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

In the Matter of the Second Amended Accusation Against: Howard Michael Gross, M.D. Physician's & Surgeon's Certificate No. G 61854 Respondent.	Case No. 800-2017-032604

DECISION

The attached Stipulated Settlement and Disciplinary Order 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 August 26, 2022.

IT IS SO ORDERED: July 28, 2022.

MEDICAL BOARD OF CALIFORNIA

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

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
REBECCA L. SMITH
Deputy Attorney General
State Bar No. 179733
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6475
Facsimile: (916) 731-2117
Attorneys for Complainant

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

In the Matter of the Second Amended Accusation Against: HOWARD MICHAEL GROSS, M.D. 1722 State Street, Suite 201 Santa Barbara, CA 93101 Physician's and Surgeon's Certificate No. G 61854, Respondent.	Case No. 800-2017-032604 OAH No. 2020080237 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Rebecca L. Smith, Deputy Attorney General.

2. Howard Michael Gross, M.D. (Respondent) is represented in this proceeding by attorneys Mark B. Connely, whose address is 1319 Marsh Street, 2nd Floor, San Luis Obispo,

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California 93401-3315 and Peter R. Osinoff, whose address is 355 South Grand Avenue, Suite 1750, Los Angeles, California 90071-1562.

3. On November 23, 1987, the Board issued Physician's and Surgeon's Certificate No. G 61854 to Howard Michael Gross, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought in Second Amended Accusation No. 800-2017-032604, and will expire on March 31, 2023, unless renewed.

JURISDICTION

4. A Second Amended Accusation in case No. 800-2017-032604 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on April 30, 2020. Respondent timely filed his Notice of Defense contesting the Second Amended Accusation.

5. A copy of Second Amended Accusation No. 800-2017-032604 is attached as Exhibit A and is incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Second Amended Accusation No. 800-2017-032604. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Second Amended Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

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CULPABILITY

9. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in Second Amended Accusation No. 800-2017-032604, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate No. G 61854 to disciplinary action.

10. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the imposition of discipline by the Board as set forth in the Disciplinary Order below.

CONTINGENCY

11. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

12. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

13. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or opportunity to be heard by the Respondent, issue and enter the following Disciplinary Order:

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DISCIPLINARY ORDER

A. PUBLIC REPRIMAND

IT IS HEREBY ORDERED THAT upon completion of the following course-work, the Physician's and Surgeon's Certificate No. G 61854 issued to Respondent Howard Michael Gross, M.D. will be Publicly Reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This Public Reprimand is issued in connection with Respondent's care and treatment of Patient 1. as set forth in Second Amended Accusation No. 800-2017-032604, is as follows:

> *In December 2016, you committed acts constituting negligence in violation of Business and Professions Code sections 2234 and 2266, in your performance of Patient 1's abdominal liposuction procedure and failure to promptly recognize the patient's subsequent deteriorating condition, as set forth in Second Amended Accusation No. 800-2017-032604.*

B. CLINICAL COMPETENCE ASSESSMENT PROGRAM – Condition Precedent.

Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence

assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. Failure to successfully complete the clinical competency assessment outlined above shall constitute unprofessional conduct and is grounds for further disciplinary action.

C. **MEDICAL RECORD KEEPING COURSE.** Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the

Second Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than fifteen (15) calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

If Respondent fails to enroll, participate in, or successfully complete the medical record keeping course within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the medical record keeping course has been completed. Failure to successfully complete the medical record keeping course outlined above shall constitute unprofessional conduct and is grounds for further disciplinary action.

D. EDUCATION COURSE. Within sixty (60) calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than forty (40) hours. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which forty (40) hours were in satisfaction of this condition.

Respondent shall submit a certification of successful completion to the Board or its designee not later than fifteen (15) calendar days after successfully completing the course, or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

If Respondent fails to enroll, participate in, or successfully complete the educational

program(s) or course(s) within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the educational program(s) or course(s) has been completed. Failure to successfully complete the educational program(s) or course(s) outlined above shall constitute unprofessional conduct and is grounds for further disciplinary action.

E. **INVESTIGATION/ENFORCEMENT COST RECOVERY.** Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, in the amount of $3,461.25 (three thousand four hundred sixty-one dollars and twenty-five cents), payable within sixty (60) calendar days of the effective date of this Decision. Costs shall be payable to the Medical Board of California. Failure to pay such costs shall constitute unprofessional conduct and is grounds for further disciplinary action.

