NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

BPMC No. 16-308

IN THE MATTER

OF

LAURAN BRYAN, M.D.

COMMISSIONER'S ORDER AND NOTICE OF HEARING

TO: LAURAN BRYAN, M.D.
[redacted]

LAURAN BRYAN, M.D.
Plastic and Reconstructive Surgery
27209 Lahser Road
Southfield, MI 48034

LAURAN BRYAN, M.D.
[redacted]

The undersigned, Howard A. Zucker, M.D., J.D., Commissioner of Health, pursuant to N.Y. Public Health Law §230, upon the recommendation of a Committee on Professional Medical Conduct of the State Board for Professional Medical Conduct, has determined that the duly authorized professional disciplinary agency of another jurisdiction, the State of Michigan, has made a finding substantially equivalent to a finding that the practice of medicine by **Lauran Bryan, M.D.**, Respondent, New York license number 181880, in that jurisdiction constitutes an imminent danger to the health of its people, as is more fully set forth in the Order of Summary Suspension, dated March 17, 2016, and the First Superseding Administrative Complaint, dated March 17, 2016, of the State of Michigan, Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing, Board of Medicine, Disciplinary Subcommittee, attached hereto as Appendix "A" and made a part hereof.

It is therefore:

ORDERED, pursuant to N.Y. Public Health Law §230(12)(b), that effective immediately, Respondent shall not practice medicine in the State of New York.

Any practice of medicine in the State of New York in violation of this (Commissioner's) Order shall constitute Professional Misconduct within the meaning of N.Y. Educ. Law §6530(29) and may constitute unauthorized medical practice, a Felony defined by N.Y. Educ. Law §6512.

This Order shall remain in effect until the final conclusion of a hearing which shall commence within thirty days after the final conclusion of the disciplinary proceeding in the predicate action. The hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230, and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on a date and at a location to be set forth in a written Notice of Summary Hearing to be provided to the Respondent after the final conclusion of the proceeding in the predicate action. Said written Notice may be provided in person, by mail, or by other means. If Respondent wishes to be provided said written notice at an address other than that set forth above, Respondent shall so notify, in writing, both the attorney whose name is set forth in this Order, and the Director of the Office of Professional Medical Conduct, at the addresses set forth below.

Respondent shall notify the Director of the Office of Professional Medical Conduct, New York State Department of Health, Riverview Center, 150 Broadway, Suite 355, Albany, New York 12204-2719 via Certified Mail, Return Receipt Requested, of the final conclusion of the proceeding in the predicate action, immediately upon such conclusion.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW §230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
September 7, 2016

[redacted]

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner,
for
Howard A. Zucker, M.D., J.D.
Commissioner of Health
New York State Health Department

Inquiries should be directed to:

Ian Silverman
Associate Counsel
Bureau of Professional Medical Conduct
Corning Tower – Room 2512
Empire State Plaza
Albany, NY 12237

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF PROFESSIONAL LICENSING
BOARD OF MEDICINE
DISCIPLINARY SUBCOMMITTEE

In the Matter of

LAURAN ANTHEA MAE BRYAN, M.D.
License Number: 43-01-058462

File Number: 43-15-136855
(Consolidated with File Number: 43-15-137303)

ORDER OF SUMMARY SUSPENSION

An Administrative Complaint has been filed against Respondent as provided by the Public Health Code, MCL 333.1101 *et seq*, the rules promulgated thereunder, and the Administrative Procedures Act, MCL 24.201 *et seq*.

After careful consideration of the documentation filed in this matter and after consultation with the Chairperson of the Board of Medicine pursuant to section 16233(5) of the Code, the Department finds that the public health, safety, or welfare requires emergency action.

Therefore, IT IS ORDERED that Respondent's license to practice medicine in the state of Michigan is SUMMARILY SUSPENDED, commencing the date this order is served.

