.D., is reproduced verbatim as follows:

> To Whom It May Concern:
>
> I have been working with [G.G.] (DOB [Redacted]) since February 2017 where he initially brought his wife in for therapy. I have had several more appointments with [G.G.] and have arrived at getting to know his life history well. It is my strong impression through getting to know [G.G.] well

that his wife [A.G.] suffers from Borderline Personality Disorder. This disorder is characterized by a poor attachment with parental figures from childhood. As an adult this personality type will manifest as someone that can create extremely dramatic situations from the smallest of life circumstances. In addition, they can often villainize or over idealize individuals, causing them to not accurately characterize a situation. They can create completely false stories and impressions. Serious cases of this personality can be very dangerous to children under their care. I very sincerely think that [G.G.] worries about their safety. As a clinician, he has discussed this safety issue about his wife before any of these legal episodes have occurred.

Borderline personality can often go through periods of stability but with enough stress, a person with borderline personality can have severe brief episodes of extremely unstable behavior and anger. It is really important to strongly consider that she is a risk to her children and that the accusation against [G.G.] is very likely false. He seems concerned about his children. He does not seem to be of violent temperament.

If you should have any questions, please feel free to contact my office at [redacted].

Under respondent's signature contained respondent's name, medical license number, and "Adult Psychiatrist."

16. In response to the board's request for medical records regarding A.G., respondent submitted a certification of records with a handwritten statement that the patient refused any medical or psychiatric evaluation and thus has no records. He also wrote: "Third party impressions were given through patient collateral just as an impression for the courts so they could conduct an official evaluation later on their own to assure safety of her children. That collateral is the record of another patient and not hers."

17. Respondent also provided G.G's intake form, which was redacted except for a single paragraph relating to his wife, A.G., where she made statements to respondent about G.G.

MAY 11, 2021, INTERVIEW OF RESPONDENT

18. On May 11, 2021, respondent was interviewed by an investigator with the department's Division of Investigations and the board's District Medical Consultant. During the interview, respondent said he met A.G. on February 7, 2017, and spoke with her between 2 to 10 minutes. A.G. did not want to become a patient but had agreed to provide collateral information about G.G. Respondent explained that G.G. had wanted to get his wife into therapy, but she refused. When respondent spoke to A.G., she told him that she did not want to be a patient or give him any information about herself. Respondent never spoke to her again other than the initial meeting.

19. Respondent explained that the letter was only an "impression," not a "diagnosis or any formal characterization of her," which he wrote "for the protection of G.G.'s children." He reiterated that it was not a diagnosis but an "impression based on fear of the protection of his kids, and the relationship, and whatever potential violence could have been going on that no one was aware of what was actually happening."

Respondent was asked why he wrote the letter. Respondent's response is summarized as follows:[5]

Most of the letter characterizes what BPD is, and is "not really characterizing her that much." Respondent's intent behind writing the letter was there was a criminal charge against G.G., and G.G. was "getting very, very fearful of her upscaling this whole relationship in a way that was misleading, and you know, may I even say deceitful and manipulative." G.G. was becoming more fearful because he was afraid for his children. G.G. wanted respondent to write the letter because there were "court records of the fact that they were having a dissolution of marriage" and a charge against him from the police, and G.G. wanted to make it very clear that "this is very manipulative and deceitful on her part." Based on respondent's working with G.G. over the year and getting to know his life history, respondent arrived at a "strong impression," but not a diagnosis, that he wanted to communicate to the judge because G.G. was having legal issues and "had a strong desire to protect his children." Initially, G.G. thought his wife was bipolar, and "we were trying to figure out and help him understand the situation and if there was a diagnosis, it would be closest to borderline personality, but in no way were we trying to characterize or diagnose her formally." The letter listed a description of the condition through "boilerplate interpretation" of the diagnosis, "but not necessarily her, but as a guide to understand her." In writing "serious cases of this personality can be very dangerous to children under their care," respondent was not saying that A.G, was dangerous but,

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[5] Throughout the interview, respondent frequently launched into long narrative answers that were often difficult to follow. Several long block quotes are cited as an examples to highlight the nature of his responses.

> It was a question to the judge so that it could be allowed – so that a case could be opened to see how stable she really is, because there was no way to really get Child Protective Services involved because there was no really [*sic*] physical abuse to the child or anything that anyone would really hang on the other person other than that.

20. Respondent admitted that the information in the letter about A.G. was obtained only from statements by G.G., during four appointments over a 10-month period. Because she had refused therapy, respondent's goal was for the court to have her evaluated by its expert. Respondent gave G.G. the letter to give to the judge, but in hindsight, respondent wished he had sent it to the judge directly, "but it's very hard to do that – uh – to get a judge and a doctor to get on the same kind of connection link like that, right." He wanted to give the judge "an impression that I have based on all these appointments with him was merely to give the judge a look inside, that this may not just be a domestic abuse case, that it could be a lot more complicated than that and she – they should keep an open mind." Respondent wanted the judge to consider the "boilerplate" information about BPD from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) so the judge could consider "who she was" with an expert psychologist. Respondent maintained this had been accomplished because the court referred both parties for an independent psychological evaluation.

21. The District Medical Consultant expressed confusion about respondent's claim that while he indicated in the letter that he had a strong impression that A.G. had BPD, the rest of the letter was not about her. Respondent answered:

> So when we do – when we do intakes on people – um – usually we will have to give a diagnosis. Uh – in the old

days, it was Axis I through V, but it's now been simplified just to diagnosis and you can give multiple diagnoses if you need to, right. Uh – but traditionally, amongst a lot of psychiatrists there is what's considered a rule out, right, where – uh – and, traditionally, it was an Axis II diagnosis. And so borderline, because we didn't want to just say you have it for sure, but because of the information that's pre – presented to us as collateral or otherwise, or by the patient, that that information is a rule out, but because of the intensity of the diagnosis, it's something that is just an impression, but it's not necessarily – like in other words, if you want to formally diagnosis somebody, you would put the code, like F whatever, and then you would put that this person has this, right. And so it's – it's the diagnosis where over time you just want to give an impression or look at that, but it's in no way of a diagnosis for sure, right. Because – because based on the history that [G.G] gave me, she wasn't a drug addict. Most of it was relational. She said – he described her as being dramatic – um – unhinged – uh very temperamental, angry, irritable – um – it could be confused with bipolar-II because – uh – bipolar-II people will have surges of that for several days and then be depressed mostly, right. But as I got – as he kept characterizing her over all the sessions it seemed more like they were just dramatic presentations that occurred, right. And in psychiatry, we don't really work in the world of – of like it

was a – it was a – it was a h- -it was a – you know, it was irreconcilable differences or anything. We kind of work in the world that this is what – the best way that we can characterize somebody. And he needed help with that to realize that this problem was not necessarily going away and that if this is our rule out diagnosis, we have to work under this framework that she may need long-term support and help, that she may not just be clearing this up easily, and that eventually they may need divorce, right. Um – so when I say it's my strong impression through getting to know [G.G] well that his wife, [A.G], suffers from borderline personality disorder, it is a rule out. Okay. It's a working theory. And in no way is it like F - you know, there's a code for it, like F - I could find it for you if you want. We're not saying that she has this diagnosis, right. And then, I said this is what the – the disorder is characterized by, and based on the discussion that he extensively talked about, about her relationship with her mother, all the things that they talked about, the psychodynamic issues they went through - uh - a lot of clear history that he gave, that this was a rule out impression that was the – in terms of all the diagnoses that could incur about her that this was the closest one that we could consider and then for them to look at, but of course, when they do their own interpretation that they have – they should go at just from – uh – strictly third-party, not by a source. But the reason why we put that in there was

> because he was being poorly characterized as being mean and abusive and physically abusive to the kids, which he sincerely and carefully told me over a 10-month period that that was exactly not happening, right. And so we needed some kind of working framework to say there are two sides to the story and this is our closest interpretation of what may be occurring, and you may want to consider that in the decision of initiating a third-party psychologist, which they did, to analyze what is really going on. If it means that [G.G] is abusive, well, then that needs to be discovered by the third-party person. Uh – if [A.G] is not that way, well, then it can all be looked at through the lens of a third-party provider.

