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

In the Matter of	)	
	)	
TIMOTHY W. CAREY	)	OAH No. 24-0001-MED
	)	Agency Nos. 2022-000262, 276, 416
	)	2023-000119

DECISION

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I. Introduction and Summary

In early 2022, the Division of Corporations, Business and Professional Licensing received the first of several complaints about the practice of Fairbanks orthopedic surgeon Timothy Carey. About two years later, it filed an Accusation seeking revocation of his medical license.

The Accusation charges Dr. Carey with seven areas of violation. They are:

- substandard clinical and surgical performance
- substandard documentation,
- falsification of medical records,
- abusive behavior towards staff,
- failure to provide follow-up care,
- unethical billing practices, and
- false advertising.

After a thirteen-day evidentiary hearing, the evidence supports one of these allegations. It has been shown that Dr. Carey has had (and admits to) longstanding deficiencies in documentation. While he has been working to improve in this area, the Board should impose discipline sufficient to ensure that they are fully rectified.

The remaining allegations were not proven. In some instances, the exaggerated nature or outright falsity of the complaints, as well as the rancor with which they have been pursued, reflects poorly on others in the medical community.

II. Factual background

A. Dr. Carey

Timothy Carey enlisted in the Army while in medical school, completing an orthopedic surgery residency at Eisenhower Army Medical Center in Georgia. He then spent several years in a busy, high-volume surgery practice at Fort Riley in Kansas, interspersed with two Middle East deployments, before moving to Alaska. He is Board-Certified by the American Board of Orthopaedic Surgery.

During his time at Fort Riley Dr. Carey accepted occasional locum tenens assignments in Fairbanks. When he left the Army in 2016, he and his wife, a sports medicine physician, decided to relocate to Fairbanks. They both began working with an experienced orthopedic surgeon who was phasing out his own practice, forming McKinley Orthopedic and Sports Medicine, LLC.

Dr. Carey considers himself an orthopedic generalist – a necessity of practice in a small community with few orthopedic surgeons. He estimates he has performed 2,300 surgeries during his time in Fairbanks. They range from trigger finger releases to joint replacements.[1]

Dr. Carey initially performed surgeries at both Fairbanks Memorial Hospital (FMH) and the Surgery Center of Fairbanks, and by 2018 he was orthopedics chair at FMH and a part owner of the Surgery Center. By the time of the hearing in this matter, Dr. Carey's relationship with both FMH and the Surgery Center had ended in a revocation of privileges at both facilities. He now performs surgeries at McKinley Surgery Center, an ambulatory surgical center he opened in 2022.

B. Key witnesses' testimony and conflicts

Because the personalities and competing interests within the orthopedic surgery community played a large part in the evidence in this case, a brief discussion of the hearing testimony of two key Division witnesses – orthopedic surgeons Mark Wade and Neal Everson – is provided at the outset.

1. Mark Wade

Longtime Fairbanks surgeon Mark Wade founded the Surgery Center of Fairbanks. He and Dr. Carey became business partners in that venture, but they are now in litigation against one another.[2]

Dr. Carey contends that Dr. Wade began trying to undermine his practice once he saw Dr. Carey as a competitor. Dr. Wade denies that he made a business decision to undermine Dr. Carey's practice, noting that Dr. Carey's loss of privileges at the Surgery Center cost the Surgery Center – and therefore Dr. Wade – financially. In this matter and in related proceedings, both Dr. Carey and Dr. Wade have accused the other of mistreating patients and staff, overlooking complications, engaging in sharp if not illegal business practices, and testifying untruthfully.

Their respective staffs and colleagues have divergent views of which surgeon wears the white hat in this falling out. There was credible testimony that a number of McKinley

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[1] The six specific patient care disputes in this case include three knee arthroscopies, one total knee replacement, one ulnar shortening osteotomy, and one pediatric traumatic hand injury. Dr. Carey also performs hip and shoulder repairs and replacements, but the Division has not raised any specific patient care allegations as to any such procedure in these proceedings.

[2] Fairbanks Superior Court Case 4FA-22-02516CI. The Surgery Center, under Dr. Wade's leadership, sued Dr. Carey in December 2022, and Dr. Carey countersued in January 2023, adding Drs. Wade and Everson and their clinic as defendants to the counterclaim.

employees came there from the Surgery Center because they felt Dr. Carey treats his staff better,[3] while others prefer working with or for Dr. Wade.

About a year after joining the Surgery Center, Dr. Carey successfully recruited Dr. Neal Everson – a Fairbanks native completing a prestigious fellowship in San Diego — to join McKinley Orthopedics. Dr. Wade contended that it had been improper for Dr. Carey to offer Dr. Everson a position before the Surgery Center did so, working to convince others at the Surgery Center of this view. The evidence at hearing did not support those allegations of impropriety by Dr. Carey. However, the circumstances of Dr. Everson's recruitment to McKinley became a sore spot between Dr. Carey and Dr. Wade, and was resented by others at the Surgery Center.[4]

There were points in Dr. Wade's testimony where he appeared to engage in self-serving exaggeration – for example, testifying that Dr. Carey over-shortened a patient's ulna by a full inch, when the evidence establishes that the error, however unfortunate, was closer to one-tenth of this length.[5] Particularly given their ongoing, high stakes legal dispute, this type of testimony undermined his overall credibility.

2. Neal Everson

After Dr. Carey recruited Neal Everson, their relationship began collegially; they scrubbed in on one another's surgeries and collaborated on cases. Several areas of friction then arose. These centered on compensation, Dr. Everson's dissatisfaction with his assigned staff,[6] and Dr. Everson's reluctance to participate in McKinley's coverage of high school football events. This friction was further compounded by the onset of the pandemic, with its attendant economic impact on the medical community. The relationship between Drs. Carey and Everson deteriorated significantly, and in June 2021 Dr. Everson left McKinley to join Dr. Wade's practice.

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[3] There was credible testimony at the hearing that Dr. Wade can be gruff in the operating room, that some colleagues feel he treats female professionals with disfavor, that he has had complications and poor patient outcomes on occasion, and that some patients report being dissatisfied with his demeanor and/or their treatment outcomes. Test. of Jenifer Holt; Timothy Carey; Milton Wright; Ana Strachan.

[4] McGee testimony.

[5] Another example is Dr. Wade's claim that Dr. Carey proposed adopting a particular surgical technology to take advantage of growing public interest in robotic-assisted surgery – and, specifically, Dr. Wade's allegation that Dr. Carey proposed calling the technique "robotic" because "no one would know the difference." Dr. Carey's more credible description of this interaction is that he proposed expanding and promoting the use of this technology because he thought it would be more beneficial than investing in "a robot." "The point wasn't 'let's deceive the public,' but rather, 'the public wants something better than my eye,'" and this technology (which Dr. Carey uses in his joint replacement procedures) meets that need.

[6] Dr. Everson felt he was assigned subpar staff, while the staff, for their part, felt he treated them poorly.

Dr. Everson then became Chair of Orthopedics at FMH, and it was at that point that the FMH investigation and de-credentialing of Dr. Carey occurred (to be revisited in more detail below).

Dr. Everson is also in litigation with Dr. Carey, and he filed one of the Board complaints against Dr. Carey. Like Dr. Wade, Dr. Everson has described Dr. Carey as a liar and a danger to patients. However, his complaint to the Board was patently inaccurate in multiple respects (for example, materially exaggerating the number of surgeries performed, and distorting shared patient histories). His conflict of interest was acknowledged in the related FMH credentialing proceeding, and his testimony in this proceeding was notable at times for his palpable scorn for Dr. Carey. While all of these factors diminished the overall credibility of Dr. Everson's testimony, the distortions in his Medical Board complaint were particularly strong markers of unreliability.

C. McKinley Orthopedics

Throughout and after the events at issue in this case, Dr. Carey has continued to develop his own practice group at McKinley Orthopedics. Dr. Gary Molk joined that group in 2018,[7] followed by Dr. Everson in September 2019 and Dr. Kim Driftmier in 2020. While Dr. Carey had not originally intended for McKinley to grow "that big, that fast," the timing of the arrivals of a group of similarly-aged and seemingly-compatible surgeons hastened the development of the practice group.[8]

As described by Dr. Carey, his vision is for McKinley to be able to provide patients a full spectrum of care for their orthopedic concerns. McKinley expanded in 2021 to open an outreach clinic in North Pole, with two PAs and a family medicine osteopath seeing patients at that location. Dr. Carey's business partner in the North Pole satellite office – family physician Bart Worthington – believes the satellite office benefits rural patients who would be less likely to travel to Fairbanks for care, while also giving Dr. Worthington access to resources (such as an onsite x-ray machine) that let him take better care of his own family medicine patients.[9] Through affiliate entities, McKinley has more recently added both an MRI as well as an ambulatory surgery center, all co-located with the McKinley Orthopedics clinic.

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[7] Drs. Carey and Molk were FMH colleagues and friends as new arrivals to Fairbanks, but no longer have a social relationship outside of work, and Dr. Molk left McKinley in early 2024 because he was no longer "satisfied or happy" working there. In comparison with Drs. Wade and Everson, Dr. Molk was significantly more measured in his comments about and assessment of Dr. Carey. He was a more credible witness in this respect.

[8] Carey test.

[9] Testimony of Worthington, McNamara, Wright, Carey.

Dr. Carey engaged McKinley in various professional development and community outreach endeavors. This has included McKinley providing free sports physicals to local high school students and physician coverage for high school athletic events, as well as (more recently) being awarded the contract to provide athletic training to collegiate athletes at UAF.[10] Multiple McKinley staff testified enthusiastically about the training and mentoring they have received at McKinley, and about Dr. Carey's commitment to professional development for staff.[11]

D. Early FMH issues

1. Resistance to Dr. Carey's Leadership and Methods

Dr. Carey became involved in FMH leadership soon after arriving in Fairbanks, and he served as Chair of the FMH Orthopedic Department from 2018 to 2020. On an interpersonal level, at least, Dr. Carey's entrée into FMH was bumpy. As he tells it, he had a brash approach that "came across the wrong way," with process improvement ideas that – however well-intended – were "a little too critical and that created some angst." Over a series of incidents that followed, Dr. Carey failed to perceive staff member distrust of his ideas and different methods, and he failed to appreciate the need to engage constructively with colleagues – and, later, with leadership – when concerns were raised.[12]

Initial conflicts involved management topics such as changes to OR scheduling protocols. As recounted by Dr. Carey, he proposed scheduling process changes that made sense to him and to administrators, but lacked broader buy-in. He was surprised then to find that, "you come in to do a case and everyone's irritated with you." Dr. Carey admits he was "a little bullheaded" in responding to staff resistance, feeding into a negative dynamic that would follow him in later interactions. That said, staff reactions to Dr. Carey were not all negative. For example, Leslie Longley, the FMH Director of Surgical Services for Dr. Carey's first two years there, found him polite and considerate to staff, and to "absolutely" put his patients first."[13]

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[10] Testimony of Jen Carlson, Palmer Trolli, Nathan Fogell, Ashlyn McKenna.

[11] Additionally, in 2018, Dr. Carey started a monthly journal club amongst local orthopedic surgeons and physical therapists to promote evidence-based practice. Testimony of Jennifer Carlson; Carey test. He also entered into an arrangement with Bryan Tomkins, a pediatric orthopedic surgeon with Shriners Children's Hospital in Spokane to offer an outreach clinic in Fairbanks to address the lack of pediatric orthopedic services in interior Alaska. After speaking with other local orthopedic providers, including Dr. Wade, Dr. Tomkins chose to work with McKinley, citing Dr. Carey's enthusiasm for the project, collaborative relationship with his staff, and community-mindedness. After six years of this partnership, Dr. Tomkins remains a strong supporter of Dr. Carey.

[12] Ex. 16, p. 6; Carey test.; Longley test.

[13] Longley test.; Ex. 16, p. 6. Similarly, Emergency Department Charge Nurse Bridget Watkins offered persuasive testimony as to the lack of complaints or concerns in Dr. Carey's frequent interactions with staff in that Department. Watkins test.; Ex. 16, p. 7.

Another concern that surfaced was Dr. Carey's reliance on physician's assistants (PAs) to perform a wider range of services than had typically been employed at FMH. Thus, some hospital staff were reportedly concerned about whether Dr. Carey was "rounding on" patients and providing appropriate follow up care, when a PA on Dr. Carey's team was providing those services. And in the operating room, Dr. Carey's PAs would position patients pre-operatively, as well as closing after surgery – all of which is appropriately within the PA's scope of licensure but was uncommon in Fairbanks. This led to some staff concerns that Dr. Carey was rushing through surgeries or was otherwise not providing appropriate care. At the same time, Dr. Carey was operating a busy OR schedule – often running two ORs on his surgery days – which compounded tensions with staff. Again, Dr. Carey was somewhat brash and flippant about concerns that were raised with him and he was not sensitive to the extent to which negative impressions or misperceptions were damaging his credibility with peers.

2. Documentation Concerns

In the meantime, some concerns arose in FMH's peer review process, which is administered by a multidisciplinary "Professional Practice Evaluation Committee" that reviews cases flagged by department-identified criteria, complaints, and other means. Like many other providers, Dr. Carey had cases reviewed by the Committee – in his case, 29 between 2017 and 2020.[14] Multiple peer reviews raised concerns about Dr. Carey's documentation – specifically, about "inaccurate or missing information" and "cutting and pasting."[15]

At least some of the perceived shortcomings in Dr. Carey's documentation arose from or were compounded by deficiencies in the process by which McKinley pre-operative clinic records were being added to FMH surgery patient charts. With the two facilities using different electronic medical record systems, clinic records from McKinley were faxed to FMH and then scanned into the FMH patient chart. But this frequently resulted in a single clinic note being incorrectly designated (in the FMH chart) as the "H & P" (History & Physical) for surgical purposes, while other clinic records were either not scanned in or were placed in other parts of the chart. The result was an FMH chart that did not always appear to support the diagnoses or procedures identified, when in fact the full McKinley charts contained "exponentially more" information than the FMH charts being reviewed by the peer reviewers.[16]

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[14] Panko test. No evidence was provided to contextualize the number of cases reviewed.

[15] Ex. 17, pp. 1, 15.

[16] Ex. 2, p. 19. Dr. Carey expressed the same concern in his testimony at hearing, pointing to examples in evidence where a more detailed history and physical was performed than what was added to the chart as "the H&P."

But these were not the only problems with his documentation – a reality to which Dr. Carey was initially resistant when the issue was raised at FMH. The other deficiencies will be revisited later in this decision.

Additionally, some of the cases reviewed were also flagged for possible patient care concerns. Of the 29 cases reviewed, two apparently identified concerns that rose to the level of a formal "Peer Review letter" to Dr. Carey.[17]

3. Credentials Committee Oversight

By the start of 2020 a constellation of concerns around communication, documentation, and patient care had reached the attention of the FMH *Credentials* Committee, not to be confused with the Professional Practice Evaluation Committee.[18] These concerns led the Committee to grant Dr. Carey a shortened period of reappointment with "monitoring conditions," including a six-month review, quarterly staff evaluations, and external reviews of two major cases per month for the first six months.[19] Minutes from the Committee's earliest meetings with Dr. Carey reflect his skepticism of the process, which he now admits was not the most helpful approach.[20]

In September 2020 the Committee directed Dr. Carey to submit a performance improvement plan ("PIP") addressing "quality of care, documentation, [and] "professionalism/ conduct."[21] The final PIP that emerged in December 2020 required prescreening of planned surgeries and proctoring of procedures by a Board certified/eligible surgeon, a suggested reduction in surgery volume, auditing of documentation, and meetings with nursing leadership to "establish ways to improve process/communication."[22]

From Dr. Carey's perspective, FMH only began raising concerns about his own performance and recordkeeping after he recruited the three other orthopedists to his practice. A number of other witnesses corroborated the perception that Fairbanks medical community can be highly competitive, beyond a point that is healthy or good for the community, and described at least in vague terms instances in which providers felt that another provider had been "forced out"

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17 Ex. 2, p. 2; Ex. 17, p. 35.

18 The credentials committee is separate from the peer review committee but considers providers' peer reviews from the previous two years as part of the credentialing process. Panko test.; Ex. 2, p. 8; Ex. 17, pp. 15-23.

19 Ex. 2, p. 1.

20 Ex. 2, p. 2; Ex. 17, p. 15 (July 2020); Carey test.

21 Ex. 2, pp. 13-17 (Sept. 2020).

22 Ex. 2, p. 37.

or significantly undermined for business reasons. At the same time, whatever the initiating cause, at least some of the concerns raised at FMH were certainly worthy of further scrutiny.

Dr. Carey admits that he chafed at the monitoring and proposed level of scrutiny.[23] Neither he nor then-Department Chair Gary Molk[24] believed there were "technical/surgical areas of concern," nor did they believe the proctoring requirement was warranted.[25] And indeed the proctoring requirement did not result in the identification of any patient care concerns. Dr. Molk served as the proctor for most of Dr. Carey's surgeries while the requirement was in place. Dr. Molk's experience in that role gave him no concerns either as to Dr. Carey's technical skills nor as to his interactions with staff and colleagues.[26]

Dr. Carey's ongoing tension with certain corners of staff/nursing management was not helped by the plan's mandatory meetings. In December 2020 and January 2021 Dr. Carey provided the FMH Chief Nursing Officer with several letters documenting his meetings with nursing and surgical tech leads. Each letter provided Dr. Carey's own rosy assessment of those meetings. The result was self-serving if not disingenuous – minimizing staff concerns and describing his relationship with staff in effusive terms.[27] The Committee discontinued the meeting requirements in April 2021 because the meetings were "not beneficial to the process."[28] Dr. Carey admits that, in retrospect, he approached concerns about his communication with staff in an unproductive manner.

Committee records from early 2021 reflect that the Credentials Committee continued to have concerns related to the quality and accuracy of Dr. Carey's documentation. They continued to raise those concerns with Dr. Carey. For his part, Dr. Carey continued to argue that the proctoring requirement was unsustainable, asking to be released from the PIP.[29] The Committee eventually recommended a one-year reappointment through February 2022.[30]

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[23] Carey test.; Ex. 2, pp. 19-34.

[24] It will be recalled that Dr. Molk was a fellowship-trained orthopedist who arrived at FMH at the same time as Dr. Carey.

[25] Ex. 17, p. 17; Ex. 2, pp. 25, 27.

[26] Molk testimony; Ex. 2, pp. 50-51.

[27] Ex. 5, Ex. 7. For one such meeting, with lead surgical tech Keith Olson, Dr. Carey prepared a draft of the letter prior to the meeting itself, and had Mr. Olson review it at the meeting. Mr. Olson agreed with the letter at the time, but two years later had second thoughts. Ex. 6, p. 3; Olson test.; Panko test.

[28] Ex. 2, p. 50.

[29] Ex. 2, p. 41-47. Meeting minutes described the documentation concerns as unidentified discrepancies between Dr. Carey's documentation and OR nursing documentation, not documenting presence of "assists," and discrepancies in implant "sizes or angles," which Dr. Carey attributed to transcription errors. *Id*., pp. 43-44.

[30] Ex. 2, p. 42.

4. Signs of improvement, and release from proctoring

Minutes from an April 2021 meeting reflect that Committee Chair Kerry Wappett questioned whether Dr. Carey "should be released from the monitoring since the external reviews are not showing any significant concerns."[31] The minutes reflect that Dr. Carey's "360 staff evaluations" had seen "a slight improvement," and that both Drs. Molk and Driftmier had reported no concerns with Dr. Carey's skills after proctoring his procedures.[32] Present at the meeting, Dr. Molk shared "that he has been scrubbing in on most of Dr. Carey's cases and has not identified any concerns with Dr. Carey's techniques."[33]

Committee member Dr. Abe Tsigonis described an "audit" of 50 of Dr. Carey's cases since December 2020, saying seven raised potential documentation concerns. Dr. Carey suggested that Dr. Tsigonis "ma[k]e time to discuss the audits with him throughout the process, so he doesn't come to the end of the six months and [not] know what the concerns are."[34]

Dr. Carey again described issues related to how McKinley clinic records were being added into the FMH record – i.e. that a particular clinic note may wind up "titled as an H & P [History & Physical] when it was not meant to be the H&P and then it does not meet the standard for an H&P" – and said he had been working to improve this situation since implementation of the PIP.[35] Dr. Carey also described efforts "to move away from templates," but noted that this had led to increased "clerical errors."[36] The minutes described Dr. Carey's attitude towards the process by this time as improved.[37]

At the next meeting, in July 2021, the Committee again noted "there was no concern identified during proctoring nor any concern identified in the FPPE completed by the Department Chair." The Committee felt Dr. Carey's "documentation continues to be a problem" (although "not excessively bad"), but that his interactions with staff had "improved." Based on the improvements noted, the Committee agreed to discontinue the proctoring requirement, reduce the "360-evaluations" to every six months, conduct a "random review of five cases per month for monitoring of documentation concerns," and conduct a committee check-in every six months.[38]

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31 Ex. 2, p. 49.
32 Ex. 2, pp. 49, 51.
33 Ex. 2, p. 50.
34 Ex. 2, p. 52.
35 Ex. 2, p. 50.
36 Ex. 2, p. 51.
37 Ex. 2, p. 52.
38 Ex. 2, pp. 55-56.

At this point, with the Credentials Committee recommending a two-year reappointment under this modified plan, Dr. Carey considered his problems at FMH to largely be behind him.

