BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS
ON REFERRAL BY THE ALASKA STATE MEDICAL BOARD

In the Matter of:	)
	)
COREY JOHN MEYERS, M.D.	) OAH No. 12-0042-MED
____	) Div. No. 2011-000437

DECISION

I. Introduction

The Division of Corporations, Business and Professional Licensing (Division) issued an accusation for the imposition of a disciplinary sanction by the Alaska State Medical Board (Board) on Dr. Corey John Meyers, based on a prior disciplinary action taken in another state and on Dr. Meyers' alleged failure to disclose an investigation in that state. Dr. Meyers requested a hearing, and the matter was referred to the Office of Administrative Hearings. The assigned administrative law judge conducted a hearing on May 7, 2012. The Division introduced the decision of the other state's disciplinary proceeding into evidence. Dr. Meyers testified.

Dr. Meyers does not dispute that the Board has authority to impose a disciplinary sanction based on the other state's disciplinary action. He asks that the Board independently assess whether the conduct he was found to have engaged in fell below the standard of care. He asserts that it does not. He adds that his failure to disclose the investigation was not intended to deceive and that, assuming a disciplinary sanction is imposed, it should be a suspension with conditions rather than revocation.

Based on the record in this case, revocation of Dr. Meyers' license is the appropriate sanction.

II. Facts

Dr. Corey Meyers graduated from the State University of New York Health Science Center in Brooklyn, New York in 1993.[1] He was a resident in emergency medicine at the University of Connecticut School of Medicine in Farmington, Connecticut for seventeen months before leaving in good status to complete a residency in internal medicine at the Berkshire

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[1] R. 44, 60, 110, 138; Resp. Ex. 44.

Medical Center in Pittsfield, Massachusetts.[2] He was first licensed as a physician in Massachusetts in 1996 and is board-certified in internal medicine.[3]

Since completing his residency, Dr. Meyer has worked primarily as a locum tenens or short-term employment physician, generally in his home state of Massachusetts, except for about two and one-half years in 1997-2000, when he worked in medical clinics in Massachusetts (one a Veterans' Administration, the other private).[4] Typically, his supervisors and co-workers on these assignments have considered him a well qualified and hard working physician, who engages well with patients and co-workers.[5] During the course of his professional engagements, he obtained additional medical licenses in New Hampshire (2002) and New York (2006).[6]

In September, 2002, Dr. Meyers applied for a medical license in Alaska.[7] At that time, Dr. Meyers had not been the subject of any disciplinary actions or investigations.[8] Dr. Meyers was issued a temporary permit,[9] and, effective October 29, 2002, a permanent, unrestricted

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2 R. 28, 31, 32, 44, 138; Resp. Ex. 42.

3 R. 45, 74, 139; Resp. Ex. 41, 67.

4 R. 35, Resp. Ex. 30 (Department of Veterans' Affairs, Massachusetts, 1998-2000); R. 45, Resp. Ex. 12 (Cheshire Medical Center, Keene, New Hampshire, 2002), 49 (Massachusetts), Resp. Ex. 16 (Ware, Massachusetts, 2000); R. 87 (Falmouth Hospital, Falmouth, Massachusetts, 2000-2001); Resp. Ex. 15 (Massachusetts, 2001), Resp. Ex. 9, 1 (Harrington Memorial Hospital, Southbridge, Massachusetts, 2002-2004), Resp. Ex. 20, 31 (North Shore Medical Clinic, Salem, Massachusetts, 2006 & 2007); Resp. Ex. 3 (Framingham, Massachusetts, "over a 4 year period during the spring and summer months of 2008 [sic]").

5 *See* R. 32-33 (Dr. Schick, University of Connecticut School of Medicine); R. 37 (Dr. Hall, Chesire Medical Center); R. 39 (Dr. Cennamo, Mary Lane Medical Associates, Ware, Massachusetts, 2000); R. 40, Resp. Ex. 14 (Dr. Solin, Northhampton, Massachusetts VA Medical Center, 2000 ("highest professional standards"); R. 41 (Dr. Kombert, Falmouth Hospital); Resp. Ex. 3 (Dr. Adner, Chief of Medicine, Framingham Hospital); Resp. Ex. 12 (Dr. Hall, Chairman, Dept. of Internal Medicine, Chesire Medical Center, Keene, New Hampshire, 2002) ("excellent clinical judgment, deep fund of knowledge, and personable bedside manner"); Resp. Ex. 24 (PA-C Trotter, Alicia Roberts Medical Clinic, Klawock, 2002) ("a very capable medical provider, demonstrating good judgment and excellent skills in patient management"); Resp. Ex. 23 (Dr. Lux, New London [New Hampshire] Hospital, 2003) ("medical knowledge and skills are above average. He is well liked by patients and staff."); Resp. Ex. 13 (Dr. Easterly, Harrington Memorial Hospital, Southbridge, Massachusetts, 2004) ("in terms of patient care, he seemed careful, cautious, and ready to go the extra mile to accommodate the patients and their complaints."); Resp. Ex. 35 (Dr. Belmont, Associate Chairman, Emergency Care Center, Harrington Memorial Hospital, undated) ("can say without reservation that he is an outstanding emergency physician"); R. 38, Resp. Ex. 15 (Dr. Epstein, Northampton, Massachusetts, 2001) ("As medical director" reviewed dictated notes: "They were complete with a thoughtful evaluation and plan….I believe that Corey would be an asset to any organization."); Resp. Ex. 19 (Dr. Veneziano, Chief of Surgical Services, Harrington Hospital, Southbridge, Massachusetts, 2004) ("His technical abilities are without question."); Resp. Ex. 21 (Dr. Karas, Director, Medical Education, North Shore Medical Center, Salem, Massachusetts, 2007) ("extremely competent and quite thorough in his evaluation and treatment"); Resp. Ex. 31 (Dr. Jacobson, North Shore Medical Center, Salem, Massachusetts, 2007) ("a reliable and hard worker"); Resp. Ex. 33 (Dr. Byrne, Director, Hospitalsit Program, North Shore Medical Center, Salem, Massachusetts, 2007) ("a strong work ethic").