Respondent said he did not know if he could trust G.G. completely, stating, "it was hard to know exactly what was going on. Um – I had a suspicion of doubt of both of them to be honest, right." Respondent reiterated that he wanted the judge to have both individuals evaluated.

22. Multiple times during the interview, respondent accused A.G. of being "misleading and deceptive" by claiming that respondent had medical records regarding her when she had never been a patient. In concluding the interview, respondent was asked if he would have done anything differently with regards to the letter. He responded:

> Uh – let me say 50/50. I would say it's 50/50. I, I might have done it or I might not have. Okay. So, again - uh – I – I want to say that I do not do this kind of stuff a lot. Um – I do not

like to get involved in these situations. Uh – this got – th – these two obviously had strong agendas to really complicate this whole matter, right. Uh – this not something I do a lot. Okay. This is probably the most - uh – challenging situation in terms of writing a letter to a judge in – in the last six years of my practice, right. So this is uh – very like kind of pushed, and pushed, and pushed to – to – to do this and it was based on making sure that these kids were okay and that these two did not continue to create volatile situations for each other, right – uh – and that this could be managed by a professional, like a judge, to look between what was going on, right. Um – had I done it all over again, I would have liked to have first communicated to the judge and talk to him and said do you want this letter, is it even important, is it going to help a lot. Uh – [G.G] did tell me that it was helpful to the judge. Again, I wasn't there, so maybe he misled me. I don't know, right. Um – but I wish I could have directly talked to them to see what was the most – uh – beneficial way of communicating anything based on the collateral and with what wording they have liked me to have used, right. So I would have liked to had better communication with the legal system back then to – how to communicate something without having to get too descriptive or intimidating with language, right. Um, the fact that I was, I was working with [G.G.], I think that's fine. Um I uh – I simply – I wish I would have worded that – um –

she was not a patient of mine at all, right. I wish I would have put that in there. And I wish I would have -- um -- I think it was fine I said I had several more appointments with [G.G.] and that I arrived at getting to know his life history well. Um -- I think that's fine. That was accurate. Uh -- the part of the letter that -- of me describing what borderline personality disorder is, it may not -- it may have been superfluous information that, you know, it was only intended to go to the judge. Um -- again, it's – it's an academic interpretation of the diagnosis in the second paragraph. Um – but I – I feel like had I done it all over again, I would have just gotten rid of all that. And, again, just -- if they wanted that information, I should have just talked to the judge specifically and said how can I communicate this to you so that you don't keep endlessly going through all these kind of – uh – because as far as we know – as far as we know, there could have been three or four times the police was called and there could have been records that none of us know about, right. So anyway to have ended and ceased this whole situation – uh – in a most diplomatic way possible without causing any harm to anybody. Um – so I wish in some way we could have developed a better system to communicate that so it would not have had to be written in a letter, and then what we way could have communicated that so that it would not have been in anyway disrespectful to [A.G]. Um – she did

want the letter by the way, like she wanted those records subpoenaed. So ironically, she did want to see that information anyway, right. Um – so that's - that's kind of an interesting paradox to this whole thing, right. Uh -- and she tried twice in different years to – to get that information. Right. Um – I, also – I, also, feel like it's really important to strongly consider that she is a risk to her children, that part, it – it – it still was a fear of mine. I think it was okay. And that the accusation against [G.G] is very likely false, I think that that was over-interpretive, and I should not have been that interpretative at that moment because honestly, it's even to this day a question mark about were both of these people equally responsible or who was really at fault. I don't think I've ever fully settled that matter to be honest. Um -- do I think she may have borderline personality, again, of all the diagnoses we have in the DSM-V, it still fits her the most closely, but it was only a strong impression at the time. And it wasn't meant to be something that was exploitive. Um – she did several times put him, you know, in court over criminal charges. So in some ways I felt like he needed a fair shake, right. But I did not want – you know, in this way I wish I could have been more – um – unbiased and helpful to the courts in a way that could have expedited this whole situation so that the kids could have been better protected and more swiftly.

The Board's Expert John Raiss, M.D.

23. John Raiss, M.D., has been licensed to practice medicine in California since 1979 and is board-certified in psychiatry and child psychiatry. Dr. Raiss received his undergraduate degree from Harvard University and his medical degree from Baylor College of Medicine in 1978. He completed an internship and residency in psychiatry at Cedars-Sinai Medical Center followed by two fellowships in child psychiatry and a research fellowship. Since that time, he has worked in private practice in the areas of adult, child, adolescent, and geriatric psychiatry. He has held several academic positions, including as an assistant clinical professor of psychiatry at UCLA. Since 1997, he has been an expert reviewer for the board.

24. The board requested Dr. Raiss review the December 2017 letter authored by respondent and the transcript of respondent's interview to determine whether there were any departures from the standard of care. Dr. Raiss prepared a report summarizing his findings and testified at hearing. The following is a summary of Dr. Raiss's report and testimony:

25. Dr. Raiss accurately defined the term standard of care as the skill and knowledge in the diagnosis and treatment of a patient used by other reasonably prudent physicians in similar circumstances. An extreme departure from the standard of care involves a higher degree of departure than a simple departure.

26. The *Principles of Medical Ethics* are published by the American Medical Association as a code of medical ethics for physicians to employ in their practice. The American Psychiatric Association publishes annotations to these ethical rules as they apply to the practice of psychiatry. Rule 7.3, known as the "Goldwater Rule," states it is unethical for a psychiatrist to offer a professional opinion unless he or she has

conducted an examination and has been granted proper authorization for such a statement. This rule is well known to psychiatrists and consistent with the standard of care which requires a psychiatrist to only diagnose a patient who is under the psychiatrist's care and for whom the psychiatrist has conducted a psychiatric diagnostic evaluation.

27. In this case, Dr. Raiss believed respondent committed an extreme departure from the standard of care by communicating a "strong impression" that A.G. suffered from BPD, when she had never been his patient, he had never conducted a diagnostic evaluation of her, and he never obtained her permission to release information about her.

28. Additionally, respondent committed an extreme departure from the standard of care by making a diagnosis without performing a psychiatric diagnostic evaluation of the patient. Psychiatric diagnostic evaluations typically last from 60 to 90 minutes. A psychiatric diagnostic evaluation consists of a detailed report containing different components addressing items such as history of present illness, past psychiatric and medical history, developmental and psychiatric family history, a detailed mental status examination, diagnostic impression, discussion of diagnosis and criteria, and a treatment plan. Dr. Raiss noted that respondent met with A.G. for no more than 10 minutes and relied exclusively on statements by G.G. to respondent about his wife. While information from third parties can be helpful, in the case of marital disputes, there is the risk that one spouse's portrayal of the other is inaccurate or distorted.

29. Dr. Raiss rejected respondent's contention that indicating a "strong impression" was different than rendering a diagnosis. All diagnoses are impressions based on varying degrees of certainty. An impression is one's view of the data. When a

psychiatrist communicates a diagnostic impression, it carries the weight of a diagnosis. Dr. Raiss believes the way respondent phrased the letter and then listed attributes constitutes making a professional diagnostic statement on the basis of scant evidence. Moreover, the Goldwater Rule addresses rendering "professional opinion," not just diagnoses. Thus, that respondent did not use the word "diagnosis" does not alter Dr. Raiss's opinion that respondent acted unethically and departed from the standard of care.

30. Dr. Raiss is familiar with diagnosing and treating BPD. BPD falls within the category of personality disorders, which are more difficult to diagnose than mood or anxiety disorders. They require an in-depth knowledge of the patient's history. To diagnose BPD, five of the nine criteria listed in the DSM-5 must be established.

