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

In the Matter of the Accusation Against: Lionel Sidney Foster, Jr., M.D. Physician's & Surgeon's Certificate No G 60284 Petitioner.	Case No.: 800-2023-103911

ORDER DENYING PETITION FOR RECONSIDERATION

The Petition filed by Jeffrey S. Kravitz, Esq. attorney for Lionel Sidney Foster, Jr., M.D., for the reconsideration of the decision in the above-entitled matter having been read and considered by the Medical Board of California, is hereby denied.

This Decision remains effective at 5:00 p.m. on December 30, 2025.

IT IS SO ORDERED: December 30, 2025

MD.

Veling Tsai, M.D., Chair
Panel A

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

In the Matter of the Accusation Against: **Lionel Sidney Foster, Jr., M.D.** **Physician's & Surgeon's Certificate No. G 60284** **Respondent.**	**Case No. 800-2023-103911** **ORDER GRANTING STAY** **(Government Code Section 11521)**

Jeffrey S. Kravitz. Esq. on behalf of Respondent, Lionel Sidney Foster, Jr. M.D., has filed a Request for Stay of execution of the Decision in this matter with an effective date of December 1, 2025, at 5:00 p.m.

Execution is stayed until December 31, 2025, at 5:00 p.m.

This stay is granted solely for the purpose of allowing the Respondent to file a Petition for Reconsideration.

DATED: November 14, 2025

Reji Varghese
Executive Director
Medical Board of California

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

In the Matter of the First Amended Accusation Against: Lionel Sidney Foster, Jr., M.D. Physician's and Surgeon's Certificate No. G 60284 Respondent.	Case No. 800-2023-103911

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 1, 2025.

IT IS SO ORDERED October 31, 2025.

MEDICAL BOARD OF CALIFORNIA

MD.

Veling Tsai, M.D., Vice 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:

LIONEL SIDNEY FOSTER, JR., M.D., Respondent

Agency Case No. 800-2023-103911

OAH No. 2025040144

PROPOSED DECISION

Administrative Law Judge Coren D. Wong, Office of Administrative Hearings, State of California, heard this matter by videoconference July 9 through 11 and 14 through 17, 2025, from Sacramento, California.[1]

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[1] This matter (secondary matter) was consolidated for hearing with *In the Matter of the Accusation Against Lionel Sidney Foster, Jr., M.D.*, Agency Case Number 800-2023-101401/OAH Number 2024110747 (primary matter). A separate Proposed Decision has been written in the primary matter pursuant to California Code of Regulations, title 1, section 1016, subdivision (d).

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

Albert J. Garcia, Attorney at Law, represented respondent Lionel Sidney Foster, Jr., M.D., only during oral argument on complainant's amended motion in limine and the admission of some of complainant's exhibits at the beginning of the first day of hearing. Respondent represented himself for the remainder of hearing.

Evidence was received, and the record was left open for respondent to submit a written closing brief and complainant to submit a written rebuttal brief. A Second Amended Protective Order Sealing Confidential Records sealing certain documents and witness names was issued. Respondent's closing briefs are included in the record as Exhibits AA through FF, and complainant's rebuttal brief is included as Exhibit 144.

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

FACTUAL FINDINGS

Jurisdictional Matters

LICENSE STATUS

1. The MBOC issued respondent Physician's and Surgeon's Certificate Number G 60284 on June 8, 1987. The certificate expires July 31, 2026, unless renewed.

PRIOR DISCIPLINE

2. On April 13, 2018, a former Executive Officer of the MBOC filed an Accusation seeking to discipline respondent's certificate for committing gross negligence while treating a patient and committing repeated negligent acts while treating the same patient and another one. Respondent resolved the Accusation by signing a Stipulated Settlement and Disciplinary Order agreeing cause for discipline could be established at an administrative hearing. He further agreed his certificate would be publicly reprimanded for erroneously incising a patient's prostate urethra instead of the bladder neck and not removing the patient's entire prostate during a robotic radical prostatectomy. The MBOC issued a Decision adopting the Stipulated Settlement as its Decision and Order, and the order was effective May 31, 2019.

CURRENT ACCUSATION

3. Complainant signed the First Amended Accusation in this matter solely in his official capacity on April 17, 2025. He alleged cause exists to discipline respondent's certificate because he was grossly negligent while treating two patients and committed repeated negligent acts while treating one of those patients and three others.

4. More specifically, complainant alleged respondent committed gross negligence by: (1) failing to immediately identify the avulsion of Patient A2's[2] right

[2] The primary matter and the secondary matter each involve a Patient A and a Patient B, but those respective patients are not the same people in both matters. The parties stipulated at hearing to referring to the patients in the secondary matter as

ureter and/or appropriately intervene; (2) performing multiple unnecessary and repetitive ureteroscopic procedures on Patient A2; (3) performing open exploratory surgeries on July 3, 2018, and April 1, 2021, that did not address Patient A2's avulsed ureter, rather than a definitive repair; (4) performing a Greenlight laser vaporization of the prostate (PVP) on Patient B2 with unknown urine cultures less than 24 hours after the administration of antibiotics; and (5) drafted an addendum to an operative report to change the operation performed from right radical nephrectomy to removal of right retroperitoneal mass.

5. Complainant further alleged respondent committed repeated negligent acts by: (1) performing a second PVP on Patient B2 without evidence of obstruction; (2) failing to correctly identify and remove Patient B2's right kidney; (3) failing to adequately manage Patient C's prostate cancer with pre- and post-operative imaging; (4) prescribing Patient C the antibiotic ciprofloxacin numerous times despite a prior history of bilateral Achilles tendon surgery; (5) performing a urethral dilation on Patient D with an unclear indication and lack of adequate workup; and (6) performing an incomplete workup for high-risk prostate cancer for Patient E.

Respondent's Background

6. Respondent earned his medical degree from the University of California (UC), San Francisco, in 1985. He completed a general surgery internship at the same facility two years later, and a urology residency at the same facility two years after that. He completed an additional year of residency as the chief resident for urology.

Patient A2 and Patient B2, and those designations are used throughout this PD for consistency with the hearing transcript.

Respondent has been continuously board-certified with The American Board of Urology since 1994.

7. Respondent has spent his entire career in private practice. He was a urologist with the San Jose Medical Group from 1991 to 2001, the Permanente Medical Group from 1991 to 2009, and the Fremont-Rideout Medical Group from 2009 to 2015. In 2009, he also joined the Oroville Hospital Medical Group, and he left sometime in 2023. It was unclear from the evidence where he practiced after he left.

Patient A2

BACKGROUND

8. On April 13, 2018, Patient A2's obstetrician/gynecologist, Peter Bippart, M.D., was removing her right fallopian tube and ovary when he discovered a cystic mass, a sac-like structure filled with fluid or other material, attached to her right ureter. The right ureter carries urine from the right kidney to the urinary bladder. During surgery, he called respondent to evaluate the ureter for possible injury prior to completing surgery.

9. Respondent performed a ureteroscopy with a semi-rigid ureteroscope to examine Patient A2's right ureter. A ureteroscope is a slender instrument used to perform diagnostic and therapeutic procedures in the urinary tract. According to his postoperative note, the ureteroscope was "driven all the way up to the renal pelvis" under direct vision, rather than by fluoroscopy. Fluoroscopy is a type of x-ray that shows internal structures moving in real time, as opposed to a standard x-ray that shows a static, single image. Respondent's impression was, "The patient with no damage to the right ureter."

10. While recovering in the hospital over the next few days, Patient A2 complained of pain, developed a fever, and had a decreased appetite. There was blood in her urine, and her abdomen was distended. Nonetheless, respondent discharged her after three days, despite her continuing to have "mild pain" according to medical records. Patient A2 returned to the emergency room later that afternoon with a fever, vomiting, and right lower quadrant pain.

11. Respondent saw Patient A2 for a follow-up visit two weeks after surgery, during which she was having pain in the right side of her back. Almost three weeks later, she complained of abdominal cramping in addition to back pain. An abdominal ultrasound revealed right hydronephrosis, swelling of the right kidney due to urine retention, and a cystic structure with septations in the middle of the right kidney. Septations refer to internal divisions or walls that create multiple compartments within a cyst.

12. A repeat ultrasound eight days later indicated the right hydronephrosis had worsened and the cystic structure had changed shape. The radiologist who reviewed the ultrasound explained it was "difficult to tell due to [the cyst's] large size [if] this is part of the kidney or part of the ureter, where exactly this is coming off of[,] it does appear to be compressing the kidney on a few of the images." A computed tomography (CT) scan three days later showed:

> [A] large complex cystic structure posterior [behind] and inferior [below] to the right kidney[,] this could represent a large exophytic cyst or potentially a large dilated ureter that is ruptured into the pararenal space, ureter diverticula less likely abscess[.] Moderate right hydronephrosis and

decreased enhancement to the right kidney[,] most likely due to ureter obstruction.

13. On June 22, 2018, respondent performed a right ureteroscopy to biopsy the cystic mass and possibly place a stent in the right ureter. He ultimately was unable to place a stent because the ureter was completely separated (avulsed) from the kidney. He called a radiologist to place a drain in the kidney, and 750 milliliters of fluid was drained. The radiologist noted in his report, "If hydronephrosis persists, a nephrostomy tube can now be placed as the decompression of the cyst has opened a sonographic window."

14. The following day, respondent documented in Patient A2's medical records, "Patient with obstruction of the right ureter. It's not clear the mechanism of injury to the ureter. Have discussed with the patient she needs to proceed with open repair of the ureter which can be done early this week."

