BEFORE THE
NORTH CAROLINA MEDICAL BOARD

In re:	)	
	)	NOTICE OF CHARGES
Lawrence Anthony Dunn, M.D.,	)	AND ALLEGATIONS;
	)	NOTICE OF HEARING
Respondent.	)	

The North Carolina Medical Board ("Board") has preferred and does hereby prefer the following charges and allegations:

1. The Board is a body duly organized under the laws of North Carolina and is the proper party to bring this proceeding under the authority granted it in Article 1 of Chapter 90 of the North Carolina General Statutes.

2. Respondent, Lawrence Anthony Dunn, M.D. ("Dr. Dunn"), is a physician licensed by the Board on or about May 3, 1986, license number 30018.

3. During the times relevant herein, Dr. Dunn practiced medicine in Durham, North Carolina, as a psychiatrist and pain management specialist.

4. Between approximately January 1999 and June 2009, Dr. Dunn treated seven patients identified herein as Patients A through G.

FIRST CLAIM – PATIENT A

5. Paragraphs one through four are re-alleged and incorporated herein by reference.

6. In relevant part, Dr. Dunn treated Patient A between November 2005 and January 2008.

7. Patient A was 42 years old when he started care with Dr. Dunn. Patient A had chronic pain related to a back injury as well as a psychiatric illness. Dr. Dunn diagnosed Patient A with major depressive disorder and prescribed medications that included included methadone for pain management as well as ziprasidone for treating depression and anxiety.

8. By July of 2006, a pattern of falls became evident with Patient A. The tranquilizer diazepam had been added and increased to 50 mg per day at this time. Patient A was to have surgery later that year, but it was delayed because of excessively high opiate dosing and coordination of care was not initiated with Patient A's other providers. Withdrawal symptoms and behavioral problems regarding Patient A were also noted during this timeframe.

9. In January 2007, Dr. Dunn prescribed an inappropriate combination of medications for panic consisting of buspirone (a benzodiazepine anti-anxiety drug) and ziprasidone.

10. Patient A was involved in a motor vehicle accident in June 2007 while on three benzodiazepines and opiate drugs prescribed by Dr. Dunn. Hydrochlorothiazide (a water pill) was prescribed for edema (swelling due to fluid in the body), but Dr. Dunn did not perform any laboratory studies or blood

pressure checks. Later that month, Patient A referred himself to inpatient treatment for substance abuse.

11. Despite Patient A's history, he continued to request highly abusable medications and Dr. Dunn continued to prescribe them to Patient A. By October 2007, Patient A was living in a truck. By late November 2007, Dr. Dunn began to suspect opiate seeking behavior by Patient A.

12. It is also believed that Dr. Dunn billed for face to face patient treatment of Patient A on several occasions when the treatment consisted of telephone consultations.

13. With regard to Patient A, Dr. Dunn engaged in unprofessional conduct including, but not limited to, departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession within the meaning of N.C. Gen. Stat. § 90-14(a)(6), which is grounds for the Board to annul, suspend, revoke, condition or limit Dr. Dunn's license to practice medicine and surgery issued by the Board based on the following:

a. Dr. Dunn failed to prescribe medications to Patient A based on rationale supported by scientific principles;

b. Dr. Dunn failed to monitor Patient A for adverse medication reactions and discontinue use of such medications when they became ineffective or were a risk to Patient A;

c. Dr. Dunn failed to obtain an appropriate history, physical examination and laboratory work before initiating treatment on Patient A;

d. Dr. Dunn failed to appropriately coordinate care of Patient A with other health care professionals;

e. Dr. Dunn failed to provide heightened care when prescribing potentially addictive drugs to Patient A after he completed a substance abuse program;

f. Dr. Dunn failed to refer Patient A for a second medical opinion or inpatient hospitalization when his treatment became ineffective or posed a risk of harm to Patient A;

g. Dr. Dunn failed to employ proper billing codes when treating Patient A; and

h. Dr. Dunn continued escalating dosages of medication for Patient A despite questionable improvement of symptoms or function.

SECOND CLAIM - PATIENT B

14. Paragraphs one through thirteen are re-alleged and incorporated herein by reference.

15. In relevant part, Dr. Dunn treated Patient B from the mid 1990s to on or about May 2009. Patient B was 56 years old when he started treatment with Dr. Dunn. Patient B had chronic pain related to a shoulder injury as well as a psychiatric illness. Dr. Dunn diagnosed bipolar disease. Dr. Dunn also prescribed several medications during his treatment with Patient B including diazepam, Levitra® (vardenafil) (an erectile dysfunction drug), Cialis® (Tadalafil) (an erectile dysfunction drug), nortriptyline (an antidepressant) and ziprasidone.

16. By 1999, Dr. Dunn became aware of Patient B's abnormal opiate use. In 2002, Dr. Dunn was informed by Patient B's girlfriend that Patient B needed more supervision in the care that Dr. Dunn was providing. Throughout Patient B's treatment with Dr. Dunn, there are a number of phone appointments that are substituted for office appointments and are poorly explained.

17. Many of the drugs that Dr. Dunn prescribed for Patient B were not consistent with treating bipolar disease. Patient B displayed a pattern of urgent appointments, lost prescriptions and motor vehicle accidents that indicated problems with Dr. Dunn's treatment plan.

18. In June 2006, Patient B required inpatient care and analgesics were reduced. However, these medications were increased by Dr. Dunn after discharge.

19. On many instances, the CPT billing codes that Dr. Dunn utilized did not correlate with Patient B's clinical notes.

20. With regard to Patient B, Dr. Dunn engaged in unprofessional conduct including, but not limited to, departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession within the meaning of N.C. Gen. Stat. § 90-14(a)(6), which is grounds for the Board to annul, suspend, revoke, condition or limit Dr. Dunn's license to practice medicine and surgery issued by the Board based on the following:

a. Dr. Dunn failed to obtain a comprehensive history to make and document a diagnosis and provide therapy consistent with the obtained diagnosis and practice guidelines;

b. Dr. Dunn utilized phone conferences as a substitute for in person treatment;

c. Dr. Dunn failed to properly assess Patient B's psychosocial variables and amend Patient B's treatment plan;

d. Dr. Dunn failed to obtain a second opinion or refer Patient B for hospitalization in the face of abnormal prescription behavior by Patient B; and

e. Dr. Dunn failed to appropriately coordinate care with other health care providers.

THIRD CLAIM - PATIENT C

21. Paragraphs one through twenty are re-alleged and incorporated herein by reference.

22. In relevant part, Dr. Dunn treated Patient C from approximately March 2006 until April 2009. Patient C was a 38 year old female when she started treating with Dr. Dunn for chronic nonmalignant pain and psychiatric illness. Dr. Dunn diagnosed generalized anxiety disorder, major depressive disorder and chronic pain. Patient C also had a history of alcohol abuse and possible diazepam abuse.

23. Although aware of Patient C's active alcohol use, Dr. Dunn prescribed diazepam. Buspirone was later added despite the lack of demonstrated efficacy in this clinical situation. In April 2006, a fentanyl patch was prescribed for pain in the absence of any stabilization on oral opiates. This was escalated within several weeks to changing the fentanyl patch every two days, which is not consistent with accepted practice

or package labeling. One month later, the diet drug phentermine was added at Patient C's request and in the absence of a weight reduction program. By November 2007, oxycodone was added.

24. Patient C's primary care physician had prescribed Concerta® (Methylphenidate) and Adderall® (amphetamine and dextroamphetamine) in addition to alprazolam between August and December 2007. Dr. Dunn was either unaware or uninformed regarding these concurrent prescriptions and did not appropriately coordinate care with Patient C's primary care physician. Dr. Dunn also failed to have Patient C execute a pain contract and did not perform any urine testing.