Any and all requests for a payment plan shall be submitted in writing by Respondent to the Board.

The filing of bankruptcy by respondent shall not relieve Respondent of the responsibility to repay investigation and enforcement costs.

F. **FUTURE ADMISSIONS CLAUSE**. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Second Amended Accusation No. 800-2017-032604 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorneys, Mark B. Connely and Peter R. Osinoff. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 4/26/22

HOWARD MICHAEL GROSS, M.D.
Respondent

We have read and fully discussed with Respondent Howard Michael Gross, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. We approve its form and content.

DATED: 4/27/22

MARK B. CONNELY
Attorney for Respondent

DATED: _____

PETER R. OSINOFF
Attorney for Respondent

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorneys, Mark B. Connely and Peter R. Osinoff. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: _____

HOWARD MICHAEL GROSS, M.D.
Respondent

We have read and fully discussed with Respondent Howard Michael Gross, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. We approve its form and content.

DATED: _____

MARK B. CONNELY
Attorney for Respondent

DATED: 4/25/2022

PETER R. OSINOFF
Attorney for Respondent

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ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: 5/2/2022

Respectfully submitted,

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

REBECCA L. SMITH
Deputy Attorney General
Attorneys for Complainant

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ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
REBECCA L. SMITH
Deputy Attorney General
State Bar No. 179733
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6475
Facsimile: (916) 731-2117
Attorneys for Complainant

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

In the Matter of the Second Amended Accusation Against: **HOWARD MICHAEL GROSS, M.D.** **1722 State Street, # 201** **Santa Barbara, California 93101-2522** **Physician's and Surgeon's Certificate No. G 61854,** Respondent.	Case No. 800-2017-032604 **SECOND AMENDED ACCUSATION**

PARTIES

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

2. On November 23, 1987, the Board issued Physician's and Surgeon's Certificate Number G 61854 to Howard Michael Gross, M.D. ("Respondent"). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2023, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

STATUTORY PROVISIONS

5. Section 2234 of the Code states:

> 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 appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
>
> (d) Incompetence.
>
> (e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.
>
> (f) Any action or conduct that would have warranted the denial of a certificate.
>
> (g) The failure by a certificate holder, in the absence of good cause, to attend 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.

6. Section 2259.7 of the Code states:

The Medical Board of California shall adopt extraction and post-operative care standards in regard to body liposuction procedures performed by a physician and surgeon outside of a general acute care hospital, as defined in Section 1250 of the Health and Safety Code. In adopting those regulations, the Medical Board of California shall take into account the most current clinical and scientific information available. A violation of those extraction and post-operative care standards constitutes unprofessional conduct.

7. Section 2266 of the Code states:

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

REGULATORY PROVISIONS

8. California Code of Regulations, title 16, section 1356.6, subdivision (b)(4), provides in pertinent part:

(b) The following standards apply to any liposuction procedure not required by subsection (a) to be performed in a general acute-care hospital or a setting specified in Health and Safety Code Section 1248.1: . . .

(4) Records. Records shall be maintained in the manner necessary to meet the standard of practice and shall include sufficient information to determine the quantities of drugs and fluids infused and the volume of fat, fluid and supernatant extracted and the nature and duration of any other surgical procedures performed during the same session as the liposuction procedure.

COST RECOVERY

9. Business and Professions Code section 125.3 states that:

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

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

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

(d) The administrative law judge shall make a proposed finding of the amount

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

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

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

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

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

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

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

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

FACTUAL ALLEGATIONS

The Operation on December 19, 2016

10. The Patient,[1] at the time, a sixty-two-year-old female was Respondent's patient and underwent surgery on or about December 19, 2016, at his operative facility. The operation consisted of removal and replacement of breast implants, liposuction of the abdomen and flanks, and a lower blepharoplasty.[2]

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[1] The patient's name is omitted to address privacy concerns and will be referred hereafter as "the Patient." The Respondent is aware of her name.

[2] Blepharoplasty is a type of surgery that repairs droopy eyelids and may involve removing excess skin, muscle, and fat.