E. Surgery Center Concerns and Staffing Issues

In the meantime, when the PIP was implemented at FMH, Dr. Carey had begun doing more of his surgeries at the Surgery Center. Dr. Carey had been a part-owner of the Surgery Center since 2018, and the evidence suggests that he was a successful practitioner there. A Surgery Center "medical staff member Ongoing Professional Performance Evaluation" in January 2020 documented that he performed 191 procedures there in 2017, 279 in 2018, and 247 in 2019.[39] The "physician review" section of the OPPE described Dr. Carey's surgical performance as "at or above nationally recognized standards," with no "specific problem areas identified," nor any concerns about behavior, judgment, or ethics.[40] A detailed audit of ten 2017 cases in the OPPE likewise identified no concerns.[41]

1. Untimely recordkeeping

Concerns eventually arose at the Surgery Center about the timeliness of Dr. Carey's documentation. Dr. Carey frequently turned in his operative reports weeks after the procedures. This created billing issues for SCF, which could not bill for Dr. Carey's cases until the operative notes were finalized. It also created concerns about patient care and accuracy, given the impossibility of remembering individualized details weeks later, with dozens of surgeries performed in between.[42] Dr. Carey was not the only provider whose post-op notes were late, but he was an outlier in terms of volume of late documentation and the extent of the lateness.[43]

There is some disagreement about when these concerns arose. Dr. Wade claims they arose "before COVID," while Center's Medical Director, Dr. Flory, says it was about eight months before Dr. Carey's last procedure at the Surgery Center in 2022. Sharon Anderson testified that, while all doctors can experience some delays in submitting their documentation, it was more of a consistent issue with Dr. Carey.

In June 2021, the Surgery Center's Board of Directors established some guidelines for dictation and signing (although it is unclear from the record what those guidelines were).[44] Dr.

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39 Ex. C, p. 1. From this group, he had one documented post-operative infection in 2017 and one in 2018, and one post-operative complication in 2019. *Id*.

40 *Id*.

41 *Id*.

42 Wade test.; Flory test.

43 Flory test.; Wade test.

44 Anderson testimony.

Flory recalls speaking with Dr. Carey several times about the untimeliness of his documentation. The Center's Board eventually implemented a policy of fining providers whose records were untimely, a policy that Dr. Flory attributes to Dr. Carey.

Once the issue of his untimely documentation was raised with him, Dr. Carey "did try to make an effort to improve his timeliness."[45] But he did not fully resolve the problem.[46]

A separate documentation concern involved, not timeliness, but rather a documentation integrity issue. Dr. Carey's PA had a practice of preparing and submitting the day's "immediate post-op notes" before any surgeries were actually performed. After this was discussed at a board meeting and employees were instructed to discontinue this practice, Dr. Carey's "immediate post op notes" were no longer turned in prior to surgery.[47]

2. Number of Surgeries

Another issue that has been raised in this hearing concerns the volume of procedures scheduled by Dr. Carey. Testimony revealed that the allegations about this issue were exaggerated by witnesses with well-established agendas. Dr. Wade claimed that Dr. Carey would do 12-14 cases in a day, and that he had concerns about how Dr. Carey could be performing these procedures in a safe and diligent manner. Dr. Wade says these concerns arose before COVID and continued "for about three years," but were never raised with Dr. Carey. It is difficult to credit this testimony. Given his responsibilities as the Surgery Center's founder and majority shareholder, if he had actually believed dangerous practices were occurring it seems certain that he would have raised them with his colleague. And while Dr. Wade now alleges he had longstanding patient care concerns about Dr. Carey, there is no documentation in the record supporting this claim.

As Dr. Carey has pointed out, it was the Surgery Center's own medical director, Dr. Flory, who actually set the surgical schedule for each day.[48] More fundamentally, the evidence does not support the characterization of Dr. Carey's surgery scheduling offered by Dr. Wade and other surgery center management.

Surgery Center co-owner and manager Sharon Anderson testified that Dr. Carey would "regularly" schedule a double-digit number of surgeries. But this number included any surgery that had ever been scheduled for a particular day, including procedures that were later canceled

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45 Wade test.
46 Anderson testimony.
47 Younker test.
48 Carey test.; Flory test; Freeman test.

or rescheduled. Ms. Anderson testified that Surgery Center records showed that Dr. Carey performed an average of just under twelve surgeries per day in his last year at the Surgery Center. But those records – showing 391 scheduled surgeries across 43 Thursdays – actually showed an average of nine surgeries per day, not twelve. Dr. Carey offered other credible evidence that his average number of surgeries was far lower than alleged by Dr. Wade and others.[49]

To the extent Dr. Carey may have typically performed more surgeries than others at the Surgery Center, the evidence presented established that a number of his surgeries were smaller, typically straightforward procedures, such as carpal tunnel or trigger finger releases. Additionally, Dr. Carey, more than other providers at the Surgery Center, uses PAs to perform more high skilled tasks within the scope of their license – including positioning surgical patients, performing mid-procedure washouts, or closing – which enables him to schedule more patients than if he were without that assistance.

As to the days when Dr. Carey did have a higher patient count, a complicating factor in terms of how that schedule impacted Surgery Center staff became Dr. Everson's departure from McKinley. When Dr. Everson joined Dr. Wade's practice in mid-2021, he requested and was assigned the same surgery block day – Thursday – that had historically been Dr. Carey's block day. This meant that two orthopedic surgeons were operating on the same day, often needing to use the same equipment (such as portable x-ray machines), creating a heightened level of activity that made those shared days longer and "very, very busy."[50]

3. Tensions with staff

At least by late 2021, Dr. Carey was experiencing tension with some staff at the Surgery Center.[51] Surgery Center nursing and allied staff were overseen by Director of Nursing Rachel Piszczek, who reported to Surgery Center Administrator Keli McGee. Ms. Piszczek disliked and distrusted Dr. Carey. She believed that he did his surgeries too quickly and was "nonchalant"

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[49] While not entirely consistent, that evidence shows that the dozen-surgeries-a-day narrative is not accurate. McKinley Office Manager Cassy Freeman testified that her review of the McKinley calendar over the past four years show that Dr. Carey performed an average of 7.5 surgeries per day, that there were only five days in four years where he did fourteen cases. This is not consistent with Dr. Carey's own Exhibit O, titled "Carey Procedures 2020 and 2021" and marked as "List of surgeries performed at the Surgery Center of Fairbanks," which lists a total of 676 procedures over a total of 105 surgery days, at an average of 6.4 surgeries per day. That list shows nine days in a two-year period when Dr. Carey performed fourteen surgeries in a day – although far more common were days where he performed between one and three surgeries. Ex. O.

[50] Carey testimony, Freeman testimony.

[51] Flory testimony.

about patient care. She didn't like that he played "party music" in his OR. She didn't like that he had "a big entourage that came into the OR with him," and she felt this "could be a distraction to patient care."[52]

In fall 2021, two Surgery Center staff members, Cassy Freeman and Alexys Boone, had left the Surgery Center to work for Dr. Carey's practice. When Ms. Freeman worked at the Surgery Center, she was a trainee who was present in the OR as part of her training. After she joined Dr. Carey's practice, she frequently accompanied his team to the Surgery Center on surgery days to facilitate the transition of patients and providers between his two ORs.

Ms. Freeman applied for and was granted Surgery Center privileges as an "Allied Health Technician" in September 2021. Those privileges -- expressly approved by both Dr. Flory and Dr. Wade – specifically allowed her to "work collaboratively with surgeon (and the patient and surgical team)" for adult and pediatric cases, to "assist with room turnover/opening sterile supplies," to "assist with dressings following closure as directed by surgeon," to "handle tissue and Instruments," and to "provide exposure and hemostasis as directed by surgeon."[53] Ms. Freeman was likewise granted approval at FMH in December 2021 "to work as a non-privileged clinical support staff to assist McKinley Orthopedics and Sports Medicine Providers in the OR" there.[54] Ms. Freeman's presence at the Surgery Center on Dr. Carey's surgical days was at times the source of some staff tension.

Another source of tension during this time was Dr. Carey's request that a particular scrub tech, Brenda Black, not participate in his surgeries. Dr. Carey made the request after hearing multiple reports of Ms. Black "saying negative things about cases, reps from other companies, and our staff," as well as hearing her making negative statements about him to another employee. Dr. Carey testified credibly that Ms. Black called him a "pretty, pretty princess," which he says was "pretty awkward," and Ms. Black admits that Dr. Carey overheard her making a derogatory statement about him.[55] Dr. Carey emailed Surgery Center Administrator Keli McGee on November 2, 2021, requesting that Ms. Black not scrub in his OR, adding, "I don't want to make a big deal about it. I would rather her just not be in the room unless necessary."[56]

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52 Piszczek testimony.

53 Ex. H.

54 Ex. J.

55 Ms. Black, whose February 2022 Medical Board Complaint called Dr. Carey "incredibly diabolical," was significantly more reserved by the time of the hearing, insisting she "never intended for the letter to take away his livelihood," but "just felt he could've done better." Black test.

56 Ex. I. Dr. Carey also added, "Recently there have been multiple issues. I am hoping we can all move past and continue to do a great job for our patients. If there are any other pending issues I would like to address them

At some point, Ms. Piszczek and the ousted scrub tech came to believe that Dr. Carey's operative notes documented procedures that he had not performed.[57] They became convinced that Dr. Carey was falsely claiming to perform microfracture during ACL surgeries. This belief was related to Dr. Carey not using an awl during procedures where he was documenting microfracture. The fact that sterilized awls were not being opened led Ms. Piszczek to conclude that Dr. Carey was documenting procedures that he was not performing. She had similar concerns about other medical device use issues – namely, whether Dr. Carey could have implanted a certain stitch without using a device that had not been opened, and when there were "no k-wires or drill bits billed to the case."[58]

Whatever Ms. Piszczek's concerns about Dr. Carey's patient care and documentation, neither she nor anyone else at the Surgery Center raised these concerns with Dr. Carey.[59] Had they done so, Dr. Carey would have explained, as he did during the hearing, that he uses an arthroscopy tool – a Stryker brand wire guide – to make microfracture holes in ACL repairs.[60]

Ms. Piszczek has also described being scrubbed in to an ulnar nerve transposition in which she observed Dr. Carey remove a piece of bone "smaller than a grain of rice" just before closing, and after saying "let's just take this off just to say we did." While Ms. Piszczek described this as evidence of "medical fraud committed by Dr. Carey," the evidence does not support that reading of the event.[61] The only testimony on epicondylectomies is that typically only a very small piece of bone – about the size of a grain of rice – is removed. Even if Dr. Carey said, "let's take this off just to say we did," that comment is not evidence that an epicondylectomy was fraudulently performed or billed for.[62]

In January 2022 another scrub tech, Jared Walker, gave his two weeks' notice that he had decided to leave Surgery Center for McKinley Orthopedics.[63] Ms. McGee had him leave

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prior to showing up Thursday so it does not disrupt the day." The Administrator responded that she would "let Rachel [the nursing supervisor] know that [he] would prefer a different scrub tech."

57 As to at least some of her criticisms, Ms. Piszczek was unable to provide specific examples. She criticized Dr. Carey's patient consent forms, for example, but was unable to remember a specific case where a consent form was not filled out accurately.

58 Piszczek test.; Ex. 21

59 Piszczek test.; Carey test.

60 Carey test.

61 Piszczek test.; Ex. 21, p. 2.

62 Carey test.

63 Walker test. Dr. Flory and Ms. McGee downplayed Mr. Walker's relationship with SCF to an extent that strained credulity. Dr. Flory claimed not to remember him at all; Ms. McGee testified that he worked for SCF for "a couple of weeks." Mr. Walker testified that he worked there for "pretty close to three months." He also testified that when he started at SCF in October 2021, he was encouraged by "the management" to tell them "anything that he

immediately, rather than working his last two weeks.[64] The following day, January 11, 2022, Ms. McGee revoked Cassy Freeman's Surgery Center privileges effective "immediately."[65] The stated reason was that Ms. Freeman's CNA certification did not authorize her to perform the tasks Ms. McGee believed she was performing in the operating room. Dr. Carey expressed deep frustration about this decision, noting in an email response that Drs. Wade and Flory had approved Ms. Freeman's credentialing form a few months earlier, and that it expressly identified her as a CNA. He said she was "functioning under her CNA," not as a "scrub tech," and pointed out that "she does similar work at the hospital." Noting that he was unaware of any issues that had arisen "with the privileges she had approved a couple months ago by the board," he asked Ms. McGee to clarify, "what do I need to do to get her back in the OR helping patients?"[66]

Dr. Carey was particularly concerned because he had a complicated surgery scheduled that week – an ulnar shortening osteotomy – on which he had historically been able to rely on Ms. Freeman's familiar routine in assisting him with the procedure. With both Jared Walker and Ms. Freeman now unexpectedly absent, Dr. Carey was dissatisfied with the assistance he received from Surgery Center staff during the procedure. The unfortunate outcome of that case is discussed in Section III(E), below.

F. January 2022 staffing incident and its aftermath

To the extent that some Surgery Center staff were secretly unhappy with Dr. Carey in early 2022, a dysfunctional communication paradigm meant that no one at the Surgery Center had communicated those concerns to Dr. Carey. Ms. Piszczek testified that, because her role was to manage staff, and the medical director's role was to manage doctors, she brought any concerns to Dr. Flory, the medical director. But Dr. Flory said he wasn't aware of staff complaints about Dr. Carey – outside of occasional "rumblings" – until the staff "walkout" described below.[67]

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saw" concerning Dr. Carey. No witness was completely credible as to these events, but it is believable that Mr. Walker understood Ms. Piszczek to be "keeping an eye" on what she considered problems with Dr. Carey.

64 Walker test.; Carey test.

65 Ex. K; Ex. 64 (Carey, 8/18/22: "So everything hit a head the day that [Jared] turned in his resignation. So [Jared] in his resignation on the 10th of January. And the 11th of January, Keli, in retaliation, dismissed [Cassy] and to void her privileges, without explanation, without any talking to. I had no idea that it was coming.").

66 Ex. L. Ms. McGee contended that the decision was chiefly motivated by an incident where a graft was wasted due to contamination. Credible testimony at the hearing supports that this event was caused by a PA, not by Ms. Freeman. Younker test.; Freeman test.

67 Flory testimony.

Instead, the concerns were allowed to build, seemingly egged on by nursing management who disliked or distrusted Dr. Carey or his staff. Thus, when Rachel Piszczek heard her staff voicing complaints about Dr. Carey's next OR day, she says she "gave them an ultimatum that if you're not going to come in tomorrow you need to tell me now so I can get them scheduled." At some point in these discussions, six staff members – including several who did not actually work with Dr. Carey – said they would not come in the next day if Dr. Carey was having his scheduled OR day.[68] These employees then met with Surgery Center management to discuss their complaints and submit written statements.

It was by now late in the workday, and the decision was made to cancel Dr. Carey's surgeries for the following day. Keli McGee left a voice mail message for Dr. Carey stating that the Surgery Center did not have staff for his surgeries the following day and they would need to be rescheduled. Her message did not offer any further details.[69]

Dr. Carey, who was seeing patients in his clinic, called Ms. McGee as soon as he got her message. Ms. McGee again did not tell Dr. Carey that staff were upset with him or offer any explanation beyond not being able to staff his OR. With surgeries scheduled for the following morning, Dr. Carey and his staff turned to notifying patients of this unexpected development and seeing whether alternate arrangements could be made.

After speaking briefly with Ms. McGee, Dr. Carey called Steve Ruppert, FMH Director of Surgical Services, to inquire about the availability of operating rooms at FMH. In a very brief call, they arranged to schedule some of Dr. Carey's cancelled January 27 surgeries to be conducted at FMH the following day, and to reschedule the remaining procedures over the coming days.[70] What was said during this discussion is sharply disputed, however, and became a turning point in Dr. Carey's career. Mr. Ruppert has long claimed that Dr. Carey told him that he needed to reschedule his surgeries because the Surgery Center was closed "due to a COVID outbreak." Dr. Carey has long contended that he never said this, noting he did not need to offer FMH a "reason" to move his surgeries there.

In the hearing in this matter, Mr. Ruppert was not a credible witness. To the contrary, he made several forceful, emphatic statements about these events that were then proven to be

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[68] None of the employees who participated in this "walkout" testified, and the testimony of Ms. Piszczek was at times difficult to credit at face value, so it is unclear exactly how this decision was reached or what alternatives may have been presented or not presented to staff.

[69] McGee test.; Ex. 47.

[70] Carey test.; Ex. 23, p. 2.

unequivocally false. When confronted with those falsehoods, he offered no explanation for his serial untrue statements, while continuing to insist that the COVID story was still accurate. It is impossible to accept that testimony. Particularly given Mr. Ruppert's false testimony during the hearing, the most credible explanation for these events is that when Dr. Carey told Mr. Ruppert there was a staffing shortage, Mr. Ruppert – perhaps reasonably, in the middle of winter, in the second year of the pandemic – surmised or assumed that the cause was COVID, later incorporated that assumption into his own description of the situation, and attributed that explanation to Dr. Carey.[71] This may not have been a malicious lie at the outset, but more of a misunderstanding that spiraled out of control.

While the evidence does not support a finding that Dr. Carey fabricated a COVID outbreak story to reschedule his surgeries, Mr. Ruppert's story was generally accepted at the time of these events.[72] And, because there was not a COVID outbreak at the Surgery Center, and because believing Mr. Ruppert's story meant concluding that Dr. Carey had fabricated an elaborate lie about rescheduling his surgeries, the consequences were significant.

In the weeks that followed, Dr. Carey was suspended first by the Surgery Center, then by FMH. Dr. Carey credibly describes the experience around the "COVID outbreak" story as disheartening, "because at the time I felt like I was on the mend with a lot of FMH people, and this incident crushed all the mend that there was." Since accepting Mr. Ruppert's story required accepting that Dr. Carey had lied, "it created this crazy amount of ill will," and "anybody that was on the fence was no longer on the fence."[73]

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[71] Dr. Molk and Dr. Carey also had a conversation about the rescheduling issues after Dr. Molk encountered FMH schedulers occupied with "shuffling patients from the Surgery Center to FMH." Dr. Molk recalls that he was trying to "figure out why and what was going on," and Dr. Carey told him he "thought there were staffing issues." When Dr. Molk pressed him, Dr. Carey offered it was "probably because of COVID," which Dr. Molk understood to refer to the ongoing staffing challenges created by the pandemic during this time. Molk test. This exchange, which appears to have occurred before Dr. Carey learned about the "staff walkout," does not establish that Dr. Carey told Steve Ruppert or anyone else that the Surgery Center was closed due to a COVID outbreak.

[72] Foundation Health Partners CMO Angelique Ramirez believed Mr. Ruppert without question. She recalled that Mr. Ruppert came to an FMH "incident command" meeting straight from his phone call with Dr. Carey, and reported that Dr. Carey had just informed him of needing to transfer patients because of a COVID outbreak. She described the report as credible based on how quickly she believed Mr. Ruppert had brought it to leadership – just minutes after his conversation with Dr. Carey, she said. But Mr. Ruppert's own email at the time described talking with Dr. Carey at 5:00 p.m. on January 26, and bringing the issue to the leadership meeting *the following day*.

[73] Carey testimony.

G. Surgery Center suspension, investigation, and revocation of privileges

1. Notice of violation

On January 28, 2022, two days after the "staff walkout" meeting, Dr. Flory delivered to Dr. Carey a letter titled, "Official notice of violation of medical staff policy #19 Disruptive/ Inappropriate Behavior." The letter accused Dr. Carey of "a pattern of unwarranted, demeaning and offensive conduct going back to October 2021," as reportedly described "through interviews and a written statement." The letter accused Dr. Carey of

- "being critical of staff competency in which you stated surgery center staff was not appropriately trained,"
- "exhibit[ing] uncooperative attitude by not offering any solutions," and
- "ma[king] inappropriate criticism and disparaging remarks about the center's leadership in front of staff members."

Dr. Carey was directed to "avoid engaging in conduct that undermines the confidence in leadership," "make suggestions to improve the process rather than being critical," and "deliver a verbal and written apology" to Ms. Piszczek and Ms. McGee.[74]

2. Notice of immediate suspension

Five days later, the Surgery Center notified Dr. Carey of the immediate suspension of his clinical privileges. The February 2, 2022 letter from Dr. Flory identified four reasons for this action:

1. Substandard care and patient harm provided to patients, as evidenced by an independent review of five medical records identified through complaints by staff.
2. Multiple patient safety and hostile work environment issues identified by operating room staff that led to operating room staff refusing to work with you. This resulted in an unprecedented staff walk-out on January 27, 2022.
3. Violation of disruptive/inappropriate behavior facility action plan in your refusal to apologize to the staff identified in the disciplinary documentation.
4. Medical record documentation deficiencies identified through chart review.[75]

The suspension letter indicated that an expedited review process would be undertaken, and that Dr. Carey would be expected to respond to the reviewers' critiques and other concerns.

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[74] Ex. 32. This "apology" was apparently related to the letter's accusation that "in the past two weeks, your conflict with the Administrator and the Director of Nursing – Operative has affected the ability of others to get their jobs done and disrupts the operation of the surgery center." *Id*., p. 1.

[75] Ex. 34.