25. With regard to Patient C, Dr. Dunn engaged in unprofessional conduct including, but not limited to, departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession within the meaning of N.C. Gen. Stat. § 90-14(a)(6), which is grounds for the Board to annul, suspend, revoke, condition or limit Dr. Dunn's license to practice medicine and surgery issued by the Board based on the following:

a. Dr. Dunn should have referred Patient C for treatment for substance abuse;

b. Dr. Dunn failed to adhere to accepted medical practice regarding his prescription of fentanyl

patches or demonstrate a need to depart from such practice and obtain Patient's C's informed consent in doing so;

c. Dr. Dunn failed to coordinate care with other providers, especially when a substance abuse disorder was possible; and

d. Dr. Dunn failed to perform an appropriate physical examination.

FOURTH CLAIM - PATIENT D

26. Paragraphs one through twenty-five are re-alleged and incorporated herein by reference.

27. In relevant part, Dr. Dunn treated Patient D from approximately January 2005 to September 2008. Patient D was a 62 year old male when he first treated with Dr. Dunn for complex nonmalignant pain with psychiatric illness. Dr. Dunn's diagnosis included chronic pain, opiate dependence, post traumatic stress disorder ("PTSD"), major depressive disorder and personality disorder.

28. There is no intake examination in Dr. Dunn's records for Patient D. At one time, Patient D requested Marinol® (Dronabinol) and Cialis® in the presence of severe pain complaints. Patient D's activity self-report was not consistent with his pain disorder. Patient D was also non-compliant with

laboratory requests and a referral to a Veteran's Administration hospital for PTSD treatment. In January of 2006, Patient D complained of severe depression, but there was no change in his treatment plan, appropriate referral or inpatient recommendation made by Dr. Dunn. In March 2006, Patient D's methadone was increased at Patient D's request without proper evaluation or medical need for this. In September 2007, a second medical opinion was obtained for Patient D (not at Dr. Dunn's request) that strongly suggested abnormal behavior on Patient D's part and opiate diversion.

29. With regard to Patient D, Dr. Dunn engaged in unprofessional conduct including, but not limited to, departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession within the meaning of N.C. Gen. Stat. § 90-14(a)(6), which is grounds for the Board to annul, suspend, revoke, condition or limit Dr. Dunn's license to practice medicine and surgery issued by the Board based on the following:

a. Dr. Dunn failed to obtain and document a history and examination prior to embarking on care of Patient D;

b. Dr. Dunn failed to assess the validity of Patient D's self-reports prior to amending his treatment plan;

c. Dr. Dunn failed to assess Patient D's therapeutic relationship in the context on his non-adherence to referrals and laboratory requests;

d. Dr. Dunn failed to obtain a second opinion for Patient D or refer Patient D for hospitalization when opiate diversion was highly likely;

e. Dr. Dunn failed to revise his treatment plan in the face of Patient D's non-compliance;

f. Dr. Dunn failed to increase frequency of outpatient appointments and reduce the size of prescription refills when opiate misuse was a concern with Patient D;

g. Dr. Dunn failed to perform appropriate pharmokinetic studies when exceptionally high medication doses appeared to be required to treat Patient D, rather than assume rapid metabolizer status was present, in the context of suspected medication abuse;

h. Dr. Dunn prescribed an inappropriate escalation of opioids for Patient D; and

i. Dr. Dunn continued treatment of Patient D despite questionable improvement of symptoms or function with escalation of medication.

FIFTH CLAIM – PATIENT E

30. Paragraphs one through twenty-nine are re-alleged and incorporated herein by reference.

31. In relevant part, Dr. Dunn treated Patient E from the mid 1990s to December 2007. Patient E was a male in his forties when he first started treating with Dr. Dunn for chronic pain in the setting of metastatic lung cancer. Dr. Dunn diagnosed a major depressive disorder, PTSD, anxiety and chronic pain. Dr. Dunn also noted facial trauma from a fall in 1985, Hepatitis C, bradycardia, hypersplenism with thrombocytopenia and a C7 fracture following a 2006 motor vehicle accident. Dr. Dunn treated Patient E with multiple opiates and diazepam.

32. Patient E was a drug seeker and had been ordered by a Court to attend a substance abuse treatment program following a driving under the influence of alcohol arrest. The Drug Enforcement Agency also investigated Patient E in 1999 related to obtaining multiple prescriptions for opiates and diazepam from multiple healthcare providers. Dr. Dunn was aware of this in 1999.

33. Patient E was admitted to a hospital in May 2006 with suspected opiate withdrawal. In December 2007, Patient E was again hospitalized in a deliriform state and discharged to hospice care.

34. With regard to Patient E, Dr. Dunn engaged in unprofessional conduct including, but not limited to, departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession within the meaning of N.C. Gen. Stat. § 90-14(a)(6), which is grounds for the Board to annul, suspend, revoke, condition or limit Dr. Dunn's license to practice medicine and surgery issued by the Board based on the following:

a. Dr. Dunn failed to maintain internally consistent, accurate and complete clinical notes;

b. Dr. Dunn failed to submit bills consistent with the care documented and provided;

c. Dr. Dunn failed to maintain a heightened sense of awareness when treating Patient E in light of his substance abuse history;

d. Dr. Dunn failed to obtain a second opinion or refer Patient E for hospitalization in the context of Patient E's treatment course;

e. Dr. Dunn failed to coordinate his care of Patient E with other providers;

f. Dr. Dunn failed to minimize the number of medications prescribed to Patient E; and

g. Dr. Dunn continued treatment of Patient E despite questionable improvement of symptoms or function with escalation of medication.

SIXTH CLAIM – PATIENT F

35. Paragraphs one through thirty-four are re-alleged and incorporated herein by reference.

36. In relevant part, Dr. Dunn treated Patient F from November 2005 to November 2007. Patient F was a 42 year old male who started care with Dr. Dunn for chronic complex nonmalignant pain and psychiatric illness. Dr. Dunn diagnosed chronic pain syndrome.

37. Dr. Dunn's treatment of Patient F included high doses of opiate medications and abnormal methadone prescriptions. Patient F also had a questionable manic episode in June 2006 and Dr. Dunn did not document these symptoms or develop a treatment plan to address this episode. Dr. Dunn continued to prescribe multiple medications for symptomatic control of nonspecific symptoms in the absence of reasonable clinical assessment for Patient F.

38. In February 2007, Dr. Dunn was notified by a pharmacy that Patient F's reports to him concerning prescription issues were not valid. In November 2007, Patient F's sister informed Dr. Dunn of Patient F's misuse of drugs and diversion concerns.

39. With regard to Patient F, Dr. Dunn engaged in unprofessional conduct including, but not limited to, departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession within the meaning of N.C. Gen. Stat. § 90-14(a)(6), which is grounds for the Board to annul, suspend, revoke, condition or limit Dr. Dunn's license to practice medicine and surgery issued by the Board based on the following:

a. Dr. Dunn failed to establish collaborative relationships with other providers to clarify Patient F's diagnoses and anticipated treatment course;

b. Dr. Dunn failed to obtain an appropriate history, physical and laboratory work before initiating treatment and changing the treatment plan on Patient F;

c. Dr. Dunn failed to accurately record medications provided and document their intended use;

d. Dr. Dunn failed to perform appropriate pharmokinetic studies when atypical metabolic patterns were suspected;

e. Dr. Dunn failed to employ appropriate billing when family members were seen in place of Patient F;

f. Dr. Dunn failed to minimize the number of medications prescribed; and

g. Dr. Dunn failed to increase the frequency of outpatient appointments and reduce the size of prescription refills when opiate misuse was a concern.

SEVENTH CLAIM – PATIENT G

40. Paragraphs one through thirty-nine are re-alleged and incorporated herein by reference.

41. In relevant part, Dr. Dunn treated Patient G from July 2006 to June 2009. Patient G was a 42 year old male when he first saw Dr. Dunn for chronic pain due to a work-related left shoulder injury and depression. Dr. Dunn diagnosed major depressive disorder and noted left shoulder repair.

