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THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK

OFFICE OF PROFESSIONAL DISCIPLINE
(718) 246-3060/3061

195 Montague Street – Fourth Floor
Brooklyn, New York 11201

October 30, 2008

Richard E. Pearl, Physician

Redacted Address

Re: Application for Restoration

Dear Dr. Pearl:

Enclosed please find the Commissioner's Order regarding Case No. CP-08-11 which is in reference to Calendar No. 22663. This order and any decision contained therein went into effect on October 29th when it was hand delivered to you.

Very truly yours,

Daniel J. Kelleher
Director of Investigations

By:
Redacted Signature

Ariana Miller
Supervisor

DJK/AM/er
cc: Anthony Z. Scher, Esq.
Wood & Scher
Attorneys at Law
222 Bloomingdale Road, Suite 311
White Plains, New York 10605

IN THE MATTER

of the

Application of RICHARD E. PEARL, for restoration of his license to practice as a physician in the State of New York.

Case No. CP-08-11

It appearing that the license of RICHARD E. PEARL, 40 Heather Drive, East Hills, New York 11576, to practice as a physician in the State of New York, was revoked by the Administrative Review Board for Professional Medical Conduct on July 3, 2001, and he having petitioned the Board of Regents for restoration of said license, and the Regents having given consideration to said petition and having agreed with and accepted the recommendations of the Peer Committee and the Committee on the Professions, now, pursuant to action taken by the Board of Regents on July 28, 2008, it is hereby

ORDERED that the petition for restoration of License No. 133973, authorizing RICHARD E. PEARL to practice as a physician in the State of New York, is granted, and his license to practice as a physician in the State of New York shall be fully restored.

IN WITNESS WHEREOF, I, Richard P. Mills, Commissioner of Education of the State of New York for and on behalf of the State Education Department, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 24th day of October, 2008.

Redacted Signature

Commissioner of Education

Case No. CP-08-11

It appearing that the license of RICHARD E. PEARL, Redacted Address to practice as a physician in the State of New York, was revoked by the Administrative Review Board for Professional Medical Conduct on July 3, 2001, and he having petitioned the Board of Regents for restoration of said license, and the Regents having given consideration to said petition and having agreed with and accepted the recommendations of the Peer Committee and the Committee on the Professions, now, pursuant to action taken by the Board of Regents on July 28, 2008, it is hereby

VOTED that the petition for restoration of License No. 133973, authorizing RICHARD E. PEARL to practice as a physician in the State of New York, is granted, and his license to practice as a physician in the State of New York shall be fully restored.

Case Number

CP-08-11
July 9, 2008

THE UNIVERSITY OF THE STATE OF NEW YORK
The State Education Department

Report of the Committee on the Professions
Application for Restoration of Physician License

Re: Richard E. Pearl

Attorney: Anthony Scher, Esq.

Richard E. Pearl, Redacted Address ..., petitioned for restoration of his physician license. The chronology of events is as follows:

03/24/78	Issued license number 133973 to practice as a physician in New York State.
09/05/00	Charged with 25 specifications of professional misconduct by the Bureau of Professional Medical Conduct of the New York State Department of Health.
04/04/01	Decision and Order BPMC-01-93 of a Hearing Committee of the State Board of Professional Medical Conduct sustained charges of gross negligence, failure to maintain records, fraudulent practice, and moral unfitness, and ordered a suspension of license to practice medicine for three years, the last two years stayed, and assessed a $50,000 fine.
07/03/01	Administrative Review Board for Professional Medical Conduct Determination and Order No. 01-93 upheld Committee's findings and conclusions, but revoked license.
06/20/02	Appellate Division, Third Department confirmed ARB decision.
09/13/04	Application submitted for restoration of physician license.
06/19/06	Peer Committee restoration review.
03/20/07	Report and recommendation of Peer Committee (See "Report of the Peer Committee").
11/15/07	Committee on the Professions meeting with applicant.
07/09/08	Report and recommendation of Committee on the Professions.

Disciplinary History. (See attached disciplinary documents.) On September 5, 2000, Dr. Pearl was charged by the Department of Health, State Board for Professional Medical Conduct (BPMC), with numerous specifications of professional misconduct regarding his treatment of six patients, patients A through F, between 1986 and 1995. After a hearing, a BPMC Committee determined that Dr. Pearl had committed gross negligence with respect to patient B, whom he had treated back in 1986, by, among other things, failing to properly evaluate pre-operative x-rays that showed a lesion on the patient's pelvic bone, failing to note that a pathological examination revealed a high grade malignancy, and performing a contra-indicated total left hip replacement. The Committee found that Dr. Pearl had failed to maintain accurate records which properly reflected his evaluation and treatment of patients with respect to A, B, C, D, and E. He was also found to have practiced medicine fraudulently by altering the records of patient F by adding a sentence to his records several months after the patient's discharge and then by trying to hide the fact by whiting out the changes later on. The Committee further found that he had lied in an application for appointment to a hospital staff by failing to disclose the termination of his privileges at the Hospital for Joint Diseases. That conduct was found to constitute both fraudulent practice and conduct evidencing moral unfitness. The Committee voted to suspend Dr. Pearl's license for three years, with two years of the suspension stayed. He was to have his record keeping monitored for the two years and pay a $50,000 fine.

Dr. Pearl requested review of the Committee's determination by the Administrative Review Board (ARB). The ARB sustained the findings and determination of the Committee, but overturned the penalty and instead, revoked Dr. Pearl's medical license effective July 17, 2001. Dr. Pearl next commenced an Article 78 proceeding seeking review of the ARB decision. The Appellate Division, Third Department, affirmed the ARB decision.

On September 13, 2004, Dr. Pearl submitted the instant application for restoration of his physician license.

Recommendation of the Peer Committee. (See attached Report of the Peer Committee.) The Peer Committee (Diamond, Robinson, Salom) convened on June 19, 2006. In its report dated March 20, 2007, the Committee voted unanimously to recommend that Dr. Pearl's application for restoration of his physician license be granted, without restriction or limitation.

Recommendation of the Committee on the Professions. On November 15, 2007, the Committee on the Professions (COP) (Muñoz, Hansen, Templeman) met with Dr. Pearl to consider his application for restoration. His attorney, Anthony Scher, accompanied him.

