

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

In the Matter of the Second Amended  
Accusation Against:

Kenneth Naoyuki Matsumura, M.D.

Physician's & Surgeon's  
Certificate No G 20670

Respondent.

Case No.: 800-2019-059098

**DENIAL BY OPERATION OF LAW  
PETITION FOR RECONSIDERATION**

No action having been taken on the petition for reconsideration, filed by Jeff Lewis, and the time for action having expired at 5:00 p.m. on December 18, 2023, the petition is deemed denied by operation of law.

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ORDER GRANTING STAY

(Government Code Section 11521)

Jeff Lewis, Esq. on behalf of Respondent, Kenneth Naoyuki Matsumura, M.D., has filed a Request for Stay of execution of the Decision in this matter with an effective date of December 7, 2023, at 5:00 p.m.

Execution is stayed until December 18, 2023, at 5:00 p.m.

This Stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: December 7, 2023

JENNA JONES FOR

Reji Varghese  
Executive Director  
Medical Board of California

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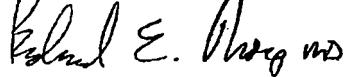
**DECISION**

**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 December 8, 2023.**

**IT IS SO ORDERED November 8, 2023.**

**MEDICAL BOARD OF CALIFORNIA**



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

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

**In the Matter of the Second Amended Accusation Against:**

**KENNETH NAOYUKI MATSUMURA, M.D.,  
Physician's and Surgeon's Certificate No. G 20670  
Respondent.**

**Agency Case No. 800-2019-059098**

**OAH No. 2022100485**

**PROPOSED DECISION**

Administrative Law Judge Juliet E. Cox, State of California, Office of Administrative Hearings, heard this matter on August 21 through 23, 2023, by videoconference.

Supervising Deputy Attorney General Greg W. Chambers represented complainant Reji Varghese, Executive Director of the Medical Board of California.

Attorneys Marvin Firestone and Jeff Lewis represented respondent Kenneth Naoyuki Matsumura, who was present throughout the hearing.

The record was held open for respondent to submit a certificate after completing a course in medical record-keeping. A certificate was submitted; it was

marked as Exhibit M and admitted into evidence. The record closed and the matter was submitted for decision on September 6, 2023.

## **FACTUAL FINDINGS**

1. Since July 1, 1971, respondent Kenneth Naoyuki Matsumura, M.D., has held Physician's and Surgeon's Certificate No. G 20670. At the time of the hearing, this certificate was active and was scheduled to expire on May 31, 2025.

2. Acting in his official capacity, the former Executive Director of the Medical Board of California filed an accusation against respondent on August 17, 2022. Respondent requested a hearing. Complainant Reji Varghese then became the Board's Interim Executive Director, and later its Executive Director. Acting in his official capacity, complainant filed a first amended accusation against respondent on February 23, 2023, and a second amended accusation on April 21, 2023.

3. Complainant alleges that the Board should revoke respondent's physician's and surgeon's certificate because of his unprofessional conduct and incompetence in treating three patients for metastatic cancer using inappropriate therapies. Respondent alleges that his therapies were not inappropriate, and also that his care qualified as "alternative or complementary medicine" for which Business and Professions Code section 2234.1 precludes discipline.

### **Education and Professional Experience**

4. According to respondent, he was "one of those boy geniuses" who established a scientific research laboratory before graduating from high school. His

*curriculum vitae* describes significant laboratory research before 1970, but no peer-reviewed publications resulting from any such work.

5. Respondent graduated from medical school in 1970. He completed one year of postgraduate medical training. Respondent is not board-certified in any medical specialty recognized by the American Board of Medical Specialties, and has not participated in any postgraduate medical training that would make him eligible for any such certification.

6. Between 1971 and 2011, respondent provided primary medical care on a volunteer basis at a clinic in Oakland. The evidence does not establish how frequently or regularly respondent worked in this clinic, or precisely what care he offered.

7. Respondent testified vaguely that he also has engaged in medical "research" since receiving his medical license. He described a laboratory at his home, in which he has at times maintained tissue culture facilities and laboratory animals. No other evidence corroborated this testimony.

8. Respondent also gave vague and conflicting testimony about his private oncology practice. He is in solo practice in Berkeley, without hospital admitting privileges. In an interview with Board investigative staff, respondent said that he established his practice in 1971 and has administered intravenous drug therapy against cancer using a protocol he developed (described in greater detail below in Findings 9 through 11) since 2015. At the hearing, he stated that he used this protocol first in 1992 and has used it consistently since about 2002, on approximately 1,000 patients. In a journal article respondent offered into evidence, he described providing cancer treatment in Ensenada, Mexico (in a "relaxing atmosphere that benefits the patient as they focus on conquering cancer"), since 2001.

## **“Side-Effect Free Chemotherapy” Protocol**

9. Respondent testified, and advertises, that he has developed a novel, highly effective protocol for treating many kinds of cancer. He describes this protocol as “side-effect free chemotherapy,” and boasts that it can achieve complete remission even in patients whose cancers have metastasized extensively, without the typical unpleasant or harmful effects of many cancer-treating medications, such as nausea, hair loss, or bone marrow damage.

10. As it relates to the three patients whose care is at issue in this matter, the “side-effect free chemotherapy” protocol involves two drugs. Respondent’s records represent<sup>1</sup> that these patients received these drugs intravenously in four-day cycles, roughly every other week.

a. One drug, mesna, is a compound that physicians commonly administer to patients who are receiving either cyclophosphamide or ifosfamide as cancer therapy. These drugs can cause severe bladder irritation, but mesna protects patients’ bladders against such irritation.

b. Respondent characterizes mesna’s role in his chemotherapy protocol as protecting neutrophil<sup>2</sup>-producing stem cells in patients’ bone marrow. He describes mesna as an “antidote” to anti-cancer medication, and attributes the “side-effect free” nature of his protocol to it. Respondent’s protocol is to administer mesna on each of

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<sup>1</sup> In light of all evidence in this matter, respondent’s medical records are not credible documentation of either his observations or his actions.

<sup>2</sup> A neutrophil is a type of white blood cell that is part of the immune system.

the treatment cycle's four days. Patients receive varying mesna doses, but respondent did not explain either in testimony or in his records how he chooses each dose.

c. The other drug, carboplatin, is a drug that came into use as treatment for some cancers in the late 1980s.<sup>3</sup> Carboplatin impairs cell division in rapidly dividing cells. Its most significant effects, aside from slowing or stopping some cancer cells' replication, are nausea (because of damage to rapidly dividing cells lining the gastrointestinal tract) and thrombocytopenia (low platelet count, because of damage to platelet-producing cells in bone marrow).

d. Respondent administers carboplatin on the treatment cycle's second day. He testified that he calculates a patient's carboplatin dose by referring to laboratory measurements of the patient's kidney function, but not to the patient's body size.

e. Respondent told the three patients whose care is at issue in this matter that he tests the carboplatin he administers, before administering it, to ensure its "potency." He represented to them that this testing was one of many ways in which his chemotherapy protocol would be superior to the protocols that other oncologists had proposed or might propose to them. Respondent also stated in testimony that he performs such testing, describing it as involving tissue culture cells in a laboratory setting. No detailed test protocol or results are in evidence.