3. External reviews

As suggested by item 1, above, the Surgery Center had sent records from five of his cases to three external reviewers. This had occurred without Dr. Carey's involvement.[76] Of the five cases, only one – referred to as "Complaint E" – has been identified as an "index patient" (Patient No. 3) in the current case.[77] The Surgery Center later asked the reviewers to address a sixth case – that of Patient No. 4 in this case.[78]

One of the reviewers, Smith Meads, expressed concern about the process by which the Surgery Center reviews were being conducted. Dr. Meads opened his review with the initial impression that "there is more of a personality conflict leading to contentious actions than medical malpractice or negligence." He noted that he had initially been provided only limited and seemingly one-sided information, which he called "disconcerting when a medical institution is calling into question the skills and capability of a surgeon, but is seemingly hiding information vital to the subject matter."[79]

In addition to the individual medical case reviews, the reviewers were also sent information about staff complaints and the FMH COVID controversy. One reviewer – Steve Ward, who would later be named a member of the FMH "Ad Hoc" investigative committee and then retained as a Division witness in this case – elected to conduct his own further investigation. Dr. Ward interviewed two Surgery Center staff members, and, without talking to Dr. Carey, accepted that "behavior by Dr. Carey has a negative effect on the staff."[80] Dr. Ward's written report on patient care repeatedly accused Dr. Carey of "intentional dishonesty" and recommended revocation of his surgery center privileges.[81] Of the three reviewers, Dr. Ward was the only one to testify in this hearing. Both his demeanor when testifying and the emotionally charged content of his written submissions during the Surgery Center process undermined Dr. Ward's credibility, both as to his role(s) in the credentialing processes and as to his testimony in this hearing.

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[76] It appears that this process was underway by October 2021. *See* Ex. 31, p. 2 ("case notes for reference" document dated 10/8/2021). Dr. Wade selected the external reviewers. He began with Steven Ward, a relatively new orthopedist at Bassett Army Medical Center. Dr. Ward gave Dr. Wade the names of two other physicians from his residency program, Mark Messmer and Smith Meads, and each produced a written report on each of the five cases.

[77] The patient in "Complaint E" is Patient 3, discussed below.

[78] Ex. 38, pp. 11-13 (Meads); Ex. 40, p. 10 (Messmer). Dr. Ward, who treated this patient, may not have been asked to review this case prior to preparation of his expert report for this proceeding.

[79] Ex. 38. Dr. Meads did not testify in this proceeding.

[80] Ex. 37.

[81] Ex. 39, pp. 15-16.

Another reviewer, Dr. Messmer, was also clearly swayed by the COVID lie narrative, adding an addendum to his report saying that his earlier hesitation to recommend suspension had been replaced because of Dr. Carey's inability to be " straightforward and truthful with a local hospital" about the need to reschedule his surgeries.[82]

4. Board meetings with Dr. Carey

The Surgery Center Board of Directors met with Dr. Carey on March 3, 2022 and again on March 14, 2022 to discuss the issues identified in the suspension letter.[83] Most of the March 3 meeting concerned either the staff situation or the COVID allegations.[84] Dr. Carey denied, as he has here, having told Steve Ruppert there was a COVID outbreak at the Surgery Center, or that his need to reschedule surgeries was COVID-related. As to the issue of staff complaints, Dr. Carey suggested the complaints had been spearheaded by a "scrub tech that was saying derogatory things that we overheard and asked to not be in our room, and from that point forward, every case we did became a problem."[85]

Dr. Carey also expressed concern that it appeared that the reviewer who interviewed staff about complaints only interviewed the person with the complaint, but not any of the other people in the room during a surgery.[86]

> So, for instance, I, you know, I talked to [Flory] about the situation a little bit and he said he volunteered that himself as well as all the anesthesia team have never witnessed anything condescending or aggressive in the OR, but the interviews with [s]taff tell something very different where they are trembling in fear at the thought of, you know, interacting with me.[87]

This observation is consistent with Dr. Flory's hearing testimony, in which he confirmed that he never witnessed inappropriate behavior in Dr. Carey's OR.

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82 Ex. 40, p. 12.

83 Anderson test.; Hammond test.; Ex. 50.

84 Anderson test.; Hammond test.; Ex. 50. The Division's Ex. 50 is an AI-generated transcript of the teleconference and is plainly inaccurate in parts – interchangeably using "the border managers"/"the Board of Managers," or "SMH"/"FMH", Florida/Flory, "buy us"/"bias," for example. *See* pp. 4, 5. Dr. Hammond agreed it is "full of errors," with certain parts simply making no sense. But multiple participants validated portions of the transcript as reflecting what was discussed, and particular statements by Dr. Carey. Where there are other indicia of reliability, it is used to supplement non-hearsay evidence about the meeting and the events that followed.

85 Ex. 50, p. 22 ("conduct" allegations driven by "a couple of people where there's a disagreement with or not the best interpersonal relationship that, you know, causes some bias and opinions").

86 Ex. 50, p. 6. (Dr. Carey: "You know, the concern is, when you look at the case on average, there's six people in the room. and out of the six people in the room, the one that made the complaint, it seemed like was the only one that was talk to about that case, not the other five people, you know, from me to the PA, to assistance the anesthesiologist and I think it'd be pretty clear if you talk to all those people.")

87 Ex. 50, p. 5.

Dr. Carey expressed frustration that he had "been here doing a bunch of cases for five years with no concern," but that the atmosphere had changed "in October."[88] He also expressed that, to the extent the complaints concerned his recent expression of frustrations about the sudden revocation of Cassy's privileges, any surgeon on the Surgery Center's Board would have been similarly displeased.[89]

As to the case reviews, Dr. Carey noted that he had only received most of the reviews earlier that day, which made it difficult to respond with specificity to "the nitpicky stuff." He conceded that "from reading the review you know and reading through the notes there's definitely room for improvement." But he also observed that no concerns about the quality of his patient care at the Surgery Center had been raised with him until these events, noting: "I would hope if there was a concern or something would be brought to my attention first."[90]

As he had at FMH, Dr. Carey suggested that, for complicated cases with multiple pre-op clinic visits, some of the documentation concerns stemmed from "which note gets in as the H&P for the surgery center." But he agreed that he could do a better job "telling that story" in terms of his "documentation on those more complicated cases," and expressed openness to a broader review of his documentation versus looking at this sliver of cases where complications had arisen.[91]

5. Documentation Problems at the Surgery Center

Two critical documentation issues arose from the two meetings and Dr. Carey's written response to the case reviews. These were (1) Dr. Carey's use of templates in general, and (2) his documentation of a common surgical procedure ("chondroplasty"), particularly in connection with its possible impact on billing.

As to the overall use of templates, Dr. Carey explained during the Board meetings, as he did in his testimony, that for many procedures he does, the procedure will typically not vary from patient to patient, other than "routinely, these minor, minor caveats."[92] In that context, nearly identical operative reports were unsurprising.

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88 Ex. 50, p. 8. *See also*, Ex. 50, p. 21. (observing that some of the tensions had been worsened by "certain surgeons that work on the board that were upset about Jared leaving.").

89 Ex. 50, p. 22.

90 Ex. 50, p. 8.

91 Ex. 50, p. 8-9.

92 Ex. 50, p. 9 ("I think at least in my practice[,] there is half to not more of the procedures that 99% of the time always go the same way, like, a carpal tunnel dictation is always going to be the same[.] [T]rigger fingers[:]. Always gonna be the same.")

At the March 3 meeting, the discussion of particular surgical procedures briefly touched on Dr. Carey's knee arthroscopy templates. Several meeting attendees claim that during the March 3 meeting, Dr. Carey said that he had not reviewed his templates in ten years.[93] Dr. Carey denies saying this and insists it would have made no sense. It certainly would not have made literal sense – Dr. Carey had not been a doctor for ten years in 2022, used different templates in the Army than when he came to Fairbanks, and – according to Dr. Everson – modified his templates when Dr. Everson joined McKinley.[94] Further, Dr. Carey's dictation practice at the time of these events involved working from a binder of dozens of templates – first indicating which template "subtype" to use, and then identifying the various "caveats" that were unique or relevant to the particular case. The most reasonable interpretation of Dr. Carey's comment about templates at the March meeting is not that he literally had not read his templates in ten years, but that he had not closely or recently analyzed with fresh eyes precisely how various inputs impact the final product under the different templates.[95]

6. Billing Allegations

This discussion of templates and similarities between operative reports arose in the context of references to certain procedures and findings in Dr. Carey's reports. At issue was Dr. Carey's use of the phrase "chondroplasty to bleeding bone." The term chondroplasty refers to the surgical smoothing and reshaping of damaged cartilage; it can vary in degree from tidying up frayed edges to the complete removal of all remaining cartilage.

As a result of the issues raised in this case and related proceedings, Dr. Carey no longer uses the term "chondroplasty to bleeding bone" in his dictations.[96] At the time of these events, however, Dr. Carey used the term "chondroplasty to bleeding bone" to refer to any chondroplasty in which bleeding was seen underneath the cartilage. Thus, with Patient 4 (discussed further below), Dr. Carey had documented a "chondroplasty to bleeding bone" in

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93 Anderson test.; Hammond test. Exhibit 50 is unhelpful here, because key parts of this section are unintelligible.

94 Carey test.; Everson test.

95 This reading is consistent with his explanation in his August 2022 Surgery Center hearing testimony, where Dr. Carey described the process as susceptible to error. *See* Ex. 64, p. 4 ("It's sometimes hard, and when you're scanning them, it is. It is a noticeable flaw in my practice. Like, I have never been forced or asked to critically read these things. I look through them, and I'm, like, "Oh, it checks that box, checks that box, checks that box." It's different than when you read it out loud. It's, like, "Wow. That doesn't really" -- like, "I could have worded that better.")

96 Carey testimony.

December 2021, but subsequent procedures by Drs. Ward and Wade led to a disagreement about what Dr. Carey had done in the earlier surgery.

Addressing the written external reviews he had received earlier that day, Dr. Carey described what he had meant by "chondroplasty to bleeding bone," saying that it "does not imply that I took good cartilage away, simply that I removed lose flaps and unstable lesions and underneath there was areas of bleeding bone. It appears that the reviewers were thinking I did an abrasion arthroplasty, which is a procedure I have never performed."[97]

This statement – that he had "never performed" abrasion arthroplasty – set off a significant controversy.[98]

Briefly, the Surgery Center had billed Dr. Carey's "chondroplasty to bleeding bone" procedures as "abrasion arthroplasty." From a medical billing and coding perspective, this has various consequences. They potentially include:

- an increased fee for the chondroplasty,
- the chondroplasty being billed separately from the meniscectomy (whereas a standard chondroplasty is considered part of the meniscectomy, so even if both are performed, only one – the meniscectomy – is billed), and
- a different approach to billing meniscectomies.

The references to "chondroplasty to bleeding bone" were interpreted by Dr. Wade and others to reflect a complete removal of cartilage alongside stimulation of the subchondral bone surface to *cause* bleeding, i.e. abrasion arthroplasty. Interpreting Dr. Carey's operative report to mean "abrasion arthroplasty," in turn, led to suspicions about overbilling – namely that Dr. Carey was up-charging patients by billing for procedures not actually performed, an allegation that in turn dovetailed into the related allegations from unhappy staff about unopened awls.[99]

Dr. Carey has consistently denied these allegations, and prior to his suspension the Surgery Center had never raised these concerns with him.[100]

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97 Ex. 40, p. 13-14.

98 Anderson testimony (Carey statement that he had never performed an abrasion arthroplasty is what started their investigation).

99 This issue was discussed during the March 3 meeting, although the brief discussion in the AI-generated transcript at Exhibit 50 is unhelpful. When that discussion is read in concert with Dr. Carey's transcribed hearing testimony in the Division's Exhibit 64, a clearer meaning emerges. *See* Ex. 50, p. 8; Ex. 64, p. 15.

100 Ex. 50; Ex. 64, p. 4.

7. Revocation of privileges

After first suspending Dr. Carey's privileges, the Surgery Center revoked his privileges on March 28, 2022. He was provided a hearing, held in August 2022. He contests the procedural validity of that hearing, at which testimony was taken until the early morning hours, and a member of the hearing panel was observed appearing to have fallen asleep.[101]

H. FMH Investigation, Hearing, and Loss of Privileges

The events at the Surgery Center – and the allegation that Dr. Carey had blamed COVID for needing to transfer his January 27, 2022 cases – led to significant fallout at FMH. When Dr. Carey arranged to transfer his January 27 Surgery Center cases over to FMH, Steve Ruppert had given FMH leadership the impression that Dr. Carey had blamed the reschedule on a COVID-related staffing shortage. Dr. Carey later rescheduled his patients for the following week. When it became clear to FMH leadership that there was no "COVID outbreak" at the Surgery Center, the impact on Dr. Carey's credibility was profound.

From Dr. Carey's perspective, things at FMH had been slowly improving until these events caused the bottom to fall out.[102] Those at FMH who had previously supported him viewed the events as a disappointing confirmation that the worst allegations against him were true.[103]

In the meantime, Dr. Everson had become Chair of Orthopedics at FMH in January 2022. When the FMH Credentials Committee released Dr. Carey from the proctoring requirement in July 2021, the agreed-upon procedure attached to his reappointment was a "random review of five cases per month for monitoring of documentation concerns."[104] Those reviews had not occurred, however. Shortly after Dr. Everson became Chair, he produced a review of fourteen of Dr. Carey's September – December 2021 cases, which he presented to the FMH Credentials Committee on March 9, 2022, just after Dr. Carey's suspension at the Surgery Center.[105] Dr. Everson contended that he had identified thirty cases for review under the reappointment PIP and had thus far reviewed fourteen at random, trying to be "as neutral as possible." The commentary was highly critical – accusing Dr. Carey of a range of issues from rarely seeing his patients when

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101 Dr. Carey's testimony at the Surgery Center hearing was introduced (over his objection) in this proceeding; it is very largely consistent with his testimony in the hearing in this case. Ex. 64.

102 Carey test.; Ex. 2, p. 49 (April 2021: "external reviews are not showing any significant concerns;" remaining concerns "are mostly around documentation.").

103 Ramirez test.; Bateman test.; Carey test.

104 Ex. 2, pp. 55-56.

105 Ex. 2, p. 57; Ex. 13; Panko test.; Everson test.

they had complications, to performing unjustified procedures, to vagueness in operative notes and H&Ps.[106] Given the differences between the agreed-upon procedure and the procedure followed by Dr. Everson, the timing of the review alongside the events at the Surgery Center, and Dr. Everson's antagonistic relationship with Dr. Carey, it is difficult to accept that this was a neutral and unbiased review.

1. Ad Hoc Committee for Investigation

Whatever its origin, Dr. Everson's presentation of concerns to the Credentials Committee – describing a series of "noticeable trends" including "incomplete or vague" operative notes, late documentation, overreliance on PAs, and "rarely see[ing] his patients postoperatively even when complications arise" – led to an "urgent" meeting of the Foundation Health Partners (FHP) Leadership Council two days later.[107] During that March 11, 2022 meeting, the Leadership Council voted to initiate an investigation. The Council also asked Dr. Carey to "voluntarily refrain from exercising [his] privileges" during the investigation, stating that the issues raised – "in areas of documentation, professionalism, and quality of care" – "raise concern of potential imminent patient risk."[108]

The Leadership Council then appointed an "Ad Hoc Committee for Investigation" to evaluate Dr. Carey's work history at FMH. The Ad Hoc Committee was comprised of two radiologists – Jessica Panko, a member of the Peer Review committee, and David Evans, a member of the Leadership Council – as well as Dr. Ward serving as the outside community member and orthopedist.[109]

Dr. Ward's engagement in this role occurred just months after his engagement in similar work for the Surgery Center – and just days after his scathing critique of Dr. Carey in that matter.[110] Dr. Carey objected to Dr. Ward's participation, citing "multiple conflicts of interest." Dr. Ward acknowledged that he "did also personally have a bad experience with Dr. Carey while engaged in the peer review activities at SCF," but said he "does not feel this constitutes a conflict of interest and only provides background to the current situation."

106 Everson test.; Ex. 13.
107 Topics discussed included Dr. Carey's "sudden change in practice" of doing all his surgeries at FMH, as well as the 14 cases critiqued by Dr. Everson. Ex. 2, p. 59.
108 Ex. 2, p. 67.
109 Ex. 2, p. 63.
110 *See* Ex. 37 (March 1, 2022 report).

Over a two-month period from March until May 2022, the Ad Hoc Committee examined numerous earlier case reviews,[111] staff "360 evaluations," meeting minutes of other committees between January 2020 - July 2021,[112] other internal data, and expedited external case reviews requested from a medical review service,[113] as well as interviewing hospital staff.[114]

Dr. Carey contends that the process was designed to find problems and was doomed from its start with cases preselected by Dr. Everson. Dr. Panko defends the process, saying the committee "looked at a large, large number of cases," then selected a subset of those for review, and notes that both external reviewers concluded that the standard of care was met in the majority of those cases. It does appear that the Committee made an effort to focus on more recent events, although a significant amount of the material they reviewed was from the early part of the PIP process. The revisiting of so much early material resulted in a review that necessarily skewed towards negative findings.

It also appears that the Ad Hoc Committee missed opportunities to speak with at least some FMH personnel who worked frequently with Dr. Carey and whose assessment was markedly different than what is described in the ad hoc committee's report. Several such witnesses later testified persuasively in Dr. Carey's favor at the FMH hearing, and at the hearing in this case.[115]

The Committee met with Dr. Carey twice – once on April 7, 2022, and a second time on May 17, 2022, the day it issued its "Report of Findings and Recommendation for Action."[116] The Committee's May 17, 2022 Recommendation for Action concluded that Dr. Carey had

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111 To the extent there are discrepancies within the large record as to the number of cases reviewed externally at various times, these discrepancies are not material, because the various reported findings are not admitted in this proceeding for the truth of the matter asserted. That is, the findings by external reviewers – for cases other than the six patients identified by the Division – are not admitted for consideration of whether Dr. Carey met the standard of care in those cases.

112 Ex. 2, pp. 5, 7, 11, 14, 15, 29, 35, 37, 43, 45, 55, 57.

113 Fourteen cases from 2020-2022 were sent for expedited external review by NorthGauge physicians Skaife and Morgan. Ex. 8 (Skaife); Ex. 9 (Morgan). Because Dr. Skaife's review concerned only shoulder surgeries, there are no shoulder surgeries at issue in this case, and Dr. Skaife did not testify, his report has not been admitted. (The Committee's summary of it, at Exhibit 1, p. 6, is considered as evidence of what the Committee based its decision on, but is not admitted for the truth of the matter asserted). Dr. Morgan performed a summary review of "every knee surgery performed" by Dr. Carey at FMH in the prior six months, a review of three years of hip surgeries (not considered here), and individual reviews of other cases. Where Dr. Morgan's individual reviews addressed individual patients at issue in this case, they are discussed in Section III, below.

114 Ex 1, pp. 1, 4. Panko testimony.

115 Testimony of Bridget Watkins (FMH ED charge nurse and staff nurse who worked with Dr. Carey regularly and believes he provided excellent care); Testimony of Leslie Longley (OR Director); testimony of Jen Carlson (Clinical Operations Director); Ex. 17, pp. 55-56.

116 Panko test.; Ex. 1.

engaged in "a pervasive pattern of behaviors" indicative of "deficits in ethics, moral character, clinical judgment, technical skill, communication, [and] documentation."

Opining that "allowing Dr. Carey to maintain his privileges poses an imminent risk of adverse effects on patient health and safety," the Ad Hoc Committee recommended revocation of Dr. Carey's FMH privileges.[117] On May 23, 2022, the FHP Leadership Council recommended that the hospital Board revoke Dr. Carey's clinical privileges.[118]

2. FMH hearing and appeal process

Dr. Carey requested a hearing to challenge that recommendation. A three-day hearing was held in July 2022 before a three-member review panel consisting of a general surgeon, a medical oncologist, and a family medicine physician, with retired Fairbanks Superior Court Judge Jane Kauvar presiding but playing no decisionmaking role.

Much as he did in the hearing here, Dr. Carey presented evidence and argument challenging the premises upon which the Ad Hoc Committee's conclusion rested. Dr. Carey addressed the merits of cases addressed by the peer reviewers. He explained his challenges and errors with documentation.

The three-physician hearing panel deliberated extensively and issued an 11-page majority decision (as well as an 11-page concurrence by the third member). It unanimously rejected the revocation recommendation. Because the Leadership Council had framed the recommendation in terms of an argument that Dr. Carey posted an "imminent risk to patients," the hearing panel addressed and ultimately rejected that finding as "unreasonable," noting a significant lack of evidence to support such a conclusion.[119]

The panel acknowledged the existence of legitimate concerns justifying an investigation, but did not find facts supporting that Dr. Carey was an imminent risk to patients. The panel "heard and reviewed evidence that showed many of the concerns presented from Dr. Carey's cases having little or no harm for patients," and noted a general lack of evidence of "concrete concerns" to support allegations of risk to patients.[120]

While the panel accepted and agreed that there was evidence of some very concerning interactions between Dr. Carey and some FMH staff, and cited his own actions as having "led to the need for this investigation," it also credited the testimony from other current and past FMH

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117 Ex. 1, p. 2.
118 Ex. B, p. 1; Ex. 17, p. 41. FMH had suspended Dr. Carey's privileges on April 11, 2022. Ex. 2, p. 71.
119 Ex. 16, pp. 1, 13.
120 Ex. 16, p. 4.

staff leadership praising Dr. Carey's demeanor.[121] And the panel appeared to accept Dr. Carey's testimony "that he recognized these behavioral concerns and [] his need to change and improve in these areas."[122]

The panel was troubled by the shift between July 2021 – when the proctoring was removed and privileges approved – to March 2022 – when Dr. Carey was asked to voluntarily suspend his privileges. The panel noted a disparity between "general statements" and the lack of documented concerns in the nine months after the Credentials Committee had indicated "that Dr. Carey was improving." Noting an ongoing concern of "the lack of unbiased orthopedic surgeons" in this process, the panel was frustrated that the agreed-upon five-cases-per-month review did not occur until the belated delivery of reports in March 2022, which it described as, "completed by Dr. Everson (previously found to be biased by both parties) and Dr. Ward."[123]

The panel also did not accept that Dr. Carey had misled FMH about the reason for rescheduling his surgeries in January 2022.