Dr. Pearl was asked to explain his understanding of why his license had been revoked. He stated that improper record keeping was a major cause of his revocation. He admitted that he had not previously been in the practice of keeping adequate medical records. He told the COP that he had been in charge of a busy clinic that dealt a lot with uninsured patients, and although the patients were treated appropriately, the records were incomplete and were not sufficiently detailed.

The Committee asked Dr. Pearl to describe what had happened with Patient B, the patient that he had been found guilty of treating with gross negligence. Dr. Pearl indicated that that patient had been referred to him in 1985 by another orthopedic surgeon for repair of the patient's fractured hip. Surgery by the referring surgeon, which had included the insertion of a screw, had failed, and the patient was in need of a hip replacement. X-rays of the hip area showed a translucency in the hip area that could have suggested a cancerous tumor. No MRI was yet available at that time, and a CAT scan could not be done because of the existence of a metal plate. He went ahead and performed the hip replacement surgery on patient B, which would have been appropriate if the cancer had been metastatic, because the cancer could have been treated with radiation after the hip surgery. He opined that the cancer had over a 95% chance of being metastatic. A biopsy on a bone sample later showed that the patient actually had a very rare primary bone tumor. He therefore went back and performed a hemipelvectomy on patient B, who ended up surviving the surgery by another 12 years. Later, in 1994, the Office of Professional Medical Conduct (OPMC) reviewed the case, but, according to Dr. Pearl, took no action. However, when OPMC brought charges against him in 2000, they also brought charges regarding his treatment of patient B 15 years earlier. At that time he had no records to defend himself on the matter, since they had previously been sent to OPMC, which no longer had them. OPMC concluded that his surgery on patient B was contraindicated because of the cancer, despite the fact that the patient lived for a long time after the surgery. Dr. Pearl emphasized that he had not been found to have treated anyone improperly for the next 15 years.

The panel next asked Dr. Pearl to discuss the case where he had been found guilty of altering medical records. Dr. Pearl explained that those records concerned a woman that he had treated for hip dysplasia. She placed a call to him at his office with a question about her condition, since she had suffered an injury from a fall and was investigating a possible lawsuit. He took the call while he was in the office records room working on charts. He told the COP that he pulled her chart out while he was speaking to her and at one point accidentally wrote on her chart, instead of the chart that he had been working on, writing that he had "discussed risks, benefits, and alternatives" with the patient. He soon realized that he had been writing on the wrong chart and whited out what he had written in her record. He indicated that he did not agree with the finding by OPMC that he had written the phrase in the patient's records fraudulently. He pointed out that the same language was in that patient's chart in many other areas and that no one ever took the position that the patient had indeed not been advised of her risks, benefits and alternatives with respect to treatment.

The panel also asked Dr. Pearl to explain the other finding in his disciplinary proceeding that he had not provided truthful information about having been denied privileges at one hospital when asked about that information on an application for a staff position at another hospital. Dr. Pearl indicated that his office personnel had completed that application form and that he had just signed it; he maintained that there had been no fraudulent intent. In addition, he stated that the hospital to which he was applying was already fully aware of his problems at the other hospital.

The COP asked Dr. Pearl to discuss his work since the loss of his license. Dr. Pearl stated that he had started a business advising attorneys about medical

malpractice cases. He later sold his house and moved his business to Colorado. As a result of providing consultation to attorneys, he has reviewed a large number of medical records, and he told the Committee he has become very aware of how important medical records are. He felt that he could even teach a course in recordkeeping at this time. He stated that he now realizes that a good physician must pay as much attention to his recordkeeping as he does to performing technical procedures.

When asked what he would plan to do if his license were restored, Dr. Pearl indicated that he would move back to New York State to return to practicing surgery. He believed that he could return to either Brooklyn Hospital or Cabrini Medical Center, since both facilities had expressed an interest in having him if his license were returned. He believed that he could return to practicing surgery quickly, since he has kept up with the profession through coursework, had operated on cadavers, and had attended Grand Rounds at Mt. Sinai Hospital.

The overarching concern in all restoration cases is the protection of the public. New York Education Law §6511 gives the Board of Regents discretionary authority to make the final decision regarding applications for the restoration of a professional license. Section 24.7 of the Rules of the Board of Regents charges the COP with submitting a recommendation to the Board of Regents on restoration applications. Although not mandated by law or regulation, the Board of Regents has instituted a process whereby a Peer Committee first meets with an applicant for restoration and provides a recommendation to the COP. A former licensee petitioning for restoration has a significant burden of satisfying the Board of Regents that there is a compelling reason that licensure should be granted in the face of misconduct that resulted in the loss of licensure. There must be clear and convincing evidence that the petitioner is fit to practice safely, that the misconduct will not recur, and that the root causes of the misconduct have been addressed and satisfactorily dealt with by the petitioner. It is not the role of the COP to merely accept, without question, the arguments presented by the petitioner, but to weigh and evaluate all of the evidence submitted and to render a determination based upon the entire record.

The COP concurs with the Peer Committee's assessment that Dr. Pearl has met the burden of proof required for the restoration of his license. We believe that he showed substantial remorse for his prior actions and has taken appropriate steps to improve himself. With respect to recordkeeping, he contacted his insurance carrier for instruction on how to properly notate a medical record. Furthermore, his present occupation, wherein he reviews medical records for attorneys, has provided him with substantial insight into the need for appropriate recordkeeping. He has also taken significant steps to maintain his surgical skills through continuing education courses, which included hands-on cadaver surgery. We were impressed in general by Dr. Pearl's dedication to improving himself and his continuing desire to contribute to the field of medicine both professionally and ethically.

We also note correspondence received subsequent to our meeting with Dr. Pearl from the Chief of the Division of Orthopaedic Surgery at The Brooklyn Hospital Center supporting Dr. Pearl's application so that he can bring his expertise in complex joint replacements to the indigent community served by that hospital, which to this point has been underserved. In the letter, it is indicated that Dr. Pearl has agreed to anchor his

practice at the hospital and to cover clinic duties, to be on-call on a regular basis, to have an office on the premises, and to perform all of his surgeries at the hospital. This dedication to provide services to those unable to pay for them appears to be consistent with Dr. Pearl's former practice as described by the witness W.T., a medical colleague at Cabrini Medical Center, and by Dr. Pearl himself.

We believe, as did the Peer Committee, that Dr. Pearl has met the goals of remorse, rehabilitation, and reeducation needed for the restoration of his license. We believe also that he is highly unlikely to engage again in the misconduct that led to the loss of his license.