42. Dr. Dunn accepted treatment of Patient G from another provider. Once Dr. Dunn's treatment started, there was a rapid escalation of opiate analgesic prescriptions including Dilaudid®

(hydromorphone), methadone, oxycontin and a fentanyl patch. By March 2007, Dr. Dunn had effectively assumed the role of Patient G's primary care provider and prescribed hormone replacement therapy for presumptive testosterone deficiency based on Patient G's history alone. Opiate misuse was suspected, but not acted upon. Dr. Dunn's treatment primarily focused on Patient G's pain and paid insufficient attention to Patient G's psychiatric illness.

43. With regard to Patient F, Dr. Dunn engaged in unprofessional conduct including, but not limited to, departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession within the meaning of N.C. Gen. Stat. § 90-14(a)(6), which is grounds for the Board to annul, suspend, revoke, condition or limit Dr. Dunn's license to practice medicine and surgery issued by the Board based on the following:

a. Dr. Dunn failed to obtain a urologic history, screen for sleep apnea, perform a physical examination (including a prostate exam) and obtain appropriate tests prior to prescribing testosterone replacement therapy for Patient G. Dr. Dunn also failed to refer Patient G to an

appropriate generalist or endocrine specialist for assessment and management;

b. Dr. Dunn failed to appropriately provide and document treatment for depressive disorder along with pain management;

c. Dr. Dunn failed to assess, or refer for proper assessment, an unexplained increase in pain in Patient G;

d. Dr. Dunn failed to properly record all services rendered to Patient G in his progress notes;

e. Dr. Dunn failed to coordinate Patient G's care with other healthcare providers to secure a diagnosis of the etiology of pain syndrome;

f. Dr. Dunn failed to refer Patient G for a second opinion or inpatient hospitalization along with medication limit setting when opiate abuse was suspected;

g. Dr. Dunn failed to maintain consistent charting regarding Patient G's symptoms, treatment plan and medications prescribed;

h. Dr. Dunn failed to minimize the number of medications prescribed to Patient G; and

i. Dr. Dunn failed to increase the frequency of outpatient appointments and reduce the size of prescription refills to Patient G when opiate misuse became a concern.

NOTICE TO DR. DUNN

Pursuant to N.C. Gen. Stat. § 90-14.2, it is hereby ordered that a hearing on the foregoing Notice of Charges and Allegations will be held before the Board, or a panel thereof, at 8:00 a.m., Wednesday, February 17, 2010, or as soon thereafter as the Board or a panel thereof may hear it, at the offices of the Board at 1203 Front Street, Raleigh, North Carolina, to continue until completed. The hearing will be held pursuant to N.C. Gen. Stat. § 150B-40, 41, and 42 and N.C. Gen. Stat. § 90-14.2, 14.4, 14.5 and 14.6. You may appear personally and through counsel, may cross-examine witnesses and present evidence in your own behalf.

You may, if you desire, file written answers to the charges and complaints preferred against you within 30 days after the service of this notice.

The identities of Patients A through G are being withheld from public disclosure pursuant to N.C. Gen. Stat. § 90-8. However, this information will be provided to you upon your request.

Pursuant to N.C. Gen. Stat. § 150B-40(c)(5), it is further ordered that the parties shall arrange a pre-hearing conference at which they shall prepare and sign a stipulation on pre-hearing conference. The pre-hearing stipulation shall be submitted to the undersigned no later than seven days prior to the hearing date.

The right to be present during the hearing of this case, including any such right conferred or implied by N.C. Gen. Stat. § 150B-40(d), shall be deemed waived by a party or his counsel by voluntary absence from the Board's office at a time when it is known that proceedings, including deliberations, are being conducted, or are about to be conducted. In such event, the proceedings, including additional proceedings after the Board has retired to deliberate, may go forward without waiting for the arrival or return of counsel or a party.

This the 4th day of September, 2009.

NORTH CAROLINA MEDICAL BOARD

By: G Saunders MD
George L. Saunders, III, M.D.
President

BEFORE THE
NORTH CAROLINA MEDICAL BOARD

In re:	)	
	)	
Lawrence Anthony Dunn, M.D.,	)	AFFIDAVIT OF SERVICE
	)	
Respondent.	)	

Patrick F. Balestrieri first being duly sworn, deposes and says as follows:

1. That a copy of the Notice of Charges and Allegations; Notice of Hearing in the above-captioned contested case was deposited in the post office for mailing to Respondent by certified mail.

2. That it was in fact received as evidenced by the attached copy of the Delivery Notice/Reminder/Receipt (PS Form 3811).

Patrick F. Balestrieri

Sworn to and subscribed before me,
this the 10th day of September, 2009.

Diana A. Edwards
Notary Public

(Seal)

My Commission expires: 11-14-09

SENDER: *COMPLETE THIS SECTION*

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to: Legal - NOC. Disc. PB - LE

LAWRENCE A DUNN MD
[redacted]

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by *(Printed Name)*

C. Date of Delivery 9-5-09

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2 Article Number
7008 3230 0001 9649 8378

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

BEFORE THE
NORTH CAROLINA MEDICAL BOARD

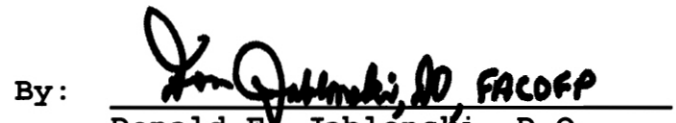
In re:	)	
	)	
Lawrence Anthony Dunn, M.D.,	)	ORDER
	)	
Respondent.	)	

This matter is before the undersigned President of the North Carolina Medical Board ("Board") regarding the hearing scheduled for February 17, 2010, in the above-captioned case. Upon consideration of the parties' motion for a continuance, I hereby enter the following ORDER:

The hearing scheduled for February 17, 2010, is continued and shall be heard at 8:00 a.m. on April 15, 2010, or as soon thereafter as the Board or a panel thereof may hear it.

This the 25th day of January, 2010.

NORTH CAROLINA MEDICAL BOARD

By: 

Donald E. Jablonski, D.O.
President

CERTIFICATE OF SERVICE

I, the undersigned counsel for the North Carolina Medical Board, hereby certify that I have served a copy of the foregoing ORDER by depositing a copy with the United States Postal Service pursuant to N.C. Gen. Stat. § 90-14.3, to Respondent's attorney at the following address:

Robert M. Clay
Attorney at Law
Young Moore & Henderson, P.A.
P.O. Box 31627
Raleigh, NC 27622

This the 25th day of January, 2010.

Patrick F. Balestrieri
Board Attorney
North Carolina Medical Board
P.O. Box 20007
Raleigh, NC 27609
919.326.1109, ext. 225

BEFORE THE
NORTH CAROLINA MEDICAL BOARD

In re:	)	
	)	
Appointment of Hearing Officers	)	ORDER
	)	

Pursuant to N.C. Gen. Stat. Section 90-14.5, the undersigned President of the North Carolina Medical Board hereby appoints the following Hearing Officers to hear the cases below which have been noticed for hearing beginning 8:00 a.m., April 15, 2010, at the offices of the NC Medical Board, 1203 Front Street, Raleigh, NC:

In re: Lawrence Anthony Dunn, M.D.

Mr. John B. Lewis, LLB, Presiding Officer
Ralph C. Loomis, MD, Board Member
Thomas R. Hill, MD, Board Member
Peggy R. Robinson, PA-C, Board Member

In re: Donald Brooks Reece, II, M.D.

Donald E. Jablonski, DO, Presiding Officer
Paul S. Camnitz, MD, Board Member
Ms. Pamela L. Blizzard, Board Member

This the 9th day of April, 2010.

