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

In the Matter of the Accusation Against: Louis Robert Mandris, M.D. Physician's and Surgeon's Certificate No. G 55865 Respondent.	Case No. 800-2022-094248

DECISION

The attached Stipulated Surrender of License and 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 May 28, 2024.

IT IS SO ORDERED May 20, 2024.

MEDICAL BOARD OF CALIFORNIA

Reji Varghese
Executive Director

ROB BONTA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
GIOVANNI F. MEJIA
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **LOUIS ROBERT MANDRIS, M.D.** **2212 Danube Way** **Upland, CA 91784** **Physician's and Surgeon's Certificate No. G 55865,** Respondent.	Case No. 800-2022-094248 **STIPULATED SURRENDER OF LICENSE AND 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. Reji Varghese (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 Giovanni F. Mejia, Deputy Attorney General.

2. Louis Robert Mandris, M.D. (Respondent) is represented in this proceeding by attorney Mark Gutterman, Esq., whose address is: LaFollette, Johnson, DeHaas, Fesler & Ames, 701 N. Brand Blvd., Suite 600, Glendale, CA 91203.

3. On or about September 21, 2007, the Board issued Physician's and Surgeon's Certificate No. G 55865 to Respondent. That license was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2022-094248 and will expire on January 31, 2025, unless renewed.

JURISDICTION

4. Accusation No. 800-2022-094248 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 March 1, 2024. Respondent filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2022-094248 is attached as exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2022-094248. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and 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 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.

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 contained in Accusation No. 800-2022-094248, a copy of which is attached hereto as exhibit A, and that he

has thereby subjected his Physician's and Surgeon's Certificate No. G 55865 to disciplinary action.

10. Respondent understands that by signing this stipulation he enables the Board, or its Executive Director on the Board's behalf, to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

11. Respondent agrees and understands that if he ever petitions for reinstatement of his Physician's and Surgeon's Certificate No. G 51708, or if an accusation or petition to revoke probation is ever filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2022-094248 shall be deemed true, correct, and admitted by Respondent for the purposes of any such proceeding or any licensing proceeding involving Respondent in the State of California.

CONTINGENCY

12. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board "shall delegate to its executive director the authority to adopt a ... stipulation for surrender of a license."

13. Respondent understands that, by signing this stipulation, he enables the Executive Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his Physician's and Surgeon's Certificate No. G 55865 without further notice to, or opportunity to be heard by, Respondent.

14. This Stipulated Surrender of License and Disciplinary Order shall be subject to the approval of the Executive Director on behalf of the Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for his consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

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15. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving respondent. In the event that the Executive Director on behalf of the Board does not, in his discretion, approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason by the Executive Director on behalf of the Board, Respondent will assert no claim that the Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

16. This Stipulated Surrender of License and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

17. The parties agree that copies of this Stipulated Surrender of License and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

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

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 55865, issued to Respondent Louis Robert Mandris, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time any such petition is filed, and all of the charges and allegations contained in Accusation No. 800-2022-094248 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny any such petition.

5. Respondent shall pay the Board its costs of investigation and enforcement in the amount of $15,576.75 prior to issuance of a new or reinstated license.

6. 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 agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2022-094248 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 licensure.

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ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney Mark Gutterman, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 5-6-2024

LOUIS ROBERT MANDRIS, M.D.
Respondent

I have read and fully discussed with Respondent Louis Robert Mandris, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 5/6/24

MARK GUTTERMAN, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: May 9, 2024

Respectfully submitted,

ROB BONTA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

GIOVANNI F. MEJIA
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2022-094248

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Attorneys for Complainant

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

In the Matter of the Accusation Against: **Louis Robert Mandris, M.D.** **2212 Danube Way** **Upland, CA 91784** **Physician's and Surgeon's Certificate No. G 55865,** Respondent.	Case No. 800-2022-094248 **ACCUSATION**

PARTIES

1. Reji Varghese (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about September 21, 2007, the Medical Board issued Physician's and Surgeon's Certificate No. G 55865 to Louis Robert Mandris, 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 January 31, 2025, unless renewed.

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JURISDICTION

3. This 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, subdivision (a) of the Code states:

> A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

5. Section 2234 of the Code states, in pertinent part:

> 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.

....

6. As in effect at all times relevant to the acts or omissions herein alleged to have occurred on or before December 31, 2023, section 2266 of the Code stated:[1]

> 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.

COST RECOVERY

7. Section 125.3 of the Code states:

> (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 licensee 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.

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[1] Effective January 1, 2024, section 2266 of the Code was amended to state:

> The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients for at least seven years after the last date of service to a patient constitutes unprofessional conduct.

(Stats. 2023, ch. 294, § 18.)