15. Patient A2 agreed to respondent performing a third ureteroscopy to excise the cyst, which he did on July 3, 2018. According to his operative report, he was able to advance the guidewire into the renal pelvis and place a stent, despite not being able to 11 days prior because of the ureteral tear. Respondent found no narrowing or abnormalities in the ureter. The following day, he documented "the patient has some complaints of scrotal discomfort." He later prepared an addendum clarifying Patient A2 complained of "flank pain, not scrotal discomfort."

16. Subsequent imaging continued to show right hydronephrosis. A July 20, 2018 ultrasound revealed "mild to moderate right hydronephrosis." A repeat ultrasound on September 10, 2018, showed "persistent moderate hydronephrosis." Serial ultrasound on November 26, 2018, and February 11 and April 5, 2019, indicated

the same. An August 23, 2019 CT reflected "severe right hydronephrosis." Throughout this period, Patient A2 continued experiencing chronic flank pain.

17. Respondent performed his fourth ureteroscopy on February 20, 2020. He did not find any narrowing or abnormalities, and he placed another stent. An ultrasound performed the following month continued to show right hydronephrosis.

18. Respondent performed another ureteroscopy four months later, during which he inserted a catheter with a deflated balloon. Once in the portion of the ureter where he found narrowing, he inflated the balloon and dilated the area. He then inserted a stent. A subsequent ultrasound revealed "questionably slightly improved moderate right hydronephrosis." A CT scan three weeks later reflected "grade 4 hydronephrosis" and "right retroperitoneal scarring . . . with surgical clips along the course of the ureter." The left kidney was "unremarkable."

19. Respondent performed repeat balloon dilations on January 21 and February 11, 2021, dilated the right ureter, and placed stents. On April 1, 2021, Patient A2 provided informed consent to respondent performing a right pyeloplasty, a surgical procedure to treat an internal obstruction in a ureter by removing the obstructed portion and connecting the healthy portion directly to the renal pelvis. However, respondent instead performed a right ureterolysis, a surgical procedure to treat an external obstruction caused by scar tissue or a mass compressing the ureter by excising the adhesion or scar tissue and moving the ureter to a different location.

20. The following day, Patient A2 experienced significant pain, and a CT of her abdomen and pelvis revealed a "right double-J ureteral stent separate[d] with one fragment in the renal pelvis and a second fragment extending from the upper ureter to the bladder." Respondent operated the following day and tried to "manipulate with

the fluoroscope the stent into the collecting system on the right side." He was unsuccessful, so he performed a ureteroscopy. He found "an obvious perforation of the ureter." He placed a stent into the collection of fluid and allowed it to drain into the bladder. The same day a radiologist installed a nephrostomy tube in the right kidney.

21. Patient A2 ultimately sought treatment from UC San Francisco. On October 26, 2021, she successfully underwent surgery to have her right kidney removed, repaired, and then transplanted back into her (autotransplantation).

EXPERT OPINIONS

David S. Finley, M.D.

22. Complainant retained David S. Finley, M.D., to determine if respondent's treatment of Patient A2 deviated from any applicable standards of care. Dr. Finley received his Bachelor of Science in plant biology from UC Davis in 1998. He received his medical degree from UC Irvine School of Medicine six years later. He completed a general surgery internship and urology residency at the same institution in 2005 and 2009, respectively. Dr. Finley completed a two-year fellowship in urologic oncology at UCLA School of Medicine in 2011.

23. Dr. Finley has been licensed to practice medicine in California since November 30, 2005. He has been continuously board-certified by The American Board of Urology since 2013.

24. Dr. Finley has been an attending urologic oncologist in the Department of Urology at Kaiser Permanente Los Angeles since completing his fellowship. He has been the Director of Robotic Surgery at Kaiser Permanente Los Angeles Medical

Center since 2013, the Assistant Residency Program Director for Urology and a Quality Management Peer Review Officer at the same facility since 2014, and an Associate Professor of Urology at Kaiser Permanente's Bernard Tyson School of Medicine since 2021. Dr. Finley was co-director of Kaiser Permanente's Minimally Invasive Urology Fellowship from 2011 to 2013.

25. Dr. Finley's analysis of respondent's treatment of Patient A2 was based solely on his review of records complainant provided, including relevant medical records. He prepared a written report identifying three departures from the applicable standard of care – failing to timely recognize and treat an avulsed ureter, unnecessarily repeating ureteroscopies, and performing two exploratory surgeries instead of a definitive repair. He identified each applicable standard and analyzed the departure. Dr. Finley testified consistently with his report.

26. Dr. Finley explained that it is common for gynecologists and gynecologic oncologists to have a urologist evaluate the ureters during hysterectomies and the removal of fallopian tubes and ovaries due to the ureters' proximity to the structures removed. The urologist typically performs the evaluation using images obtained by C-arm fluoroscopy, a medical imaging device shaped like a "C" that generates real-time x-ray images. If no C-arm is available, a ureteroscope may be used.

27. When inserting a ureteroscope, it is important for the urologist to stop advancing it if he encounters too much resistance. The basic maxim is, "If it doesn't go easy, it doesn't go at all." A flexible or a semi-rigid ureteroscope may be used, but the former "are best suited for the upper ureter, where they can safely maneuver through the angulations of the ureter." A semi-rigid scope "is typically used for evaluation of the lower ureter below the level of iliac vessels."

28. Avulsion of the ureter is "a very rare problem, but it's the most feared during the ureteroscopy. Which is why we would often use a flexible ureteroscope, which is less traumatic than a rigid ureteroscope." When a urologist recognizes the ureter has been avulsed, "the standard of care would be to intervene immediately, whether it's a stent or a repair."

29. Dr. Finley concluded respondent "almost certainly avulsed the patient's right ureter from traumatic semirigid ureteroscopy at the time of the robotic salpingo-oophorectomy 4/13/2018." Respondent documented in his operative note that he advanced the ureteroscope "all the way up to the pelvis." After surgery, Patient A2's abdomen was distended, there was blood in her urine, and she was in significant pain. Nonetheless, respondent discharged her after only three days, only to have her return to the emergency room later that day with a fever, vomiting, and right lower quadrant pain.

30. Respondent did not order imaging until one month after surgery, despite Patient A2's repeated complaints of back and abdominal pain. An ultrasound revealed right hydronephrosis and a cystic mass with septations in the middle of the kidney. A ureteral stent or a nephrostomy tube should have immediately been placed to drain what Dr. Finley determined was likely blood and urine from respondent tearing the ureter from the kidney. But respondent instead waited a month before attempting a second ureteroscopy. He was unsuccessful due to the avulsion, and he had to call in a radiologist to place a nephrostomy tube.

31. Dr. Finley opined that respondent's treatment did not comport with the standard of care for recognizing and treating an avulsion. He explained:

> Well, I think that intervening when you -- you know, when one becomes aware that there's hydronephrosis and a fluid collection, a cystic structure next to the kidney, you know, that mandates that you must intervene urgently at that time.
>
> And so, you know, the ultrasound, you know, which showed hydronephrosis and this mass, was May 21. You know, to take the patient a month later, you know, is slow and does not convey any urgency.
>
> And then, you know, to do a ureteroscopy, I think that's not unreasonable. But after that point, you know, you need a nephrostomy tube right away. You need to do something definitive to fix this rather than just repeating the same thing over and over and causing -- causing more problems.

32. Dr. Finley further opined respondent's departure from the standard of care was an extreme departure "because this complication was not recognized and no intervention was initiated as such." It was an extreme departure, rather than a simple one, because not identifying and treating the avulsion was "the complete want of care."

33. When a ureter has been avulsed during ureteroscopy, additional ureteroscopies are unlikely to result in a different outcome. Instead, "a nephrostomy tube should have been placed immediately and then an attempt to restore ureteral continuity should [have been] undertaken through either robotic or open pyeloplasty, Boari flap, ureterocalicostomy, appendiceal interposition, buccal graft, simple

nephrectomy[,] or autotransplantation. If the surgeon [was] not comfortable or capable of this repair, the patient should have been referred out at that time."

34. Respondent attempted a ureteroscopy to place a stent two months post-surgery. He was unable to place a stent because the ureter was avulsed from the kidney. Nevertheless, he performed a third ureteroscopy only 11 days later. Dr. Finley commented about the third procedure as follows:

> Somehow where the ureter was totally injured just 11 days prior, now he was able to get a stent across this. And, you know, again, there's no images that were saved or available to review. So it's kind of unclear how that happened. But, you know, it's just highly unlikely or extremely lucky that, you know, a stent was able to be placed.
>
> But when we looked at the images again, I'm not so sure that the stent was actually in the right place, because there was still hydronephrosis. And it just looked a little bit off on the image.

35. Eighteen months later, respondent performed his fourth procedure. He found no narrowing or abnormalities but still elected to dilate and stent the ureter. Both procedures were unnecessary if the ureter "was normal." But a subsequent ultrasound showed there was still hydronephrosis, thereby raising questions about respondent's conclusion that there was no narrowing or abnormalities.

36. Respondent performed his fifth ureteroscopy, which included a repeat balloon dilation. However, when performing a repeat balloon dilation, "you'd want a laser. You'd want to cut the tissue so that you have fresh tissue that can heal. Just

dilating a diseased ureter, particularly a long stricture over 3 centimeters, that's – that's almost always going to fail." Respondent performed his sixth ureteroscopy eight months later, which also included a ballon dilation. "So . . . basically . . . he just sort of did what he did before and expecting a different result."

37. The stent was fractured during the last procedure, so respondent operated and attempted to reposition the stent using the fluoroscope. He could not, so he performed a seventh ureteroscopy.

38. Dr. Finley opined respondent committed an extreme departure from the standard of care by "repeating the same procedure over and over again and expecting a different outcome." He explained that not only was it unnecessary for respondent to do so, but he "caused damage to the patient."

