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

In the Matter of the Second Amended Accusation Against: Barry Martin Rose, M.D. Physician's & Surgeon's Certificate No. A 38658 Respondent.	Case No. 800-2019-060322

DECISION

The attached Proposed Decision 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 March 2, 2023.

IT IS SO ORDERED: January 31, 2023.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, Chair
Panel B

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

In the Matter of the Second Amended Accusation Against:

BARRY MARTIN ROSE, M.D.,

Physician's and Surgeon's Certificate No. A 38658

Respondent.

Agency Case No. 800-2019-060322

OAH No. 2022050094

PROPOSED DECISION

Administrative Law Judge Holly M. Baldwin, State of California, Office of Administrative Hearings, heard this matter on September 26 through 28, 2022, by videoconference.

Deputy Attorney General Caitlin Ross represented complainant William Prasifka, Executive Director of the Medical Board of California.

Attorney Ivan Weinberg represented respondent Barry Martin Rose, M.D., who was present.

The record was held open for the submission of closing briefs. Complainant's closing brief was marked for identification as Exhibit 28. Respondent's closing brief

was marked for identification as Exhibit AF. Complainant also submitted copies of previously admitted Exhibits 21 and 25 (cost declarations) with the PDF formatting corrected, which were admitted into evidence as Exhibits 26 and 27.

The record closed and the matter was submitted for decision on October 21, 2022.

FACTUAL FINDINGS

1. The Medical Board of California (Board) issued Physician's and Surgeon's Certificate Number A 38658 to respondent Barry Martin Rose, M.D., on July 1, 1982. The certificate is renewed and current with an expiration date of October 31, 2023. There is no prior discipline against respondent's certificate.

2. Acting in his official capacity as Executive Director of the Board, complainant William Prasifka filed an accusation against respondent on November 30, 2020. A first amended accusation was filed on December 29, 2021. A second amended accusation was filed on January 25, 2022, alleging that respondent committed unprofessional conduct by taking medical supplies from a hospital with the intent to use them to care for a patient at an unaffiliated private outpatient location; and that respondent committed unprofessional conduct and violated professional confidence by accessing a patient's medical record without authorization. Complainant seeks an order disciplining respondent's certificate, and recovery of investigation and enforcement costs. Respondent filed a notice of defense and this hearing followed.

3. Voluminous evidence was presented at hearing. Only the most pertinent items are discussed in this decision. All contentions raised by the parties were

considered, and to the extent those contentions are not expressly addressed in this decision, they were found to be without merit.

Respondent's Background

4. Respondent received his medical degree in 1981. He then completed an internship and a residency in internal medicine, ending in 1984, followed by a residency in anesthesia, which he completed in 1986.

5. Respondent is board-certified in anesthesiology and internal medicine.

6. Since 1989, respondent has worked as a staff anesthesiologist at California Pacific Medical Center (CPMC) in San Francisco. He provides anesthesia services at CPMC hospital campuses, ambulatory surgery centers, and private medical offices. Respondent has also organized and participated in many medical missions in other countries, providing anesthesia for reconstructive and transplant surgeries.

Access of J.D.'s Electronic Medical Record

7. J.D. (referred to as "Individual 1" in the second amended accusation) is a nurse who works at CPMC, and who has an electronic medical record contained in the Epic system. Respondent and J.D. have never had a physician-patient relationship. Respondent and J.D. had a romantic relationship for a few months in 2003 and 2004.

8. On June 4, 2019, between 9:06 and 9:07 p.m., while at CPMC, respondent accessed J.D.'s electronic medical record using Epic. The portions of J.D.'s medical record accessed by respondent were the main page screen (containing personal identifying information such as name, contact information, date of birth, medical record number, and social security number) and a "patient station" screen containing

past visit history and a "problem list." Respondent did not have authorization or a medical reason for accessing J.D.'s record.

9. Nicholas So, the Privacy Officer for CPMC, received an alert that an employee's medical record had been accessed and that the employee had not recently received any medical services at CPMC. Such an access is automatically flagged for review. So sent an email message to Jeffrey Swisher, M.D., the Chair of Anesthesiology at CPMC, stating that respondent had accessed J.D.'s medical record and asking whether respondent would have any legitimate reason to do so. Dr. Swisher is responsible for ensuring compliance by CPMC anesthesiologists with hospital policies and procedures.

