STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

April 5, 2001

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Mr. Terrence Sheehan, Esq.
NYS Department of Health
Division of Legal Affairs
5 Penn Plaza – Sixth Floor
New York, New York 10001

Kevin D. Porter, Esq.
Thurm & Heller, LLP
261 Madison Avenue
New York, New York 10016

Richard E. Pearl, M.D.
Redacted Address

RE: In the Matter of Richard E. Pearl, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 01-93) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Redacted Signature

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah
Enclosure

STATE OF NEW YORK: DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT
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IN THE MATTER

OF

RICHARD E. PEARL, M.D.
----------X

COPY

ORDER # BPMC 01-93

DETERMINATION AND ORDER OF THE HEARING COMMITTEE

The undersigned Hearing Committee consisting of **GERALD S. WEINBERGER M.D.**, Chairperson, **WILLIAM W. WALENCE Ph.D.**, and **JOSEPH GEARY M.D.**, were duly designated and appointed by the State Board for Professional Medical Conduct. **MARY NOE** served as Administrative Officer.

The hearing was conducted pursuant to the provisions of Sections 230 (10) of the New York Public Health Law and Sections 301-307 of the New York State Administrative Procedure Act to receive evidence concerning alleged violations of provisions of Section 6530 of the New York Education Law by RICHARD E. PEARL M.D. (hereinafter referred to as "Respondent"). Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record.

SUMMARY OF PROCEEDINGS

Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, N.Y.
Pre-Hearing Conferences:	10/27/00
Hearing dates:	November 17, 2000 November 21, 2000 December 1, 2000 December 6, 2000 December 19, 2000 December 20, 2000 January 3, 2001 January 10, 2001
Dates of Deliberation:	March 9, 2001
Petitioner appeared by:	NYS Department of Health by: Terrence Sheehan, Esq., Associate Counsel
Respondent appeared by:	Thurm & Heller, LLP 261 Madison Avenue New York, New York 10016 by: Kevin D. Porter, Esq.

WITNESSES

For the Department:	Gilbert H. Young, M.D. Maureen Begley Keys Ansel Marks, M.D. J.D.
For the Respondent:	Richard Pearl, M.D. Mark G. Lazansky, M.D. Allan Inglis, MD. Stanley Soren, M.D.

SIGNIFICANT LEGAL RULINGS

The Committee has considered the entire record in the above captioned matter and hereby renders its decision with regard to the charges of medical misconduct. With regard to the expert testimony herein, including Respondent's, the Committee was instructed that each witness should be evaluated for possible bias and assessed according to his or her training, experience, credentials, demeanor and credibility.

FINDINGS OF FACT

1. RICHARD E. PEARL, M.D., the Respondent, was authorized to practice medicine in New York State on or about March 24, 1978 by the issuance of license number 133973 by the New York State Education Department. (Dept. Ex. 1)

PATIENT A

2. Respondent failed to maintain a record for Patient A which accurately reflects the evaluation and treatment he provided including Patient examination, history, valid diagnoses, treatment plan, rationales for surgery, operative reports, progress notes, test results and interpretations and discharge summary. (Exh. 11; T. 170, 171, 173, 174)

PATIENT B

3. Respondent on or about 1986 treated Patient B for pain and inability to walk at the Hospital for Joint Disease. (Exh. 4, 5)

4. Respondent improperly failed to appropriately evaluate pre-operative x-rays which showed a lesion of the left pubic bone. (Exh. 18, T. 346 - 347, 359 - 361)

5. On or about February 29, 1986, Respondent performed a left total hip replacement which was contraindicated. (Exh. 4, T. 359 - 361)

6. Respondent improperly failed to timely order an oncology workup including biopsy and definitive tumor surgery. (Exh. 4, T: 350)

7. Pathological examination of the excised femoral head and tissues from the acetabular reamings revealed a high grade malignant Histiocytoma. (Exh. 4) Respondent improperly failed to note in Patient B's summary both this finding and the lesion described in the preoperative x-rays. (Exh. 4)

8. Respondent failed to maintain a record for Patient B which accurately reflects the evaluation and treatment he provided including Patient examination, history, valid diagnoses, treatment plan, rationales for surgery, operative reports, progress notes, test results and interpretations and discharge summary. (Exh. 4,5; T. 450, T. 368 - 370)