39. Last, Dr. Finley explained the standard of care required respondent to immediately place a nephrostomy tube or surgically repair the ureter once he was unable to place a stent on June 22, 2018. "Ureterolysis does nothing for this type of injury." Any repair should be performed immediately because doing so "spares the patient from weeks or months or years (as in this case) of suffering." If surgical repair cannot be performed immediately, "the suggested time frame for delayed repair is generally 6-12 weeks."

40. Dr. Finley determined respondent should have discovered the avulsed ureter no later than June 22, 2018, when he was unable to place a stent. Nonetheless, on July 3, 2018:

> [H]e elected to perform ureteroscopy again followed by an open retroperitoneal "exploration." Ureteroscopy was done (again) without C-arm to provide fluoroscopic guidance. A

> stent was blindly placed and then he proceeded to make a large incision. After manually palpating the ureter, he "gained an understanding that the ureter was intact" and closed. This was a useless sequence of events that did nothing to resolve the underlying injury other than cause more pain for the patient. As expected, the hydronephrosis persisted after this. Subsequently, multiple useless procedures which were not indicated were performed culminating with another open exploration on 4/1/21 in which a "ureterolysis" was performed. Ureterolysis again would do nothing to fix the underlying stricture. This procedure resulted in complications necessitating another operation the following day to address a broken ureteral stent and another urinoma.

Dr. Finley opined that performing two unnecessary surgeries rather than a definitive repair constituted an extreme departure from the standard of care.

Chris Threatt, M.D.

41. Respondent retained Chris Threatt, M.D., to determine if his treatment of Patient A2 deviated from any applicable standards of care. Dr. Threatt earned his Bachelor of Science in physiology from UC Davis, in 1990. He earned his medical degree from UC Irvine School of Medicine, six years later. He completed a two-year internship in general surgery and a four-year residency in urology at Duke University Medical Center.

42. Dr. Threatt has been licensed to practice medicine in the State of California since May 8, 2002. He has been continuously board-certified by The American Board of Urology since 2004. He began practicing medicine at a urological medical group in June 2002. Dr. Threatt opened his own urology practice almost three years later, and he has had his own urology practice ever since.

43. Dr. Threatt's analysis of respondent's treatment of Patient A2 was based solely on his review of records, including relevant medical records. He prepared a written report itemizing the records upon which he based his opinion; summarizing respondent's treatment; and concluding "in my professional opinion, while the events perioperatively were unfortunate and [Patient A2's] complication significant, the standard of care was met, within a reasonable degree of medical certainty." Dr. Threatt did not identify the applicable standard of care or explain the basis for his conclusion that respondent met that standard.

44. At hearing, Dr. Threatt confirmed he reviewed Dr. Finley's report regarding Patient A2 and the First Amended Accusation prior to forming his opinions in this matter. He admitted he did not identify in his report either document as one he relied upon, explaining: "My reports probably aren't as pristine as I would have liked them to be."

45. Dr. Threatt concluded respondent did not depart from the applicable standard of care while treating Patient A2. He did not describe the standard by which he measured respondent's treatment, and he did not explain the basis for his conclusion.

RESPONDENT'S EVIDENCE

46. Respondent did not designate himself as an expert witness regarding his treatment of Patient A2. To the extent he testified to any expert opinions, they were not considered.

47. Respondent discussed his treatment of Patient A2 at length and opined it met all applicable standards of care. He explained that a person has a left and right ureter. One end of each ureter attaches to the kidney on the same side of the body, and the other end attaches to the bladder. A ureteral avulsion occurs when the ureter becomes completely separated from the kidney or bladder. He analogized a ureteral avulsion to the amputation of a limb when explaining an avulsion does not self-heal.

48. Respondent contrasted a ureteral avulsion with a ureteral perforation, which occurs when "there's a hole in the ureter." A perforation can self-heal and is a common complication of a ureteroscopy. He explained Patient A2 had a ureteral perforation, not a ureteral avulsion. If she had the latter, the entire surgical field would have been flooded with urine and blood, which did not occur. Additionally,

> In a case where you have a ureteral avulsion, to even consider that you might have had a normal-range creatinine is not possible. And this is why: Physiologically, when creatinine gets in the belly, it actually raises your blood creatinine to usually two or three times the normal amount.
>
> So if your normal creatinine is 1.0, and I avulse your ureter, close your bladder, or close your body, and send you to the wards -- a couple of things: You're not going to have

normal vital signs. You're not going to have an elevation in your temperature. You're not going to be able to eat.

Moreover:

It states in that discharge summary that the patient had a bowel movement prior to discharge. And the importance of that is that when you have ascites [an accumulation of excess fluid in the abdominal cavity], that's traumatic.

Whether it's from a ruptured kidney in an auto accident; whether it's from a ruptured bladder; a stab wound -- whatever it is -- your bowels basically go into something called an ileus. They freeze.

And so although the patient required some pain medicine, she still had a bowel movement because the only thing that was happening was that she had normal postoperative pain where she had her right ovary and her fallopian tube removed.

But she did not have an ileus, which is what you would see if urine was circulating throughout the abdominal cavity.

The other thing that is present -- on Exhibit 39, A6816 -- is a charting of the vital signs on discharge. And, again, the patient's vital signs -- on A6816 -- show a low-grade fever, but mostly normal vital signs. The pulse is normal. The respiratory rate is normal. The blood pressure is normal.

None of these findings are consistent with an amputated ureter.

49. Respondent cited several articles as support for his testimony. No discussion of the articles is necessary because each was hearsay and given no weight.

Patient B2

BACKGROUND

50. Patient B2 was a 54-year-old obese man with a history of multiple hospital admissions due to diabetic ketoacidosis, the body breaking down fat, instead of glucose, for energy, secondary to uncontrolled diabetes. He suffered recurrent urinary tract infections (UTIs), the basis for his referral to respondent.

51. On August 25, 2021, Patient B2 was admitted to the hospital for a possible bacterial infection and sepsis in his left kidney. He was given the antibiotic ceftriaxone and fluid, and a urine culture was obtained. He complained of painful urination and blood in his urine, so respondent was consulted. Respondent had been treating Patient B2 for benign prostatic hyperplasia (BPH), an enlarged prostate not due to cancer, with Flomax, a medication commonly prescribed to treat an enlarged prostate.

52. After evaluating Patient B2 in the hospital, respondent obtained authorization to perform a PVP to remove Patient B2's prostate. Surgery was performed the following day. Respondent documented in his urology note that he performed a "LASER TURP." His discharge summary indicated that a urine culture taken the day before surgery "are growing Enterococcus faecalis," a bacterium that causes UTIs. He wrote in his operative report, "The prostate fossa was 50 g[rams] and

obstructive." Less than 15 months later, respondent performed a second PVP because Patient B2 was having "residual obstructive voiding symptoms."

53. On November 7, 2021, respondent performed shock wave lithotripsy (ESWL) on a left kidney stone, a medical procedure that generates high-energy shock waves and directs them at kidney stones to break them into smaller fragments to be passed in urine. He returned to the operating room on March 8, 2023, to perform a "Right radical nephrectomy," removal of the right kidney. His preoperative and postoperative diagnoses were "Right atrophic kidney" and "Right recurrent urinary tract infections." An atrophic kidney is one that has shrunk in size and lost all its function.

54. Respondent noted in his operative report, "I got to the small, diminutive kidney, which was superiorly located and deep under the liver. The Endo-GIA auto sutures were used to isolate the kidney and remove it en bloc." The final pathology report issued two days later, however, indicated "no kidney tissue identified" in the specimen respondent submitted.

55. Almost three months after the final pathology report was issued, respondent prepared an addendum to his operative report. He wrote, "Corrected note. The following addendum was originally documented for this patient, however [*sic*] on an incorrect note title. This is a recreation [*sic*] of the original note which has been retracted." He documented for the first time, "[T]he patient did in fact have a retroperitoneal mass, which was in the right retroperitoneum where the kidney typically lies."

56. Respondent explained:

> The atrophic nature of the kidney allowed me to believe that this mass was the kidney. It phenotypically and characteristically looked like a small atrophic right kidney. After securing the vessels and all other attached structures, this approximately 60 [*sic*] gram mass was removed. The normal size of the kidney was about 100 g[rams]. Therefore, this fit the description and location of what would be an atrophic kidney.

Respondent did not describe in his original operative report the size of the specimen removed.

EXPERT OPINIONS

Dr. Finley

57. Complainant retained Dr. Finley to also determine if respondent's treatment of Patient B2 departed from any applicable standards of care. His analysis was based solely on his review of records complainant provided, including relevant medical records. He prepared a report identifying four departures from the standard of care – failing to remove Patient B2's kidney, preparing an addendum changing the procedure performed, performing a transurethral resection of the prostate (TURP) on a potentially septic patient, and performing a second TURP that was not indicated. Dr. Finley identified each applicable standard of care and analyzed each departure. He testified consistently with his report.

58. Dr. Finley explained that although "it would have been prudent" for respondent to open up the specimen after it was removed to confirm it was the kidney because of Patient B2's "abnormal anatomy," "I don't think that this is an essential --

you know, if you follow the vena cava up and you have the ureter around the vessel loop and you, you know, staple off the artery and the vein, I don't need to open that up on the back table."

59. Dr. Finley further explained respondent should have looked for and identified certain "landmarks" prior to attempting to remove Patient B2's right kidney to confirm that was in fact what he was removing. The psoas muscle usually can be easily identified due to its large size, and the kidney sits on top. Additionally, the right ureter can be located and traced upward. The blood supply to the right kidney also needs to be identified and controlled, and the vena cava is the landmark.

60. Dr. Finley characterized respondent's failure to remove Patient B2's right kidney as a simple departure from the standard of care because "surgical misadventures can occur." Additionally, he explained, "[T]his is a difficult patient. He has difficult anatomy. He's got, you know, more fat in the retroperitoneum."