11. Respondent offers his patients ondansetron, an anti-nausea medication that became available in the early 1990s and that is commonly used to counter nausea

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<sup>3</sup> Respondent testified that he uses carboplatin not because of its particular efficacy against his patients' cancers, but because its patent has expired, making inexpensive generic versions available.



in cancer patients receiving cytotoxic chemotherapy. Respondent also prescribes either Neupogen or Zarxio, which are drugs that stimulate white blood cell production and that are commonly used to counter bone marrow damage in cancer patients receiving cytotoxic chemotherapy or radiation therapy. Respondent testified, however, that many of his patients do not need either medication because mesna is so effective.

12. Respondent presented no evidence other than his own testimony to support his contention that his "side-effect free chemotherapy" protocol is safe or effective. No formal clinical trials of this protocol ever have occurred, and no reputable peer-reviewed medical journal ever has published an article describing it.<sup>4</sup> As described below in greater detail, all of the patients whose care is at issue in this matter suffered significant pain, as well as nausea and bone marrow damage, during treatment with respondent; and all of them died at about the time that treating physicians other than respondent had predicted they would die.

13. Each of the three patients whose care is at issue in this matter signed a document respondent had prepared, purporting to memorialize the patient's informed consent to "side-effect free chemotherapy."

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<sup>4</sup> Respondent offered an article into evidence that he authored, describing several case studies of patients who had used his protocol with near-miraculous results. Despite the article's anecdotal and promotional nature (and rampant typographical errors), he characterized it as having been published in a reputable peer-reviewed medical journal. This testimony is not credible.

a. The document states that the patient will receive “one or more cytotoxic chemotherapy drugs . . . which will be combined with mesna to protect my body’s healthy cells from the chemotherapy, to prevent or reduce side effects.”

b. The document identifies respondent as “a physician-scientist who also has developed the world’s first bio-artificial liver.”<sup>5</sup>

c. The document describes “side-effect free chemotherapy” falsely as having “been studied in a phase 2 trial” that showed “substantial reduction of side effects of chemo agent carboplatin” including protection of “blood circulating levels of platelets and white blood cell neutrophils.” It also states that the protocol is “substantially” more likely than “conventional chemotherapy” to cause cancer remission, “and with less side effects.”

d. The document states that by signing it, the patient endorses one or both of two statements: “A. I am not currently being offered medical treatment for my cancer, either because all standard medical treatments have failed, or because my oncologist (or other specialist) has determined that there are no proven treatment options for me”; or “B. I have been offered generally accepted medical treatments for my cancer. After reviewing the risks and benefits of those treatments with my doctor(s), I voluntarily chose not to receive them.”

e. The document states that no part of respondent’s treatment is “yet covered by insurance or Medicare,” and that the patient will be fully responsible for

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<sup>5</sup> No evidence aside from respondent’s statements supports this assertion.

paying respondent as well as for “any tests that may be necessary but are not covered under my health insurance.”

14. Complainant presented expert testimony about drug therapies for cancer from three board-certified oncologists. Before reviewing respondent’s records in this matter, none of these witnesses had ever heard of respondent’s “side-effect free chemotherapy” protocol, or of any similar drug protocol combining strong effectiveness against a wide variety of cancers with a comfortable patient experience.

a. Sara Hurvitz, M.D., is board-certified in internal medicine and medical oncology. Until recently, she served as a professor of medicine and as director of the breast oncology program at the University of California, Los Angeles, medical center. She now is the Senior Vice President of Clinical Research and a professor of medicine at the Fred Hutchinson Cancer Center at the University of Washington.

b. Michael Benjamin, M.D., is board-certified in hematology and medical oncology. He is in private practice as a medical oncologist in Southern California, and also serves as an adjunct clinical instructor of medicine at the University of California, Los Angeles.

c. John Shin, M.D., is board-certified in internal medicine, hematology, and medical oncology. He is an assistant professor of medicine at Loma Linda University, where he provides clinical care and trains medical students and residents in oncology.

15. Drs. Hurvitz, Benjamin, and Shin testified that mesna’s only value in cancer treatment is to protect against bladder irritation from cyclophosphamide or ifosfamide. Mesna has no effect on the gastrointestinal tract or bone marrow, no drug interaction with carboplatin, and no independent anti-cancer effect. It is not an “antidote” to anything. This testimony is credible and persuasive.

16. Drs. Hurvitz, Benjamin, and Shin also testified that carboplatin is effective against some cancers but ineffective against others. To calculate an appropriate carboplatin dose for a patient who may benefit from carboplatin, a physician must consider not only the patient's kidney function as measured by laboratory testing but also the patient's age, body mass and surface area, and sex. This testimony also is credible and persuasive.

17. Finally, Drs. Hurvitz, Benjamin, and Shin emphasized that carboplatin is a very dangerous drug that has significant risks for every patient despite its potential benefits for some patients. For this reason, the standard of care among all physicians is that only physicians with postgraduate training in medical oncology should prescribe or administer this drug. A physician without such training who prescribes or administers carboplatin commits an extreme departure from the standard of care. This testimony also is credible and persuasive.

### **Unprofessional Treatment of Patients 1, 2, and 3**

18. The evidence does not establish that respondent's medical practice involves any treatment other than "side-effect free chemotherapy." Detailed records are in evidence regarding three patients respondent treated between 2018 and 2020.

#### **PATIENT 1**

19. Patient 1 and her husband lived in Arizona, but traveled to Berkeley approximately twice a month for about a year for respondent to treat Patient 1. They paid respondent more than \$100,000, and also incurred travel and lodging costs, for futile care. This experience significantly diminished Patient 1's quality of life during her final year, and continues through traumatic memory to diminish her husband's quality of life.

## Treatment and Death

20. Patient 1 contacted respondent first in June 2018. She said that she had learned in July 2010 that she had ductal carcinoma in situ (DCIS) in her left breast, and that she had undergone no treatment for it other than "diet and supplements" and "hyperthermia treatment in Germany." When Patient 1 contacted respondent, her tumor had grown to occupy "most of my left breast and some lymph nodes."

21. In July 2018, before meeting respondent for the first time, Patient 1 underwent a radiologic scan in Arizona to determine the extent to which her cancer might have spread. The radiologist's report states that Patient 1 had "extensive" metastatic cancer in her liver, skeleton, and lymph nodes, and probable metastasis to her lungs.

22. Patient 1 brought the July 2018 radiologist's report summarized in Finding 21 to respondent at her first appointment, at the end of that month. At that appointment, Patient 1 agreed to undergo "side-effect free chemotherapy," and signed a copy of the document described above in Finding 13 purporting to memorialize her informed consent to this protocol. Patient 1's document does not indicate whether she endorsed statement A (failed all prior care), statement B (understood but did not want other care), or both.

23. Respondent referred Patient 1 to Alta Bates Hospital in Berkeley for installation of a venous access port. His referral letter states that the port's purpose would be for Patient 1 to receive "Neutrophil-potentiated Chemotherapy" to treat "Massive left breast cancer with stage 4 spread extensively to the liver and bones." Robert Y. Kim, M.D., placed the port in Patient 1 on July 30, 2018.

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24. Respondent's records state that Patient 1 received 21 "side-effect free chemotherapy" treatment cycles between July 30, 2018, and May 23, 2019. Each treatment cycle followed the protocol described generally above in Finding 10.

25. Patient 1 had laboratory blood chemistry testing approximately biweekly between July 2018 and May 2019. Until February 2019, she had no further radiologic scan to evaluate whether her metastatic cancer had grown or spread. Respondent's records occasionally mention Patient 1's physical condition, but do not report that he performed regular complete physical examinations of Patient 1 during her treatment.

