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8
9 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against,

Case No. 800-2018-044728

13 **MAHER M. ANOUS, M.D.**
14 **435 North Bedford Drive, Suite 206**
Beverly Hills, CA 90210-4350

DEFAULT DECISION
AND ORDER

15 **Physician's and Surgeon's Certificate**
16 **No. C 55037,**

[Gov. Code, §11520]

17 Respondent.

18
19 **FINDINGS OF FACT**

20 1. On or about January 6, 2012, the Medical Board of California (Board) issued
21 Physician's and Surgeon's Certificate No. C 55037 to MAHER M. ANOUS, M.D. (Respondent).
22 The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the
23 charges brought herein and will expire on September 30, 2021, unless renewed.

24 2. Title 16, California Code of Regulations, section 1303, provides: "Each person
25 holding a certificate, license, permit or any other authority issued under the Medical Practice Act
26 shall file his or her proper and current mailing address with the division in its principal office, and
27 shall immediately notify the division at its office of any and all changes of mailing address,
28 giving both the old and new address. A true and correct copy of the Certification of Respondent's

1 license status, including his current address of record, is attached hereto as **Exhibit A**, and is
2 incorporated herein by reference.

3 3. On or about April 30, 2021, Complainant William Prasifka, in his official capacity as
4 the Executive Director of the Medical Board of California, Department of Consumer Affairs, filed
5 Accusation No. 800-2018-044728 against Respondent before the Medical Board of California.

6 4. On or about April 30, 2021, Andrea Geremia, an employee of the Complainant
7 Agency, served by Certified Mail a copy of the Accusation No. 800-2018-044728, Statement to
8 Respondent, notice of defense forms, Request for Discovery, and Government Code sections
9 11507.5, 11507.6, and 11507.7 to Respondent's address of record with the Board, which was and
10 is 435 North Bedford Drive, Suite 206, Beverly Hills, CA 90210-4350. A copy of the
11 Accusation, the related documents, and Declaration of Service are attached as **Exhibit B**, and are
12 incorporated herein by reference.

13 5. Service of the Accusation was effective as a matter of law under the provisions of
14 Government Code section 11505, subdivision (c). On May 3, 2021, at 4:12 p.m., the
15 aforementioned documents were delivered by the U.S. Postal Service to an individual at
16 Respondent's address of record. A copy of the post office confirmation of delivery is attached as
17 **Exhibit C**, and is incorporated herein by reference.

18 6. On or about June 9, 2021, after Respondent failed to return a notice of defense,
19 Cristina Gomez, an employee of the California Department of Justice, served by First Class U.S.
20 Mail, a copy of the Courtesy Notice of Default, a copy of the Accusation No. 800-2018-044728,
21 Statement to Respondent, notice of defense forms, Request for Discovery, and Government Code
22 sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record with the Board, which
23 was and is 435 North Bedford Drive, Suite 206, Beverly Hills, CA 90210-4350. The documents
24 were delivered by the U.S. Postal Service as addressed, and were not returned. A true and correct
25 copy of the Courtesy Notice of Default and all of the attachments, including Declaration of
26 Service thereof is attached hereto as **Exhibit D**.

27 7. On or about June 23, 2021, Vladimir Shalkevich, Deputy Attorney General accessed
28 the contact page on Respondent's medical practice website, at www.dranous.com/contact, which

1 enables the public to “get in touch with Dr. Anous.” Deputy Attorney General Shalkevich left his
2 contact information and the following message: “I am the attorney representing the Medical
3 Board. I need to speak with Dr. Anous as soon as possible. He has not returned a Notice of
4 Defense in response to the Accusation before the Medical Board and may lose his license. Please
5 call me today to avoid a default for failure to return a Notice of Defense. Thank you.” A true and
6 correct copy of the website screen and the message that Deputy Attorney General Vladimir
7 Shalkevich left for Respondent on his website is attached hereto as **Exhibit E**. Deputy Attorney
8 General Shalkevich also telephoned Respondent’s practice at the telephone number on
9 Respondent’s website. This is the same telephone number that has been provided by Respondent
10 during the investigation, and recorded in the Report of Investigation. According to the
11 responding message, provided by the telephone company, the number that Deputy Attorney
12 General Shalkevich dialed was changed and there was no forwarding number. Deputy Attorney
13 General Shalkevich then telephoned a cell phone number provided to the Board investigators by
14 Respondent during the investigation, and left a voice mail at that phone number. As of today,
15 Respondent has not responded to any of the above listed efforts to reach him, and has not returned
16 a Notice of Defense.