61. Almost three months after the final pathology report was issued, respondent prepared an addendum to his operative report. He changed the procedure he performed from removal of Patient B2's right kidney to removal of a peritoneal mass. Although an addendum may be issued, it should not be issued to explain a subsequent pathology report that was unfavorable. Moreover, an addendum cannot change the procedure performed or the events that occurred during surgery based on hindsight. The purpose of an operative report is to memorialize the surgical care provided "from the surgeon's point of view." Dr. Finley explained:

> Well, again, it's -- you know, it's a medical-legal document. It is, you know -- if it -- it's not in the chart, it didn't happen. It's sort of all we have to memorialize what we do.

> And, you know, whether it's an informed consent discussion or an operative report or an office visit, you know, that is a legal document. And it's part of our duty to be honest and to write what happened and what we did and what care we performed. So to change that later, you know, is unacceptable.

Dr. Finley considered respondent's addendum an extreme departure from the standard of care.

62. Respondent performed Patient B2's first TURP without knowing the results of his urine culture and with less than a 24-hour course of antibiotics, despite there being no pus in the transition zone prostate. Dr. Finley explained a "TURP should not be performed in a septic patient unless the sepsis is due to a large transition zone prostate abscess." Moreover, a TURP should be performed with sterile urine, and "sterilization of urine requires culture specific antibiotics for 7 days on average."

63. Dr. Finley further explained:

> Any manipulation of the urinary tract in the setting of infected urine potentially can worsen sepsis by causing more bacteria to get into the bloodstream. Because you're manipulating an infected system.
>
> [¶] . . . [¶]
>
> In this case, you know, if you've got a high bacterial burden in the urine and then you're going to go in with a camera with irrigation, the irrigation is going to push those bacteria

into the bloodstream and -- and make things worse. So for any TURP you would need sterile urine, if you can accomplish that.

64. Dr. Finley characterized respondent's conduct as an extreme departure from the standard of care because it was "the opposite of all teaching of, you know, operating on the urinary tract with infected urine for an elective procedure. It's something that you would never -- you would never do unless you were in an extenuating circumstance that we alluded to."

65. Finally, respondent performed the second TURP on Patient B2 less than 15 months after the first. Dr. Finley determined there was no medical indication for performing the second procedure. He explained, "It would be uncommon for it to be redone within a year. You know, a good TURP should last five to 10 years." He concluded respondent performing the second TURP constituted a simple departure because there was no data Patient B2 "actually [was] retaining urine."

Dr. Threatt

66. Respondent retained Dr. Threatt to also determine if his treatment of Patient B2 deviated from any applicable standards of care. Dr. Threatt's analysis of respondent's treatment was based solely on his review of records, including relevant medical records. He prepared a written report itemizing the records upon which he based his opinion; summarizing respondent's treatment; and concluding "in my professional opinion, while the events perioperatively were unfortunate and [Patient B2's] complication significant, the standard of care was met, within a reasonable degree of medical certainty." Dr. Threatt did not identify the applicable standard of care or explain the basis for his conclusion that respondent met that standard.

67. At hearing, Dr. Threatt confirmed he reviewed Dr. Finley's report regarding Patient B2 and the First Amended Accusation prior to forming his opinion. He admitted he did not identify in his report either document as one he relied upon, explaining: "My reports probably aren't as pristine as I would have liked them to be."

68. Dr. Threatt concluded respondent did not depart from the applicable standard of care while treating Patient B2. Again, he did not describe the standard by which he measured respondent's treatment, and he did not explain the basis for his conclusion.

RESPONDENT'S EVIDENCE

69. Respondent did not designate himself as an expert witness regarding his treatment of Patient B2. To the extent he testified to any expert opinions, they were not considered.

70. Respondent testified extensively about his treatment of Patient B2 and opined it met all applicable standards of care. He described Patient B2 as "a complicated 54-year-old diabetic, who has compromised renal function, who was treated by myself and my team over the course of -- I believe from 2018 to currently." He believed he did nothing wrong by preparing the addendum to his operative report. He explained, "And in order to guide future care of this particular patient, it is important for the notes to be accurate. And accuracy means putting in the fact that the diagnosis had changed -- what you did was different."

71. Respondent claimed it was inaccurate to describe Patient B2 as being septic when the first TURP was performed because "he was not septic. No elevated white count. No hemodynamic instability. No elevated temperature. So that was not

accurate. He had no positive culture. So I want to make that clear. He did not have a positive culture at that time."

72. Additionally, Patient B2 was on ceftriaxone for more than 24 hours prior to surgery. "He was started on antibiotics at 7:00 in the morning on -- I guess it was August 25th. And he had his operation late afternoon on August 26th. He had two doses of a broad-spectrum antibiotic called ceftriaxone, which -- to which that organism was sensitive postoperatively." The urine culture did not mature until after the TURP was performed.

73. Respondent said the first TURP was successful because Patient B2 was "voiding well." However, he also said Patient B2 was "on maximum doses of the medicine called Flomax." He then explained, "So what that means is that he's voiding well and that's great, but why should he need maximum doses of Flomax? And that can be either that his bladder doesn't work well, or perhaps there's more prostate that needs to be taken out."

74. Therefore, respondent felt the second procedure was necessary. However, he conceded there was no current imaging showing a blockage: "The operation -- the second operation was based on endoscopic findings that were made on that cystoscopy years prior."

75. Respondent again relied on several articles to support his testimony. None were given any weight for the same reason the other articles were not given any.

Patient C

BACKGROUND

76. Patient C was a 65-year-old male who was referred to respondent because of a high prostate specific antigen (PSA) blood test. He had a history of prior bilateral Achilles tendon repair. On June 26, 2018, respondent performed an ultrasound prostate biopsy, which revealed high-risk prostate cancer. A subsequent bone scan was negative. Respondent did not obtain a CT, positron emission tomography (PET) or magnetic resonance imaging (MRI) scans.

77. On August 9, 2018, respondent performed a radical prostatectomy, removal of the prostate to treat localized cancer. Final pathology indicated only three nodes were obtained due to insufficient lymph node dissection. "A focal positive margin was noted on the right 'peripheral margin' possible [*sic*] related to nerve sparing on the right." A focal positive margin refers to the discovery of a small limited area of cancer cells at the edge of the specimen removed. Patient C's PSA continued to rise after surgery. Despite this information and the final pathology results, respondent did not order imaging.

78. On November 18, 2019, Patient C saw respondent and complained of symptoms of a UTI and painful urination. Urinalysis was cloudy and positive for nitrite and leukocyte esterase, the presence of either of which was indicative of a UTI. Respondent prescribed the antibiotic ciprofloxacin. He prescribed an additional 30-day supply less than two months later, and another seven-day supply a little more than three weeks after that.

EXPERT OPINIONS

Dr. Finley

79. Complainant retained Dr. Finley to also determine if respondent's treatment of Patient C departed from any applicable standards of care. His analysis was based solely on his review of records complainant provided, including relevant medical records. He prepared a report identifying two departures from the standard of care – suboptimal management of high-risk prostate cancer and contraindicated medication prescribing. Dr. Finley identified each applicable standard of care and analyzed each departure. He testified consistently with his report.

80. Respondent obtained a bone scan but no soft tissue imaging prior to performing a radical prostatectomy. He did not obtain any imaging after surgery despite final pathology results indicating there was insufficient lymph node dissection and cancer cells were found on the edge of the specimen removed.

81. Dr. Finley explained that the standard of care for treating a patient with high-risk prostate cancer requires the physician to:

> [M]ake sure that the patient does not have metastatic disease cancer that has spread. Because removing the prostate usually would not be indicated in that scenario. So prostate cancer typically can go to the bones, to the lymph nodes, other soft tissues.
>
> So you need to get two types of imaging. A bone scan and CT scan, or a PET scan.
>
> [¶] . . . [¶]

But it's the combination of looking at the skeleton plus the lymph nodes and the other soft tissues that is important.

82. Dr. Finley concluded respondent's failure to obtain pre- and post-operative imaging was a simple departure from the standard of care. He explained it was only a simple departure because "[I] think he did part of it. It wasn't a complete lack or want of medical care. You know, it's -- it's negligent, but it's -- you know, it's not completely negligent, because he did do half of it."

83. Respondent prescribed the antibiotic ciprofloxacin for Patient C on three occasions over the course of 10 weeks despite his prior history of bilateral Achilles tendon repair. Prescribing that antibiotic is contraindicated for patients with such history because the medication is associated with an increased risk of tendon rupture. Dr. Finley concluded respondent committed a simple departure from the standard of care by prescribing ciprofloxacin on three occasions.

Dr. Threatt

84. Respondent retained Dr. Threatt to also determine if his treatment of Patient C deviated from any applicable standards of care. Dr. Threatt's analysis of respondent's treatment was based solely on his review of records, including relevant medical records. He prepared a written report itemizing the records upon which he based his opinion; summarizing respondent's treatment; and concluding "in my professional opinion, given the American urologic [*sic*] Association guidelines for workup and management of prostate cancer in 2018 the standard of care was met, within a reasonable degree of medical certainty." Dr. Threatt did not identify the applicable standard of care or explain the basis for his conclusion that respondent met that standard.

85. At hearing, Dr. Threatt confirmed he reviewed Dr. Finley's report regarding Patient C and the First Amended Accusation prior to forming his opinion. He admitted he did not identify in his report either document as one he relied upon, explaining: "My reports probably aren't as pristine as I would have liked them to be."

86. Dr. Threatt concluded respondent did not depart from the applicable standard of care while treating Patient C. Again, he did not describe the standard by which he measured respondent's treatment, and he did not explain the basis for his conclusion.