10. Dr. Swisher contacted respondent and J.D. to ask about the access. J.D. told Dr. Swisher that respondent had not provided medical care to her, and she was upset that respondent had accessed her medical record and felt that her privacy had been violated. Respondent told Dr. Swisher that his access of J.D.'s medical record was accidental. Respondent said that he was tired at the end of a long day, was returning calls about patients, accidentally entered J.D.'s name while trying to look up another patient, and closed J.D.'s record quickly after he realized the error.

11. As part of his investigation, So reviewed the Epic access audit log, confirming the location of the computer used by respondent to access J.D.'s record, the time of the access, that respondent accessed the record by looking up the patient's first and last name, and that the demographic screen and the patient station screens were accessed. So also found that respondent accessed another patient's record before accessing J.D.'s record, and returned to that other patient's record afterward. So did not find that respondent accessed any patient record with a name similar to J.D. around that time.

12. Documents reflecting various investigative interviews stated that respondent's access of J.D.'s medical record lasted for 46 seconds. At hearing, So testified that his review of the audit log showed respondent's access of the record lasted for 76 seconds—he did not know where the 46-second information came from. The difference between 46 seconds and 76 seconds is not material to the factual findings reached in this decision.

13. Both Dr. Swisher and So explained in their testimony that information in a patient's electronic medical record is private and confidential, and that CPMC staff may not access it without a legitimate work-related reason. As Privacy Officer, So investigates instances of unauthorized access of patient medical records. Sometimes he finds the access was accidental. If respondent's access of J.D.'s medical record was unintentional, it would not be inappropriate. However, So thought respondent's access questionable because he did not access a patient record with a similar name.

14. On June 14, 2019, respondent wrote a statement, which he subsequently forwarded to Robert Margolin, M.D., the Chief of Staff at CPMC. Respondent stated that on June 4, 2019, he was serving as "first call" anesthesiologist for the CPMC Van Ness campus, and in that role he would receive calls from providers asking various types of questions about patients. Respondent stated he was handling such a question and "somehow—perhaps absentmindedly or distractedly or in a moment of free association—typed in [J.D.'s] name ([J.D.] is a nurse I have known and worked with for many years) and clicked on that chart." Respondent stated he did not realize it was J.D.'s chart until he clicked through to the "summary window" and that he was shocked when he realized it was J.D.'s chart and immediately closed her record. Respondent apologized for his error and acknowledged J.D.'s distress and sense of violation.

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15. After investigation and review by CPMC's Medical Executive Committee, respondent's clinical privileges were suspended for 30 days, and he was required to attend a HIPAA training. Dr. Margolin submitted a report to the Board on October 2, 2019, regarding the suspension of respondent's privileges.

16. This matter was investigated by Board investigator Jillian Medeiros. Respondent told Medeiros that his access of J.D.'s medical record was accidental, and that he had been trying to access the record of a patient with a similar name. He did not provide the other patient's name.

17. At hearing, respondent explained further the circumstances of accessing J.D.'s medical record, which he said was unintentional. Respondent was serving as "first call" anesthesiologist. As was his habit, when he received calls asking questions about patients, if the issue was not emergent or urgent, he would write down a note on a piece of paper and return the call at the end of the day, discarding the paper note afterwards. On June 4, 2019, respondent had been working since about 7:00 a.m., and it had been a busy day including multiple surgeries. He had also been fielding calls that day from care providers for his elderly mother who was in hospice care in another state, and he had not been sleeping well due to worry. Respondent was exhausted and distracted when he was completing his first call responses at about 9:00 p.m.

Respondent, Dr. Swisher, and So each provided testimony about the ways in which a provider can access a patient's medical record in Epic. The provider can select a patient name from the daily operating room schedule for a particular campus. Or the provider can search for a patient by name or medical record number. Searching by the patient name may yield a list of results from which the provider must choose and click on the intended name. Respondent is not sure exactly how he got into J.D.'s medical

record. He was trying to reconstruct what happened, and thought he must have been trying to search for a patient with a similar name, but he does not recall for certain.

Respondent's usual practice when opening a medical record is to click through to the screen showing a problem list. When he got to that screen, he saw that the problem list seemed unusually short for a patient that someone would be asking him anesthesia-related questions about. He looked at the name, realized he was viewing J.D.'s record, and was shocked and dismayed. He then closed J.D.'s record.

Respondent stated that he realized he was in no shape to complete his patient call returns and stopped working for the night. Respondent reports that he threw away the pieces of paper upon which he had written patient names for these return calls. He noted he was still on call until 7:00 the next morning, so if there was a remaining issue that became urgent, a provider could call him again.

Respondent did not report his accidental access of J.D.'s medical record, because he did not think there was a need to do so. Respondent is remorseful for having accessed J.D.'s record and for the distress caused to J.D.

EXPERT OPINION

18. Complainant did not offer expert opinion testimony on the issue of respondent accessing J.D.'s medical record.

19. Thomas C. Neylan, M.D., testified as an expert witness for respondent. Dr. Neylan is board-certified in psychiatry and neurology, and in sleep disorder medicine. He is a professor and researcher at the University of California, San Francisco and the VA Medical Center in San Francisco. His research includes a focus on how fatigue and disturbed sleep affect performance and cognition. In Dr. Neylan's opinion, given

respondent's reported state of fatigue on the evening of June 4, 2019, he finds it credible that respondent could have made an error such as mistakenly typing in the wrong name or clicking on the wrong name in a list.

Taking Supplies From Hospital to Unaffiliated Outpatient Locations

20. On January 6, 2020, respondent was scheduled to provide anesthesia for a surgery on an 88-year-old woman at a private medical office that was unaffiliated with CPMC. That morning, respondent went to the CPMC hospital and began collecting medications and supplies from an anesthesia cart, intending to bring them to the private medical office for use in the surgery if needed. A nurse observed respondent gathering these supplies and asked what he was doing; he explained. The nurse told respondent he could not take the supplies, and he left them at the hospital.

21. CPMC investigated this incident after it was reported by the nurse. Respondent stated that he had taken medications and supplies from CPMC on multiple occasions in the past, for use at non-affiliated private facilities. Respondent also stated other anesthesiologists had done the same thing.

22. On January 27, 2020, Dr. Swisher sent an email to the entire anesthesiology group with reminders about several compliance and quality assurance issues. He reminded the group that they were required to follow CPMC policies and procedures. Dr. Swisher wrote: "The hospital's equipment/supplies/services must be used for patient care provided within the hospital and not be given or taken by physicians for their private use—even for charity endeavors, such as medical missions. There are avenues for donation of expired and surplus equipment for such purposes."

23. At hearing, Dr. Swisher confirmed that it is not permissible for an anesthesiologist to take medications or supplies from the hospital for use at a private

medical office, even if done for the purpose of patient safety. He does not believe that anesthesiologists regularly engage in such a practice. Dr. Swisher also noted that if medications or supplies are taken off-campus, then they will not be billed to the patient they are used for.

24. After investigation and review by the Medical Executive Committee, respondent's clinical privileges at CPMC were suspended for 60 days. Dr. Margolin submitted a report to the Board on July 21, 2020.

25. This matter was investigated by Daniel Schuman, an investigator for the Department of Consumer Affairs Division of Investigation Health Quality Investigation Unit. Respondent told Schuman that in the past six years he had taken supplies from the hospital for use at private offices perhaps two to four times.

26. At hearing, respondent estimated that he had taken supplies from the hospital for use at that private office on one to three occasions in the past six years, and on one to two occasions for use at a different private medical office. He never took controlled substances to a private medical office. If respondent did not use the medications or supplies, he returned them to the hospital.

27. Respondent described the differences between providing anesthesia at a private medical office and at the hospital. Private offices are not as well-equipped as the hospital, and their medications and supplies may not be well-organized. They also do not have on-site anesthesia technicians during surgery. For certain surgeries scheduled at private offices, respondent was concerned that the office would not have all the items he might need. On such occasions, he would take items that he thought he might need from the hospital and bring them to the private office, for the purpose of ensuring patient safety during the surgery. Respondent did not make any

accounting or track these items for billing purposes. Respondent stated that it is an unspoken practice or unspoken agreement for anesthesiologists to take such items if needed for patient safety. He stated he did not know it was against hospital policy; that belief, even if sincerely held, is not reasonable.

28. For the surgery scheduled on January 6, 2020, respondent was concerned because he had never provided anesthesia for such an elderly patient in an office setting, and did not know if the office would have everything he might need, such as particular medications or a small-size endotracheal tube. After the nurse stopped respondent from gathering medications and supplies at CPMC, he went to the private office for the scheduled surgery. Respondent found that the office did indeed lack some of the necessary items. He delayed the surgery until later that day, so that the office staff could arrange to obtain the needed materials.

29. Respondent has not taken medications or supplies from CPMC for use at private offices since this incident. He now understands this practice is not allowed. Respondent no longer provides anesthesia services at that particular office location. Since January 2020, the private medical offices at which respondent does provide anesthesia have begun hiring anesthesia technicians to order anesthesia supplies for the offices, and to organize those supplies in a manner similar to the hospital anesthesia carts.

EXPERT OPINION

30. Complainant retained anesthesiologist Richard John Novak, M.D., as an expert to opine on whether respondent departed from the standard of care. Dr. Novak wrote a report and testified at hearing. Dr. Novak is board-certified in anesthesiology

and internal medicine. He practices at Stanford Hospital and at surgery centers and offices. Dr. Novak is also the medical director of an outpatient surgery center.

31. Respondent retained anesthesiologist Jeffrey Levy, M.D., as an expert. Dr. Levy wrote a report, but he did not testify at hearing.

32. Dr. Novak provided the following opinions. It is the standard of care for anesthesiologists to use supplies from the facility where they are working. It was a simple departure from the standard of care for respondent to take supplies from CPMC for use at an unaffiliated outpatient location, even if he did so for the purpose of patient safety, and it was unprofessional conduct. Even if respondent returned any unused supplies to the hospital, it is still a departure from the standard of care. If a facility lacks the necessary medications or supplies for a surgery, the standard of care is to postpone or cancel the surgery until the necessary items are obtained. If the anesthesiologist finds the facility lacks necessary supplies, the anesthesiologist should discuss it with the facility's medical director.

Dr. Novak opined that it is not a common practice for anesthesiologists to take supplies from a hospital for use at an unaffiliated location, and that it is not acceptable unless approval has been obtained to do so.

Dr. Novak reviewed the report of Dr. Levy, in which Dr. Levy opined that there was no departure from the standard of care because this is an administrative issue, not a patient-care issue. Dr. Novak disagreed, explaining persuasively that respondent's taking of supplies is patient-related, because he intended to use those supplies to treat a patient. He described it as an example of pre-operative care.

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Respondent's Additional Evidence

33. Respondent offered the testimony of six physicians and a nurse, as well as letters and declarations from several others. Respondent's witnesses uniformly described him as a highly skilled and compassionate anesthesiologist who provides excellent patient care. The witnesses also described respondent as a person of good character.

34. Several witnesses stated that occasionally an anesthesiologist will bring supplies to a private office location for a surgery, or request that supplies be brought from a hospital by an anesthesia technician. However, the witnesses did not know whether such supplies had been pre-approved, tracked, or billed for.

Ultimate Factual Findings

35. It was not established by clear and convincing evidence that respondent intentionally accessed J.D.'s electronic medical record. Respondent's testimony on this topic was generally credible, despite his lack of recollection as to the specific details of how he accidentally accessed the medical record.

36. It was established by clear and convincing evidence that respondent engaged in unprofessional conduct by taking medical supplies from CPMC intending to use them at unaffiliated private office locations. Dr. Novak's opinions on this point were persuasive and unrebutted by non-hearsay evidence. Respondent's conduct was done with good intentions, but it was still a violation.

Costs

37. The Board seeks to recover $21,435 in costs for investigation and enforcement in this case for expenses incurred after January 1, 2022. These costs

include $21,210 for attorney and paralegal time billed by the Department of Justice, and $225 in estimated costs for hearing preparation by an expert witness. As to the $21,210 in costs billed by the Department of Justice, the claim is supported by a declaration that complies with California Code of Regulations, title 1, section 1042, and is found to be reasonable. The $225 in estimated costs for the expert witness is not found to be reasonable, as California Code of Regulations, title 1, section 1042 only provides for estimates in the case of services provided by agency employees.

LEGAL CONCLUSIONS

1. It is complainant's burden to establish the truth of the allegations by "clear and convincing evidence to a reasonable certainty," and that the allegations constitute cause for discipline of respondent's physician's and surgeon's certificate. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence "requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind." (*Copp v. Paxton* (1996) 45 Cal.App.4th 829, 846, citations omitted.)

2. The burden of establishing mitigation or rehabilitation is on respondent and the standard of proof is a preponderance of the evidence. (*Whetstone v. Board of Dental Examiners* (1927) 87 Cal.App. 156, 164; Evid. Code, §§ 115, 500.)

3. The Board may discipline respondent's physician's and surgeon's certificate if he has engaged in unprofessional conduct, including violations of the Medical Practice Act. (Bus. & Prof. Code, §§ 2227, 2234, subd. (a).) The willful,

unauthorized violation of professional confidence constitutes unprofessional conduct. (Bus. & Prof. Code, § 2263.)

First Cause for Discipline (Hospital Supplies: General Unprofessional Conduct)

4. Respondent engaged in unprofessional conduct by taking medical supplies from CPMC intending to use them at unaffiliated private office locations. (Factual Finding 36.) Cause for discipline exists under Business and Professions Code section 2234 for general unprofessional conduct.

Second Cause for Discipline (Medical Record Access: Violation of Professional Confidence; General Unprofessional Conduct)

5. The evidence did not establish that respondent intentionally accessed J.D.'s medical record. (Factual Finding 35.) Cause for discipline was not established under Business and Professions Code sections 2234 and 2263 for this access.

Determination of Discipline

6. In exercising its disciplinary functions, protection of the public is the Board's paramount concern. (Bus. & Prof. Code, § 2229, subd. (a).) At the same time, the Board is charged with taking disciplinary action that is calculated to aid the rehabilitation of the licensee whenever possible, as long as the Board's action is not inconsistent with public safety. (Bus. & Prof. Code, § 2229, subds. (b), (c).)

7. As cause for discipline has been established, the appropriate level of discipline must be determined. The Board's Manual of Disciplinary Orders and Disciplinary Guidelines (Disciplinary Guidelines) (12th ed., 2016), recommends a

minimum of stayed revocation and five years' probation, subject to appropriate terms and conditions, for general unprofessional conduct.

8. In this case, it is a matter of concern that respondent did not acknowledge that his taking of hospital supplies without permission was misconduct. His contentions that there was an unspoken practice endorsing such activity, and that this should excuse his behavior, were not persuasive. Remedial training regarding professionalism is appropriate to improve respondent's practice. However, respondent's actions were well-intentioned. Respondent by all accounts is a highly skilled anesthesiologist, and he has no record of prior discipline. He now understands that such taking of supplies is against hospital policy. Respondent no longer engages in this conduct, and practices have been changed at the offices where he provides anesthesia.

Upon consideration of the record as a whole, it is determined that a period of probation would not be likely to improve respondent's practice further, and is not necessary for public protection. A public reprimand, with an education requirement, is appropriate in this case.

Costs

9. A licensee found to have committed a violation of the licensing act may be required to pay the Board the reasonable costs of its investigation and prosecution of the case. (Bus. & Prof. Code, § 125.3.) Respondent has committed a violation of the licensing act. (Legal Conclusion 4.) As set forth in Factual Finding 37, the reasonable costs of prosecution in this matter are $21,210.

10. In *Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, 45, the California Supreme Court set forth standards for determining whether costs

should be assessed in the particular circumstances of each case, to ensure that licensees with potentially meritorious claims are not deterred from exercising their right to an administrative hearing. Those standards include whether the licensee has been successful at hearing in getting the charges dismissed or reduced, the licensee's good faith belief in the merits of his or her position, whether the licensee raised a colorable challenge to the proposed discipline, financial ability of the licensee to pay, and whether the scope of investigation was appropriate to the alleged misconduct.

In this matter, only one of two causes for discipline was proved at hearing, and respondent presented evidence sufficient to support a lesser degree of discipline. It is appropriate to reduce the Board's cost recovery to $10,000.

ORDER

1. Respondent Barry Martin Rose, M.D., Physician's and Surgeon's Certificate Number A 38658, is hereby reprimanded within the meaning of Business and Professions Code section 2227, subdivision (a)(4).

2. Respondent must also complete an educational course, and failure to do so in accordance with this order may be cause for further disciplinary action.

Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this decision, respondent shall enroll in a professionalism program that meets the requirements of California Code of Regulations, title 16, section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the

classroom component of the program not later than six months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

A professionalism program 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 program would have been approved by the Board or its designee had the program been taken after the effective date of this decision.

3. Respondent shall pay $10,000 to the Board as reimbursement for its costs of enforcement pursuant to Business and Professions Code section 125.3.

DATE: 11/17/2022

Holly M. Baldwin

HOLLY M. BALDWIN
Administrative Law Judge
Office of Administrative Hearings

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

In the Matter of the Second Amended Accusation Against: **BARRY MARTIN ROSE, M.D.** **75 George Lane** **Sausalito, CA 94965** **Physician's and Surgeon's Certificate No. A 38658,** Respondent.	Case No. 800-2019-060322 **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 or about July 1, 1982, the Board issued Physician's and Surgeon's Certificate Number A 38658 to Barry Martin Rose, 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 October 31, 2023, unless renewed.

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.

5. Sections 2234 and 2234 subdivision (a) state:

"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.

. . .

6. Section 2263 of the Code states: the willful, unauthorized violation of professional confidence constitutes unprofessional conduct.

COST RECOVERY

7. Effective January 1, 2022, Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to 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, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FIRST CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

8. Respondent Barry Martin Rose, M.D. is subject to disciplinary action under Code sections 2234 in that he took medical supplies from a hospital with the intent to use the supplies

to care for a patient at an unassociated freestanding private outpatient location. The circumstances are as follows:

9. Respondent is an anesthesiologist in a group practice. As part of his practice, Respondent provides anesthesiology at California Pacific Medical Center, San Francisco (CPMC).

10. In addition to providing anesthesia for patients at CPMC, Respondent also provided anesthesia at various private outpatient locations that were not CPMC facilities.

11. On January 6, 2020, Respondent was scheduled to provide anesthesia at a private physician's office. The private office was not a CPMC facility.

12. Before the planned anesthesia at the private physician's office, Respondent collected multiple medications from the CPMC hospital anesthesia cart, intending to take them for use during the anesthesia at the private physician's office. Respondent also collected various supplies, including tubing, IV catheter, gauze, and tourniquet, intending to take them for use during the anesthesia at the private physician's office. While collecting the items, a nurse saw Respondent and confronted him about taking the items. Respondent accordingly left the items there at CPMC. As a result of this incident, Respondent's CPMC privileges were temporarily suspended.

13. Within the past seven years, there have been multiple occasions, other than the January 6, 2020 occasion, when Respondent stopped at CPMC and picked up items to take with him for use during a procedure at a private non-CPMC facility.

14. Respondent's conduct in taking medical supplies from a hospital with the intent to use the supplies to care for a patient at an unassociated freestanding private outpatient location constitutes unprofessional conduct. Said conduct is cause for disciplinary action pursuant to Business and Professions Code sections 2234.

SECOND CAUSE FOR DISCIPLINE

(Violation of Professional Confidence; General Unprofessional Conduct)

15. Respondent Barry Martin Rose, M.D. is subject to disciplinary action under Code sections 2234; 2234 subdivision (a); and 2263 in that he accessed the confidential medical record of Individual 1[1] without authorization from Individual 1. The circumstances are as follows:

16. Paragraphs 8 through 15 above are incorporated here as set forth herein.

17. As part of his practice, Respondent provides anesthesiology at California Pacific Medical Center, San Francisco (CPMC). Individual 1 also works for CPMC. Respondent had no physician-patient relationship or treating responsibility for Individual 1. Individual 1 has never been a patient of Respondent's. Individual 1 did have a medical record with CPMC.

18. On June 4, 2019, Respondent typed Individual 1's name into the CPMC confidential electronic medical record system, clicked on the medical record for the name he had typed, and accessed Individual 1's confidential medical record. Respondent did not have any appropriate reason for accessing Individual 1's medical record. Respondent had a prior relationship with Individual 1 many years before the date he accessed Individual 1's medical record.

19. Respondent's conduct in accessing Individual 1's private and confidential patient information and medical records without authorization when he had no physician-patient relationship or treating responsibility constitutes unprofessional conduct and/or violation of professional confidence. Said conduct is cause for disciplinary action pursuant to Business and Professions Code sections 2234 and/or 2234(a) and/or 2263.

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 A 38658, issued to Respondent Barry Martin Rose, M.D.;

[1] For protection of privacy, the name of Individual 1 has been withheld. Respondent is aware of Individual 1's identity.

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

3. Ordering Respondent Barry Martin Rose, 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: JAN 25 2022

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

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