As the judge in the current case has done, the panel appears to have found Dr. Carey credible, including finding that he had taken responsibility for earlier communication concerns and problems with his documentation. The panel agreed with Dr. Carey's testimony acknowledging "his needs for and plans for improvement in the future."[124] The panel did not, however, accept that harmful patient care had occurred.

The Leadership Council further appealed that decision as provided in the FMH bylaws. A three-member review committee then considered that appeal and recommended that the Board uphold the original recommendation. The appellate committee concluded the hearing panel had exceeded the bounds of its jurisdiction, taking the position that the only role of the hearing panel had been to determine whether Dr. Carey had proved that the Council's recommendation was so lacking in factual basis as to be arbitrary, unreasonable or capricious. In other words, the review committee took the position that even if a physician hearing panel believes, after hearing all the evidence, that a practitioner is fully competent in every way, it must terminate that practitioner's privileges as long as the original suspicions of the investigators were not arbitrary, unreasonable,

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121 Ex. 16, p. 6. Three of the four witnesses identified – Leslie Longley, Jennifer Carlson, and Bridget Watkins – testified in this case, and gave similar testimony as described by the review panel.

122 Ex. 16, p. 5.

123 Ex. 16, pp. 2, 5.

124 Ex. 16, pp. 1, 13.

or capricious. On October 26, 2022, the FMH Board of Directors voted to adopt the appellate committee's recommendation and terminated Dr. Carey's privileges.[125]

I. Complaints and Division investigation

All of the issues described above came to the attention of the Division and then the Board through a pair of complaints in February 2022 from Brenda Black and Rachel Pisczcek, and a third complaint from Dr. Everson a year later.[126]

The first complaint, from Brenda Black, came February 7, 2022, two months after Dr. Carey asked for her to not be scheduled in his OR and two weeks after the "staff walkout." Ms. Black accused Dr. Carey of fraudulent practices – specifically, "cases where he dictated completing a micro-fracture to treat chondral defects" when "no staff have ever witnessed this procedure by Dr. Carey" – as well as poor surgical technique relating to hip and shoulder arthroscopies. Ms. Black's complaint closed with a paragraph describing Dr. Carey as "incredibly diabolical," and treating OR staff in a "belittling" and "very disrespectful" manner.[127]

Rachel Piszczek then filed a scathing seven-page complaint with the Board two weeks later. Her wide-ranging accusations included Dr. Carey "typically" scheduling "10-16" surgeries per day, "speeding through" surgeries, engaging in "medical fraud" and "Medicare and Medicaid fraud," committing various patient care violations (including allegations related to Patients 3 and 4 in this case), "demeaning" and "inappropriate" behavior towards staff, and lying to FMH about a Surgery Center COVID outbreak.[128]

Division Investigator Angel Romero began an investigation in March 2022.[129] Mr. Romero interviewed a number of Surgery Center affiliates, including Dr. Flory, Sharon Anderson, Dr. Everson, Dr. Wade, and Ms. Piszczek. Inexplicably, however, he did not interview Dr. Carey. Mr. Romero initially testified under oath that he had interviewed Dr. Carey, but later conceded that there was no evidence of such an interview ever taking place.

In April 2023, three months after being countersued by Dr. Carey, Dr. Everson submitted a 3-page complaint to the Medical Board. He accused Dr. Carey of "fraudulent activity and

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125 Ex. 18.

126 Patient 6 filed a complaint with the Board in February 2024, after this administrative hearing matter was opened.

127 Ex. 22. As observed in footnote 55 above, Ms. Black has since moderated her views, testifying at hearing that she's ""a little bummed" about the course this matter has taken, "because I don't want to take away his license so he can't work, that wasn't my intention."

128 Ex. 21.

129 Romero testimony.

deceit" alongside multiple alleged patient care violations. The complaint has multiple factual misstatements. One gross exaggeration was that it was "not uncommon" for Dr. Carey to perform "14-16" surgeries per day. There were misstatements about the timing of Patient 2's second surgery (suggesting that it was done three or six months after the initial surgery, which it was not) and the circumstances of Patient 1's injury. Also included was a broad allegation of "many other patients" being subjected to "malpractice that resulted in catastrophic results for the patients." He accused Dr. Carey of "fraudulently using his MRI for material gain" and "performing surgeries in his office."[130]

When interviewed by Investigator Romero, Dr. Everson accused Dr. Carey of having operated unnecessarily on Patient 2 because of her "excellent insurance," which Dr. Everson said he had looked at her chart to verify. But Patient 2 is a Medicaid patient. Not only did she not have "excellent insurance," but Dr. Everson's claim of having verified such coverage calls his other assertions into doubt. Dr. Everson also told Investigator Romero that he had noticed "surgical drapes" in trash bags next to dumpsters in the McKinley clinic parking lot while driving home one day. The likelihood of Dr. Everson seeing this level of detail across the four-lane road and through the parking lot to the McKinley building is slim at best, raising further questions about the accuracy of some of Dr. Everson's testimony and/or his motivation to be less than candid with the tribunal.

By this point in the investigation process, Mr. Romero had come to believe that Dr. Carey was performing operations in his office at the same time that he was trying to open a licensed facility. Mr. Romero then took a period of personal leave. When he returned, he did not update his investigation by checking the facilities licensure status associated with these allegations. Nor, did he make Dr. Carey aware of the new allegations against him, or solicit any response from Dr. Carey.

III. Specific patient care allegations

Against the backdrop of the discord described above, the overturning of a physician panel decision in Dr. Carey's favor, and the incomplete Division investigation of overstated allegations, we turn to the six specific patients whose care has been put at issue in this case. These six patients were identified by the Division in response to a prehearing order directing it to

[130] Ex. 12.

identify the specific patients whose care it contends was substandard.[131] The majority of these patients were not cases analyzed or at issue in the Surgery Center or FMH proceedings. Each is addressed below, in order by date of Dr. Carey's surgery.

A. Patient 1: May 2020 pediatric crush injury

The earliest of the six cases is a pediatric fracture stabilization performed by Dr. Carey at the Surgery Center in May 2020. Four-year old Patient 1 was seen in the FMH Emergency Department on Sunday, May 3, 2020, after her right thumb was caught in tire chains on an ATV. With her finger stuck between the chain and the tire, it had been necessary to complete the rotation of the tire in order to free her thumb, causing a significant crush injury.[132]

1. Pre-operative course of care

In the Emergency Department Patient 1 was seen by PA Jeri Reid, who diagnosed a fracture and consulted with Dr. Carey by phone and text message. They agreed Reid would clean and splint the thumb, and Dr. Carey would see Patient 1 the next day.

There is an evidentiary dispute about how Patient 1's thumb was bandaged at the ED. The ED records state that Patient 1's mother was educated on how to check capillary refill through a window in the dressing.[133] Dr. Carey's records describe the dressing as fully covering the thumb – although those records were signed well after the events at issue. Dr. Carey notes that the thumb of a four-year old is very small and says it would simply not be possible to stabilize this injury while leaving a viewing window.[134]

There is also some initial dispute about the severity or nature of the fracture. While it is undisputed that Patient 1 had a fracture and two lacerations on her thumb, Dr. Carey takes issue with the emergency department notes characterizing Patient 1's injury as an "open fracture." Dr. Carey contends that the lacerations – "a laceration at the base of the thumb measuring approximately 8 mm full-thickness," and "a separate laceration on the medial side of the right thumb measuring approximately 5 mm" – were avulsion injuries caused by pressure from the

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131 The Division characterizes these as "examples" of substandard care. But the Order was to identify each patient whose care would be put at issue. Basic fairness and due process entitle a licensee to this information.

132 Ex. 59, pp. 13-14.

133 Ex. 50, p. 15 ("Mother is advised to check the fingertip again which is visible through the distal end of the dressing this evening for any duskiness of the fingertip. She feels comfortable this plan").

134 Patient 1 weighed 34 pounds at the time of her injury, which occurred less than a month after her fourth birthday. Ex. 59. The fact that neither Patient 1's parents nor any member of her care team identified an issue through a viewing window also tends to support that there was no such window, or that if one was created, it was too small to be functional.

crush injury, and were not caused by the fracture itself.[135] He also maintains that PA Reid's chart note – stating that she "did a closed reduction of the fingertip" – does not support a finding that this was an open fracture.[136] Dr. Carey's own operative note references a closed displaced fracture.[137] The evidence as a whole – including the x-ray, in which the tip and base of the thumb are fully visible and far from the surface of the thumb – support that the fracture was certainly not a classic "protruding" open fracture.[138]

It is undisputed that Dr. Carey saw Patient 1 in the office on Monday, May 4, the day after her injury and ED visit. He reviewed the ED x-rays as well as photos of the laceration on her mother's phone but did not remove the bandage to inspect the finger himself. He scheduled Patient 1 for surgery to pin the broken finger (to stabilize it) that Thursday.[139] At the preop appointment two days later, Patient 1's father noted "concern for odor coming from the thumb." Believing that changing the bandage in the clinic would be traumatically painful, and with Patient 1 scheduled for surgery the next morning, Dr. Carey did not inspect her finger beneath the bandage.[140]

2. Surgical reduction and subsequent care

When Patient 1's finger was unwrapped under anesthesia on May 7, it was visibly apparent that some sort of vascular injury had occurred. Her skin was "dusky." The injury was significant enough that Dr. Carey had staff bring the Patient's parents back for a discussion before surgery, explaining that the injury was more extensive than had been believed.

Dr. Carey performed the reduction and pinning as planned. Patient 1's thumb bled when the pin was inserted, suggesting that blood flow was intact. PA Tommie Younker recalls that "the belief in the OR was that the finger would come back."[141] Because of the obvious vascular

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135 Ex. 59, p. 14. Drs. Carey and Tompkins both testified that full thickness in this context means through the skin, not necessarily deeper into tissue or to bone.

136 Ex. 59, p. 15 (ED Course: "closed reduction;" "Clinical Impression: acute open fracture").

137 Ex. 51, p. 5.

138 On the second to last day of the hearing, the Division indicated that it wanted to call PA Reid in rebuttal, but that Ms. Reid would not testify unless subpoenaed and would require several weeks to coordinate with her own counsel. Because accommodations of the parties' and counsels' schedules had meant that a full month had passed since Dr. Carey's testimony about his interactions with PA Reid, and the allowable schedule for rebuttal testimony had been known since that time, the administrative law judge declined to continue the hearing an additional 2-3 weeks to accommodate the Division's last-minute request.

139 Ex. 59, p. 14. He did not schedule the surgery for the following day because the situation was not an emergency and to allow more time to plan for Patient 1's complicated health history, including a seizure disorder and heart surgery within the past year. *Id*., Carey test.

140 Unwrapping a severely broken finger on a four-year-old child would cause trauma. Tompkins test.; Carey test. Indeed, Dr. Carey mistakenly believed Patient 1 had been sedated for the initial splinting. Carey test.

141 Younker testimony.

injury, however, Dr. Carey consulted with two experienced pediatric orthopedists – Shriner's pediatric orthopedic surgeon Bryan Tompkins and Jeffrey Friedrich, a pediatric hand specialist at Seattle Children's Hospital – about Patient 1's further care.[142]

At a follow-up appointment four days post-op, Patient 1's "dusky" thumb had "turned completely black," and Dr. Carey transferred her care to Seattle Children's. Dr. Friedrich assumed charge of Patient 1's care, and performed a series of surgeries – first, an unsuccessful attempt to save the thumb through a groin flap transplant, followed by the successful reconstruction of a big toe transferred to the thumb position – with Dr. Carey continuing to assist in her post-surgical care.[143]

3. Evidence about standard of care

The Division alleges that Dr. Carey's failure to unwrap and inspect the bandaged thumb sooner caused Patient 1 to lose her thumb. The Division did not provide expert testimony in support of this claim, however – neither as to standard of care nor as to causation. The Division contended it was not required to do so, reasoning that the negligence in this case was so obvious that expert testimony was not required.

At the hearing, Dr. Everson was permitted to testify about this patient because he contended Dr. Carey had consulted with him about Patient 1's care, and because his complaint to the medical board had specifically raised concerns about Patient 1's care. Testifying as a fact witness, Dr. Everson suggested that Dr. Carey had blamed the ER for wrapping the thumb too tightly because he (Dr. Carey) should have operated sooner and/or unwrapped the thumb earlier. However, Dr. Everson's involvement, if any, was limited to a conversation in passing, and his written complaint contained several material incorrect factual statements.[144]

The significantly more persuasive testimony of Dr. Tompkins, who did provide an expert report, supports the conclusion that Dr. Carey's care of Patient 1's injury was appropriate, and

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142 He also mentioned the situation to Surgery Center Medical Director David Flory. Dr. Flory testified that he felt Dr. Carey was "not sufficiently worried about the little girl or her thumb." At the time, however, the Surgery Center did not take any action that would reflect such concerns. Indeed, while Dr. Flory told investigator Romero that Patient 1's injury had been a "sentinel" moment, there is no evidence that these events were treated as cause for concern about Dr. Carey's practice at the Surgery Center – either when they occurred or at any time thereafter.

143 Carey test., Tomkins test, Ex. LL.

144 Dr. Everson attributes these errors to misleading statements by Dr. Carey, who denies discussing this case in any detail with Dr. Everson. The evidence on a whole does not support that Dr. Everson was "consulted" on Patient 1's care. At the same time, licensees should be able to report concerns to the Board, and to offer testimony to explain those concerns. This is not limited to treating providers or those formally consulted on care. However, the evidentiary value of such testimony is significantly lessened where, as here, the witness has limited or incorrect information about the actual underlying facts.

that it did not cause the vascular injury. As Dr. Tompkins explained, the presence of blood flow when the thumb was pinned is evidence that the vascular injury had occurred distally, as would be expected in a crush injury, and not proximally, as would be expected in a tourniquet injury.[145]

Further evidence that the thumb had not "died" from a tourniquet wound is found in Dr. Friedrich's course of treatment – namely, that he performed a surgery that would not have been attempted if the thumb was dead. The groin flap procedure relies on vascularization around the thumb. Patient 1's medical team would not have attempted this procedure if the thumb had been necrotic from a tourniquet injury.[146]

The FMH external peer review of this incident – offered as an exhibit by the Division – *also* concluded that "the most likely culprit" for the necrotic thumb was the original mechanism of injury.[147] Dr. Carey also notes that a tourniquet injury would have caused Patient 1 intense pain over the days that the inappropriately tight bandage was in place. Patient 1's lack of such complaints further supports the likelihood that the vascular injury was caused by the crush injury, not the bandage.

A March 11, 2024 letter from Dr. Friedrich likewise finds no fault in the "acute phase of [Patient 1's] thumb injury care," stating that Dr. Carey's care of the injury "was appropriate in terms of the interventions rendered and the timeliness thereof," and that the ultimate outcome in the case was "more likely than not due to the mechanism of injury rather than the care provided."[148] A preponderance of the evidence supports that Patient's 1 vascular injury was caused by the original crush injury, and not by any action or inaction by Dr. Carey.

4. Documentation

Dr. Carey's clinic visit records for Patient 1 were not signed until months after those visits. The clinic notes do not indicate the date the note was dictated, only the date it was signed, and Dr. Carey presented unrebutted testimony that note signing would sometimes be delayed by the need to edit an initial transcription. Thus, a clinic note dated in July may have been dictated

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145 Tomkins test; Ex. JJ.

146 Carey test.

147 Ex. 9, pp. 54-56. While the review found a standard of care violation based on the length of time between referral and when the patient was seen, the reviewer appears to have been given incomplete records. His opinion was that Dr. Carey should have seen Patient 1 the day after her injury, and he found a violation based on a belief that "[i]n fact, the patient was not seen for three days following injury." This is incorrect, however: it is undisputed Patient 1 was seen at McKinley the day after the initial injury.

148 Ex. LL. The exhibit is hearsay, but supplements the testimony of Drs. Tomkins and Carey about the course of events in this patient's care. (Dr. Friedrich was on Dr. Carey's witness list, but was not ultimately called to testify after the Division indicated it had no witnesses beyond Dr. Everson who would testify about Patient 1's care).

much earlier, then clarified or corrected, and not finalized until a later date set aside for catching up on paperwork.

The operative note, however, *does* include the date of dictation. Dr. Carey dictated the operative note for the May 7 surgery four days later, on May 11. Testimony of standard of care for dictation and submission of operative notes varied, with Dr. Flory saying the standard is for records to be "timely enough that their reliability can be reasonably inferred," and Dr. Ward saying that operative notes should be signed "if not within 24 hours, for sure within a day or two." Dr. Everson first testified that "the standard of care in the community" is to dictate an operative note within 24 hours. He later said that 24 hours is the "ideal" timeframe, but acknowledged sometimes falling short of that himself. (Indeed, Dr. Carey presented evidence of clinic notes and operative reports that Dr. Everson signed weeks or months after the event). Dr. Wade testified that standard of care for an operative report being dictated and signed is "usually within three days."

Considerable ink has been spilled over a reference in Dr. Carey's chart note to one of the reasons he had not unwrapped the thumb: a mistaken belief that Patient 1 had been sedated to splint it in the ED. The ED records reflect that PA Reid initially intended to repair the lacerations and reduce the fracture herself under conscious sedation, but instead ultimately splinted the thumb using only Tylenol for pain relief. The Division also argues that Dr. Carey altered his records after becoming aware of the vascular injury. The basis for this claim is that the version of the May 4 clinic note found in the Surgery Center chart – the one sent over to place the patient on the May 7 surgery schedule – was less detailed than the final signed version of the note. The later signed version was more detailed, including an explanation of why Dr. Carey had not unwrapped the bandage.[149] To the extent the Division alleges that Dr. Carey's supplementation of the draft note with further details is evidence of malfeasance, that argument is rejected. However, the fact that the details were not written contemporaneously is a factor that has been considered in assessing the evidence as a whole.

B. Patient 2: June 2020 MPFL Reconstruction

[149] Ex. 51, p. 7 ("We performed reduction and pinning on 5/7. Prior to pinning we had seen pictures of the injury on Moms phone which were not concerning for vascular injury but did not remove splint because of the unstable fracture requiring sedation. In the OR there was vascular compromise not prior reported or suspected. Hard to determine if this is secondary to prior injury or the dressing/splint being too tight in the ER. When placing the pin in the OR there was blood flow to the tip making me think the blood flow is intact. Patient is now back 4 days after surgery and the dusky nature of the thumb has turned completely black.")

The second patient whose care is at issue is a young woman who had a successful knee surgery with Dr. Carey in June 2020. Thirty-year-old Patient 2 had an earlier ACL repair performed by Dr. Everson in September 2019.[150] She continued having pain and ongoing issues and was unsuccessful in her postoperative physical therapy. Patient 2 saw Dr. Carey, who by January 2020 concluded that she had patellar instability and, more generally, ligamentous laxity causing her ongoing problems.[151] As he describes: "She was progressing the wrong way with PT, we were trying to rehab her out of it and rehab her out of it and she was getting worse." Nine months after the ACL repair, Dr. Carey performed a second procedure which was, by all accounts, a success.

The document that McKinley Orthopedics office faxed to the Surgery Center the day before Patient 2's surgery, and which was treated as the "H&P" (History & Physical) for this procedure, was a June 1 clinic visit note. The note is internally inconsistent in parts, variously describing Patient 2 as 6-months versus 9-months post-op, and at one point stating her repeat MRI had not been completed, while elsewhere saying it was "discussed with the patient today."[152]

The note does reliably document Patient 2's symptoms as "sharp" pain, "bone on bone pressure" and "instability" ("Pt states she fell about a 1 week ago"), with pain is described as severe (7 out of 10) with prolonged walking, and exacerbated by walking, bending, and descending stairs.[153] Dr. Carey notes Patient 2 has been in physical therapy three times per week, but "continues to have knee pain despite rest, ice, oral anti-inflammatories, and quadriceps strengthening exercises with physical therapy."[154] The June 1 clinic note describes "a long discussion about the risks, benefits, and alternatives to a surgical procedure," and a decision to go forward with "diagnostic left knee arthroscopy, possible meniscal debridement versus repair, chondroplasty, lateral release and open MPFL reconstruction."[155]

Dr. Carey's operative note from Patient 2's June 18, 2020 surgery lists the procedures performed during the 42-minute surgery as: "left knee arthroscopy with medial meniscal debridement," "chondroplasty to bleeding bone" of the medial, lateral, and patellofemoral

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150 Ex. 54, p. 1; Everson test. This was Dr. Everson's first ACL repair after joining Dr. Carey's clinic, and Dr. Carey assisted in that surgery. *Id*.

151 Ex CC, pp. 43-44 (January 29, 2020: doing PT and home exercises, taking NSAIDs, following activity restrictions; to follow up in two months).

152 Ex. 14, pp. 7, 8.

153 Ex. 14, p. 7.

154 Ex. 14, p. 8.

155 Ex. 14, p. 9.

compartment, "lateral release," "removal of a 10-mm loose body in the articular notch," and "medial patellofemoral ligament reconstruction with allograft tendon."[156]

Patient 2 recovered successfully from the MPFL repair and remains a patient of Dr. Carey's. Nonetheless, this surgery was one of the topics about which Dr. Everson complained to the Board three years later, and which the Division now alleges was substandard care.[157]

The Division's expert, Dr. Ward, opined that an MPFL reconstruction was not indicated for Patient 2. But this belief appeared to derive from having reviewed only a limited subset of Dr. Carey's records for Patient 2, not including the repeat MRI, a visibly unstable patellar x-ray, or exam findings all consistent with an MPFL diagnosis.[158] In their reports and testimony, Drs. Mustovich and Tompkins both agree that Patient 2 had "injury, imaging, and exam findings consistent" with an MPFL injury, and that the procedure Dr. Carey performed was appropriate and indicated.[159] The evidence presented supports that conclusion.