PATIENT C

9. In or about 1993 and 1994, Respondent treated Patient C for hip disease at the Hospital for Joint Diseases. Respondent failed to maintain a record for Patient C which accurately reflects the evaluation and treatment he provided including Patient examination, history, valid diagnoses, treatment plan, rationales for surgery, operative reports, progress notes, test results and interpretations and discharge summary. (Exh. 6, 7; T. 475, 479, 480, 490)

PATIENT D

10. In or about 1994, Respondent treated Patient D at the Hospital for Joint Diseases for osteoarthritis of both knees. Respondent failed to maintain a record for Patient D which accurately reflects the evaluation and treatment he provided including Patient examination, history, valid diagnoses, treatment plan, rationales for surgery, operative reports, progress notes, test results and interpretations and discharge summary. (Exh. 8, 9; T. 1031, 1044, 1055, 1061)

PATIENT E

11. In or about 1995, Respondent treated Patient E at the Hospital for Joint Diseases. Respondent failed to maintain a record for Patient E which accurately reflects the evaluation and treatment he provided including Patient examination, history, valid diagnoses, treatment plan, rationales for surgery, operative reports, progress notes, test results and interpretations and discharge summary. (Exh. 10, 11; T. 1333, 1334)

PATIENT F

12. In or about November 1994, Patient F was treated by Respondent at the Hospital for Joint Diseases. (Exh 12, 13)

13. Several months after Patient F's discharge from the hospital Respondent altered the Patient's medical record by the addition of one sentence to his original admission note. The added sentence states that "risks, alternatives and benefits have been thoroughly explained to her." (Exh. 12, 21, 22, 23, 24, T. 205)

14. Sometime thereafter, Respondent learned that an unaltered copy of Patient F's chart had already been forwarded to Patient F's attorney. Respondent then altered the chart a second time by whiting-out the sentence he had previously added. (Exh. 12; T. 1122, 1123, 1124)

15. Respondent intentionally altered the chart with the intent to deceive. (T. 1143)

BETH ISRAEL MEDICAL CENTER

16. On or about November 20, 1996, Respondent applied for re-appointment to the staff of Beth Israel Medical Center, North Division, New York. Respondent deliberately lied on the application when he denied that any of his privileges had been or were in the process of being investigated, denied, revoked, suspended, limited or now renewed. In fact, prior to the date of the application, Respondent had been notified by Joseph Zuckerman, M.D., Chairman of the Department of Orthopedic Surgery at the Hospital for Joint Diseases that the Respondent would not be reappointed to the medical staff at the Hospital for Joint Diseases, and an administrative hearing before a H.J.D. hearing panel to review Dr. Zuckerman's decision had already begun. (Exh.29; T. 1158, 1159)

DISCUSSION

The Hearing Committee finds the Respondent less than credible. The Respondent is both inaccurate in his record keeping (Exh. T. 808, 855, 866, 893, 910, 925)) and repeatedly deceitful. (Exh 26, T. 869, 887, 888, 932 - 935, 1048, 1068, 1137 - 1138, 1159, 1174, 747, 1164, 1124) In the Respondent's reapplication for privileges to Doctors Hospital of Staten Island, the Respondent misrepresented his dismissal from the Hospital for Joint Diseases. (Exhibit 26) During the course of the hearing the Respondent would

inaccurately represent information to this hearing Committee such as his status with the American Board of Medical Specialties; (T. 1174) authoring special techniques in books; (T. 747) his denial of receiving the letter from Beth Israel denying reappointment; (Exh 29, T 1164); his rationale for using whiteout on Pt. F's medical chart (T. 1124); dictating a second operative record six months after an operation (T. 1069, 1080). The Respondent had little insight into these deceptions nor could he provide rational or plausible explanations. The Respondent was reluctant to take responsibility for his actions and often deferred to the actions of subordinates or associates. (T. 773, 856, 898, 901, 1071)

The Hearing Committee found that the Respondent was grossly negligent in his care for Patient B. Although the Respondent appears to be a competent surgeon, he takes a careless approach to his patients and practice. Patient B's pre-operative x-rays showed an unmistakable suspect lesion of the left pubic bone. Despite this information, Respondent performed a total hip replacement. Patient B's lesion was a high grade malignant Histiocytoma. The surgery the Respondent performed was unnecessary and a life threatening procedure. (T. 339) His inexcusable gross negligence caused Patient B to have delayed treatment of his malignancy and unnecessary surgery. The Respondent intentionally left out of Patient B's chart any information regarding his malignant tumor, which was an inaccurate representation of Patient B's condition. (Exh. 4, 5)

The Respondent repeatedly blamed others for actions that were his responsibility. (T. 1158).