Therefore, after a careful review of the record and its meeting with Dr. Pearl, the Committee on the Professions voted unanimously to concur with the recommendation of the Peer Committee that Dr. Pearl's application for restoration of his license to practice as a physician in the State of New York be granted without restriction or limitation.

Frank Muñoz
Stanley Hansen
Leslie Templeman

The University of the State of New York

NEW YORK STATE EDUCATION DEPARTMENT
OFFICE OF PROFESSIONAL RESPONSIBILITY
STATE BOARD FOR MEDICINE
---------------------------------------X

In the Matter of the Application of

RICHARD ERWIN PEARL

REPORT OF THE PEER COMMITTEE
CAL. NO. 22663

for the restoration of his license to practice as a physician in the State of New York.

---------------------------------------X

Richard Erwin Pearl, hereinafter known as the applicant, was previously licensed to practice as a physician in the State of New York by the New York State Education Department. In July, 2001, said license was revoked by the Office of Professional Medical Conduct Administrative Review Board (ARB), New York State Department of Health, as a result of a professional misconduct proceeding. The applicant has applied for restoration of his license.

BACKGROUND INFORMATION

The written application, supporting papers provided by the

applicant and papers resulting from the investigation conducted by the Office of Professional Discipline (OPD) have been compiled by the prosecutor from OPD into a packet that has been distributed to this Peer Committee in advance of its meeting and also provided to the applicant.

PRIOR DISCIPLINE PROCEEDINGS

Board for Professional Medical Conduct Action

April 4, 2001 - by order dated April 4, 2001, Case No. BPMC 01-93 the Board of Professional Medical Conduct (BPMC) of the Department of Health of the State of New York hearing committee determined that the applicant was guilty of numerous specifications of professional misconduct. The BPMC hearing committee determined that the applicant's license to practice as a medical doctor in the State of New York should be suspended for three years; that the suspension be stayed for the last two years of the three year suspension; that the applicant pay a fine of $50,000.00; and that his patient records be monitored for two years.

Administrative Review Board for Professional Medical Conduct: On July 3, 2001 the Administrative Review Board (ARB), by Determination and Order 01-93, considered the applicant's request for review of the determination of the hearing committee. The ARB sustained the findings and determinations of the hearing committee on the charges that the applicant committed professional misconduct, and it overturned the penalty set forth

by the hearing committee (suspension of the applicant's medical license, stay of suspension, fine, and monitoring of patient records) and instead, revoked the applicant's medical license.

Order of the Professional Medical Conduct Administrative Review Board: On July 10, 2001, Determination and Order 01-93, enforcing the penalty, was served by mail upon the applicant to be effective five days after the applicant received the order.

Article 78 Proceeding: Pursuant to CPLR Article 78, initiated under Public Health Law, Section 230-c[5], the applicant petitioned the Appellate Division of the New York State Supreme Court for review of the ARB Determination and Order 01-93. On June 20, 2002, the Appellate Division "confirmed" Determination and Order 01-93, without costs, and dismissed the applicant's petition.

Specifications of misconduct

The applicant was found guilty of:

1. the second specification, paragraphs B1 through B3 regarding patient "B", in violation of Education Law, section 6530(4), practicing with gross negligence;
2. the thirteenth specification, paragraphs F1 through F3 regarding patient "F", in violation of Education Law, section 6530(2), practicing fraudulently;
3. the nineteenth specification, paragraph A6

regarding patient "A", in violation of Education Law, section 6530(32), failing to maintain a record for each patient which accurately reflects the care and treatment of the patient;

4. the twentieth specification, paragraph B6 regarding patient "B", in violation of Education Law, section 6530(32), failing to maintain a record for each patient which accurately reflects the care and treatment of the patient;
5. the twenty-first specification, paragraph C5 regarding patient "C", in violation of Education Law, section 6530(32), failing to maintain a record for each patient which accurately reflects the care and treatment of the patient;
6. the twenty-second specification, paragraph D5 regarding patient "D", in violation of Education Law, section 6530(32), failing to maintain a record for each patient which accurately reflects the care and treatment of the patient;
7. the twenty-third specification, paragraph E3 regarding patient "E", in violation of Education Law, section 6530(32), failing to maintain a record for each patient which accurately reflects the care and treatment of the patient;
8. the twenty-fifth specification, paragraphs F1-3

and G regarding patients "F" and "G", in violation of Education Law, section 6530(20), engaging in conduct that evidences moral unfitness to practice.

Nature of the misconduct:

Misconduct as to Patient "A":

Sometime in 1993, the applicant treated Patient "A" for repair of a 19-year old hip replacement. The applicant failed to maintain a record for Patient "A" which accurately reflected 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.

Misconduct as to Patient "B":

Sometime during 1986, the applicant treated Patient "B" for pain and inability to walk. The applicant practiced with gross negligence in that he improperly ignored or failed to appropriately evaluate pre-operative x-rays, which showed a lesion of the left pubic bone; on or about February 29, 1986, he performed a left total hip replacement, which was contraindicated; and he improperly failed to order an oncology workup. The applicant also failed to maintain a record for Patient "B" which accurately reflected the evaluation and treatment he provided including patient

examination, history, 0valid diagnoses, treatment plan, rationales for surgery, operative reports, progress notes, test results and interpretations and discharge summary.

Misconduct as to Patient "C":

In either 1993 or 1994, the applicant treated Patient "C" for hip disease. The applicant failed to maintain a record for Patient "C" which accurately reflected 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.

Misconduct as to Patient "D":

Sometime during 1994 the applicant treated Patient "D" for osteoarthritis of both knees. The applicant failed to maintain a record for Patient "D" which accurately reflected 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.

Misconduct as to Patient "E":

Sometime during 1995, the applicant treated Patient "E" for an undocumented complaint. The applicant failed to maintain a record for Patient "E" which accurately reflected 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.

Misconduct as to Patient "F":

Sometime in November 1994, the applicant treated Patient "F" at the Hospital for Joint Diseases. The applicant practiced medicine fraudulently when, several months after Patient "F" was discharged from the hospital, the applicant altered Patient "F"'s medical record by adding one sentence, "Risks, alternatives and benefits have been thoroughly explained to [the patient]", to his original admission note. The applicant practiced medicine fraudulently when, thereafter, the applicant learned that an unaltered copy of Patient "F"'s chart had been forwarded to Patient "F"'s attorney, the applicant again altered the medical record by whiting-out the sentence he had earlier added. In both instances the applicant intended to deceive.