Section 7311(6) of the Code provides that a controlled substance license is automatically void if a licensee's license to practice is suspended or revoked under Article 15 of the Code.

Under Mich Admin Code, R 792.10702, Respondent has the right to petition for the dissolution of this Order of Summary Suspension. This petition shall clearly state that it is a "Petition for Dissolution of Summary Suspension" and shall be filed with the Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing, P.O. Box 30670, Lansing, MI 48909.

MICHIGAN DEPARTMENT OF LICENSING
AND REGULATORY AFFAIRS

Dated: 2-17-16

By [redacted]
Kim Gaedeke, Director
Bureau of Professional Licensing

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF PROFESSIONAL LICENSING
BOARD OF MEDICINE
DISCIPLINARY SUBCOMMITTEE

In the Matter of

LAURAN ANTHEA MAE BRYAN, M.D. File Number: 43-15-136855
License Number: 43-01-058462 (Consolidated with File Number: 43-15-137303)

FIRST SUPERSEDING ADMINISTRATIVE COMPLAINT

The Michigan Department of Licensing and Regulatory Affairs (Complainant) by Kim Gaedeke, Director, Bureau of Professional Licensing, files this complaint against Lauran Anthea Mae Bryan, M.D. (Respondent) as follows:

1. The Michigan Board of Medicine is an administrative agency established by the Public Health Code, MCL 333.1101 *et seq*. Pursuant to section 16226 of the Code, the Board's Disciplinary Subcommittee is empowered to discipline licensees for violations of the Code.

2. Respondent is licensed to practice medicine in the state of Michigan and has a controlled substance license.

3. Section 16233(5) of the Code provides for the summary suspension of a license, reading in pertinent part, as follows:

> After consultation with the chair of the appropriate board or task force or his or her designee, the department may summarily suspend a license or registration if the public health, safety, or welfare

requires emergency action in accordance with section 92 of the administrative procedures act of 1969, MCL 24.292.

FACTUAL ALLEGATIONS

Medications

4. Hydrocodone is an opioid and a Schedule II controlled substance used to treat pain.

5. Oxycodone is an opioid and a Schedule II controlled substance used to treat pain.

6. Suboxone (buprenorphine and naloxone) is a Schedule III controlled substance used to treat opioid dependency.

Patient H.D.[1]

7. Between February 2011 and January 2015, Respondent authorized 153 hydrocodone prescriptions for patient H.D.

8. Between March 2011 and November 2012, Respondent authorized nine oxycodone prescriptions for patient H.D.

9. Between June 2011 and April 2012, Respondent authorized eight Suboxone prescriptions for patient H.D. to treat patient H.D.'s drug addiction.

[1] Initials are used to protect the patient's privacy.

10. Respondent did not possess the required Drug Enforcement Administration (DEA) license to prescribe Suboxone to treat drug addiction.

11. After a review of the relevant records, Complainant's retained medical expert opined that prescribing an individual Suboxone at the same time as opioids "makes no clinical sense" because the purpose of the Suboxone is to relieve a patient's urges for opioids.

Patient T.D.

12. T.D. was patient H.D.'s grandmother.

13. Between January 2013 and February 2015, Respondent authorized 39 hydrocodone prescriptions for T.D. although Respondent never met T.D.

14. Respondent provided T.D.'s prescriptions to patient H.D. knowing that patient H.D. would fill them for herself.

15. Respondent failed to create or maintain a medical record for T.D.

Patient K.D.

16. Patient K.D. was patient H.D.'s mother.

17. According to Respondent's medical records, Respondent saw patient K.D. only once (on October 11, 2012) for a cosmetic surgery consultation regarding scars.

18. Between January 2012 and October 2014, Respondent authorized 107 oxycodone prescriptions for patient K.D.

19. Respondent provided patient K.D.'s prescriptions to patient H.D. knowing that patient H.D. would fill them for herself.

Patient E.N.

