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

In the Matter of the Accusation Against:	)	
	)	
	)	
TERRILL BROWN, M.D.	)	**Case No. 08-2010-211019**
	)	
Physician's and Surgeon's Certificate No. G 53967	)	
	)	
	)	
Respondent.	)	
	)	

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 June 24, 2013.

IT IS SO ORDERED June 17, 2013.

MEDICAL BOARD OF CALIFORNIA

By: Kimberly Kirchmeyer

Kimberly Kirchmeyer
Interim Executive Director

KAMALA D. HARRIS
Attorney General of California
E.A. JONES III
Supervising Deputy Attorney General
VLADIMIR SHALKEVICH
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California Department of Justice
300 So. Spring Street, Suite 1702
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **TERRILL BROWN, M.D.** **5756 N. Marks Ave #161** **Fresno, CA 93291** **Physician's and Surgeon's Certificate No. G53967** Respondent.	Case No. 08-2010-211019 OAH No. 2013040542 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties in this proceeding that the following matters are true:

PARTIES

1. Linda K. Whitney (Complainant) is the Executive Director of the Medical Board of California. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Vladimir Shalkevich, Deputy Attorney General.

2. TERRILL BROWN, M.D. (Respondent) is represented in this proceeding by attorney Alfred A. Gallegos, whose address is 123 North D Street, Suite D, Madera, CA 93638, and by John Fleer, whose address is 1850 Mt. Diablo Blvd, Ste 120, Wallnut Creek, CA 94596 .

3. On or about November 13, 1984, the Medical Board of California issued Physician's and Surgeon's Certificate No. G53967 to TERRILL BROWN, M.D. (Respondent). Said license

was in full force and effect at the time of Respondent's acts alleged in the Accusation No. 08-2010-211019, and will expire on September 30, 2013, unless renewed.

JURISDICTION

4. Accusation No. 08-2010-211019 was filed before the Medical Board of California (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on March 29, 2013. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 08-2010-211019 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 08-2010-211019. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel, at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations contained in Accusation No. 08-2010-211019 and that he has thereby subjected his license to disciplinary action. Respondent agrees that cause exists for discipline and hereby surrenders his Physician's and Surgeon's Certificate No. G53967 for the Board's formal acceptance.

9. Respondent was suffering from bipolar disorder at the time of Respondent's acts alleged in the Accusation No. 08-2010-211019.

10. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

11. Respondent agrees that if he ever petitions for reinstatement, all of the charges and allegations contained in Accusation No. 08-2010-211019 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. The parties understand and agree that facsimile copies of this Stipulated Surrender of License and Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G53967, issued to Respondent TERRILL BROWN, M.D., is surrendered and accepted by the Medical Board of California.

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 Medical Board of California.

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. Respondent may file a petition for reinstatement two years after the effective date of this Order. 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 license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 08-2010-211019 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney, Alfred A. Gallegos. 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: 5/29/13

Terrill E Brown MD, MPH

TERRILL BROWN, M.D.
Respondent

I have read and fully discussed with Respondent TERRILL BROWN, 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: 5/31/2013

ALFRED R. GALLEGOS
Attorney for Respondent

I have read and fully discussed with Respondent TERRILL BROWN, 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: 6-1-13

JOHN FLEER
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: 6-3-13

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General

VLADIMIR SHALKEVICH
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 08-2010-211019

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

In the Matter of the Accusation against: **TERRILL EUGENE BROWN, M.D.** **5706 W Elowin Dr.** **Visalia, CA 93291-9282** **Physician and Surgeon's Certificate** **No. G 53967** Respondent.	Case No. 08-2010-211019 OAH No. 2013020722 **ACCUSATION**

Complainant alleges:

PARTIES

1. Linda K. Whitney (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about November 13, 1984, the Medical Board of California issued Physician and Surgeon Number G 53967 to Terrill Eugene Brown, M.D. (Respondent). Said license was in full force and effect at all times relevant to the allegations brought herein and will expire on September 30, 2014, unless renewed. On or about March 19, 2013, said license was suspended pursuant to an Interim Order of Suspension. Respondent's license is currently suspended.