RESPONDENT'S EVIDENCE

87. Respondent did not designate himself as an expert witness regarding his treatment of Patient C. To the extent he testified to any expert opinions, they were not considered.

88. Respondent testified at length about his treatment of Patient C and opined it met all applicable standards of care. Patient C's primary care physician ordered a PSA blood test in January 2018, but he never followed through with the test. Another primary care physician ordered the same test in June 2021, which revealed a PSA of 22. Patient C was referred to respondent for follow-up.

89. Respondent explained, "A PSA of 22 is probably a 60 percent chance or higher of being positive for prostate cancer." The score also "indicates that the chances of bony metastases are somewhere around 15 percent, so much higher. So he did have that [bone] study." Respondent performed a prostate biopsy, which included a rectal exam. The results showed "the highest risk prostate cancer."

90. Patient C's bone scan "indicated that he didn't have involvement of his bones with this disease." "And the lymph node dissection, which is the gold standard, was done to determine the status of his lymph nodes" prior to respondent performing a radical prostatectomy.

91. Respondent explained, "The most sensitive way [to manage very high-risk prostate cancer postoperatively] is to use blood tests," which he did. After prostate removal, the PSA "should go to zero." If that does not occur within six weeks, "then that can indicate that there is some residual disease or that, you know, the disease is not completely cured." Respondent further explained postoperative imaging was unnecessary because Patient C's blood tests had already detected recurrence of cancer, and he underwent radiation therapy.

92. Respondent described ciprofloxacin as "probably the most commonly used antibiotic because it can cover the bacteria that typically colonize the rectum." He said The American Urological Association lists the drug "as its number one antibiotic to use." He disagreed with Dr. Finley's testimony that the use of ciprofloxacin in patients with a history of bilateral Achilles tendon repair is associated with a higher risk of developing tendon ruptures. He described the risk of developing tendon ruptures after taking ciprofloxacin as "less than the risk of having a reaction to penicillin or cephalosporin."

93. Respondent again relied on several articles to support his testimony. None were given any weight for the same reason the other articles were not given any.

Patient D

BACKGROUND

94. Patient D was a 62-year-old woman who initially visited respondent's practice on August 24, 2018, due to a prior history of UTIs and urinary hesitancy, delay in initiating urination. It was recommended that she undergo a cystoscopy, a medical procedure whereby a physician examines her urinary tract using a thin, lighted tube called a cystoscope. She never followed up, and the procedure was not performed.

95. Patient D reestablished care with respondent's physician assistant on November 18, 2019. Her complaints included bladder pressure, trouble urinating, painful urination, frequent urination with little output, and frequent urination at night. She denied blood in her urine, flank pain, and fever. She experienced chills. The physician assistant did not document a past medical history of urinary incontinence, the voluntary loss of urine, or a past surgical history for hysterectomy. He did not physically examine Patient D's genitalia or urinary tract.

96. Respondent prescribed the medication terazosin and recommended a cystoscopy. He discontinued the medication four days later due to Patient D complaining of dizziness. Respondent attempted a cystoscopy the following week. He documented the following indication for the procedure in his operative note: "The patient is a woman with a history of urethral stenosis." However, he was unable to perform the surgery because, according to his operative note, "the urethra was too stenotic to admit the scope." Respondent did not document performing a vaginal examination or the status of the urethral meatus, the opening to the urethra through which urine exits the body. He did not order any imaging, and he did not perform or order any testing to determine the functionality of the urinary tract.

97. Respondent recommended a cystoscopy with urethral dilation, a procedure whereby increasingly larger metal bars are inserted into the urethra to stretch it. Patient D deferred and was prescribed the medication tamsulosin. However, she called the following week and requested the recommended procedure as soon as possible. Respondent performed a cystoscopy on December 20, 2019, during which he dilated Patient D's urethra to "18[*sic*]m[illileters]." After, she continued to complain of painful urination, and for the first time she complained of incontinence. However, she no longer had urinary hesitancy, and she had good flow.

98. Respondent continued medication management by prescribing imipramine. After three months, Patient D reduced her use of incontinence pads by half, so she declined respondent's referral to physical therapy to strengthen her pelvic floor muscles. In May 2020, she reported experiencing stress incontinence, the involuntary loss of urine during activities that increase pressure on the bladder, such as coughing, laughing, sneezing, or exercising. Five months later, she indicated she increased her use of incontinence pads, woke up to urinate 30 times each night, and experienced sleepiness from the medication.

99. Respondent changed Patient D's medication to oxybutynin and recommended a cystoscopy, which he performed the following day. He wrote in his operative report, "The urethra was somewhat stenotic [unusually narrowed or constricted]. The patient has spastic neurogenic bladder [a condition where the bladder muscles involuntarily contract, leading to frequent and urgent urination], I believe due to the intrinsic quality of the bladder." He prescribed the medication myrbetriq, but Patient D had to stop taking it because it caused drowsiness.

100. Respondent brought Patient D into the operating room on January 8, 2021, for a bladder Botox injection. He explained, "[T]he reason that was done . . . after

urethral dilation she now had better urodynamics and lower bladder pressure . . . but her renal function was still compromised – it was only 63-64." However, respondent's medical records show he never performed urodynamics.

101. The following month, Patient D reported a significant reduction in the number of times she was waking up at night to urinate (nocturia), but she was still experiencing incontinence and using three to four pads each day. Respondent recommended a transobturator tape (TOT) procedure, which he performed the following week. A TOT is a surgical procedure to treat stress incontinence by placing a polypropylene tape sling to support the urethra.

102. Three days later, respondent's medical assistant documented in Patient D's medical record that she called complaining of "extreme pain in her right groin." She came in for treatment complaining of trouble moving her right leg, slow urine flow, and less leakage during the day but more at night. A subsequent post-void residual showed she was not emptying her bladder, and respondent prescribed the medication Flomax.

103. Patient D returned three days later and complained about pelvic pain, incontinence, and urinary hesitancy. A Foley catheter was placed, and 50 to 100 milliliters of urine was drained with no relief. Respondent prescribed oxybutynin and recommended a cystoscopy. A cystoscopy was performed a few weeks later, and respondent noted in his report that Patient D's "urethra was well supported" but "she may need urethral dilation."

104. Respondent performed a second cystoscopy with urethral dilation on April 13, 2021. He noted in his operative report, "The urethra was somewhat stenotic. The urethra was dilated to 24 French with male sounds." He subsequently noted after a

follow-up appointment that Patient D "still has trouble emptying her bladder, she has nocturia x15+." Patient D subsequently transferred her care to a different urologist, because she was dissatisfied with respondent's care.

EXPERT OPINIONS

Dr. Finley

105. Complainant retained Dr. Finley to also determine if respondent's treatment of Patient D departed from any applicable standards of care. His analysis was based solely on his review of records complainant provided, including relevant medical records. He prepared a report identifying one departure from the standard of care – performing a urethral dilation. Dr. Finley identified the applicable standard of care and analyzed the alleged departure. He testified consistently with his report.

106. Urethral stenosis can occur when scar tissue forms on the urethra and causes narrowing of the lumen, the space in the urethra through which urine flows. It can cause UTIs or create blockages that prevent the flow of urine, decrease the stream of urine, or make it harder to start urinating. Urethral dilation is a procedure to treat urethral stenosis. Dr. Finley described urethral dilation in women as "an outdated intervention which rarely has a place in contemporary urologic practice." It is "exceedingly rare" to perform a urethral dilation on a woman, "we're talking about less than 1 percent of cases." Yet respondent performed the procedure on Patient D twice.

107. Patient D initially presented to respondent due to repeated UTIs and other urinary problems that did not include incontinence. Indeed, respondent first documented a complaint of incontinence after he performed the first urethral dilation. Although he claimed during his interview with the MBOC that Patient D experienced

incontinence since her hysterectomy in 1995, he wrote nothing about that in her medical records.

108. Moreover, Dr. Finley explained:

> But you don't really get urethral strictures [narrowing of the urethra], you know, from a hysterectomy. There's no real evidence of that, and, you know, one of the papers that was provided by Dr. Foster, you know, from UCSF, you know, said, quote, "We virtually never see incontinence right after hysterectomy."

109. Dr. Finley explained that the standard of care for treating a female patient suspected of having urethral stenosis requires a "complete workup." That starts with asking her current symptoms and past surgical history to determine if she previously suffered trauma or had a Foley catheter. If she had a hysterectomy, it is important to know if it was to treat cancer and, if so, she underwent radiation.

110. Next, "a physical exam is mandatory, including, you know, a focused exam with a pelvic exam." A cystoscope should be used to evaluate the pelvic organs. If a cystoscope cannot be easily inserted, imaging should be obtained. A retrograde urethrogram (RUG), an imaging procedure during which a radiologist takes a series of x-rays as contrast dye is injected into and passes through the urethra, will show any actual narrowing, its location, and its extent. A voiding cystourethrogram (VCUG) is another imaging option. During this test, x-ray or ultrasound images are obtained while the patient's bladder is filled with contrast dye and then urinates.

111. Testing for true incontinence is an option. "The urodynamic testing is . . . the formal testing where you would actually put pressure transducers into the

bladder, into the rectum, and measure, as you fill the bladder up, with or without x-rays, the . . . contractility of the bladder, the detrusor or the bladder muscle pressures, the compliance." A post-void residual (PVR) test is another option. During this test, an ultrasound or a catheter is used to measure the amount of urine remaining in the bladder after the patient urinates. Uroflow, a test to measure the rate and flow of urine, may also be performed.

112. Although respondent attempted a cystoscopy, he noted in Patient D's medical records that "the urethra was too stenotic to admit the scope." He did not order any imaging as an alternative. Nor did he perform any type of physical exam or order or perform any testing. Dr. Finley concluded respondent committed a simple departure from the standard of care by performing a "urethral dilation in the absence of adequate workup."