26. Patient 1 complained consistently about pain in her left breast or left chest during her treatment. She also reported, and respondent noted, that some of her visibly or palpably swollen lymph nodes became larger during treatment. Nevertheless, respondent's records state that he reassured Patient 1 regularly that the treatment protocol was effective: He told her that he saw "validation that her tumor is responsive," that pain was "proof therapy was affecting her cancer" and that "cancer in lymphatics takes longer to eradicate."

27. On November 19, 2018, Patient 1 had a left mastectomy at a hospital in Arizona. The surgical report states that Patient 1's tumor had invaded "deep to the skeletal muscle" under her breast. Patient 1 provided a copy of the surgical report to respondent.

28. On February 12, 2019, Patient 1 underwent an abdominal ultrasound at Alta Bates Hospital. Respondent had referred her for the ultrasound, describing Patient 1 as having "extensive stage 4 breast cancer involving bones, liver, multiple nodes" and as having been "under immuno-chemotherapy with" respondent. The radiologist who read the ultrasound (Shlomo Leibowich, M.D.) interpreted it as showing "Extensive

hepatic metastatic disease" as well as lymph node inflammation, "right lower quadrant mass[,] and periumbilical mass extending to the left."

29. Respondent knew (although Dr. Leibowich did not) that the report from Patient 1's July 2018 radiological scan did not mention a "right lower quadrant mass" or a "periumbilical mass," but instead stated that the previous radiologist did "not identify nodal metastases within the abdomen or pelvis." Nevertheless, respondent continued after the February 2019 scan to tell Patient 1 that her cancer had not progressed. He wrote in his records that a radiologist he did not name had assured him despite Dr. Leibowich's "non-descript report" that the liver lesions visible on the February 2019 scan were "cysts—benign ones," not malignant metastatic cancer; he testified similarly. This testimony is not credible; moreover, if respondent actually believes for any reason that Patient 1's February 2019 radiologic scan showed her cancer to have regressed rather than progressed, this belief is delusional.

30. During June 2019, Patient 1 did not come to Berkeley for treatment. In early July 2019, however, she was admitted to a hospital in Arizona because of difficulty breathing. A radiologic scan from that hospital admission showed "diffuse metastatic disease involving the liver, visualized axial skeleton, pleura, with bilateral large probably malignant pleural and pericardial effusions."

31. The physicians who treated Patient 1 in Arizona in early July 2019 recommended palliative care, and admission to a skilled nursing facility near Patient 1's home in Arizona. Patient 1 refused this advice, stating that she preferred to return to Berkeley and resume treatment with respondent. One of Patient 1's Arizona physicians documented having spoken to respondent about this plan, and having explained that he did not believe Patient 1 could travel safely. Respondent agreed to help Patient 1 arrange admission to a skilled nursing facility in the Bay Area, however.

32. Patient 1 entered residential skilled nursing care at McClure Post-Acute in Oakland on July 12, 2019. Within about two weeks, she had lost more than five pounds because of poor appetite and difficulty swallowing. After about a month, Patient 1 began experiencing more severe and frequent pain.<sup>6</sup> In addition, as Patient 1 grew weaker from malnutrition and chronic pain, she began requiring more staff assistance to leave her bed.

33. Respondent's records state that Patient 1 received three more "side-effect free chemotherapy" treatment cycles between July 12, 2019, and August 18, 2019, while residing at McClure. The records also state that at the end of at least one of those cycles respondent gave Patient 1 300 milligrams of gemcitabine, a cytotoxic drug that sometimes is used in much larger doses as an adjunct to carboplatin.

34. Respondent wrote in his records, and testified, that he believed during this period that Patient 1's overuse of opioid pain medication was her chief medical problem. He persuaded Patient 1 and her husband that Patient 1 should reduce her consumption of such medication, on the theory that opioid medication would interfere with her chemotherapy treatment. As a pain-control alternative, he referred Patient 1 to a hypnotherapist, who respondent understood to have told Patient 1 that her constant chest pain derived from "her childhood," rather than from a breast tumor that had metastasized through her chest wall. Respondent's testimony that he believed Patient 1 to be overusing opioid pain medication in July and August 2019 is not credible; moreover, if respondent actually believes any of the statements he made in

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<sup>6</sup> Liver and bone metastases cause excruciating pain.



testimony or in his records regarding Patient 1's pain and use of pain medication in July and August 2019, his beliefs are both cruel and delusional.

35. McClure staff physician Francesco Isolani, M.D., wrote in Patient 1's chart on August 20, 2019, "breast CA—pain, palliative tx not desired.....poor prognosis pt in denial, defer all care to oncologist." Deferring care to respondent was unwise: Respondent told Patient 1 and her husband at about this same time that Patient 1 did not need further treatment because her cancer was fully in remission. Based chiefly on respondent's advice, and despite advice from Dr. Isolani and from Patient 1's Arizona physicians, Patient 1 and her husband believed in late August 2019 that her two chief medical challenges were opioid addiction and unintentional weight loss, and that by ending opioid use and regaining body mass she would recover her health enough to leave the skilled nursing facility and return home.

36. On August 26, 2019, Patient 1 arrived at Summit Hospital in Oakland by ambulance, intending to request a gastrointestinal feeding tube. Hospitalist Mary Kathryn McClellan, M.D., admitted Patient 1 to the hospital. Dr. McClellan's medical note states that imaging showed Patient 1 to have "extensive metastatic disease including blastic osseous metastases involving nearly the entire visualized skeleton, numerous hepatic metastases and lung metastases, and a large left pleural effusion with collapse of the left lower lobe." Patient 1 died on August 30, 2019.

37. Dr. McClellan testified credibly that Patient 1 was "quite sick" when Dr. McClellan met her, but that neither Patient 1 nor her husband seemed to understand that Patient 1 would die soon from advanced metastatic cancer. Because Dr. McClellan did not understand what treatment Patient 1 had been receiving, or why she had continued to receive it even as her disease worsened, Dr. McClellan telephoned respondent. Respondent told Dr. McClellan that Patient 1's "large doses of morphine"

made further chemotherapy impossible, which he deemed unfortunate because his protocol had been so successful for Patient 1. Dr. McClellan immediately reported her concerns about respondent to the Board.

38. Respondent testified that he believes Patient 1 to have died from a pulmonary embolism and opioid addiction, and that he believes that Patient 1 still would be alive if she had not become addicted to opioids and discontinued treatment with him. This testimony is not credible; moreover, if respondent actually does believe that Patient 1 died from any cause other than metastatic cancer, his belief is delusional.

### **Unprofessional and Incompetent Conduct**

39. In light of the opinions summarized above in Findings 16 and 17 and the training (or lack thereof) summarized in Findings 4 and 5, respondent's use of carboplatin to treat Patient 1 was an extreme departure from the standard of care. In addition, according to Dr. Hurvitz's persuasive testimony, respondent's use of gemcitabine was an extreme departure from the standard of care (because of his lack of oncology training relating to cytotoxic chemotherapy medications), and his underdosing of gemcitabine was a simple departure from the standard of care. Finally, in light of the opinions summarized above in Finding 15, respondent's use of mesna for Patient 1 as an "antidote" to carboplatin was both incompetent and an extreme departure from the standard of care.