6 R. 6, 45, 184.

7 R. 133-140.

8 R. 62, 74, 77, 93.

9 R. 26, 132.

license.[10] After obtaining his temporary permit, Dr. Meyers worked at the Alicia Roberts Medical Clinic in Klawock.[11] His Alaska license was renewed in 2004 and 2006 without incident,[12] and over the years Dr. Meyers has provided services to other rural Alaska health care facilities.[13]

From December, 2006, through May, 2007, Dr. Meyer worked in the Emergency Department at Columbia Memorial Hospital in Hudson, New York.[14] Among his patients while employed there were four for whom his treatment was deficient, according to the findings made by the New York licensing authority, as follows:[15]

(A) Patient A

This patient was a 60 year old female who presented at the Columbia Memorial Hospital emergency department at 7:43 p.m. on May 4, 2007.[16] The patient's chief complaint was of pain (10/10), particularly in the mid-back, radiating around to under her left breast.[17] The pain had onset suddenly around 7:00 p.m.; it "was associated with dyspnea and diaphoresis and started when the patient was taking food out of her refrigerator."[18] A triage note records "no dyspnea" and a past history including HIV and gall bladder surgery.[19] A nurse's assessment noted "hx of pain similar a few months ago but not as bad and pain dx as GI ulcer."[20] Her initial blood pressure was 229/115, with respiration of 22 breaths per minute.[21]

Dr. Meyers' initial notes for "History of Presenting Illness" state:

> Chest pain, maybe epigastric pain, stopped Zantac, no SOB. No V or D. No dysuria or changes in bowel. The patient noted while lying flat, now while physically active.[22]

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[10] R. 24-25.
[11] Resp. Ex. 11, 24.
[12] R. 22-23 (2004), 20-21 (2006).
[13] May 22, 2012 Filing by Dr. Meyers, p. 3.
[14] R. 165-172, 184, 220.
[15] The findings with respect to Dr. Meyers' treatment of these four patients in the text pertaining to footnotes 16-77 are taken directly from the decision of the New York board, except as otherwise stated with respect to the findings pertaining to footnotes 19-20, 26, 29, 33-34, 37 and 43. Both parties agreed that the Board may rely on the New York board's findings for purposes of determining what actions Dr. Meyers took, but not to establish that his actions did or did not meet the standard of care for Alaska.
[16] R. 196.
[17] R. 196-197.
[18] R. 197.
[19] Resp. Ex. 73.
[20] Resp. Ex. 73.
[21] R. 197.
[22] R. 198, 203.

His notes for "Constitutional" (cardiac), state, "No SOB [shortness of breath]."[23] His notes for "Musculolskeletal" state, "No…back pain." He did not record a past medical history.[24] (The panel found that Patient 1 had a history of hypertension, with poor control, but does not state when that information was obtained, or by whom.[25])

In his initial orders, at 8:05 p.m., in addition to chest x-rays and laboratory work,[26] Dr. Meyers ordered a GI cocktail[27] and three administrations of an agent to reduce her blood pressure,[28] the first of which was provided at that time.[29] A second infusion of the blood pressure agent was provided at 8:25-8:30 p.m., "with positive effect on bp,"[30] in that the patient's blood pressure decreased to 157/104 at 8:45 p.m.[31] At around 9:30 p.m., the patient continued to report pain of 10/10.[32] Dilaudid was administered and her pain was reduced to 0 or 3/10 from 9:45 p.m. through 7:30 a.m.[33] At 9:55, nursing staff elected to forego a third administration of the blood pressure agent, notifying Dr. Meyers.[34]

Dr. Meyers twice ordered administration of one liter of normal saline.[35] Following the initial administration of saline at 11:50 p.m., the patient's blood pressure increased,[36] but "remained controlled."[37] At 12:14 a.m., Dr. Meyers noted "'medistium [*sic*] slightly widened?'" and an impression of "'likely gastr/esoh itus'."[38] A second liter of saline was administered at

