State of Rhode Island
Department of Health
Board of Medical Licensure and Discipline

IN THE MATTER OF:
Mark Brody, MD
License No.: MD 08028
Case No.: 210009

CONSENT ORDER

Mark Brody, MD ("Respondent") is licensed as a physician in Rhode Island. The Rhode Island Board of Medical Licensure and Discipline ("Board") has reviewed and investigated the above-referenced complaint pertaining to Respondent through its Investigative Committee. The Board makes the following

FINDINGS OF FACT

1. Respondent graduated from Columbia University College of Physicians and Surgeons in 1986. Respondent's license was issued on July 16, 1991. Respondent lists his specialty with the Rhode Island Department of Health ("RIDOH") as Psychiatry.

2. On January 4, 2021, the Board received a complaint from a pediatrician in Connecticut, No. C210009, regarding Respondent's care rendered of Patient A (alias), a child. The complaint stated, "*Dr. Brody has ordered a course of 'chelation therapy for autism symptoms' in a 2.5 year old child who is in foster care with CT DCF (parents still reserve medical decision making). Dr. Baum from Yale toxicology has stated that not only is this*

not recommended or science-based therapy, it could be dangerous or even fatal. I am concerned that this Dr. Brody is administering potentially harmful substances for chelation therapy in a child who is diagnosed with autism as this treatment is not accepted as a valid or safe treatment."

3. Respondent is the attending physician for Patient A, who was brought to see Respondent by Patient A's grandmother because of concern regarding Patient A's development.

4. Respondent provided the Investigative Committee with a written response to the above-referenced complaint, as well as Patient A's medical record, and appeared before the Investigative Committee.

5. Review of Patient A's medical record revealed that Patient A was identified as being three days old at the time of treatment, though this was determined to be a typographical error.[1] It was later determined that Patient A was, in fact, 2 years and 5 months old at the time of treatment. The chief complaint was identified only as "meeting with grandmother." There is no Past Medical History, no Family or Social History. There were no vital signs; specifically, no assessment of Patient A's weight, height, head circumference or growth percentiles. The medical record does not show that Patient A was examined. The history of present illness does not include a developmental history. There was no assessment of whether speech milestones were ever obtained and then lost, or simply not attained. The assessment at the end of the visit was simply "*slow development. May be related to heavy metal, environmental or other genetic factors.*"

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[1] Respondent, instead of sending his medical records to the Investigative Committee whole had exported the data from his electronic health record to a Word document, which document was provided to the Investigative Committee.

6. The care of Patient A was reviewed by an expert board certified in pediatrics who opined, "*It appears the care was rendered [by a physician] who has no training in pediatrics, the medical record is rudimentary and does not contain an adequate history, developmental history, past history, social history, physical or assessment and plan. It is not clear why the child is in custody of a state agency, which is relevant. There is no evidence of medical decision making. It is evident from the medical record the child is not talking, is this new, or has this been the case for some time, was a audiology evaluation completed – which is often the first step in a child who is not talking to make sure the child is not hearing impaired. Based on a reasonable degree of medical certainty, the care rendered is below the minimum acceptable community standard.*"

7. Respondent supplied a letter from the lab, Doctor's Data, that performed the urinalysis for Patient A following Respondent's "provoked urine test" of Patient A, which involved the administration of a chelating agent to Patient A prior to collection of Patient A's urine to test for metals. The letter, written by Douglas Fields, Vice President of Sales and Administration, stated in relevant part, "*If considering the analysis of provoked urine specimens, do not just order testing on the post-challenge specimen. Also order an analysis of an unprovoked specimen in order to compare results.*" Respondent was asked at his appearance why he did not start with an unprovoked specimen and replied that he wanted to spare the family the expense. Respondent could not otherwise explain why he did not follow the advice of his own expert.

8. Following its review of Patient A's medical record, the Investigative Committee subpoenaed and obtained from Respondent additional medical records, including records

of other minor patients.

9. Respondent was the attending physician for Patient B (alias), a minor, who was brought to Respondent for routine well child care starting at day three of life. Review of Patient B's medical record revealed lack of documentation of vital signs, including usual growth assessments, such as weight and applicable percentile, length and applicable percentile, and head circumference and applicable percentile. Documentation of Patient B's initial visit does not include an assessment of Patient B's weight, whether weight loss is appropriate, what Patient B is using for nutrition, or whether Patient B's weight or nutrition is adequate.

10. Respondent's care of Patient B was reviewed by an expert board certified in pediatrics who opined, "*Standard of care is to obtain a weight, measure length and head circumference at every health supervision visit, additionally this is plotted on standard growth charts and % are ascertained compared to established norms – this is not done. Physical exams and developmental assessment are not done which is below the standard of care. It is also standard of care to give anticipatory guidance which is not done. There is no diagnosis at each visit, rather an impression it is below the standard to not assign a diagnosis, typically a diagnosis of Well baby or Health Supervision is assigned as well as other comorbidities. Homeoprophylaxis is a controversial (even in the homeopathy community) for vaccination – there is no discussion or risks and benefits of this for this patient. The medical record does not reveal usual standards regarding prevention of health problems or adherence to accepted minimum standards.*"

11. Respondent is the attending physician for Patient C (alias). Review of Patient C's

medical record revealed that there is no date of birth recorded therein. Patient C was diagnosed with heavy metal toxicity for thallium and lead, but was apparently not examined. The documented history is disorganized, and there is no evaluation of whether a possible exposure to lead or thallium may have occurred.