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JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions 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 which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview scheduled by the mutual agreement of the certificate holder and the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

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6. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

7. Section 2261 of the Code states:

"Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

8. 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

(ILLEGAL PRESCRIBING)

9. Respondent is subject to disciplinary action pursuant to Business and Professions Code section 2242 in that Respondent prescribed controlled substances and/or dangerous drugs, as defined in sections 4021 and 4022, to two patients, without an appropriate prior examination and a medical indication. The circumstances are as follows:

10. After receiving complaints that Respondent recommended medical marijuana without first conducting any prior medical examination and that he prescribed controlled substances to individuals who may have been illegally diverting the medications, the Medical Board of California conducted several undercover operations to determine the nature and extent of Respondent's prescribing practices.

UNDERCOVER OPERATION ON SEPTEMBER 22, 2011

11. On September 22, 2011, the Medical Board of California conducted an undercover operation at Respondent's office located at 5756 N. Marks Ave. #161 in Fresno California. The undercover operative was a female Medical Board Investigator, who utilized an undercover identity of a patient whose initials are R.S.[1] The undercover operation was digitally recorded. During this undercover operation, Respondent personally collected $200 cash and issued a medical marijuana recommendation, together with a prescription for 180 10-325 Norco[2] tablets to R.S. During the visit on September 22, 2011, Respondent did not review any medical records and did not conduct any physical examination or R.S. whatsoever.

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[1] The identification documents for R.S. undercover identity were issued to her by the State of California. All future references to R.S. herein are referring to a Medical Board Investigator working in her undercover capacity.

[2] Norco is a mixture of Acetaminophen and Hydrocodone. Also known as dihydrocodeinone, it is a Schedule III controlled substance as designated by Health and Safety Code section 11056(e) (4), and a dangerous drug pursuant to Business and professions Code section 4022.

UNDERCOVER OPERATION OF JANUARY 5, 2012

12. R.S. returned to Respondent's office, located at 5756 N. Marks Ave. #161 in Fresno, California on January 5, 2012. The undercover operation was digitally recorded. During this office visit, Respondent revealed to R.S. that he had utilized a man named "Bounmy" to bring different female patients to his office to receive prescriptions for controlled substances. He referred to "Bounmy" as a "donkey" for the female patients. During the office visit, Respondent personally collected $120 cash from R.S. and discussed prescribing to her 120 tablets of instant release oxycodone[3]. She asked Respondent if she could have additional pills of oxycodone, to pay back a friend who had given her oxycodone pills previously. Respondent asked how many additional pills she wanted. R.S. asked Respondent for 10 additional pills. Respondent then issued a prescription for a total of 130 pills of 30 mg instant release oxycodone. Respondent then informed R.S. that he would be increasing her quantity of oxycodone on subsequent visits.

13. During the office visit on January 5, 2012, Respondent did not conduct any physical examination of R.S. whatsoever. Respondent did not inquire as to the effectiveness of Norco which he previously prescribed to R.S., or whether she was taking this medication. Respondent did not inquire about the effectiveness of the medical marijuana he previously recommended to her. Respondent expressed no concern at the patient's admission that some of the oxycodone, a Schedule II controlled substance that he was prescribing to his patient, was intended for another person. Respondent scheduled R.S. to return for her next appointment on January 31, 2012.

UNDERCOVER OPERATION ON JANUARY 31, 2012

14. R.S. returned to see Respondent on January 31, 2012, at his Fresno office located at 5756 N. Marks Ave. #161 in Fresno, California. The undercover operation was digitally recorded.

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[3] Oxycodone is a semi-synthetic narcotic analgesic with multiple actions quantitatively similar to those of morphine. It is generally used as an analgesic, but it also has a high potential for abuse. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055 (b)(1)(M) and a dangerous drug pursuant to Business and Professions code section 4022. It is also a Schedule II controlled substance as defined by the Code of Federal Regulations Title 21, section 1308.12 (b)(1).

15. During the January 31, 2012 visit, Respondent questioned R.S. about why he had prescribed to her an "odd number" of oxycodone pills on her prior visit. She reminded him the "odd number" was due to the 10 extra pills she had given to her friend. R.S. told Respondent that she owed her friend again and asked about prescribing a higher dose tablets of oxycodone. Respondent explained that he typically increases the number of pills he prescribes instead of increasing the size or dosage of the pills. He told R.S. that he would "bump up" her quantity to 150 pills, and stated "I would be shocked if we didn't."