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23 R. 198. The panel elsewhere identified the abbreviation "SOB" as "shortness of breath." *See* R. 216.
24 R. 198.
25 R. 200.
26 Resp. Ex. 74.
27 R. 203. A "GI cocktail" consists of Maqalox, Donnatol, and viscous Lidocaine. It is intended to treat GI pathology, primarily esophagitis or gastritis. *Id.*
28 R. 201. The New York panel found that Dr. Meyer ordered the administration of nitroglycerin, and stated that "[n]itroglcycerin is not a good medication for treating blood pressure." *Id.* However, what Dr. Meyers claims to have ordered was three administrations of labetalol. Resp. Ex. 76. Whether nitroglycerin and labetalol are the same thing is unknown. Nor is it known whether both were administered. In the absence of any direct evidence as to the nature of the agent administered, the administrative law judge declines to adopt the New York panel's finding that it was nitroglycerin. *See* Misyura v. Misyura, 242 P.3d 1037, 1040 (Alaska 2010) (application of collateral estoppel is within the discretion of the court). In the absence of admissible evidence as to the nature of the agent provided, no finding is made on this point.
29 *See* Resp. Ex. 76.
30 Resp. Ex. 77.
31 R. 200.
32 R. 204.
33 Resp. Ex. 76.
34 Resp. Ex. 77.
35 R. 201.
36 R. 201.
37 Resp. Ex. 77.
38 R. 202, 204. It appears that this finding was based on an x-ray that Dr. Meyers reviewed, since the "mediastinum is a projection on x-ray or CT scan," no CT scan had yet been ordered, and Dr. Meyers recorded his reading of an x-ray about three hours and 45 minutes after the x-ray was available. *See* R. 202, 206 (¶53). Dr.

2:00 a.m.[39] At 2:11 a.m., Dr. Meyer noted "'patient is feeling much better – more IVF than ambulate and likely D/C'."[40] Discharge plans were noted in the chart, but the patient expressed dissatisfaction, and Dr. Meyers considered "further CT studies of her thorax, abdomen and pelvis to 'look for vasc catastrophy'."[41] The patient's blood pressure became significantly elevated (234/114) at 2:45 a.m.[42] and the blood pressure agent was again administered.[43] Dr. Meyers ordered a CT scan at 5:30 a.m.[44] His impression was "'unclear but it is most likely gastro/esph and possible partial SBO.'"[45] Another physician replaced Dr. Meyers at 8:30 a.m.[46] The patient's blood pressure remained elevated until 9:27 a.m.[47] The replacement physician diagnosed an aortic dissection at 9:44 a.m.[48]

(B) Patient B

This patient "was a 58-year old developmentally disabled woman who presented to the Columbia Memorial hospital on January 14, 2007 with a chief complaint of vomiting."[49] The vomiting had been occurring for a week, and for the past two nights while eating dinner.[50]

Dr. Meyers "ordered blood work, including a complete blood count (CBC), comprehensive metabolic panel, lipase, serum amylase, and a urinalysis."[51] The patient's "liver enzymes were abnormally high. Her AST was 170, the ALT was 220, and the alkaline phosphate was elevated to 881. She also had an elevated white blood cell count of 12.9, and a total bilirubin of 5.0, the upper limit of normal" at the hospital's laboratory.[52] At 11:40 p.m., Dr. Meyers "ordered an ultrasound of the abdomen with a presumptive diagnosis of cholelthiasis."[53]

Meyers' note reflected in this finding was recorded about four and one-half hours after the patient arrived, and is consistent with an x-ray having been taken shortly after her arrival.

[39] R. 201.

[40] R. 204.

[41] R. 204-205. The panel's findings do not state the time of these events. Since, according to the panel's findings, Dr. Meyers did not order a CT scan until 5:30 a.m., either the reference to "further" scans is mistaken, or this event occurred after his 5:30 a.m. order.

[42] R. 200; Resp. Ex. 77.

[43] Resp. Ex. 77.

[44] R. 203.

[45] R. 205.

[46] R. 205.

[47] R. 200.

[48] R. 205.

[49] R. 206.

[50] R. 206.

[51] R. 207.

[52] R. 207.

[53] R. 208.

He reviewed the ultrasound and made a preliminary reading of it at 12:59 a.m.[54] He consulted with Dr. Wayne Maben, the patient's regular physician.[55] Following the consultation, at 1:10 a.m., Dr. Meyers discharged the patient, with instructions to follow up with her regular physician.[56]

(C) Patient C

This patient "was an eleven year old female who presented to the Columbia Memorial Hospital emergency department on December 31, 2006, with a chief complaint of congestion, cough and a temperature of 100.9."[57] "She was reported to be allergic to Sulfa and Augmentin. A list of current medications included Amoxicillin."[58] "She was slightly tachycardic, at 113 beats per minute."[59] The symptoms had begun about two weeks earlier; the child's pediatrician suspected a viral infection and had prescribed Amoxicillin.[60]

Dr. Meyers' history did not refer to cough or fever, as found in the triage notes.[61] He ordered chest x-rays,[62] which he found to show "no acute pathology" and "likely neg[ative]."[63]

(D) Patient D

This patient "was a 70 year old female who presented to the Columbia Memorial Hospital emergency department on March 17, 2007 at [8:06 p.m.] with a chief complaint of 'vomiting and abdominal pain.'"[64] Dr. Meyers "noted that [the patient's] abdomen revealed 'normal bowel sounds, mildly distended; diffusely tender; no palpable organomegaly.'"[65] "Under 'History of Present Illness", [Dr. Meyers] noted 'one day of vomiting and diarrhea. + ABD pain, no CP

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54 R. 206.