20. E.N. was patient H.D.'s friend.

21. Between November 2012 and September 2014, Respondent authorized 55 hydrocodone prescriptions for E.N. although Respondent never met E.N.

22. Respondent provided E.N.'s prescriptions to patient H.D. knowing that patient H.D. would fill them for herself.

23. Respondent failed to create or maintain a medical record for E.N.

Patient R.P.

24. Patient R.P was patient H.D.'s friend.

25. According to Respondent's medical records, Respondent saw patient R.P. only once (on February 25, 2014) for a cosmetic surgery consultation regarding a scar.

26. Between October 2013 and February 2015, Respondent authorized 51 hydrocodone prescriptions for patient R.P.

27. Respondent provided patient R.P.'s prescriptions to patient H.D. knowing that patient H.D. would fill them for herself.

Patient F.L.

28. Patient F.L. is not affiliated with patient H.D.

29. Between January 2012 and November 2015, Respondent authorized at least 106 oxycodone prescriptions for patient F.L. (81 were filled in Michigan; 25 were filled in Illinois).

30. Respondent often authorized multiple controlled substance prescriptions on the same day for patient F.L.

31. For example, on January 5, 2015, Respondent authorized two prescriptions for 180 tablets of oxycodone 30 mg for patient F.L. Patient F.L. completely filled both prescriptions on January 11, 2015. One was filled in Michigan and the other was filled in Chicago, Illinois.

32. Respondent claimed she would authorize two prescriptions for the same controlled substance to patient F.L. on the same day because patient F.L. claimed that pharmacies did not have enough controlled substances to completely fill one of the

prescriptions. Respondent claimed that by issuing multiple prescriptions, patient F.L. could receive partial prescription fills at multiple pharmacies if necessary.

33. Respondent failed to obtain a Michigan Automated Prescription System (MAPS) report to determine whether patient F.L. was filling whole or partial prescriptions.

Respondent's DEA Registration

34. Respondent acknowledged to the DEA that patient H.D. would not be physically capable of consuming all of the controlled substances that Respondent prescribed for patient H.D., and agreed that diversion of those controlled substances was possible.

35. On December 4, 2015, Respondent surrendered her DEA Certificate of Registration. Respondent's surrender stated, in part:

> In view of my alleged failure to comply with the Federal requirements pertaining to controlled substances...I hereby voluntarily surrender my [DEA] Certificate of Registration...as evidence of my intent to relinquish my privilege to handle controlled substances...

36. Respondent's surrender was, in part, the result of Respondent's admissions to the DEA that she prescribed controlled substances for no legitimate medical purpose, including to the patients mentioned above.

Probation Violations

37. On August 30, 2012, Complainant executed an Administrative Complaint against Respondent based on allegations of Respondent's negligent operation of her cosmetic surgery practice, including storing medical supplies, biological material, and a used syringe in a break room refrigerator near her employees' food; reusing intravenous bags without proper sterilization; and storing patient body fat in a freezer with the intention of placing the fat back into a patient's body.

38. On June 27, 2014, after an administrative hearing, the Board's Disciplinary Subcommittee executed a Final Order which, in part, placed Respondent on probation for a minimum of two years with terms. The terms of Respondent's probation, in part, required that "Respondent's practice including inspection of Respondent's storing, refrigeration and use of intravenous bags and 'biohazard materials' shall be subject to [at least quarterly] random reviews by a member of the...Board...or a monitoring service designated by the Chairperson of the Board." In addition, the Final Order provided that Respondent must arrange the initial meeting with the reviewing board member or monitoring service. A copy of the Final Order, marked Exhibit A, is attached and incorporated.

39. The Final Order also provided that "Respondent shall comply with all applicable provisions of the Public Health Code" and that any violation of the Final Order may constitute grounds for further disciplinary action.

40. On July 9, 2014, the Chairperson of the Board designated Affiliated Monitors, Inc. (AMI) to conduct the inspections described above.