16. During the January 31, 2012, visit, the R.S. told Respondent that she ran out of her medication because she had given it to her friend, and having ran out, she once again owed more medication to her friend. Respondent asked about the friend and stated that giving away a controlled substance was a felony. He stated "I don't know her name. I don't want to know her name, and I'm not a narc." When R.S. asked if Respondent was willing to prescribe to her friend, he stated he was avoiding taking on new patients because he spends too much time with prescription patients. He stated that his practice is "overran with prescription."

17. During the January 31, 2012 visit, Respondent asked R.S. if her friend was compensating her for the medications. R.S. responded she was being compensated. She asked Respondent if he was willing to prescribe more to her for her friend if she paid extra. Respondent refused and stated he would only prescribe after meeting with the patient. Respondent explained that all his patients must first receive a cannabis recommendation, even if they are not interested in becoming cannabis patients. He explained: "What I do if I'm going to pick up a new patient is they have to become a cannabis patient even if they're not interested in it, because I'm not prescribing to non-cannabis patients basically. And when I pick them up for prescriptions as well, and I do that for ongoing patients, is about the - anybody that has a sort of a ticket to get anybody else in. It's like an exclusive show if you have backstage passes. Well, if you know somebody who knows somebody you can get an extra pass, you know, and because of the prescreen... So, it's a little bit like that with my scripts. So what we've been doing though is charging people $300 that day." Respondent then provided R.S. a business card on which was written: "Okay RX for Amy," which would serve as a pass for a new patient to receive controlled

substance prescriptions in the future. Respondent stated that he would take R.S.'s friend as a patient. He referred to R.S. as his "screening agent."

18. During the January 31, 2012 visit, Respondent personally collected $60.00 cash and provided R.S. with a prescription for 150 30 mg instant release oxycodone and 150 10-325 Norco tablets. During this office visit Respondent did not conduct any physical examination of R.S. whatsoever, did not inquire as to the effectiveness of previously prescribed medications. Respondent did not inquire whether R.S. was taking the medications he prescribed to her and conducted no testing to ensure that R.S. was taking (as opposed to diverting) the medications he prescribed to her. Nevertheless, Respondent increased the amount of oxycodone being prescribed to R.S. from 130 pills of 30 mg instant release oxycodone to 150 pills, without making any effort to ascertain a medical need to do so. Respondent expressed no concern at the patient's admission that some of the oxycodone, a Schedule II controlled substance that he was prescribing to his patient, was intended for another person, or that the patient was "being compensated" by the other person for providing the other person with oxycodone which he was prescribing to her.

UNDERCOVER OPERATION ON MARCH 15, 2012

19. R.S. returned to see Respondent at his office located at 5756 N. Marks Ave. #161 in Fresno, California on March 15, 2012. The undercover operation was digitally recorded. R.S. did not have a scheduled appointment. Respondent contacted R.S., and led her to his office. He asked how she was doing. She informed him she was out of oxycodone and needed a refill. He indicated her quantity of 30 mg instant release oxycodone needed to be increased from 150 30 mg pills of instant release oxycodone to 180 pills.

20. R.S. then asked for oxycodone for her friend. She indicated she had brought with her a friend's identification, and would be willing to pay for the medical marijuana card and the prescription for oxycodone for her friend, whose initials are T.B.[4] Respondent stated he would not prescribe without her friend physically present. Respondent clarified that at the follow up visit he could prescribe to her friend without them present, and R.S. could pick up his

[4] T.B. is an undercover identity issued to Medical Board Senior Investigator, to whom this and all subsequent references to patient "T.B." shall refer herein.

prescriptions for him. He explained he would reserve her friend a $100.00 start up fee as a prescription patient. Respondent prepared the medical records for T.B.'s medical marijuana recommendation, and in the presence of R.S., forged T.B.'s signature on them.

21. During the office visit on March 15, 2012, Respondent personally collected $280.00 cash and provided R.S. with a prescription for 180 30 mg instant release oxycodone. Respondent never examined R.S., never inquired about whether prior prescriptions were effective, and did not express concern that a portion of the controlled substance prescription he was issuing was intended for another person. Respondent did not inquire whether R.S. was taking the medications he prescribed to her and conducted no testing to ensure that R.S. was taking (as opposed to diverting) the medications he prescribed to her. Nevertheless, Respondent increased the number of oxycodone pills he was prescribing to R.S. from 150 to 180, for no medical reason whatsoever. Respondent also issued a medical marijuana recommendation for T.B. without a good faith prior examination, and without reviewing any prior medical records to establish that T.B. was qualified for a medical marijuana recommendation. T.B. was not even present when Respondent issued a medical marijuana recommendation for him.