NORTH CAROLINA MEDICAL BOARD

Donald E Jablonski, DO, FACOFP

By: _____
Donald E. Jablonski, DO
President

BEFORE THE
NORTH CAROLINA MEDICAL BOARD

In re:	)	
	)	
Lawrence Anthony Dunn, M.D.,	)	RECOMMENDED DECISION
	)	
Respondent.	)	

This matter was heard by a panel ("the Panel") of the North Carolina Medical Board ("Board") on April 15, 2010, and April 16, 2010. Panel members were The Honorable John B. Lewis, Jr., LLB, Board Member and Presiding Officer, Peggy Robinson, PA-C, Board Member, Thomas R. Hill, M.D., Board Member and Ralph C. Loomis, M.D., Board Member. Patrick F. Balestrieri represented the Board. Robert M. Clay and Joseph W. Williford represented Lawrence Anthony Dunn, M.D. ("Dr. Dunn").

The panel considered the pleadings, testimony of witnesses, exhibits and arguments of counsel.

Based upon the evidence presented and the arguments of counsel, the Panel enters the following Recommended Decision:

Findings of Fact

1. The Board is a body duly organized under the laws of North Carolina and is the proper party to bring this proceeding under the authority granted it in Article 1 of Chapter 90 of the North Carolina General Statutes.

2. Respondent, Dr. Dunn, is a physician licensed by the Board on or about May 3, 1986, license number 30018.

3. During the times relevant herein, Dr. Dunn practiced psychiatry and pain management in Durham, North Carolina.

4. Dr. Dunn treated Patients A through G for psychiatric conditions and chronic pain. The Board's reviewing experts concluded that Dr. Dunn's care of Patients A through G was below the standard of care in several respects.

5. With regard to Patient A:

a. Dr. Dunn failed to prescribe medications to Patient A based on rationale supported by scientific principles;

b. Dr. Dunn failed to obtain and document an appropriate history, physical examination and laboratory work on Patient A;

c. Dr. Dunn failed to appropriately coordinate care of Patient A with other health care professionals;

d. Dr. Dunn failed to provide heightened care and appropriate pharmacovigilance to Patient A when prescribing drugs that have a high abuse and diversion potential;

e. Dr. Dunn failed to refer Patient A for a second medical opinion or inpatient hospitalization when his treatment became ineffective or posed a risk of harm to Patient A; and

f. Dr. Dunn continued escalating dosages of medication for Patient A despite questionable improvement of symptoms or function.

6. With regard to Patient B:

a. Dr. Dunn failed to perform and document an appropriate physical examination;

b. Dr. Dunn failed to provide heightened care and appropriate pharmacovigilance to Patient B when prescribing drugs that have a high abuse and diversion potential;

c. Dr. Dunn inappropriately utilized phone conferences as a substitute for in person treatment;

d. Dr. Dunn failed to obtain a second opinion or refer Patient B for hospitalization in the face of abnormal prescription behavior by Patient B; and

e. Dr. Dunn failed to appropriately coordinate care with other health care providers.

7. With regard to Patient C:

a. Dr. Dunn failed to timely refer Patient C for treatment for substance abuse;

b. Dr. Dunn failed to coordinate care with other providers;

c. Dr. Dunn failed to perform and document an appropriate physical examination on Patient C; and

d. Dr. Dunn failed to provide heightened care and appropriate pharmacovigilance to Patient C when prescribing drugs that have a high abuse and diversion potential.

8. With regard to Patient D:

a. Dr. Dunn failed to obtain and document an appropriate history and physical examination of Patient D;

b. Dr. Dunn failed to obtain a second opinion for Patient D or refer Patient D for hospitalization when opiate diversion was highly likely;

c. Dr. Dunn failed to revise his treatment plan in the face of Patient D's non-compliance;

d. Dr. Dunn failed to increase frequency of outpatient appointments and reduce the size of prescription refills when opiate misuse was a concern with Patient D;

e. Dr. Dunn failed to perform appropriate pharmokinetic studies when exceptionally high medication doses were used to treat Patient D, rather than assume rapid metabolizer status was present, in the context of suspected medication abuse;

f. Dr. Dunn prescribed an inappropriate escalation of opioids for Patient D;

g. Dr. Dunn continued treatment of Patient D despite questionable improvement of symptoms or function with escalation of medication; and

h. Dr. Dunn failed to provide heightened care and appropriate pharmacovigilance when prescribing drugs to Patient D that have a high abuse and diversion potential.

9. With regard to Patient E:

a. Dr. Dunn failed to provide heightened care and appropriate pharmacovigilance when prescribing drugs to Patient E that have a high abuse and diversion potential.

b. Dr. Dunn failed to maintain a heightened sense of awareness when treating Patient E in light of his substance abuse history;

c. Dr. Dunn failed to obtain a second opinion or refer Patient E for hospitalization in the context of Patient E's treatment course;

d. Dr. Dunn failed to coordinate his care of Patient E with other providers;

e. Dr. Dunn failed to minimize the number of medications prescribed to Patient E; and

f. Dr. Dunn continued treatment of Patient E despite questionable improvement of symptoms or function with escalation of medication.

10. With regard to Patient F:

a. Dr. Dunn failed to provide heightened care and appropriate pharmacovigilance when prescribing drugs to Patient F that have a high abuse and diversion potential;

b. Dr. Dunn failed to establish collaborative relationships with other providers to clarify Patient F's diagnoses and anticipated treatment course;

c. Dr. Dunn failed to obtain and document an appropriate history, physical examination and laboratory work on Patient F;

d. Dr. Dunn failed to perform appropriate pharmokinetic studies when atypical metabolic patterns were suspected;

e. Dr. Dunn failed to minimize the number of medications prescribed; and

f. Dr. Dunn failed to increase the frequency of outpatient appointments and reduce the size of prescription refills when opiate misuse was a concern.

11. With regard to Patient G:

a. Dr. Dunn failed to provide heightened care and appropriate pharmacovigilance when prescribing drugs to Patient G that have a high abuse and diversion potential;

b. Dr. Dunn failed to obtain a urologic history, perform a physical examination (including a prostate exam) and obtain appropriate tests and screening prior to prescribing testosterone replacement therapy for Patient G. Dr. Dunn also failed to refer Patient G to an appropriate generalist or endocrine specialist for assessment and management;

c. Dr. Dunn failed to appropriately provide and document treatment for depressive disorder along with pain management;

d. Dr. Dunn failed to assess, or refer for proper assessment, an unexplained increase in pain in Patient G;

e. Dr. Dunn failed to coordinate Patient G's care with other healthcare providers to secure a diagnosis of the etiology of pain syndrome;

f. Dr. Dunn failed to refer Patient G for a second opinion or inpatient hospitalization along with medication limit setting when opiate abuse was suspected; and

g. Dr. Dunn failed to minimize the number of medications prescribed to Patient G.

12. Three witnesses testified for the Board. The first witness, a Board certified psychiatrist licensed to practice medicine in North Carolina, testified regarding whether Dr. Dunn's care of Patients A through G met the standard of care in North Carolina. The second witness, a Board certified psychiatrist and internal medicine specialist licensed to practice medicine in North Carolina, testified regarding whether Dr. Dunn's care of Patients A through G met the standard of care in North Carolina. The third witness, a Board certified anesthesiologist with pain management certification and licensed to practice medicine in North Carolina, testified regarding whether Dr. Dunn's care of Patients A through G met the standard of care in North Carolina. The Panel also received documentary evidence.

13. Dr. Dunn testified on his own behalf regarding whether his care of Patients A through G met the standard of care in North Carolina.

14. The Panel also received an exhibit demonstrating Dr. Dunn's prior history with the Board.

Conclusions of Law

1. The Board has jurisdiction over Dr. Dunn and this subject matter.

2. Dr. Dunn's care of Patients A through G departed from, or failed to conform to, the standards of acceptable and prevailing medical practice within the meaning of N.C. Gen. Stat. § 90-14(a)(6).

