

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

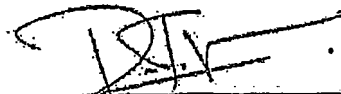
DECISION

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

1 ROB BONTA
Attorney General of California
2 MATTHEW M. DAVIS
Supervising Deputy Attorney General
3 GIOVANNI F. MEJIA
Deputy Attorney General
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8 *Attorneys for Complainant*

9
10 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
11 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA
12

13 In the Matter of the Accusation Against:

Case No. 800-2022-094248

14 **LOUIS ROBERT MANDRIS, M.D.**
2212 Danube Way
15 Upland, CA 91784

**STIPULATED SURRENDER OF
LICENSE AND ORDER**

16 **Physician's and Surgeon's Certificate**
No. G 55865,

17 Respondent.
18

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

21 **PARTIES**

22 1. Reji Varghese (Complainant) is the Executive Director of the Medical Board of
23 California (Board). He brought this action solely in his official capacity and is represented in this
24 matter by Rob Bonta, Attorney General of the State of California, by Giovanni F. Mejia, Deputy
25 Attorney General.

26 2. Louis Robert Mandris, M.D. (Respondent) is represented in this proceeding by
27 attorney Mark Gutterman, Esq., whose address is: LaFollette, Johnson, DeHaas, Fesler & Ames,
28 701 N. Brand Blvd., Suite 600, Glendale, CA 91203.

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

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

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

12 CONTINGENCY

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

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

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

28 ///

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.

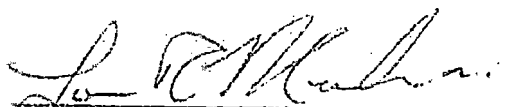
6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2022-094248 shall be deemed to be true, 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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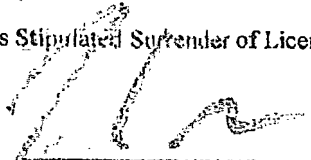
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ACCEPTANCE

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.

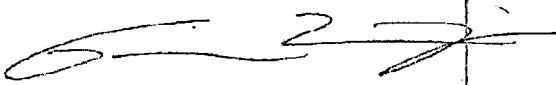
DATED: 5/6/24 
MARK GUTTERMAN, ESQ.
Attorney for Respondent

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

1 ROB BONTA
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2 MATTHEW M. DAVIS
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MEDICAL BOARD OF CALIFORNIA
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11 **STATE OF CALIFORNIA**

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13 In the Matter of the Accusation Against:

Case No. 800-2022-094248

14 **Louis Robert Mandris, M.D.**
2212 Danube Way
15 Upland, CA 91784

A C C U S A T I O N

16 **Physician's and Surgeon's Certificate**
17 **No. G 55865,**

Respondent.

18
19 **PARTIES**

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

23 2. On or about September 21, 2007, the Medical Board issued Physician's and
24 Surgeon's Certificate No. G 55865 to Louis Robert Mandris, M.D. (Respondent). The Physician's
25 and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought
26 herein and will expire on January 31, 2025, unless renewed.

27 *////*

28 *////*

1 JURISDICTION

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, subdivision (a) of the Code states:

6 A licensee whose matter has been heard by an administrative law judge of the
7 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 5. Section 2234 of the Code states, in pertinent part:

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

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

27 (b) Gross negligence.

28 (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

1 licensee's conduct departs from the applicable standard of care, each departure
2 constitutes a separate and distinct breach of the standard of care.

3

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

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

9 COST RECOVERY

10 7. Section 125.3 of the Code states:

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

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

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

25 (d) The administrative law judge shall make a proposed finding of the amount
26 of reasonable costs of investigation and prosecution of the case when requested
27 pursuant to subdivision (a). The finding of the administrative law judge with regard to
28 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.)

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

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

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

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

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

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

19 FACTUAL ALLEGATIONS

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

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

27 10. On or about September 26, 2017, Patient A returned to Respondent for consultation
28 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.

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

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

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

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

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

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

19 18. In the PACU, at approximately 5:25 p.m., Patient A was noted to complain of
20 dizziness and be orthostatic³ when standing to get out of bed. Patient A's documented blood
21 pressure and heart rate at or around this time were approximately 85/60 mm Hg and 105 beats per
22 minute.

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

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

28 ³ I.e., she suffered from hypotension upon standing.

1 the CRNA, or both, documented or caused to be documented, that Patient A was much weaker
2 and orthostatic, and complaining of nausea, dizziness, vomiting and pain. At or around the outset
3 of the visit, Patient A had a blood pressure and heart rate of approximately 127/81 mm Hg and
4 115 beats per minute (bpm). Patient A commenced receiving intravenous (IV) fluid resuscitation
5 at approximately 12:40 p.m. At or about 12:45 p.m., Patient A's blood pressure and heart rate
6 were approximately 117/78 mm Hg and 112 bpm. Patient A continued to complain of pain all
7 over. At or about 1:15 p.m., Patient A's blood pressure and heart rate were approximately
8 111/80 mm Hg and 103 bpm. Patient A continued to receive IV fluid resuscitation, and
9 documented blood pressures at or about 1:45 p.m. were 110/78 and 108/75 mm Hg; documented
10 heart rates at or about this time were 99 and 112 bpm. Documented hematocrit values obtained
11 during the course of this visit were approximately 27% and 30%. IV fluid resuscitation was
12 discontinued at approximately 2:00 p.m. and Respondent discharged Patient A home.

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

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

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

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

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

28 ////

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

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

8 **SECOND CAUSE FOR DISCIPLINE**

9 **(Repeated Negligent Acts)**

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

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

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

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

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

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

3
4 PRAYER

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

- 7 1. Revoking or suspending Physician's and Surgeon's Certificate No. G 55865, issued
8 to Respondent Louis Robert Mandris, M.D.;
- 9 2. Revoking, suspending or denying approval of Respondent Louis Robert Mandris,
10 M.D.'s authority to supervise physician assistants and advanced practice nurses;
- 11 3. Ordering Respondent Louis Robert Mandris, M.D., to pay the Board the costs of the
12 investigation and enforcement of this case, and if placed on probation, the costs of probation
13 monitoring; and
- 14 4. Taking such other and further action as deemed necessary and proper.

15
16 DATED: MAR 01 2024



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

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