UNDERCOVER OPERATION ON APRIL 12, 2012

22. R.S. returned to Respondent's office, located at 5756 N. Marks Ave. #161 in Fresno, California, on April 12, 2012. R.S. brought T.B.'s driver's license with her. The undercover operation was digitally recorded.

23. R.S. had a scheduled appointment at 3:25 p.m. She waited several hours before she was seen by the Respondent. After discussing his personal problems and describing selling a car, Respondent reviewed R.S.'s prescription history and medical chart. He stated he would like to keep her at the 180 30 mg instant release oxycodone. R.S. indicated that she had run out of oxycodone early, and Respondent agreed to increase the number of oxycodone pills prescribed to her from 180 to 210.

24. R.S. asked Respondent to write a prescription for either oxycodone or Norco for her friend. Respondent asked how long her friend had been his marijuana patient. She responded her friend had been his marijuana patient since March of 2012. Respondent asked if her friend

was given the "polk-a-dot" (which would indicate prior approval) for the medicine. R.S. pulled out Respondent's business card which he previously gave her, on which he had written the words "Okay RX for Amy." Respondent stated that wasn't it but it was important. R.S. then pulled out T.B's ID and handed it to Respondent. He stated that "it was golden," his chart would be pulled, and he could write T.B. a prescription "for anything we need to." R.S. stated to Respondent that he was good to her. Respondent stated "I would do it even if I didn't mind you."

25. R.S. then retrieved T.B.'s chart from the receptionist and brought it to the Respondent. Respondent reviewed T.B's chart and threw away the note. He reminded R.S. that T.B.'s fee for the visit was $100.00 and her fee was $80.00 Respondent personally collected $180.00 cash from R.S.

26. Respondent asked what prescription T.B. wanted, explaining that he could ask her for this information because she knew T.B. well. R.S. stated that T.B. wanted oxycodone. She said to Respondent that she had told T.B. that she wasn't even prescribed oxycodone the first time she saw Respondent and only received Norco. She stated she did not want to make Respondent uncomfortable. Respondent said: "I don't want you to feel like you have to share with him" and agreed to prescribe oxycodone and Norco to T.B. Respondent informed R.S. that T.B. had to come to his office monthly in order to obtain a refill of the oxycodone, but issued a prescription for 120 30mg instant release oxycodone and 150 pills of Norco to T.B., which he gave to R.S.

27. Respondent asked R.S. about her relationship with T.B. She stated they were just friends. Respondent continued to discuss his relationship with his wife. Afterwards he concluded the office visit.

28. During the office visit, Respondent did not conduct a medical examination of either R.S. or T.B. Respondent never inquired about whether prior prescriptions to R.S. were effective, whether she was taking the medications he prescribed to her, and did not conduct any testing to verify that R.S. actually took the medications he prescribed to her. Nevertheless, he increased the number of oxycodone pills prescribed to R.S. from 180 pills of 30 mg instant release oxycodone to 210 pills. Sight unseen, he prescribed 150 10-325 Norco and 120 30 mg

instant release oxycodone to T.B., who was not even present at the Respondent's office and was never examined by the Respondent.

UNDERCOVER OPERATION ON MAY 14, 2012

29. R.S. returned to see Respondent at his office, located at 636 W. Oak Ave. Visalia, California, on May 14, 2012. She brought with her T.B.'s driver's license. The undercover operation was digitally recorded.

30. R.S. was informed both her and T.B's charts were not transferred to Respondent's Visalia office. She had an appointment at 10:00 am and T.B. had an appointment 10:20 a.m. Respondent asked about T.B. and R.S. told him that she was there for refills for both her and T.B. Respondent stated without T.B.'s charts did not know his numbers. R.S. told him that her prescriptions were filled at Costco in Riverpark in Fresno, CA. She reminded Respondent that her prescription was for 210 oxycodone pills and T.B.'s had been either 150 or 180. Respondent stated lets go with 180 to not "undercut" him.

31. Respondent then discussed his new fees with R.S. He offered to charge her the old fee to make up for the long wait in the reception. He told R.S. that he was now charging $100.00 for medical marijuana renewals. In addition, his monthly fees for prescription refills increased from $60.00 to $80.00 dollars. For patients that show up every four months for refills, their fees increased from $60.00 to $100.00 dollars.