40. Dr. Hurvitz testified credibly and persuasively that the standard of care for treating metastatic breast cancer is to monitor the patient's physical condition closely during treatment, with physical examinations and imaging studies; to document the patient's condition thoroughly; and to discontinue treatment if it is not

effective. According to her, “[c]ontinuing a chemotherapy regimen in the face of unequivocal progression of disease is an extreme departure from the standard of care.” The course of treatment summarized in Findings 22 through 36 was incompetent, and was an extreme departure from the standard of care. In addition, even if respondent conducted more thorough physical examinations than his records reflect, his failure to document those examinations of Patient 1 regularly during treatment also would have been an extreme departure from the standard of care.

41. Dr. Hurvitz testified credibly and persuasively that an important component of the modern standard of care for treating cancers that originate in the breast is to determine whether the tumor cells express hormone receptors for estrogen or human epidermal growth factor. Drugs are available that are highly effective in many patients against cancers that express either or both of these hormone receptors, but ineffective against cancers that do not. Failure to evaluate a breast tumor’s hormone receptiveness, and to tailor treatment accordingly, is incompetent and is an extreme departure from the standard of care.

42. Respondent’s records do not reflect whether Patient 1 ever had undergone hormone receptor testing for her cancer, and respondent did not order any. Respondent’s records also do not reflect that respondent advised Patient 1, or confirmed with her that someone else had advised her, about the treatment choices that such testing might offer her. Respondent’s testimony did not demonstrate that he has any knowledge whatsoever about this topic. With respect to hormone receptor testing and to hormonally appropriate treatment, respondent’s care for Patient 1 was incompetent, and was an extreme departure from the standard of care.

43. Dr. Hurvitz also testified credibly and persuasively that for patients with skeletal metastases, such as Patient 1, drugs are available to stabilize and strengthen

bones. These drugs do not eliminate metastatic cancer, but can prevent painful fractures that otherwise may occur as cancer causes the bones' structure to disintegrate. Failure to recommend such medication to a patient with breast cancer that has metastasized to the skeleton (but who does not have overt fractures) is a simple departure from the standard of care.

44. Respondent's records do not reflect that respondent advised Patient 1, or confirmed with her that someone else had advised her, that bone-stabilizing drugs might be appropriate to preserve her quality of life. Respondent's testimony did not demonstrate that he has any knowledge whatsoever about this topic. To the contrary, respondent testified that he believes that bone-stabilizing medication for Patient 1 would have impaired the effectiveness for her of his "side-effect free chemotherapy" protocol. With respect to Patient 1's skeletal metastases, respondent's care for Patient 1 was a simple departure from the standard of care.

45. Dr. Hurvitz testified credibly and persuasively that the standard of care where mesna is an appropriate component of cancer therapy is to document each dose in milligrams. She stated that respondent's practice of documenting Patient 1's mesna dose only in milliliters, without referencing its concentration to permit conversion to milligrams, was a simple departure from the standard of care. This opinion is consistent with respondent's records, and is persuasive.

46. Patient 1's medical records show her to have had medical insurance, and Dr. Hurvitz testified credibly that medical insurance carriers routinely cover carboplatin treatment if it is medically appropriate. They do not cover "potency" testing, however (as respondent described, summarized in Finding 10.e), because it is unnecessary. Dr. Hurvitz stated her opinion that charging patients for unnecessary procedures is an extreme departure from the standard of care.

47. Respondent admitted in his interview with Board investigators and in testimony, however, that he demanded and received cash payment from Patient 1, advised her that insurance would not pay or reimburse for her treatment with him, and incorporated the significant cost for his carboplatin "potency" testing into the price. In light of Dr. Hurvitz's persuasive opinion, this conduct is an extreme departure from the standard of care.

## **PATIENT 2**

48. Patient 2 and her husband lived in Oakland. She sought treatment from respondent after having received treatment through Kaiser Permanente, where she also had worked before her illness. Respondent's treatment for Patient 2 cost her and her family more than \$60,000. It diminished Patient 2's and her family's quality of life during her final six months, and hastened her death.

## **Treatment and Death**

49. Patient 2 contacted respondent first in October 2019. She explained that she had undergone surgery and chemotherapy in 2016 for colon cancer, but had learned in July 2019 that her cancer had metastasized to her liver and lungs. Despite additional chemotherapy treatments at Kaiser Permanente in fall 2019, follow-up radiologic scans in October and November 2019 showed that Patient 2's liver and lung metastases had enlarged.

50. Respondent and Patient 2 exchanged email for several weeks before her first in-person visit.

a. Respondent told Patient 2 that "the reason our therapy is superior to ordinary chemo is because we use strategies to protect the body's immune cells called

the neutrophils.” As noted above in Findings 11 and 15, respondent’s implication that his protocol involves any neutrophil-protecting measures that “ordinary chemo” does not involve is false.

b. He also told her that he had treated other Kaiser Permanente patients, whose “oncologists are offended that their members are going out of Kaiser—they don’t realize people don’t really like to die and ordinary chemo is mostly toxicity and very little benefit.”

c. Respondent told Patient 2 that treatment would cost between \$5,600 and \$7,700 per treatment cycle, “depending on complexity,” and ascribed the majority of this cost to testing the “chemo agents” for “potency.” When Patient 2 expressed concern about the cost of treatment, respondent’s first answer was that he would lose money if he charged less than \$6,500 per treatment cycle. When she then expressed interest in continuing treatment at Kaiser Permanente, respondent offered Patient 2 a “discount”: \$7,200 per treatment for the first six cycles, and \$5,600 per treatment thereafter. Patient 2 accepted this offer.

51. Patient 2 and respondent met in person on November 18, 2019. His notes from their meeting say that he spent two hours discussing his protocol with her, including “side effects,” and that the treatment plan would be to switch “from traditional chemo” to his “side-effect free” protocol.

52. Patient 2’s treating oncologist at Kaiser Permanente (Ashok Pai, M.D.) had recommended a further chemotherapy regimen to Patient 2 in November 2019. Neither respondent’s records nor his testimony show that he ever knew precisely what therapy Dr. Pai had recommended to Patient 2, or compared its potential risks and benefits for Patient 2 (accurately or otherwise) against the potential risks and benefits

to her of the "side-effect free chemotherapy" protocol he proposed. In addition, neither respondent's records nor his testimony show that he conferred in any way with Dr. Pai, such that Dr. Pai could give Patient 2 accurate information comparing the potential risks and benefits for her of the therapy he had recommended against the potential risks and benefits of the therapy respondent proposed.

53. Patient 2 agreed on November 18, 2019, to undergo "side-effect free chemotherapy," and signed a copy of the document described above in Finding 13 purporting to memorialize her informed consent to this protocol. Patient 2's document does not indicate whether she endorsed statement A (failed all prior care), statement B (understood but did not want other care), or both.

54. Respondent's records state that Patient 2 received 10 "side-effect free chemotherapy" treatment cycles between November 18, 2019, and April 8, 2020. Each treatment cycle followed the protocol described generally above in Finding 10.

55. Patient 2 experienced consistent abdominal pain and nausea throughout this period, which worsened in March 2020. Respondent's records occasionally mention Patient 2's physical condition, but do not report that he performed regular complete physical examinations of Patient 2 during her treatment.