Dr. Threatt

113. Respondent retained Dr. Threatt to also determine if his treatment of Patient D deviated from any applicable standards of care. Dr. Threatt's analysis of respondent's treatment was based solely on his review of records, including relevant medical records. He prepared a written report itemizing the records upon which he based his opinion; summarizing respondent's treatment; and concluding "in my professional opinion, while the events perioperatively were unfortunate and [Patient D's] complication significant, the standard of care was met, within a reasonable degree of medical certainty." Dr. Threatt did not identify the applicable standard of care or explain the basis for his conclusion that respondent met that standard.

114. At hearing, Dr. Threatt confirmed he reviewed Dr. Finley's report regarding Patient D and the First Amended Accusation prior to forming his opinion. He

admitted he did not identify in his report either document as one he relied upon, explaining: "My reports probably aren't as pristine as I would have liked them to be."

115. Dr. Threatt concluded respondent did not depart from the applicable standard of care while treating Patient D. Again, he did not describe the standard by which he measured respondent's treatment, and he did not explain the basis for his conclusion.

RESPONDENT'S EVIDENCE

116. Respondent did not designate himself as an expert witness regarding his treatment of Patient D. To the extent he testified to any expert opinions, they were not considered.

117. Respondent testified at length about his treatment of Patient D and opined it met all applicable standards of care. He said she was "incontinent before I ever saw her. In fact, I saw the patient years after her incontinence was documented. On this document, this is a visit with the patient's nurse practitioner, which documents that the patient had recurrent UTIs and urgency incontinence and was sleeping on an incontinent bed." Moreover, "In this same document, another PA documented, in November of 2019, that the patient had urinary incontinence." Respondent also testified Patient D's records documented a hysterectomy "30 years prior to my intervention with her."

118. Respondent referenced a compilation of Patient D's medical records he created by cutting and pasting portions of her medical records into his own document. But the November 18, 2019 progress note indicated Patient D saw respondent's physician assistant, not his nurse practitioner, and the physician assistant did not document a history of incontinence or a prior hysterectomy.

119. Respondent further testified, "So when I saw her, in my original note, which is on A28534, in the initial urinary consultation, I document that she has had a hysterectomy in 1995 and that she is having difficulty urinating, pushing to void." Again, the document he referenced was his compilation of Patient D's medical records. And while he notated she had a hysterectomy in 1995, the history of present illness he copied from her medical records mentioned nothing about that event. Respondent did not introduce the medical records for Patient D's August 24, 2018 visit.

120. Respondent again relied on several articles to support his testimony. None were given any weight for the same reason the other articles were not given any.

Patient E

BACKGROUND

121. Patient E was a 79-year-old male who first presented to respondent in October 2021 with an elevated PSA blood test. He complained of painful urination, retention of urine, and nocturia. Respondent did not perform a digital rectal exam but recommended a prostate biopsy, which he performed on October 19, 2021. The results revealed very high-risk prostate cancer.

122. Respondent's notes from a November 4, 2021 visit indicated Patient E said "he would like the prostate removed ASAP." Respondent discussed different treatment options, including monitoring the progression of the cancer, hormone treatment, robotic versus open radical prostatectomy, and radiation. He notated, "Given the patient's life expectancy of >10 years, I recommend open radical prostatectomy vs. external beam radiation therapy. Pt. would like to proceed with ORP. Bone scan ordered to r/o metastasis." Respondent did not order any other imaging.

123. Patient E was admitted to the hospital in urinary retention on November 10, 2021. Respondent performed a radical prostatectomy the following day. "Pathology showed a [123-gram] prostate, stage 3b prostate cancer with multiple positive margins[,] and a minimal lymph node yield of 0/4 lymph nodes involved."

EXPERT OPINIONS

Dr. Finley

124. Complainant retained Dr. Finley to also determine if respondent's treatment of Patient E departed from the applicable standards of care. His analysis was based solely on his review of records complainant provided, including relevant medical records. He prepared a report identifying one departure from the standard of care – incomplete workup for very high-risk prostate cancer. Dr. Finley identified the applicable standard of care and analyzed the alleged departure. He testified consistently with his report.

125. Dr. Finley explained that the standard of care for treating a patient with very high-risk prostate cancer is to evaluate him for metastatic disease by performing a bone scan and soft tissue imaging, such as a CT, MRI, or PET scan. "Imaging is required for the detection and characterization of disease to select treatment or guide change in disease management." If imaging reveals that the cancer has spread beyond the prostate, "radiation is preferred over surgery, especially in an older patient."

126. A combination of different cancer treatments is often needed for very high-risk cancer. A radical prostatectomy is an appropriate treatment option for patients with localized cancer and life expectancies of 10 years or more. Generally, younger patients prefer surgery while older patients opt for radiation.

127. Dr. Finley concluded respondent's "failure to obtain proper imaging represents a simple departure from the standard of care."

Dr. Threatt

128. Respondent retained Dr. Threatt to also determine if his treatment of Patient E deviated from any applicable standards of care. Dr. Threatt's analysis of respondent's treatment was based solely on his review of records, including relevant medical records. He prepared a written report itemizing the records upon which he based his opinion; summarizing respondent's treatment; and concluding "in my professional opinion, given the American urological [*sic*] Association guidelines for workup and management of prostate cancer in 2018 the standard of care was met, within a reasonable degree of medical certainty." Dr. Threatt did not identify the applicable standard of care or explain the basis for his conclusion.

129. At hearing, Dr. Threatt confirmed he reviewed Dr. Finley's report regarding Patient E and the First Amended Accusation prior to forming his opinion. He admitted he did not identify in his report either document as one he relied upon, explaining: "My reports probably aren't as pristine as I would have liked them to be."

130. Dr. Threatt concluded respondent did not depart from the applicable standard of care while treating Patient E. Again, he did not describe the standard by which he measured respondent's treatment, and he did not explain the basis for his conclusion.

RESPONDENT'S EVIDENCE

131. Respondent did not designate himself as an expert witness regarding his treatment of Patient E. To the extent he testified to any expert opinions, they were not considered.

132. Respondent testified at length about his treatment of Patient E and opined it met all applicable standards of care. He found it "striking" that Patient E first came to him after having an elevated PSA for nine years "never having had an evaluation of this abnormality at all -- including any biopsies, any MRIs, or anything like that -- means that, basically, this patient might have had prostate cancer for eight or nine years before I ever saw him."

133. Respondent explained, "It was clear there was time to change course," meaning he was "someone who definitely required or was deserving of a more complete analysis of his prostate." Furthermore, one of the physicians with the practice who referred Patient E to respondent:

> documents his notes that are in the Chico notes that are fixed to the Medical Board's evidence in the 2022 year -- he documents the fact that this patient had a PSA that's been elevated for the last nine years.
>
> When he comes to see me, he shows me that same list. When you look at his documentation from Enloe Hospital prior to seeing me, you can see he saw several doctors for this elevated CM-PSA. And it's upon his election that no evaluation was done.

134. Respondent described a rectal exam as "really not that painful, but it's definitely not pleasant. So if you know that you're going to proceed with biopsy of the prostate, the thing to do is to do your rectal exam at the time of the prostate biopsy." He performed a rectal examination while performing "a prostate biopsy using a transrectal ultrasound probe." Biopsy revealed Patient E had "very high-risk prostate cancer."

135. Respondent opined that the treatment options for managing Patient E's prostate cancer were the same as those for managing Patient C's. However, Patient E "had probably the most deadly prostate cancer that you can have." Although "most men in this country will die with their prostate cancer and not from their prostate cancer," Patient E's "prostate cancer is completely the opposite. Most men with this prostate cancer will die from this prostate cancer."

136. Respondent did not order imaging prior to performing a radical prostatectomy because Patient E "was emergently admitted in kidney failure" because "his kidneys were no longer working" the day before surgery. Staging lymph nodes with imaging requires the use of contrast, which "is a very risky procedure to do" on a patient in renal failure. Therefore, both a CT and an MRI were contraindicated for Patient E, and a PET scan was not yet available as an imaging modality. Moreover, CT and MRI scans provided useful information only 40 percent of the time.

137. Respondent again relied on several articles to support his testimony. None were given any weight for the same reason the other articles were not given any.

Analysis

WITNESS CREDIBILITY

Respondent

138. Evidence Code section 780 provides criteria for evaluating a witness's credibility. Three criteria relevant to evaluating respondent's credibility are the character of his testimony, inconsistencies between his testimony and prior statements, and the truth or accuracy of facts to which he testified. (*Id.*, at subds. (b), (h), & (i).) When discussing the primary matter, respondent explained he prescribed finasteride to control Patient A1's postoperative prostate bleeding. However, he wrote in the treatment note for the day he prescribed the medication that it was for "benign prostatic hyperplasia with lower urinary tract symptom." He also testified that the only symptom Patient A1 was experiencing when he saw Dr. Scarborough in April 2023 "was a little dysuria [painful urination]." Such testimony was belied by the medical records.

139. When discussing the secondary matter, respondent quibbled with Dr. Finley's opinion that respondent should not have performed the first TURP on Patient B2 because he potentially had a bacterial infection and sepsis. It was undisputed Patient B2 was admitted to the hospital for a possible bacterial infection and sepsis the day before the procedure. He was immediately started on antibiotics, and a urine culture was obtained. The culture did not mature until after respondent performed the TURP.