32. R.S. handed $200.00 cash to Respondent for her and T.B.'s prescription refills. However, Respondent only accepted $100.00. He explained he was upset she waited. He stated he would normally charge $60.00 each for a total of $120.00 but was willing to accept only $100.00. She indicated she thought it was $80.00 each patient. He stated the next time he saw her he would accept "two of those" referring to the $100 bills. He added that it was nice of her to bring T.B.'s driver's license, but she did not need to bring it because he normally does not need to see it. Respondent made the comment he believed T.B.'s prescription was at 180. He stated "If he were below that I'm okay with this."

33. Respondent asked about Costco and if R.S. had problem filling her prescriptions. R.S. told him she did not have any problems filling her prescriptions, but the pharmacist told her that T.B. had to pick up his own prescriptions.

34. Respondent stated he would put all the information about her and T.B. in the transfer folder when he goes to his Fresno office the next day. Respondent told R.S. that he doesn't like to make people mad or disappointed and added "especially as pretty as you." In addition, he revealed that another patient had waited four hours in the office and that patient's chart was not transferred from Fresno to the Visalia office either. Respondent then concluded the office visit and hugged R.S.

35. During the office visit on May 14, 2012, Respondent did not conduct a medical examination of either R.S. or T.B. Respondent never inquired about whether prior prescriptions were effective, whether either of the patients was taking the medications he prescribed to them, and did not conduct any testing to verify that R.S. actually took the medications he prescribed to her. Nevertheless, Respondent personally collected $100.00 from R.S. and provided her with a prescription for 210 30 mg instant release oxycodone, as well as T.B.'s prescription for 180 30 mg instant release oxycodone. T.B. was not present at the Respondent's office and was never examined by him.

UNDERCOVER OPERATION ON JUNE 14, 2012

36. R.S. returned to Respondent's office, located at 5756 N. Marks Ave. #161 in Fresno, California, on June 14, 2012. The undercover operation was digitally recorded. Her appointment was scheduled at 11:15 a.m. Three hours later, she was taken to the back office by the receptionist. Respondent greeted R.S. and commented that he couldn't associate her name with her "pretty face." He stated he was glad she did not have to wait. She responded she waited for three hours. Respondent reviewed R.S.'s chart. He stated her and T.B's chart had been transferred from his Visalia office. He stated he would hold her at the same quantity of 210 pills of 30 mg instant release oxycodone.

37. After discussing issues with banking and several other patients' prescriptions, and after being interrupted several times, Respondent wrote a prescription for oxycodone to R.S. He

then asked: "When do I get to see T.B.?" R.S. responded that it was more convenient for T.B. to send her in. Respondent wanted to prescribe 180 30 mg instant release oxycodone to T.B., one every four hours. He added that T.B. can take two every eight hours. He stated "I honestly don't care how it is taken as long as it is not more than six in a 24 hour time period."

38. During the office visit on June 14, 2012, Respondent discussed several patients with R.S. and showed her a cell phone video of a female patient. He stated the video was for his son. His son is single and thought maybe the female patient would be interested in dating his son. He shared photos he had also taken of the female patient with R.S. He stated the patient was very beautiful like R.S. He revealed the patient on the photographs was a mother of three. He also described his son as socially shy. His son lived and attended school in Orange County. Respondent stated his wife would be happy if his son moved back home. Respondent revealed he owned a condo in Orange County near his son. Respondent then offered a free exam to R.S. if her wait was longer than two hours for the next office visit.

39. T.B. was not present during the office visit on June 14, 2012. Respondent did not conduct a medical examination of either R.S. or T.B. Respondent never inquired about whether prior prescriptions were medically necessary or medically indicated, whether the medications were effective, whether either of the patients was taking the medications he prescribed to them, and did not conduct any testing to verify that R.S. actually took the medications he prescribed to her. Nevertheless, Respondent personally collected $160.00 cash from R.S. in exchange for a prescription for 210 30 mg instant release oxycodone written to her, as well as a prescription for T.B. for 180 30 mg instant release oxycodone.

UNDERCOVER OPERATION ON JULY 12, 2012

40. R.S. returned to Respondent's office located at 5756 N. Marks Ave. #161 in Fresno, California, on July 12, 2012. The undercover operation was digitally recorded. R.S.'s scheduled appointment was at 11:15 a.m. She was taken to the back office.