56. Patient 2 had laboratory blood chemistry testing approximately biweekly between November 2019 and April 2020. Until January 2020, she had this testing through Kaiser Permanente, and brought the results to respondent herself. In February and March 2020, Patient 2 had most of this testing through a different laboratory, ordered by respondent.

a. The testing between November 2019 and January 2020 through Kaiser Permanente included measuring Patient 2's blood concentration of carcinoembryonic

antigen (CEA), which Patient 2 and Dr. Pai understood as an indicator of her overall bodily cancer load. This concentration rose steadily, from 236.7 nanograms per milliliter on November 10, 2019, to 566.8 nanograms per milliliter on January 22, 2020. Respondent's records include some of these test results, but do not reflect that he considered the results or discussed them with Patient 2.

b. On January 22, 2020, Patient 2's platelet count was very low. Respondent noted the result in his records, but nevertheless recorded that he administered carboplatin to Patient 2 on January 28, 2020. A repeat count on February 3, 2020, was only slightly higher, and showed as well that Patient 2 was anemic. Respondent recommended that Patient 2 go to the Kaiser Permanente emergency department, where she received a whole blood transfusion. Respondent recorded that he administered more carboplatin to Patient 2 on February 11, 2020.

c. On March 10, 2020, respondent ordered only a comprehensive metabolic panel for Patient 2, not a blood cell and platelet count. His records summarize her platelet count in mid-March as "good," however, and he again recorded administering carboplatin to her on March 17, 2020. In fact, Patient 2 also gave a blood sample at Kaiser Permanente on March 10, 2020, for a blood cell and platelet count, which again showed that her platelet count was dangerously low.

d. Respondent did order a blood cell and platelet count for Patient 2 on March 25, 2020, which revealed that her platelet count was critically low. Respondent's records include this laboratory result but do not reflect what, if anything, he did about it. On March 27, 2020, however, Patient 2 received a platelet transfusion in the Kaiser Permanente emergency department, after her primary care provider received a laboratory report showing that she had almost no circulating platelets.



e. Respondent ordered another blood cell and platelet count for Patient 2 on April 2, 2020. This test again showed her to have almost no circulating platelets. Kaiser Permanente records, but not respondent's records, state that respondent advised Patient 2 to go again to the Kaiser Permanente emergency department for a platelet transfusion, which she did on April 4, 2020. Respondent then documented administering more carboplatin to Patient 2 on April 7, 2020, despite noting that Patient 2 recently had received "2 units of platelets and one of blood."

57. Patient 2 had ultrasound abdominal imaging at Kaiser Permanente on January 7, 2020, that showed "many hepatic masses corresponding to known liver metastases." Respondent received this report and dismissed it as uninformative. He ordered similar imaging at Alta Bates Hospital in Berkeley on March 26, 2020, which also showed that Patient 2's liver was "severely enlarged," but that "[d]iscrete hepatic masses [were] difficult to delineate."

58. Patient 2 was hospitalized at the Kaiser Permanente hospital in Oakland between February 23 and 29, 2020. During this admission, on February 23, 2020, she had a radiologic scan that showed her liver and lung metastases to have grown. This report is not in respondent's records, but Kaiser Permanente records state that physicians there described it to respondent. These records also reflect that Patient 2 "insisted on leaving the hospital so that she could continue" in respondent's care.

59. Alyssa Cowell Luddy, M.D., a member of Patient 2's Kaiser Permanente care team during her February 2020 admission, wrote a chart note saying that she spoke to respondent on February 24, 2020, about Patient 2's condition and he insisted that her cancer was shrinking rather than growing. Dr. Luddy reported the team's concerns about respondent to the Board on February 27, 2020.

60. Despite the matters summarized in Findings 56.a and 57, respondent also assured Patient 2 and her husband repeatedly between November 2019 and March 2020 that his treatment for her was causing her cancer to shrink rather than to grow. As late as March 17, 2020, respondent documented having told Patient 2 that her severe pain was "indicative that we are hitting the target." In testimony, respondent endorsed these statements, stating that he "became encouraged" about Patient 2's treatment because she experienced such severe upper abdominal pain. As for Patient 1, respondent's testimony that he believed Patient 2's cancer to have regressed, rather than to have progressed, between November 2019 and March 2020 is not credible; and if he actually believes so, he is delusional.

61. When Patient 2 arrived at respondent's office on February 29, 2020, to begin her eighth treatment cycle, respondent noted in her record that she "came directly from hospital," but not how long she had been there or why. She was so weak that respondent had to meet her at the curb with a wheelchair to escort her into the office. The next day, respondent documented administering carboplatin to Patient 2.

62. On April 6, 2020, respondent administered mesna to Patient 2 while she remained in her car, because she was unable because of weakness or pain to move to respondent's office. As noted above in Finding 56.e, his records show that she received carboplatin the next day.

63. On April 9, 2020, both Patient 2 and her husband spoke by telephone with Kaiser Permanente palliative care physician Bonnie Gar-Mon Chen, M.D. Dr. Chen's note regarding the call describes Patient 2 as "screaming 'Please! Get me to the ER! I'm in pain!'" while her husband described Patient 2 as "delirious" and asked Dr. Chen to refer Patient 2 for physical therapy. Dr. Chen advised Patient 2's husband to bring Patient 2 to the hospital emergency department. She noted, "I was frank with

husband that patient is dying and likely has days, and she is suffering. He seems to be in complete denial or not processing what I'm saying."

64. Patient 2 again was admitted to the Kaiser Permanente hospital in Oakland on April 9, 2020. She insisted on remaining in the hospital because she feared that if she returned home, even with hospice care, her husband would insist that she resume "aggressive care" to extend her life. She also revoked her husband's health care power of attorney, and instructed hospital staff members to refuse to allow her husband to visit her. Patient 2 died on April 13, 2020.

65. Respondent testified that he believes Patient 2 to have died because treating physicians at Kaiser Permanente were "so stingy" with platelets. He believes, and persuaded Patient 2's husband to believe, that she should have received further platelet transfusions and nutritional support during her April 2020 hospital admission, rather than the comfort care she requested, because if she had regained strength she could have continued "side-effect free chemotherapy" until it had cured her cancer. This testimony is not credible. Also, if respondent actually does believe that Patient 2 died from any cause other than metastatic cancer, his belief is delusional. Finally, whether dishonest or delusional, respondent's efforts to encourage Patient 2 and her husband to pursue further treatment rather than palliative care were cruel.

### **Unprofessional and Incompetent Conduct**

66. In light of the opinions summarized above in Finding 16 and 17 and the training (or lack thereof) summarized in Findings 4 and 5, respondent's use of carboplatin to treat Patient 2 was an extreme departure from the standard of care. In addition, in light of the opinions summarized above in Finding 15, respondent's use of

mesna for Patient 2 as an “antidote” to carboplatin was both incompetent and an extreme departure from the standard of care.

67. Dr. Benjamin testified credibly and persuasively that the standard of care for treating metastatic colon cancer is to monitor the patient’s physical condition closely during treatment, with physical examinations and imaging studies; to document the patient’s condition thoroughly; and to discontinue treatment if it is not effective. He believes that no reasonable physician would have treated Patient 2 as respondent did, because “clinicians must offer treatment choices that are not futile” rather than offering “false hope” that increases rather than decreases dying patients’ suffering. The course of treatment summarized in Findings 54 through 62 was incompetent, and was an extreme departure from the standard of care.

68. Dr. Benjamin testified credibly that although carboplatin is an effective treatment for some cancers, no clinical evidence ever has shown carboplatin to be effective against metastatic colon cancer. For this reason as well, he deems respondent’s use of carboplatin for Patient 2 to have been an extreme departure from the standard of care. This opinion is persuasive.

