

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.)
)

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.

MEDICAL BOARD OF CALIFORNIA

By: Kimberly Kirchmeyer
Kimberly Kirchmeyer
Interim Executive Director

1 KAMALA D. HARRIS
Attorney General of California
2 E.A. JONES III
Supervising Deputy Attorney General
3 VLADIMIR SHALKEVICH
Deputy Attorney General
4 State Bar No. 173955
California Department of Justice
5 300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
6 Telephone: (213) 897-2148
Facsimile: (213) 897-9395
7 *Attorneys for Complainant*

8 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
9 **DEPARTMENT OF CONSUMER AFFAIRS**
10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

12 **TERRILL BROWN, M.D.**
13 **5756 N. Marks Ave #161**
14 **Fresno, CA 93291**
Physician's and Surgeon's Certificate No.
G53967

15 Respondent.

Case No. 08-2010-211019

OAH No. 2013040542

STIPULATED SURRENDER OF
LICENSE AND ORDER

16
17 IT IS HEREBY STIPULATED AND AGREED by and between the parties in this
18 proceeding that the following matters are true:

19 PARTIES

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

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

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

1 was in full force and effect at the time of Respondent's acts alleged in the Accusation No. 08-
2 2010-211019, and will expire on September 30, 2013, unless renewed.

3 JURISDICTION

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

9 ADVISEMENT AND WAIVERS

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

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

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

23 CULPABILITY

24 8. Respondent does not contest that, at an administrative hearing, complainant could
25 establish a prima facie case with respect to the charges and allegations contained in Accusation
26 No. 08-2010-211019 and that he has thereby subjected his license to disciplinary action.
27 Respondent agrees that cause exists for discipline and hereby surrenders his Physician's and
28 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:

1 ORDER

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

5 1. The surrender of Respondent's Physician's and Surgeon's Certificate and the
6 acceptance of the surrendered license by the Board shall constitute the imposition of discipline
7 against Respondent. This stipulation constitutes a record of the discipline and shall become a part
8 of Respondent's license history with the Medical Board of California.

9 2. Respondent shall lose all rights and privileges as a Physician and Surgeon in
10 California as of the effective date of the Board's Decision and Order.

11 3. Respondent shall cause to be delivered to the Board his pocket license and, if one was
12 issued, his wall certificate on or before the effective date of the Decision and Order.

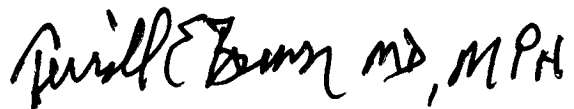
13 4. Respondent may file a petition for reinstatement two years after the effective date of
14 this Order. If Respondent ever files an application for licensure or a petition for reinstatement in
15 the State of California, the Board shall treat it as a petition for reinstatement. Respondent must
16 comply with all the laws, regulations and procedures for reinstatement of a revoked license in
17 effect at the time the petition is filed, and all of the charges and allegations contained in
18 Accusation No. 08-2010-211019 shall be deemed to be true, correct and admitted by Respondent
19 when the Board determines whether to grant or deny the petition.

20 ACCEPTANCE

21 I have carefully read the above Stipulated Surrender of License and Order and have fully
22 discussed it with my attorney, Alfred A. Gallegos. I understand the stipulation and the effect it
23 will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of
24 License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the
25 Decision and Order of the Medical Board of California.

26
27 DATED: _____

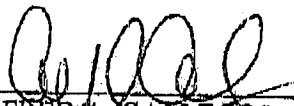
5/29/13



TERRILL BROWN, M.D.
Respondent

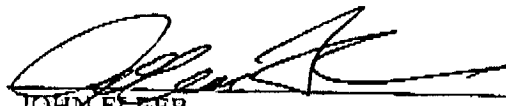
1 I have read and fully discussed with Respondent TERRILL BROWN, M.D. the terms and
2 conditions and other matters contained in this Stipulated Surrender of License and Order. I
3 approve its form and content.

4 DATED: 5/31/2013


ALFRED A. GALLEGOS
Attorney for Respondent

7 I have read and fully discussed with Respondent TERRILL BROWN, M.D. the terms and
8 conditions and other matters contained in this Stipulated Surrender of License and Order. I
9 approve its form and content.

10 DATED: 6-1-13


JOHN FLEER
Attorney for Respondent

12 ENDORSEMENT

13 The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted
14 for consideration by the Medical Board of California of the Department of Consumer Affairs.