As to documentation, Dr. Carey did not dictate the operative note for this June 18 surgery until July 15.[160] While the testimony varied about what the standard of care requires in terms of timing of dictation, there is no doubt that the month-long delay between surgery and dictation was outside of what it is considered to be the standard of care.[161] Dr. Carey also admits that his H&P should have been better – specifically, that it should have included details of her PT, the repeat MRI, and the full diagnostic basis for the procedure. But in terms of treatment and

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156 Ex. 14, p. 10. The knee joint is comprised of three compartments. The medial (outside) compartment is the joint between the femur and tibia on the outer side of the knee. The lateral (inside) compartment is the joint between the femur and tibia on the inside of the knee. The joint between the patella (kneecap) and its groove on the femur is the patellofemoral compartment. The condyles of the knee are two rounded joint surfaces at the lower end of the thigh bone. Between each condyle and its corresponding compartment is a meniscus – a piece of fibrous cartilage – located on the tibial joint surface.

157 Dr. Carey notes that Dr. Everson's statements to the Division's investigator about this patient contained multiple significant inaccuracies, including the claim that Dr. Carey did his MPFL 3 months after the ACL repair (it was 9 months) and the claim to have "looked up" that Dr. Carey did the surgery because Patient 2 "had really good insurance" (Patient 2 was a Medicaid patient).

158 Mustovich test.; Tomkins testimony; Ex. CC, pp. 35-36, 43-44, 79, 86. The Division seeks to discredit Dr. Mustovich's testimony as unreliable because he is relatively new surgeon. Dr. Mustovich is a Board certified orthopedic surgeon who was entering his fourth year out of practice at the time of the hearing. Dr. Ward has only marginally more practice experience, and no showing has been made that any of the three testifying experts is significantly more or less knowledgeable about these procedures than the others.

159 Ex. CC; Ex. II.

160 Ex. 14, p. 12. For context, this was during the time that the FMH Credentials committee was identifying and addressing Dr. Carey's documentation problems. It was in July 2021 that the committee observed that Dr. Carey's documentation continued to be a problem while relationships with staff had improved. Ex. 2, pp. 55-56.

161 While Dr. Ward testified that Dr. Carey's documentation for Patient 2 fell below the standard of care in other ways as well, it became clear that Dr. Ward did not have Dr. Carey's full pre-operative documentation for Patient 2, including documentation that noted her ligamentous laxity, her repeat MRI, and her preoperative physical therapy. *See* Ex. CC, pp. 35-36, 43-44, 79, 86.

outcomes, he urges, Patient 2 "got the right care, got the right surgery, and she got better."[162] The Division did not prove otherwise.

C. Patient 3: Post-operative fracture following August 2021 total knee arthroplasty

The next patient at issue is a 58-year old man upon whom Dr. Carey performed a total knee arthroplasty in August 2021. For context, this was nearly a year after Patient 2's surgery. It was before any issues relating to Dr. Carey's patient care had been raised at the Surgery Center and was the month after the FMH Credentials Committee discontinued the proctoring requirement due to the absence of patient care concerns.[163] Patient 3's total knee arthroplasty was later one of the cases selected by the Surgery Center for external review.

Like Patient 2, Patient 3 had been treated previously by Dr. Everson who—four months before Dr. Carey's surgery—had performed an arthroscopy. At the time of Dr. Everson's surgery, Patient 3 had been experiencing persistent knee pain and dysfunction since an injury about six months earlier.[164] Dr. Everson diagnosed a bone marrow lesion and patellar chondromalacia, and performed a partial meniscectomy, a patellar chondroplasty, and an interosseous bioplasty – essentially, an injection of platelet rich plasma into a bone lesion on his medial femoral condyle.[165] Patient 3's pain continued, however, and he returned to McKinley repeatedly with severe and "lifestyle limiting" pain.[166] MRIs in June 2021 and August 2021 showed osteonecrosis in the medial femoral condyle (the rounded part of the femur on the inside of the knee), leading to a diagnosis of "spontaneous osteonecrosis of the knee."[167]

With Patient 3 in "excruciating pain," "having a fair amount of difficulty ambulating," and "getting worse," Dr. Carey performed a total knee arthroplasty on August 12, 2021.[168] Early in the surgery, it became apparent that the bone quality of Patient 3's *lateral* femoral condyle was compromised. Thus, when Dr. Carey began removing the joint surface, he found

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162 Carey testimony.
163 *See* Ex. 2, pp. 55-56.
164 Ex. DD, pp. 67-72.
165 Ex. DD, pp. 115-117.
166 Ex. DD, pp. 131-169; Carey test. ("He came to see me because he was irritated with Dr. Everson putting him off.")
167 Ex. DD, p. 1; 136-139.
168 Ex. DD, pp. 131-169; Carey test. Dr. Everson has contended that it was improper for Dr. Carey to perform a total knee arthroplasty on Patient 3 because his knee looked "pristine" and undamaged at his initial surgery. Everson test. But Patient 3's chart contains ample evidence of both the damage to his knee and the worsening pain and suffering he was experiencing as a result. Dr. Everson also testified that PA Jen Holt told him that, during the August surgery, Dr. Carey had described Patient 3's knee as "pristine," and wondered aloud, "why am I doing a total knee on this?" But Jen Holt did not participate in that surgery. Dr. Everson's critiques on Dr. Carey's care of Patient 3 were not well founded.

concerningly "soft" bone quality at the end of the femur.[169] Before proceeding further, Dr. Carey (1) asked the device manufacturer representative in the OR about various possible implant options, and (2) phoned Dr. Molk to consult about the complication.

As Dr. Molk describes their discussion, Dr. Carey reported having "discovered some compromised bone quality" after making his initial cuts, and "had some concerns for the structural integrity of the bone," so had called Dr. Molk "to see if [he] had any ideas on how he'd handle it." Dr. Molk recalls Dr. Carey being concerned about soft bone under the joint where he was about to cement a prosthetic, and wanting to know if Dr. Molk had any suggestions on how to best maximize the patient's chances of avoiding a post-operative fracture.[170] The solution Drs. Molk and Carey discussed and which Dr. Carey ultimately implemented was to fill the defect with additional bone cement.[171] Dr. Molk credibly described this as a "very standard" approach to this problem, and as meeting the standard of care. The evidence supports this conclusion.

Two months after his total knee replacement, Patient 3, now back to full weightbearing and in physical therapy, "took a step and felt like his leg gave out on him." He was taken to the emergency room and diagnosed with a fracture just above the joint, adjacent to his total knee prosthesis.[172] The following day, Dr. Molk performed an open reduction internal fixation to repair the fracture.[173]

The Division's expert, Dr. Ward, contends that Dr. Carey did an insufficient pre-operative workup for this patient. But Dr. Ward reached his conclusion without actually viewing either of the two preoperative MRIs.[174] These did not show the level of necrosis that was revealed during the surgical procedure, nor did they show a bone lesion in the location where the later fracture occurred.[175] When Dr. Ward reviewed the MRI under cross-examination, he identified the bone lesion Dr. Everson had previously injected with PRP, as well as osteonecrosis in the medial femoral condyle, but not the lateral femoral condyle osteonecrosis that was apparent at the time of the surgery.[176]

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169 Molk testimony.
170 Molk testimony.
171 Molk testimony; Carey testimony; Ex. DD, pp. 198, 201.
172 Ex. DD, pp. 221-222; Molk test. ("supracondylar distal femur" fracture).
173 Ex. DD, pp. 224-226; Molk test.
174 Ward test.
175 Carey test., Molk test.
176 Ward test.; Ex. 31, pp. 12-13.

Dr. Molk credibly testified that, having both reviewed the patient's MRI and provided his later care, he would not have planned anything differently than what Dr. Carey prepared for this surgery. As to the repair Dr. Carey performed once the compromised bone quality was identified during the surgery, Dr. Molk describes this as a "very standard," "appropriate" approach that met the standard of care.

During the hearing, Dr. Ward also opined that Dr. Carey may have actually caused the fracture himself during the August surgery, perhaps by driving in the implant with too much force. This speculation is not supported by the evidence. Indeed, an FMH peer review – which the Division seeks to rely on as to other issues – rejected this possibility.[177] And Patient 3's post-operative chart notes prior to the ED admission include multiple x-ray reports in which no fracture was seen.[178] The evidence does not support a finding that Dr. Carey fractured Patient 3's femur inter-operatively.

As to documentation, Dr. Carey's Operative Report for Patient 3 was lacking in some respects. Its description of "indications for procedure" omits mentioning the arthroscopy four months earlier, stating only: "[t]he patient has progressive lifestyle limiting pain and dysfunction despite comprehensive conservative treatment to include physical therapy, NSAIDs, brace wear, physical therapy, and activity modification."[179] The Operative Report also does not mention the interoperative consult.

Dr. Molk characterized the operative note as more templated and sparse than he would "prefer," but not so deficient as outside the standard of care.[180] While Dr. Carey has fairly been criticized for templated reports in other instances, this report describes the unique concern encountered during this surgery and the approach taken to remedy it.[181] And while issues have

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177 Ex. 9, pp. 45-48 (Dr. Morgan).

178 Ex. DD, pp. 200-201 (8/13/21: "X-rays show hardware in appropriate position/ alignment. We discussed procedure in detail[.] I made patient aware his femoral condyle was not very strong and I had to supplement with cement. He will remain NWB for 4 weeks."); pp. 206-208 (8/25/21: "Findings: 3 views of the knee are performed focusing at the right knee today hardware remains in place no significant change in positioning today remain stable without obvious signs of loosening. Today's x-rays are compared to those previous performed on August 13, 2021., again no significant change in positioning remaining stable."); p. 212 (9/8/21 x-ray: "Normal postop total knee arthroplasty"); p. 218 (10/7/21: x-ray "demonstrating obvious signs of fracture with dislocated distal femur hardware.").

179 Ex. DD, pp. 196-199. As seen with other patients, the McKinley clinic notes as a whole for Patient 3 provide a more comprehensive treatment history than is apparent in the H&P.

180 Molk test. Dr. Morgan, the external NorthGauge reviewer, likewise found Dr. Carey's documentation for Patient 3 to be acceptable. Ex. 9, p. 47, p. 56.

181 Ex. DD, pp. 221-223. ("The lateral femoral condyle was significantly compromised consistent with osteonecrosis. This was reinforced with bone cement and will alter weightbearing in the initial post operative period").

been raised in this case about the timing of some of Dr. Carey's documentation, the operative report in this case was dictated on August 14, 2021, two days after surgery. It was transcribed the following day, and then signed by Dr. Carey on August 24.

D. Patient 4: December 2021 chondroplasty and meniscal debridement

The next patient care issue raised by the Division is a December 2021 left knee arthroscopy performed on Patient 4, a 44-year old man with a decade-old ACL injury. He came to McKinley Orthopedics in November 2021 complaining of acute knee pain after a new injury.[182] Like Patient 3, Patient 4 was identified for external review in the Surgery Center process, which occurred very shortly after Patient 4 experienced a post-operative complication treated by Drs. Ward and Wade. Of particular controversy here are (1) the nature or Patient 4's chondral injury, (2) whether and to what extent Dr. Carey performed a meniscal debridement and/or meniscectomy, and (3) whether, to what extent, and which compartment(s) Dr. Carey performed a chondroplasty. The Division also argues that Dr. Carey did not sufficiently document his work through arthroscopic photographs.

1. Course of treatment

X-rays at Patient 4's initial clinic visit in November 2021 showed "moderate degenerative changes within the patellofemoral joint," as well as "more mild degenerative changes" in the medial compartment of the knee.[183] PA Jen Holt performed a steroid injection, which improved his symptoms, but he continued to experience "sharp shooting pain."[184] An MRI two weeks later showed "moderate chondral fissuring along the patella," "mild superficial chondral irregularity with the articular cartilage in the medial and later compartments," and a small medial meniscal tear.[185]

Patient 4 continued to have pain and mechanical issues after the steroid injection. The patient, who lived more than 100 miles from Fairbanks with extremely limited access to services like physical therapy, expressed a strong interest in proceeding to surgery.[186] On December 16, 2021, Dr. Carey performed a left knee arthroscopy on Patient 4 at the Surgery Center, assisted by

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182 Ex. AA, p. 1, 10, 13. This patient's case was added to the Surgery Center peer review after the March 3 meeting described above. Dr. Messmer produced a highly critical report, to which Dr. Carey produced a written response. The Division did not call Dr. Messmer to testify, leaving largely unrebutted Dr. Carey's critiques of his conclusions. (To be sure, Drs. Ward and Wade had their own critiques, addressed herein).

183 Ex. AA, p. 10.

184 Ex. AA, p. 17.

185 Ex. AA, pp. 13-14.

186 Carey test.

his longtime PA, Tommie Younker. His operative report, dictated the following day, lists procedures performed as:

> Medial and later meniscal debridement
> Chondroplasty to bleeding bone of the medial, lateral, and patella femoral compartments
> Lateral release, and
> Removal of a loose body in the articular notch.[187]

The report lists a 12-minute torniquet time and recites the following "description of procedure."

> The arthroscopy revealed degenerative fraying of the anterior meniscus debrided back to a stable rim using a 4.0 shaver, split tear of the posterolateral meniscus debrided back to a stable rim using a 4.0 shaver. There was grade 3-4 chondromalacia diffusely in the medial and lateral compartments well as patellofemoral joint that was debrided back to a stable rim and good bleeding bone using a 4.0 shaver and lateral tracking of the patella that was released using an arthroscopic wand performing a lateral release. Loose body was removed from anterior notch.

Six pages of arthroscopic photos were attached to the original report, but apparently not retained in the chart.[188]

Patient 4 eventually developed a post-operative infection. On February 12, 2022 – eight weeks after the initial surgery – he was admitted to FMH for treatment of the infection, beginning with an arthroscopic "wash out" performed by Dr. Ward.[189] For context, this occurred two weeks after the Surgery Center "staff walkout" and ten days after the Surgery Center's summary suspension of Dr. Carey's privileges.

Dr. Ward's operative report from the February 12, 2022 "washout" indicates that, in addition to an infection, he found grade 2 and grade 3 chondromalacia in the patellofemoral and medial joints, fraying of both menisci, and synovitis in all three compartments. Dr. Ward drained the infected fluid, debrided the synovium in all three compartments, and debrided the frayed edges of both menisci.[190] Dr. Ward maintains that he saw no evidence that either a meniscal resection or "chondroplasty to bleeding bone" had been performed.[191]

About a week after being discharged from the hospital, Patient 4 continued to show signs of infection. Two subsequent washout procedures were then performed by Dr. Wade on

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187 Ex. AA, pp. 25-27.
188 Ex. AA, pp. 28-33.
189 At this time, Patient 4 was still under Dr. Carey's care, but was seen in clinic by Dr. Molk while Dr. Carey was out of town. Because Dr. Molk does not perform arthroscopies, he asked Dr. Ward (the orthopedist on call) to perform an arthroscopic irrigation, debridement and synovectomy. Ex. AA, p. 85.
190 Ex. AA, pp. 93-95.
191 Ward testimony.

February 24 and February 28, 2022.[192] These were performed less than a week before the Surgery Center meeting with Dr. Carey.

2. Disagreements about what the evidence shows

In earlier proceedings, Drs. Wade and Ward criticized Dr. Carey's decision to operate on Patient 4 after a steroid injection. With infection being a known complication of any surgery, the concern that arises is that steroids will suppress the patient's immune system. Dr. Wade suggested that steroid injection at the time of an acute injury is acceptable only if the patient doesn't need a surgical intervention.[193] But Dr. Mustovich testified to more recent research on the acceptable length of time between a steroid injection and surgical intervention – specifically, that the risk of infection is not statistically increased by steroids injected, as here, more than a month before surgery.[194] To the extent the Division is claiming so here, the steroid injection, given more than thirty-days preoperatively, did not violate the standard of care.

Turing to Patient 4's post-operative course, Dr. Wade contends that he was concerned because, when he did the second washout, he did not see evidence of grade 3 chondromalacia, nor did he see evidence that "chondroplasty to bleeding bone" had been performed. Additionally, he and the Surgery Center had by this time developed concern about overwhelming similarities amongst Dr. Carey's operative reports; he did not believe the procedures described could be performed in the twelve minute procedure time reflected in the operative note; and he was suspicious, based on his own experience of which procedures he performs together and with what frequency, that Dr. Carey's operative report might list procedures that had not actually been performed.[195]

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192 Ex. AA, pp. 120-121, Ex. Z.

193 Wade testimony.

194 Mustovich test.; Ex. AA, pp. 3-4. The Division also offered Exhibit 10, deposition testimony from another proceeding by NorthGauge physician Morgan, to support this principle and its position about Patient 4. *See* Ex. 10, p. 12 ("I don't see any reason to do a steroid injection at the time of an acute injury, particularly if you're considering a surgical debridement, or a surgical procedure, not necessarily a debridement"). But Dr. Morgan was not named or called as a witness in this case. His deposition testimony in another proceeding is not admissible here to establish a violation of the standard of care. To the extent it is considered, it is given far less weight than the report and testimony of Dr. Mustovich, who was properly identified and called in this matter.

195 Dr. Wade was also unhappy that Dr. Carey had not preserved interoperative photographs of the procedure. There was disagreement – as to this patient and in general – about whether Dr. Carey creates adequate photographic documentation during arthroscopies. Dr. Wade testified that the standard of care for arthroscopic documentation is to take a photo of the pathology, the process of correcting it, and the completed repair, but he agreed that this standard is not required by any credentialing organization or the Medical Board. Dr. Mustovich agreed that the standard of care is to take photos during arthroscopies and agreed that failing to take photos at all would violate the standard of care, but also indicated he was never instructed on any specific standard, such as the one described by Dr. Wade. Dr. Carey, likewise, did not agree that the standard is as described by Dr. Wade. Dr. Carey testified that he takes photos during arthroscopies and gives a copy to the patient as part of explaining their treatment, but he does

As to whether Patient 4 had advanced chondromalacia, Dr. Wade conceded on cross-examination that the assessment of chondromalacia can be "subjective."[196] He also agreed that his own interoperative photographs for this patient *did* show "Grade 3" chondromalacia.[197]

Regarding the issue of similarities in operative reports, Dr. Wade testified that "over the years we'd found 75 patients with the exact same op report, with just minor changes." While 75 examples were not produced, Surgery Center co-owner Sharon Anderson testified to an exhibit involving a much smaller number of patients – Exhibit 48, containing operative reports for eleven knee arthroscopy patients.[198] To the extent that the Division contends Dr. Carey's operative reports for knee arthroscopies were *identical*, its exhibit does not support this. While much of the operative procedure description is identical and clearly templated, there are differences within the eleven reports as to the grade of chondromalacia encountered, the nature of degeneration seen, the size of shaver used, and the tool used for debridement and lateral release.[199]

The exhibit *does* show, however, that for each patient, Dr. Carey listed "chondroplasty to bleeding bone" in all three compartments. And in ten of the eleven records, the operative report's "procedures performed" section listed medial and lateral meniscal debridement, chondroplasty to bleeding bone of all three compartments, lateral release, and removal of a loose body in the articular notch.

A number of points of disagreement relate to Dr. Carey's description of particular surgical procedures ("chondroplasty to bleeding bone," "lateral release") and findings ("complex tears"). As previously noted, in describing "chondroplasty to bleeding bone," Dr. Carey was

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not typically take a photo of each completed repair process. Because the photos themselves are bulky, he typically doesn't retain a copy in the chart. Dr. Mustovich explained that he uses the photographs to remind himself what he did, and to show the patient, but – like Dr. Carey – he does not typically retain the photos in the chart.

196 Ex, P, p. 1.

197 NorthGauge reviewer Dr. Morgan described those images as showing "full-thickness chondral injury." Ex. 10, p. 24.

198 The exhibit contains a partial record, missing page 2 of the operative report, for a twelfth patient. That patient's partial record (Ex. 48, pp. 42-44) has been disregarded.

199 *See, e.g.,* Patient Z.L., 5/6/21 ("The arthroscopy revealed degenerative fraying of both posterior and medial meniscus as well as noticeable synovitis and scar tissue from prior procedures debrided back with an arthroscopic ablator and shaver."); Patient K.H., 6/17/21 ("The arthroscopy revealed the patient had degenerative fraying of the posteromedial and lateral meniscus with a parrot-beak tear of the posteromedial meniscus, 7-mm loose body, grade 2-3 chondromalacia diffusely."); Patient D.K., 7/15/21 (The arthroscopy revealed degenerative fraying of the posteromedial and lateral meniscus, grade 3 chondromalacia diffusely between all three compartments, 7-mm loose body intra-articularly and lateral tilting patella.); Patient C.C., 8/12/21 ("The arthroscopy revealed degenerative fraying of the medial and lateral meniscus, grade 4 chondromalacia diffusely throughout. The patient had severe early osteoarthritis unexpected from prior exam and radiographs.").

using that term for any chondroplasty in which bleeding was visualized beneath the cartilage.[200] (An example is seen, in Patient 4's case, in the arthroscopy photos taken by Dr. Wade).