12. An expert board certified in preventive medicine reviewed Patient C's medical record and opined, "*It is usual and customary to assess potential sources of exposure, so if elevation is discovered, mitigation can occur; additionally, it is usual and customary to obtain a detailed history and appropriate physical exam. The care rendered is below the minimum acceptable community standards.*"

13. Respondent was the attending physician for Patient D (alias). Review of Patient D's medical record revealed no documentation of physical exams at multiple visits, no documented vital signs, and no documented mental status exam. Further it was noted that all the dates of service were in the future. Respondent explained, as noted in footnote 1, above, that he had exported the data from his electronic health record and then manually entered the dates. He presumed, therefore, that the incorrect dates were a typographical error.

14. Respondent's care of Patient D was reviewed by an expert who opined, "*The minimum standard is to examine a patient, if it is a psychiatric visit, which this could be, a mental status exam is done at every visit. There is no diagnosis, yet treatment is offered, additionally changes at subsequent visits occur without documented justification. The medical record reveals there was an issue about mother force feeding her, yet Patient D is not weighed and this problem is not evaluated. A diagnosis of a problem with microbiome*

is made without clear understanding of why it is made. The care to Patient D, falls below the accepted minimum community standards."

15. Respondent is the attending physician for Patient E (alias). Patient E's medical record was reviewed by an expert in pediatrics who opined that "*it is not clear from the medical record why this 9 year old is being evaluated or treated for anything other than being a 9 year old. There are no vital signs, patient is not examined, the child is given various herbs and it is not clear if there is clinical progress. The care rendered to Patient E is below the accepted minimum community standard.*"

16. Respondent is the attending physician for Patient F (alias). Patient F's medical record was reviewed by an expert who opined that "*the medical record reveals no vital signs, the patient has a history of persistent asthma yet is on no medications and there was no medication reconciliation, there is no past medical, family or social history, the patient is not examined. The documentation falls below acceptable community standards.*"

17. Respondent is the attending physician for Patient G (alias). Patient G's medical record was reviewed by an expert board certified in pediatrics who opined, "*The medical record of this patient reveals several deficiencies, the patient is not examined, there are no vital signs, the diagnosis, autism and obsessive compulsive disorder is not supported by the documentation, there is no documentation of a past medical history, yet clearly the patient has underlying conditions. There is no immunization record, yet there is a concern about past vaccines. The standard of care is not met, the entire encounter is globally deficient – appears to be done by someone with no training in pediatrics.*"

18. At his appearance before the Investigative Committee, Respondent admitted that he was

trained in psychiatry, not pediatrics, internal medicine, or family medicine. Respondent was clear that he was not trained as a primary care provider. Respondent stated that he tells his patients he is not a primary care provider, but admitted that he does not document this disclaimer; rather, he provides it orally. The Investigative Committee reviewed Respondent's website, https://www.markbrodymd.com, last visited April 18, 2021, and noted that it states, "*I treat most health problems that are commonly seen in a primary care physicians office. As an Integrated Medicine practitioner, I emphasize improved success rates and minimization of risks and dangerous side, through a combination of treatment approaches.*"

19. Respondent was asked why he did not perform medication reconciliation and he responded that it was not necessary since the medicines he prescribed were safe.

20. At his appearance before the Investigative Committee, Respondent explained that he does not perform complete physical exams; specifically, that he does not do rectal or pelvic exams or other routine parts of physical exams. He does not routinely order established health screening tests such as mammograms, pap smears, or colonoscopies, for example, to achieve early detection of various cancers, unless patients ask for these tests.

21. Respondent also explained that references he uses for medication dosage included Samuel Hahnemann's *Organon of Medicine*, which was published in 1893.

22. Respondent could only supply proof of 1.5 hours of continuing medical education ("CME") for the two-year time period from July 1, 2018 through June 30, 2020. At his appearance before the Investigative Committee, Respondent admitted that he did not have the necessary CME for this time period.