41. Respondent informed R.S. that he was preparing a class action lawsuit against pharmacies not filling his prescriptions. He believed the pharmacies had no legitimate reasons to not fill his prescriptions. He stated there maybe "soft reasons" and rumors about him that may

have caused pharmacies to be paranoid of the DEA. He asked patients whose prescriptions were denied by pharmacies to fill a three page document and be video interviewed. He asked if she had any problems with filling her prescriptions. R.S. told him that she had no problems with her prescriptions being filled.

42. Respondent then engaged R.S. in a detailed discussion about buying and selling cars and about his problems with various banks and his strategy of keeping cash bank deposits under $10,000.00.

43. Respondent then asked R.S. if a prescription for 210 oxycodone pills, seven per day, was good enough. She answered that yes it was. R.S. asked about the new office security guard, and Respondent explained that he had to hire security because the landlord threatened to evict him from the office, because Respondent's patients were going to his office in Fresno on days they were not open. The patients were going to other tenants at the building asking where his office was.

44. Respondent told R.S. that his office recently obtained a blood pressure gauge. He asked R.S. if she wanted her blood pressure checked. She stated that if he wanted he could do that. He said "Wouldn't actually hurt to do." Resspondent, however, did not measure R.S.'s blood pressure. Threafter, Respondent wrote a prescription for Norco with three refills for T.B. He took the money for the examination from R.S., which consisted of two $100 bills, and gave back $40.00 dollars in change. Thereafter, Respondent resumed a discussion about cars. After discussing cars, Respondent concluded R.S.' office visit.

45. The total cost of the office visit was $160.00 cash, in exchange for which Respondent provided R.S. with prescriptions for 210 30 mg instant release oxycodone issued to R.S. and a prescription for 180 30 mg instant release oxycodone and 150 10-325 Norco issued to T.B. T.B. was not present and was never examined by Dr. Respondent.

46. Respondent violated Business and Professions Code section 2242 in that during his care and treatment of R.S. and T.B. he never performed a medical examination of either one of these patients. With respect to Respondent's care and treatment of T.B., he never even met the

patient, never examined him, never took his history, and did not established any medical indication whatsoever to prescribe scheduled substances to him.

SECOND CAUSE FOR DISCIPLINE

(GROSS NEGLIGENCE)

47. Respondent's license is subject to discipline pursuant to Business and Professions Code section 2234, subdivision (b), in that he has committed acts of gross negligence in the care and treatment of two patients.

48. The circumstances are as follows: The allegations of paragraphs 10 through 45 are incorporated by reference as if fully set forth here.

49. Respondent's care and treatment of R.S. on September 22, 2011, constituted an extreme departure from the standard of care.

50. Respondent's care and treatment of R.S. on January 5, 2012 constituted an extreme departure from the standard of care.

51. Respondent's care and treatment of R.S. on January 31, 2012 constituted an extreme departure from the standard of care.

52. Respondent's care and treatment of R.S. on March 15, 2012 constituted an extreme departure from the standard of care.

53. Respondent's care and treatment of T.B. on March 15, 2012 constituted an extreme departure from the standard of care.

54. Respondent's care and treatment of R.S. on April 12, 2012 constituted an extreme departure from the standard of care.

55. Respondent's care and treatment of T.B. on April 12, 2012 constituted an extreme departure from the standard of care.

56. Respondent's care and treatment of R.S. on May 14, 2012 constituted an extreme departure from the standard of care.

57. Respondent's care and treatment of T.B. on May 14, 2012 constituted an extreme departure from the standard of care.

58. Respondent's care and treatment of R.S. on June 14, 2012 constituted an extreme departure from the standard of care.

59. Respondent's care and treatment of T.B. on June 14, 2012 constituted an extreme departure from the standard of care.

60. Respondent's care and treatment of R.S. on July 12, 2012 constituted an extreme departure from the standard of care.

61. Respondent's care and treatment of T.B. on July 12, 2012 constituted an extreme departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(REPEATED NEGLIGENT ACTS)

62. Respondent's license is subject to discipline pursuant to Business and Professions Code section 2234, subdivision (c), in that he has repeated acts of negligence in the care and treatment of two patients.

63. The circumstances are as follows: The allegations of paragraphs 10 through 45 are incorporated by reference as if fully set forth here.