Similarly, Dr. Carey's use of the descriptor "complex tears" is inconsistent with Dr. Wade's view of a complex tear. Dr. Wade describes a complex tear as one impacting a large portion of the meniscus, and surgical treatment of such a tear involves removing a significant portion of the meniscus, which did not appear to have been done on Patient 4's knee. Dr. Carey's testimony – and his earlier statements to the Surgery Center board – support that he performed a less drastic repair than Dr. Wade was looking for, e.g. not removing the meniscus entirely, but performing more subtle repairs.[201]

As to Dr. Carey's documentation of having performed a lateral release – "a small release of lateral fibers holding the patella" – Dr. Carey explained that he performs this procedure frequently: "Whenever there is patella femoral cartilage fraying, I perform a lateral release to loosen the lateral restraints that could be causing that fraying.[202] He rejected the notion that Dr. Wade could determine that he had not performed a lateral release months earlier. "The concerns about seeing a lateral release on an arthroscopic procedure 2 months later is confusing. … After 2 months all of those fibers have scarred back down."[203]

As to the claims about doing procedures in all three compartments, PA Ambria Younker, Dr. Carey's primary surgical PA, credibly testified that Dr. Carey commonly does all three compartments, and certainly does all three if they are listed on the consent. She described this as "pretty standard" in "a degenerative type knee." And she says that she knows this is occurring because she moves the patient's knee for positioning the scope into the different compartments.

A related allegation has been that Dr. Carey routinely documents performing procedures in all three compartments of the knee, that this must be false/exaggerated and done for billing purposes, and that surgeries – such as Patient 4's – could not be done in all three compartments

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200 Ex. 40, p. 13 ("In review of my documentation[,] chondroplasty to bleeding bone does not imply that I took good cartilage away, simply that I removed lose flaps and unstable lesions and underneath there was areas of bleeding bone. It appears that the reviewers were thinking I did an abrasion arthroplasty, which is a procedure I have never performed. They expect to find a lar[ge] area of raw bone but that is not implied. …. By no means did I take good cartilage - I only removed what was unstable and following completion of this, felt it to be Grade 3-4 with bleeding bone surfaces.").

201 *Accord*, Ex. 9, p. 6 (Dr. Morgan review) ("From a technical standpoint you can theoretically bill for the procedures described for even the smallest chondral lesions or meniscal fraying's that are debrided and this certainly could be done with a shaver alone.")

202 Ex. 40, pp. 13-14, 15.

203 Ex. 40, p. 15. As to the use of interoperative photographs, he noted: "I did take a final picture of the tracking after it was performed … I did take pictures of the patella at the end showing normal tracking after lateral release but not the actual lateral release because [photographing it] adds no value." Ex. 40, pp. 13-14.

in the time documented. Dr. Everson called it "theoretically impossible." The evidence does not support this claim. Dr. Carey introduced unrebutted video evidence that arthroscopic chondroplasties can competently be performed in all three compartments well within the twelve minutes at issue for Patient 4.[204]

E. Patient 5: January 2022 ulnar shortening[205]

The next patient, Patient 5, had surgery with Dr. Carey at the Surgery Center just after Cassy Freeman's Surgery Center privileges were revoked, and shortly before the "staff walkout" incident. Patient 5 had first visited Dr. Carey's practice in November 2021 with sharp wrist pain that had developed at the beginning of the year. A recent MRI showed a suspected partial tear of the triangular fibrocartilage complex ("TFCC"-- soft tissue in the wrist that supports the wrist and forearm), and an x-ray showed "a mild ulnar neutral variance" – that is, the ulna and radius sitting level to one another. After discussing possible continued non-surgical interventions as well as surgical options, Physician's Assistant Jen Holt recommended Patient 5 "follow up with Dr. Carey for preoperative evaluation."[206]

In an appointment with Dr. Carey the following week, a plan was made "for diagnostic arthroscopy with TFCC repair and ulnar shortening osteotomy" – a procedure to correct variance in the ulna and radius by removing a thin slice of ulna from the forearm – in January 2022.[207] When he performed the TFCC repair and ulnar shortening osteotomy, however, Dr. Carey removed more of Patient 5's ulna than he had intended or planned.[208]

While the amount of the discrepancy – both what was *intended* to be removed and what was *actually* removed – is in dispute, the evidence supports a finding that Dr. Carey removed about three millimeters more than he had intended. A later x-ray describes Patient 5's wrist post-operatively as having an "8 mm ulnar negative variance."[209] Having begun with an "ulnar

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204 Carey test.; Ex. SS. Dr. Morgan, one of the NorthGauge reviewers, described Dr. Carey's listed operative times for knee arthroscopies as "on the faster side of a normal distribution of operative times and would represent a highly competent technician with a lot of experience performing these procedures," but he also noted that "there are some indications that make the times believable." Ex. 9, p. 6. He posited that "[i]n general, the procedures being performed based on the operative reports and surgical times are likely being performed at a very minimal level," but also noted that a number of the procedures described can theoretically be documented and/or billed "for even the smallest chondral lesions or meniscal fraying's (sic) that are debrided."

205 Patient 5, through counsel, filed a medical malpractice lawsuit against Dr. Carey in early 2024. That case is in its early stages.

206 Ex. 52, pp. 1-4.

207 Ex. 52, pp. 7-8.

208 Ex. 52, pp. 588-600.

209 Ex. 52, p. 158. A negative variance refers to a variance where the ulna is shorter than the radius; a positive variance is one in which the radius is shorter.

neutral" variance, and intended to remove 5 mm, the resulting *8 mm* negative variance this suggests that Dr. Carey removed roughly 3 mm more than the five he had intended. This conclusion is consistent with a May 2022 Eielson Airforce Base Clinic note in which Patient 5 is described as reporting: "she was told he shortened her ulna by 7 mm and was only intending to shorten in (sic) by 4 mm."[210]

The exact reason for the over-shortening is unknown and probably unknowable. Dr. Carey has offered various suggestions for what may have contributed to the error. One factor is that he was performing the surgery with different surgical staff than he had intended, as the procedure was performed two days after SCF revoked Cassy Freeman's OR privileges. According to Dr. Carey, Ms. Freeman had received specialized training from the product manufacturer that included specialized training related to this procedure. He had been uneasy about not having her in the OR to provide the support he expected but was assured by Rachel Piszczek and Keli McGee that the OR would be appropriately staffed.[211]

It is undisputed that Dr. Carey's operative note does not reflect the over-shortening, instead stating: "we shortened the ulna by 5 mm per our pre-templated measurements."[212] But it does not appear that Dr. Carey or his team realized the error inter-operatively or in the early post-operative period. Findings from post-operative x-rays two and four weeks after the procedure do not reflect an awareness of the over-shortening, nor do PA Holt's clinic notes.[213] Notes from a six-week post-op visit describe the x-ray findings as "routine healing ulnar shortening osteotomy," and describe the patient as "doing very well" and having "no concerns."[214]

The first indication of concern is a March 30, 2022 note from PA Tommie Younker, who describes that Patient 5 reports experiencing moderate pain with wrist flexion, and "mentions that her physical therapist is concerned that she is not progressing the way she should at this time."[215] A plan was made for more imaging and a follow up with Dr. Carey, who performed a steroid injection the following week and saw her again one month later.[216]

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210 Ex. 52, p. 257.
211 *See* Ex. 64, p. 8.
212 Ex. 52, p. 14.
213 Ex. 52, p. 18 (Two weeks post-op: "Interval post-surgical changes consistent with right wrist ulnar shortening osteotomy. Fracture is in good position and alignment. Hardware is in good position."); p. 21.
214 Ex. 52, pp. 23-25.
215 Ex. 52, p. 28.
216 *Id*., pp. 30-35.

Two months later, Patient 5 saw Dr. Wade for a second opinion. According to Dr. Wade, she was tearful, describing her post-operative pain as worse than the pre-operative pain.[217] Dr. Wade's records describe Patient 5's post-operative x-ray as reflecting "the ulna is approximately 12 mm shorter than the radius," causing "disruption of the distal radial ulnar joint."[218] As noted above, two other sources support that the variance was smaller than described by Dr. Wade.[219] But it is undisputed that very small changes in ulnar length can have significant impacts. In this case, the patient ultimately went on to require further surgical intervention.

The Division contends that Dr. Carey breached the standard of care by performing an ulnar shortening at all, by planning to take off 4-5 mm, and by taking off more than was planned. The Division supports those allegations with the testimony of Dr. Wade, who saw Patient 5 and referred to her a surgeon out of state. Neither party presented expert witness testimony as to Patient 5 other than the providers who treated her – Dr. Wade for the Division, and Dr. Carey on his own behalf.[220]

Dr. Wade is significantly less familiar with the procedure than Dr. Carey. Dr. Wade has performed a couple; Dr. Carey performs one about every other month. Dr. Wade testified that ulnar shortening is not appropriate until an arthroscopic tendon repair has failed, with a year between the two procedures. Dr. Carey presented credible evidence that ulnar shortening is used contemporaneously with or in place of a TFCC repair.

Dr. Wade also testified that when ulnar shortening is performed, only one to two mm of ulna is removed. If true, this would make Dr. Carey's error more significant. But Dr. Carey presented credible evidence that the average removal is more than what Dr. Wade claimed. In the peer reviewed studies he referenced in his testimony, not one of the surgeries had a removal as small as the "average" Dr. Wade described.[221]

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217 Ex. 52, p. 39.

218 Ex. 52, p. 39.

219 Ex. 52, p. 158 (8 mm ulnar negative variance); 257 (Pt. 5 reporting that Dr. Carey disclosed removing 7 mm instead of 4 mm). It should be noted that Dr. Wade's later assertion of a one-inch (25.4 mm) over-shortening was even less accurate.

220 Dr. Carey also supports his position with a report from Dr. Barnes, who was on his witness list but was not ultimately called to testify. The Division objects to consideration of Dr. Barnes's report because Dr. Barnes did not testify. The Division makes this argument while seeking to rely on reports by external peer reviewers for other cases. The argument itself is well taken, in that Dr. Barnes has not been subjected to cross examination. His report, while not excluded to the extent that it supports or explains Dr. Carey's testimony, is given very little weight. Dr. Barnes's characterization of over shortening as a "known complication" of this procedure is given no weight, in light of the lack of apparent support for that claim.

221 *See* Luria, Shai. et al, Comparison of Ulnar-Shortening Osteotomy With a New Trimmed Dynamic Compression System Versus the Synthes Dynamic Compression System: Clinical Study, J Hand Surg 2008; 33A: 1493 – 1497 (Average of 4 mm); Ex. EE, p. 16 (Teunissen article) (same).

Ulnar shortening procedures have a known high rate of complication. The Division disputes Dr. Carey's assertion that "over resection" is a known complication of this procedure. However, the Division did not present expert testimony about this procedure or this case, leaving the evidence on this point insufficient to make a finding.

F. Patient 6: December 2022 hardware removal[222]

The final patient whose care is directly at issue in this case is Patient 6, who sought treatment with Dr. Carey following a January 2022 knee injury that left her "unable to walk unsupported."[223] An MRI showed a torn anterior cruciate ligament and a torn meniscus, and Dr. Carey performed an ACL reconstruction on January 13, 2022. Dr. Carey attached the ACL graft by "suspensory fixation," using "a cortical button on the femoral side, and a bio-interference screw for the tibial side."[224]

Patient 6 almost immediately began to experience "pinpoint" post-operative pain. Noting many possible transient causes of such pain post-operatively, most of which resolve, Dr. Carey encouraged her to be patient and see if the pain subsided before pursuing further exploratory and/or remedial surgery. An MRI in May 2022 showed the tibial "interference screw" to be "proud to the cortex," and was felt to correspond to the painful "bump" at her surgical site.[225]

In December 2022, still in pain, thin on patience, and eager to avoid additional insurance costs she would incur if treatment ran into the next calendar year, Patient 6 told Dr. Carey she wanted to move forward with a follow-up procedure.

Dr. Carey planned to remove the interference screw, and proposed performing the procedure in his clinic's procedure room under local anesthesia – a form of surgery referred to by the acronym "WALANT," i.e. "wide awake, local anesthesia, no tourniquet." Dr. Carey is a proponent of WALANT procedures, which can offer patients shorter recovery times and a variety of benefits in terms of patient logistics.[226] Patient 6 recalls that Dr. Carey told her that

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222 Patient 6, through counsel, filed a medical malpractice lawsuit against Dr. Carey in early 2024, but dismissed it two weeks later.

223 Ex. 49, p. 1,

224 Ex. BB, p. 1. Interference screws are biodegradable implants commonly used in ACL reconstruction to anchor the graft to the bone. *See generally*, Ex. BB, pp. 4-26.

225 *See* Ex. HH.

226 Carey test. Several patients and providers testified to their positive experiences with WALANT procedures. Testimony of Jared Walker (as patient); Testimony of Bridget Watkins (as provider); Testimony of Jen Holt (as patient). While Dr. Everson testified that Dr. Carey never performed a WALANT procedure before his privileges were revoked, the evidence does not support this. See, e.g., Watkins test.

"he wasn't current practicing at the Surgery Center," and that the hospital was too booked out, but that he did "more invasive procedures" than this in his office "all the time."

Patient 6 ultimately had the five-minute procedure done in the clinic procedure room under local anesthesia. Dr. Carey had originally intended to remove the entire interference screw. But when he began the procedure, he discovered a loose piece of the interference screw that had broken off. Satisfied that this was the cause of the patient's pain, he removed it, leaving the rest of the screw in place.[227] Patient 6 initially reported (in a written complaint to the medical board) that removal of the screw fragment had resolved her post-operative pain.[228] PA Ambria Younker describes her as "ecstatic" about the improvement at her 2 week post-op check-up.[229]

Patient 6 later went to Dr. Wade, who told her Dr. Carey should not have removed the screw as an in-office procedure and recommended that she reach out to the Medical Board.[230] The evidence at hearing did not support the view that doing this procedure in a sterile procedure room under local anesthetic was improper.[231]

Patient 6 now contends she was misled about the reason for Dr. Carey performing the procedure in clinic because Dr. Carey did not tell her his privileges had been revoked, and that if he had done so, she would have gone elsewhere. Patient 6 says she "would not have allowed" Dr. Carey to operate on her "if [she] had known that he was not allowed to practice."[232] But the staff member who has worked as Dr. Carey's longtime scribe testified that she "specifically recalls" Patient 6's preoperative visit, describing Dr. Carey as "very transparent" and "never misleading" in terms of laying out the options of having the procedure in the procedure room versus being referred to Dr. Molk.[233] She describes Patient 6 as "eager to get it done," and

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227 Carey test., Ex. 49.

228 Ex. 49, p. 3.

229 Younker test.

230 Patient 6 testimony.

231 Dr. Tomkins does simple procedures under similar conditions, and notes that appropriateness of such a procedure here, on an easily accessible spot on the tibia. Tomkins testimony. According to Patient 6, Dr. Wade also told her there were additional screw remnants, including the screw "used to secure the ACL" being "1/3 of the way out of the bone." Patient 6 may have misunderstood Dr. Wade's statements, or he may have misspoken. No records related to this subsequent consult with Dr. Wade were introduced, and there is no non-hearsay evidence to support the suggestion of either the interference screw or the cortical button being 1/3 out of the bone.

232 Patient 6 testimony.

233 Strachan testimony. While lacking any specific recollection of what Dr. Carey told Patient 6 about why a procedure at FMH would involve Dr. Molk, Ms. Strachan credibly described being with Dr. Carey in numerous patient encounters in which he has disclosed that his FMH privileges are revoked.

choosing to have the procedure done in the procedure room because she wanted it done as soon as possible.[234]

Dr. Carey likewise believes he gave Patient 6 the option to see Dr. Molk and go to the hospital if she didn't want to have the procedure done on site. It may well be that Dr. Carey omitted the information about hospital privileges because he understood the patient wanted the procedure done during the current calendar year and knew that the hospital was too booked out for a referral to Dr. Molk to perform the procedure there within that timeframe.

IV. General Observations from the Testimony about Dr. Carey and his Practice

The following section covers a variety of matters regarding Dr. Carey's general character and competence that do not correspond to the six index patients or to the chronological summary in the first part of this decision.

A. Recent efforts to address charting deficiencies

Dr. Carey admits that his documentation at the time of these events was flawed, and that he was "not always diligent enough" in reviewing his dictated reports. Steps he has taken to improve his documentation since the incidents giving rise to this case include:

- He signs and submits notes within 24 hours.
- He is more intentional about ensuring that the record used as a surgical H&P is "a better summation document."
- He has reworked his templates, including removing language that had suggested abrasion arthroplasty in place of a simpler chondroplasty.
- When dictating from a template, he dictates individual paragraphs rather than just dictating individual terms to fill in itemized checklists.
- Most recently, he has switched McKinley to an entirely new electronic medical record system.

Dr. Carey notes that no one has raised documentation concerns with him since 2022, and he believes his documentation is significantly improved.

B. Dr. Carey's professionalism and judgment

No witness testified to observing Dr. Carey behaving unprofessionally towards staff in the operating room or otherwise. Physicians who have operated with him described him as both

[234] Cassy Freeman, who was present in the procedure room, recalled Patient 6 being curious about what was causing her pain, and never expressing unhappiness or discomfort during the smooth and "minor little procedure."

"excellent in the OR" as well as wholly appropriate with staff.[235] Anesthesiologist James Price, who has done about 100 cases with Dr. Carey, described him as a good surgeon with good demeanor, and described his McKinley team as "one of the best teams [he has] ever worked with."[236] PA Shannon Kuhta described Dr. Carey as a "nice guy," who "values every member of the team," and not the kind of doctor who yells at people or makes people cry. No testimony was offered from Surgery Center or FMH staff claiming to have experienced unprofessional OR behavior. Rachel Piszczek admitted she had never actually experienced Dr. Carey being rude or intimidating in the OR. Leslie Longley, the FMH Director of Surgical Services for the Dr. Carey's first two years there, testified she had never had staff bring her a patient care complaint about Dr. Carey.

Ambria (Tommie) Younker, who has been Dr. Carey's main surgical PA for seven years, described him as even-keeled and respectful in the OR, even when inevitable frustrations happen. Having done "hundreds of surgeries" with Dr. Carey and seen him interact with a variety of people in a variety of settings, she was a credible witness on this point. Multiple McKinley staff members likewise testified about positive experiences at McKinley and working for Dr. Carey. Staff describe an excellent rapport and communication with patients, and a work environment in which they feel supported and valued.[237] Staff clearly appreciate Dr. Carey's efforts to make professional development available to them.[238] Other providers who work with Dr. Carey's staff also described their work as excellent.[239]

Both PAs and non-surgeon physicians at McKinley praised Dr. Carey's promotion of non-surgical alternatives – as did several patients.[240] Veterinarian Elizabeth Milman described her appreciation for Dr. Carey as a surgeon who didn't always push a surgical approach, and for feeling that he considered her and her individual circumstances in devising a treatment path. She also recounted him going out of his way to assist in several urgent/emergency situations.[241]

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235 Testimony of Hugh Hall.

236 Price testimony. Dr. Cameron Carier, a Washington-based anesthesiologist who worked with Dr. Carey on 15-20 surgeries during a weeklong locum visit, echoed these observations. He was impressed by Dr. Carey's relationships with his patients and staff, and his clinical and technical skills. Carier testimony.

237 Testimony of Sonja Kuhta, Ashlee Schultz. Some staff members described Dr. Everson as "not approachable" and "dismissive," saying that he underutilized their skills or "made [them] feel dumb." Testimony of Ana Strachan, Shannen McNamara. Medical scribe Ana Strachan described a number of McKinley patients reporting that other local orthopedists have "terrible bedside manner," and/or failed to give patients "a full range of options."

238 Testimony of Drew Cumbrow, Sonja Kuhta, Ana Strachan, Ashlee Schultz, Shannen McNamara.

239 Tomkins testimony, Worthington testimony.

240 Testimony of Sonja Kuhta, Bart Worthington, Milton Wright.

241 Elizabeth Millman testimony. *Accord*, William Schultz testimony; Robert Hart testimony.

Other physicians and other staff likewise described Dr. Carey going out of his way for patients and treating challenging patients with dignity and respect regardless of their personal circumstances.[242] FMH ER charge nurse Bridgett Watkins, who worked with Dr. Carey regularly, described him as providing an excellent standard of care, going "above and beyond" for his patients and being a provider who she felt put in his best efforts with patients.[243]

An array of physicians testified in support of Dr. Carey – variously, in terms of clinical judgment, surgical skills, and moral character.[244] Dr. Driftmier considers Dr. Carey to possess "all the qualities a physician needs." Acknowledging previous and now-corrected deficiencies "interacting with other providers' staff members," Dr. Driftmier praised Dr. Carey's "excellent" clinical acumen and ability to determine when patients can benefit from surgery versus other therapies.[245] Shriner's Hospital pediatric orthopedist Bryan Tomkins described his positive impressions from observing Dr. Carey "in clinic every time I'm up here," the community oriented nature of his practice, and his appreciation for McKinley having provided a location to from which the Shriner's outreach clinic can operate.[246]

Multiple providers also credibly described a "cutthroat" and "painful" level of competition amongst Fairbanks orthopedic surgeons, and the ways in which that dynamic impairs patient and community trust.[247]

C. Dr. Carey's hearing demeanor and character

Dr. Carey, who testified at length, was a credible witness. He took ownership of his early missteps with staff, and of considerable shortcomings in his 2020-2022 documentation. He presents as knowledgeable, with a genuine commitment to the community and to professional growth for himself and his staff.

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242 Worthington test; Strachan test.

243 Watkins test.

244 Testimony of Robert Hart, Kim Driftmier, Bryan Tomkins.

245 He described Dr. Carey has having a "big heart" and a willingness to take on patients who "may not be a good candidate on paper" if he believes he can help them.