69. Dr. Benjamin testified credibly that giving cytotoxic chemotherapy to a patient who is too weak to leave her car is an extreme departure from the standard of care. In addition, giving cytotoxic chemotherapy intravenously in a car, rather than in a clean, controlled clinical environment, is an extreme departure from the standard of care regardless of the patient’s strength. In light of this persuasive opinion, respondent committed extreme departures from the standard of care with respect to Patient 2 by giving her carboplatin on March 1, 2020, and on April 7, 2020.

70. Dr. Benjamin also testified credibly and persuasively that continuing carboplatin therapy for a patient with clear evidence of thrombocytopenia, as respondent did for Patient 2 (summarized in Finding 56) is an extreme departure from the standard of care, reflecting reckless disregard for patient safety as well as gross incompetence.

71. Dr. Benjamin testified credibly that respondent's failure to document physical examinations of Patient 2, and in particular his failure to document her weight and to intervene as her weight and apparent nutritional status declined, was an extreme departure from the standard of care. He also testified credibly that respondent's failure to document referring Patient 2 for platelet transfusions was a simple departure from the standard of care. These opinions are consistent with respondent's records, and are persuasive.

72. Like Dr. Hurvitz, Dr. Benjamin believes that testing carboplatin for "potency" is unnecessary. He also observes that the absence of any testing records suggests that respondent may not even have conducted the testing for which he charged Patient 2. His persuasive opinion is that whether respondent actually did such testing or not, he committed an extreme departure from the standard of care by representing to Patient 2 that she needed to pay for this process.

### **PATIENT 3**

73. Patient 3 lived in San Diego, but traveled to Berkeley approximately twice a month for about five months for respondent to treat her. Despite self-reported financial hardship, she paid respondent about \$30,000, and also incurred travel and lodging costs, for futile care. This experience significantly diminished Patient 3's quality of life during her final year.

## Treatment and Death

74. Patient 3 contacted respondent for the first time in June 2019. She told him that she had received a diagnosis of pancreatic cancer in October 2017. Patient 3 had received chemotherapy and radiation therapy in San Diego, but learned in June 2019 that her cancer had metastasized.

75. Patient 3 corresponded by email with respondent for a few weeks about the prospect that he might treat her. She expressed concern about the price of treatment, travel, and lodging, to which respondent answered that he had “asked our billing”<sup>7</sup> and “was told” that he could discount her treatment cost to \$4,200 per cycle.

76. Respondent and Patient 3 met for the first time on July 29, 2019. She agreed to undergo “side-effect free chemotherapy,” and signed a copy of the document described above in Finding 13 purporting to memorialize her informed consent to this protocol. Patient 3’s document does not indicate whether she endorsed statement A (failed all prior care), statement B (understood but did not want other care), or both.

77. Respondent’s records do not reflect what information, if any, Patient 3 sent or brought to him about her prior treatment in San Diego. They also do not reflect that respondent ever conferred in any way with other physicians who had treated or who were treating Patient 3. For this reason, neither respondent’s records nor his testimony show that he ever compared (accurately or otherwise) the potential risks and benefits for Patient 3 of any therapy she might receive by continuing

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<sup>7</sup> Respondent does not have a billing service or any administrative employees.

treatment with her San Diego team against the potential risks and benefits to her of the "side-effect free chemotherapy" protocol he proposed.

78. According to respondent's records, Patient 3 had seven "side-effect free chemotherapy" treatment cycles between July 29, 2019, and November 8, 2019, conforming generally to the protocol described above in Finding 10.

79. Patient 3 complained regularly of abdominal pain and nausea during her treatment, and her weight dropped steadily. Respondent's records occasionally mention Patient 3's physical condition, but do not report that he performed regular complete physical examinations of Patient 3 during her treatment.

80. In September and October 2019, Patient 3 began experiencing greater back pain, and learned from radiologic scanning in San Diego that she had at least one vertebral fracture. Respondent's notes from her visit to him on October 7, 2019, acknowledge this development, but do not reflect that he counseled Patient 3 about it or changed his treatment course in any way.

81. Respondent did not order any radiologic imaging for Patient 3 while he treated her.

82. Patient 3 had laboratory blood chemistry testing regularly between July and November 2019. Respondent's records include only a few laboratory printouts from these tests, but indicate that Patient 3 also either showed or told him results from testing at laboratories in San Diego.

a. Patient 3 had regular tests of her blood concentration of a protein known as CA19-9. Such tests are routine during pancreatic cancer treatment, because higher

blood concentrations of CA19-9 correlate with greater pancreatic cancer burden. These concentrations rose significantly during Patient 3's treatment with respondent.

b. Patient 3 had regular blood cell and platelet counts. In mid-August 2019, she had a low platelet count and anemia (likely caused by gastrointestinal bleeding). In September 2019, her platelet count fell further, and respondent's notes indicate that he did not treat Patient 3 in late September 2019 because of her low platelet count. Nevertheless, respondent's records show that he gave carboplatin to Patient 3 in early November 2019, when her platelet count remained similarly and dangerously low.

c. On July 30, 2019, and September 10, 2019, respondent took blood samples from Patient 3 and sent them to a German laboratory to test her blood concentration of "circulating tumor cells." The two results were identical.

83. Respondent prescribed Zarxio to Patient 3 in September 2019. His records do not reflect why, and they do not reflect what if any instructions he gave to Patient 3 about when or how to use this medication.

84. As he had for Patients 1 and 2, respondent told Patient 3 regularly during treatment that he believed that her cancer was regressing. His notes state that he told her in early September and in early October that her increasing CA19-9 concentrations were good signs. He also testified that Patient 3's persistent pain indicated to him that treatment was effective. Respondent's testimony that he believed Patient 3's cancer to have regressed, rather than to have progressed, between July and November 2019 is not credible; and if he actually believed or believes so, he was or is delusional.

85. On November 5, Patient 3 was too weak to come to respondent's office to receive mesna. He came to her lodging on a "house call," and administered carboplatin to her the next day.



86. When Patient 3 returned to San Diego after receiving mesna from respondent on November 8, 2019, she went directly to a hospital emergency department complaining of severe back pain. She returned to the hospital emergency room on November 12 and was diagnosed with a small bowel obstruction.

87. Patient 3 never returned to respondent for further treatment. She moved from San Diego to Oregon to be nearer to her husband and children, and died in February 2020. Her husband filed a complaint about respondent with the Board in April 2020.

88. Respondent testified that he believes Patient 3 to have died because she abandoned her treatment with him despite its success. This testimony is not credible. Also, if respondent actually does believe that further "side-effect free chemotherapy," might have cured Patient 3's metastatic pancreatic cancer, this belief is delusional.

### **Unprofessional and Incompetent Conduct**

89. Dr. Shin testified credibly that no clinical evidence ever has shown carboplatin therapy, in the manner respondent provided it, to be effective against metastatic pancreatic cancer. His opinion that the course of treatment summarized in Findings 78 through 85 was an extreme departure from the standard of care is persuasive.

90. Dr. Shin also testified credibly that neither mesna nor Zarxio has a routine role in treating metastatic pancreatic cancer. Although Zarxio may be appropriate for some patients whose therapy impairs their neutrophil production, Dr. Shin saw no evidence in respondent's records to support its use for Patient 3. Providing these drugs to Patient 3 exposed her to their risks, with no corresponding benefits, and was an extreme departure from the standard of care. This opinion also is persuasive.

