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.: 800-2023-101401

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. 800-2023-101401** **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 22, 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 Board time to review and consider the Petition for Reconsideration.

DATED: December 11, 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 Accusation Against: **Lionel Sidney Foster, Jr., M.D.** **Physician's & Surgeon's Certificate No. G 60284** **Respondent.**	**Case No. 800-2023-101401** **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 November 20, 2025, at 5:00 p.m.

Execution is stayed until December 22, 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 4, 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 Accusation Against: Lionel Sidney Foster, Jr., M.D. Physician's and Surgeon's Certificate No. G 60284 Respondent.	Case No. 800-2023-101401

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 November 20, 2025.

IT IS SO ORDERED October 21, 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 Accusation Against:

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

Agency Case No. 800-2023-101401

OAH No. 2024110747

PROPOSED DECISION

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

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[1] This matter (primary matter) was consolidated for hearing with *In the Matter of the First Amended Accusation Against Lionel Sidney Foster, Jr., M.D.*, Agency Case Number 800-2023-103911/OAH Number 2025040144 (secondary matter). A separate Proposed Decision will be written in the secondary 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

LICENSED 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 Accusation in this matter solely in his official capacity on August 28, 2024. He alleged cause exists to discipline respondent's certificate because he was grossly negligent and committed repeated negligent acts while treating two patients, and committed general unprofessional conduct and/or violated professional confidence by requesting and obtaining one of the patient's treatment records without authorization or a legitimate medical purpose.

4. More specifically, complainant alleged respondent committed gross negligence by: (1) failing to order a preoperative urine culture and possible subsequent antibiotic therapy even though Patient A1 had preoperative catheterization; and (2) failing to recognize and timely treat Patient B1's urinary

sphincter cuff erosion.[2] He committed repeated negligent acts while treating Patient A1 by not providing proper informed consent and inappropriately prescribing and/or dosing finasteride. He committed repeated negligent acts while treating Patient B1 by prescribing nitrofurantoin as a long-term treatment for urethral erosion without properly monitoring B1's renal function. Finally, he committed general unprofessional conduct and/or violated professional confidence by obtaining Patient A1's subsequent medical records after he was no longer treating Patient A1.

5. Prior to closing arguments, complainant moved to amend the Accusation by adding an allegation that respondent was negligent for failing to perform a complete transurethral resection of the prostate (TURP) on Patient A1. Complainant's expert witness discussed the alleged negligence in his report and at hearing, but the allegation was inadvertently omitted from the Accusation. Respondent objected, his objection was overruled, and complainant's motion was granted pursuant to Government Code section 11507. Paragraph 87 of the Accusation was amended by interlineation to include the following at the end of the sentence ", and his failure to perform a complete TURP on January 25, 2023."

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[2] The primary matter and the secondary matter 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 primary matter as Patient A1 and Patient B1, and those designations are used throughout this PD for consistency with the hearing transcript.

Respondent's Background

6. Respondent earned his medical degree from University of California, 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. 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 A1

BACKGROUND

8. Patient A1 was a 68-year-old male with a history of unstable atrial fibrillation, an irregular and often very rapid heart rhythm, and angina, chest pain or discomfort due to reduced blood flow to the heart. He took anticoagulants daily for those conditions.

9. Patient A1 presented to Enloe Medical Center on January 14, 2023, with acute abdominal pain and urinary retention, an inability to completely empty his bladder. Abdominal and pelvic computed tomography (CT) scans were negative for acute abdominal or pelvic process, and urinalysis was abnormal. A urine culture was obtained (and subsequently determined to be negative for bacteria), and a Foley

catheter was placed. A Foley catheter is a tube that goes through a patient's urethra and into his bladder to drain urine into a bag outside his body. Medications upon discharge included the antibiotic metronidazole.

10. Respondent saw Patient A1 five or six days later for a two-week follow-up to a previous referral for pelvic pain and prostatitis, inflammation of the prostate gland. According to respondent's progress note, Patient A1 explained "he was informed he possibly might have a UTI [uterine tract infection]."

11. Respondent diagnosed Patient A1 with benign prostatic hyperplasia (BPH), enlargement of the prostate gland not due to cancer that causes problems with urination, pelvic pain, and hematuria, blood in the urine. He documented the following recommendation and treatment plan in his progress note:

> -Patient with BPH and pelvic pain
>
> -Recommend Laser Transurethral Resection of the Prostate, discussed procedure and post [*sic*] procedure as well as benefits, risks and potential complications. Pt understands and wishes to proceed.

12. Respondent itemized Patient A1's active outpatient medications in the progress note, none of which was an antibiotic. Respondent scheduled surgery for January 25, 2023, and ordered the antibiotic Cefazolin to be given prophylactically "within one hour prior to surgical incision." According to the progress note, respondent did not order a urine culture even though Patient A1 still had his Foley catheter, and there was no reference to laboratory or radiology reports from Enloe Medical Center. Respondent did not document having discussed with Patient A1 other

treatment options, such as further medication management with different drugs, a voiding trial, or alternative surgical procedures.

13. Patient A1 signed an Informed Consent to Surgery or Special Procedure, and respondent countersigned it. The form identified the operation as a laser TURP and respondent as the practitioner. It included the following language:

> 6. Your doctor has discussed with you the following:
>
> a. The reason for the operation or procedure.
>
> b. The nature of the operation or procedure.
>
> c. The risks and benefits of the operation or procedure.
>
> d. Any adverse reactions that may reasonably be expected to occur.
>
> e. Reasonable alternatives and the relevant risks, benefits and side effects of such.
>
> f. The potential problems that may occur during recuperation.
>
> g. Any research or economic interest the doctor may have.
>
> h. Recent COVID infection/positive test result (if applicable): COVID or SARS CoV2 infection carries certain associated risk factors such as pulmonary (breathing) complications and/or vascular (blood clot) complications.
>
> [¶] . . . [¶]

8. Your signature on this form indicates that:

• You have read and understand the information provided in this form;

• Your doctor has adequately explained to you the operation or procedure and the anesthesia set forth above, along with the risks, benefits, and the other information described above in this form;

• You have had a chance to ask your doctors questions;

• You have received all of the information you desire concerning the operation or procedure and the anesthesia and you authorize and consent to the performance of the operation or procedure and anesthesia.