140. Dr. Finley persuasively explained there was no evidence the TURP was urgently needed. Additionally, sterile urine is necessary when performing a TURP to prevent spreading bacteria, and "sterilization of urine requires culture specific

antibiotics for 7 days on average." Respondent countered by going over ad nauseum the evidence that Patient B2 had no objective signs of infection or sepsis on the day of the procedure. But he missed the point of Dr. Finley's testimony: the TURP did not need to be performed when it was, Patient B2 was potentially infected and septic, and sterile urine was essential for the procedure to be safely performed. Whether he displayed objective symptoms of an infection or sepsis was irrelevant.

141. Respondent also explained in painstaking detail that Patient B2 had been taking an antibiotic for more than 24 hours prior to the procedure, contrary to Dr. Finley's testimony. Respondent testified: "He was started on antibiotics at 7:00 in the morning on – I guess it was August 25th. And he had his operation late afternoon on August 26th." Whether Patient B2 had been taking an antibiotic for less than, or slightly more than, 24 hours before the PVP, he had not been taking it for seven days as Dr. Finley persuasively established was needed to sterilize Patient B2's urine. Furthermore, the antibiotic prescribed was not culture specific because Patient B2's urine culture had not matured when the specific antibiotic was chosen. The culture was ultimately positive for Enterococcus faecalis group d, a species of bacteria that causes UTIs.

142. Respondent insisted he documented Patient D's prior hysterectomy and resulting incontinence throughout her medical records. But the records he referenced were documents he created by cutting and pasting portions of Patient D's medical records and adding editorial comments. Some of the information he included in his manufactured documents was inconsistent with the underlying medical records. Other information had no corresponding medical records in the record. The record persuasively established Patient D did not complain about incontinence to respondent

or his staff until after the first urethral dilation. There was no evidence in the record that respondent or anyone else from his office documented her prior hysterectomy.

143. In addition to respondent's quibbling and contradictory and uncorroborated testimony, he displayed a haughty attitude throughout hearing and refused to conform to fundamental rules for questioning witnesses. (Evid. Code, § 780, subd. (a) [demeanor while testifying].) He was repeatedly admonished not to ask witnesses to read into the record documents already admitted. He was also continually told not to testify under the guise of asking a witness a question.

144. Indeed, respondent was admonished to stop testifying while asking Dr. Finley questions no less than 35 times before cross-examination was terminated. He continued testifying instead of asking Dr. Finley questions during recross-examination and while subsequently asking Dr. Alan Weinberg, complainant's expert witness in the primary matter, questions. Respondent's obstinance throughout hearing negatively impacted his credibility. (Evid. Code, § 780, subd. (j) [attitude during proceeding].) Considering the above, he was not a credible witness.

Dr. Finley

145. Dr. Finley testified in a straightforward manner, and he explained how several of the articles he provided supported his opinions and conclusions. (Evid. Code, § 780, subds. (a) & (i).) He testified consistently with his written reports. (*Id.* at subd. (g) [prior consistent statements].) Moreover, Dr. Finley found "issues" with some of respondent's treatment, but he ultimately conceded they did not constitute deviations from the applicable standards of care. (*Id.* at subd. (f) [absence of bias].) Lastly, he explained the applicable standards of care, how respondent deviated from them, and why his deviations constituted extreme or simple departures. (*People v. Bassett* (1968)

69 Cal.2d 122, 144 [the value of an expert's opinion lies with his explanation of the factual predicate for such opinion].)

Dr. Threatt

146. In each of his written reports, Dr. Threatt itemized the documents upon which he relied in forming his opinion. He did not list the First Amended Accusation or any of Dr. Finley's reports. Yet he testified he reviewed both documents prior to forming any opinions in this matter. Dr. Threatt's testimony was inconsistent with statements he made in his reports. (Evid. Code, § 780, subd. (h) [prior inconsistent statements].) Furthermore, his testimony was uncorroborated. (*Id.* at subd. (i) [the existence or nonexistence of corroborating evidence].)

147. Additionally, Dr. Threatt opined all the treatment respondent provided met the applicable standards of care, but he did not describe any of those standards. Nor did he explain why respondent's treatment met the applicable standards of care. Although Dr. Threatt referenced "the American urologic [*sic*] Association guidelines for workup and management of prostate cancer in 2018" in his reports regarding Patient C and Patient E, he did not explain what those guidelines were or how respondent complied with them. An expert opinion that is "unaccompanied by a reasoned explanation connecting the factual predicates to the ultimate conclusion" is conclusory and meaningless. (*Jennings v. Palomar Pomerado Health Systems* (2004) 114 Cal.App.4th 1108, 1117.) That is because an opinion "is no better than the reasons upon which is based." (*People v. Williams* (1962) 200 Cal.App.2d 838, 845.)

148. Dr. Threatt's uncorroborated testimony that contradicted his prior statements raised concerns about his credibility as a witness. His failure to explain any of his opinions rendered each unpersuasive.

CAUSES FOR DISCIPLINE

149. Complainant produced clear and convincing evidence respondent committed gross negligence when he: (1) failed to timely identify Patient A2's avulsed right ureter and appropriately intervene; (2) performed multiple unnecessary and repetitive ureteroscopic procedures on Patient A2; (3) performed two open exploratory surgeries that did not address Patient A2's avulsed ureter, rather than a definitive repair; (4) performed a PVP on Patient B2 with an unknown urine culture and without properly sterilizing his urine; and (5) drafted an addendum to an operative report and changed the operation performed. Respondent and Dr. Finley referred to Patient A2's August 26, 2021 surgery interchangeably as a PVP, Laser TURP, and TURP, and the evidence established those terms are synonymous for purposes of this matter.

150. Complainant also produced clear and convincing evidence respondent committed repeated negligent acts when he: (1) performed a second PVP on Patient B2 without medical indication; (2) failed to correctly identify and remove Patient B2's right kidney; (3) failed to adequately manage Patient C's prostate cancer; (4) repeatedly prescribed ciprofloxacin for Patient C despite a history of bilateral Achilles tendon surgery; (5) performed urethral dilations on Patient D without a clear medical indication and an adequate workup; and (6) performed an incomplete workup for high-risk prostate cancer for Patient E.

151. Dr. Finley credibly and persuasively established the applicable standards of care, how respondent deviated from them, and why his deviations were extreme or simple departures, as explained in Factual Finding 145. Dr. Threatt did not persuasively rebut Dr. Finley's opinions and conclusions, as explained in Factual Findings 146 through 148.

152. To the extent respondent offered his own opinions and conclusions about his treatment of the five patients, none were considered. He did not designate himself as an expert in this matter, and his opinions and conclusions went beyond the permissible scope of lay opinion testimony. Additionally, respondent was not a credible witness for the reasons explained in Factual Findings 138 through 144, and he did not present credible evidence to corroborate his testimony. As previously explained, the articles he produced were hearsay and "inherently unreliable." (*In re Cindy L.* (1997) 17 Cal.4th 15, 27.)

APPROPRIATE DISCIPLINE

153. The MBOC has adopted the "Manual of Model Disciplinary Orders and Disciplinary Guidelines" (12 Edition/2016) for consideration when evaluating the appropriate discipline for violations of the Medical Practice Act (Bus. & Prof. Code, § 2000 et seq.) and regulations adopted pursuant to it. (Cal. Code Regs., tit. 16, § 1361, subd. (a).) The discipline recommended for the violations of the Medical Practice Act alleged in the First Amended Accusation ranges from stayed revocation with probation for five years to outright revocation.

154. The MBOC's highest priority is public protection. (Bus & Prof. Code, § 2229.) Although the primary purpose of license discipline is public protection, it also prevents future harm and improves the physician's rehabilitation. (*Griffiths v. Super. Ct.* (2002) 96 Cal.App.4th 757, 772.) "Fully acknowledging the wrongfulness of [one's] actions is an essential step towards rehabilitation." (*Seide v. Com. of Bar Examiners of the State Bar of Cal.* (1989) 49 Cal.3d 933, 940.)

155. Here, not only did respondent not fully acknowledge his wrongdoing, but he vehemently denied it. Such obstinance demonstrated a complete lack of insight

into his misconduct and is the antithesis of rehabilitation. The only discipline supported by the evidence is the outright revocation of respondent's certificate.

Request for Investigation and Enforcement Costs

156. Complainant requested that respondent be ordered to pay the MBOC $48,307.75 for investigation costs and $72,200.25 for enforcement costs, for a total of $120,508, pursuant to Business and Professions Code section 125.3. He submitted a Certification of Prosecution Costs for OAH Case No. 2025040144: Declaration of Deputy Attorney General Christine A. Rhee and a Supplemental Certification of Prosecution Costs for OAH Case No. 2025040144: Declaration of Deputy Attorney General Christine A. Rhee.

157. Ms. Rhee verified, under penalty of perjury, that this matter involved the MBOC's Health Quality Investigation Unit's (HQIU) joint investigation of five matters – Case Numbers 800-2023-103911 (103911), 800-2024-106405 (106405), 800-2024-106729 (106729), 800-2024-108455 (108455), and 800-2024-111817 (111817). The Office of the Attorney General prosecuted all five matters under Case Number 103911.

158. Ms. Rhee further verified that the Office of the Attorney General billed the MBOC $72,200.25 for the time she and her colleagues spent working on the matter through July 8, 2025. She attached a document entitled "Matter Time Activity By Professional Type" itemizing those charges by employee, date, task, hours, hourly rate, and total amount.

159. Complainant also introduced three Declarations of Investigative Activity, each of which Rachel Rivera, a Supervising Investigator with HQIU, signed under penalty of perjury. She declared the MBOC incurred $18,078.50 in costs for the time MBOC staff spent through December 30, 2024, investigating Case Numbers 103911,

106405, and 108455. All three Declarations itemized the time spent by date, number of hours spent, investigator, task code, and task performed. They included the hourly rates charged.