11. In his operative report, dated December 19, 2016, Respondent described the procedures that he performed on the Patient. The first was the breast procedure. The procedure consisted of removal and replacement of breast implants along with total capsulectomy. Respondent performed liposuction next. Respondent documented injecting the Patient with tumescent solution. However, he did not describe the composition of the tumescent solution. He also did not describe the amounts of the tumescent solution that were instilled in the Patient. Respondent stated in the operative report that he removed 2,200 cubic centimeters of aspirate from the upper and lower portions of the Patient's abdomen, and that he removed 550 cubic centimeters of aspirate from each flank. He further contoured the Patient, rolling her side to side, and removed an additional 700 cubic centimeters of aspirate. According to the operative report, he removed a total of 4,000 cubic centimeters of aspirate from the Patient.

12. Respondent's operative report lacked essential details. He failed to document the locations of where he made the stab incisions for the liposuction. He also failed to document the size of the cannula or whether he used a power-assist device. In the final portion of the operative report, Respondent described the lower blepharoplasty as performed through a transconjunctival incision.

13. When interviewed on November 7, 2019, Respondent explained that on the evening of December 19, 2016 (that is, the same day as the surgery), he saw the Patient when she returned to his office after the surgery with complaints of chest pain. He stated that the Patient came to see him after her husband had called, stated that she was having pain in her chest, and that the pain was located in her clavicular area. Respondent examined her, observed that there was no hematoma, and concluded there was no other reason why she should have been having pain in her clavicular area. His main concern was pulmonary embolus[3] or pneumothorax.[4] He listened to her lungs and measured her oxygen saturation. Believing that she was fine, Respondent cleared her to go home. ///

[3] Pulmonary embolus means a blockage in a lung artery.

[4] Pneumothorax means a presence of air or gas in the cavity between the lungs and chest wall, causing collapse of the lung.

Post- Operative Day No. 1 – Tuesday, December 20, 2016

14. Respondent's post-operative notes for Post-Operative Day No 2, dated December 20, 2016, and labeled "POD#1" states that the patient was seen in the evening complaining of pain. She had removed her garment,[5] and he replaced it. Her lungs were clear. She was tender in the right clavicle. She had 95 percent oxygen on room air. The end of the note appears to indicate that she should return in one week to see him.

15. When questioned on November 7, 2019, Respondent stated that when he saw the Patient on Post-Operative Day 1, December 20, 2016, the Patient was not having abdominal pain or any further pain in the clavicular area.

Post-Operative Day No. 2 – Wednesday, December 21, 2016

16. When questioned on November 7, 2019, Respondent stated that on December 21, 2016, the Patient's husband called his office and said that the Patient was somnolent. The Patient presented to Respondent's office later on December 21, 2016. When he saw her in his office, Respondent's impression was that she had the typical look of someone who might be overmedicated. He also believed she might be dehydrated. Her blood pressure was 83 (systolic) over 54 (diastolic), her pulse rate was 112 beats per minute, and she was lethargic and somnolent. When asked by the DCA's medical consultant during the November 7, 2019 Subject Interview if, on December 21, 2016, Respondent considered the possibility of intraabdominal injury, Respondent stated that he did not. His thought was that she was dehydrated, and if there was medication overload, to allow that issue to resolve.

17. On December 21, 2016, the Patient arrived at Respondent's office at 8:15 a.m. Her blood pressure was 83 over 54. A chart note indicates that the Patient presented quite somnolent at his office and further documents that she had not been drinking or eating. She had no complaints of pain or shortness of breath. At 8:30 a.m., Respondent started the first intravenous drip. In the following 10 ½ hours, Respondent administered six (6) liters of normal saline to her intravenously. Respondent's plan was to observe and hydrate her. At 8:50 a.m., Respondent

[5] Garment refers to a post-operative compression garment that aids in recovery after a tummy tuck, liposuction, or body lift.

administered the second bag of saline. The Patient's blood pressure went up to 117 over 70 at 8:55 a.m. with oxygen saturation at 98%. At 9:05 a.m., the Patient's blood pressure was 100 over 63 - oxygen saturation was at 95%. At 10:00 a.m., Respondent administered the third bag of saline. At 11:00 a.m., Respondent introduced the fourth IV bag of saline. Sometime between 11:30 a.m. and 1:00 p.m., the Patient's oxygen level was at 94%. At 2:50 p.m., Respondent introduced the fifth IV bag of saline. At 3:00 p.m., the Patient's blood pressure was 92 over 63 with a heart rate of 120 beats per minute, respiration of 16 times per minute, and oxygen saturation of 92 to 93 percent on room air. Patient had an oxygen level of 95 at 3:30 p.m. After 4:45 p.m., the Patient's blood pressure was 84 over 65 with 95% oxygen saturation. At 4:45 p.m., Respondent introduced the sixth IV bag of saline.