The form also included the following just above respondent's signature:

I, the undersigned physician, hereby certify that I have discussed the procedure described in this consent form with this patient (or the patient's legal representative), including:

•The reason for the operation or procedure;

•The nature of the operation or procedure;

•The risks and benefits of the operation or procedure;

•Any adverse reactions that may reasonably be expected to occur;

•Reasonable alternatives and the relevant risks, benefits and side effects of such;

•The potential problems that may occur during recuperation;

•Any research or economic interest I may have regarding this treatment. [*sic*]

•Provided standardized written summary regarding blood transfusion or products.

14. Patient A1's appeared for surgery as scheduled. The presurgical nurse note identified the surgical procedure as a laser TURP and indicated "consent for surgery [was] obtained." Patient A1's Foley catheter was removed, and he was administered the prophylactic antibiotic intravenously. Respondent performed surgery without incident. His operative report included preoperative and postoperative diagnoses of BPH, and identified the operation performed as a "GreenLight laser-assisted transurethral vaporization of the prostate."

15. Patient A1 was discharged home the same day with a Foley catheter in place and instructions to resume his regular diet, rest until that evening, not drive a vehicle or operate heavy machinery for the remainder of the day, and walk as tolerated. He was given a prescription for the antibiotic nitrofurantoin.

16. Patient A1 saw respondent's physician assistant five days later for a postoperative follow-up. He complained of a lot of postsurgical pain in his scrotum and penis and explained "everything hurts." Urinalysis revealed trace amounts of leukocytes and large amounts of blood. He was advised to discontinue taking

nitrofurantoin and prescribed cephalexin instead. Patient A1's Foley catheter was removed.

17. Patient A1 saw respondent approximately five weeks after surgery for a second follow-up. He continued to complain of substantial groin pain and said he experienced some hematuria. He had severe pain prior to removal of the Foley catheter. Respondent's plan was to contact Patient A1's pain management physician to discuss how to better manage his pain. Respondent told Patient A1 to stop taking cephalexin. He was also told to start taking 5 mg of finasteride twice daily for "benign prostatic hyperplasia with lower urinary tract symptom," according to respondent's progress note.

18. Patient A1 transferred his care to another urologist, Patrick Scarborough, M.D., at Enloe Urology Services. He first treated with Dr. Scarborough on April 28, 2023. He complained of frequent urination; inability to empty his bladder; and chronic burning pain, weak stream, and dribbling while urinating. Dr. Scarborough recommended a cystoscopy, which Patient A1 consented to.

19. Dr. Scarborough performed a cystoscopy the following week. He discovered "significant obstruction from the bilateral prostatic lateral lobes" and "mild protrusion of the median lobe of the prostate." He performed a TURP to resect the remainder of Patient A1's prostate, after which the patient voided successfully and with much improvement. Dr. Scarborough resected approximately 8 grams of benign prostate tissue.

COMPLAINANT'S EXPERT WITNESS

Background

20. Complainant retained Alan C. Weinberg, M.D., F.A.C.S., to review respondent's treatment of Patient A1 and determine if he deviated from any applicable standards of care. Dr. Weinberg obtained his bachelor's degree from Duke University in 1977 and his medical degree from University of Virginia four years later. He completed a one-year internship in general surgery at the University of Southern California in 1982 and a three-year residency in urology at the same institution three years after that. He completed an additional year of residency as the chief resident for urology.

21. Dr. Weinberg has been licensed to practice medicine in California since July 1, 1982. He has been licensed to practice medicine in Arizona since February 15, 2022. He was continuously board-certified by The American Board of Urology from February 21, 1988, through October 2023, when he relinquished active certification for retired certification. Dr. Weinberg retired from the practice of medicine December 21, 2023.

22. Dr. Weinberg held staff appointments at numerous hospitals throughout Los Angeles and Orange Counties. He also served on several of those hospitals' internal committees and held leadership positions on some. For example, he served as Chairman and Vice Chairman of the Department of Surgery at Placentia Linda Hospital and St. Jude Medical Center. He also served on St. Jude Medical Center's Board of Trustees and Surgery Quality Review Committee. Dr. Weinberg was a Clinical Assistant Professor in the Department of Urology at Los Angeles County/University of Southern

California School of Medicine and a Clinical Associate Professor in the Department of Urology at University of California, Irvine.

23. Dr. Weinberg's analysis of respondent's treatment of Patient A1 was based solely on his review of records complainant provided, including relevant medical records. He prepared a written report identifying four departures from the applicable standard of care – failing to obtain informed consent, improperly prescribing finasteride, performing surgery without determining if Patient A had a UTI, and failing to remove the entire prostate gland. He identified each applicable standard and analyzed each departure. Dr. Weinberg testified consistently with his report.

Informed Consent

24. Dr. Weinberg explained that the standard of care for informed consent required respondent to discuss with Patient A1 different treatment options and the risks of each in a manner that could be easily understood. He was required to provide sufficient information to allow Patient A1 to decide which treatment option he wanted to pursue. Respondent was required to document the discussion in Patient A1's medical record.