The Hearing Committee found the Respondent's testimony regarding Pt. F incredulous. (T. 1139, 1140, 1141) Specifically, Respondent stated:

> "Well, what happened is, at that time I was having professional difference with the chairman of my department about his billing practices....So he decided to teach me a lesson about questioning the chief....he sent investigators to her house and said, listen, come to the hospital, say that you were sitting at home and - and you fell and we will say it's Dr. Pearl's fault." (T. 1128)

The Panel finds this testimony unbelievable, nor was it corroborated in any way by the introduction of evidence or testimony from any of the numerous participants noted by the Respondent.

Respondent's expert witness Dr. Lazansky is the leading expert in the area of hip revision, orthopedic surgery. However, the Hearing Committee discredited his testimony not only because he was a friend of Dr. Pearl's for approximately 30 years, but more significantly, he was fired from his position as medical coordinator for the Office of Professional Medical Conduct. (T. 1218 - 1220) The basis for his discharge was due to his review of one of Dr. Pearl's cases without his disclosure to the agency that he was a long-term friend and partner. (T. 1220)

The Hearing Committee has given minimal weight to the testimony of Dr. Young, State's expert regarding Patient A, C, D, E. Dr. Young testified that he was inexperienced in several of the types of surgeries performed by the Respondent. (T. 81, 497, 587) The Committee did find Dr. Young credible in areas of general medical practice, surgery and medical record keeping.

The Committee has reviewed all possible penalties. There was no issue presented at the hearing regarding the Respondent's surgerical abilities, however the Respondent consistently exhibited a careless attitude towards his patients. The Respondent's violations were founded in his inaccurate record keeping and repeated deceitful behavior. This Committee has recognized the impact the Respondent's behavior has had on his patients and therefore decided the foregoing penalty.

THE FOLLOWING CHARGES AS LISTED IN THE STATEMENT OF CHARGES ARE SUSTAINED (charges not listed are not sustained)

Paragraphs A 6

Paragraphs B1; B2; B3; B4; B6;

Paragraphs C5

Paragraphs D5

Paragraphs E3

Paragraphs F1; F2; F3

Paragraph G

SPECIFICATION OF CHARGES

PRACTICING WITH GROSS NEGLIGENCE

Paragraph B and B(1) through B(4), B(6)

FRAUDULENT PRACTICE

Paragraph F (1) through F(3)

MORAL UNFITNESS

Paragraph F (1) through F(3)

Paragraphs G

FAILURE TO MAINTAIN A RECORD

Paragraphs A6

Paragraphs B 6

Paragraph C 5

Paragraph D 5

Paragraph E 3

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee, unanimously, after giving due consideration to all the penalties available have determined that the Respondent's license to practice medicine in the state of New York should be SUSPENDED for three years. The suspension is STAYED for the last two years of the three year suspension. During the later two year suspension the Respondent will have a monitor for record keeping.

In addition, the Hearing Committee, unanimously fines the Respondent $50,000.00.

ORDER

IT IS HEREBY ORDERED THAT:

1. The Respondent's license to practice medicine in the State of New York is SUSPENDED for three (3) years. The suspension is STAYED for the last two (2) years of the three (3) year suspension.
2. During the later two (2) year suspension the Respondent will have a monitor for record keeping.
3. The Respondent shall pay a fine in the sum of Fifty Thousand Dollars ($50,000.00).
4. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by the State of New York. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non renewal of permits or licenses (Tax Law §171(27); State Finance Law §18; CPLR §5001; Executive Law §32).
5. This Order shall be effective upon service on the Respondent or Respondent's attorney by personal service or by certified or registered mail.

DATED: Ardsley, New York
April 4, **2001**

Redacted Signature

GERALD S. WEINBERGER, M.D.
Chairperson

WILLIAM W. WALENCE, Ph.D.
JOSEPH E. GEARY, M.D.

MAIL PAYMENT TO

New York State Department of Health
Bureau of Accounts Management
Corning Tower Building-Room 1258
Empire State Plaza
Albany, New York 12237

APPENDIX I

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

IN THE MATTER

OF

RICHARD E. PEARL, M.D.