55 The panel quoted from Dr. Meyers' note stating that he had reviewed the case with Dr. Maben. R. 209. Dr. Maben testified at the hearing that he did not recall a consultation, but, after reviewing records, confirmed that he had treated the patient in early 2007. R. 211. The panel made no specific finding as to whether Dr. Meyers had or had not consulted with Dr. Maben before discharging the patient. Dr. Meyers' contemporaneous note is highly persuasive evidence that the consultation occurred, and therefore the finding in this case is that Dr. Meyers consulted with Dr. Maben.

The New York panel was persuaded that Dr. Meyers had more likely than not failed to provide Dr. Maben with complete information about the patient's condition, but made no specific finding to that effect. *See* R. 231. No finding as to the substance of the consultation is made in this case, either.

56 R. 209.

57 R. 212.

58 R. 212.

59 R. 212.

60 R. 213.

61 R. 213.

62 R. 213.

63 R. 213.

64 R. 215.

65 R. 216.

[chest pain] or SOB [shortness of breath].'"[66] He did not describe "the severity or quality of the pain, its radiation, associated symptoms, or the time course of the pain."[67]

Dr. Meyers ordered laboratory tests at 8:27 p.m., including CBC, CMP, type and screen, lipase, amylase and urinalysis, and chest x-rays.[68] Dr. Meyers did not comment on the laboratory results until 4:52 a.m.,[69] seven hours after they were performed.[70] He then noted that the "'labs are benign'."[71] At 6:47 a.m., he noted these laboratory results: "'wbc 11.2 with 18 bands, CAL 13.6, amy 351 with lipase 246'."[72] The laboratory results also showed 15% lymphocytes.[73] Dr. Meyers admitted the patient at 6:59 a.m.[74]

A consulting physician, Dr. Clarence Henry, examined the patient after her admission[75] and noted she gave "'a history of hypertension, non-insulin dependent diabetes mellitus, total abdominal hysterectomy and bilateral salpingo-cophorectomy'" and "'pelvic cancer surgery.'"[76] He noted she reported "'a one-day complaint of sudden abdominal pain followed by nausea, vomiting, diaphoresis and a gait disorder'," with diarrhea on presentation to the emergency department.[77]

Shortly after treating these patients, in the spring of 2007, Dr. Meyer raised concerning billing practices at the facility, and following a confrontation with security personnel, he resigned from his position in May, 2007.[78]

When submitting his application for Alaska license renewal in December, 2008,[79] Dr. Meyers provided information concerning a medical malpractice action in which he (with others) was a named defendant that at some point during 2008 had been settled (with a payment on his behalf by the insurance company) against his wishes.[80] That action had been based on treatment

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66 R. 216.
67 R. 216.
68 R. 218.
69 R. 218.
70 R. 218. The panel found that "[t]he 'run time' for the blood work was timed at [9:52 p.m.], or one hour and twenty five minutes after [Dr. Meyers] wrote the order." R. 218.
71 R. 218.
72 R. 218.
73 R. 219.
74 R. 219.
75 R. 234.
76 R. 216.
77 R. 216-217.
78 *See* Resp. Ex. 96, 102.
79 R. 6-8.
80 R. 9-13.

provided to a patient in 2000 in Massachusetts.[81] Dr. Meyers' Alaska license was renewed effective December 16, 2008.[82]

On August 5, 2009, Dr. Meyers submitted an application for employment at the Catskill Regional Medical Center in New York.[83] On that application, he did not disclose his former employment at Columbia Memorial Hospital.[84] On August 26, 2009, the New York Department of Health, Office of Professional Medical Conduct notified Dr. Meyers that it was "currently investigating your professional conduct."[85] Subsequently, following extensive interviews, Dr. Meyers was offered and accepted employment at Catskill Regional Medical Center.[86]

In October, 2010, Dr. Meyers was contacted by Ilanka Health Clinic in Cordova about serving as a locum tenens physician. He began working there immediately after being approached about the position. On November 17, 2010, Dr. Meyers submitted an online application for renewal of his Alaska license for the 2011-2012 licensing cycle.[87] One of the questions on the online application form asked, "Have you been the subject of an investigation by any licensing jurisdiction or are you currently under investigation by any licensing jurisdiction or is any such action bending?"[88] Dr. Meyers answered, "No."[89] His answer was false: he had been the subject of an investigation in New York since 2009.[90] Dr. Meyers was unsure if he had answered the question correctly but did not obtain clarification before submitting his application.[91] His license was renewed effective November 17, 2010.

After he obtained his locum tenens assignment at the Ilanka Medical Clinic, Dr. Meyers was recruited by the clinic's administrator for a permanent position as the clinic's medical

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81 R. 12-13

82 R. 5.

83 R. 27.

84 R. 220; Resp. Ex. 96.

85 R. 152. The document in the record does not include a description of the nature of the issues under investigation, but it does state that an attachment provided to Dr. Meyers contained a list of the issues under investigation.

86 *See* Resp. Ex. 96. Dr. Meyers testified at the New York hearing that during the interviews he disclosed his prior employment at Columbia Memorial Hospital. *Id.* However, he did not provide any corroborating witnesses or evidence. R. 236.

87 R. 3-4.

88 R. 3.

89 R. 3.

90 *See* note 85, *supra*.