25. Dr. Weinberg opined respondent committed a "simple departure from [the] standard of care for not discussing and documenting alternatives in the management of acute urinary retention during informed consent discussion." He explained respondent's notes documenting his discussion with Patient A1 were "sketchy, simply saying that laser TURP was discussed, 'as well as benefits, risks and potential complications. Pt understands and wishes to proceed.'" Respondent did not itemize the risks and complications discussed, and he did not document other treatment options discussed. Dr. Weinberg was taught that if something was not

documented in the medical record, "it did not happen." He concluded, "Informed consent was incomplete."

Prescription for Finasteride

26. Finasteride is a medication that "blocks the conversion of testosterone to dihydrotestosterone." Without dihydrotestosterone, "the prostate shrinks. And [finasteride] is a medical therapy for bladder outlet obstruction due to prostate enlargement." The drawbacks of using finasteride to treat BPH are the amount of time it takes to work and its relatively low efficacy rate. "It is always prescribed at a standard dose of 5 mg once a day."

27. Dr. Weinberg explained that the standard of care is to prescribe finasteride 5 mg once daily, explaining that is "the only recommended and prescribed dose." He further explained the medication "is an alternative to [prostate] surgery." He asked rhetorically, "So why would one prescribe, at twice the standard dose, a drug to treat an enlarged prostate in a patient who, a week or so ago, you removed all the obstruction?"

28. Dr. Weinberg concluded respondent committed a simple departure from the standard of care by prescribing the medication "for a twice daily regimen, twice the standard dose," rather than prescribing it in the first place, because:

> It's a pretty benign drug. And while it should be useless after a TURP; even at twice the standard dose, it's safe. And I thought it was simple and not extreme. To me, it showed a lack of education, but I didn't consider it extreme.

Performing Surgery with Possible UTI

29. Bacterial colonization refers to the presence of bacteria without any symptoms or immune response. A bacterial infection occurs when there are symptoms or an immune response to bacteria. Dr. Weinberg explained the standard of care prohibited respondent from performing a TURP on a patient with a UTI because of "the significant risk of sepsis." Patient A1 had a Foley catheter for more than a few days, "and almost invariably – and probably invariably, there will be bacteria – significant bacteria in the bladder by that time." Thus, he "should be presumed to be colonized or infected," a urine culture ordered, and treatment provided if the culture was positive, prior to surgery.

30. Dr. Weinberg opined respondent committed an extreme departure from the standard of care by performing surgery without first determining if Patient A1 had a UTI. Patient A1 appeared for surgery with the Foley catheter Enloe Medical Center placed 11 days prior, and he told respondent during his presurgical visit that he "might have a UTI." Dr. Weiberg concluded respondent committed an extreme departure, rather than a simple one, because "it's well established in urologic literature and training and teaching that urine infection is a contraindication to prostate surgery."

31. Dr. Weinberg also explained why ordering an antibiotic to be given shortly before surgery was insufficient to meet the standard of care:

> No. It's not. The way that drug [cefazolin] works is by -- bacteria have to be dividing, and it upsets their cell wall synthesis. Usually, with that antibiotic, if someone has an infection, it's a seven to 10-day course.

He'd had one dose. You've had a sore throat before. You take your first dose of ampicillin or amoxicillin, you're not better half an hour later. You still have the infection. It takes several days of antibiotic therapy to sterilize the urine.

Failure to Remove Entire Prostate

32. A conventional bisection TURP is typically performed by using an electric loop to scrape or hollow out the prostate so nothing remains. Laser TURP is another method of removing the prostate by vaporizing it. Dr. Weinberg explained "it is the same end result for both," but different tools are used to accomplish that result. He analogized the prostate to an orange. During a TURP, the portion of an orange that one eats is removed while the peel (i.e., the prostate capsule) remains.

33. The standard of care for performing a conventional bisection or laser TURP requires removing the entire prostate fossa. Lateral lobes should be removed in their entirety. Simultaneous bladder neck incision to prevent postoperative contracture is optional. Occasionally, bleeding or other indications of patient instability require the procedure to be terminated prior to removing the entire prostate.

34. Respondent documented in his postoperative report the complete removal of Patient A1's prostate. He did not indicate he had to terminate the surgery prematurely. However, Patient A1 continued having trouble urinating after surgery, and he eventually sought treatment from Dr. Scarborough, who performed a cystoscopy and discovered "significant obstruction from the bilateral prostatic lateral lobes" and "mild protrusion of the median lobe of the prostate." He then performed a TURP and removed approximately 8 grams of benign prostate tissue. Patient A1's difficulty urinating subsequently resolved.

35. Dr. Weinberg explained that Dr. Scarborough's findings on cystoscopy meant "that significant prostate tissue remain[ed]. If you've resected the lateral lobes and the median lobe -- which is essentially all of the prostate -- down to the capsule, they wouldn't be there. [¶] . . . [¶] You would see some clot on the capsule. You might not be able to identify the capsule. But if you were looking after a thorough, adequate TURP, there would be no obstruction."

36. Dr. Weinberg opined that respondent committed a "simple departure from the standard of care" by "performing an incomplete transurethral prostate surgery." He explained that respondent documented his complete removal of Patient A1's prostate, but "the endoscopic findings failed to support that and an inadequate resection was performed."

37. Respondent did not designate himself as an expert witness regarding his treatment of Patient A1. At hearing, he did not call an expert witness to discuss his treatment, and he did not introduce an expert report about his treatment.

RESPONDENT'S EVIDENCE

38. Respondent testified at length about his treatment of Patient A1. He first saw Patient A1 for erectile dysfunction in 2018, about five years prior to the laser TURP. Respondent and his physician assistant treated Patient A1 exclusively for erectile dysfunction, until "he was having significant problems with BPH" in 2020. A November 2020 rectal examination showed the prostate to be 35 grams.