STATEMENT

OF

CHARGES

RICHARD E. PEARL, M.D., the Respondent, was authorized to practice medicine in New York State on or about March 24, 1978, by the issuance of license number 133973 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. In or about 1993, Respondent treated Patient A at the Hospital for Joint Diseases, 30 East 17th Street, New York, N.Y. for a repair of a 19-year-old total hip replacement. (Patient names are contained in the attached Appendix). Respondent's care deviated from accepted standards in the following respects:

1. On or about 6/10/93, Respondent performed an aspiration arthrogram and ordered a culture and sensitivity. Respondent improperly failed to record the results of the culture and sensitivity until July 11, 1993.

2. The culture revealed a coagulase-negative ~~positive~~ Staph. Respondent improperly failed to treat this infection.

3. Respondent performed a right acetabular replacement on August 20, 1993. This procedure was not indicated in the presence of the untreated infection.

4. Prior to this operation, Respondent failed to perform another aspiration arthogram and culture and sensitivity to determine the status of the infection.

5. Post operatively, a virulent infection developed and the acetabular component became loose. These events were caused by Respondent's failure to appropriately treat Patient A's infection pre-operatively. Three subsequent corrective surgical procedures were required.

6. Respondent failed to maintain a record for Patient A which accurately reflects the evaluation and treatment he provided including Patient examination, history, valid diagnoses, treatment plan, rationales for surgery, operative reports, progress notes, test results and interpretations and discharge summary.

B. In or about 1986, Respondent treated Patient B for pain and inability to walk at the Hospital for Joint Diseases. Respondent's care deviated from accepted standards in the following respects:

1. Respondent improperly ignored or failed to appropriately evaluate pre-operative x-rays which showed a lesion of the left pubic bone.

2. On or about February 29, 1986, Respondent performed a left total hip replacement which was contraindicated.

3. Respondent improperly failed to timely order an oncology workup

including biopsy and definitive tumor surgery.

4. Pathological examinations of the excised femoral head and tissues from the acetabular reamings revealed a high grade malignant histiocytoma. The discharge summary improperly fails to note both this finding and the lesion described in the preoperative x-rays.

5. Respondent entered a progress note in Patient B's chart indicating that Patient B was going to have a biopsy of the left pubis ramus. This note was knowingly false and made with intent to deceive.

6. Respondent failed to maintain a record for Patient B which accurately reflects the evaluation and treatment he provided including Patient examination, history, valid diagnoses, treatment plan, rationales for surgery, operative reports, progress notes, test results and interpretations and discharge summary.

C. In or about 1993 and 1994, Respondent treated Patient C for hip disease at the Hospital for Joint Diseases. Respondent's care deviated from accepted standards in the following respects:

1. On or about June 15, 1993, Respondent performed a revision of the Patient's left acetabulum. Respondent's surgical technique was substandard. He improperly placed screws in the soft tissue and failed to attempt to correct this defect when it was revealed on intra-operative x-rays.

2. Eight days after the operation, the acetabular component was sub-luxed, according to x-rays. Respondent improperly failed to correct this condition until 17 months later.

3. On or about July 25, 1994, Respondent operated to remove painful cables attached to various components in the left hip. Respondent inappropriately failed during this operation to also correct the loose acetabular component. As a result, Patient C was subjected to an additional operation several months later.

4. Respondent improperly failed to order pre-operative x-rays prior to the July 25, 1994 operation.

5. Respondent failed to maintain a record for Patient C which accurately reflects the evaluation and treatment he provided including Patient examination, history, valid diagnoses, treatment plan, rationales for surgery, operative reports, progress notes, test results and interpretations and discharge summary.

D. In or about 1994, Respondent treated Patient D at the Hospital for Joint Diseases for osteoarthritis of both knees. Respondent's care deviated from accepted standards in the following respects:

1. On or about October 3, 1994, Respondent performed bilateral total knee replacements. Respondent's surgical technique was substandard, resulting in bilateral rupture of the patellar tendons and numbness in the lateral aspect of the left foot.

2. Respondent failed to adequately evaluate and monitor Patient D's post surgical condition.

3. Respondent improperly failed to perform corrective surgery in a timely fashion.

4. In a letter to a Dr. Pittman dated May 4, 1995. Respondent, with intent to deceive, deliberately mischaracterized Patient D's hospital course, including the date when he first learned of Patient D's complaint of post-surgical clicking in the right knee.