Order of Discipline

Based upon the foregoing Findings of Fact and Conclusions of Law, the Panel recommends the following Order of Discipline:

1. Dr. Dunn's license is hereby indefinitely suspended beginning at 5:00 p.m., Friday, June 18, 2010. Dr. Dunn may not apply to have the suspension of his license removed until December 18, 2010. During the interim period of time between the date of this Order and June 18, 2010, Dr. Dunn is allowed an appropriate period of time to wind down his medical practice. During this wind down period, Dr. Dunn shall practice within standards of acceptable and prevailing medical practice. Furthermore, Dr. Dunn should make best efforts to provide his

patients with a copy of their medical records and make referrals, when appropriate, to other physicians.

This, the 03rd day of May, 2010.

NORTH CAROLINA MEDICAL BOARD

By: _____
The Honorable John B. Lewis, Jr, LLB
Presiding Officer

BEFORE THE
NORTH CAROLINA MEDICAL BOARD

In re:	)	
	)	MEMORANDUM IN SUPPORT OF
Lawrence A. Dunn, M.D.,	)	PANEL'S RECOMMENDED DECISION
	)	
Respondent.	)	

This memorandum is submitted in support of the April 16, 2010, recommendation of a panel ("Panel") of the North Carolina Medical Board ("Board") to indefinitely suspend Lawrence A. Dunn, M.D.'s ("Dr. Dunn") medical license and to further not permit Dr. Dunn to apply to have such indefinite suspension lifted for a period of six (6) months.

RELEVANT FACTUAL AND PROCEDURAL HISTORY

Dr. Dunn is a physician who specializes in psychiatry and pain medicine and practices in Durham, North Carolina. Dr. Dunn was licensed to practice medicine in North Carolina on May 3, 1986.

In June of 1999, Dr. Dunn was issued a Private Letter of Concern ("Dr. Dunn PLOC") relating to prescriptions and prescription refills. The Dr. Dunn PLOC stated, in part, as follows:

> [t]he Board wants you to be aware of the importance of being vigilant in monitoring prescriptions that you issue to patients. Close communication with pharmacists, especially in situations where the patient travels and uses multiple pharmacies, can be helpful.

Thereafter, in May 2007, the Board received information

related to a concern over Dr. Dunn's methadone and oxycodone prescribing. Board Investigator, Rick Sims, thereafter obtained a controlled substance registry report and, with the assistance of the Board's Office of Medical Director, selected seven (7) of Dr. Dunn's patient charts for expert review. The patients whose treatment is embodied in these charts will be referred to as Patients A through G.

The Board thereafter obtained expert review of Dr. Dunn's treatment records for Patients A through G, which care was found to be below acceptable standards for North Carolina physicians for all seven (7) patients. Charges were then issued against Dr. Dunn on September 9, 2009, and a hearing was scheduled for February 17, 2010.

After one postponement, this matter was heard by the Panel of the Board on April 15, 2010, and April 16, 2010. Panel members were The Honorable John B. Lewis, Jr., LLB, Board Member and Presiding Officer, Peggy Robinson, PA-C, Board Member, Thomas R. Hill, M.D., Board Member and Ralph C. Loomis, M.D., Board Member. Patrick F. Balestrieri represented the Board. Robert M. Clay and Joseph W. Williford represented Dr. Dunn.

The Panel considered the evidence, testimony of witnesses and arguments of counsel. Based upon the evidence presented at the hearing on this matter, the Panel made a finding and conclusion that Dr. Dunn's care of Patients A through G departed from, or failed to conform to, the standards of acceptable and

prevailing medical practice within the meaning of N.C. Gen. Stat. §90-14(a)(6).

Based upon this finding and conclusion, the Panel recommended that Dr. Dunn's North Carolina medical license be indefinitely suspended and that Dr. Dunn not be allowed to apply to have the indefinite suspension lifted for a period of six (6) months.

THE EVIDENCE OVERWHELMINGLY DEMONSTRATED THAT DR. DUNN DEPARTED FROM ACCEPTABLE STANDARDS OF PSYCHIATRIC AND PAIN MANAGEMENT CARE WHILE TREATING PATIENTS A THROUGH G.

Dr. Dunn treated Patients A through G for psychiatric and pain conditions over an extended period of time. The Board alleged, and the evidence at the hearing conclusively showed, that Dr. Dunn's psychiatric and pain management care of Patients A through G was below acceptable standards for North Carolina Physicians. At the hearing, the Board's evidence consisted in part of expert testimony from the following Board Certified physicians who are all licensed to practice medicine in North Carolina:

1. Dr. Stephen Kramer, Board Certified Psychiatrist.
2. Dr. Robert Brown, Board Certified in Psychiatry and Internal Medicine.
3. Dr. Eduardo Fraifeld, Board Certified in Anesthesia and Pain Medicine.

Dr. Kramer, Dr. Brown and Dr. Fraifeld all authored reports and testified that Dr. Dunn practiced below the standard of care

in regard to his care of Patients A through G. Specifically, Dr. Kramer, Dr. Brown and Dr. Fraifeld testified and explained that:

1. Dr. Dunn failed to practice appropriate pharmacovigilance and prescribed large amounts of controlled substances in the face of lost prescriptions, patterns of early refills, positive drug screen testing for illicit substances and other possible signs of medication abuse or diversion.
2. Dr. Dunn's treatment model for treating pain patients is below acceptable standards of care.
3. Dr. Dunn failed to coordinate care with other health care professionals.
4. Dr. Dunn failed to discontinue medications that proved ineffective or posed an immediate risk to patients.
5. Dr. Dunn failed to obtain appropriate histories and perform appropriate physical examinations and laboratory tests.

NO INDEPENDENT EXPERTS TESTIFIED ON DR. DUNN'S BEHALF IN SUPPORT OF THE CARE DR. DUNN RENDERED TO PATIENTS A THROUGH G.

Three Board Certified medical experts testified that the care Dr. Dunn rendered to Patients A through G was below acceptable standards of care. Further, the over one-thousand (1,000) pages of patient records contains criticisms and concerns relating to Dr. Dunn's care by other Physicians and

Pharmacists. The only evidence Dr. Dunn brought forth in support of his care was his own subjective testimony that his care of Patients A through G was appropriate. Therefore, weighing the Board's expert testimony and Dr. Dunn's own testimony together, the evidence overwhelmingly and convincingly showed that Dr. Dunn departed from acceptable and prevailing standards of medical practice in North Carolina in regard to his management and treatment of Patients A through G.

> DR. DUNN WAS ISSUED THE DR. DUNN PLOC IN 1999 RELATING TO ISSUES THAT ARE AGAIN BEFORE THE BOARD TODAY. AS SUCH, DR. DUNN HAS NOT CHANGED HIS BEHAVIOR AND THE RECOMMENDED DECISION IS APPROPRIATE.

Dr. Dunn was issued the Dr. Dunn PLOC in June 1999, which advised Dr. Dunn to be more pharmacovigilant with monitoring prescriptions and prescription refills. As the Board can see from the medical records of Patients A through G, which span in some cases from 1999 to 2009, Dr. Dunn has not changed his behavior in any significant way. The result of Dr. Dunn's continued lack of pharmacovigilance is a danger to the people of North Carolina by potentially letting tens of thousands of narcotics on our streets and subject to abuse and diversion. The only certain method by which this Board can assure the People of North Carolina that the danger created by Dr. Dunn's practices will be stopped is to indefinitely suspend his medical license.