31. Respondent did not list any of the DSM-5 diagnostic criteria in the letter. For example, respondent wrote that people with BPD "can create completely false stories and impressions . . . the accusation against G.G. is very likely false." Deceitfulness, or repeated lying, is a characteristic of antisocial personality disorder, not BPD. Dr. Raiss believed it was an extreme departure from the standard of care to make a diagnosis of BPD without presenting evidence that any of the criteria were met. Instead, respondent essentially made a "pejorative slur" against A.G. without regard for establishing that she satisfied the required diagnostic criteria.

32. On cross-examination, Dr. Raiss agreed that some of the characteristics respondent identified as being associated with BPD could be encompassed by the diagnostic criteria contained in the DSM-5, but the characteristics respondent listed in the letter were not diagnostic criteria. Moreover, some of the characteristics he listed are more closely associated with other personality disorders.

33. Respondent's subjective intent in writing the letter does not change Dr. Raiss's opinion that respondent acted unethically and departed from the standard of care. Dr. Raiss noted that respondent's intent is nowhere noted in the letter itself. Moreover, a psychiatrist cannot ethically communicate a "strong impression" or diagnose someone who is not a patient. If respondent had a legitimate concern about the safety of the children, as a mandated reporter, he should have contacted Child Protective Services. In this case, respondent was aware that G.G. had been arrested and was the subject of a restraining order against him, yet authored the letter based solely on the information G.G. provided.

Respondent's Evidence

TESTIMONY AND LETTER BY TIMOTHY WIELAND

34. Timothy Wieland has worked as a medical assistant and department manager (overseeing five medical assistants) for Crownview Co-Occurring Institute (CCI) for the past three years, where he has worked closely with respondent. Prior to this, he was in the military for eight years in the medical field, including as an emergency medical technician instructor. He described respondent as one of the most passionate providers he has ever worked with and called respondent a "phenomenal" and "brilliant" doctor. Respondent works with a difficult patient demographic and does a "fantastic job" making ground where other providers are not able to. Respondent has a fantastic rapport with his patients who rave about respondent. Respondent is one of the most respected doctors Mr. Wieland has ever worked with. He has never seen respondent do anything unsafe or illegal and would trust respondent in his care and that of his family. Mr. Wieland was "somewhat aware" of the nature of the accusation based on a DUI. He is not aware of respondent's previous discipline. He has

seen respondent drink at social events but never to excess. He has never seen respondent drunk.

TESTIMONY AND LETTER BY MARK MELDEN, D.O.

35. Mark Melden, D.O. is board-certified in psychiatry and addiction medicine and is the owner of Crownview Medical Group, which operates residential care, day programs, and outpatient services. Dr. Melden met respondent in 2014 when respondent applied for a position as a psychiatrist. Since that time, Dr. Melden has worked alongside respondent as his direct supervisor. Dr. Melden reviews all of respondent's cases to go over strategy and medication management. Dr. Melden believes respondent makes good clinical decisions and has outstanding knowledge of psychopharmacology. Respondent's charting is exceptionally thorough, and respondent goes into great detail. He spends much more time with patients than others and is very therapeutic in his approach.

Dr. Melden is not aware of any incident where respondent has done something dangerous or illegal. Respondent is empathetic to his patients and approaches every patient with compassion and respect. Dr. Melden has no qualms about respondent's abilities as a physician.

Dr. Melden was aware that respondent was on probation when he hired him. Respondent disclosed his prior addiction to methamphetamine. Dr. Melden has observed respondent drinking alcoholic beverages at parties and "mildly intoxicated." However, he has not observed respondent acting inappropriately. Dr. Melden "briefly" read the accusation in this matter and is aware of respondent's DUI arrest. However, respondent did not report this arrest to Dr. Melden until earlier this year. When asked

if he thought an employee with a prior methamphetamine addiction should have disclosed the arrest for DUI to him, Dr. Melden answered, "not necessarily."

Dr. Melden has since been made aware of the letter respondent wrote involving A.G. He was not aware at the time that respondent wrote this letter. Dr. Melden, who is not familiar with the Goldwater Rule, thinks the letter was "poorly worded," but he does not believe respondent made a clinical diagnosis or gave a professional opinion. Although Dr. Melden does not think the letter was "worded appropriately," he does not think it is reflective of respondent's clinical practice or consistent with how respondent practices "99 percent of the time."

TESTIMONY AND REPORT BY DEBBIE HARKNESS

36. Debbie Harkness is a licensed Advanced Alcohol and Drug Counselor through the California Consortium of Addiction Programs and Professionals (CCAPP) and has been licensed since 2015 by the Board of Behavioral Sciences as an Associate Marriage and Family Therapist. She holds an associate degree in substance abuse counseling, a bachelor's degree in psychology, and a master's in family therapy. She has extensive experience as a substance abuse counselor and in conducting forensic substance abuse assessments. She has owned and operated Assessment, Training & Research Associate, which provides forensic assessments for various courts and other entities, since 2002. She also is certified to provide continuing education for the State Bar of California and CCAPP on areas such as addiction.

37. Ms. Harkness conducted a chemical dependency and mental health assessment for the purposes of this hearing. She interviewed respondent on March 3, 2022, and prepared a detailed report (which was co-signed by a licensed psychologist). Following the report, she spoke to respondent again and spoke to Kenneth Gladstone

and Dr. Melden, who both work with respondent. The following is a summary of her testimony and report:

38. Respondent reported that that he experienced symptoms of depression beginning in 2004, relating to an abusive relationship and other situational factors (omitted from this decision to preserve respondent's privacy). The depression prompted respondent to begin using methamphetamine from 2008 to 2010 in addition to periods of binge drinking. In 2010 he was arrested and convicted for overprescribing Xanax, but other charges for overprescribing were dropped. When he was released from custody he entered a six-month residential treatment program at Allen House, followed by a year of house arrest. He attended Alcoholics Anonymous (AA) meetings from 2012 to 2013 and lived at a sober living facility for two years. He attended therapy from 2014 to 2016 as part of his board-probation, but these were "check-ins" and not therapy. In 2015, respondent began drinking again because there was no limitation by the board. He drank two to three times per week and would binge drink on most weekends. After his DUI arrest, he reduced his drinking to two to three ounces of liquor, once or twice per week. Respondent increased his drinking in 2019 due to depression and would have five to seven drinks two to three times per week. He stopped all drinking on September 3, 2021, when he was served with the accusation in this matter. He began attending AA two to three times per week in January 2022. Respondent expressed understanding that his alcohol use has been problematic and is seeking permanent abstinence. He expressed openness in enrolling in an outpatient treatment program and starting therapy.

39. Following Ms. Harkness's evaluation, respondent enrolled in an intensive outpatient treatment program where is he is receiving therapy. Ms. Harkness believes that respondent has post-traumatic stress disorder (PTSD) dating back to childhood

and an abusive relationship. However, this had never been formally assessed or treating, which resulted in respondent experiencing chronic depression, which he self-treated with methamphetamine and alcohol. Ms. Harkness believes that his untreated mental health issues were the root cause for his substance abuse.

40. Ms. Harkness diagnosed respondent with dysthymia (persistent depressive disorder), PTSD, and alcohol use disorder, severe, in early remission. Based on her assessment, Ms. Harkness made the following conclusions: Respondent recognized that alcohol is as problematic as any other mind-altering substance. Respondent's willingness and actions treating his alcohol abuse and PTSD symptoms show an altitude of desire to maintain positive growth in his life and prevent a compromise to his personal and professional life in the future. He presented behaviors, attitude, and statements of a person practicing recovery and a desire to maintain abstinence from alcohol. He presented evidence of an ability to place his stimulant abuse into remission to date even though he was experiencing emotional pain associated with his unresolved trauma. He also presented with skills to maintain stability in his lifestyle, environment, and decision making to maintain permanent abstinence if mental health symptoms are treated collaboratively with his alcohol use disorder. In addition he displayed "an attitude of desire" to attend and continue with treatment and mental health care to place his alcohol use disorder into full remission and maintains a stable lifestyle and environment placing him at the lowest risk of recidivism for abuse of alcohol or other controlled substances in the future. Respondent was consistent during the interview in accepting personal responsibility for his current demise and attending therapeutic and alcohol treatment services voluntarily to improve his ability to manage PTSD symptoms to stabilize him personally and professionally. His actions show a willingness and strong desire to complete all recommended services to prevent relapse in the future. In Ms. Harkness's

opinion respondent's prognosis is excellent that he will continue to maintain a lifestyle that will not present harm or safety risk to others or the community in the future by attending and completion of therapeutic counseling to manage his PTSD, and alcohol treatment to prevent relapse.