In addition, as a result of the acts described immediately above, the applicant engaged in conduct that evidenced moral unfitness to practice medicine.

Misconduct as to the Applicant's application for re-appointment:

On or about November 20, 1996, the applicant applied for re-appointment to the staff of Beth Israel Medical Center in New York. He deliberately lied on said application when he denied that any of his privileges had or were in the process of being investigated,

denied, revoked, suspended, limited or not renewed, since prior to said application, J.Z.*, M.D., Chair of the Department of Orthopedic Surgery at the Hospital for Joint Diseases, had notified the applicant that he would not be reappointed to the medical staff at Joint Diseases and, an administrative hearing was still pending on that issue.

Other states proceedings: Connecticut: In about October, 2002 the applicant voluntarily surrendered his license to practice as a physician and surgeon in the State of Connecticut, on the basis that he was "currently disabled and unable to practice medicine." New Jersey: In about January 2002, the applicant was reprimanded and his license to practice medicine and surgery in the State of New Jersey was revoked as a result of the disciplinary proceeding in New York State.

APPLICATION FOR RESTORATION

On September 13, 2004, the applicant executed the State Education Department's standard form for applying for restoration of licensure. The application contained information and attachments as referred to, below:

Entries in the basic application form:

Continuing Education: The applicant lists approximately 80 hours of continuing medical education credits in the form of

*Initials rather than names may be used in this report when referring to persons other than the respondent, panel members, Administrative Officer, those representing the parties, and those that may appear in any annexed exhibit.

orthopedic courses sponsored by the American Academy of Orthopedic Surgeons from December 2003 to March 2004, 28 credits of which derive from the annual meeting in March 2004. Based on his testimony that he "performed shoulder and hip replacements on cadavers at a course in Arizona", it is assumed that the applicant personally attended some of the courses noted above in February 2004; it is assumed that he personally attended the annual meeting as well. He also earned 9 hours of continuing medical education credits for an in-person course in orthopedic imaging sponsored by Weill Medical College of Cornell University in May 2004; he lists attendance at a non-credit course in "Moral Philosophy" at the New School University taken during the summer term of 2003.

The applicant states that he has not taken any courses in medical record-keeping.

Professional Rehabilitation Activities: The applicant lists the courses noted above in which he performed surgery on cadavers. The applicant attended Grand Rounds at Mt. Sinai School of Medicine in New York between approximately September 2002 and September 2004.

Volunteer Work/Community Service: The applicant listed service on the Board of Trustees at his local Jewish Community Center, approximately 4 hours per month from September 2001 to the date of his application; service as a soccer coach for the New Hyde Park Youth League, approximately 3 hours per month in

September 2004; and assisting as co-Chair with the Chabad dinner for Roslyn Chabad in September 2004.

Submissions of Affidavits: The applicant submits supporting affidavits from five individuals, all of whom are medical doctors.

Employment History: The applicant noted in his application and also testified that since the revocation of his license in September 2002 he has earned a living from the medical/legal consulting business that he established, HMP Medical Review. His business receives referrals from attorneys who are seeking "medical/legal analysis" of medical records of their clients. He personally reviews medical records and provides his attorney clients with an explanation of the medical procedures, suggests referrals to specialists that are appropriate to the cases, and assesses the success of a case from a medical perspective. The applicant told us that he has not testified in any of the cases for which he reviewed medical records. He indicated that he earned enough from his business to adequately support his family. He also said that about eight months prior to our meeting he moved from New York to Colorado, where he now resides and continues to work as a medical/legal reviewer.

Additional attachments to the application:

- **Exhibit A in response to Part B, Question 8,** a 3-page document listing the applicant's medical malpractice claims handled through his insurance carrier, Medical

Liability Mutual Insurance Company (MLMC).

INVESTIGATIVE INFORMATION

The packet provided by OPD contains the following additional information from the investigation that resulted from the filing of the application for restoration:

- **Reports of the OPD Investigator**, May 20, 2005, by K.O., Senior Investigator, that summarizes an interview of the applicant conducted on or about March 10, 2005, during which the investigator and applicant, with his attorney present, went over the questions and answers given on Form 1R. The applicant essentially said that he ought to have documented his records better, and that he would do so in the future, and if his license was restored, that he hoped to return to Cabrini Hospital to handle orthopedic cases. A second Progress Report, author unknown, dated October 15, 2005, summarizes the May 20, 2005 interview, adding nothing further.
- **May 3, 2006 letter from Dennis J. Graziano, Director, OPMC,** indicating OPMC's opposition to the restoration of the applicant's license to practice medicine. The OPMC takes the position that "… a brief, non-credit literature course is inadequate to address the moral and ethical misconduct at issue… There is no evidence that Dr. Pearl recognizes his record-keeping deficits

or the ethical shortcomings identified by the BPMC and the ARB. He does not demonstrate any remorse for the impact on his patients due to unnecessary or subsequent surgeries and the delay in cancer treatment. This leaves no assurance that the public would be protected or that there would be no repetition of the previous misconduct."

PEER COMMTTEE MEETING

On June 19, 2006 this Peer Committee met to consider this matter. The applicant appeared before us personally and was represented by Anthony Z. Scher, Esq. The Division of Prosecutions, OPD, was represented by Michael Gary Hilf, Esq.

The applicant's attorney, Mr. Scher, gave an opening statement that very briefly described the charges of which the applicant was found guilty and that the applicant would speak about what he had accomplished since the revocation of his license.

The applicant testified and described his medical education, internships, residencies, fellowships and employment history at Brookdale Hospital, Caledonian Hospital, the Hospital for Joint Diseases (from the early 1980's to 1995), and how he came to be employed at Cabrini Medical Center.

While employed at Joint Diseases, the applicant was solicited by the medical staff at Cabrini to join their facility

and establish an orthopedics unit with them. Over time, the applicant brought more of his patients to Cabrini and eventually exclusively established his hospital practice there during the period of 1995-2001. He told us that "It created a lot of animosity at the Hospital for Joint Diseases and they ultimately decided not to renew my privileges at Joint Diseases. I was at Cabrini, [so it] didn't bother me and I continued to practice at Cabrini where I started recruiting people for Cabrini." It was only after his privileges were not renewed by Joint Diseases that he learned that "anytime your privileges are not renewed, it is reportable to the State. And then I got in front of the State and then I got charged with a host of these things."