DR. DUNN'S CARE OF PATIENTS A THROUGH G CREATED A DANGER TO PATIENTS A THROURH G AND THE PEOPLE OF NORTH CAROLINA. DR. DUNN ACCEPTS NO REPSONSIBILITY FOR HIS ACTIONS AND REFUSES TO ACKNOWLEDGE THE SIGNIFICANT WRONGDOING AND DANGER CREATED BY HIS PRACTICES.

During the hearing, Dr. Kramer, Dr. Brown and Dr. Fraifeld explained in detail why Dr. Dunn's treatment of Patients A through G was below acceptable standards of care. The Board's experts also explained how Dr. Dunn's treatment posed a danger to Patients A through G and the People of North Carolina by way of controlled substance abuse and diversion. Despite all of this, Dr. Dunn refused to acknowledge his wrongdoing, the danger it created and accept responsibility for his actions.

Dr. Dunn's refusal to acknowledge his wrongdoing and accept responsibility for his actions are significant aggravating factors that suggest that Dr. Dunn will not conform his conduct to acceptable and prevailing standards of medical practice in the future. The presence of these aggravating factors militates in support of the Panel's recommendation to indefinitely suspend Dr. Dunn's North Carolina medical license.

CONCLUSION

Dr. Dunn inappropriately treated Patients A through G for psychiatric and pain conditions. Dr. Dunn's treatment of Patients A through G created a danger to Patients A through G and the People of North Carolina. Accordingly, the Panel's recommended discipline of indefinite suspension is appropriate and should be adopted by the Board in its entirety.

Respectfully submitted this the 3rd day of May, 2010.

Patrick F. Balestrieri
Board Attorney
NC Medical Board
1203 Front Street
Raleigh, NC 27609
(919) 326-1109, ext. 225

CERTIFICATE OF SERVICE

I certify that the foregoing document was served on the following individual(s) by electronic mail and by depositing a copy of the same in the United States mail, postage prepaid, addressed as follows:

Robert M. Clay via electronic mail to rmc@youngmoorelaw.com
Joseph W. Williford via electronic mail to JWW@youngmoorelaw.com

United States Mail Address:
Young Moore and Henderson, PA
PO Box 31627
Raleigh, NC 27622
Phone: 919-782-6860
Fax: 919-782-6753

This, the 3rd day of May, 2010.

Patrick F. Balestrieri
Board Attorney

BEFORE THE

NORTH CAROLINA MEDICAL BOARD

In re:	)	
Lawrence A. Dunn, M.D.,	)	MEMORANDUM IN OPPOSITION TO
Respondent	)	PANEL'S RECOMMENDED DECISION

Respondent, by and through his undersigned counsel, hereby submits this memorandum in respectful opposition to the Panel's recommended decision in the above matter.

The Panel, after hearing the evidence at the hearing, recommended that Respondent's medical license be indefinitely suspended, but that Respondent be permitted to apply to have such indefinite suspension lifted after six months.

Counsel for the Board, in opening statement and in closing statements, acknowledged that Respondent is a nice person and a compassionate and caring doctor, well-trained and intelligent, and that he was trying to do the best thing for his patients.

An expert called by the Board, Dr. Robert Brown, stated in his report and testified at trial that Dr. Dunn was to be commended for trying to help a difficult set of patients with mental illness and reports of chronic pain. "My report does not capture the good he has otherwise done, helping these patients through crisis and being readily available to them."

The primary complaint regarding the respondent involved his treatment of pain patients with narcotics and, in general, the experts for the Board seemed to believe that he was too trusting, and over-prescribed narcotics without sufficient justification and without doing physical examinations. In his own defense, Dr. Dunn explained that it was his training that he should accept the subjective pain complaints of his patients as being true unless he had evidence to the contrary, and that as a psychiatrist, he did not usually do physical examinations of patients because of concerns about boundary violations. His treatment and prescriptions were only for the purpose of alleviating the pain of his patients.

Respondent, in his own testimony before the Panel, expressed his willingness to do whatever the Board thinks he needs to do to change whatever shortcomings he may have in his practice to bring his practice into conformance with what the Board wants him to do, without any limitation or reservation whatsoever. He is perfectly willing to alter his practice model so as to perform such physical examinations of his patients as may be indicated by the Board.

Respondent genuinely believed that he was in compliance with the Board's letter of concern and with the Board's position statement, and did not intentionally practice in any way which would not conform with those writings. He is familiar with Dr. Fishburn's book, *Responsible Opioid Prescribing*, and will follow the precepts set out in the book. He has taken the criticisms by the Board experts to heart and is able to change and adjust his practice to conform to such criticisms.

Based on the foregoing, counsel for Respondent respectfully submits the following recommended punishment: Place Dr. Dunn on probation for a period of two years, and restrict his license during the period of probation such that he cannot prescribe any opioid medication or practice pain management. During the period of probation, require him to obtain intensive CME courses in Controlled Substance Management and Medical Record Documentation. Permit him to practice psychiatry and psychotherapy during the period of probation and to prescribe psychotrophic medications and other medications usually used in the practice of psychiatry, with the exception of pain medications.

Although in some respects this proposed punishment is more severe than the punishment proposed by the Panel, it does allow Dr. Dunn to offer some degree of continuity of care to his psychiatric patients and to those with a psychiatric component to their care needs, and allows him to continue to practice in an area where there was no substantial criticism of his performance, while at the same time taking steps to remediate the deficiencies identified in his practice.

Respectfully submitted this 12TH day of May, 2010.

YOUNG MOORE AND HENDERSON, P.A.

BY: _____

ROBERT M. CLAY
N. C. State Bar No. 834
JOSEPH W. WILLIFORD
N. C. State Bar No. 10111
Attorneys for Respondent,
LAWRENCE A. DUNN, M.D.
Post Office Box 31627
Raleigh, North Carolina 27622
Telephone (919) 782-6860

393-080/886097

CERTIFICATE OF SERVICE

The undersigned attorney hereby certifies that he served the foregoing document upon the attorney shown below by fax as follows:

Patrick F. Balestrieri
North Carolina Medical Board
1203 Front Street
Raleigh, North Carolina 27609
Attorney for North Carolina Medical Board
FAX: (919) 326-0036

This the 19th day of May, 2010.

YOUNG MOORE AND HENDERSON, P.A.

BY: _____
ROBERT M. CLAY
N. C. State Bar No. 834
JOSEPH W. WILLIFORD
N. C. State Bar No. 10111
Attorneys for Respondent,
LAWRENCE A. DUNN, M.D.
Post Office Box 31627
Raleigh, North Carolina 27622
Telephone (919) 782-6860

BEFORE THE
NORTH CAROLINA MEDICAL BOARD

In re:	)	
	)	FINDINGS OF FACT,
Lawrence Anthony Dunn, M.D.,	)	CONCLUSIONS OF LAW AND
	)	ORDER OF DISCIPLINE
Respondent.	)	

This matter was heard by the North Carolina Medical Board ("Board"), pursuant to N.C. Gen. Stat. §90-14.5, on May 20, 2010, to consider a Recommended Decision of a panel ("Panel") of the Board. Patrick F. Balestrieri and Thomas W. Mansfield represented the Board. Robert M. Clay and Joseph W. Williford represented Lawrence Anthony Dunn, M.D. ("Dr. Dunn").

Panel members were The Honorable John B. Lewis, Jr., LLB, Board Member and Presiding Officer, Peggy Robinson, PA-C, Board Member, Thomas R. Hill, M.D., Board Member and Ralph C. Loomis, M.D., Board Member. The Panel heard evidence in this case and made the Recommended Decision. The Panel members did not participate in the May 20, 2010, proceedings.

In addition to the Recommended Decision, the Board considered the arguments of Mr. Balestrieri and Mr. Mansfield, Mr. Clay and Mr. Williford as well as the Board's Memorandum in Support on Panel's Recommended Decision and Dr. Dunn's Memorandum in Opposition To Panel's Recommended Decision.