RESPONDENT'S TESTIMONY

41. Respondent's testimony is summarized as follows: He completed his undergraduate degree at Brigham Young University and his medical degree at the University of California, Irvine. He was licensed to practice medicine in 2003. Halfway through his residency program in psychiatry at UCLA-San Fernando Valley, he resigned. Beginning in 2006, he worked at several outpatient centers and in private practice until his arrest in 2010. His conviction was for writing a prescription for no legitimate medical purpose. All other charges were dismissed. As part of his board probation, he completed the Physician Assessment and Clinical Education Program (PACE) at the University of California, San Diego, in March 2014.

42. In October 2014, he was hired by Crownview, where he has worked ever since. At Crownview, he performs intake assessments that involve interviews from one-and-a-half to two hours in length. He then prepares a detailed report including his diagnostic impressions. He is also involved with medication management at CCI. He sticks with medication management, which is what he is good at. The patient population ranges from simple cases to some of the "most difficult cases across the state and country." Dr. Melden supervises his work to ensure it is done correctly. Dr. Melden is always available for consultation. Respondent does not perform psychotherapy.

43. G.G. was his patient who was very concerned about his wife. He told respondent that A.G. was "unstable, volatile, and unhinged." G.G. became worried about her erratic behavior, but she refused to get help. Around November or December 2017, G.G. told respondent that his wife had made false accusations about him that resulted in her obtaining a restraining order against him. He was worried about this and asked respondent to write a letter. Respondent was "absolutely not" attempting to convey a clinical diagnosis of A.G. when he indicated his "strong impression" about her. By writing, "through getting to know [G.G.] well," respondent indicated that the source of his information was G.G., and not A.G. herself. His intent in writing the letter was to describe A.G.'s behavior in relation to DSM-5 criteria so she could be referred for a third-party evaluation. He described the letter as "basically a referral" for a third-party psychological evaluation, which was ultimately performed by William Dees, Ph.D. G.G. also expressed to respondent G.G.'s intent to have A.G. evaluated. Respondent believed they both needed to be evaluated given the false allegations that G.G. told respondent about. Respondent now recognizes that the language in the letter could be "misconstrued," and he would never do anything like this again.

44. Regarding his DUI arrest, respondent had been drinking with a friend, where he had four or five large IPA beers. He started drinking at around 8:00 or 8:30 p.m. and stopped drinking 10 to 15 minutes before driving home. He had "bad sushi" at dinner the night before. He pulled over on the freeway off-ramp because he had to vomit from the sushi. He vomited inside the vehicle. He then fell asleep "in the process of recovering from bad digestion."

45. Respondent complied with all the terms of his criminal probation and the court terminated his probation early and dismissed the charge. As part of his criminal

probation, he completed a three-month first offender program and MADD panel, which was particularly poignant. Respondent feels terrible about what happened, recognizes he should never have gotten into a car, and has learned that it is never okay to drink and drive. After his DUI, respondent stopped driving after he has been drinking. He wishes he had stopped drinking completely and believes that the board should have prohibited him from drinking as part of his probation. He stopped drinking completely on September 3, 2021, when he was served with the accusation in this matter. He never wants to pick up a drink again and intends to remain sober for the rest of his life. He learned a lot from Ms. Harkness's diagnostic evaluation. He agrees that he meets enough criteria for diagnosis with PTSD and that it was an underlying condition. Based on her recommendation, in late March 2022, he entered an intensive outpatient treatment program through Lionrock. The program consists of three weekly one-hour intensive sessions. He expects the program to last between three to five months. He believes the program is "really well done." He intends to comply with all conditions of the program and will continue with therapy for years to come. His support group consists of the Lionrock staff, his AA sponsor and participants, and his sister.

46. Respondent has had no patient care complaints or discipline while at Crownview. He enjoys being a doctor and loves saving lives. He believes he is safe to continue practicing. He reiterated that he understands how the letter about A.G. could be misunderstood and would never do it again. He expressed remorse for drinking and driving and that the letter was "misinterpreted."

47. Respondent submitted results showing weekly negative drug and alcohol screens beginning on February 24, 2022, up to the hearing date. Respondent also had negative tests on February 3, 8, and 10, 2022. He submitted documentations from the

federal probation office stating he had negative screens from June 2011 through December 2013.

48. Respondent submitted AA attendance records showing attendance on average of once or twice per week since February 20, 2022.

49. Respondent submitted records showing completion of 51.25 continuing medical education hours from March 6 to May 7, 2022.

50. On cross-examination, respondent admitted that he sold prescriptions for controlled substances and used methamphetamine. He failed to comply with his board-probation when he failed to check-in for biological fluid testing, but this occurred predominantly during the first three years of his probation. He "was good" the last three years. When pressed, he admitted he received a citation in 2018 for failing to comply. He abstained from drinking alcoholic beverages for a number of years following his conviction but then started drinking again. He would go for periods without drinking and would then resume, occasionally drinking excessively. Respondent agreed that a 0.17 percent BAC involved excessive drinking. Respondent only drank at night when he was not working. After his arrest he stopped drinking and driving and would drink less. Although he had curtailed his drinking, he picked up drinking again until September 2021.

51. Respondent was required to attend therapy while under board probation, but it was not "good therapy". He met with the therapist every three months who would then write that respondent was stable and was safe to practice. However, there was no actual therapy involved. Ms. Harkness helped respondent realize that he has underlying issues that need to be addressed. Although respondent is familiar with the

signs and symptoms of depression, he said doctors are often not good at treating themselves. He is at the point in his life where he never wants to drink again.

52. Respondent could not articulate his understanding of the Goldwater Rule. He again maintained his intention in writing the letter was for G.G. to provide it to the judge. Based on what G.G. told him, respondent had a "strong impression" consistent with the DSM-5 category. He described the letter as "collateral" and not a diagnosis. G.G. had told respondent for 10 months that A.G. was volatile, and respondent was worried about the interactions. He wanted both of them to be evaluated to see if either one was dangerous. When asked if there was any evidence A.G. was dangerous, respondent said G.G. told him her behavior was volatile, erratic, and she was making false accusations. This was all "hearsay," so respondent could not make a report to CPS. Respondent believes the letter made clear that his opinion was based on hearsay statements from G.G.

53. Respondent admitted he did not state anything in the letter about referral to a third party. It is his "greatest regret" that he neglected to include anything about his recommendation for a third party evaluation. G.G. wanted to keep the letter general. Respondent does not believe communicating a "strong impression" is a professional opinion. It is just an "impression for a referral to get properly evaluated." He understands it could be misinterpreted as a diagnosis. When asked if he thought it was as an ethical violation, respondent said "no," but was willing to learn based on the administrative law judge's decision. He now sees that he needs to be more careful about the way he words things. He added it was "obvious to both of us," presumably G.G., what the intention of the letter was. He again maintained he never intended to provide a clinical diagnosis.

ADDITIONAL REFERENCE LETTERS

54. Respondent submitted a questionnaire completed by Kelly Schwarzer, LVN. In the form, Ms. Schwarzer indicated that she has known respondent for three and a half years and wrote that respondent is honest, ethical, trustworthy, and open and clear with his clients. There was no indication of any knowledge about respondent's disciplinary history or the nature of the present allegations.