(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

8. On or about August 5, 2017, Patient A,[2] at the time an approximately 44-year-old patient, presented to Respondent for consultation. Patient A was interested in procedures including, but not limited to, a tummy tuck, liposuction, or fat transfer to the buttocks, or any combination thereof.

9. In the consultation note for the encounter with Patient A on or about August 5, 2017, Respondent failed to adequately document a physical examination, or discussion of the potential risks and benefits of the procedures in which Patient A expressed interest.

10. On or about September 26, 2017, Patient A returned to Respondent for consultation regarding breast augmentation.

11. In the consultation note for the encounter with Patient A on or about September 26, 2017, Respondent failed to adequately document whether Patient A had an up-to-date mammogram, or discussion of the potential risks and benefits of breast augmentation.

[2] A pseudonym is used for any patient referenced in the instant Accusation in order to preserve the confidentiality of medical information. The true name and identity of any patient referenced herein is known to Respondent or will be disclosed to him upon Complainant's receipt of a duly-issued request for discovery.

12. On or about September 27, 2017, Respondent received laboratory testing results for Patient A revealing a hemoglobin value of 14.5 g/dL and a hematocrit value (i.e., the percentage of red blood cells in the patient's blood) of 42.1%.

13. On or about October 4, 2017, Respondent performed a torso liposuction, buttocks fat transfer and breast augmentation on Patient A (the Procedure).

14. In a "PHYSICIAN'S PRE-OP HISTORY & PHYSICAL EXAMINATION" form completed by Respondent at or prior to the commencement of the Procedure, Respondent documented that physical examination of Patient A, including of her heart and lungs, yielded acceptable results for the Procedure.

15. In fact, pre-Procedure examination of Patient A's heart and lungs was performed not by Respondent, but rather by a certified registered nurse anesthetist (CRNA). The "PHYSICIAN'S PRE-OP HISTORY & PHYSICAL EXAMINATION" form completed and signed by Respondent included no notation indicating that a CRNA, as opposed to Respondent himself, had performed the pre-Procedure examination of Patient A's heart and lungs.

16. On or about October 4, 2017, at approximately 12:45 p.m., Patient A was transferred from the operating room to the post-anesthesia care unit (PACU).

17. In the PACU, Patient A was hypotensive (i.e., had a low blood pressure) with tachycardia (i.e., an elevated heart rate).

18. In the PACU, at approximately 5:25 p.m., Patient A was noted to complain of dizziness and be orthostatic[3] when standing to get out of bed. Patient A's documented blood pressure and heart rate at or around this time were approximately 85/60 mm Hg and 105 beats per minute.

19. On or about October 4, 2017, Respondent ordered Patient A's discharge even though she was exhibiting tachycardia and orthostatic hypotension.

20. On or about October 5, 2017, at approximately 12:30 p.m., Patient A presented to Respondent's office. During this visit, Patient A was examined by Respondent and a CRNA. In the progress notes for Patient A's visit to Respondent's office on October 5, 2017, Respondent or

[3] I.e., she suffered from hypotension upon standing.

the CRNA, or both, documented or caused to be documented, that Patient A was much weaker and orthostatic, and complaining of nausea, dizziness, vomiting and pain. At or around the outset of the visit, Patient A had a blood pressure and heart rate of approximately 127/81 mm Hg and 115 beats per minute (bpm). Patient A commenced receiving intravenous (IV) fluid resuscitation at approximately 12:40 p.m. At or about 12:45 p.m., Patient A's blood pressure and heart rate were approximately 117/78 mm Hg and 112 bpm. Patient A continued to complain of pain all over. At or about 1:15 p.m., Patient A's blood pressure and heart rate were approximately 111/80 mm Hg and 103 bpm. Patient A continued to receive IV fluid resuscitation, and documented blood pressures at or about 1:45 p.m. were 110/78 and 108/75 mm Hg; documented heart rates at or about this time were 99 and 112 bpm. Documented hematocrit values obtained during the course of this visit were approximately 27% and 30%. IV fluid resuscitation was discontinued at approximately 2:00 p.m. and Respondent discharged Patient A home.

21. On or about October 5, 2017, Respondent ordered a blood draw from Patient A for laboratory testing.

22. On or about October 6, 2017, Respondent's office received the laboratory report for the blood specimen drawn from Patient A on or about October 5, 2017. The report documented a hemoglobin level of 6.2 g/dL and a hematocrit value of 18%.

23. On or about October 7, 2017, Patient A presented to Respondent's office. Patient A reported to Respondent that she was not nearly as dizzy, but she was dizzy when she stood up quickly. Respondent explained to Patient A that she may need a blood transfusion, and that if she got any worse she should head to her local emergency room, have them draw blood and that they would provide her a blood transfusion, if necessary.

24. During the encounter with Patient A on or about October 7, 2017, Respondent failed to recommend another blood draw and laboratory test to further evaluate Patient A's hematocrit.