The applicant next described the medical procedures he performed in 1985-86 that gave rise to the original charges of unnecessary procedures, as well as his lack of knowledge about how to properly record medical information on patient charts that led to the charge(s) of record-keeping error(s).

He told us of the BPMC hearing panel determination to impose a one-year suspension, a fine of $50,000 and the suspension of his medical license. [This determination was appealed, with the result that the ARB revoked his license, which decision was appealed under CPLR Article 78 to the New York State Supreme Court, Appellate Division. In June 2002, the Appellate Division affirmed the ARB and sometime thereafter the revocation of the applicant's license became final.]

The applicant described his life post-revocation - he moved to Colorado about eight months prior to our meeting, but had previously lived on Long Island, where he "…started reviewing cases for lawyers, personal injury cases mostly, both from plaintiffs [attorneys] and defense work." His work included evaluating the merits of the cases and directing the attorneys to an appropriate specialist where necessary. He continues to do this type of work in Colorado. He acknowledged that his current business, the review of medical records, led to the realization that record-keeping had been the "weakest part of his practice…looking at records, understanding the importance of what you write down…That's all another doctor has to look at, is your record, sometimes… [I]t was the weakest part of my practice; it [has now] turned into the strongest part…"

To stay abreast of medical practice, he read(s) journals such as the "Journal of BJS", and when he was still in New York, he attended weekly meetings of grand rounds at Mt. Sinai Hospital, and has also attended "orthopedic meetings".

After he lost his license, he began to look within himself and had questions about his integrity, with the result that he took a three-credit course in ethics at the New School "to understand the true meaning of what honesty is." He found that "I can always learn to be a better person" and has done some self-examination in an effort to improve himself as a person.

Although he acknowledged that his medical review business provided sufficient income even though it did not make him "wealthy," the a pplicant eventually came to the realization that his former medical practice had given him an emotional and personal satisfaction that he does not find in his current business, and that he wants to recover that deep sense of satisfaction in his work. He told us that he has learned that "for those of us who are doctors, it is a very special thing, it is not a right, it is a privilege, and I miss it terribly."

He continued, saying that when he was at Joint Diseases and at Cabrini he "operated on close to seven or eight hundred Medicaid patients and that gave me the same satisfaction as the wealthier patients…I don't get gratification from anything else….Not having medicine, I have not been able to replace it…and that's not from an economic point of view. I have no economic need to go back to medicine. I have tremendous emotional need. I haven't finished teaching people what I know, how to do revisions." As a former teacher of residents at both Joint Disease and Cabrini, he "would love to go back" and "give in that regard…".

In an effort to reacquire his medical license, he took several review courses in medicine including a 2-3 day surgical course to see if he had retained any surgical skills. He told us, as noted in his application, that he performed surgeries on cadavers - two hips and two shoulders. His course instructor

reviewed his work and judged it to be "…a great job." This assessment gave the applicant a sense of "satisfaction" that he still had surgical skills and gave him additional impetus to try to return to doing surgeries. He found the course "interesting" and believes that he "hadn't really lost that much."

We learned that he had personally had three surgeries on his shoulders (two on his left in 1995 and 2001, one on his right in 2005) to address arthritic conditions. He acknowledged that the results of these surgeries might very well limit his surgical skills. He underwent physical therapy for both shoulders and believes that he could "gradually start doing cases as an assistant and ultimately, as the surgeon." As a result of undergoing physical therapy, he also began to "tak[e] care of himself" and now does yoga to stay in shape. However, he realizes that he may not be capable of doing the volume of surgeries he did before and made it clear to us that if he were not able to perform surgeries, he would still welcome the option to teach as a way to remain in the medical profession and use his medical and surgical knowledge.

In describing the charge(s) relating to record-keeping, wherein he whited-out several written notations in a patient's medical chart, the applicant essentially characterized his actions as absent-mindedness and a lack of knowledge, rather than deceitfulness. He told us that he now "[knows] what to do…." In an effort to learn the proper way to record, he contacted his

malpractice carrier after his license was revoked and was advised how to properly record notes on a medical chart. He stated that he would be assiduous in keeping to the correct practice in the future. However, the applicant has not taken any course that focuses on medical record-keeping.

Several witnesses testified about their professional and personal knowledge of the applicant. P.B., M.D., an orthopedic surgeon, testified that he first knew the applicant as "an acquaintance" in about 1989, then "got to know" him in about 1995 or 1996 when the applicant made efforts to recruit P.B. to work at Cabrini. Then sometime in about 1998, when P.B. became Director of Orthopedic Surgery at Cabrini, he got to know the applicant in a closer, professional capacity, as a "Director of Attendings." P.B. told us that his personal and business experiences with the applicant have been pleasant and honorable. Because he and the applicant worked at Cabrini, he was familiar with the circumstances that led to the charges filed against the applicant. He also told us that, even in light of the fact that the applicant had been found guilty of fraud, his opinion of the applicant did not change, because that had not been his personal experience with the applicant at Cabrini. He considered the applicant a "competent professional" and noted that his characterization included the concept of "integrity."

When we asked P.B. about the possible restoration of the applicant's license and hospital privileges, P.B. indicated that

he "kn[e]w for a fact that the institution [Cabrini] would be disposed to accept the applicant's] application" and he elaborated on a type of apprenticeship designed to get the applicant up-to-speed with his surgical skills. P.B. explained that the applicant would probably participate in a short-term program with supervision/monitoring with people who possessed "equal skill" at Cabrini, where the applicant would either participate in surgeries with, or be supervised by, equally skilled colleagues. P.B. posited that the length of time it would
take the applicant to get back up to speed would be case number-dependent, with one to thirty cases being most typical. He said that he didn't expect that the short-term program would need to last very long. Upon successful completion of the program, Cabrini would be disposed to offer the applicant a position.

M.C., M.D., an internist with a specialty in arthritis and rheumatology, told us that he first came to know the applicant as a colleague at the Hospital for Joint Diseases over 20 years ago, where they sometimes collaborated on cases together and exchanged professional opinions. After the applicant left Joint Diseases, M.C. continued to maintain a social relationship with him, meeting from time to time over the last few years. His opinion of the applicant is that he is "very professional in all activities, both social and business," "very intelligent in his approach to patients" and because of his surgical skills, has "helped a lot of people to stay ambulatory and have active lives." M.C. is aware

of the findings of fraudulent behavior, but admits that he does not understand them fully. Despite the findings, he remains steadfast in his opinion that the applicant is "trustworthy" and possesses "great integrity," because it is based on his personal experience dealing with the applicant over a number of years and having heard no complaints from any of the applicant's colleagues in the medical community. M.C. did admit that the applicant had been his patient at some point in the last five years or so, and that he knew that the applicant "had a shoulder problem at some point."