17 8. Government Code section 11506 states, in pertinent part:

18 (c) The respondent shall be entitled to a hearing on the merits if the respondent
19 files a notice of defense, and the notice shall be deemed a specific denial of all parts
20 of the accusation not expressly admitted. Failure to file a notice of defense shall
21 constitute a waiver of respondent's right to a hearing, but the agency in its discretion
22 may nevertheless grant a hearing.

23 Respondent failed to file a Notice of defense within 15 days after service upon him of the
24 Accusation, and therefore waived his right to a hearing on the merits of Accusation No. 800-
25 2018-044728.

26 9. California Government Code section 11520 states, in pertinent part:

27 (a) If the respondent either fails to file a notice of defense or to appear at the
28 hearing, the agency may take action based upon the respondent's express admissions
or upon other evidence and affidavits may be used as evidence without any notice to
respondent.

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ORDER

IT IS SO ORDERED that Physician's and Surgeon's Certificate No. C 55037, heretofore issued to Respondent MAHER M. ANOUS, M.D., is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective at 5:00 p.m. on **AUG 25 2021**.

It is so ORDERED **JUL 26 2021**



WILLIAM PRASEJKA
EXECUTIVE DIRECTOR
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:
13 **MAHER M. ANOUS, M.D.**
14 **435 North Bedford Drive, Suite 206**
Beverly Hills, CA 90210
15 **Physician's and Surgeon's Certificate**
16 **No. C 55037,**
17 Respondent.

Case No. 800-2018-044728
A C C U S A T I O N

18
19 **PARTIES**

- 20 1. William Prasifka (Complainant) brings this Accusation solely in his official capacity
21 as the Executive Director of the Medical Board of California, Department of Consumer Affairs
22 (Board).
23 2. On or about January 6, 2012, the Medical Board issued Physician's and Surgeon's
24 Certificate Number C 55037 to Maher M. Anous, M.D. (Respondent). The Physician's and
25 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought
26 herein and will expire on September 30, 2021, unless renewed.

27 ///
28 ///

JURISDICTION

1
2 3. This Accusation is brought before the Board, under the authority of the following
3 laws. All section references are to the Business and Professions Code (Code) unless otherwise
4 indicated.

5 4. Section 2227 of the Code states:

6 (a) A licensee whose matter has been heard by an administrative law judge of
7 the Medical Quality Hearing Panel as designated in Section 11371 of the Government
8 Code, or whose default has been entered, and who is found guilty, or who has entered
9 into a stipulation for disciplinary action with the board, may, in accordance with the
10 provisions of this chapter:

11 (1) Have his or her license revoked upon order of the board.

12 (2) Have his or her right to practice suspended for a period not to exceed one
13 year upon order of the board.

14 (3) Be placed on probation and be required to pay the costs of probation
15 monitoring upon order of the board.

16 (4) Be publicly reprimanded by the board. The public reprimand may include a
17 requirement that the licensee complete relevant educational courses approved by the
18 board.

19 (5) Have any other action taken in relation to discipline as part of an order of
20 probation, as the board or an administrative law judge may deem proper.

21 (b) Any matter heard pursuant to subdivision (a), except for warning letters,
22 medical review or advisory conferences, professional competency examinations,
23 continuing education activities, and cost reimbursement associated therewith that are
24 agreed to with the board and successfully completed by the licensee, or other matters
25 made confidential or privileged by existing law, is deemed public, and shall be made
26 available to the public by the board pursuant to Section 803.1.