41. On July 10, 2014, Complainant notified Respondent that the Board Chairperson designated AMI to conduct the inspections and directed Respondent to contact AMI to arrange for monitoring.

42. On May 27, 2015, Complainant executed an Administrative Complaint against Respondent because, as of that date, Respondent had failed to arrange an initial meeting with AMI and had not undergone a quarterly inspection, contrary to the terms of the Final Order.

43. On July 9, 2015, Respondent retained AMI to conduct the inspections required by the Final Order.

44. On November 12, 2015, AMI conducted an inspection of Respondent's office and found issues related to the disposal of biohazardous waste, including:

a. two of three "sharps" containers were filled beyond the "full" level;

b. one sharps container lid was not properly secured; and

c. one of the sharps containers had items stacked on top of it, which blocked safe disposal of material into the container.

45. Respondent's failure to ensure proper disposal of biohazardous waste evidences a violation of the Code, which is a violation of the terms of the Final Order.

46. Respondent's failures to timely arrange an initial meeting with AMI or timely undergo her first quarterly inspection evidence violations of the Final Order.

47. Respondent's conduct after the date of the Final Order, including her controlled substance prescribing practices and failure to maintain adequate patient records, evidence violations of the Code, which are violations of the Final Order.

COUNT I

Respondent's conduct, as set forth above, evidences violations of general duty, consisting of negligence or failure to exercise due care, including negligent delegation to or supervision of employees or other individuals, whether or not injury results, in violation of section 16221(a) of the Code.

COUNT II

Respondent's conduct, as set forth above, evidences departures from, or failure to conform to, minimal standards of acceptable and prevailing practice for the health profession, whether or not actual injury to an individual occurs, in violation of section 16221(b)(i) of the Code.

COUNT III

Respondent's conduct, as set forth above, evidences a lack of good moral character, in violation of section 16221(b)(vi) of the Code.[2]

COUNT IV

Respondent's conduct, as set forth above, evidences obtaining, possessing, or attempting to obtain or possess a controlled substance or drug without lawful authority, or selling, prescribing, giving away, or administering drugs for other than lawful diagnostic or therapeutic purposes, in violation of section 16221(c)(iv) of the Code.

COUNT V

Respondent's conduct, as set forth above, evidences a violation of a final order issued by the Board's Disciplinary Subcommittee, contrary to Mich Admin Code, R 338.1632, in violation of section 16221(h) of the Code.

COUNT VI

Respondent's conduct, as set forth above, evidences a failure to keep and maintain a record for each patient for whom she has provided medical services, including a full and complete record of tests and examinations performed, observations made, and

[2] "Good moral character" is defined as "the propensity on the part of the person to serve the public in the licensed area in a fair, honest and open manner." MCL 338.41(1).

treatments provided, contrary to section 16213(1) of the Code, supra, in violation of section 16221(h) of the Code.

The Administrative Complaint previously filed against Respondent on May 27, 2015 is withdrawn and replaced in full by this First Superseding Administrative Complaint.

After consultation with the chairperson of the Board or his or her designee pursuant to section 16233(5) of the Code, Complainant states that the public health, safety, and welfare requires emergency action and, accordingly, Respondent's license to practice medicine in the state of Michigan is summarily suspended, pending a hearing and final determination of this matter.

Pursuant to section 16231(8) of the Code, Respondent has 30 days from the date of receipt of this complaint to submit a written response to the allegations contained in this complaint. The written response shall be submitted to the Bureau of Professional Licensing, Department of Licensing and Regulatory Affairs, P.O. Box 30670, Lansing, MI 48909.

Pursuant to section 16231(9) of the Code, Respondent's failure to submit a written response within 30 days shall be treated as an admission of the allegations contained in the complaint and shall result in transmittal of this complaint directly to the Board's Disciplinary Subcommittee for imposition of an appropriate sanction.

[redacted]

Kim Gaedeke, Director
Bureau of Professional Licensing

Dated: 5-17-16