15 Dated: 6-3-13

16 Respectfully submitted,

17 KAMALA D. HARRIS
18 Attorney General of California
19 E. A. JONES III
20 Supervising Deputy Attorney General


21 VLADIMIR SHALKEVICH
22 Deputy Attorney General
23 Attorneys for Complainant

24 LA2013607710
25 61005632.doc
26
27
28

Exhibit A

Accusation No. 08-2010-211019

1 KAMALA D. HARRIS
Attorney General of California
2 GLORIA L. CASTRO
Supervising Deputy Attorney General
3 VLADIMIR SHALKEVICH
Deputy Attorney General
4 State Bar No. 173955
300 So. Spring Street, Suite 1702
5 Los Angeles, CA 90013
Telephone: (213) 897-2148
6 Facsimile: (213) 897-9395
Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO MARCH 29, 2013
BY: J. Telchak ANALYST

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

In the Matter of the Accusation against:

Case No. 08-2010-211019

TERRILL EUGENE BROWN, M.D.
5706 W Elwin Dr.
Visalia, CA 93291-9282

OAH No. 2013020722

ACCUSATION

Physician and Surgeon's Certificate
No. G 53967

Respondent.

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.

///

///

///

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:

1 "(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the
2 violation of, or conspiring to violate any provision of this chapter.

3 "(b) Gross negligence.

4 "(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or
5 omissions. An initial negligent act or omission followed by a separate and distinct departure from
6 the applicable standard of care shall constitute repeated negligent acts.

7 "(1) An initial negligent diagnosis followed by an act or omission medically appropriate
8 for that negligent diagnosis of the patient shall constitute a single negligent act.

9 "(2) When the standard of care requires a change in the diagnosis, act, or omission that
10 constitutes the negligent act described in paragraph (1), including, but not limited to, a
11 reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the
12 applicable standard of care, each departure constitutes a separate and distinct breach of the
13 standard of care.

14 "(d) Incompetence.

15 "(e) The commission of any act involving dishonesty or corruption which is substantially
16 related to the qualifications, functions, or duties of a physician and surgeon.

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

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

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

26 ///

27 ///

1 6. Section 2242 of the Code states:

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

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

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

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

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

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

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

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

24 7. Section 2261 of the Code states:

25 "Knowingly making or signing any certificate or other document directly or indirectly
26 related to the practice of medicine or podiatry which falsely represents the existence or
27 nonexistence of a state of facts, constitutes unprofessional conduct."
28

1 8. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain
2 adequate and accurate records relating to the provision of services to their patients constitutes
3 unprofessional conduct."

4 **FIRST CAUSE FOR DISCIPLINE**
5 **(ILLEGAL PRESCRIBING)**

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

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

15 **UNDERCOVER OPERATION ON SEPTEMBER 22, 2011**

16 11. On September 22, 2011, the Medical Board of California conducted an undercover
17 operation at Respondent's office located at 5756 N. Marks Ave. #161 in Fresno California. The
18 undercover operative was a female Medical Board Investigator, who utilized an undercover
19 identity of a patient whose initials are R.S.¹ The undercover operation was digitally recorded.
20 During this undercover operation, Respondent personally collected \$200 cash and issued a
21 medical marijuana recommendation, together with a prescription for 180 10-325 Norco² tablets to
22 R.S. During the visit on September 22, 2011, Respondent did not review any medical records and
23 did not conduct any physical examination or R.S. whatsoever.

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

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

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21
- 22
- 23
- 24
- 25
- 26
- 27
- 28

2
3
4
5
6
7
8
9
10
11
12

13
14
15
16
17
18
19
20

21

22
23
24

25
26
27
28

1 15. During the January 31, 2012 visit, Respondent questioned R.S. about why he had
2 prescribed to her an "odd number" of oxycodone pills on her prior visit. She reminded him the
3 "odd number" was due to the 10 extra pills she had given to her friend. R.S. told Respondent that
4 she owed her friend again and asked about prescribing a higher dose tablets of oxycodone.
5 Respondent explained that he typically increases the number of pills he prescribes instead of
6 increasing the size or dosage of the pills. He told R.S. that he would "bump up" her quantity to
7 150 pills, and stated "I would be shocked if we didn't."