39. Respondent explained it is best to manage BPH medicinally first. "And if medical [*sic*] management is successful, that's great." But if the prostate continues to grow despite medication, "you have to start to think about thinking about [*sic*] surgical options." He initially prescribed Flomax, a medication that allows the bladder to empty

more completely by relaxing the prostate and the pubic floor. Respondent stated, "It is not designed to arrest the development or the progression of BPH, but it does allow a gentleman to keep more completely."

40. Patient A1 developed an intolerance to Flomax due to low blood pressure, and respondent switched him to Cialis. Patient A1 had limited success with Cialis, and in October 2021 respondent offered a different medication and "discussed further evaluation with cystoscopy for possible TURP." Patient A1 declined both options and elected to stay with Cialis. Respondent offered a cystoscopy again the following month, but Patient A1 declined. Patient A1 did not consider surgical intervention "until 1/2023, when 5 years of medication failed, and [he] developed urinary retention."

41. Respondent stated, "So one of the things that we try to migrate to in urology now is called minimally invasive prostate surgery." Three minimally invasive technologies were laser TURP, UroLift, and Rezum. However, the American Urological Association (AUA) recommended against performing UroLift or Rezum on patients with median lobes. Patient A1 previously declined a cystoscopy, which was "principally the only way to determine whether or not there [was] a median lobe." Respondent could have obtained imaging using a transrectal ultrasound, but "that would be extraordinarily aggressive to do that to get that information." Therefore, he recommended a laser TURP to Patient A1 and obtained his informed consent to that procedure by having him sign an informed consent form. Respondent verified obtaining proper informed consent by cosigning the form. However, he conceded at hearing he did not discuss any surgical procedures other than the laser TURP.

42. Respondent explained it was within the standard of care for him to perform a laser TURP on Patient A1. Although Patient A1 had a Foley catheter placed

for five or six days when respondent recommended a laser TURP, his urine sample taken when the catheter was placed was negative for bacteria. Also, he had already been on metronidazole for 10 days for diverticulitis, and respondent prescribed cephalexin. A third antibiotic was administered shortly before surgery, and Patient A1 was discharged with a fourth. Postoperative urinalysis was negative for bacteria.

43. Respondent prescribed finasteride to control Patient A1's postsurgical prostate bleeding while allowing him to continue anticoagulation therapy to reduce the risk of heart attack and stroke. A higher dose of finasteride was necessary to counter the anticoagulants, but was well below that which could lead to toxicity. Respondent explained:

> If this patient had three days of treatment with this medication, and it was 5 milligrams twice a day, then that dose is not anywhere near being a toxic dose, nor has anyone ever recorded or ever seen anyone overdosing on finasteride. And in my own experience, I've seen doctors -- urologists -- use up to 20 milligrams two times a day to control bleeding.

44. Finally, respondent observed that Patient A1's only symptom when Dr. Scarborough performed the second TURP "was a little dysuria -- a little burning on urination." He did not have trouble urinating, the need to go frequently, or hematuria, and he was not frequently getting up in the middle of the night to urinate. "So the second operation, unlike the first operation, didn't really fix anything because, in fact, the patient had already achieved emptying his bladder, and his symptoms have resolved in the visit prior to the operation."

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

OBTAINING MEDICAL RECORDS

46. It was undisputed Patient A1 transferred his care from respondent to Dr. Scarborough in April 2023. It was further undisputed respondent obtained copies of Dr. Scarborough's treatment records for Patient A1 from Enloe Medical Center to help respondent prepare for his interview with the MBOC.

47. At hearing, respondent explained "there is a shared medical record agreement that has been executed between Enloe Hospital and Orville Hospital, since we share so many [patients]." He further explained physicians have access to medical records, including those for whom they are not treating, "for the sake of quality control." He opined he was entitled to copies of Patient A1's medical records because he was participating in the MBOC's review of the treatment he received.

48. Respondent further claimed that Patient A1 gave him a written release authorizing Enloe Medical Center to provide the records. When respondent was asked if he provided a copy of the release to the MBOC, he initially stated he did. But when asked when he provided the release, he provided several nonresponsive answers before finally conceding he never did.

Patient B1

BACKGROUND

49. Patient B1 was a 74-year-old male with diabetes, coronary artery disease, congestive heart failure, and hypertension. He had elevated creatinine, an indication of kidney malfunction, a history of robotic radical prostatectomy, and possible

postoperative radiation therapy. He sought treatment from respondent for incontinence.

50. Respondent's notes reflected a diagnosis of stress incontinence, the involuntary leakage of urine during movements that increase pressure on the abdomen, such as laughing, coughing, sneezing, and lifting. He recommended an artificial urinary sphincter (AUS), a medical device that is surgically implanted and helps control leakage of urine in men with urinary incontinence.

51. Respondent implanted Patient B1's AUS on February 1, 2019. Subsequent progress notes reflected multiple visits after the AUS was activated on March 15, 2019, because the patient was having difficulty learning how to use the device when urinating. A March 2019 note indicated he had gross hematuria that resolved on its own, and respondent did not evaluate the condition. During a second visit, respondent told the patient to "drink more water to help lower his creatinine level."

52. Patient B1 continued to struggle with properly using the AUS. Nonetheless, respondent wrote in a November 2019 note that it was "working well," despite Patient B1 reporting having used two to three diapers each day. Respondent documented repeated gross hematuria on March 13, 2020, and a cystoscopy three days later that showed a thin urethra, "no true erosion, but close." Respondent did not deactivate the AUS but included a note indicating "pending sphincteric erosion." He prescribed nitrofurantoin "to avoid this."