W.T., M.D., an internist with a specialty in pulmonary medicine, testified that he knew of the applicant when the applicant was at Joint Diseases and W.T. was at Beth Israel. W.T. had cases where he "interacted with…orthopedic surgeons…including [the applicant]." W.T. later got to know the applicant in the "early 90's… when [the applicant] arrived at Cabrini as the new chief of the joint replacement service." They had professional interaction for approximately the next 12 years. In 1993, W.T. was appointed as Acting Chairperson, Department of Internal Medicine at Cabrini, and in 1996 was appointed permanently as Chair, where he served until 2005, when he decided to pursue a private practice.

W.T. was particularly impressed with the applicant's services for the Medicaid population at Cabrini - "…he embraced [them] wholeheartedly… he looked at our …clinic patients who had no

advocate and provided excellent joint replacement therapy for many…who could not afford it." He continued further - "My biggest recollection of [the applicant] was that he was a fair-minded orthopedic surgeon of great integrity, who would operate or provide a procedure to any patient who deserved it, regardless of a willingness to pay." This was of consequence to W.T. because "…it was important that the best physicians available operate on our in-service patients, as that was the standard they were trying to reach."

W.T. next told us that he has "an old dad," who had had two hip replacements at Joint Diseases. A problem developed in one of the hips, but none of the doctors could figure out what was wrong. W.T. took him to see the applicant who diagnosed a separated hip, did revision surgery, and "to this day, my father is still walking everywhere." W.T. believes the applicant possesses "clinical astuteness, [an] ability to correctly diagnose and provide a remedy," and in his opinion, "he's a man of integrity." Further, in the medical community, "…if you had a prosthetic device and it needed revision, [the applicant] was the person to come to", "he had a reputation of handling the more difficult cases… of being the first to call for medical clearance, consultations, and wanting the best medical care for his patients as possible."

Finally, when asked whether he knew of the findings of fraudulent behavior, W.T. said he understood that there was "a question of delayed entry into the medical record… that happened

15, 16, 17 years ago…when he didn't know [the applicant] well at the time." Regardless of those findings, W.T. said, "Those of us who worked with [the applicant] for years never had any reason to question his honesty or his integrity, despite what happened."

We questioned W.T. whether, given the number of years that the applicant hasn't performed surgery, he would recommend that the applicant perform surgery on his father? W.T. responded that it was his understanding that the applicant "…has made significant attempts to keep his skills fresh… [that] hip replacement is a typical procedure not forgotten by someone like him, he has done very, very many. I am confident that with the tutoring that he had during that 5-year absence of his license, his overall integrity and the way he has managed patients, and knowing there haven't been any leaps and bounds in the field of hip surgery in the last 5 years… that if my father needed surgery…[and] I had this conversation with him to make sure he and the department director…felt comfortable with his skills, I would have no hesitation in allowing him to operate."

Mr. Hilf cross-examined the applicant about the charges that related to the decision by Joint Diseases to not reappoint him. The applicant described the circumstances - sometime in 1985-86, while at Joint Diseases, the applicant was presented with a patient who needed to have a fractured hip repaired and in addition, may have had a cancerous tumor in or around the hip. In consultation with a bone tumor specialist, the applicant first

performed a biopsy, then performed a hip replacement. The biopsy later revealed that there was a primary bone tumor, so the applicant "went back [in] and did a hemipelvectomy, and the patient survived." OPMC charged the applicant with performing an unnecessary hip replacement, claiming that only the biopsy was necessary in order to diagnose. The applicant explained to us that in retrospect he would have not done the hip replacement, but that at the time, he didn't have the modern techniques to diagnose (such as MRI) and that he is now also "a little wiser."

The applicant continued - that OPMC investigated and asked the applicant for his original medical records, which he provided. OPMC eventually determined that he had done nothing wrong, but also never returned the original records to the applicant. When OPMC brought the charges once again in 2001, the applicant no longer had any original records with which to defend himself, and, did not make copies of the original records. This circumstance led OPMC to find the applicant guilty of gross negligence as to Patient "B".

Mr. Hilf asked about the status of the applicant's Connecticut license after the revocation by New York. The applicant explained that Connecticut did not bring charges, but wanted an explanation about what occurred in New York. Rather than go forward with a "costly hearing, [he] handed his license in."

Mr. Hilf next confronted the applicant about the signed and notarized document dated October 10, 2002, that accompanied his license surrender to Connecticut. This document stated, "I hereby voluntarily surrender my license to practice as a physician and surgeon in the state of Connecticut. I'm currently disabled and unable to practice medicine." Mr. Hilf questioned whether the applicant, since October 2002, had undergone any more rehabilitation for his left shoulder. The applicant advised that he was not undergoing formal rehabilitation with a licensed physician, but was "working" with trainers and on himself.

Mr. Hilf did not inquire about the status of the applicant's New Jersey license to practice medicine.

In closing, Mr. Hilf took no position on the issue before us - the restoration of the applicant's license to practice medicine.

RECOMMENDATION

We have reviewed the entire record in this matter, including the written materials received before and during our meeting. In arriving at our recommendation, we note that, in a licensure restoration proceeding, the burden is on the applicant to demonstrate that which would compel the return of the license. Greenberg v. Board of Regents of University of New York, 176 A.D. 2d, 1168, 575 N.Y.S. 2d 608, 609. In reaching our recommendation, we consider whether the applicant demonstrates sufficient remorse, rehabilitation and reeducation. However, we are not limited to formulaic criteria but may consider other factors, particularly

the seriousness of the original offense and, ultimately, our judgment as to whether the health and safety of the public would be in jeopardy should the application be granted.

At our meeting we had the opportunity to carefully observe, question and evaluate the applicant. We saw his demeanor and reactions to our questions. We believe that the applicant feels remorse and that he has demonstrated remorse for his past actions. We believe that he has learned from his past actions and has a new awareness that he must pay attention to the other aspects of a medical practice, and not only perform surgeries. He demonstrated a very strong psychological and emotional need to return to the world of orthopedic medicine, either as a surgeon, teacher, or in any other capacity. He also demonstrated a consistent concern for the welfare of his patients, even as he described the limitations of medical technology during the time in which he practiced.

Regarding rehabilitation, in an effort to avoid future errors, he contacted his insurance carrier to learn the appropriate way in which to notate a medical record. He admits that even his current business demonstrates the importance of accurate record-keeping in a way that a seminar course could not and as a result, we believe that the applicant has learned at least as much as about record-keeping as he would in a seminar course. We are convinced that he has a new outlook on the importance of keeping regular and accurate medical records and notations and that his new outlook will extend to whatever type of

medical practice in which he finds himself. We also note that none of the earlier tribunals found the applicant guilty of professional incompetence.

All his character witnesses expressed high opinions of the applicant's integrity, competence and skill as an orthopedic surgeon, as well as his reputation in the medical community for said integrity, competence and skill. We are particularly mindful of the fact that Cabrini is willing to accept an application from the applicant to return to medical practice at their hospital. We are even more mindful of the efforts that P.B. described on behalf of Cabrini, and that they have crafted an "in-house" remedial program to supervise and assist the applicant in his return to medical practice or teaching, and that they look forward to his return should his license be restored.

Regarding reeducation, we were convinced by the applicant's efforts to determine and maintain his own level of surgical competence by virtue of his participation in a continuing education course on surgical techniques. He described his effort at reeducating himself about the ethical aspects of medicine - by taking a non-medically focused course in ethics. We unanimously agree that the applicant has a new understanding of this aspect of medicine and that he will incorporate his new understanding in his future endeavors.

We are convinced that upon his return to some type of

orthopedic practice or instruction, he will do whatever is necessary to remain professionally competent, ethically aware, and that he is looking forward to sharing his medical knowledge with other medical professionals with whom he comes into contact. We were impressed by the witnesses' descriptions of the applicant's dedication to his patients and by their opinions of his diagnostic and surgical skills as especially strong and innovative. Finally, we were impressed by the applicant's clear desire to return to the practice of medicine, and in particular, of his love for his specialty, orthopedic surgery.

We find that the applicant has met the goals of remorse, rehabilitation and reeducation that would enable this Peer Committee to recommend that his license to practice medicine be restored. Thus, it is our unanimous recommendation that restoration of the applicant's license to practice as a physician in the state of New York be granted without restriction or limitation.

Respectfully submitted,

Martin Diamond, D.O., Chairperson

Ira L. Salom, M.D.

Benjamin Robinson, Esq.

Redacted Signature

Chairperson / / Date

7

State of New York
Supreme Court, Appellate Division
Third Judicial Department

Decided and Entered: June 20, 2002 90131

In the Matter of RICHARD E. PEARL,
Petitioner,
v
NEW YORK STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT,
Respondent.

MEMORANDUM AND JUDGMENT

Calendar Date: April 30, 2002

Before: Mercure, J.P., Crew III, Mugglin, Rose and Lahtinen, JJ.

Thurm & Heller L.L.P., New York City (Kevin D. Porter of counsel), for petitioner.

Eliot Spitzer, Attorney General, New York City (Kristin R. White of counsel), for respondent.

Mugglin, J.

Proceeding pursuant to CPLR article 78 (initiated in this Court pursuant to Public Health Law § 230-c [5]) to review a determination of the Administrative Review Board for Professional Medical Conduct which revoked petitioner's license to practice medicine in New York.

On September 5, 2000, the Bureau of Professional Medical Conduct (hereinafter BPMC) charged petitioner with 24 specifications of professional misconduct arising from his treatment of six patients (hereinafter patients A, B, C, D, E and

F) between 1986 and 1995, his alteration of patient F's medical records and his false statements on an application for hospital privileges. After the close of evidence, the Hearing Committee of respondent (hereinafter Committee) sustained 10 of these specifications. Among these were that petitioner had committed gross negligence in his care of patient B, that he had failed to maintain records which accurately reflected the evaluation and treatment of patients A, B, C, D and E, and that he had committed fraud by altering patient F's medical record and by misrepresenting the termination of his privileges at the Hospital for Joint Diseases when applying for privileges at another institution. As a result, the Committee fined petitioner $50,000 and suspended his medical license for three years, the latter two years of which were stayed. Subsequently, the Administrative Review Board for Professional Medical Conduct (hereinafter ARB) affirmed the Committee's findings and conclusions, but overturned its penalty of suspension and fine and, instead, revoked petitioner's license to practice medicine. Petitioner then instituted the instant CPLR article 78 proceeding seeking review of the ARB's determination.

In his 67-page brief, petitioner makes no argument concerning the Committee's findings of inadequate or incomplete recordkeeping. His attacks on the Committee's findings of gross negligence, fraud and deliberate false reporting are premised on his claim that there is no basis for the Committee finding that he lacked credibility. Even if there might be some merit to petitioner's claim that the Committee erroneously decided that he had lied about his authorship of certain medical papers and his board certification status, petitioner's testimony on those issues is not particularly relevant to the Committee's determination that he lacked credibility with respect to the gross negligence, fraud and deliberate false reporting charges. Moreover, credibility issues are to be exclusively determined by the administrative factfinder and are outside the scope of this Court's review (see, Matter of Richstone v Novello, 284 AD2d 737, 737; Matter of O'Keefe v State Bd. for Professional Med. Conduct, 284 AD2d 694, 695, lv denied 96 NY2d 722; Matter of Wahba v New York State Dept. of Health, 277 AD2d 634, 635; Matter of Corines v State Bd. for Professional Med. Conduct, 267 AD2d 796, 799, lv denied 95 NY 2d 756).

In addition, it is well settled that our review of an ARB determination is whether the "'determination was made in violation of lawful procedure, was affected by an error of law, or was arbitrary and capricious or an abuse of discretion'" (Matter of Rudell v Commissioner of Health of State of N.Y., 194 AD2d 48, 50, lv denied 83 NY2d 754, quoting CPLR 7803 [3]). Applying that standard, we conclude that there is a rational basis for the finding that petitioner was grossly negligent in electing to proceed with patient B's total hip replacement despite clear evidence of a cancerous lesion, thereby delaying treatment therefor. The finding of fraud is similarly supported. A physician is guilty of fraud when there is evidence of an intentional misrepresentation or concealment of a known fact with intent to deceive (see, Matter of Choudhry v Sobol, 170 AD2d 893, 894). With respect to patient F's records, there is credible evidence that petitioner obtained this closed record from the Medical Records Room, inserted a notation that "risks, alternatives and benefits" of certain treatments had been explained to her, and then, after discovering that an unaltered copy of the record had already been sent to the patient's attorney, petitioner used "white-out" to eliminate the alteration. Also, based on petitioner's own testimony and the documentary proof, the Committee appropriately concluded that petitioner falsely indicated that he was in good standing with the Hospital for Joint Diseases when he applied for appointment to the medical staff of one of the hospitals under the control of Beth Israel Medical Center.