27 5. Section 2234 of the Code, states:

28 The board shall take action against any licensee who is charged with
unprofessional conduct. In addition to other provisions of this article, unprofessional
conduct includes, but is not limited to, the following:

 (a) Violating or attempting to violate, directly or indirectly, assisting in or
abetting the violation of, or conspiring to violate any provision of this chapter.

 (b) Gross negligence.

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

 (1) An initial negligent diagnosis followed by an act or omission medically

1 appropriate for that negligent diagnosis of the patient shall constitute a single
negligent act.

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

5 (d) Incompetence.

6 (e) The commission of any act involving dishonesty or corruption that is
7 substantially related to the qualifications, functions, or duties of a physician and
surgeon.

8 (f) Any action or conduct that would have warranted the denial of a certificate.

9 (g) The failure by a certificate holder, in the absence of good cause, to attend
10 and participate in an interview by the board. This subdivision shall only apply to a
certificate holder who is the subject of an investigation by the board.

11 6. Section 2240 of the Code provides:

12 “(a) A physician and surgeon who performs a medical procedure outside of a general
13 acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety
14 Code, that results in the death of any patient on whom that medical treatment was
performed by the physician and surgeon, or by a person acting under the physician and
15 surgeon's orders or supervision, shall report, in writing on a form prescribed by the board,
that occurrence to the board within 15 days after the occurrence.

16 ...

17 (f) The failure to comply with this section constitutes unprofessional conduct.”

18
19 7. Section 2266 of the Code states:

20 The failure of a physician and surgeon to maintain adequate and accurate records relating to
21 the provision of services to their patients constitutes unprofessional conduct.

22 **FIRST CAUSE FOR DISCIPLINE**

23 **(Gross Negligence)**

24 8. Respondent, Maher M. Anous, M.D., is subject to disciplinary action under section
25 2234, subdivision (b) of the Code in that he was grossly negligent in the care and treatment of
26 Patient 1.¹ The circumstances are as follows:

27 ¹ The patient in this matter is designated as “Patient 1” for privacy reasons. Respondent
28 knows Patient 1's identity, or it will be provided to him in response to a written Request for
Discovery.

1 9. On or about May 24, 2018, the Board received a report of a settlement on behalf of
2 the Respondent from his medical malpractice liability insurance carrier, pursuant to the
3 mandatory reporting provisions of Business and Professions Code section 801, et seq. The Board
4 initiated an investigation on the basis of that settlement report.

5 10. The Board's investigation revealed that on or about November 20, 2015, Respondent
6 performed a cosmetic procedure on Patient 1 that included a suction lipectomy of the back,
7 thighs, arms and ankles, with fat transfer into the buttocks. Patient 1 died as a result of the
8 procedure performed by the Respondent. In response to the Board's inquiry about this matter, on
9 or about June 6, 2018, Respondent provided a narrative statement, where he wrote, in part: "I
10 was the sole surgeon involved and the captain of the surgical team present. No one else but me
11 takes responsibility for the events of this fateful day." Prior to the Board's inquiry, Respondent
12 failed to report Patient 1's death to the Board, in the manner required by Business and Professions
13 Code section 2240.

14 11. Patient 1 was a female of approximately 50 years of age with no significant past
15 medical history. She was seen preoperatively, and subsequently taken by Respondent to the
16 operating room at Beverly Hills Physicians' Rancho Surgical Institute. The planned surgery
17 involved extensive liposuction and a fat transfer to the patient's buttocks. Prior to the surgery,
18 Respondent failed to perform and/or document the patient's concerns and goals regarding fat
19 transfer to her buttock area, and failed to perform and/or document a history and physical
20 examination of the patient's buttock area.

21 12. The surgery started at approximately 8:50 a.m., when anesthesia began. A certified
22 nurse anesthetist monitored the patient under Respondent's supervision. The surgery itself began
23 at approximately 9:45 a.m., with the patient in the supine position. The first part of the surgery,
24 according to Respondent's June 18, 2018 narrative statement to the Board, involved liposuction
25 of the patient's abdomen, flanks and arms. In his operative report, written after the patient's
26 death, Respondent omitted any mention of performing liposuction on the patient's abdomen.