53. The following month, respondent concluded the AUS was continuing to work well and prescribed nitrofurantoin for an additional 90 days, albeit at a reduced dose because urinalysis showed moderate blood. He did not reevaluate endoscopically his previously noted "thin urethra" that was near erosion.

54. In July 2020, respondent saw Patient B1 for gross hematuria and mild dysuria and recommended hydration. Three months later he prescribed an additional 90 days of nitrofurantoin with two refills. He referenced his March 2020 findings after cystoscopy in a note by writing "there was no true erosion, but this was close." He indicated he was going to rely on urinalysis to determine if surgery to exchange the device was indicated.

55. On November 10, 2020, respondent performed a cystoscopy, after which he wrote in his procedure note "what was prominent in the urethra was the cuff of the sphincter could be visualized through a thin coat the skin." His postoperative diagnosis was "erosion of AMS 800 artificial sphincter." Respondent provided the following diagnosis in his request for prior authorization from insurance to replace the AUS: "Urinary Incontinence/Erosion of AMS 800 Artificial Urinary Sphincter N39.3 T83.191A."

56. On January 7, 2021, respondent removed Patient B1's AUS and replaced it with a new one. Respondent did not document in his operative report the status of Patient B1's urethra. An ultrasound performed three days later showed a large complex scrotal and peroneal collection "likely representing a hematoma." Respondent wrote in a note documenting Patient B1's follow-up visit the following month, "Pts wound is continuing to heal well, still too swollen to activate the device today in clinic, will have pt RTC in 1 week for education on use of the AMS 800."

57. The AUS migrated to an improper location, and respondent performed surgery to reposition it on March 26, 2021. The AUS was reactivated on May 7, 2021. There were multiple postoperative visits for Patient B1 to learn how to use the AUS. A note the following month indicated he was still unable to properly operate it and "thinks he has UTI." Respondent did not order a urine culture or urinalysis but prescribed nitrofurantoin.

58. In December 2021, Patient B1 underwent surgery with another provider at UC Davis Medical Center for removal of his AUS. The pump tubing had broken through Patient B1's skin and a urethral diverticulum, a pocket or sac along the urethra that can fill with urine or pus and lead to infections, was noted. Patient B1's urethra was surgically repaired.

COMPLAINANT'S EXPERT WITNESS

Background

59. Complainant retained Dr. Weinberg to review respondent's treatment of B1 and determine if he deviated 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 written report identifying two departures from the applicable standard of care – prescribing nitrofurantoin for UTIs in an elderly patient with compromised renal function, and failing to recognize and timely treat the erosion of an AUS. Dr. Weinberg identified each applicable standard and analyzed each departure. He testified consistently with his report and provided further explanation at hearing.

Prescription for Nitrofurantoin

60. Dr. Weinberg explained that the standard of care required respondent to exercise caution when prescribing nitrofurantoin due to Patient B1's age and elevated creatinine. Instead of doing so, respondent repeatedly prescribed lengthy courses of the medication, without evaluating his creatinine levels to assess renal function. Respondent previously acknowledged awareness of Patient B1's renal impairment when he recommended increased hydration to "help lower" his creatinine level. Dr.

Weinberg opined respondent committed a simple departure from the standard of care.

Urethral Erosion

61. Dr. Weinberg described an AUS as consisting of a fluid-filled cuff around the urethra, pump in the scrotum, and pressure-regulating balloon in the pelvis. When filled with fluid, the cuff prevents urinary leakage by compressing the urethra. When the patient needs to urinate, he presses a button on the pump through his scrotum, the pump circulates the fluid from the cuff to the balloon, the cuff loosens, and urine is allowed to flow out the urethra. The pump automatically circulates the fluid back into the cuff after a few minutes. The AUS may be deactivated, in which case the cuff remains loose, and the fluid remains in the balloon.

62. A common complication of an AUS is urethral erosion, which occurs when the cuff cuts through the urethra tissue and mucosa and is exposed in the urethra lumen. The AUS becomes infected by the colonization of bacteria in the urethra lumen and stops working. Dr. Weinberg explained that once there is erosion, the standard of care requires immediate removal of the AUS. Only after the urethra has healed may a replacement AUS be implanted.

63. Respondent's description of Patient B1's AUS as "impending" or "pending" erosion was meaningless because the existence of erosion was binary. Although the mere existence of a thin urethra warranted removal because erosion was likely, "impending" or "pending" was not the correct verbiage to describe the status of Patient B1's urethra. If the urethra was thin and the cuff visible, there was erosion into the urethra through the bulbospongiosus muscle, and the AUS needed to be removed.

64. Dr. Weinberg opined respondent committed an extreme departure from the standard of care by failing to timely recognize and treat erosion of Patient B1's urethra. He further deviated from the standard of care by replacing the AUS without allowing the urethra time to heal and confirming "there's no significant scar tissue."

65. Dr. Weinberg concluded respondent's deviations were extreme departures, rather than simple ones, because he relied on urinalysis results rather than his own visual evaluation of the urethra to conclude there was no erosion. Moreover, respondent made contradictory notes by interchangeably describing "erosion," "pending erosion," and "no true erosion." He never deactivated the AUS to eliminate pressure on the urethra after making any of those findings.

66. Respondent's visualization of a "thin urethra" was a sign that erosion was likely. Dr. Weinberg explained, "It's not going to get better. It never gets better. It only gets worse." Respondent's visualization of the "urethral cuff" during cystoscopy was indicative of erosion. Patient B1's recurrent hematuria was his history of having trouble operating the AUS. Respondent's treatment with nitrofurantoin was improper because antibiotics neither stop nor treat erosion.

67. Respondent eventually removed Patient B1's AUS, but he immediately replaced it. Dr. Weinberg clarified:

> The reason it's removed is because it's colonized with bacteria and infected, and the urethra has been damaged. You need to remove it, generally wait six months, reassess the urethra to be sure that it's healed and there's no significant scar tissue, and then replace the device.