91. Dr. Shin testified credibly and persuasively that the standard of care for treating metastatic pancreatic cancer is to monitor the patient's treatment response closely, particularly using both imaging studies and blood testing, and to discontinue futile therapy.

a. The German "circulating tumor cells" test that respondent ordered has not demonstrated clinical effectiveness, according to Dr. Shin's credible testimony.

b. Although respondent attended to Patient 3's CA19-9 level, Dr. Shin deems respondent's stated belief that its increase reflected treatment effectiveness, rather than treatment failure, to be incompetent.

c. Dr. Shin stated that imaging studies are more important than blood testing for assessing whether treatment is effective. Respondent's failure to order any was a departure from the standard of care.

d. Respondent's stated belief that Patient 3's disease had regressed and that further "side-effect free chemotherapy" was appropriate represents "a profound deficit in clinical judgment."

For all these reasons, Dr. Shin deems the course of treatment summarized in Findings 78 through 85 to have been an extreme departure from the standard of care. This opinion is persuasive.

92. Finally, Dr. Shin testified credibly and persuasively that the standard of care for any medical practitioner is to communicate truthfully with patients about their own conditions and about their treatment options. For the reasons summarized in Findings 12, 13.c, 75, 77, and 84, his opinion that respondent committed extreme

departures from the standard of care by lying to Patient 3 about “side-effect free chemotherapy” and about her own medical condition is persuasive.

### **Treatment of Additional Patients**

93. Respondent offered testimony from one patient and from family members of two other patients, and a letter from a fourth patient. These persons’ testimony suggested that respondent’s treatment for these patients was similar in its incompetence and unprofessionalism to his treatment of Patients 1, 2, and 3.

94. Patient B.A. testified that he received “side-effect free chemotherapy” from respondent for bladder cancer and later for colon cancer. After learning in 2015 that he had bladder cancer, B.A. consulted several oncologists, all of whom recommended the same “cookie cutter” chemotherapy protocol. B.A. elected instead to pursue “side-effect free chemotherapy” with respondent, because respondent persuaded B.A. that respondent had a “really good track record” with a customized protocol that would be “more powerful than standard chemo with less side effects.” B.A. later returned to respondent for more “side-effect free chemotherapy” when B.A. developed a colon tumor. He believes himself currently to be cancer-free.

95. C.M. and L.M. testified regarding respondent’s treatment for their late daughter, and wrote a letter summarizing their opinions regarding respondent. C.M.’s and L.M.’s daughter had breast cancer, and refused all conventional treatment. She consulted respondent in September 2019 and died in September 2020. Beginning in spring 2020, respondent came to their home in Tracy to administer “side-effect free chemotherapy” to this patient. C.M. recalled these house calls as an accommodation relating to the COVID-19 pandemic, but L.M. recalled the house calls as having occurred because their daughter was in too much pain from bone metastases to travel

by car between Tracy and Berkeley. C.M. and L.M. understand their daughter's breast cancer to have been in remission as of early 2020. They believe that she died not from breast cancer but from congenital "auto-immune thrombocytopenia," which no physician had identified before their daughter began treatment with respondent but which caused her to be "unable to produce blood platelets in sufficient amounts to keep her alive."

96. D.R. testified regarding respondent's treatment for her late husband, and wrote a letter summarizing her opinion regarding respondent. D.R.'s husband learned in September 2021 that he had a fast-growing, invasive brain tumor. He consulted oncologists at Memorial Sloan-Kettering Cancer Center and Columbia University Irving Medical Center in New York, and at the Dana-Farber Cancer Institute in Boston, who recommended radiation therapy but advised him that his prognosis for long-term survival was poor. Upon advice from a nutritional adviser (a "keto specialist"), and after being persuaded by respondent that the "side-effect free chemotherapy" protocol had a much greater likelihood of success than the treatments proposed by physicians at any of the three East Coast centers they had consulted, D.R. and her husband elected to relocate from New York to Berkeley. D.R.'s husband received treatment from respondent between October 2022 and January or February 2023, during which time D.R.'s husband became physically weak enough that respondent had to come to their hotel to treat him rather than asking him to come to respondent's office. D.R. and her husband believed respondent to have cured the cancer, but D.R.'s husband developed aspiration pneumonia and died after a six-week hospitalization.

97. A letter from patient D.K. praised respondent's care, without identifying precisely when or for what cancer he treated her. A note accompanying this letter signed by D.K.'s friend states that D.K. died soon after writing it.

## **Additional Evidence**

98. As summarized in Findings 23, 28, 35, 36, 56 through 59, 80, and 86, Patients 1, 2, and 3 received treatment from other California medical providers while also receiving sham treatment from respondent. Likewise, as summarized in Finding 8, respondent professes to have been offering his sham treatment for about 20 years, to hundreds of patients. The evidence does not establish that any other members of the California medical community before Dr. McClellan had reported concerns about respondent's practice to the Board, however.

99. Although all patients whose care was in evidence during this hearing already were terminally ill with metastatic cancer when respondent began treating them, respondent testified that ordinarily he refuses treatment to terminally ill patients. This testimony is not credible. Rather, the evidence in aggregate shows that respondent preys on vulnerable patients and their families by exploiting their fear and denial about impending death to extract payment for worthless treatments. This conduct is despicable.

100. Moreover, if respondent had treated patients whose cancers were or might have been curable when they began treatment with respondent, his treatment would have caused actual harm to these patients by encouraging them to substitute his ineffective treatment for potentially curative treatment. Respondent's testimony about his patient selection demonstrated no insight into the profound public health hazard his practice represents.

## **Costs**

101. Since January 1, 2022, the Board has incurred \$9,410.50 in costs for investigative services relating to this matter. Complainant's claim for reimbursement of

these costs is supported by a declaration that complies with California Code of Regulations, title 1, section 1042, subdivision (b)(1). These costs are reasonable.

102. Since January 1, 2022, the Board has incurred \$26,300.00 in costs for legal services provided to complainant by the California Department of Justice in this matter. Complainant's claim for reimbursement of these costs is supported by a declaration that complies with California Code of Regulations, title 1, section 1042, subdivision (b)(2). These costs are reasonable.

## **LEGAL CONCLUSIONS**

1. The Board may discipline respondent's physician's and surgeon's certificate only upon clear and convincing proof, to a reasonable certainty, of the facts establishing cause for discipline. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence supports the factual findings above.

### **Causes for Discipline**

2. The Board may suspend or revoke respondent's physician's and surgeon's certificate if he has engaged in unprofessional conduct. (Bus. & Prof. Code, §§ 2227, 2234.) Unprofessional conduct includes medical practice reflecting gross negligence (acts involving extreme departures from the professional standard of care), repeated negligence (simple departures from the professional standard of care), or incompetence. (Bus. & Prof. Code, § 2234, subds. (b), (c), (d).)

3. Respondent prescribed and administered carboplatin and gemcitabine to Patient 1 negligently, incompetently, and without proper training, as summarized in

Findings 17, 24, 33, 39, 41, and 42. He continued cytotoxic chemotherapy for Patient 1 even though her cancer was advancing rather than responding favorably to treatment, as summarized in Findings 21, 26, 28 through 30, 32, 33, and 40. He failed to document Patient 1's condition, failed to document her treatment fully or accurately, and failed either to give or to document giving accurate information to the patient about her treatment choices, all as summarized in Findings 22, 25, 40, 42, and 44. He failed to address Patient 1's bone metastases competently, as summarized in Findings 21, 43, and 44. He charged Patient 1 excessive fees for useless testing, as summarized in Findings 19, 46, and 47. In all, respondent's conduct with respect to Patient 1 was incompetent, repeatedly and grossly negligent, and cruel. It constitutes cause to revoke his physician's and surgeon's certificate.