55. Respondent submitted a letter from Keary Lynn Mason, an associate marriage and family therapist, who works at Crownview and has known respondent for nine months. They work closely together in treatment, team meetings, consultations, and clinical meetings. She described respondent as dedicated, trustworthy. She wrote that respondent takes extra time with patients to build a relationship with them and goes above and beyond with both patients and staff. She believes respondent is an asset to his patients. She wrote she is aware of the allegations against respondent but did not state what those were. She has observed respondent at social functions, and he has never been drunk.

56. Respondent submitted a letter from Karie Peel, a mental health clinician, who worked with respondent since March 2021. She wrote that respondent is "conscientious" in writing detailed and accurate reports. She wrote he is willing to spend time to discuss complex cases and his reports are carefully written, detailed, and lengthy. She indicated awareness of the underlying allegations but provided no other details.

57. Respondent submitted a letter from Jenny Li, another mental health clinician who has worked with respondent since May 2020. Since January 2021, she has been the clinical director of CCI. She wrote that respondent has demonstrated careful

thought and consideration during treatment meetings. He is dedicated to their clients, spends time with them, and writes detailed reports. She indicated awareness of the underlying allegations but provided no other details.

58. Respondent submitted a letter from Kenneth Gladstone, the chief operating officer of CCI, who has worked with respondent for eight years. He wrote that respondent performs diagnostic evaluations and medication management at CCI. Mr. Gladstone has known respondent to be ethical, professional, and compassionate with his clients and coworkers. Respondent is relied on to treat patients who are most resistant to treatment, where respondent goes to great lengths to build therapeutic relationships. He believes respondent has a gift of putting patients at ease. Respondent's documentation is always consistently detailed, organized, and thoughtful. Mr. Gladstone has socialized with respondent at functions and events and never observed him drinking in excess. Mr. Gladstone did not reference knowledge of the current allegations against respondent.

59. Respondent submitted a letter from Anne Cox, M.D., who is a board-certified psychiatrist and has worked for Crownview since 2014. She has known respondent since that time and was his probation practice monitor until his probation ended. She wrote respondent was prompt in attending supervision meetings and efficient in providing records for review. She wrote his exceptional knowledge regarding psychotropic medications are exemplified in his treatment plans and appropriate for their diagnosis. She wrote respondent is well-loved by the staff. Dr. Cox did not reference knowledge of the current allegations against respondent.

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.) The standard of proof in an administrative action seeking to suspend or revoke a professional license is "clear and convincing evidence." (*Ettinger v. Bd. 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; it requires sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

Relevant Statutory Authority

2. Business and Professions Code section 2227, subdivision (a), provides:

> 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.

3. Under Business and Professions Code section 2234, the board shall take action against a licensee charged with unprofessional conduct. Grounds for unprofessional conduct include:

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act

described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care. . . .

4. The conviction of any offense substantially related to the qualifications, functions, or duties of a licensee constitute unprofessional conduct. (Bus. & Prof. Code, § 2236, subdivision (a).)

5. It is unprofessional conduct to use an alcoholic beverage to the extent, or in such a manner, as to be dangerous or injurious to the licensee or the public. (Bus. & Prof. Code, § 2239, subd. (a).)

6. "[A] crime, professional misconduct, or act shall be considered to be substantially related to the qualifications, functions or duties of a person holding a license if to a substantial degree it evidences present or potential unfitness of a person holding a license to perform the functions authorized by the license in a manner consistent with the public health, safety or welfare." (Cal. Code Regs., tit. 16, § 1360, subd (a).) In making the substantial relationship determination required under subdivision (a) for a crime, the board shall consider the following criteria: (1) The nature and gravity of the crime; (2) The number of years elapsed since the date of the crime; and (3) The nature and duties of the profession. (*Id.* at subd. (b).)

Evaluation

EXCESSIVE USE OF ALCOHOL – FIRST CAUSE FOR DISCIPLINE

7. Cause exists to discipline respondent's license pursuant to Business and Professions Code sections 2227 and 2234 for unprofessional conduct based on the excessive use of alcoholic beverages in violation of Section 2239, subdivision (a). There is a nexus between a physician's use of alcoholic beverages and his or her fitness to practice medicine, established by the Legislature in section 2239, "in all cases where a licensed physician used alcoholic beverages to the extent or in such a manner as to pose a danger to himself or others." (*Watson v. Superior Court* (2009) 176 Cal.App.4th.1407, 1411.) On December 28, 2018, respondent operated a motor vehicle with a BAC of 0.17 percent, which constitutes the excessive use of alcoholic beverages in such a manner as to pose a danger to himself or the public.

SUBSTANTIALLY RELATED CONVICTION -SECOND CAUSE FOR DISCIPLINE

8. Cause exists to discipline respondent's license pursuant to Business and Professions Code sections 2227 and 2234 for unprofessional conduct based on a substantially related conviction as defined by Section 2236. Convictions involving alcohol consumption reflect a lack of sound professional and personal judgment that is relevant . . . to practice of medicine." (*Griffiths v. Superior Court* (2002) 96 Cal.App.4th 757, 769-770.) To establish a nexus between misconduct and fitness to practice a profession, it is not necessary for the misconduct to have occurred in the actual practice of the profession and patient harm is not required. The laws are designed to protect the public before a licensee harms any patient rather than after harm has occurred. (*Ibid.*) Respondent's conviction for wet reckless driving is

substantially related to the qualifications, functions, or duties of a physician. (Cal. Code Regs., tit. 16, § 1360.)

GROSS NEGLIGENCE – THIRD CAUSE FOR DISCIPLINE

9. Complainant alleges respondent committed gross negligence in the care and treatment of G.G. and A.G. by 1) communicating "a strong impression" regarding the diagnosis of A.G., a person who was never under his care, never diagnostically evaluated, and never provided authorization for release of information; 2) communicating a "strong impression" that A.G. had a diagnosis of BPD without regard for the criteria for the disorder; and 3) communicating a "strong impression" of a diagnosis of BPD without sufficient evidence that criteria for the disorder was present.

10. Ordinary or simple negligence has been defined as a departure from the standard of care. It is a "remissness in discharging known duties." (*Keen v. Prisinzano* (1972) 23 Cal.App.3d 275, 279; *Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1055-1056.) Medical providers must exercise that degree of skill, knowledge, and care ordinarily possessed and exercised by members of their profession under similar circumstances. (*Powell v. Kleinman* (2007) 151 Cal.App.4th 112, 122.) Because the standard of care is a matter peculiarly within the knowledge of experts, expert testimony is required to prove or disprove that a medical practitioner acted within the standard of care unless negligence is obvious to a layperson. (*Johnson v. Superior Court* (2006) 143 Cal.App.4th 297, 305.)

11. "Gross negligence" long has been defined in California as either a "want of even scant care" or "an extreme departure from the ordinary standard of conduct." (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 195-197.)

> Negligence and gross negligence are relative terms. "The amount of care demanded by the standard of reasonable conduct must be in proportion to the apparent risk. As the danger becomes greater, the actor is required to exercise caution commensurate with it." (Prosser, Law of Torts (4th ed. 1971), at p. 180.)

(*Id.* at p.198.)

12. Dr. Raiss offered the only expert opinion in this case. He was well qualified to render an expert opinion in this matter. His testimony and report were well-reasoned and exceptionally credible. Clear and convincing evidence established respondent's actions were reckless, demonstrated a want of scant care, and constituted an extreme departure from the standard of care. Respondent, identifying himself as a psychiatrist, provided a "strong impression" that A.G. suffered from BPD. He then listed a number of attributes he believed were associated with the condition (which were not the DSM-5 diagnostic criteria), to include the statement that A.G. was "a risk to her children and that the accusation against [G.G.] is very likely false." Respondent's only interaction with A.G. lasted no more than 10 minutes, and his "strong impression" was based solely on statements by patient G.G., over the course of four appointments, over a nine-month period. Respondent authored this letter with knowledge that G.G. had been arrested for domestic violence two weeks before and was the subject of a temporary restraining order against him. During his interview with the board, respondent admitted that he had concerns about G.G. as well and wanted him to be evaluated too. Nowhere was this concern about G.G. indicated or implied in the letter.