The Patient was discharged at 6:45 p.m. and instructed by the Respondent to go to the emergency room at Cottage Hospital in Santa Barbara. Respondent accompanied her to Cottage Hospital. Upon presentation there, she showed signs of shock. At the hospital, there was a CT Scan taken of the Patient in the emergency room, and she was admitted. The CT scans revealed the intraabdominal or retroperitoneal presence of free fluid and bubbles of free air, indicating the possibility of intraabdominal injury. Doctors at the hospital concluded that the Patient sustained a perforation to the duodenum[6] as well as a retroperitoneal injury[7] during the liposuction procedure performed by Respondent on or about December 19, 2016. The Patient developed infectious complications secondary to the intestinal perforation.

18. That same day, December 21, 2016, Dr. Bounoua performed an exploratory laparoscopy. That procedure continued into the early morning of December 22, 2016.

19. At the November 7, 2019 Subject Interview, the DCA medical consultant asked Respondent whether, on December 21, 2016, he was concerned that the Patient was having a progressive problem on presentation. Respondent replied that he did not think there was a

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[6] The duodenum is the first part of the intestinal tract immediately beyond the stomach, leading to the jejunum.

[7] The retroperitoneum is the space located between the peritoneum and the posterior abdominal wall. In this retroperitoneal space sit portions of or entire organs and tissue structures, such as the duodenum, colon, pancreas, and kidneys.

progressing problem. On presentation, he thought it was a treatable problem with dehydration or hyper-medication. However, as the day progressed, Respondent realized that the Patient's condition failed to improve.

Post-Operative Date No. 4 – Friday, December 23, 2016

19. On December 23, 2016, Dr. Dunn performed a procedure on the Patient. When Dr. Dunn saw the Patient that day, he assessed her situation as critical. Dr. Dunn knew that Dr. Bounoua had previously done a laparoscopy. On December 23, 2016, Dr. Dunn decided that the Patient needed to have an open exploration. During this exploration, he discovered that she had a perforation. He found out before that the Patient had fat saponification throughout her upper abdomen and retroperitoneal bile staining in her upper abdomen. Subsequently, he found the hole in the duodenum. That discovery was made using the Kocher Maneuver[8].

20. During the next four months, the Patient was hospitalized. She had more than 20 other surgical procedures in an attempt to address her infection. On April 14, 2017, the Patient died.

Departures from the Standard of Care

21. On December 19, 2016, Respondent performed surgical procedures on the Patient in a grossly negligent manner, including, without limitation, when he injured and perforated her bowel. Although bowel perforations have been described in the medical literature and are a known risk of abdominal liposuction, those injuries are usually associated with an unrecognized hernia or scarring of the abdomen. Respondent's medical records for the Patient fail to document any of those associated conditions. Furthermore, the perforation of the Patient's duodenum and retroperitoneum is deeper within her abdominal cavity than is described in the medical literature discussing bowel perforations during abdominal liposuction.

22. In the post-operative period, the Patient began displaying symptoms related to her injury very soon after the operation. Respondent saw her on the evening of approximately December 19, 2016, only a few hours after her surgery, at which time she was complaining of

[8] Kocher maneuver is a **surgical maneuver** to expose structures in the retroperitoneum behind the duodenum and pancreas.

clavicular pain, which is a significant sign. The Patient had tenderness at the right clavicle as well as her abdomen. Respondent failed to adequately investigate those complaints.

23. By post-operative day number 2, December 21, 2016, the Patient was very clearly in a great deal of distress. Respondent felt that her somnolence and low blood pressure were due to dehydration and an overdose of her medication. He treated her that day in his office for approximately 10 ½ hours with six (6) liters of intravenous fluid. Ten and one-half hours was too long to observe the Patient in an office or clinic setting. Instead, the Patient should have been moved to a higher level of care after the first two hours in which her condition did not markedly improve.