4. Respondent prescribed and administered carboplatin and mesna to Patient 2 negligently, incompetently, and without proper training, as summarized in Findings 17, 54, 66, and 68. He continued cytotoxic chemotherapy for Patient 2 even though her cancer was advancing rather than responding favorably to treatment, as summarized in Findings 55, 56.a, 57, 58, 60, and 67, and even though she had severe thrombocytopenia, as summarized in Findings 56.b through 56.e and 70. He treated Patient 2 in an unsafe setting (a car), and when she was too weak to support treatment, as summarized in Findings 61, 62, and 69. Respondent failed to document Patient 2's condition, failed to document her treatment fully or accurately, and failed either to give or to document giving accurate information to the patient about her treatment choices, all as summarized in Findings 50.a, 51, 52, 55, 60, and 71. He charged Patient 2 excessive fees for useless testing that he may not even have performed, as summarized in Findings 10.e, 48, 50.c, and 72. In all, respondent's conduct with respect to Patient 2 was incompetent, repeatedly and grossly negligent, and cruel. It constitutes cause to revoke his physician's and surgeon's certificate.

5. Respondent prescribed and administered carboplatin and mesna, and prescribed Zarxio, to Patient 3 negligently and incompetently, as summarized in Findings 17, 78, 83, 89, and 90. He failed to use appropriate measures to monitor Patient 3's response to treatment, and misinterpreted the measures he did use, as summarized in Findings 79 through 82, 84, and 91. Respondent lied to Patient 3, as summarized in Findings 75, 77, 84, and 92. In all, respondent's conduct with respect to Patient 3 was incompetent, repeatedly and grossly negligent, and cruel. It constitutes cause to revoke his physician's and surgeon's certificate.

6. A physician's failure to maintain adequate and accurate patient care records is unprofessional conduct. (Bus. & Prof. Code, § 2266.) The matters summarized with respect to Patients 1, 2, and 3 in Findings 25, 29, 40, 42, 45, 52, 55, 56, 61, 71, 77, 79, and 83 constitute cause to revoke respondent's physician's and surgeon's certificate.

### **Alternative or Complementary Medicine**

7. Respondent contends that his care for Patients 1, 2, and 3 was not unprofessional or incompetent, but rather qualified as "alternative or complementary medicine" for which Business and Professions Code section 2234.1 precludes discipline. This argument is meritless.

8. In the first place, Business and Professions Code section 2234.1, subdivision (b), defines "alternative or complementary medicine" as treatment that is not only uncommon, but also offers "a reasonable potential for therapeutic gain in a patient's medical condition that is not outweighed by the risk of the health care method." As summarized in Findings 9 through 12 and 14 through 17, respondent's "side-effect free chemotherapy" is uncommon only because it is an incompetent use of



standard cytotoxic chemotherapy agents, not because it is a uniquely insightful use of these agents. Moreover, and as summarized in Finding 11, to the extent that any of respondent's patients experience "side-effect free" carboplatin treatment (which Patients 1, 2, and 3 certainly did not), they do so because they receive the same anti-nausea and pro-marrow medications they would receive from any oncologist. Finally, and as summarized in Findings 14, 39, 41, 43, 67, 68, 89, and 90, this protocol offered no potential for therapeutic gain for any of Patients 1, 2, or 3. Instead, these drugs risked increasing these patients' discomfort and weakening their already-frail bodies for no reason. These facts confirm that Business and Professions Code section 2234.1 does not apply to the sham treatment respondent offered.

9. In the second place, "alternative or complementary medicine" is exempt from discipline only if the physician rendering this treatment has performed a "good-faith prior examination of the patient." (Bus. & Prof. Code, § 2234.1, subd. (a)(1).) As summarized in Findings 22, 25, 51, 52, 55, 77, and 79, respondent neither conducted any such examination for any of Patients 1, 2, or 3 nor obtained records about them from other providers that would have allowed him to evaluate their conditions thoroughly, prudently, and accurately.

10. In the third place, "alternative or complementary medicine" is exempt from discipline only if the physician rendering this treatment has secured the patient's consent to the treatment after giving the patient complete, accurate information both about conventional treatments for the patient's illness and about the potential risks and benefits of the "alternative or complementary" treatment. (Bus. & Prof. Code, § 2234.1, subds. (a)(1), (a)(2).) As summarized in Findings 9, 13, 26, 29, 34, 35, 42, 44, 50, 52, 60, 65, 75, 77, 84, and 88, respondent did no such thing. Rather, he gave his patients and their families wildly inaccurate information about the potential benefits

and risks of the treatment he offered, about the benefits and risks of other available treatments, and about the patients' own conditions.

11. Finally, "alternative or complementary medicine" is exempt from discipline only if the physician rendering this treatment has described to the patient his own "education, experience, and credentials . . . related to the alternative or complementary medicine." As summarized above in Findings 4 through 9, 13, 50, 94, and 96, respondent lied to his patients about his experience and qualifications, and continued this misrepresentation to the Board at this hearing.

### **Disciplinary Considerations**

12. All matters stated in Findings 8 through 100 and in Legal Conclusions 3 through 11 confirm that respondent has harmed numerous terminally ill people and their families, including Patients 1, 2, and 3. As summarized in Findings 29, 34, 38, 60, 65, 84, and 88, two possibilities exist to explain this conduct: (1) respondent is profoundly dishonest, or (2) respondent is profoundly delusional. Regardless of the explanation for respondent's cruel and dangerous conduct, clear and convincing evidence shows that respondent intends to continue it as long as he retains his medical license. Public safety requires the Board to revoke this license.

### **Costs**

13. A physician who has committed a violation of the laws governing medical practice in California may be required to pay the Board the reasonable costs of the investigation and enforcement of the case, but only as incurred on and after January 1, 2022. (Bus. & Prof. Code, § 125.3.) The matters stated in Findings 101 and 102 establish that these costs for this matter total \$35,710.50.

14. In *Zuckerman v. State Bd. of Chiropractic Examiners* (2002) 29 Cal.4th 32, the California Supreme Court set forth the standards by which a licensing board or bureau must exercise its discretion to reduce or eliminate cost awards to ensure that the board or bureau does not deter licensees with potentially meritorious claims from exercising their administrative hearing rights. The court held that a licensing board requesting reimbursement for costs relating to a hearing must consider the licensee's "subjective good faith belief" in the merits of his position and whether the licensee has raised a "colorable challenge" to the proposed discipline. (*Id.*, at p. 45.) The board also must consider whether the licensee will be "financially able to make later payments." (*Ibid.*) Last, the board may not assess full costs of investigation and enforcement when it has conducted a "disproportionately large investigation." (*Ibid.*)

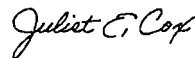
15. All these matters have been considered. They do not justify any reduction in respondent's obligation to reimburse the Board for its reasonable costs.

## ORDER

1. Physician's and Surgeon's Certificate No. G 20670, held by respondent Kenneth Naoyuki Matsumura, M.D., is revoked.

2. Respondent Matsumura shall reimburse the Medical Board of California for its enforcement costs in this matter by paying the Board \$35,710.50 within 30 days after the effective date of this order.

DATE: 09/19/2023



JULIET E. COX

Administrative Law Judge

Office of Administrative Hearings