Respondent's claims that by employing the term "strong impression" he was not making a formal diagnosis, he was not rendering a professional opinion, and the criteria he listed as being associated with BPD did not apply specifically to A.G., are disingenuous. Any reasonable person would understand from the letter that a psychiatrist was rendering a professional opinion that A.G. suffered from BPD, was prone to deceit, and was a danger to her children. Similarly, respondent's testimony that he wrote the letter in the hope that the judge would order an independent psychiatric evaluation of both A.G. and G.G. is not credible. Nothing in the letter indicated his intent was to refer both parties for an independent psychological evaluation as respondent claimed. Instead, it is readily apparent that G.G., who felt he was being accused by his wife unfairly, requested respondent write a letter as ammunition to use against A.G., which respondent readily agreed. Even if it was respondent's subjective intent for a judge to order a psychological evaluation, the statements he made about A.G. still constituted extreme departures from the standard of care and) were thus, grossly negligent. Finally, respondent repeatedly emphasized that the court ultimately ordered independent psychological evaluations. However, this in no way vindicates respondent's actions.

In sum, respondent abused his status as a psychiatrist to impugn A.G.'s character as it relates to truthfulness, and fitness to parent, based on scant and biased information gleaned solely from his patient, who had just been arrested for domestic violence and was not a disinterested party. Respondent's conduct was grossly negligent and cause for discipline pursuant to Business and Professions Code section 2234, subdivision (b).

REPEATED NEGLIGENT ACTS – FOURTH CAUSE FOR DISCIPLINE

13. The accusation alleges respondent committed repeated negligent acts. Section 2234, subdivision (b). states: "To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts." Repeated negligent acts mean one or more negligent acts; it does not require a "pattern" of negligent acts or similar negligent acts to be considered repeated. (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462, 468.)

Complainant failed to establish that respondent committed repeated negligent acts. Here, the grossly negligent conduct was the authoring of a single letter about A.G. While there are several reasons why the letter was grossly negligent, the letter itself was a single negligent act, not repeated negligence. Accordingly, cause does not exist to discipline respondent's license pursuant to Business and Professions Code section 2234, subdivision (c).

GENERAL UNPROFESSIONAL CONDUCT – FIFTH CAUSE FOR DISCIPLINE

14. Cause exists to discipline respondent's license pursuant to Section 2234, subdivision (a), for unprofessional conduct. General unprofessional conduct has been defined as: "conduct which indicates an unfitness to practice medicine . . . conduct which breaches the rules or ethical code of a profession, or conduct which is unbecoming a member in good standing of a profession." (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575 and n.5.) There is no question that respondent violated the ethical principles of psychiatry by rendering a professional opinion about a person, who was not his patient, whom he had not evaluated, and who did not provide consent to make his statements. Additionally, driving after

consuming alcoholic beverages to an extent that was over twice the legal limit, while on board-ordered probation, constitutes unprofessional conduct.

Appropriate Discipline

15. Complainant requests revocation of respondent's license in light of his serious disciplinary history and the commission of misconduct while on probation. Respondent argues that revocation is not required for public protection, and an additional term of probation is warranted under the circumstances. He notes that the conviction occurred in March 2019, almost a year and a half before his probation terminated, and the board took no action. Similarly, the letter to the court was written over four years ago. Respondent also argued that even though he admitted to the federal court that he struggled with methamphetamine addiction, the board "failed to accurately assess his condition and his underlying co[-]occurring conditions" and failed to prohibit the use of alcohol during the course of his probation. Respondent argues that the board's failure to impose a prohibition against consuming alcoholic beverages "essentially 'set him up for defeat' by inadequately addressing cooccurring conditions and mental health issues."

16. "Protection of the public shall be the highest priority" for the board in exercising its disciplinary authority. (Bus. & Prof. Code, § 2229, subd. (a).) The main purpose of disciplinary licensing schemes is protection of the public through the prevention of future harm and the improvement and rehabilitation of the licensee. (*Griffiths v. Sup. Ct.* (2002) 96 Cal.App.4th 757, 772.) The purpose of the Medical Practice Act is to assure the high quality of medical practice. (*Shea, supra,* at p. 574.) Administrative proceedings before the board are not designed to punish but to afford protection to the public upon the rationale that respect and confidence of the public is merited by eliminating from the ranks of practitioners those who are dishonest,

immoral, disreputable, or incompetent. (*Fahmy v. Medical Bd. of California* (1995) 38 Cal.App.4th 810, 817.)

17. California Code of Regulations, title 16, section 1361, subdivision (a), provides that when reaching a decision on a disciplinary action, the board must consider and apply the "Manual of Model Disciplinary Orders and Disciplinary Guidelines" (12th Edition/2016). The guidelines state:

> In addition to protecting the public and, where not inconsistent, rehabilitating the licensee, the Board finds that imposition of the discipline set forth in the guidelines will promote uniformity, certainty and fairness, and deterrence, and, in turn, further public protection.
>
> [¶] . . . [¶]
>
> The Board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake Board- ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the Board and proposed settlements submitted to the Board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

18. Under the Disciplinary Guidelines, the minimum discipline for gross negligence, excessive use of alcohol, conviction of a crime, and general unprofessional conduct is a stayed revocation for five years. The maximum discipline is revocation.

19. Rehabilitation is a "state of mind" and the law looks with favor upon rewarding with the opportunity to serve, one who has achieved "reformation and regeneration." (*Pacheco v. State Bar* (1987) 43 Cal.3d 1041, 1058.) Fully acknowledging the wrongfulness of past actions is an essential step towards rehabilitation. (*Seide v. Committee of Bar Examiners* (1989) 49 Cal.3d 933, 940.) While a candid admission of misconduct and full acknowledgment of wrongdoing is a necessary step in the rehabilitation process, it is only a first step; a truer indication of rehabilitation is presented if an individual demonstrates by sustained conduct over an extended period of time that he or she is rehabilitated. (*In re Trebilcock* (1981) 30 Cal.3d 312, 315-316.)

20. Probation is granted when a regulatory agency has reasonable concerns about a licensee's moral character, temperance, or professional competence. Probation affords a regulatory agency the opportunity to impose condition s of probation required to protect the public and to closely monitor a licensee's activities and rehabilitation. It affords the licensee with the opportunity to demonstrate to the regulatory agency that he or she is capable of remediating any deficiencies in his or her nursing practice and that he or she has achieved reformation and rehabilitation. It is a licensee's opportunity to regain trust. A licensee's demonstrated inability or unwillingness to comply with reasonable conditions of probation leaves a regulatory agency with few options.

21. Respondent engaged in highly corrupt acts by writing massive numbers of fraudulent prescriptions for controlled substances in 2009. Despite this manifest abuse of his medical license, the board permitted respondent to continue to practice

under conditions of probation. After only two years following the board's decision, respondent sought to terminate his probation, or alternatively, remove several conditions. This request was largely denied, and respondent's remaining time on probation was not without issue. During the course of his probation, on multiple occasions, he failed to check-in or report for drug testing, which resulted in the board issuing two separate citations in lieu of seeking revocation of his probation. During an administrative hearing contesting one of the citations, respondent blamed the board for being too stringent in its enforcement.

22. Both instances of misconduct in this matter occurred while respondent was on probation, during which respondent was expected to maintain exemplary behavior. Respondent's argument that the board inadequately addressed his "cooccurring conditions and mental health issues" and "set him up for defeat" by not including abstinence from alcoholic beverages as a condition of his previous probation is nothing short of audacious. First, respondent is a psychiatrist who works in the field of addiction and should have the knowledge and training to recognize that any alcohol use (let alone excessive use) is incompatible with his history of addiction to methamphetamine. Respondent -not the board – is solely responsible for his decision to drive after consuming enough beer that he was over twice the legal limit. Despite being arrested while on probation with the board, and initially informing his probation monitor that he had stopped drinking altogether, respondent continued to drink excessively. He made no attempt to seek any treatment for alcohol use or his mental health conditions. Not until September 2021, when he was served with an accusation, did respondent cease drinking. He did not begin attending AA until February 2022, and did not begin formal treatment until several weeks before this hearing.