Based upon the information presented and the arguments of counsel, the Board enters the following:

Findings of Fact

1. The Board is a body duly organized under the laws of North Carolina and is the proper party to bring this proceeding under the authority granted it in Article 1 of Chapter 90 of the North Carolina General Statutes.

2. Dr. Dunn is a physician licensed by the Board on or about May 3, 1986, license number 30018.

3. During the times relevant herein, Dr. Dunn practiced psychiatry and pain management in Durham, North Carolina.

4. Dr. Dunn treated Patients A through G for psychiatric conditions and chronic pain.

5. Three witnesses testified for the Board at the hearing of this matter. The first witness was a Board certified psychiatrist licensed to practice medicine in North Carolina. The second witness was a Board certified psychiatrist and internal medicine specialist licensed to practice medicine in North Carolina. The third witness was a Board certified anesthesiologist with pain management certification and licensed to practice medicine in North Carolina. At the hearing on this matter, these three Board Certified medical experts all concluded that Dr. Dunn's care of Patients A through G was below the standard of care in several respects.

6. With regard to Patient A:

a. Dr. Dunn failed to prescribe medications to Patient A based on rationale supported by scientific principles;

b. Dr. Dunn failed to obtain and document an appropriate history, physical examination and laboratory work on Patient A;

c. Dr. Dunn failed to appropriately coordinate care of Patient A with other health care professionals;

d. Dr. Dunn failed to provide heightened care and appropriate pharmacovigilance to Patient A when prescribing drugs that have a high abuse and diversion potential;

e. Dr. Dunn failed to refer Patient A for a second medical opinion or inpatient hospitalization when his treatment became ineffective or posed a risk of harm to Patient A; and

f. Dr. Dunn continued escalating dosages of medication for Patient A despite questionable improvement of symptoms or function.

7. With regard to Patient B:

a. Dr. Dunn failed to perform and document an appropriate physical examination;

b. Dr. Dunn failed to provide heightened care and appropriate pharmacovigilance to Patient B when prescribing drugs that have a high abuse and diversion potential;

c. Dr. Dunn inappropriately utilized phone conferences as a substitute for in person treatment;

d. Dr. Dunn failed to obtain a second opinion or refer Patient B for hospitalization in the face of abnormal prescription behavior by Patient B; and

e. Dr. Dunn failed to appropriately coordinate care with other health care providers.

8. With regard to Patient C:

a. Dr. Dunn failed to timely refer Patient C for treatment for substance abuse;

b. Dr. Dunn failed to coordinate care with other providers;

c. Dr. Dunn failed to perform and document an appropriate physical examination on Patient C; and

d. Dr. Dunn failed to provide heightened care and appropriate pharmacovigilance to Patient C when prescribing drugs that have a high abuse and diversion potential.

9. With regard to Patient D:

a. Dr. Dunn failed to obtain and document an appropriate history and physical examination of Patient D;

b. Dr. Dunn failed to obtain a second opinion for Patient D or refer Patient D for hospitalization when opiate diversion was highly likely;

c. Dr. Dunn failed to revise his treatment plan in the face of Patient D's non-compliance;

d. Dr. Dunn failed to increase the frequency of outpatient appointments and reduce the size of prescription refills when opiate misuse was a concern with Patient D;

e. Dr. Dunn failed to perform appropriate pharmokinetic studies when exceptionally high medication doses were used to treat Patient D, rather than assume rapid metabolizer status was present, in the context of suspected medication abuse;

f. Dr. Dunn prescribed an inappropriate escalation of opioids for Patient D;

g. Dr. Dunn continued treatment of Patient D despite questionable improvement of symptoms or function with escalation of medication; and

h. Dr. Dunn failed to provide heightened care and appropriate pharmacovigilance when prescribing drugs to Patient D that have a high abuse and diversion potential.

10. With regard to Patient E:

a. Dr. Dunn failed to provide heightened care and appropriate pharmacovigilance when prescribing drugs to Patient E that have a high abuse and diversion potential.

b. Dr. Dunn failed to maintain a heightened sense of awareness when treating Patient E in light of his substance abuse history;

c. Dr. Dunn failed to obtain a second opinion or refer Patient E for hospitalization in the context of Patient E's treatment course;

d. Dr. Dunn failed to coordinate his care of Patient E with other providers;

e. Dr. Dunn failed to minimize the number of medications prescribed to Patient E; and

f. Dr. Dunn continued treatment of Patient E despite questionable improvement of symptoms or function with escalation of medication.

11. With regard to Patient F:

a. Dr. Dunn failed to provide heightened care and appropriate pharmacovigilance when prescribing drugs to Patient F that have a high abuse and diversion potential;

b. Dr. Dunn failed to establish collaborative relationships with other providers to clarify Patient F's diagnoses and anticipated treatment course;

c. Dr. Dunn failed to obtain and document an appropriate history, physical examination and laboratory work on Patient F;

d. Dr. Dunn failed to perform appropriate pharmokinetic studies when atypical metabolic patterns were suspected;

e. Dr. Dunn failed to minimize the number of medications prescribed; and

f. Dr. Dunn failed to increase the frequency of outpatient appointments and reduce the size of prescription refills when opiate misuse was a concern.

12. With regard to Patient G:

a. Dr. Dunn failed to provide heightened care and appropriate pharmacovigilance when prescribing drugs to Patient G that have a high abuse and diversion potential;

b. Dr. Dunn failed to obtain a urologic history, perform a physical examination (including a prostate exam) and obtain appropriate tests and screening prior to prescribing testosterone replacement therapy for Patient G. Dr. Dunn also failed to refer Patient G to an appropriate generalist or endocrine specialist for assessment and management;

c. Dr. Dunn failed to appropriately provide and document treatment for depressive disorder along with pain management;

d. Dr. Dunn failed to assess, or refer for proper assessment, an unexplained increase in pain in Patient G;

e. Dr. Dunn failed to coordinate Patient G's care with other healthcare providers to secure a diagnosis of the etiology of pain syndrome;

f. Dr. Dunn failed to refer Patient G for a second opinion or inpatient hospitalization along with medication limit setting when opiate abuse was suspected; and

g. Dr. Dunn failed to minimize the number of medications prescribed to Patient G.

13. Dr. Dunn testified on his own behalf regarding whether his care of Patients A through G met the standard of care in North Carolina.

14. The Panel also received evidence at the hearing from the Board and Dr. Dunn.

Conclusions of Law

1. The Board has jurisdiction over Dr. Dunn and this subject matter.

2. Dr. Dunn's care of Patients A through G departed from, or failed to conform to, the standards of acceptable and prevailing medical practice within the meaning of N.C. Gen. Stat. § 90-14(a)(6).

Order of Discipline

Based upon the foregoing Findings of Fact and Conclusions of Law, the Board enters the following Order of Discipline:

1. It is ORDERED that Dr. Dunn's North Carolina medical license is hereby indefinitely suspended beginning at 5:00 p.m., on Friday, June 18, 2010. Dr. Dunn may not apply for reinstatement of his medical license until December 18, 2010. During the interim period of time between the date of this Order and June 18, 2010, Dr. Dunn is allowed an appropriate period of time to wind down his medical practice. During this wind down period, Dr. Dunn shall practice within standards of acceptable and prevailing medical practice. Furthermore, Dr. Dunn shall make best efforts to provide his patients with a copy of their medical records and make referrals, when appropriate, to other physicians.

This, the 20th day of May, 2010.