23. Based on the foregoing, the Investigative Committee determined that Respondent violated R.I. Gen. Laws § 5-37.5.1(19) and (24), which define "unprofessional conduct" as including, respectively, "*[i]ncompetent, negligent, or willful misconduct in the practice of medicine, which includes the rendering of medically unnecessary services, and any departure from, or the failure to conform to, the minimal standards of acceptable and prevailing medical practice in his or her area of expertise as is determined by the board;*" and "*[v]iolating any provision or provisions of [R.I. Gen. Laws § 5-37] or the rules and regulations of the board or any rules or regulations promulgated by the director or of an action, stipulation, or agreement of the board.*"

24. Respondent also violated Section 1.5.5(A) of the rules and regulations for Licensure and Discipline of Physicians (216-RICR-40-05-1) ("Regulations"), which provides in relevant part that "*[e]very physician licensed to practice allopathic or osteopathic medicine in Rhode Island . . . shall on or before the first (1st) day of June in each even-numbered year, on a biennial basis, earn a minimum of forty (40) hours of AMA PRA Category 1 Credit™/AOA Category 1a continuing medical education credits and shall document this to the Board;*" and Section 1.5.12(D) of the Regulations, which provides that "*[m]edical Records shall be legible and contain the identity of the physician or physician extender and supervising physician by name and professional title who is responsible for rendering, ordering, supervising or billing each diagnostic or treatment procedure. The records must contain sufficient information to justify the course of treatment, including, but not limited to: active problem and mediation lists; patient histories; examination results; test results; records of drugs prescribed, dispensed, or*

administered; and reports of consultations and hospitalizations."

Based on the foregoing, the parties agree as follows:

1. Respondent admits to and agrees to remain under the jurisdiction of the Board.

2. Respondent has agreed to this Consent Order and understands that it is subject to final approval of the Board and is not binding on Respondent until final ratification by the Board.

3. If ratified by the Board, Respondent hereby acknowledges and waives:

a. The right to appear personally or by counsel or both before the Board;

b. The right to produce witnesses and evidence on his behalf at a hearing;

c. The right to cross examine witnesses;

d. The right to have subpoenas issued by the Board;

e. The right to further procedural steps except for those specifically contained herein;

f. Any and all rights of appeal of this Consent Order;

g. Any objection to the fact that this Consent Order will be presented to the Board for consideration and review; and

h. Any objection to the fact that this Consent Order will be reported to the National Practitioner Data Bank and Federation of State Medical Boards and posted to the RIDOH public website.

4. Respondent agrees to pay, within 5 days of the ratification of this Consent Order, an administrative fee of $1630.00 for costs associated with investigating the above-referenced complaint. Such payment shall be made by certified check, made payable to "**Rhode Island General Treasurer**," and sent to Rhode Island Department of Health, 3

Capitol Hill, Room 205, Providence, RI 02908, Respondent will send notice of compliance with this condition to DOH.PRCompliance@health.ri.gov within 30 days of submitting the above-referenced payment.

5. Respondent hereby agrees to the suspension of his physician license for five years, with the provision that the Respondent shall serve six weeks of such suspension, beginning 30 days after the ratification of this Consent Order. The remainder of such suspension shall be stayed, provided Respondent registers for an evaluation of his clinical competency by Center for Personalized Education for Physicians ("CPEP") or Lifeguard Physician Services ("Lifeguard") within 90 days of the ratification of this Consent Order. Provided Respondent complies with the terms of this Consent Order, the balance of Respondent's suspension shall be vacated upon Respondent's successfully passing the above-referenced evaluation with endorsement by the evaluating agency that Respondent is safe to practice medicine. Any recommendations of the evaluating agency shall be incorporated into this Consent Order by reference.

6. Respondent agrees not to see any patient younger than age 12.

7. Respondent, at his own expense, shall successfully complete within 90 days of ratification of this Consent Order a Board approved course in medical records, such as the Case Western Reserve University Intensive Course on Medical Documentation; Clinical, Legal and Economic Implications for Healthcare Providers. Respondent will send notice of compliance with this condition to DOH.PRCompliance@health.ri.gov within 30 days of successful completion.

8. In addition to the Respondent's extant CME requirements for the current period from July 1, 2020 to June 30, 2022 and from July 1, 2022 to June 30, 2024, Respondent shall complete an additional 80 hours of Category 1 approved CME within 12 months of ratification of this Consent Order.

9. Respondent will not approach the Board for reinstatement until providing satisfactory evidence of successfully passing CPEP or Lifeguard; any recommendations of CPEP or Lifeguard shall be reasonably incorporated into the terms of Respondent's reinstatement.

10. If Respondent violates any term of this Consent Order after it is signed and accepted, the Director of RIDOH ("Director") shall have the discretion to impose further disciplinary action, including immediate suspension of Respondent's medical license. If the Director imposes further disciplinary action, including summary suspension, Respondent shall be given notice and shall have the right to request within 20 days of the suspension and/or further discipline an administrative hearing. Respondent expressly agrees that failure to register for an evaluation, as required above, or to be deemed safe to practice medicine by the evaluating agency, constitute evidence that Respondent's continuation in practice would constitute an immediate danger to the public and, therefore, grounds for summary suspension. The Director shall also have the discretion to request an administrative hearing after notice to Respondent of a violation of any term of this Consent Order. The Administrative Hearing Officer may suspend Respondent's license, or impose further discipline, for the remainder of Respondent's licensing period if the alleged violation is proven by a preponderance of evidence.

[SIGNATURE PAGE FOLLOWS]

Signed this 25 day of June, 2021.

Mark Brody, MD

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Ratified by the Board of Medical Licensure and Discipline on the 14th day of July, 2021.

Nicole Alexander-Scott, MD, MPH
Director
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