25. In the progress note for the encounter with Patient A on or about October 7, 2017, Respondent documented or caused to be documented that Patient A was "much improved" and had a hematocrit value of "~19[%]?"

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26. In the progress note for the encounter with Patient A on or about October 7, 2017, Respondent failed to adequately document Patient A's vital signs.

27. In the progress note for the encounter with Patient A on or about October 7, 2017, Respondent failed to adequately document discussion with Patient A regarding the possible need to seek emergency care or blood transfusion.

28. On or about October 10, 2017, Patient A presented to Respondent's office. In his progress note for this encounter, Respondent documented or caused to be documented that Patient A complained of not having any bowel movement since the procedure Respondent performed, and that Respondent recommended Patient A cease taking narcotic pain medication.

29. In the progress note for the encounter with Patient A on or about October 10, 2017, Respondent failed to adequately document Patient A's vital signs.

30. On or about October 10, 2017, after her visit to Respondent's office, Patient A presented to the emergency room at St. Bernardine Medical Center in San Bernardino, California (St. Bernardine), reporting that she was weak and might need a blood transfusion.

31. During the course of her subsequent hospitalization at St. Bernardine, hospital records document, among other things, that Patient A reported decreased vision in her left eye, exhibited a hematocrit value as low as 18.3%, and received transfusion of two units of packed red blood cells.

32. On or about October 11, 2017, a neurologist at St. Bernardine diagnosed Patient A with "an ischemic left optic neuritis, most likely related to her anemia."

33. On or about October 16, 2017, St. Bernardine discharged Patient A.

34. On or about October 17, 2017, Patient A presented to an ophthalmologist who diagnosed Patient A with ischemic optic neuropathy of the left eye. Patient A would subsequently continue to report vision loss in her left eye.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

35. Respondent Louis Robert Mandris, M.D. has subjected his Physician's and Surgeon's Certificate No. G 55865 to disciplinary action under sections 2227 and 2234, as defined by

section 2234, subdivision (b), of the Code, in that Respondent committed gross negligence. The circumstances are as follows:

36. Respondent committed gross negligence in the course of his care and treatment of Patient A in that he discharged Patient A following the Procedure even though Patient A was exhibiting tachycardia and orthostatic hypotension as more particularly alleged in paragraphs 13 and 16 through 19, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

37. Respondent Louis Robert Mandris, M.D. has further subjected his Physician's and Surgeon's Certificate No. G 55865 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts. The circumstances are as follows:

38. Paragraphs 35 and 36, above, are hereby incorporated by reference and realleged as if fully set forth herein.

39. Respondent committed negligence in the course of his care and treatment of Patient A in that he failed to adequately document one or more informed consent discussions with Patient A as more particularly alleged in paragraphs 8 through 11, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

40. Respondent committed negligence in the course of his care and treatment of Patient A in that he failed to adequately document the mammography status of Patient A as more particularly alleged in paragraphs 10 and 11, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

41. Respondent committed negligence in the course of his care and treatment of Patient A by documenting satisfactory pre-Procedure examination of Patient A's heart and lungs when he had failed to perform any such pre-Procedure examination, as more particularly alleged in paragraphs 13 through 15, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

42. Respondent committed negligence in the course of his care and treatment of Patient A in that he failed to adequately document patient vital signs for one or more post-Procedure encounters with Patient A as more particularly alleged in paragraphs 23, 26, 28 and 29, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

43. Respondent committed negligence in the course of his care and treatment of Patient A in that he failed to adequately document discussion with Patient A, during their encounter on or about October 7, 2017, regarding the possible need to seek emergency care or blood transfusion, as more particularly alleged in paragraphs 23 and 27, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

44. Respondent committed negligence in the course of his care and treatment of Patient A in that he failed to request repeat blood analysis following receipt of Patient A's hematocrit value of 18% as more particularly alleged in paragraphs 20 through 24, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

45. Respondent Louis Robert Mandris, M.D. has further subjected his Physician's and Surgeon's Certificate No. G 55865 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records relating to the provision of services to Patient A as more particularly alleged in paragraphs 8 through 11, 13 through 15, 23, 26 through 29, and 39 through 43, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Violation of the Medical Practice Act)

46. Respondent Louis Robert Mandris, M.D. has further subjected his Physician's and Surgeon's Certificate No. G 55865 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (a), of the Code, in that Respondent violated or attempted to violate, directly or indirectly, assisted in or abetted the violation of, or conspired to violate any

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provision of the Medical Practice Act as more particularly alleged in paragraphs 8 through 45, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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 No. G 55865, issued to Respondent Louis Robert Mandris, M.D.;

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

3. Ordering Respondent Louis Robert Mandris, 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: MAR 0 1 2024

REJI VARGHESE
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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