24. When interviewed, Respondent stated that he did not consider any alternative cause of her increasingly alarming symptoms, specifically the possibility of intestinal perforation. By the time the Patient presented to the hospital's emergency room later on the evening of December 21, 2016, she was displaying signs of shock, with a likely etiology of septic shock[9] and required emergency surgery after a CT scan[10] revealed air within her abdomen. On December 19, 2016, and thereafter, Respondent committed gross negligence when he failed to adequately recognize and address the seriousness of the Patient's rapidly deteriorating condition.

25. Respondent's medical record-keeping for the Patient, including, without limitation, his operative report and post-operative notes, is inadequate and represents repeated acts of negligence. Respondent failed to adequately describe his care and treatment of the Patient and the Patient's condition. Respondent also failed to adequately include in his operative report an appropriate level of detail, including, without limitation, the location of the Patient's stab incisions, the cannulas used for liposuction, the composition of the tumescent fluid, the amounts of the tumescent solution that were instilled, and whether a power assist device was used.

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[9] Septic shock (namely, infection throughout the body) is a potentially fatal medical condition that occurs when sepsis, which is organ injury or damage in response to infection, leads to dangerously low blood pressure and abnormalities in cellular metabolism.

[10] A computerized tomography scan (CT or CAT scan) uses computers and rotating X-ray machines to create cross-sectional images of the body. These images provide more detailed information than normal X-ray images. They can show the soft tissues, blood vessels, and bones in various parts of the body.

Respondent's lack of detail and lack of an adequate description of the operation and post-operative follow up care represents negligence.

26. During the next four months, the Patient was hospitalized. She had more than twenty additional surgical procedures to address her abdominal infection. On April 14, 2017, the Patient succumbed to her infection and died.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

27. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that he committed grossly negligent acts in connection with his care and treatment of the Patient. The circumstances are as follows:

28. The facts and allegations as set forth in Paragraphs 10 through 26, above, are incorporated by reference and re-alleged as if fully set forth herein. Respondent's acts and omissions constituting gross negligence are as follows:

A. Intraoperative perforation of the Patient's duodenum during the surgery performed on December 19, 2016.

B. The cannula employed during the surgery deviated from a proper plane, penetrated the abdominal wall, and perforated the Patient's duodenum. This resulted in spillage, which caused peritonitis and sepsis.

C. On December 21, 2016, he failed to evaluate his patient's symptoms fully and in a timely manner, failed to entertain any further possibilities as to the cause of her condition other than dehydration or overmedication, and failed to adequately recognize and address the seriousness of the Patient's rapidly deteriorating condition.

D. On December 21, 2016, he kept the Patient in his surgery center too long, about 10 ½ hours, and failed to send the Patient to the emergency room sooner.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

29. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that he engaged in repeated negligent acts in his care and treatment of the Patient. The

circumstances and allegations are as set forth in Paragraphs 10 through 28, above, are incorporated by reference and re-alleged as if fully set forth herein. In addition, Respondent's inadequate medical record-keeping constitutes negligence.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

30. Respondent is subject to disciplinary action under Code section 2266, and California Code of Regulations, title 16, section 1356.6, subdivision (b)(4), in that he maintained incomplete and inadequate records concerning his care and treatment of the Patient. The circumstances are as follows:

31. The facts and allegations as set forth in Paragraphs 10 through 29, above, are incorporated by reference and re-alleged as if fully set forth herein. Respondent failed to note in the medical records the following:

A. Where the stab incisions for the liposuction were placed.

B. The size of the cannula used.

C Whether a power assist device was used.

D. The composition of the tumescent solution.

E. The amounts of the tumescent solution that were instilled.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

32. Respondent is subject to disciplinary action under section Code section 2234, generally, in that he engaged in unprofessional conduct with respect to his care and treatment of the Patient. The circumstances are as follows, including the facts and allegations as set forth in Paragraphs 10 through 31, above, are incorporated by reference and re-alleged as if fully set forth herein.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 61854, issued to Respondent Howard Michael Gross, M.D.;

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

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

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

DATED: DEC 24 2021

Reji Varghese
Deputy Director

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

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