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

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

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

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

15 UNDERCOVER OPERATION ON MARCH 15, 2012

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

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

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

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

4 21. During the office visit on March 15, 2012, Respondent personally collected
5 \$280.00 cash and provided R.S. with a prescription for 180 30 mg instant release oxycodone.
6 Respondent never examined R.S., never inquired about whether prior prescriptions were
7 effective, and did not express concern that a portion of the controlled substance prescription he
8 was issuing was intended for another person. Respondent did not inquire whether R.S. was taking
9 the medications he prescribed to her and conducted no testing to ensure that R.S. was taking (as
10 opposed to diverting) the medications he prescribed to her. Nevertheless, Respondent increased
11 the number of oxycodone pills he was prescribing to R.S. from 150 to 180, for no medical reason
12 whatsoever. Respondent also issued a medical marijuana recommendation for T.B. without a
13 good faith prior examination, and without reviewing any prior medical records to establish that
14 T.B. was qualified for a medical marijuana recommendation. T.B. was not even present when
15 Respondent issued a medical marijuana recommendation for him.

16 UNDERCOVER OPERATION ON APRIL 12, 2012

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

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

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

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

7 25. R.S. then retrieved T.B.'s chart from the receptionist and brought it to the
8 Respondent. Respondent reviewed T.B.'s chart and threw away the note. He reminded R.S. that
9 T.B.'s fee for the visit was \$100.00 and her fee was \$80.00 Respondent personally collected
10 \$180.00 cash from R.S.

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

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

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

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

3 UNDERCOVER OPERATION ON MAY 14, 2012

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

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

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

19 32. R.S. handed \$200.00 cash to Respondent for her and T.B.'s prescription refills.
20 However, Respondent only accepted \$100.00. He explained he was upset she waited. He stated
21 he would normally charge \$60.00 each for a total of \$120.00 but was willing to accept only
22 \$100.00. She indicated she thought it was \$80.00 each patient. He stated the next time he saw
23 her he would accept "two of those" referring to the \$100 bills. He added that it was nice of her to
24 bring T.B.'s driver's license, but she did not need to bring it because he normally does not need to
25 see it. Respondent made the comment he believed T.B.'s prescription was at 180. He stated "If
26 he were below that I'm okay with this."

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

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

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

18 **UNDERCOVER OPERATION ON JUNE 14, 2012**

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

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

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

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

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

22 **UNDERCOVER OPERATION ON JULY 12, 2012**

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

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

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

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

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

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

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

25 46. Respondent violated Business and Professions Code section 2242 in that during
26 his care and treatment of R.S. and T.B. he never performed a medical examination of either one
27 of these patients. With respect to Respondent's care and treatment of T.B., he never even met the
28

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

3 **SECOND CAUSE FOR DISCIPLINE**

4 **(GROSS NEGLIGENCE)**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 **THIRD CAUSE FOR DISCIPLINE**

10 **(REPEATED NEGLIGENT ACTS)**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 **FOURTH CAUSE FOR DISCIPLINE**

16 **(FALSE MEDICAL RECORDS)**

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

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

22 **FIFTH CAUSE FOR DISCIPLINE**

23 **(CORRUPT OR DISHONEST ACTS)**

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

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

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

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

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

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

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

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

26 DISCIPLINE CONSIDERATIONS

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

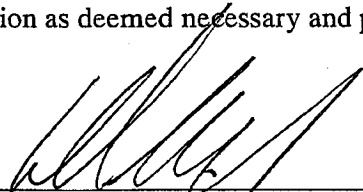
1 Board of California, Case Number 09-1998-90460, Respondent was issued a Public Letter of
2 Reprimand, which states: "In a Decision adopted by the Division of Medical Quality of the
3 Medical Board of California, it was found that you engaged in unprofessional conduct in the
4 treatment and care of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

11 PRAYER

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

- 14 1. Revoking or suspending Physician's and Surgeon's Certificate Number G 53967
15 issued to Respondent Terrill Eugene Brown, M.D.,
16 2. Revoking, suspending or denying approval of Terrill Eugene Brown, M.D.'s authority
17 to supervise physician assistants, pursuant to section 3527 of the Code;
18 3. Ordering Terrill Eugene Brown, M.D., if placed on probation, to pay the costs of
19 probation monitoring;
20 4. Taking such other and further action as deemed necessary and proper.

21
22 DATED: March 29, 2013

23 
24 LINDA K. WHITNEY
25 Executive Director
26 Medical Board of California
27 Department of Consumer Affairs
28 State of California
Complainant

LA2013607358
60971731.docx