NORTH CAROLINA MEDICAL BOARD

By: _____
Donald E. Jablonski, D.O.
President

BEFORE THE
NORTH CAROLINA MEDICAL BOARD

In re:	)	
	)	
Lawrence Anthony Dunn, M.D.,	)	AFFIDAVIT OF SERVICE
	)	
Respondent.	)	

Donald R. Pittman first being duly sworn, deposes and says as follows:

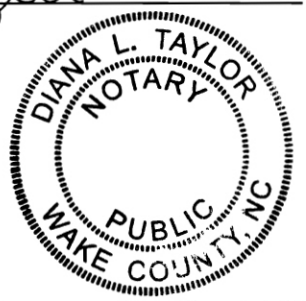
1. That I personally delivered and served a copy of the Findings of Fact, Conclusions of Law and Order of Discipline in the above-captioned case on Lawrence Anthony Dunn, MD.

Donald R. Pittman (5-24-10)
Donald R. Pittman

Sworn to and subscribed before me,
this the 25th day of May, 2010.

Diana L. Taylor
Notary Public

(Seal)



My Commission Expires: 11-14-2014

BEFORE THE
NORTH CAROLINA MEDICAL BOARD

In re:	)	
	)	
Lawrence A. Dunn, M.D.,	)	CONSENT ORDER
	)	
Respondent.	)	

This matter is before the North Carolina Medical Board ("Board") on the application of Lawrence A. Dunn, M.D., ("Dr. Dunn") for reinstatement of his license to practice medicine and surgery previously issued by the Board. Dr. Dunn admits, and the Board finds and concludes, that:

Whereas, the Board is a body duly organized under the laws of North Carolina and is the proper party to bring this proceeding under the authority granted it in Article 1 of Chapter 90 of the North Carolina General Statutes; and

Whereas, the Board first issued Dr. Dunn a license to practice medicine and surgery on May 3, 1986, license number 30018; and

Whereas, on May 20, 2010, the Board issued Findings of Fact, Conclusions of Law and an Order of Discipline that found Dr. Dunn's care of Patients A through G departed from, or failed to conform to, the standards of acceptable and prevailing medical practice within the meaning of N.C. Gen. Stat. § 90-14(a)(6)

and, as a result, indefinitely suspended Dr. Dunn's North Carolina medical license; and

Whereas, on or about December 22, 2010, Dr. Dunn applied for reinstatement of his North Carolina medical license; and

Whereas, in March 2011, Dr. Dunn met with a committee of the Board for a licensing interview; and

Whereas, the Board thereafter advised Dr. Dunn to have a medical skills assessment performed by the Center For Personalized Education for Physicians ("CPEP") as well as take a problem based ethics course that CPEP offers called the "ProBE Course"; and

Whereas, Dr. Dunn was assessed by CPEP from May 5-6, 2011, and, as a result of the CPEP assessment, an assessment report was generated on July 7, 2011 ("CPEP Report"); and

Whereas, while the CPEP Report found that Dr. Dunn demonstrated medical knowledge that was acceptable in most areas, the CPEP Report also made several educational recommendations that Dr. Dunn needs to address; and

Whereas, Dr. Dunn acknowledges and agrees that the Board has jurisdiction over him and the subject matter of this case; and

Whereas, Dr. Dunn knowingly waives his right to any hearing and to any judicial review or appeal in this case; and

Whereas, Dr. Dunn acknowledges that he has read and understands this Consent Order and enters into it voluntarily; and

Whereas, the Board has determined it to be in the public interest to resolve this matter as set forth below; and

Whereas, Dr. Dunn would like to resolve this matter without the need for more formal proceedings.

NOW, THEREFORE, with Dr. Dunn's consent, it is ORDERED that:

1. The Board shall issue Dr. Dunn a license to practice medicine and surgery to expire on the date shown thereon.

2. Dr. Dunn shall fulfill and complete all of the educational requirements embodied in the CPEP Report including obtaining an educational preceptor. CPEP will manage and administer the educational intervention. Dr. Dunn's temporary license will be issued once he obtains an approved preceptor and begins the educational intervention program with CPEP.

3. Dr. Dunn shall complete the CPEP ProBE course within four (4) months of the date of the execution of this Consent Order. Dr. Dunn shall also authorize CPEP to send a copy of the assessment report and completion materials to the Director of Investigations, North Carolina Medical Board, P.O. Box 20007, Raleigh, NC 27619-0007.

4. Dr. Dunn shall not treat patients for chronic or acute pain conditions.

5. Dr. Dunn shall not prescribe any Schedule II narcotic controlled substances or any Schedule III narcotic controlled substances.

6. Dr. Dunn shall obey all laws. Likewise, Dr. Dunn shall obey all rules and regulations involving the practice of medicine.

7. Dr. Dunn shall notify the Board in writing of any change in his residence and practice addresses within ten (10) days of the change.

8. Dr. Dunn shall return for an investigative interview with the Board or a member of the Board within six (6) months after his temporary license has been issued. Dr. Dunn shall also appear before the Board at such other times as may be requested by the Board.

9. If Dr. Dunn fails to comply with any of the terms of this Consent Order, that failure shall constitute unprofessional conduct within the meaning of N.C. Gen. Stat. § 90-14(a)(6) and shall be grounds, after any required notice and hearing, for the Board to annul, revoke, suspend or limit his license or to deny any application he might then have pending or might make in the future for a license.

10. This Consent Order shall take effect immediately upon its execution by both Dr. Dunn and the Board and it shall continue in effect until specifically ordered otherwise by the Board.

11. Dr. Dunn hereby waives any requirement under any law or rule that this Consent Order be served on him.

12. Upon execution by Dr. Dunn and the Board, this Consent Order shall become a public record within the meaning of Chapter 132 of the North Carolina General Statutes and shall be subject to public inspection and dissemination pursuant to the provisions thereof. Additionally, it will be reported to persons, entities, agencies and clearinghouses as required by and permitted by law including, but not limited to, the Federation of State Medical Boards, the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank.

By Order of the North Carolina Medical Board this the 10th day of October, 2011.

NORTH CAROLINA MEDICAL BOARD

By: Janice E. Huff, MD
Janice E. Huff, M.D.
President

Consented to this the 7th day of October, 2011.

Lawrence A. Dunn, M.D.

State of North Carolina

County of DURHAM

I, JAMIL A. SAGHIR, a Notary Public for the above named County and State, do hereby certify that Lawrence Anthony Dunn, M.D. personally appeared before me this day and acknowledged the due execution of the foregoing instrument.

Witness my hand and official seal

this the 7th day of OCTOBER, 2011.

Notary Public

JAMIL A. SAGHIR
NOTARY PUBLIC
WAKE COUNTY STATE OF NORTH CAROLINA
MY COMMISSION EXPIRES 6-9-2012

(SEAL)

My Commission Expires: 9 JUNE 2012

TEMPORARY MEDICAL LICENSE

The North Carolina Medical Board, having reviewed pertinent data, hereby authorizes

LAWRENCE A. DUNN, M.D.

to practice medicine and surgery in the State of North Carolina under the laws of the State and the rules of this Board. (Further public records exist at the Board regarding this physician.)

License Number: 30018

Issue Date: 11/14/2011

Expiration Date: 11/30/2012

R David Henderson

R. David Henderson
Executive Director

SEAL

R. David Henderson
Executive Director

1203 Front Street
Raleigh, North Carolina 27609-7533

Mailing:
P.O. Box 20007
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NORTH CAROLINA
MEDICAL BOARD

William A. Walker, MD
President

Paul S. Camnitz, MD
President-Elect

Cheryl L. Walker-McGill, MD
Secretary/Treasurer

TEMPORARY MEDICAL LICENSE

The North Carolina Medical Board, having reviewed pertinent data, hereby authorizes

LAWRENCE ANTHONY DUNN

to practice medicine and surgery in the State of North Carolina, under the laws of the State and the rules of this Board. (Further public records exist at the Board regarding this physician.)

License Number: 30018

Issue Date: 11/15/2012

Expiration Date: 11/30/2013

R David Henderson

R. David Henderson, Executive Director
North Carolina Medical Board

SEAL

R. David Henderson
Executive Director

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Raleigh, North Carolina 27609-7533

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