To suggest that the board "set respondent up for defeat" for not requiring him to abstain from alcohol belies true acceptance of responsibility for his misconduct. There is a legal prohibition against drinking and driving, punishable by incarcerations, yet this did not deter respondent from drinking and driving. While respondent testified that he was wrong to have driven after drinking, this acceptance of responsibility is largely diminished by his specious argument that the board bears responsibility for his misuse of alcohol.

Moreover, respondent's explanation of the incident, including that he had "bad sushi" and was too cold to perform the field sobriety tests, further demonstrates a minimalization of his responsibility by suggesting that intoxication was not the cause of the police stop. This minimalization of responsibility is part of a larger pattern, as respondent has previously minimized the seriousness of the conduct leading to his drug conviction. Even during his interview with Ms. Harkness and at this hearing, he described the conviction as "overprescribing" of Xanax or issuing *a* non-legitimate prescription. Respondent was convicted of distributing drugs. That he continues to characterize this as "overprescribing" demonstrates respondent has yet to establish accountability, even after 12 years.

Respondent is correct that his most recent driving conviction occurred over three years ago, and the board did not take action against his license until two and a half years later. In most cases, such a delay only advantages a licensee as it provides the person time to establish rehabilitation. In this case, respondent did not avail himself of the opportunity to engage in any rehabilitation efforts until he stopped drinking after the accusation in this matter was filed. That respondent has finally sought sobriety and treatment is a positive step. Ms. Harkness's assessment and opinion were persuasive and credible that if respondent sticks to his treatment

program, he is likely to be highly successful in his recovery. While respondent has started down the right path, insufficient time has passed for respondent to establish that he is not at significant risk for relapse. Respondent should have taken this step long ago.

23. In addition to his history of drug distribution and his misuse of alcohol, the letter he authored about A.G. reflect a continued pattern of incidents raising concerns about respondent's judgment. The exercise of solid judgment and ethical behavior is paramount to the practice of psychiatry. Respondent is lacking in both areas.

Respondent repeatedly stated that he would have written the letter differently and understands how it could be misinterpreted. However, he also repeatedly justified his actions and did not admit that he departed from the standard of care or ethical practice, instead stating that he would defer that conclusion to the undersigned. His claim that the letter was a "referral" for the court to conduct an independent evaluation of both parties was not credible. Respondent stated in his interview and at hearing that he had concerns about G.G. and wanted him to be evaluated as well; this is alarming given what respondent actually wrote in the letter. At hearing, respondent could not articulate his understanding of the Goldwater Rule, even after hearing Dr. Raiss's testimony just hours before. His answers during the interview (and occasionally during the hearing) were frenetic, rambling, and in some instances, nonsensical. In sum, it is clear that respondent has not engaged in any meaningful introspection about his actions or gleaned significant insight, which raises concerns about his competency. There is little evidence to support a finding that respondent has been rehabilitated or would not commit a similar act in the future.

Although respondent presented laudatory references by his coworkers, not a single one, with the exception of Dr. Melden, specified knowledge of the nature of the allegations against respondent. Dr. Melden seemed generally unconcerned about respondent's actions except to state that the letter to the court was "poorly worded." Dr. Melden did not believe respondent acted unethically or that that letter reflected a diagnosis or clinical judgment, which was contradicted by the evidence in the record. Moreover, Dr. Melden had no concern that respondent failed to inform him of his DUI arrest, even when respondent was on probation by the board and had been addicted to methamphetamine. Accordingly, Dr. Melden's opinion of respondent is given very little weight and does not provide any assurance that he would adequately supervise respondent in the future.

24. In conclusion, considering respondent's serious criminal and disciplinary history, the occurrence of both violations during his period of probation, and his failure to establish rehabilitation, revocation is the only discipline sufficient to protect the public.

Recovery of Investigation and Enforcement Costs

25. Complainant requests cost recovery under Business and Professions Code section 125.3. A certification by the deputy attorney general contained information related to services provided by the Office of the Attorney General and included actual costs of $8,713.75 as of May 4, 2022, with an estimate that an additional five hours would be incurred totaling $1,100. The certification and attached documents for the actual costs incurred satisfied the requirements of California Code of Regulations, title 1, section 1042, subdivision (b), and the certification supports a finding that costs in are reasonable in both the nature and extent of the work performed. However, the estimate for additional costs did not comply with statute or

regulation because it failed to establish why the actual costs were not available and are thus disallowed.

The California Supreme Court in *Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, held that a regulation imposing costs for investigation and enforcement under California Code of Regulations, title 16, section 317.5, which is similar to Business and Professions Code section 125.3, did not violate due process. But it was incumbent on the board in that case to exercise discretion to reduce or eliminate cost awards in a manner such that costs imposed did not "deter [licensees] with potentially meritorious claims or defenses from exercising their right to a hearing." (*Ibid.*)

The Supreme Court set forth five factors to consider in deciding whether to reduce or eliminate costs: whether the licensee used the hearing process to obtain dismissal of other charges or a reduction in the severity of the discipline imposed; whether the licensee had a "subjective" good faith belief in the merits of his or her position; whether the licensee raised a "colorable challenge" to the proposed discipline; whether the licensee had the financial ability to make payments; and whether the scope of the investigation was appropriate in light of the alleged misconduct. The reasoning of *Zuckerman* must be applied to Business and Professions Code section 125.3 since the language in the cost recovery regulation at issue in *Zuckerman* and section 125.3 are substantially the same.

Based on the revocation of his license, respondent will not be ordered to pay costs at this time. After applying the *Zuckerman* criteria, costs are reduced to $6,000. Should respondent seek reinstatement, the board, in its discretion, may order respondent to pay costs of $6,000.

ORDER

Physician and Surgeon Certificate No. A 89368 issued to respondent Nathan Brian Kuemmerle is revoked.

Should respondent apply for reinstatement, the board, in its discretion, may order respondent to pay costs not to exceed $6,000 as a condition of reinstatement.

DATE: June 8, 2022

Adam Berg (Jun 8, 2022 11:31 PDT)

ADAM L. BERG

Administrative Law Judge

Office of Administrative Hearing

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Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **NATHAN BRIAN KUEMMERLE, M.D.** **13924 Recuerdo Drive** **Del Mar, CA 92014-3129** **Physician's and Surgeon's Certificate No. A 89368,** Respondent.	Case No. 800-2019-051542 **FIRST AMENDED ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this First Amended Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about November 17, 2004, the Medical Board issued Physician's and Surgeon's Certificate No. A 89368 to Nathan Brian Kuemmerle M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2022, unless renewed.

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JURISDICTION

3. This First Amended Accusation, which supersedes the Accusation filed on August 25, 2021, is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states, in pertinent part:

> (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.
>
> ...

5. Section 2234 of the Code, states, in pertinent part:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
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6. Unprofessional conduct under Business and Professions Code section 2234 is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

7. Section 2236 of the Code states, in pertinent part:

(a) The conviction of any offense substantially related to the qualifications, functions, or duties of a physician and surgeon constitutes unprofessional conduct within the meaning of this chapter [Chapter 5, the Medical Practice Act]. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred.

...

(d) A plea or verdict of guilty or a conviction after a plea of nolo contendere is deemed to be a conviction within the meaning of this section and Section 2236.1. The record of conviction shall be conclusive evidence of the fact that the conviction occurred.

8. Section 2239 of the Code states:

(a) The use or prescribing for or administering to himself or herself, of any controlled substance; or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the licensee, or to any other person or to the public, or to the extent that such use impairs the ability of the licensee to practice medicine safely or more than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of such unprofessional conduct.

(b) A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section. The Division of Medical Quality may order discipline of the licensee in accordance with Section 2227 or the Division of Licensing may order the denial of the license when the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing such person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, complaint, information, or indictment.