91 *See* Resp. Ex. 68 ("I did have questions regarding a review, inquiry or investigations. When I filed my online application I wanted to add explanations and use words like 'I am not sure'….I did not expect the New York review to become formal allegations. I also read that the New York State law allowed a physician to swear under oath that there was not an investigation of [*sic*] allegations were found to be unsupported." "I was wrong to not fully understanding [*sic*] a review, inquiry vs. an investigation.")).

director.[92] During the interview process, Dr. Meyers disclosed the existence of the New York investigation.[93] The clinic checked on Dr. Meyers' status and decided to offer him the position.[94] Dr. Meyers began work as the Medical Director at the clinic effective December 3, 2010.[95]

On March 3, 2011, the New York licensing authority filed a formal Statement of Charges, alleging that Dr. Meyers had deviated from acceptable medical standards with respect to four patients he treated at Columbia Memorial Hospital between December 31, 2006, and May 4, 2007.[96] The charges included negligence and incompetence in all four cases, as well as gross negligence and gross incompetence.[97] The allegations also included the failure to list his prior employment at Columbia Memorial Hospital when he applied for the position at the Catskill Regional Medical Center.[98]

After formal charges were filed in New York, by consensual agreement Dr. Meyers terminated his employment at the Cordova clinic effective March 18, 2011, with two months' severance pay.[99] In April, 2011, the Division opened an investigative file concerning alleged false information in his application for renewal, based on the failure to disclose the ongoing investigation in New York.[100]

Over the course of the summer of 2011, a hearing panel in New York conducted a hearing on the allegations contained in the March 3, 2011, statement of charges.[101] Dr. Meyers was represented by counsel at the hearing. While awaiting a decision, Dr. Meyers continued to work as a locum tenens in Alaska.[102] On January 4, 2012, the panel issued its decision, finding gross negligence and gross incompetence with respect to two patients and negligence and incompetence with respect to the two other patients. The panel also found that Dr. Meyers had intentionally failed to disclose information on his employment application at the Catskill facility. The panel concluded that revocation of Dr. Meyers' license was the appropriate sanction.

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92 Resp. Ex. 110.
93 Resp. Ex. 110.
94 Resp. Ex. 110.
95 Resp. Ex. 5, 6.
96 R. 165-172.
97 R. 169-170.
98 R. 168, 171-172.
99 Resp. Ex. 4.
100 R. 143. The Division opened the file based on information received from Dr. Meyers' Alaska employer, the Ilanka Community Health Clinic. R. 144, 186.
101 R. 195.
102 Resp. Ex. 1-2 (Wrangell Medical Center).

III. Analysis

A. Issues To Be Determined

1. Count I

Count I alleges that Dr. Meyers' New York license has been revoked based on conduct in New York, and that his Alaska license is therefore subject to revocation pursuant to AS 08.64.326(a)(13) (license revocation in another state) and AS 08.64.326(a)(9) (unprofessional conduct).

Dr. Meyers does not dispute that his license was revoked and that this provides the Board with authority to impose a disciplinary sanction, including revocation, pursuant to AS 08.64.326(a)(13). Accordingly, the only issue to be determined with respect to Count I is the nature of the appropriate sanction.[103] The Board does not need to determine whether Dr. Meyers' actions in the cases reviewed by the New York board fell below the standard of care for practice in Alaska. Rather, the Board need only review the factual findings of the New York board and the record in this case, and independently determine whether Dr. Meyers' actions warrant revocation or a lesser sanction, such as suspension or the imposition of conditions.

2. Counts II and III

Count II alleges that in his 2010 Alaska renewal application, Dr. Meyers failed to report that he was under investigation in New York, that the failure to disclose that information was deceptive, and that he is therefore subject to discipline under AS 08.64.326(a)(1) (secured a license through deceit, fraud or intentional misrepresentation). Count III alleges that in his 2010 Alaska renewal application, Dr. Meyers failed to the investigation, but specifies AS 08.64.326(a)(9) (unprofessional conduct) as grounds for a sanction. The essential difference between Count II and Count III is that the former involves deceit, while the latter does not.

With respect to Counts II and III, Dr. Meyers does not deny that he failed to disclose the existence of an investigation when he filed his application for renewal in 2010. However, he asserts that his failure to do so was not intended to deceive, and that, in any event, this conduct warrants a lesser disciplinary sanction than revocation. Thus, there are two issues to be

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[103] Because Dr. Meyers concedes that the Board his discretion to impose any disciplinary sanction, up to and including revocation, based on the revocation of his license in New York pursuant to AS 08.64.326(a)(13), it is not necessary to consider whether the Board also has discretion to impose a disciplinary sanction based on his alleged out-of-state conduct unprofessional conduct, pursuant to AS 08.64.326(a)(9). *See* 12 AAC 40.967(30).

determined with respect to Counts II and III: first, whether Dr. Meyer's failure to disclose the investigation was intended to deceive, and second, what is the appropriate sanction.

B. Burden of Proof

The burden of proof is on the Division. By presenting the final decision of the New York board, the Division has made a "prima facie case that the license was…revoked and the grounds under which the …revocation was granted."[104] Making a prima facie case created a presumption and cast upon Dr. Meyers the burden of producing evidence to rebut the presumption.[105] In this case, as previously stated, Dr. Meyers did not dispute that his license was revoked, on the grounds stated in the New York decision.

