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

In the Matter of the Accusation Against:	Case No. 800-2018-044728
MAHER M. ANOUS, M.D. **435 North Bedford Drive, Suite 206** **Beverly Hills, CA 90210** **Physician's and Surgeon's Certificate No. C 55037,** Respondent.	**A C C U S A T I O N**

PARTIES

1. William Prasifka (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 January 6, 2012, the Medical Board issued Physician's and Surgeon's Certificate Number C 55037 to Maher M. Anous, 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 September 30, 2021, 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 of the Code states:

(a) 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.

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

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 2240 of the Code provides:

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

...

(f) The failure to comply with this section 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.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent, Maher M. Anous, M.D., is subject to disciplinary action under section 2234, subdivision (b) of the Code in that he was grossly negligent in the care and treatment of Patient 1.[1] The circumstances are as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

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

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

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

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

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

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

THIRD CAUSE FOR DISCIPLINE

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

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

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

FOURTH CAUSE FOR DISCIPLINE

(Inaccurate and Inadequate Record Keeping)

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

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

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 C 55037, issued to Maher M. Anous, M.D.;

2. Revoking, suspending or denying approval of Maher M. Anous, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Maher M. Anous, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: APR 30 2021

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

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