Respondent did not document his evaluation of Patient B1's urethra in his operative report.

68. Respondent did not designate himself as an expert witness regarding his treatment of Patient B1. At hearing, he did not call an expert witness to discuss his treatment, and he did not introduce an expert report about his treatment.

RESPONDENT'S EVIDENCE

69. Respondent testified at length about his treatment of Patient B1, who was referred to him on November 18, 2018, for hematuria. Patient B1 was previously diagnosed with prostate cancer, but he declined treatment for five years before undergoing a robotic prostatectomy prior to respondent treating him. The procedure "was a very new technology" at the time, and he developed complications and "became severely incontinent because he had severe damage done to his urinary sphincter."

70. Respondent evaluated Patient B1 during his initial visit "just to determine whether or not there was anything in the bladder that causes blood in the urine." He determined "that was clear." Patient B1 returned two months later complaining of urinary incontinence. Respondent began treating his incontinence with imipramine, a medication that relaxes the bladder and tightens the sphincter. Patient B1 failed medication management and could not be around his family because he smelled of urine. He was desperate for a solution, and he agreed to an AUS in February 2019.

71. Patient B1 returned six weeks after the AUS was implanted to have it activated. He returned two months after that and reported he was doing well without complications. However, he returned in July 2019, for further instructions on how to use the AUS because he may have deactivated it. He returned twice the following

month for further instructions. In November 2019, Patient B1 reported the AUS worked well, but he continued to leak with movement.

72. Patient B1 returned in January and February 2020, and reported the AUS was working well. He also reported in February 2020 accidentally deactivating the device. He complained of substantial blood in his urine due to him placing excessive pressure on his sphincter the following month. Respondent performed a cystoscopy on March 16, 2020, and found the urethra "clear, but very thin in the area of the sphincter. There was no true erosion, but close." His impression was "patient with pending sphincteric erosion." He explained:

> So you could see, you know, the implant or the impression of the sphincter more than normal, but you couldn't see it in the urethra.
>
> To have erosion, you'll see the device in the urethra. That, I never saw during my entire management of this patient.

73. Respondent further explained that AUSs have high failure rates. The options upon failure are replacing either part or all of the device. "A contemporary management of it is to replace the entire device" when there is no erosion. Respondent replaced Patient B1's AUS with a new one on January 7, 2021, because it was not working.

74. After replacement of the AUS, Patient B1 did "moderately well" managing the new device. He had elevated white blood cells in his urine, so respondent prescribed nitrofurantoin to reduce those levels "to keep the bacterial counts down" because "bacterial counts cause inflammation. Inflammation in an already compromised organ is the death of that organ." Patient B1's urethra underwent

medical prostatectomy, a sling, radiation therapy, and a prior AUS. Therefore, the "tissue [was] more prone to breaking down."

75. On March 26, 2021, respondent performed surgery to reposition Patient B1's pump because it had migrated away from its original location in the scrotum. The device was activated six weeks later, after which Patient B1 repeatedly returned for instructions on activating the AUS.

76. Respondent eventually performed another cystoscopy in August 2021 because Patient B1 was uncertain if the AUS was working, having problems urinating, and wanted to see if anything was wrong internally. Respondent noted in his report: "The urethra was clear. I activated and deactivated the sphincter. The skin over the sphincter of the urethra was thin, but it was noteroded [*sic*] at this point."

77. Patient B1 transferred his care after August 2021 to UC Davis Medical Center. Erosion of his AUS was discovered during a November 28, 2021 examination.

78. 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

CREDIBILITY OF WITNESSES

Dr. Weinberg

79. Respondent argued in his closing argument that "Dr. Weinberg is not qualified to act as an MBC [*sic*] expert witness as he was no [*sic*] in practice at the time of his review of Patient A1 [*sic*] and Patient A2 [*sic*] cases." But the provisions of the MBOC's Expert Reviewer Guidelines cited do not support his argument. The Guidelines

provide, "It is very important that you have had significant experience with the procedure or medical issue *during the exact time period* in question." (Italics original.) The relevant period was when respondent treated Patient A1 and Patient B1, not when Dr. Weinberg reviewed such treatment as respondent claimed. It was undisputed that such treatment occurred well before Dr. Weinberg's retirement in December 2023.

80. Respondent also argued Dr. Weinberg was disqualified because he surrendered his certification status with The American Board of Urology in October 2023 due to retirement. His argument lacked factual support. Dr. Weinberg described the status of his board certification at hearing:

> Certified, but emeritus. They have a retired status. I relinquished the active one because I stopped practicing, but they have some sort of retired certification thing.

81. Respondent further argued Dr. Weinberg was disqualified because he knew respondent when the MBOC retained him. At that time, the MBOC had retained Dr. Weinberg as an expert in another investigation pending against respondent. The portion of the MBOC's Expert Reviewer Guidelines respondent cited do not preclude one from serving as an expert witness simply because he is familiar with the physician being investigated. Rather, the Guidelines instruct the expert to contact the investigator or analyst and disclose the nature of his relationship with the physician to determine if there is an impermissible conflict of interest. Respondent failed to present evidence that the nature of his relationship with Dr. Weinberg was such that it created an impermissible conflict of interest for Dr. Weinberg to serve as an expert in this matter.

82. Respondent additionally argued Dr. Weinberg was disqualified because he acted as an advocate for the MBOC by drafting questions for its investigative team to ask respondent during his subject interview. Although the MBOC's Expert Reviewer Guidelines require its experts to remain neutral and not act as an advocate for either party, respondent's argument ignores the very reason why expert witnesses are retained in the first place – they have specialized knowledge, skill, training, or experience that lay people do not. Preparing interview questions is not evidence of a bias against respondent.