C. Intent to Deceive

Dr. Meyers admits that his response regarding the existence of an investigation was false. He explains his response by asserting that he was unclear whether the New York board was conducting a "review" preliminary to an actual "investigation", and that in any event it was his understanding that in New York a physician may deny the existence of an investigation until it has been completed.[106] Dr. Meyers claims to have spoken to an Alaska licensing staff person who informed him that he did not need to disclose the New York matter,[107] but there is no record of any such contact.[108] Dr. Meyers asserted that he "wanted to add explanations and use words like 'I am not sure'."[109]

Dr. Meyers' alleged belief the New York matter constituted a "review" rather than an "investigation" is contrary to the clear and unequivocal wording of the letter that was sent to him by New York's Office of Professional Medical Conduct dated August 26, 2009, which states:

> The Office of Professional Medical Conduct…is authorized to investigate instances or complaints of suspected professional misconduct. The Office is currently investigating your professional conduct.[110]

While it may be that in New York, as in other states, complaints to the medical licensing board undergo a formal review process before an investigation is initiated,[111] there is no

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[104] AS 08.63.326(b).
[105] *See* 2 AAC 64.290(b); Evidence Rule 303(b).
[106] *See* Resp. Ex. 67-68 (July 14, 2011 email to D. Newman).
[107] Resp. Ex. 54 (investigative note, May 24, 2011); Resp. Ex. 67 (July 14, 2011 email to D. Newman).
[108] Resp. Ex. 55 (investigative note, June 9, 2011).
[109] Resp. Ex. 68 (July 14, 2011 email to D. Newman).
[110] R. 152.
[111] *See* In Re Kohler, at 2, OAH No. 07-0367-MED (Medical Board 2008) (describing pre-investigative review process in Washington).

evidence to suggest that the New York matter was, at the time of Dr. Meyers filed his renewal application, at a preliminary, pre-investigation review stage. Such a characterization of the status of the matter is directly contrary to the express language of the August 26 letter. To the extent Dr. Meyers believed that at the time he submitted his Alaska application the New York matter was anything other than a formal investigation subject to disclosure under the clear and express provisions of the Alaska online application form, his belief was unreasonable. Moreover, Dr. Meyers admits that he had doubts as to the accuracy of his response at the time it was made, and there is no record of the telephone call he claims to have made to clarify his obligation. Under these circumstances, the preponderance of the evidence is that Dr. Meyers failed to disclose the existence of the New York investigation with the intent to deceive the Board.

D. Appropriate Sanction: Count I

1. New York Findings and Dr. Meyers' Response

As previously noted, whether Dr. Meyers' actions fell below the standard of care for an Alaska physician need not be determined. However, in determining an appropriate sanction the Board may consider Dr. Meyers' actions, as outlined above.

Dr. Meyers argues that, in general, the New York board's determination that his actions fell below the standard of care is not well-grounded in the facts, in that the expert witness in that case did not review all of the relevant medical records[112] and was not aware of the level of staffing and availability of radiological services at the hospital where the incidents occurred.[113] More specifically, Dr. Meyers' asserts that his actions met the standard of care. The course of his treatment for the four patients that resulted in the New York disciplinary action is set out above. The New York board's conclusions as to his actions, and Dr. Meyers' response, is as follows:

(A) Patient A

The New York licensing agency concluded that Dr. Meyers' actions fell below the standard of care in that: (1) the patient history, as reflected in his notes, did not reconcile differences from the nurse's history;[114] (2) he did not "aggressively treat [the patient's] hypertension";[115] (3) he did not order a CT scan until after nine hours;[116] and (4) he did not

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112 Resp. Ex. 71, 74.
113 Resp. Ex. 72-73.
114 R. 198, 206.
115 R. 202, 206.

timely diagnose [the patient's] aortic dissection.[117] The agency concluded his actions demonstrated both gross negligence and gross incompetence.[118] It also concluded that Dr. Meyers' medical record for the patient did not "accurately reflect the evaluation and treatment of the patient."[119]

Dr. Meyers asserts that he took an adequate patient history; specifically, he denies that there was a discrepancy between his notes and in the nurse's notes.[120] He asserts that his treatment of her hypertension by infusion of labetalol was reasonable and effectively controlled the condition.[121] He asserts that a CT scan was "not available until morning"[122] and that in any event he elected to control her hypertension before ordering a CT scan.[123] He asserts that he "considered a broad differential diagnosis due to her presentation of chest and abdominal pain, and her surgical and medical history, including gastric issues and nausea."[124] Dr. Meyers' view is that until the CT scan results were reviewed, other diagnoses than an aortic dissection were reasonable, focusing on gastro-intestinal conditions.[125]

(B) Patient B

The New York licensing agency concluded that Dr. Meyers' actions fell below the standard of care in that the ultrasound and laboratory findings required admission of the patient "for an ECRP."[126] The New York agency concluded his actions demonstrated negligence and incompetence.[127]

Dr. Meyers asserts that the decision not to admit the patient was made by her regular physician, Dr. Maben, over his own recommendation for admission.[128] Whether Dr. Meyers

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116 R. 203.
117 R. 205.
118 R. 229.
119 R. 229.
120 Resp. Ex. 75.
121 Resp. Ex. 76-77.
122 Resp. Ex. 78.
123 Resp. Ex. 78.
124 Resp. Ex. 80
125 *See* Ex. Resp. 81-82.
126 R. 209. The panel also stated that Dr. Meyers "should have administered antibiotics to prevent the potential spread of infection," but did not state that the failure to do so fell below the minimum standard of care. R. 209.
127 R. 231.
128 Resp. Ex. 85.

provided Dr. Maben with complete information regarding the laboratory and ultrasound is unknown.[129]

(C) Patient C

The New York licensing agency concluded that Dr. Meyers' actions fell below the standard of care in that (1) his reading of the lateral view lung x-ray failed to detect "a significant haziness in the posterior aspect of the projection" and (2) he failed to diagnose pneumonia.[130] The New York licensing agency concluded his actions demonstrated negligence and incompetence.[131]

Dr. Meyers disagrees. With respect to his reading of the x-ray, he suggests that his reading was consistent with the radiologist's impression, which was:

> Left lower lobe air space consolidation with patchy increased markings consistent with poor inspiration. Bibasilar atelectasis also noted. The heart size is normal.[132]

Poor inspiration, he asserts, can lead to a "false impression."[133] With respect to his diagnosis, Dr. Meyer contends that "an x-ray with poor inspiration has limited significance and cannot provide a basis for diagnosing pneumonia."[134] He points out that he diagnosed "upper respiratory infection",[135] and he asserts that the patient's clinical findings "did not support of diagnosis of pneumonia", in that her oxygen saturation was 96%, her respiratory rate was 20, her temperature was 100.9°, and her "breath sounds [were] clear and equal bilaterally; no wheezes, rhonchi, or rales."[136]

(D) Patient D

The New York licensing agency concluded that Dr. Meyers' actions fell below the standard of care in that (1) he did not comment on the laboratory results until seven hours after they were performed;[137] (2) he should have ordered a CT scan, "[g]iven the patient's age, prior surgical history and laboratory values"[138] and if no CT scan was available should have admitted

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129 *See* note 55, *supra*.
130 R. 213-214.
131 R. 233.
132 Resp. Ex. 88.
133 Resp. Ex. 88-89.
134 Resp. Ex. 88.
135 Resp. Ex. 89.
136 Resp. Ex. 89.
137 R. 218.
138 R. 219.

the patient sooner "for further work-up and observation."[139] The agency concluded that "[h]is actions rose to the level of both gross negligence and gross incompetence."[140] It also concluded that his medical record "failed to meet acceptable minimum standards."[141]

Dr. Meyers contends that he was unable to obtain a complete medical history. His examination notes state that the patient was "'[p]roviding only minimal assistance in her evaluation",[142] and he asserts that the patient "was not cooperative and [was] unable to provide assistance to nursing staff o[r] Dr. Meyers."[143] He adds that he reviewed and commented on the laboratory results "as soon as they were made available to him."[144] He noted that the hospital did not have a CT scan technician available at the time.[145]

3. Revocation is Appropriate

Under AS 08.64.326(a)(13), another state's disciplinary action may be the basis for discipline in Alaska even if the conduct that was sanctioned in the other state would not have been subject to discipline Alaska. That the Board may impose discipline for an out-of-state disciplinary action on grounds that would not be subject to discipline in Alaska, however, does not mean that it should. Accordingly, in determining the appropriate sanction in a case of reciprocal discipline, the Board should first consider whether the stated grounds for discipline in the other state would also be grounds for discipline in Alaska. In this case, with respect to Count I, the stated grounds for discipline in New York were that in two cases, Dr. Meyers' actions demonstrated gross negligence and gross incompetence, and in two others negligence and incompetence. Under AS 08.64.326(a)(8)(A), discipline may be imposed for gross negligence, repeated acts of negligence, and professional incompetence. Thus, to the extent that gross negligence, negligence, and incompetence as those terms are defined in New York are substantially similar to gross negligence, negligence and professional incompetence, respectively, as those terms are defined in Alaska, the grounds cited in New York would constitute grounds for discipline in Alaska (assuming the same standards of care and

139 R. 219.
140 R. 235.
141 R. 236.
142 Resp. Ex. 92.
143 Resp. Ex. 95. *See also* Resp. Ex. 91 (patient "was very simple and unable to provide specific data regarding her recent or current presentation, review of systems, or past history".).
144 Resp. Ex. 92.
145 Resp. Ex. 99.

competence). Comparison of the definitions used in New York with the meaning attached to those terms in Alaska reveals substantial similarity.[146] [147]

Accordingly, for purposes of considering an appropriate disciplinary sanction, the grounds identified by the New York board are substantially equivalent to the grounds specified in AS 08.64.326(a)(8)(A).

Turning to the specific facts of this case, the Board has not previously considered a case of reciprocal revocation, that is, a case in which revocation is premised not on any findings by the Board with respect to whether a physician's actions fell below the standard of care, but rather in which revocation is premised entirely on the disciplinary action taken by another licensing board. Moreover, the Division has not identified, and the administrative law judge has not located, a prior Board disciplinary decision involving similar circumstances, that is, a decision issued following a hearing that resulted in findings of multiple instances of substandard care (other than with respect to prescription practices), including some creating a risk of serious health consequences to the patient, by a physician lacking significant prior disciplinary or malpractice history and with substantial support from previously-associated professionals. The Board therefore has no established record against which it can assess the nature of the appropriate discipline in this case.

The Board's prior decisions, to the extent they shed light on discipline for doctors found to have engaged in substandard or incompetent practice, suggest that where the errors or incompetence are correctible, it will impose conditions intended to achieve that effect. [148] Dr.

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[146] In New York, "negligence" is defined as "the failure to exercise the care that a reasonably prudent physician would exercise under similar circumstances" involving "a deviation from acceptable standards in the treatment of patients." R. 221. In Alaska, conduct may be considered negligent for licensing purposes when it is below the ordinary standard of care exercised by reasonable members of the profession in the physician's specialty. *See* In Re Kohler at 15, note 48 and at 48, OAH No. 10-0635-MED (Board of Medicine 2011). In New York "gross negligence" is "negligence involving a serious or significant deviation from acceptable medical standards that creates the risk of potentially grave consequence to the patient." R. 222. In Alaska, it is "an extreme departure from the ordinary standard of care" entailing "more than ordinary inadvertence or inattention." *See* In Re Kohler, at 14, OAH No. 10-0635-MED (Board of Medicine 2011), *citing* Storrs v. Lutheran Hospitals and Homes Society of America, Inc., 661 P.2d 632, 634 & n. 1 (Alaska 1983). Incompetence in New York is "a lack of the requisite knowledge or skill necessary to practice medicine safely." R. 222. This, as well as gross incompetence, falls within the definition of professional incompetence in 7 AAC 40.970 ("lacking sufficient knowledge, skills, or professional judgment in that field of practice in which the physician…engages, to a degree likely to endanger the health of his or her patient.").

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[148] *See* In Re Kohler, at 51, OAH No.10-0635-MED (Board of Medicine 2011) ("This board generally has not punished physicians in the traditional sense in incompetence cases, but rather has directed its efforts to imposing appropriate limits on their practice or seeking to upgrade their performance.").

Meyers' argument, in substance, is that notwithstanding the New York board's findings, his actions fell within the range of reasonable medical judgment, and that rather than revoking his license based on the New York board's disciplinary sanction this Board should suspend his license or impose conditions that will ensure patient safety.

Dr. Meyers has not shown that the New York board's decision was procedurally or substantively flawed: he simply disagrees with that board's judgment. Moreover, he did not identify any specific conditions that, in his view, would provide adequate assurance of patient safety. However, Dr. Meyers did provide statements dating from 2000 through 2008 from a variety of physicians to the effect that he was considered a hard-working, and conscientious doctor who performed his duties with adequate professional skills in a variety of clinical settings.[149] Moreover, there is no evidence that in any of his prior practice in Alaska his professional skills were deemed less than satisfactory.

If the Board were persuaded that a sanction other than revocation might adequately protect the public health, the matter could be remanded for further proceedings. At present, however, the record in this case warrants reciprocal revocation in Alaska.

E. Appropriate Sanction: Count II

The Board has considered and imposed disciplinary sanctions for the intentional provision of false and deceptive information on a number of occasions. In a 2011 decision, In Re Cooper, the Board observed that "the Board generally does not refuse or revoke licenses on the basis of failure to disclose, even when the failure involved deliberate action."[150] More recently, the Board has indicated that it will typically impose a non-reportable fine without reprimand for negligent, unintentional provision of false information.[151]

In a 2009 decision, In Re Sykes, the Board reviewed five recent cases reviewed involving the deliberate provision of false information.[152] Of the cases reviewed, in one the Board denied a license; in the other four it imposed a fine ranging from $500 (for a single non-disclosure) to

[149] These statements are summarized at note 5, *supra*.

[150] In Re Cooper, at 17 OAH No. 10-0148-MED (Board of Medicine 2011).

[151] *See* In Re Migden, at 10, OAH No. 10-0376-MED (Board of Medicine). In that case, the Board imposed a fine of $1,000. No reprimand was issued in that case; however, the Board's order does not state that the fine was non-reportable. *Id.*, at 13.

[152] In Re Sykes, at 11-13, OAH No. 08-0475-MED (Board of Medicine 2009).

$3,000 (for deliberate misrepresentations on two separate applications).[153] All of those cases included a reprimand.

Considering the actions taken in prior cases, a civil fine of $1,500 and a reprimand would be consistent with the Board's prior actions.

IV. Conclusion and Order

Dr. Meyers does not dispute that his license was revoked in another jurisdiction on the ground of negligence and incompetence. He argues that his conduct fell within the range of reasonable professional judgment, but he has not shown that he was not provided a full and fair opportunity to contest the matter in the other jurisdiction, or that the other board's conclusion was unreasonable. In light of the findings and conclusions of the New York board, and based on the record before the Board, revocation is the appropriate reciprocal sanction under Count I. For his intentional deception with regard to the existence of an open investigation at the time of his application for renewal, a civil fine of $2,000 is the appropriate sanction under Count II. In light of the revocation, a reprimand is superfluous.

Therefore, effective upon adoption of this decision by the Board, it is ordered:

1. The license of Corey John Meyers is revoked.
2. A civil fine of $1,500 is imposed.

DATED March 7, 2013. By: *Signed*
Andrew M. Hemenway
Administrative Law Judge

[153] *Id.,* at 12.

Adoption

On behalf of the Alaska State Medical Board, the undersigned adopts this decision as final under the authority of AS 44.64.060(e)(1). Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with AS 44.62.560 and Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 18th day of May, 2013.

By: *Signed*
Signature
David Miller
Name
Chair Medical Board
Title

[This document has been modified to conform to the technical standards for publication.]