64. Respondent's care and treatment of R.S. on September 22, 2011, constituted a departure from the standard of care.

65. Respondent's care and treatment of R.S. on January 5, 2012 constituted a departure from the standard of care.

66. Respondent's care and treatment of R.S. on January 31, 2012 constituted a departure from the standard of care.

67. Respondent's care and treatment of R.S. on March 15, 2012 constituted a departure from the standard of care.

68. Respondent's care and treatment of T.B. on March 15, 2012 constituted a departure from the standard of care.

69. Respondent's care and treatment of R.S. on April 12, 2012 constituted a departure from the standard of care.

70. Respondent's care and treatment of T.B. on April 12, 2012 constituted a departure from the standard of care.

71. Respondent's care and treatment of R.S. on May 14, 2012 constituted a departure from the standard of care.

72. Respondent's care and treatment of T.B. on May 14, 2012 constituted a departure from the standard of care.

73. Respondent's care and treatment of R.S. on June 14, 2012 constituted a departure from the standard of care.

74. Respondent's care and treatment of T.B. on June 14, 2012 constituted a departure from the standard of care.

75. Respondent's care and treatment of R.S. on July 12, 2012 constituted a departure from the standard of care.

76. Respondent's care and treatment of T.B. on July 12, 2012 constituted a departure from the standard of care.

FOURTH CAUSE FOR DISCIPLINE

(FALSE MEDICAL RECORDS)

77. Respondent's license is subject to discipline pursuant Business and Professions Code section 2261 in that he has knowingly made or signed medical records of T.B., directly or indirectly related to the practice of medicine which falsely represent the existence or nonexistence of a state of facts. The circumstances are as follows:

78. Allegations of paragraphs 19 through 53 are incorporated herein by reference.

FIFTH CAUSE FOR DISCIPLINE

(CORRUPT OR DISHONEST ACTS)

79. Respondent's license is subject to discipline pursuant Business and Professions Code section 2234, subdivision (e) in that he has committed acts of dishonesty or corruption which are substantially related to the qualifications, functions or duties of a physician and surgeon. The circumstances are as follows:

80. Allegations of paragraphs 10 through 45 are incorporated herein by reference.

81. On or about December 7, 2012, members of law enforcement executed a Search Warrant at the Respondent's medical practice. Respondent agreed to speak with the investigating officers, and his statement was digitally recorded. During this conversation, Respondent made the following admissions regarding a common scheme or plan to the one alleged in paragraphs 10 through 45 hereinabove:

a. Respondent has made arrangements with several individuals, besides R.S., who "represented" pain management patients in his practice for the purpose of obtaining prescriptions for controlled substances.

b. The patients who were represented, were brought to the Respondent's medical practice by the "representatives," being either friends or family of the "representatives." Occasionally, Respondent met with "representatives" and the patients they brought on days when his medical practice was closed.

c. Respondent's arrangement with such "representatives" and patients who were represented by them, allowed "representatives" to pick up his patients' controlled substance prescriptions, written by Respondent, after the "representatives" paid Respondent his patients' fees for the given office visit.

d. Respondent's arrangement with such "representatives" included occasions when the "representatives" picked up prescriptions for patients who were not present at the Respondent's office and were not examined by Respondent.

e. Respondent was made aware by some of his patients who were represented in the manner alleged herein, that the patients did not receive their medications or prescriptions from the "representatives" after Respondent had given these patients' prescriptions to the "representatives," and did not wish to be represented by these individuals. However, Respondent continued his arrangement with these "representatives" in his care and treatment of the remaining patients.

DISCIPLINE CONSIDERATIONS

82. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about August 23, 2007, in a prior disciplinary action, Medical

Board of California, Case Number 09-1998-90460, Respondent was issued a Public Letter of Reprimand, which states: "In a Decision adopted by the Division of Medical Quality of the Medical Board of California, it was found that you engaged in unprofessional conduct in the treatment and care of four patients. You failed to adequately and accurately document medical services provided to these four patients. This failure to maintain adequate records constitutes a violation of California Business and Professions Code section 2266. Pursuant to the authority of sections 495 and 2227 of the California Business and Professions Code, the Medial Board of California hereby issued a Public Reprimand in this matter and understands that this violation will not be repeated." The Decision that resulted in the Public Reprimand as alleged above is now final.

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 53967 issued to Respondent Terrill Eugene Brown, M.D.,

2. Revoking, suspending or denying approval of Terrill Eugene Brown, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Terrill Eugene Brown, M.D., if placed on probation, to pay the costs of probation monitoring;

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

DATED: March 29, 2013

LINDA K. WHITNEY
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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