83. Lastly, respondent argued Dr. Weinberg violated the MBOC's Expert Reviewer Guidelines by reaching his conclusions about respondent's treatment of Patient A1 and Patient B1 prior to respondent's subject interview. At most, respondent's argument goes to the weight of Dr. Weinberg's opinions and conclusions rather than their admissibility.

84. Evidence Code section 780 provides criteria for evaluating a witness's credibility. Respondent did not present sufficient evidence of any criterion to support a finding that Dr. Weinberg was not a credible witness and his testimony should be rejected. (See *Howard v. Owens Corning* (1999) 72 Cal.App.4th 621, 633 [uncontroverted expert testimony may not be arbitrarily rejected].) At most, respondent presented evidence that may be considered when weighing Dr. Weinberg's opinions and conclusions against contrary evidence.

Respondent

85. On the other hand, there was evidence of several criteria in Evidence Code section 780 to question respondent's credibility. He rationalized it was appropriate for him to proceed with Patient A1's laser TURP because Patient A1 had

been on an antibiotic since January 14, 2023, respondent prescribed another five or six days later, and he prescribed a third to be administered an hour prior to surgery. But respondent's January 19 and 20, 2023 treatment notes showed Patient A1 had no active prescriptions for antibiotics, and the only antibiotic respondent ordered was cephalexin to be administered shortly before surgery.

86. Respondent testified he prescribed finasteride to control Patient A1's postoperative prostate bleeding, but he wrote in the treatment note that the medication 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." Such testimony was belied by the medical records.

87. Respondent further testified he provided the MBOC Patient A1's signed release authorizing respondent to obtain copies of Patient A1's medical records before finally conceding he never did. Regarding the erosion of Patient B1's urethra, respondent explained, "I never saw [erosion] during my entire management of this patient." Yet his postoperative diagnosis on November 10, 2020 was "Erosion of AMS 800 artificial sphincter."

88. Respondent providing testimony that was inconsistent with his medical records impaired his credibility. (Evid. Code, § 780, subd. (h) [prior inconsistent statements].) So did his inconsistent testimony. (*Id.* at subd. (b) [character of testimony].)

89. In addition to respondent's contradictory testimony, he continuously displayed a haughty attitude during hearing and refused to conform to fundamental rules for questioning witnesses. He was repeatedly admonished not to ask witnesses to

read into the record documents already admitted into evidence. He was also constantly told not to testify under the guise of asking a witness a question.

90. Indeed, respondent was admonished to stop testifying while asking Dr. David S. Finley questions no less than 35 times before cross-examination was terminated. He continued testifying instead of asking Dr. Finley questions on recross-examination or asking Dr. Weinberg questions on cross-examination. Respondent's obstinance throughout hearing negatively impacted his credibility. (Evid. Code, § 780, subd. (j) [attitude during proceeding].)

Considering respondent's prior inconsistent statements, inconsistent testimony, and recalcitrance throughout hearing, he was not a credible witness.

GROSS NEGLIGENCE

91. Complainant produced clear and convincing evidence that respondent committed gross negligence by performing the laser TURP on Patient A1 without first confirming he did not have a UTI or treating the UTI if he did. Dr. Weinberg explained the applicable standard of care, how respondent deviated from that standard, and why his deviation was an extreme departure rather than a simple one. His testimony was credible, persuasive, and unrefuted.

92. Complainant also produced clear and convincing evidence that respondent committed gross negligence by failing to recognize and timely treat Patient B1's AUS erosion. Again, Dr. Weinberg explained the applicable standard of care, how respondent deviated from that standard, and why his deviation was an extreme departure rather than a simple one. Such testimony was also credible, persuasive, and unrefuted.

93. Although respondent offered his own opinions and conclusions about Patient A1's and Patient B1's treatment, 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, 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.)

REPEATED NEGLIGENT ACTS

94. Complainant produced clear and convincing evidence that respondent committed repeated negligent acts while treating Patient A1 by not providing proper informed consent and prescribing too high of a dose of finasteride. Dr. Weinberg credibly and persuasively explained why respondent's informed consent to a laser TURP "was incomplete." He also credibly and persuasively explained why respondent's prescribed dose of finasteride was excessive.

95. Respondent's opinions that UroLift and Rezum were not recommended surgical options for patients such as Patient A1 were not considered because they were beyond the scope of proper lay witness opinions. His opinion that he prescribed a proper dose of finasteride for controlling postoperative bleeding was not considered for the same reason, in addition to it having no factual support. Respondent clearly documented in Patient A1's medical records that he prescribed finasteride for "benign prostatic hyperplasia with lower urinary tract symptoms."

96. The Accusation alleges respondent committed only one negligent act while treating Patient B1 – he prescribed nitrofurantoin "for long-term use to treat a urethral erosion, without proper monitoring." But "to be repeated, there must be two

or more negligent acts or omissions." (Bus. & Prof. Code, § 2234, subd. (c).) Therefore, respondent cannot be disciplined for committing repeated negligent acts while treating Patient B1 as a matter of law. (See *Wheeler v. State Bd. of Forestry* (1983) 144 Cal.App.3d 522, 526–527 [an order imposing discipline may be based only on the grounds for discipline alleged in the accusation].)

VIOLATION OF PROFESSIONAL CONFIDENCE

97. Respondent conceded he obtained copies of Patient A1's medical records from Enloe Medical Center after he stopped treating Patient A1. He further conceded he obtained the records for the sole purpose of preparing for his interview with the MBOC. Respondent's claim that Patient A1 signed a release authorizing him to obtain the records was uncorroborated and not credible for reasons previously explained. He engaged in unprofessional conduct by willfully violating his professional confidence without Patient A1's authorization.