27 13. At approximately 11:30 a.m., after Patient 1 was turned to the prone position for
28 additional liposuction of her back, and other areas, and for the gluteal fat transfer portion of the

1 procedure, her blood pressure dropped precipitously and her heart rate accelerated. In response to
2 the patient's change in condition, the Certified Nurse Anesthetist decreased the amount of a gas
3 anesthetic (sevoflurane) the patient was receiving, increased the amount of IV fluids she was
4 receiving, and administered three different vasopressors in an attempt to stabilize the patient's
5 blood pressure. According to the Nurse Anesthetist's statement, Respondent, in consultation with
6 her, made the decision to continue the procedure, which continued for approximately another
7 hour and twenty minutes, with Patient 1 in the prone position.

8 14. During his interview with the Board's investigators, Respondent was asked about
9 what was happening in the operating room at approximately 11:30 a.m. when three different
10 vasopressors were administered to Patient 1. Respondent answered: "I don't know because it is
11 the anesthesia records. I don't know if the CRNA was having problems with the blood pressure
12 or not. Okay?... I mean, to my recollection, the minute that I knew that there was any problems
13 with, um, the blood pressure, I very quickly ended out the case." Respondent further explained
14 during his interview that while the patient was in the prone position, the nurse anesthetist told him
15 that she could not get the patient's blood pressure reading. After repeated attempts to adjust or
16 reconnect the patient's blood pressure cuff, the patient still had no measurable blood pressure.
17 The incisions were closed, the patient was turned over to the supine position and awakened from
18 anesthesia.

19 15. Respondent was also interviewed by the Coroner's investigator. Respondent told the
20 Coroner's investigator that about 20 to 25 minutes after turning Patient 1 to the prone position,
21 the nurse said the blood pressure was "unobtainable." Respondent thought that it was a positional
22 problem with the blood pressure cuff because the patient's heart rate was normal and her oxygen
23 saturation was 100%. About 5-10 minutes later, Respondent was done with the procedure.

24 16. According to the anesthesia record, the procedure ended at 12:50 p.m.

25 17. The patient was placed on a gurney and taken to the recovery room where,
26 Respondent claimed, she was placed on monitors and given fluid boluses. Respondent stated that
27 Patient 1 was speaking with the staff and/or him, and yet had no measurable blood pressure.
28 Respondent explained: "And, that I mean, I'm recalling a very confused time and, um, and -- and

1 then, I don't know how long in the recovery room, we were giving her fluids and -- and still the
2 patient was awake and responsive to us. And, um, then all of a sudden she crashed. And so, we
3 called 9-1-1.”

4 18. Respondent told the Coroner's investigator that he went to the recovery room to
5 check on Patient 1 about 30 minutes after the end of the procedure. He talked with Patient 1.
6 While in recovery room, the nurse could not get a blood pressure again. Since the surgery facility
7 dealt with outpatients only, Respondent told the office manager that Patient 1 could not go home
8 because of her blood pressure and he wanted her to go to the hospital. The ambulance did not
9 need to roll code. Respondent told the Coroner's investigator that 911 was called about 20 – 25
10 minutes before Patient 1's blood pressure was lost.

11 19. The ambulance records show that 9 – 1 – 1 was called at approximately 1:55 p.m.
12 The initial call was not an emergency, but the call status was raised to an emergency while the
13 ambulance was en-route. The paramedics arrived at Patient 1's bedside at 2:04 p.m. The patient
14 was being re-intubated by the nurse anesthetist when they arrived. The patient was not connected
15 to the facility's monitoring equipment. The paramedics documented their attempts to obtain a
16 report from Respondent and his staff, but “were receiving multiple stories from different staff,
17 with no story adding up to patient outcome.” A fire department paramedic who arrived on the
18 scene also attempted to obtain a report from Respondent, with the same result. “The physicians
19 on the scene did not state nor know that patient was pulseless, were giving me a normal report
20 prior to realizing she was in cardiac arrest at about [2:07 p.m.]” The paramedics had Respondent
21 begin CPR, and connected Patient 1 to a monitor, at which time they noted that the patient was in
22 pulseless electric activity. CPR continued while Patient 1 was rushed to the hospital. Respondent
23 followed the ambulance to the hospital.