9. California Code of Regulations, title 16, section 1360, states:

For the purposes of denial, suspension or revocation of a license, certificate or permit pursuant to Division 1.5 (commencing with Section 475) of the code, a crime or act shall be considered to be substantially related to the qualifications, functions or duties of a person holding a license, certificate or permit under the Medical Practice Act if to a substantial degree it evidences present or potential unfitness of a person holding a license, certificate or permit to perform the functions authorized by the license, certificate or permit in a manner consistent with the public health, safety or welfare. Such crimes or acts shall include but not

be limited to the following: Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision of the Medical Practice Act.

COST RECOVERY

10. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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

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

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

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

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

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

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

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

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

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

FIRST CAUSE FOR DISCIPLINE

(Excessive Use of Alcohol)

11. Respondent has subjected his Physician's and Surgeon's Certificate No. A 89368 to disciplinary action under sections 2227 and 2234, as defined by section 2239, subdivision (a), of the Code, in that he has used, or administered to himself, alcoholic beverages to the extent, or in such a manner, as to be dangerous or injurious to himself, another person, or the public, as more particularly alleged hereinafter:

12. On or about 12:01 a.m., a Carlsbad Police Officer was on routine patrol when he observed Respondent's vehicle stopped on the off-ramp of the freeway. The officer approached the vehicle and witnessed Respondent passed out in the driver's seat with the vehicle in drive and the display screen illuminated inside the vehicle. The officer also witnesses fresh vomit on the outside of the driver's door and window.

13. After the officer was able to awaken Respondent, he noted Respondent smelled of alcohol, slurred when he spoke, and had red bloodshot eyes. Respondent informed the officer that there was nothing wrong with his vehicle and denied he was sick, but admitted drinking prior to driving.

14. Respondent had difficulty exiting his vehicle and had to be assisted with walking and sitting on the nearby curb. After performing poorly on field sobriety tests, the officer placed Respondent under arrest for driving under the influence of alcohol.

15. At approximately 1:17 a.m., a blood sample was obtained from Respondent that was subsequently tested for alcohol. The blood test result indicated Respondent had a blood alcohol content (BAC) of .17 percent.

16. On or about January 30, 2019, the San Diego County District Attorney filed a criminal complaint against Respondent in the matter of *The People of the State of California v.*

Nathan Brian Kurmmerle (aka Nathan Brian Kuemmerle), San Diego County Superior Court Case No. CN395898. Count one of the complaint charged Respondent with driving under the influence of drugs and/or alcohol, in violation of Vehicle Code section 23152, subdivision (a), a misdemeanor. Count two of the complaint charged Respondent with driving with a blood alcohol content level of 0.08 percent or more, in violation of Vehicle Code section 23152, subdivision (b), a misdemeanor. Both counts were charged with a further allegation that Respondent's concentration of blood alcohol was 0.15 percent by weight or more, within the meaning of Vehicle Code section 23578.

17. On or about March 5, 2019, Respondent was convicted of a lesser related offense to count one, of "wet reckless driving," pursuant to Vehicle Code sections 23013(a) and 23103.5. On that date, the Superior Court sentenced Respondent to three years of probation subject to various terms and conditions.

SECOND CAUSE FOR DISCIPLINE

(Conviction of an Offense Substantially Related to the Qualifications, Functions, or Duties of a Physician and Surgeon)

18. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 89368 to disciplinary action under sections 2227 and 2234, as defined by section 2236, of the Code, and California Code of Regulations, title 16, section 1360, in that he has been convicted of an offense substantially related to the qualifications, functions, or duties of a physician and surgeon, as more particularly alleged in paragraphs 11 through 17, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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THIRD CAUSE FOR DISCIPLINE

(Gross Negligence)

19. Respondent has subjected his Physician's and Surgeon's Certificate No. A 89368 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he was grossly negligent in his care and treatment of Patients A and B,[1] as more particularly alleged hereinafter:

20. On or about February 3, 2017, Patient A presented to Respondent for psychiatric treatment. At this visit, Patient A brought his wife, Patient B, to his session for therapy, but Patient B specifically informed Respondent that she did not want to be a patient. Respondent spent a total of approximately two to ten minutes speaking with Patient B, during which time Patient B stated that her husband was "yelling at me in front of the kids, says bad words, he spit on me on my face twice...I don't see any respect in front of the kids. He interrupts me. I don't feel like I have a voice and feel controlled. I feel offended." Respondent did not conduct a diagnostic evaluation or psychometric testing of Patient B at any time, and had no further interaction with Patient B after that visit.

21. Between in or around February 2017, and in or around December 2017, Respondent had multiple visits with Patient A that occurred approximately every three months. During these visits, Patient A informed Respondent that he and Patient B were going through a contentious divorce. Patient A also informed Respondent that he felt Patient B was deceitful and manipulative, and he felt fearful for his children.

22. In or around November 2017, Patient A and Patient B were involved in a domestic violence incident that resulted in Patient A's arrest.

23. On or about December 1, 2017, Respondent voluntarily wrote a letter to the court on Patient A's behalf. This letter was written on his medical group's letterhead, Respondent identified himself as an adult psychiatrist, and included his California Medical License number.

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[1] To protect the privacy of the patients involved, the patient names have not been included in this pleading. Respondent is aware of the identity of the patients referred to herein.

Respondent did not obtain authorization from Patient B prior to writing this letter. In this letter, Respondent stated, in part, the following:

> It is my strong impression through getting to know [Patient A] well that his wife [Patient B] suffers from Borderline Personality Disorder. This disorder is characterized by a poor attachment from parental figures from childhood. As an adult this personality type will manifest as someone that can create extremely dramatic situations from the smallest of life circumstances. In addition they can villainize or over idealize individuals, causing them to not accurately characterize the situation. They can create completely false stories and impressions. Serious cases of this personality can be very dangerous to children under their care...
>
> Borderline personality can often go through periods of stability but with enough stress, a person with borderline personality can have severe brief episodes of extremely unstable behavior and anger. It is really important to strongly consider that she is a risk to her children and that the accusation against [Patient A] is very likely false...

24. On or about May 11, 2021, Respondent participated in an interview with an investigator for the Board. During this interview, Respondent denied he had formally diagnosed Patient B but only provided a "strong impression." Respondent admitted that all of the information he knew about Patient B was obtained from his brief encounter with her on February 3, 2017, and from information provided by Patient A during their sessions. Respondent further stated that one of the reasons he wrote the letter was to "balance the playing field," for Patient A.

25. Respondent committed gross negligence, which included, but was not limited to, the following:

(A) Communicating a "strong impression" regarding the diagnosis of Patient B, a person who was never under his psychiatric case, whom Respondent never diagnostically evaluated, and who never provided authorization for the release of her information;

(B) Communicating a "strong impression" of a diagnosis of Patient B of borderline personality disorder without regard for the criteria for the disorder; and

(C) Communicating a "strong impression" of a diagnosis of Patient B of borderline personality disorder without sufficient evidence that criteria for the disorder was present.

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FOURTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

26. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 89368 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient A, as more particularly alleged in paragraphs 19 through 25(C), above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

27. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 89368 to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 11 through 26, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

DISCIPLINARY CONSIDERATIONS

28. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about February 1, 2013, in a prior disciplinary action entitled, *In the Matter of the Accusation Against Nathan B. Kuemmerle M.D.,* Case No. 17-2009-197899, before the Medical Board of California, Respondent's license was suspended for a period of one (1) year, and placed on probation for a period of seven (7) years subject to various terms and conditions of probation. While on probation, on or about January 20, 2017, Respondent was issued Citation No. 8002016028990 for noncompliance, and on or about May 25, 2018, Respondent was issued Citation No. 8002017038046 for noncompliance. Respondent completed probation in Case No. 17-2009-197899 on or about September 29, 2020, and that Decision is now final and incorporated by reference as if fully set forth herein.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 89368, issued to Respondent, Nathan Brian Kuemmerle M.D.;

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

3. Ordering Respondent, Nathan Brian Kuemmerle M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: FEB 0 3 2022

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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