98. Respondent's argument that he was entitled to the records because he was participating in "quality control" when the MBOC interviewed him was unpersuasive. The MBOC was investigating his treatment of Patient A1, not Dr. Scarborough's. Respondent failed to explain why the MBOC's investigation entitled him to records of subsequent treatment that did not involve him.

APPROPRIATE DISCIPLINE

99. The MBOC has adopted "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 Accusation ranges from stayed revocation with probation for five years to outright revocation.

100. 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.)

101. 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

102. Complainant requested that respondent be ordered to pay the MBOC $15,226.50 for investigation costs and $45,661.75 for enforcement costs, for a total of $60,888.25, pursuant to Business and Professions Code section 125.3. He submitted Certification of Prosecution Costs for OAH Case No. 2024110747: Declaration of Deputy Attorney General Christine A. Rhee and Supplemental Certification of Prosecution Costs for OAH Case No. 2024110747: Declaration of Deputy Attorney General Christine A. Rhee. Ms. Rhee verified, under penalty of perjury, that this matter involved the MBOC's Health Quality Investigation Unit's (HQIU) joint investigation of two matters – Case Numbers 800-2023-101401 (101401) and 800-2023-103855 (103855). The Office of the Attorney General prosecuted both matters under Case Number 101401. Ms. Rhee further verified that the Office of the Attorney General

billed the MBOC $45,661.75 for the time she and her colleagues spent working on the matter through July 8, 2025.

103. Complainant also introduced two Declarations of Investigative Activity from Mark Loomis, a commander with HQIU. The Declaration for Case Number 101401 was unsigned and indicated the MBOC incurred $5,096 in costs for time staff spent investigating the matter through August 9, 2024. The Declaration for Case Number 103855 was signed under penalty of perjury and indicated the MBOC incurred $4,930.50 in costs for time staff spent investigating the matter through June 26, 2024. Both Declarations itemized the time spent by date, number of hours spent, investigator, task code, and task performed. They included the hourly rates charged.

104. Complainant also submitted two certifications from Therese Kelly, a Staff Services Manager I with the MBOC, signed under penalty of perjury. Between the two certifications, she attested that Dr. Weinberg billed the MBOC a total of $5,200 in this matter. The first certification covered April 2 through June 25, 2024, and provided the total number of hours spent on "Case review – conference with City Attorney [*sic*]," his hourly rate, and his total charge of $2,650. The second certification covered April 2 through May 4, 2024, and provided the total number of hours spent on "Case review – records review, report preparation," his hourly rate, and his total charge of $2,550.

105. 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 15 through 18.

LEGAL CONCLUSIONS

Applicable Burden/Standard of Proof

1. Complainant has the burden of proving the grounds for discipline alleged in the 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.)

CAUSE FOR DISCIPLINE

5. 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).) It also includes "the willful, unauthorized violation of professional confidence." (Bus. & Prof. Code, § 2263.)

Conclusion

GROSS NEGLIGENCE

6. Respondent committed gross negligence while treating Patient A1 as explained in Factual Findings 91 and 93. Therefore, cause exists to discipline his certificate pursuant to Business and Professions Code section 2234, subdivision (b).

7. Respondent also committed gross negligence while treating Patient B1 as explained in Factual Findings 92 and 93. Therefore, cause exists to discipline his certificate pursuant to Business and Professions Code section 2234, subdivision (b).

REPEATED NEGLIGENT ACTS

8. Respondent committed repeated negligent acts while treating Patient A1 as explained in Factual Findings 94 and 95. Therefore, cause exists to discipline his certificate pursuant to Business and Professions Code section 2234, subdivision (c), based on his treatment of Patient A1.

9. Complainant did not prove by clear and convincing evidence that respondent committed repeated negligent acts while treating Patient B1 as explained in Factual Finding 96. Therefore, no cause exists to discipline his certificate pursuant to Business and Professions Code section 2234, subdivision (c), based on his treatment of Patient B1.

VIOLATION OF PROFESSIONAL CONFIDENCE

10. Respondent violated professional confidence as explained in Factual Findings 97 and 98. Therefore, cause exists to discipline his certificate pursuant to Business and Professions Code section 2234, as that statute relates to Business and Professions Code section 2263.

11. Cause exists to discipline respondent's certificate for the reasons explained in Legal Conclusions 6 through 8 and 10, 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 99 through 101. Therefore, his certificate must be revoked.

Award of Costs

12. 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.*)

13. 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.*)

14. 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.)

15. Complainant presented prima facie evidence that the MBOC's reasonable costs of enforcement were $45,661.75. (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 investigating Case Number 103855 were $4,930.50.

16. Although Ms. Kelly certifications that the MBOC incurred $5,250 in investigation costs for Dr. Weinberg'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. Weinberg'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. Weinberg's time. (*Id.* at subd. (b).)

17. However, complainant did not present sufficient evidence of the reasonable costs the MBOC incurred for staff's time investigating Case Number 101401. Commander Loomis did not sign his Declaration for that matter, and there was no other evidence of the costs the MBOC incurred. Therefore, no investigation costs based on the MBOC's staff's time are awarded, and $5,096 must be deducted from the total amount of investigation costs complainant requested.

18. The MBOC's reasonable costs of investigation are $10,130.50, and its reasonable costs of enforcement are $45,661.75. Respondent did not rebut that evidence. 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 investigation of $10,130.50 and costs of enforcement of $45,661.75. The total cost award is $55,792.25.

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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 $55,792.25 for its costs of investigation and enforcement of this matter.

DATE: September 22, 2025

Coren D. Wong (Sep 22, 2025 16:19:46 PDT)

COREN D. WONG
Administrative Law Judge
Office of Administrative Hearings