24 20. Patient 1 arrived at San Antonio Regional Hospital, at approximately 2:20 p.m. At
25 2:40 p.m. her hemoglobin level was found to be 1.3. Respondent claimed that he assisted in the
26 resuscitative efforts by the emergency room staff by placing a central line for Patient 1. Despite
27 all of the efforts to save her, including multiple blood transfusions, Patient 1 was not able to
28 regain a consistent pulse. She was pronounced dead at 3:43 p.m.

1 21. A subsequent autopsy revealed that the cause of death was hypovolemic shock caused
2 by an intraoperative hemorrhage, due to penetration into the patient's chest cavity with multiple
3 perforations of the diaphragm, right lung, psoas muscle, left posterior chest cavity and multiple
4 punctures of the liver that occurred during Respondent's procedure.

5 22. Each of the following acts and/or omissions by Respondent was an extreme departure
6 from the standard of care:

7 A) Respondent's penetrating and puncturing unintended areas of vital structures of
8 Patient 1 so far outside of the intended surgical field on both sides of the patient was an extreme
9 departure from the standard of care.

10 B) Respondent's failure to diagnose and timely treat hypotension and pulseless electrical
11 activity suffered by Patient 1 was an extreme departure from the standard of care.

12 **SECOND CAUSE FOR DISCIPLINE**

13 **(Repeated Negligent Acts)**

14 23. Respondent, Maher M. Anous, M.D., is subject to disciplinary action under section
15 2234, subdivision (c) of the Code, in that he committed repeated acts of negligence while
16 providing care and treatment to Patient 1. The circumstances are as follows:

17 24. The allegations of paragraphs 9 through 21 are incorporated by reference.

18 25. Each of the following acts and/or omissions by Respondent was a departure from the
19 standard of care:

20 A) Respondent's penetrating and puncturing unintended areas of vital structures of
21 Patient 1 so far outside of the intended surgical field on both sides of the patient was a departure
22 from the standard of care.

23 B) Respondent's failure to diagnose and timely treat hypotension and pulseless electrical
24 activity suffered by Patient 1 was a departure from the standard of care.

25 C) Respondent's failure to perform and/or document a history and physical exam
26 regarding Patient 1's buttock augmentation was a departure from the standard of care.

27 **THIRD CAUSE FOR DISCIPLINE**

28 **(Unprofessional Conduct - Failure to Report Patient's Death)**

1 26. Respondent, Maher M. Anous, M.D., is subject to disciplinary action under section
2 2240 of the Code, in that he failed to report the death of Patient 1 to the Board as required by law.
3 The circumstances are as follows:

4 27. The allegations of paragraphs 9 through 21 are incorporated by reference.

5 **FOURTH CAUSE FOR DISCIPLINE**

6 **(Inaccurate and Inadequate Record Keeping)**

7 28. Respondent, Maher M. Anous, M.D., is subject to disciplinary action under section
8 2266 of the Code in that he failed to keep accurate and adequate records of his care of Patient 1.
9 The circumstances are as follows:


10 29. The allegations of paragraphs 9 through 21 are incorporated by reference.

11 **PRAYER**

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

- 14 1. Revoking or suspending Physician's and Surgeon's Certificate Number C 55037,
15 issued to Maher M. Anous, M.D.;
- 16 2. Revoking, suspending or denying approval of Maher M. Anous, M.D.'s authority to
17 supervise physician assistants and advanced practice nurses;
- 18 3. Ordering Maher M. Anous, M.D., if placed on probation, to pay the Board the costs
19 of probation monitoring; and
- 20 4. Taking such other and further action as deemed necessary and proper.

21
22 DATED: APR 30 2021



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

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