5. Respondent failed to maintain a record for Patient D which accurately reflects the evaluation and treatment he provided including Patient examination, history, valid diagnoses, treatment plan, rationales for surgery, operative reports, progress notes, test results and interpretations and discharge summary

E. In or about 1995, Respondent treated Patient E at the Hospital for Joint Diseases for an undocumented complaint. Respondent's care deviated from accepted standards in the following respects:

1. On or about January 3, 1995, Respondent performed arthroscopic knee surgery on Patient E. This procedure was not indicated.

2. During the course of the procedure, a knife blade broke. Respondent improperly failed to accurately describe this incident in his operative

report, omitting mention, for instance, of the fact that another surgeon, Dr. Rose, was called into the operating room to remove the broken knife blade.

3. Respondent failed to maintain a record for Patient E which accurately reflects the evaluation and treatment he provided including Patient examination, history, valid diagnoses, treatment plan, rationales for surgery, operative reports, progress notes, test results and interpretations and discharge summary.

F. In or about November, 1994, Patient F was treated by Respondent at the Hospital for Joint Diseases.

1. Several Months after Patient F's discharge from the hospital Respondent altered the Patient's medical record by the addition of one sentence to his original admission note. The added sentence states that "risks, alternatives and benefits have been thoroughly explained to her."

2. Some time thereafter, Respondent learned that an unaltered copy of Patient F's chart had already been forwarded to Patient F's attorney. Respondent then altered the chart a second time by whiting-out the sentence he had previously added.

3. Respondent engaged in the conduct described in paragraphs F.1 and F.2, with the intent to deceive.

G. On or about November 20, 1996, Respondent applied for re-appointment to the staff of Beth Israel Medical Center, North Division, New York. Respondent deliberately lied on the application when he denied that any of his privileges had been or were in the process of being investigated, denied, revoked, suspended, limited or not renewed. In fact, prior to the date of the application, Respondent had been notified by Joseph Zuckerman, M.D., Chairman of the Department of Orthopedic Surgery at the Hospital for Joint Diseases that the Respondent would not be reappointed to the medical staff at the Hospital for Joint Diseases, and an administrative hearing before a H.J.D. hearing panel to review Dr. Zuckerman's decision had already begun.

SPECIFICATION OF CHARGES

FIRST THROUGH FOURTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 2000) by practicing the profession of medicine with gross negligence as alleged in the facts of the following paragraphs:

1. A and A(1) through A(5).
2. B and B(1) though B(3).
3. C and C(1) through C(4).
4. D and D(1) through D(3).

FIFTH THROUGH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 2000) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following paragraphs:

5. A and A(1) through A(5).
6. B and B(1) though B(3).
7. C and C(1) through C(4).
8. D and D(1) through D(3).

NINTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 2000) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following paragraphs:

9. A and A(1) through A(6); B and B(1) through B(6); C and C(1) through C(5); D and D(1) through D(5) and E and E(1) through E(3).

TENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 2000) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following paragraphs:

10. A and A(1) through A(6); B and B(1) through B(6); C and C(1) through C(5); D and D(1) through D(5) and E and E(1) through E(3).

ELEVENTH THROUGH FOURTEENTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 2000) by practicing the profession of medicine fraudulently as alleged in the facts of the following paragraphs:

11. B and B(5).

12. D and D(4).

13. F and F(1), F(2), F(3).

14. G.

FIFTEENTH THROUGH EIGHTEENTH SPECIFICATIONS

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21)(McKinney Supp. 2000) by wilfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, as alleged in the facts of the following paragraphs:

15. B and B(5).

16. D and D(4).

17. F and F(1), F(2), F(3).

18. G.

NINETEENTH THROUGH TWENTY-FOURTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 2000) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of the following paragraphs:

19. A and A(6).

20. B and B(4), B(5), B(6).

21. C and C(5).

22. D and D(4), D(5).

23. E and E(2), E(3).

24. F and F(1), F(2), F(3).

TWENTY-FIFTH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20)(McKinney Supp. 2000) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following paragraphs:

25. B and B(5), D and D(4), F and F(1), F(2), F(3) and G.

DATED: Sept. 5
~~August~~, 2000
New York, New York

Redacted Signature

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct