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

In the Matter of the Accusation Against: **BARRY JOEL BROCK, M.D.** **150 North Robertson Blvd., Suite 200** **Beverly Hills, CA 90211-2144** **Physician's and Surgeon's Certificate No. G 36218,** Respondent.	Case No. 800-2022-091409 **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 April 11, 1978, the Board issued Physician's and Surgeon's Certificate Number G 36218 to Barry Joel Brock, 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 May 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 2004 of the Code states:

The board shall have the responsibility for the following:

(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

(b) The administration and hearing of disciplinary actions.

(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions. . .

(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

(f) Approving undergraduate and graduate medical education programs.

(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

(h) Issuing licenses and certificates under the board's jurisdiction.

(i) Administering the board's continuing medical education program.

5. 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.

STATUORY PROVISIONS

6. 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 no later than 30 calendar days after being notified by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

(h) Any action of the licensee, or another person acting on behalf of the licensee, intended to cause their patient or their patient's authorized representative to rescind consent to release the patient's medical records to the board or the Department of Consumer Affairs, Health Quality Investigation Unit.

(i) Dissuading, intimidating, or tampering with a patient, witness, or any person in an attempt to prevent them from reporting or testifying about a licensee.

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.

COST RECOVERY

8. 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

(Repeated Negligent Acts)

9. Respondent Barry Joel Brock, M.D., is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in connection with his care and treatment of Patient A[1]. The circumstances are as follows:

10. For all times relevant herein, Barry Joel Brock, M.D., was an obstetrician/gynecologist; he failed to appropriately treat Patient A in his office, and failed to provide appropriate follow-up care to Patient A.

11. In or around 2010, Patient A, a 47-year-old female, first presented to Respondent. She had type 1 diabetes and Hashimoto's disease[2].

12. On or about April 21, 2015, Patient A saw Respondent for a consult regarding getting pregnant. During subsequent visits with Patient A in or around 2015, Respondent conducted ultrasounds and performed an HSG, and pelvic ultrasounds, and well woman visits, among other things.

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[1] The Patient is referred to by the letter A to protect her identity.

[2] Hashimoto's disease is an autoimmune disorder that can cause hypothyroidism, or an underactive thyroid.

13. On or about September 4, 2015, Respondent conducted a well woman exam on Patient A.

14. On or about July 17, 2017, Patient A again presented to Respondent for an examination.

15. On or about August 8, 2017, Respondent saw Patient A for a pre-operative visit prior to performing a dilation and curettage ("D&C")[3], to treat her endometrial polyps and metrorrhagia. [4]

16. In or around July of 2018, Patient A's infertility specialist referred her to see Respondent for continued care after she underwent In Vitro Fertilization ("IVF") treatment.

17. On or about August 31, 2018, an ultrasound was performed in Respondent's office. It confirmed a blighted ovum. Patient A should have been 7.4 weeks pregnant based on the IVF cycle, but only a sac was seen. No pelvic exam was conducted by Respondent at that time.

18. On or about September 13, 2018, Respondent performed a repeat ultrasound on Patient A which confirmed a blighted ovum[5], missed abortion. Respondent then provided Patient A with treatment options. Patient A decided to undergo a D&C in Respondent's office.

19. On or about September 17, 2018, the day prior to the D&C, Respondent brought Patient A in for placement of laminaria.[6] Patient A alleged that Respondent had her get undressed in front of him, did not wear gloves, and that there was no chaperone in the room.

20. On or about September 18, 2018, Respondent performed a suction D&C in his office. There was no chaperone present. Patient A reported that Respondent did not wear gloves during the procedure. Patient A felt severe pain during the procedure because Respondent did not administer enough pain medication to provide adequate anesthesia. Respondent did not perform a sharp curette, only a suction curette during the surgery. Patient A did not sign any informed consent documents prior to the procedure and the documentation related to the procedure was

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[3] A D&C is a surgical procedure in which the cervix is dilated so that the uterine lining can be scraped with a spoon shaped instrument called a curette, to remove abnormal tissues.

[4] Metrorrhagia is abnormal bleeding between menstrual cycles.

[5] An empty gestational sac will not turn into an embryo or baby.

[6] Laminaria are sterilized dried sticks of seaweed that absorb fluid from the cervix and slowly expand to dilate the cervix.

minimal. No follow up appointment was scheduled for Patient A and she did not receive a phone call to discuss the pathology following the surgery.

21. For the two-month period following the procedure, Patient A continued to experience vaginal bleeding.

22. On or about November 14, 2018, Patient A presented to a physician's assistant. An endometrial biopsy and ultrasound were performed. They confirmed that Patient A had retained products of conception.

23. On or about November 28, 2018, Patient A underwent another suction D&C procedure to remove the remaining products of conception.

24. In or around 2020, Patient A underwent IVF treatment again. The treatment resulted in her giving birth to twins in a premature delivery at 32 weeks. It required a cesarean hysterectomy due to a placenta increta and severe hemorrhaging.

25. Respondent was negligent in his care of Patient A in that he:

A. Failed to administer to her enough pain medication to prevent her from being in pain during an in-office procedure on or about September 18, 2018;

B. Failed to remove all of the products of conception during the suction D&C performed on or about September 18, 2018;

C. Failed to follow-up with the pathology from the suction D&C performed on or about September 18, 2018, and did and not maintain the pathology report in the patient's chart; and

D. Failed to maintain complete and accurate documentation related to office visits and failed to obtain appropriate informed consent.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Records)

26. Respondent Barry Joel Brock, M.D., is subject to disciplinary action under Business and Professions Code section 2266 in that he failed to maintain adequate and accurate records in connection with his care and treatment of Patient A. The circumstances are as follows:

27. The facts and allegations set forth in the First Cause for Discipline are incorporated herein by reference as if fully set forth.

28. Respondent failed to adequately and accurately document pertinent and required information related to the care and treatment of Patient A.

29. Respondent failed to obtain the appropriate informed consent for the D&C procedure.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 36218, issued to Respondent Barry Joel Brock, M.D.;

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

3. Ordering Respondent Barry Joel Brock, 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

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

DATED: SEP 23 2024

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

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