160. Complainant also introduced two Declarations of Investigative Activity Deborah Sherrick, an Investigator with HQIU, signed under penalty of perjury. She declared the MBOC incurred $14,229.25 in costs for the time MBOC staff spent through March 20, 2025, investigating Case Numbers 106729 and 111817. Both Declarations itemized the time spent by date, number of hours spent, investigator, task code, and task performed. They included the hourly rates charged.

161. Finally, complainant submitted five certifications Therese Kelly, a Staff Services Manager I with the MBOC, signed under penalty of perjury. She attested that Dr. Finley billed the MBOC a total of $16,000 for the time he spent working on this matter. Each certification covered one of the five matters jointly investigated, specified the dates on which he worked, and provided the total number of hours spent on "Case review – records review, report preparation," his hourly rate, and his total charge.

162. Respondent did not object to complainant's request for costs or any of the evidence submitted in support of the request. Nor did he introduce evidence of his ability or inability to pay costs. The reasonable costs of investigation and enforcement in this matter are discussed further in Legal Conclusions 10 through 15.

LEGAL CONCLUSIONS

Applicable Burden/Standard of Proof

1. Complainant has the burden of proving the grounds for discipline alleged in the First Amended Accusation by clear and convincing evidence to a reasonable certainty. (*Daniels v. Dept. of Motor Vehicles* (1983) 33 Cal.3d 552, 536 [an administrative agency seeking to discipline a license has the burden of proving cause for discipline]; *Realty Projects, Inc. v. Smith* (1973) 32 Cal.App.3d 204, 212 [the standard of proof applicable to proceedings to discipline a professional license is clear and convincing evidence to a reasonable certainty].) "The courts have defined clear and convincing evidence as evidence which is so clear as to leave no substantial doubt and as sufficiently strong to command the unhesitating assent of every reasonable mind. [Citations.] It has been said that a preponderance calls for probability, while clear and convincing proof demands a *high probability* [citations]." (*In re Terry D.* (1978) 83 Cal.App.3d 890, 899, italics original.)

Applicable Law

OPINION TESTIMONY

2. The general rule is that opinion testimony is inadmissible. (*People v. Phillips* (2022) 75 Cal.App.5th 643, 682.) The two exceptions are lay opinions and expert opinions. (*Ibid.*) A lay witness may provide an opinion if it is "rationally based" on his perception, and it is "helpful to a clear understanding of his testimony." (Evid. Code, § 800, subds. (a) & (b).) He is limited to opining about matters of such common knowledge that they require no special training, knowledge, or skill. (*People v. Phillips*, *supra*, 75 Cal.App.5th at p. 682.)

3. On the other hand, an expert witness may opine about matters "that [are] sufficiently beyond common experience that the opinion of an expert" would be helpful. (Evid. Code, § 801, subd. (a).) Such opinions may be "based on matter . . . perceived by or personally known to [him] or made known to him at or before the hearing, whether or not admissible, that is of a type that reasonably may be relied upon by an expert in forming an opinion upon the subject to which his testimony relates....." (*Id.* at subd. (b).) An expert opinion regarding the applicable standard of care is necessary when the MBOC seeks to discipline a physician for gross negligence and/or repeated negligent acts. (*Podiatric Medical Bd. of Cal. v. Super. Ct.* (2021) 62 Cal.App.5th 657, 668 ["As with civil malpractice actions, disciplinary proceedings against a physician or podiatrist for negligence will commonly require consideration of the profession's standard of care, requiring testimony from experts"].)

4. When testifying about his opinion, an expert witness "may state on direct examination the reasons for his opinion and the matter..... upon which it is based, unless he is precluded by law from using such reasons or matter as a basis for his opinion." (Evid. Code, § 802.) However, this rule does not allow for the admission of otherwise inadmissible evidence "under the guise of reasons." (*People v. Coleman* (1985) 38 Cal.3d 69, 92, disapproved on different grounds by *People v. Sanchez* (2015) 63 Cal.4th 665, 686, fn. 13.)

EXPERT WITNESSES

5. A party to a disciplinary proceeding before the MBOC is precluded from introducing expert testimony if he fails to disclose the expert's identity, qualifications, and written report prior to hearing. (Bus. & Prof. Code, § 2334, subd. (b); *In the Matter of the Accusation Against Jill Siren Meoni, M.D.* (2011) Precedential Decision No. MBC-2011-01 DMQ, 7 (*Meoni*).) An order excluding expert testimony is mandatory

whenever a party fails to comply with the statutory disclosure requirements, and the administrative law judge has no discretion to not issue such an order. (*Meoni* at pp. 8–9.)

CAUSE FOR DISCIPLINE

6. A certificate may be disciplined if the physician has engaged in unprofessional conduct. (Bus. & Prof. Code, § 2234.) Such discipline may consist of outright revocation, suspension, probation, or public reprimand. (Bus. & Prof. Code, § 2227, subd. (a)(1)–(4).) Unprofessional conduct includes gross negligence and repeated negligent acts. (Bus. & Prof. Code, § 2234, subds. (b) & (c).) "To be repeated, there must be two or more negligent acts or omissions." (*Id.* at subd. (c).)

Conclusion

GROSS NEGLIGENCE

7. Respondent committed gross negligence while treating Patient A2 and Patient B2 as explained in Factual Findings 149, 151, and 152. Each act of gross negligence constitutes separate cause to discipline his certificate pursuant to Business and Professions Code section 2234, subdivision (b).

REPEATED NEGLIGENT ACTS

8. Respondent also committed repeated negligent acts while treating Patient B2, Patient C, Patient D, and Patient E as explained in Factual Findings 150 through 152. Therefore, cause exists to discipline his certificate pursuant to Business and Professions Code section 2234, subdivision (c).

APPROPRIATE DISCIPLINE

9. Cause exists to discipline respondent's certificate for the reasons explained in Legal Conclusions 7 and 8, individually and collectively. Respondent did not produce evidence of sufficient rehabilitation to demonstrate his continued ability to practice medicine in a manner consistent with public health, safety, and welfare, even on a probationary basis, for the reasons explained in Factual Findings 153 through 155. Therefore, his certificate must be revoked.

Award of Costs

10. An agency may be awarded "the reasonable costs of investigation and enforcement of the case" if it prevails in a license disciplinary proceeding. (Bus. & Prof. Code, § 125.3, subd. (a).) "A certified copy of the actual costs . . . shall be prima facie evidence of reasonable costs of investigation and prosecution of the case." (*Id.* at subd. (c).) "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." (*Ibid.*)

11. Costs may be proven at hearing "by Declarations that contain specific and sufficient facts to support findings regarding actual costs incurred and the reasonableness of the costs." (Cal. Code Regs., tit. 1, § 1042, subd. (b).) If the services are provided by an agency employee, "the Declaration may be executed by the agency or its designee and shall describe the general tasks performed, the time spent on each task and the method of calculating the cost." (*Id.* at subd. (b)(1).) If the services are provided by someone other than an agency employee, "the Declaration shall be executed by the person providing the service and describe the general tasks performed, the time spent on each task and the hourly rate or other compensation for

the service." (*Id.*, at subd. (b)(2).) Alternatively, "the agency may attach to its Declaration copies of the time and billing records submitted by the service provider." (*Ibid.*)

12. In *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, the California Supreme Court set forth factors for evaluating the reasonableness of the costs sought pursuant to statutory provisions like Business and Professions Code section 125.3. These factors include: 1) the licensee's success in getting the charges dismissed or the severity of the discipline imposed reduced; 2) the licensee's subjective good faith belief in the merits of his position; 3) whether the licensee raised a colorable challenge to the proposed discipline; 4) the licensee's financial ability to pay; and 5) whether the scope of the investigation was appropriate in light of the alleged misconduct. (*Zuckerman v. Bd. of Chiropractic Examiners, supra*, 29 Cal.4th at p. 45.)

13. Complainant presented prima facie evidence that the MBOC's reasonable costs of enforcement were $72,200.25. (Bus. & Prof. Code, § 125.3, subd. (c); Cal. Code Regs., tit. 1, § 1042, subd. (b)(1), (2).) He also presented prima facie evidence that the MBOC's reasonable costs of investigation for staff's time were $32,307.75. (Bus. & Prof. Code, § 125.3, subd. (c); Cal. Code Regs., tit. 1, § 1042, subd. (b)(1).)

14. Although Ms. Kelly's certifications that the MBOC incurred $16,000 in investigation costs for Dr. Finley's time did not constitute prima facie evidence of the reasonableness of those costs because she was not the one who provided services, compliance with California Code of Regulations, title 1, section 1042, subdivision (b)(2), is only one method of proving third-party costs. She prepared her certifications based on her review of Dr. Finley's invoices to the MBOC, and she attested, under penalty of perjury, to the accuracy of the information she provided. Her certifications "contain

specific and sufficient facts to support findings regarding actual costs incurred and the reasonableness of the costs" incurred for Dr. Finley's time. (*Id.* at subd. (b).)

15. The MBOC's reasonable costs of enforcement are $72,200.25, and its reasonable costs of investigation total $48,307.75. Respondent did not rebut evidence of the reasonableness of those amounts. Nor did he present evidence that any of the *Zuckerman* factors apply and require reducing the MBOC's reasonable costs of investigation and enforcement. Therefore, the MBOC is awarded costs of enforcement of $72,200.25 and costs of investigation of $48,307.75, for a total cost award of $120,508.

ORDER

1. Physician's and Surgeon's Certificate Number G 60284 issued to respondent Lionel Sidney Foster, Jr., M.D., is REVOKED.

2. Respondent shall pay the MBOC $120,508 for its costs of investigation and enforcement of this matter.

DATE: September 29, 2025

Coren D. Wong (Sep 29, 2025 08:50:59 PDT)

COREN D. WONG

Administrative Law Judge

Office of Administrative Hearings