246 Tompkins testimony.

247 Carlson testimony ("I've witnessed individuals trying to remove surgeons from the community based on personality conflicts rather than on clinical outcomes."); James testimony (describing Fairbanks as a "very difficult place to do business" for a provider who doesn't want to join an existing practice); Tompkins testimony (describing Fairbanks as "100% cutthroat" amongst orthopedic surgeons, with infighting" contributing to "generalized distrust in the community") ; Worthington testimony (that he would take any reason given for losing privileges "with a grain of salt" given the "small town" dynamics and how larger providers "have tried to force out small guys like me.").

D. Billing Issues

A significant portion of the Division's pre-hearing brief was devoted to the premise that Dr. Carey engaged in fraudulent billing practices. The billing allegations were that (1) Dr. Carey was falsely describing doing work in all of the compartments of the knee so he could bill separately for each compartment, and (2) Dr. Carey was up-charging by billing falsely for abrasion arthroplasty when actually just doing less invasive chondroplasty. [248]

The Division retained Stephanie Lawrence as an expert to support that theory, and Ms. Lawrence testified about problems in bills submitted for Patient 4's surgery. But the bills Ms. Lawrence had reviewed and was critiquing were not Dr. Carey's bills. They were the Surgery Center's bills. As it turned out, Ms. Lawrence had not reviewed *Dr. Carey's* bills.[249] As to Patient 4, the Surgery Center billed to codes 29879 (which it calls abrasion arthroplasty), 29881 (meniscectomy), and 29873 (lateral release).[250] It was that bill which Ms. Lawrence reviewed. Dr. Carey, it appears, billed to just two codes: 29879 (which he refers to as "more extensive chondroplasty") and 29880 (medial and lateral meniscal debridement).[251]

As to the related allegation that Dr. Carey was falsely describing doing work in all of the compartments of the knee so he could bill for each compartment, Dr. Carey's response to the multiple compartment allegation was (and is) that with "bundled coding" of knee procedures, the same code would be billed regardless of whether one or more compartments is treated.[252]

Neither party called either practice's medical coders/billers to testify. Further confusing the evidence, Sharon Anderson testified that the Surgery Center changed its billing practices on knee arthroscopies after its coder (her daughter) attended a class that changed her perspective on billing for these procedures. Specifically, at some point the Surgery Center changed its billing practice for certain types of chondroplasty, which it used to bill to Code 29877, and began billing

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248 This issue was discussed during the March 3 meeting, although the brief discussion in the AI-generated transcript at Exhibit 50 is unhelpful. When that discussion is read in concert with Dr. Carey's transcribed testimony in the Division's Exhibit 64, a clearer meaning emerges. *See* Ex. 50, p. 8; Ex. 64, p. 15.

249 Ex. 60, Lawrence testimony.

250 Ex. 53, p. 25.

251 Ex. 53, p. 16, 18; Carey test.

252 Ex. 40, p. 14 ("Dr. Ward seems to be unaware that when partial meniscectomy is performed, there is not an additional code for chondroplasty. Adding any type of chondroplasty after performing any type of meniscal work does not change the billing or coding for the medial and lateral compartment. It does not matter if there is bleeding bone or not. In fact, listing the chondroplasty portion of the procedure is overall irrelevant when it comes to billing and coding because it is a bundled code. 29880 was the code used in this case for medial and lateral meniscal pathology and includes chondroplasty regardless of compartments and grades. Please refer to the coding sheets attached article 3. Dr. Ward's assumption is factually inaccurate and further supports the fact that this is a biased review.").

to the higher revenue code 29879. The result was that procedures that *used* to be billed as chondroplasty were now being billed as abrasion arthroplasty. But no one discussed this change with Dr. Carey – either to inform him of the change or to confirm that this new approach was consistent with the work he was doing. This factual history supports Dr. Carey's defense that the longstanding language in his templates, while imprecise, was not intended to mislead.

Also useful for context here is that Drs. Carey, Mustovich, and Driftmier all came to practice out of military surgery settings, and all described the fast-paced and differently-oriented nature of those practices. Dr. Mustovich echoed Dr. Carey's testimony that, in training and working as a military surgeon, he was not exposed to the kind of billing and coding concerns seen "in the civilian world," saying the focus was on "writing down what you do," but not "how to document" for billing purposes.[253]

E. McKinley website

McKinley Orthopedics uses the services of an Austin-based web designer for its website. At some point after the events described above, McKinley directed its contract web designer to remove references to Dr. Carey performing surgeries at FMH or the Surgery Center.[254] At the time of the hearing in this case, the website did not appear to contain such references. However, the Division produced an exhibit, Exhibit 57, titled "Archived website photos," containing screenshots of an earlier version of the website. It is unclear from the exhibit when this version of the website was published or was last visible online, and no witness testified to these facts, but the version of Dr. Carey's "provider biography" in Exhibit 57 includes the sentence: "He operates at Fairbanks Memorial Hospital and the Surgery Center of Fairbanks."[255] Dr. Carey offered unrebutted testimony that McKinley had directed its contractor to remove such references from the webpage, and that the inclusion of a stray reference was simply an oversight which has since been corrected.

V. Procedural History

Based on the notion that Dr. Carey was performing surgical procedures in an unlicensed facility, the Division pursued a summary suspension of Dr. Carey's medical license. The Board initially entered an order summarily suspending Dr. Carey's license but vacated that order days

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253 Mustovich test.

254 Carey test.

255 Ex. 57, p. 2. This sentence appears midway through the 450-words biography, which follows a list of Dr. Carey's educational credentials, society memberships, research and publications, and operative and nonoperative procedures.

later. The Division then filed an eight-count disciplinary accusation against Dr. Carey, leading to the current case. The Division's accusation accuses Dr. Carey of: substandard clinical and surgical performance, failure to provide appropriate continuing care, substandard documentation of care, falsely documenting procedures "which he knew he did not perform," ethical violations, unprofessional conduct towards staff, and false advertising.[256]

An in-person evidentiary hearing in this matter was conducted over the course of 13 hearing days, most of which were held in Fairbanks, between April 22 and June 14, 2024. In addition to Dr. Carey, the parties presented testimony from more than fifty witnesses:

- As to FMH matters, testimony was taken from Drs. Terry Bateman, Richard Hattan, Gary Molk, Jessica Panko, and Angelique Ramirez; Senior Operations Director Jennifer Carlson; nurses Leslie Longley, Cat Miller, Keith Olson, Steve Ruppert, and Bridgett Watkins; facilities director Keith Fehr; and Information security officer John Free
- From the Surgery Center, testimony was taken from Drs. Neal Everson, David Flory, Thomas Hammond, and Mark Wade; administrator/part-owner Sharon Anderson; and current or former staff Branda Black, Keli McGee, and Rachel Piszczek.
- Testimony was taken from many McKinley personnel professionals affiliated with McKinley: Drs. Hugh Hall, James Price, Kim Driftmier, Bart Worthington; and Milton Wright; PAs Jen Holt, Sonja Kutha, Shannen McNamara, Robert Wood, and Tommie Younker; Nurses Drew Cumbrow and Vanessa Geiger; athletic trainers Nathan Fogell, Ashlyn McKenna, and Palmer Trolli,; and staff members Alexys Boone (medical scribe), Cassie Freeman (office manager); Ana Strachan (medical scribe), Ashlee Schultz (surgical coordinator), Bill Schultz (facilities manage), and Jared Walker (scrub tech). Two of Dr. Carey's business partners, North Pole family physician Bart Worthington and MRI technologist Stanley James, also testified.
- The Division offered retained expert testimony on billing issues from Stefanie Lawrence and on Patients 2 and 3 from Dr. Steve Ward. Dr. Carey offered retained expert testimony on billing issues from Olivia Wolf, and on patient care issues from Drs. Bryan Tompkins (Pts 1, 2, 6), Gary Molk (Pt. 3), and Anthony Mustovich (Pts. 2, 3, 4, 6).
- Testimony was also taken from Division investigator Angel Romero; several of Dr. Carey's current and former patients; Patient 6; a physician and a PA who worked with Dr. Carey in the Army; and an anesthesiologist who worked with Dr. Carey for several one week at McKinley.

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[256] The Division had also accused Dr. Carey of failing to report his privilege suspension to the Board, but it withdrew this claim at the close of the hearing.

VI. Findings

A. The Division did not meet its burden of proof as to counts involving substandard clinical and/or surgical performance and/or follow-up care (Counts I, VI, VII)

Three counts in the Division's Amended Accusation allege deficiencies in Dr. Carey's clinical and/or surgical performance or other aspects of patient care. Count I alleges that Dr. Carey's "clinical and surgical performance did not conform to the generally accepted standards of practice and demonstrated that he was lacking sufficient knowledge, skills, or professional judgment to a degree likely to endanger the health of his patients." Count VI accuses Dr. Carey of "failure to provide and document continuing care of patients following surgery—either directly or through another medical professional," and alleges that this failure violated his obligations under AS 08.64.326(a)(7) and (9), 12 AAC 40.940(b), and 12 AAC 40.967(28). And Count VII alleges that Dr. Carey's treatment of his patients violated his codified ethical obligations.[257] Construing these claims to allege patient care violations for the "index patients" in this case, this decision finds that the Division did not prove these violations.[258]

1. Gross negligence claims

The Division claims that Dr. Carey was "grossly negligent" as to Patients 1 and 5. These claims fail.

Patient 1, the Division did not make a threshold showing that Dr. Carey's treatment of Patient 1's crush injury fell below the standard of care at all. First, the Division failed to provide competent expert testimony to establish that the standard of care required what the Division contends is required. Having failed to identify an expert witness, the Division suggested that Dr. Everson could "certainly be asked to give opinions about" her care, adding, "it doesn't have to be

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[257] Count VII lists a series of actions which Dr. Carey is alleged to have taken, and which the Division believes violate his codified ethical obligations. Relevant to the issues discussed in this subpart, the Division alleges that Dr. Carey violated these obligations by "scheduling patients for surgeries they did not need, performing surgeries without adequate preparation, performing surgery in a non-sterile office setting, disrespecting patient rights, and failing to provide appropriate aftercare."

[258] To the extent that the Division seeks to establish its claims of incompetence or professional negligence based on broad accusations about Dr. Carey's clinical or surgical performance untethered to specific identified patients, such an argument is not permissible. The Division was directed at the outset of this case to identify the specific patients as to whom it contended Dr. Carey's care was substandard, and it agreed on the record that it would do so. It identified Patients 1 – 6, and Dr. Carey was then able to present a defense addressing those specific cases. Insofar as the Division now seeks to invoke the issues raised in various peer reviews of other patients' care, due process does not permit this broad brush approach. Nor would the evidence support it. No evidence was presented during the hearing in this case of any situation in which a proctor identified a problem with Dr. Carey's proposed plan, surgical skill, or patient care. And when Dr. Carey was able to respond directly to individual patient care allegations during the FMH hearing, the three-physician panel who heard that evidence found it sufficiently compelling to warrant rejection of the recommendation to revoke his privileges.

an expert opinion, he could give opinion as a practicing – you know, as a parent, as a practicing orthopedic surgeon, you don't need an expert in this, you don't always need an expert in medical cases." But the testimony established that this was indeed more complicated than the division believed – that it was, contrary to the Division's assertion, "beyond the ken of anyone who has a thumb, of anyone who has taken one of those all-day CPR classes." And the Division failed to rebut the expert testimony of Dr. Tompkins as to the preoperative course and the mechanism of injury. The Division did not meet its burden of establishing that the standard of care required Dr. Carey to unwrap the bandage placed in the Emergency Department before the surgery. Further, a preponderance of the evidence supports that Patient's 1 vascular injury was caused by the original crush injury, and not by any action or inaction by Dr. Carey.

As to Patient 5, Dr. Carey over-resected Patient 5's ulna to the point that additional significant medical care was required. There is no doubt that this was an unintended negative outcome. But the question here is whether the Division showed that this outcome was the result of gross negligence by Dr. Carey. In contextualizing Patient 5's complication, Dr. Carey noted that some surgeries – including ulnar shortenings – have inherently higher complication rates. The parties disagree about whether "over-resection" is a known complication.

The Division did not present an expert on this procedure, and Dr. Carey's identified expert did not testify. We do not know how the measurement error came about, and it is certainly impossible to determine whether it reflected a gross lapse in judgment by the physician as opposed to an operative mishap, perhaps attributable in part to other team members or to equipment failure.

The Division's argument that it was gross negligence for Dr. Carey to proceed with the surgery without Ms. Freeman present after previously remarking that without her the surgery was "going to be a complete disaster" is specious.[259] It cannot be that a Board-certified surgeon commits negligence – let alone "gross negligence" – by performing a particular surgery in a fully-staffed operating room but without a particular unlicensed scrub technician. Dr. Carey's expression of genuine concern about the disruptive last-minute staffing changes does not constitute an admission that he actually expected his surgery to be "a disaster."

[259] Ex. 64, p. 8 (Carey: "So the next day, on the 13th, we had this ulnar shortening osteotomy … and I'm, like, "This is going to be a complete disaster if I don't have Cassie in there. What are we going to do?")

2. "Incompetence"/standard of care claims

a. Patient 1

As noted above in connection with gross negligence, the Division did not show a departure from the standard of care.

b. Patient 5

Dr. Carey described over-resection as a known complication, but at least some articles cited by Dr. Carey's (non-testifying) expert for that premise do not appear to support it. The evidence does support that ulnar shortening procedures have a high complication rate; whether "over-resection" is a known complication is not clear from the evidence. But Dr. Carey's broader point is that the complication experienced in this patient's case is unique in his practice. In terms of whether this case should impact his licensure, he testified, "if I was making these kind of mistakes over and over again that'd be one thing, but that's not the case." The point is well taken in the context of the complete lack of information about how the error occurred. The Division did not establish that this outcome was caused by professional incompetence.

It is a closer question whether a finding can be made that the over-shortening fell below the standard of care. It may well have. But what the Division asks the Board to do is to surmise—with no expert testimony and no circumstantial information—that if an isolated instance of over-shortening occurs it *must* be because the surgeon was at fault. This the Board cannot do. Moreover, "a single instance of negligence is not a basis for discipline under any statute or regulation of the board."[260] Thus, unless actual negligence could be shown in the care of other patients, an isolated finding as to the ulnar shortening surgery would not lead to discipline. The Division would need to show, instead, that the physician performed below the standard of care in a manner that demonstrated incompetence. With no context about how the error occurred, such a finding cannot be made as to Patient 5.

c. Other patients

Nor does the evidence otherwise support the Division's contention that Dr. Carey's treatment of the remaining patients was incompetent or below the standard of care. As to Patient 2, the Division contends that Dr. Carey's successful surgery on Patient 2's knee was "incompetent" because its expert does not believe the surgery was warranted. The Division did not meet its burden of making this claim. As discussed in detail previously, the weight of

[260] *In re Kohler*, OAH No. 10-0635-MED (Alaska State Med. Bd. 2011), at 48.

credible evidence shows that the patient's ligamentous laxity was causing ongoing symptoms and interfering with her expected recovery after ACL surgery, leading him to perform a second, more complex procedure – the MPFL repair, a reasonable and successful intervention.

The Division likewise argues that Dr. Carey's treatment of Patient 3's knee was incompetent – arguing that the total knee replacement surgery was unwarranted, that Dr. Carey was insufficiently prepared, and that repairing the lesion with cement was improper. Again, as we have seen, the evidence did not support these allegations. Dr. Ward's critiques of Dr. Carey's preoperative preparation were undermined by his not having viewed the patient's full medical record, while strong evidence supported that Dr. Carey's actions upon encountering necrosis during the total knee were appropriate and met the standard of care. The evidence supports that the interoperative consultation was appropriate and well-advised, and that the operative course taken was well-reasoned and carried out within the standard of care.

The Division also did not meet its burden of showing that Dr. Carey's treatment of Patient 4's knee injury – specifically, performing an arthroscopy more than one month after a steroid injection – fell below the standard of care. While Patient 4 experienced a post-operative infection, the evidence does not establish that Dr. Carey violated the standard of care with regard to Patient 4's care.

As to Patient 6, the Division argues that Dr. Carey maltreated Patient 6 by leaving in mal-positioned hardware and by conducting the procedure in a procedure room instead of an OR. As to the first claim, no records were produced to support Dr. Wade's assertions about other loose screws or mispositioned hardware remaining after the loose hardware removal in December 2022. As to the use of WALANT techniques, the evidence supports that this procedure is a valid use of those techniques, and doing so in a procedure room does not violate the standard of care. Lastly, the Division also contends that Dr. Carey deceived Patient 6 about his surgical privileges, but, as discussed above, the weight of the evidence did not bear this out. The evidence does not support that Dr. Carey violated an ethical obligation in scheduling Patient 6's screw removal procedure to occur in the clinic setting.

To the extent the Division's Amended Accusation makes broad claims about Dr. Carey's patient care generally – for example the allegation that he did not provide sufficient follow up care – these claims were not proven. First, the Division would need to prove those allegations with regard to specific identified patients. A generalized complaint that Dr. Everson didn't feel that Dr. Carey looked after his complicated patients is insufficient, as are the vague hearsay

allegations that unnamed FMH hospitalists felt this way about unnamed patients six years ago. The Division did not identify specific patients whose follow up care Dr. Carey supposedly neglected. And Dr. Carey provided credible evidence – both his testimony and the testimony of other providers – about his willingness to take on and follow through in overseeing the care of challenging cases.

B. The Division met its burden of proof as to inadequate documentation (Count II), but not as to falsification of records or fraudulent billing (Counts III, VII)

Count II of the Division's Amended Accusation alleges that Dr. Carey failed "to maintain accurate and complete records of treatment including surgeries in accordance with the generally accepted standards of practice."[261] The evidence at hearing supports a finding that Dr. Carey's documentation was sufficiently flawed as to violate his professional obligations. The evidence does not, however, support the Division's more serious allegations of fraudulent documentation as set out in Counts III and VII.[262]

1. Accurate and complete treatment records (Count II)

The Division's Count II categorizes Dr. Carey's documentation failures as "unprofessional conduct," citing to AS 08.64.326(a)(7) and (9), and to the Board's regulations at 12 AAC 40.940(b)(9) and 40.967(9). Alaska Statute 08.64.326 sets out the range of actions for which disciplinary sanctions may be imposed, including failure to comply with the Board's statutes and regulations,[263] as well as "unprofessional conduct."[264] 12 AAC 40.940, "Standards of practice for record keeping," sets out the minimum requirements for recordkeeping, including that each record shall "reflect the treatment provided to or recommended for the patient."[265] The other regulation cited by the Division, 12 AAC 40.967(9), identifies "failing to prepare and

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261 Amended Accusation, Count II.

262 Count III of the Amended Accusation alleged that Dr. Carey documented "patients having undergone non-surgical management knowing the cited management did not happen," as well as "having performed certain procedures during surgery which he knew he did not perform." Count VII alleges that Dr. Carey violated his codified ethical obligations by "misrepresenting services rendered" and "billing for operations not performed and equipment not used."

263 AS 08.64.326 (a)(7)

264 AS 08.64.326 (a)(9)

265 12 AAC 40.940 ("(b) Each patient record shall meet the following minimum requirements: (1) be legible; (2) contain only those terms and abbreviations that are or should be comprehensible to similar licensees; (3) contain adequate identification of the patient; (4) indicate the dates that professional services were provided to the patient; (5) reflect what examinations, vital signs, and tests were obtained, performed, or ordered concerning the patient and the findings and results of each; (6) indicate the chief complaint of the patient; (7) indicate the licensee's diagnostic impressions of the patient; (8) indicate the medications prescribed for, dispensed to, or administered to the patient and the quantity and strength of each medication; (9) reflect the treatment provided to or recommended for the patient; (10) document the patient's progress during the course of treatment provided by the licensee.").

maintain accurate, complete, and legible records in accordance with generally accepted standards of practice for each patient" as a form of "unprofessional conduct" under the Board's statute.

The evidence establishes several ongoing deficiencies in Dr. Carey's documentation. Concerns that surfaced repeatedly in this case involved documentation that was untimely, incomplete, and at times inaccurate.

As to timeliness, testimony of standard of care for dictation of operative notes varied, and there is significant evidence that many providers fall short of ideal standards from time to time. Certainly, records signed long after the visit date raise concerns for accuracy, and this concern is heightened when the record is an operative note, which requires a heightened level of detail. Considering the standard articulated by Dr. Flory – that records be "timely enough that their reliability can be reasonably inferred" – there is considerable evidence that, during the time at issue in this case, Dr. Carey's timeliness fell well outside of peer norms, and even outside of the norms of other *untimely* providers.

Patient 1's clinic notes, for example, were not signed until months after the initial surgery. And while the underlying cause may have been a valid need for editing, the testimony established that the delay exceeded any generally accepted standard of practice. As to the operative note, Dr. Carey performed the surgery on May 7, and dictated the note four days later, on May 11. A number of other examples were reviewed above.

The evidence supports a finding that during 2020-2022 Dr. Carey's clinical and surgical documentation practices were sufficiently untimely as to fall outside of generally accepted standards of practice. Dr. Carey has testified to changes he has implemented since this time to improve his documentation, including a self-imposed standard of dictating all reports within 24 hours. While these improvements do not mitigate against a finding that a violation occurred, they may be relevant to the determination of a sanction, discussed below.

The second area where Dr. Carey's documentation fell short was completeness. Multiple operative reports reviewed in this case omitted information that would be expected to be present – such as identifying a recent surgery on the same joint (Patients 2 and 3), or mentioning an interoperative consultation (Patient 3). As Dr. Carey acknowledged, his H&Ps during the period under review were frequently missing information. He attributes this problem to a disconnect between the contents of the McKinley chart and the specific document that was being put into the surgical record. Regardless of the cause, Dr. Carey did an insufficient job of ensuring that the patient record was complete and accurate.

Some of Dr. Carey's records for the index patients were either incomplete or otherwise confusing. The H&P for Patient 2, for example, was unclear about whether the repeat MRI had been done, and unclear about the timing of various falls she suffered between her first and second surgeries. Some of the criticisms of Dr. Carey's patient care appeared to stem directly from misunderstandings arising from such confusion.[266]

At least in some instances, Dr. Carey's documentation was inaccurate or at least confusing – in particular, as relates to descriptions of particular surgical procedures and findings. Dr. Carey's use of the phrase "chondroplasty to bleeding bone" to describe chondroplasty without abrasion arthroplasty is the strongest example of this concern. More broadly, it appears that Dr. Carey's operative reports for knee arthroscopies, at least during 2021-2022, used templated language that skewed towards overstating the degree of surgical intervention involved.

A related problem was the inclusion of boilerplate language in operative reports; Dr. Carey sometimes kept such language in a patient record when it should have been omitted or modified. The operative report for Patient 4, for example, says, "the patient has failed an extensive course of nonoperative management to include physical therapy, nonsteroidal anti-inflammatories, activity modification, and brace wear and elected to undergo the procedure described above."[267] But Patient 4 had not pursued physical therapy; he had declined it for various well-established reasons, and elected to pursue surgery one month after his steroid injection. Thus, the reference to physical therapy was an artifact from use of a template with insufficient attention to editing it. The chart note confirms that the operative report was both inaccurate and incomplete as to non-operative management.[268] The report was also inaccurate or otherwise unclear as to the extent of Patient 4's meniscal tearing: The MRI report is described in the chart note as identifying a "small tear in the medial meniscus along the posterolateral meniscocapsular junction." But the operative report describes two tears: a "complex medial meniscal tear" and a "complex lateral meniscal tear."[269] The source of the reference to a lateral meniscal tear is unclear.

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[266] Documentary completeness was also an issue with regard to interoperative photographs. The evidence did not establish a clear standard of care governing documentation for arthroscopic photographs, but it cannot be denied that some of the factual disputes in this case could have been avoided had more photographs been taken.

[267] Ex. 53, p. 55.

[268] Ex. 53, p. 43. The more accurate chart note says that "the patient has failed all attempts at non operative management to include steroid injections, activity modifications, rest and oral medications."

[269] *Compare* Ex. 53, p. 43 *with* Ex. 53, p. 55.

There was testimony criticizing Dr. Carey for denying that he had been made aware of documentation concerns.[270] Certainly early on, as Dr. Carey has admitted, he was resistant to criticisms about his own practice, including criticisms about his documentation. But some of the "awareness" disagreement likely stems from a shifting identification of "the documentation problem." That is, while Dr. Carey knew early on that there were concerns about the timeliness of his documentation, or even concerns about certain types of errors, the far more serious documentation allegations did not arise until years later. The evidence supports that some of the overarching documentation concerns – such as an overreliance on templates, and an inattention to detail – were known to Dr. Carey by the time of the FMH PIP in 2020, and concerns about timeliness were known to him at least by 2021 if not before. But concerns about the "definitional" issues in his templates were not raised until the termination of his relationship with the Surgery Center. His statements that *these* documentation issues had not been raised with him are fairly understood and accurate in that context.

It is also true that medical documentation is not an exact science, that many if not all providers have room for improvement in the quality of the documentation, and that the Board has not historically enforced its documentation expectations with a zero-tolerance standard for the occasional late dictated-note or careless error. That said, this decision finds that Dr. Carey's documentation practices for surgical patients in the May 2020 – January 2022 period at times fell sufficiently below reasonable professional expectations to constitute unprofessional conduct. Indeed, Dr. Carey now acknowledges "a personal problem with [his] documentation" during this time, and credibly described in his testimony a commitment to resolve that problem.

2. Fraudulent documentation/misrepresenting services rendered (Counts III and VII)

While the Division met its burden of showing that Dr. Carey's documentation practices have at times fallen below the professional standards, it did not meet its burden of showing that those shortcomings were part of an intentional effort to misrepresent his services. The Division's main allegations in this regard concern (1) Patient 1's preoperative chart note, (2) the scope of surgical intervention on Patient 4, and (3) the broader "chondroplasty to bleeding bone" issue.

As to Patient 1, this decision has rejected the claim that Dr. Carey committed malfeasance in the May 4 clinic note. The initial version of the note -- sent over to enable Patient

[270] Panko test.

1 to be scheduled for her May 7 surgery – was less detailed than the final signed version, which included an explanation of why Dr. Carey had not unwrapped the bandage. The Division did not establish anything untoward about Dr. Carey's inclusion of further explanation. As to Patient 4, while the evidence about the state of his knee is conflicting, the evidence does not establish that Dr. Carey completely failed to perform the procedures documented (as opposed to performing them to a lesser degree than Dr. Wade contends Dr. Carey's operative report implied).[271] Among other reasons not to believe this claim is that Dr. Carey was not alone in the operating room with Patient 4; there was a roomful of medical staff, including PA Tommie Younker, as well as Dr. Flory. The notion that Dr. Carey was fraudulently pretending to perform surgical procedures on Patient 4 is simply not plausible, whereas the explanation of divergent use of broad terms is a far more reasonable explanation for the factual disputes here.

As to the final allegation, the evidence establishes that Dr. Carey was using the term "chondroplasty to bleeding bone" to describe chondroplasty *to expose* bleeding bone – that is, "debriding loose chondral flaps when there is subchondral bone exposed."[272] To the extent Dr. Wade was focused on whether *abrasion arthroplasty* had been performed, plainly it had not been. It does not follow, however, that no chondroplasty was performed, or that chondroplasty was not performed in all three compartments of Patient 4's knee. Dr. Carey's explanation at the time and testimony since that time – that he never intended to misrepresent his chondroplasty as abrasion arthroplasty – is consistent with the patient's immediate post-operative report, which lists the procedures performed as "Lt knee arthroscopic meniscal debridement, chondroplasty x 3;" and the multitude of contemporaneous records describing the procedure as a standard chondroplasty.[273] In short, while the evidence does establish that Dr. Carey's documentation was imprecise, it does not establish that he was either fabricating procedures in his operative reports, or intentionally manipulating his patients' records for personal gain.

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271 *See* Ex. 40, p. 14 (Carey: "Overall, there is a huge discrepancy regarding the Outerbridge classification of a chondral injury, with poor inter- and even intra-observer reliability, which is well documented in the literature (see article 5). However, disagreement with a classification system does not make us liars")

272 Ex. 64, p. 15.

273 Ex. 53, pp. 53, 63, 78, 88). Similarly, as to the meniscectomy, the Surgery Center's reviewers did not agree about the extent of meniscal debridement performed. *See* Ex. 40, p. 15 (Carey: "[One reviewer] says there are no signs of meniscal debridement, where Dr. Ward says clear lateral debridement and questionable medial."). And, while Dr. Wade testified that Dr. Ward told him Patient 4's knee had no evidence of a meniscal repair *or* a meniscal tear, Dr. Ward's own operative note documented performing a meniscal repair, which strong implies there *was* a meniscal tear. Ex. AA, p. 94.

Turning to the related billing allegations, the testimony related to the proper billing code for knee arthroscopies established that medical billing is highly complex and is performed by specialists within a medical practice. There are dozens of separate billing codes for knee arthroscopies, and complex rules governing which procedures can be billed alongside one another and which are considered included when certain others are billed. Accurate billing requires common language and understanding and strong communication between billing staff and medical providers.

On the billing front, specifically, Dr. Carey's response to the multiple compartment allegation was (and is) that with "bundled coding" of knee procedures, the same code is billed regardless of whether one or more compartments is treated.[274] It is not entirely clear that this is always so, but the Division did not establish that it is not, much less that Dr. Carey would have known that it is not. A further complicating factor is that "abrasion arthroplasty" can be billed alongside a meniscectomy, whereas a simpler chondroplasty without the abrasion/microfracture aspect cannot be billed alongside a meniscectomy – in that situation the chondroplasty is considered part of the meniscectomy, and isn't billed separately. Even the Division's own billing expert testified that, in this context – i.e. if Dr. Carey performed a chondroplasty but "did not perform abrasion arthroplasty" – billing for chondroplasty alongside a meniscectomy would be "inaccurate" but not "fraudulent."

Likewise as to the issue of work done in multiple compartments, the Division did not prove the very serious allegation that Dr. Carey is or was fraudulently documenting and billing for procedures not performed. Tommie Younker's testimony – as someone present in the OR with him and who physically maneuvers the knee to allow access to the different compartments – was sufficient to undermine this narrative. The video evidence of knee arthroscopies performed in all three compartments was extremely helpful in demonstrating and demystifying the mechanics associated with that procedure, and further supported Dr. Carey's testimony that it is possible and reasonable to scope the three compartments of a knee in the amount of time listed on his briefer operative reports.

All of this brings us back to the issue of "chondroplasty to bleeding bone." Dr. Carey no longer uses "chondroplasty to bleeding bone" in his templating, and, having studied this issue "way more than [he's] ever wanted to" in this hearing, agrees that billing to Code 29879 should

[274] Carey test.; Ex. 64, p. 15.

be reserved for situations where "as the physician you're stimulating the bleeding/ including something to cause the healing potential." But as he noted at the Surgery Center hearing and reiterated in these proceedings:

> The frustrating part is, is that most of the time when you see these done, like even in the military, the coders would come up to your office and say, 'Hey, this is what we're doing, and this is what you're doing. Let's make sure we're doing the right code.' In six years [at the Surgery Center], that's never happened once. There's never been one question unless it's for an authorization.[275]

This is particularly unfortunate given the testimony that the Surgery Center changed its approach to billing for these procedures after the coder took a course encouraging her to bill more aggressively.[276]

The Surgery Center refunded most or all of the costs charged to Patient 4.[277] But the fact that the Surgery Center has not engaged in a broader refund program in the intervening several years undermines its allegations about Dr. Carey's procedures having been "fraudulently" billed.[278]

The evidence supports a finding that, at least as to knee arthroscopies, Dr. Carey's operative notes in the 2020 – 2021 period tended to describe procedures using overly broad terminology, creating the potential for confusion and possible overbilling in settings of poor communication between providers and billing staff. However, Dr. Carey is not a medical coder and was unaware of any related controversy (a situation that might have been averted had Surgery Center staff or management brought their concerns to him when these questions arose). The failure to have the Division's expert review or address Dr. Carey's billings specifically, the failure to clearly delineate in the thousands of pages of exhibits which billings were generated by Dr. Carey's practice versus by the Surgery Center, and the lack of evidence about physicians' roles or responsibilities in billing coding decisions all significantly undermine the claims here. The evidence does establish that Dr. Carey's documentation was imprecise, and the finding as to Count II addresses that concern. But the evidence does not establish that Dr. Carey was either fabricating procedures in his operative reports, or intentionally manipulating his patients' records for personal gain.

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275 *See* Ex. 64, p. 16

276 Anderson testimony. On the other side of the spectrum, it was very difficult to credit Dr. Wade's hearing testimony that even simple chondroplasty is rarely appropriate or rarely performed.

277 Ex. 53, p. 25.

278 During the Surgery Center hearing in 2022, Sharon Anderson testified that her office had identified 13 cases which should be refunded based on concerns about Dr. Carey's billings. At the hearing in this matter more than two years later, those refunds had not occurred. Anderson testimony.

C. Other Counts[279]

Count IV of the Division's Accusation alleges that Dr. Carey engaged in "bullying, demeaning, harassing, passive-aggressive, disruptive, and dishonest behavior toward staff" in violation of 12 AAC 40.967(14) and (15).[280] The Division did not meet its burden of proving this allegation. Indeed, the evidence to the contrary was overwhelming.

Count VIII of the Division's Accusation alleges that Dr. Carey engaged in false and misleading advertising because by representing "on his website that he performs surgery at FMH and SCF."[281] As noted, the only evidence on this point is that, for some period of time after McKinley directed its contract web designer to remove from its website references to Dr. Carey performing surgery at FMH or the Surgery Center, a single stray reference to those facilities inadvertently remained on the McKinley website before it was brought to Dr. Carey's attention and removed. There is no evidence that Dr. Carey intentionally left this item on his webpage.

VII. Disciplinary sanctions

Alaska Statute 08.64.326 sets forth the bases upon which the Board may exercise the disciplinary powers provided by Alaska's centralized licensing statutes at AS 08.01.075. Of relevance to the facts of this case, the Board may impose disciplinary sanctions if it finds, after a hearing, that the physician has "demonstrated professional incompetence, gross negligence, or repeated negligent conduct," or engaged in "unprofessional conduct … in connection with the delivery of professional services to patients."[282] Under AS 08.36.315, the Board may consider the nature and circumstances of the conduct at issue, community reaction to conduct, the licensee's experience and professional record, any other relevant information, and its actions in comparable prior case.[283]

The legislature has directed that the Board apply disciplinary sanctions consistently, and explain significant departures from prior decisions in factually comparable cases that the same Board has issued.[284] There is relatively little Board precedent relating specifically to

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279 Count V of the Division's Accusation alleged that Dr. Carey failed to report the suspension of his surgical privileges to the Board, and that this failure constitutes unprofessional conduct under 12 AAC 40.967(b)(20). The Division withdrew this count during the hearing.

280 Accusation, Count IV.

281 Accusation, Count VIII.

282 AS 08.64.326(a)(8)(A), (9)

283 *Lookhart v. State, Board of Dental Examiners, 548 P3d 1094, 1098-1099 (Alaska 2024); Wendte v. State, Bd. of Real Estate Appraisers*, 70 P.3d 1089, 1095, n. 33 (Alaska 2003); *In re Pappenheim*, 22-0613-MED (Alaska State Med. Bd. 2023) ("Pappenheim II"); *In re Gerlay*, OAH No. 05-0321-MED (Alaska State Med. Bd. 2008).

284 AS 08.64.331(f).

documentation deficiencies, because, more commonly, such violations have been found in the context of broader patient care violations, typically in the context of controlled substance prescribing. For example, this Board very recently imposed a three-year suspension and a hefty fine ($25,000, with $10,000 suspended) in a controlled substance over-prescribing case that also included findings of substandard recordkeeping – but the central basis for discipline was substandard controlled substance prescribing with attendant actual patient harm. Relevant to the *documentation* issues, the Board in that case also imposed a one-year practice monitoring requirement "intended to ensure both evidence-based decisionmaking and its documentation," as well as an additional CME requirement targeted to topics of concern, including "documentation, ethics, [and/or] practice management."[285]

Looking further back, in *Halter v. State*, the Alaska Supreme Court upheld the Board's finding that a physician's incomplete and erratic charting amounted to "professional incompetence" under the Board's statutes and regulations. There, an expert witness testified that the provider's "recordkeeping was definitely inadequate," including "incomplete" histories, "sketchy or incomplete" treatment plans, and "rarely" providing "a good rationale or justification" for treatment decisions. The case arose in the context of controlled substance prescribing, but there was no separate finding of improper prescribing. Noting the *potential* for harm to arise from failure to adequately document and monitor controlled substance prescribing, but also the provider's "praiseworthy" motive and lack of ill intent, the hearing officer recommended a fine of $3,000. The Board adopted the decision but stayed the fine for two years, such that if no further violations occurred in the two year period, the fine would be dismissed.[286] This combination of a reprimand with a fine was similarly seen in Board-adopted Consent Agreements to resolve first-time documentation violations in *Davidhizer I* (2000) and in *Herold* (2004).[287]

In 2009, in *Davidhizer II*, the Board adopted a second consent agreement imposing significant penalties because the provider had previously been sanctioned for significant charting

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285 *In re: Andreassen*, OAH No. 22-0897-MED (August 9, 2024 Order, at pp. 68-72) (stayed pending appeal). While the Board's modification of the ALJ's proposed decision in that case did not specify which count(s) were associated with which additional sanctions, that case involved proven counts of substandard medical decisionmaking, with actual patient harm.

286 *Halter v. State, Dep't of Commerce & Econ. Dev., Med. Bd.*, 990 P.2d 1035 (Alaska 1999).

287 *In re Davidhizar*, Case No. 2802-00-002 (Consent Agreement adopted 10/27/00); *In re Herold*, Case No. 2800-02-09 (Consent Agreement adopted 1/15/04) (controlled substance prescribing for dozens of patients over a two year period while failing to "maintain appropriate medical records" for those patients; reprimand regarding "failure to maintain appropriate records supporting" prescription decisions, and $2,500 civil fine).

violations. The first consent agreement, after the provider issued 13 prescriptions over a two-month period without maintaining *any* records, had included a reprimand, a civil fine of $5,000, and two years' probation. The second consent agreement, nine years later and involving five substantiated instances of inadequate recordkeeping, included a reprimand, additional CME and "reeducation" requirements, 6 months of intensive chart auditing, a $35,000 civil fine ($7,000 per violation), and five years of probation.[288] The detailed chart auditing terms in *Davidhizer II* are the model for the terms of probation set out on pages 72-73 of this decision.

Considered together, we see in *Halter*, *Herod*, and *Davidhizer I* that the Board has historically placed the consequence for first violations of charting requirements—even quite serious ones—within the milieu of a stern reprimand, a moderate fine, and some sort of arrangement (e.g. probation or a suspended fine) whereby more consequences would follow if there were further violations in the immediate future. If a practitioner comes back a second time with the same kind of violation – as in *Davidhizer II* – the consequences are much larger fines and/or severe probation.

There is no record of suspension or revocation in a case centered primarily around charting.

Moving beyond the specific prior examples to the overarching principles behind them, it is undisputed that adequate documentation is an obligation of every physician. Multiple witnesses testified about the importance of complete and accurate documentation in the provision of medical care. Complete and accurate documentation is important to patients whose future health care requires their providers knowing what was done and why. It is important to insurers and other payors who rely on accurate representations of what was done and why in order to make and enforce uniform coverage decisions. It is important to other providers, who rely on their colleagues to inform them about a patient's prior (or contemporaneous) care. Surgeons, in particular, must be meticulous in their documentation because of the frequent absence of externally-available confirmation of what was done, how, or why.

An appropriate remedy both sanctions the prior noncompliance and helps reduce the likelihood of future problems. The sanction terms set out below seek to address both of these important aspects, while placing a high premium on restoring medical community trust through a combination of skill-building (through mandatory CMEs) and verification (by dual chart audits).

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[288] *In re Davidhizar*, Case No. 2802-01-003 (Consent Agreement adopted 10/22/09).

VIII. Conclusion and Order

In light of all of the foregoing, the following sanctions are imposed:

(1) A reprimand. Pursuant to AS 08.64.331(a)(4), Dr. Carey is formally reprimanded for producing patient records that are untimely, imprecise, and at times inaccurate. While this decision concludes that his documentation errors were not deliberate, they were at times unacceptably careless, and a formal reprimand is warranted.

(2) A civil fine. Considering prior Board precedent, the scope of concerns identified, and the failure to promptly remedy early concerns, a fine of $15,000, with $7,500 suspended, is imposed pursuant to AS 08.64.331(a)(7).

(3) Probation. Pursuant to AS 08.64.331(a)(5), a two-year period of probation is imposed,[289] during which Respondent will:

a. Submit quarterly reports to the Board

b. Satisfactorily complete, in addition to yearly CME requirements, at least 20 additional CME hours each year on topics specifically related to documentation and recordkeeping, and approved in advance by the Board's agent.[290] The first 20 hours of CME shall be completed within 90 days of the effective date of this decision in this case.

c. For a period of one year, Respondent shall participate in a collaborative practice monitoring process focused on the quality and consistency of documentation.

Within sixty days of the effective date of this decision, Respondent shall contract with two physician practice monitors, at least one of whom who is licensed in Alaska, each with a minimum of five (5) years of orthopedic surgery experience, and neither of whom practices in Fairbanks. Before entering into an agreement under this section, respondent shall provide the Board's agent with the names, contact information, and CV for each physician for approval. Respondent will provide each monitor with a copy of this decision.

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[289] AS 08.64.331(a)(5) (Board may "place a licensee on probationary status," during which time the licensee may be required to "report regularly to the board on matters involving the basis of probation," and to "continue professional education until a satisfactory degree of skill has been attained in those areas determined by the board to need improvement.")

[290] Additional related CME topics may submitted for consideration if requested in advance and approved by the Board's agent.

At least once per month for the first six months, and once every other month for the next six months, each practice monitor will randomly review at least five surgical patient charts from the prior month. The practice monitors will review patient charts to oversee, evaluate, and advise on the quality, accuracy, and consistency of respondent's documentation, and will meet with the Respondent, in person or via video conference, to facilitate these reviews. The practice monitors shall be allowed access to whatever charts or files in Respondent's office that are needed to make a valid determination of the treatment provided.
Each practice monitor will submit an independent written report to the Board's agent on a monthly basis for the first six months and every other month thereafter while the monitoring is in progress, and shall indicate in their report whether respondent's documentation reviewed meets the standard of care.

This order shall become effective if adopted by the Alaska State Medical Board below.

Dated: November 15, 2024

[redacted]
Cheryl Mandala
Administrative Law Judge

Revision and Adoption

The Alaska State Medical Board, in accordance with AS 44.64.060(e)(3), hereby revises the proposed decision to impose only the following sanction:

(1) A reprimand as set out in Paragraph VIII (a),

(2) A civil fine of $15,000, with $3,000 suspended, and

(3) A period of probation until respondent pays the non-suspended portion of the civil, fine and satisfactorily completes at least 20 hours of additional CME as described in paragraph VIII(3)(b).

The Board revises the sanction as described above, and adopts the proposed decision as so revised.

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 distribution of this decision.

DATED this 16th day of January 2025.

By: [redacted]
Eric Nimmo
Chairperson, State Medical Board