

1 4. All admissions made by Respondent are solely for final disposition of this
2 matter and any subsequent related administrative proceedings or civil litigation involving
3 the Board and Respondent. Therefore, said admissions by Respondent are not intended
4 or made for any other use, such as in the context of another state or federal government
5 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or
6 any other state or federal court.

7 5. Respondent acknowledges and agrees that, although said Consent
8 Agreement and Order has not yet been accepted by the Board and issued by the
9 Executive Director, Respondent may not make any modifications to the document. Upon
10 signing this agreement, and returning this document (or a copy thereof) to the Board's
11 Executive Director, Respondent may not revoke acceptance of the Consent Agreement
12 and Order. Any modifications to this Consent Agreement and Order are ineffective and
13 void unless mutually approved by the parties.

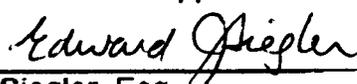
14 6. Respondent further understands that this Consent Agreement and Order,
15 once approved and signed, shall constitute a public record document that may be publicly
16 disseminated as a formal action of the Board.

17 7. If any part of the Consent Agreement and Order is later declared void or
18 otherwise unenforceable, the remainder of the Order in its entirety shall remain in force
19 and effect.

20
21 
22 _____
Hosea E. Brown, M.D.

Dated: 8/3/01

23 Reviewed and approved as to form by:

24 
25 _____
Ed Siegler, Esq.
(Counsel for Hosea E. Brown, M.D.)

Dated: 8/3/01

1 **FINDINGS OF FACT**

2 1. The Board is the duly constituted authority for the regulation and control of
3 the practice of allopathic medicine in the State of Arizona.

4 2. Hosea E. Brown, M.D. (Respondent) is the holder of license number 24719
5 for the practice of allopathic medicine in the State of Arizona.

6 3. The Board initiated case number MD-99-0890 upon receiving a complaint
7 from patient M.S. regarding Respondent's quality of care.

8 4. On March 25, 1998, Respondent saw patient M.S. at his office. Patient M.S.
9 complained of sinusitis, post nasal drip and wheezing. Respondent performed a complete
10 examination and scratch tests, which revealed significant positive reactions to airborne
11 allergens.

12 5. Respondent recommended allergy desensitization injections
13 (immunotherapy) on a weekly basis and to continue treatment for a year. Then patient
14 M.S. should be re-evaluated to determine if continued treatment was needed. Patient
15 M.S. continued the weekly immunotherapy for a year. There were no subsequent clinical
16 notes in the chart other than documentation of injections and there were no additional
17 visits with Respondent.

18 6. In September 1999, patient M.S. phoned Respondent's office to report her
19 dissatisfaction with the care and that she was not improving. Respondent, in a letter to the
20 Board dated December 26, 1999, stated that he invited patient M.S. to his office to review
21 her treatment and to discuss her concerns, but patient M. S. did not make an appointment.
22 Patient M. S.'s treatment was discontinued.

23 7. While investigating the complaint, Board staff discovered that Respondent
24 has three allergy clinics in Arizona and several clinics in California. Respondent informed
25 Board staff, in a February 21, 2001, telephone conversation, that he performs the initial

1 consultation, makes a recommendation, and allows medical assistants to administer
2 immunotherapy. Respondent further admitted that the medical assistants are not licensed
3 but are trained by him to perform duties in his absence, and that he is usually not at the
4 offices.

5 8. According to the American Academy of Allergy and Immunology, "...allergen
6 immunotherapy should be administered under the supervision of an appropriately trained
7 physician who can recognize early symptoms and signs of anaphylaxis and administer
8 emergency medications if necessary." Therefore, Respondent fell below the standard of
9 care in his failure to have a physician present when immunotherapy was administered.

10 CONCLUSIONS OF LAW

11 1. The Board possesses jurisdiction over the subject matter hereof and over
12 Hosea E. Brown, M.D.

13 2. The conduct and circumstances described above in paragraphs 4 to 8
14 constitute unprofessional conduct pursuant to A.R.S. § 32-1401(25)(q) (Any conduct or
15 practice which is or might be harmful or dangerous to the health of the patient or the
16 public).

17 ORDER

18 IT IS HEREBY ORDERED THAT:

19 1. Respondent is issued a Letter of Reprimand for the unprofessional conduct
20 described above.

21 2. Respondent is placed on probation for three (3) years with the following
22 terms and conditions:

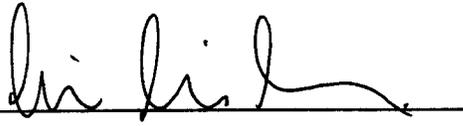
23 a. Immunotherapy shall not be administered at any clinics owned or
24 managed by Hosea E. Brown, M.D., in the State of Arizona, unless a licensed physician is
25 physically present at the time.

1 EXECUTED COPY of the foregoing mailed
2 this 20 day of August, 2001, to:

3 Edward Siegler, Esq.
4 11755 Wilshire Blvd., Ste. 1450
5 Los Angeles, CA 90025
6 (Attorney for Hosea E. Brown, M.D.)

7 EXECUTED COPY of the foregoing
8 hand-delivered to each of the following
9 this 20 day of August, 2001, to :

10 Christine Cassetta, Assistant Attorney General
11 Sandra Waitt, Management Analyst
12 Lynda Mottram, Compliance Officer
13 Arizona Board of Medical Examiners
14 9545 E. Doubletree Ranch Road
15 Scottsdale, AZ 85258

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