Parenthetically, we find no credible basis for petitioner's claim that his due process rights were violated because of a 14-year delay between his care of patient B and the filing of these charges. There is no Statute of Limitations and the doctrine of laches does not apply to physician disciplinary proceedings (see, Matter of Schoenbach v De Buono, 262 AD2d 820, 823, lv denied 94 NY2d 756; Matter of Reddy v State Bd. for Professional Med. Conduct, 259 AD2d 847, 848, lv denied 93 NY2d 813). Therefore, petitioner must make a showing of actual prejudice to succeed in this contention (see, Matter of Kashan v De Buono, 262 AD2d 817, 818). Here, although petitioner's office records were no longer available, he testified in great detail from the hospital records of patient B concerning "one of the most unusual cases [of his]

career". As the negligent treatment charge only involved treatment of the patient while in the hospital, petitioner has failed to show how any purportedly unavailable documents would exonerate him or assist in his defense (see, Matter of Giffone v De Buono, 263 AD2d 713, 714-715), and petitioner has failed to show that the unavailability of Michael Lewis, patient B's treating oncologist, would have altered the outcome by Lewis's favorable testimony on his behalf (see, Matter of Kashan v De Buono, supra, at 818).

Finally, the penalty of revocation imposed is "not so shocking to one's sense of fairness nor disproportionate to the misconduct to be deemed irrational as a matter of law" (Matter of Shoenbach v De Buono, supra, at 823; see, Matter of Kole v New York State Educ. Dept., 291 AD2d 683, 687). Indeed, the findings of fraud by petitioner are alone sufficient to merit the penalty imposed. Thus, revocation is all the more appropriate given the finding of gross negligence (see, Matter of Harris v Novello, 276 AD2d 848, 851; Matter of Post v New York State Dept. of Health, 245 AD2d 985, 987).

Mercure, J.P., Crew III, Rose and Lahtinen, JJ., concur.

ADJUDGED that the determination is confirmed, without costs, and petition dismissed.

ENTER:

Redacted Signature

Michael J. Novack
Clerk of the Court

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

July 10, 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 Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon 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 if said license has been revoked, annulled, suspended or surrendered, 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.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

Redacted Signature

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH
ADMINISTRATIVE REVIEW BOARD FOR PROFESSIONAL MEDICAL CONDUCT

In the Matter of	
Richard E. Pearl, M.D. (Respondent)	**Administrative Review Board (ARB)**
A proceeding to review a Determination by a Committee (Committee) from the Board for Professional Medical Conduct (BPMC)	**Determination and Order No. 01-93**

COPY

Before ARB Members Grossman, Lynch, Pellman, and Briber[1]
Administrative Law Judge James F. Horan drafted the Determination

For the Department of Health (Petitioner):	**Terrence Sheehan, Roy Nemerson, Esqs.**
For the Respondent:	**Kevin D. Porter, Esq.**

After a hearing below, a BPMC Committee determined that the Respondent practiced medicine fraudulently and with gross negligence, engaged in conduct that evidenced moral unfitness and failed to maintain accurate records. The Committee voted to suspend the Respondent's License to practice medicine in New York State (License) for three years, to stay the suspension for all but one year, to fine the Respondent $50,000.00 and to monitor the Respondent's patient records for two years. In this proceeding pursuant to N.Y. Pub. Health Law § 230-c (4)(a)(McKinney's Supp. 2001), the Petitioner asks the ARB to modify that Determination by increasing the penalty to revocation, or in the alternative, to supervised probation following the actual suspension. The Respondent asks that the ARB dismiss the charges or eliminate the suspension. After considering the hearing record and the parties' briefs, we vote to sustain the Committee's Determination that the Respondent committed professional misconduct. We overturn the Committee and vote to revoke the Respondent's License.

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[1] ARB Member Winston Price, M.D. was unavailable to take part in the review on this case. The ARB reviewed the case with a four member quorum, see Matter of Wolkoff v. Chassin, 89 N.Y.2d 250 (1996).

Committee Determination on the Charges

The Petitioner commenced the proceeding by filing charges with BPMC alleging that the Respondent violated N. Y. Educ. Law §§ 6530(2-6), (20-21) & (32) (McKinney Supp. 2001) by committing professional misconduct under the following specifications:

- practicing medicine fraudulently,
- practicing medicine with negligence on more than one occasion,
- practicing medicine with gross negligence,
- practicing medicine with incompetence on more than one occasion,
- practicing medicine with gross incompetence,
- engaging in conduct that evidences moral unfitness to practice medicine,
- willfully filing a false report, and,
- failing to maintain accurate patient records.

The negligence, incompetence and inadequate record charges relate to the care that the Respondent, a surgeon, provided to five patients A-E. The record refers to the Patients by initials to protect patient privacy. The moral unfitness, fraud and false report charges alleged that the Respondent made false entries in patient records or false statements about patient condition and made a false statement on an application for hospital staff re-appointment. The Respondent denied the charges and a hearing ensued before the BPMC Committee that rendered the Determination now on review.

The Committee found that the Respondent practiced with gross negligence in treating Patient B by:

- failing to evaluate appropriately pre-operative x-rays that showed a lesion on the left pubic bone;
- performing a contra-indicated total left hip replacement;
- failing to order a timely oncology work-up including a biopsy and definitive tumor surgery;
- failing to note that a pathological examination revealed a high grade malignant Histiocytoma; and,

- failing to note the lesion that the pre-operative x-rays revealed.

The Committee concluded that the Respondent performed an unnecessary and life threatening procedure on Patient B that delayed treatment for the malignancy. The Committee also concluded that the Respondent left information out of Patient B's chart intentionally concerning the malignant tumor. The Committee sustained neither incompetence charge concerning Patient B and sustained no negligence and incompetence charges concerning the care for Patients A, C, D and E. The Committee found that the Respondent failed to maintain accurate records for Patients A-E.

As to a sixth person, Patient F, the Committee found that the Respondent altered the Patient's medical record, several months after the Patient's discharge, to add a sentence indicating that that the Patient received a thorough explanation about risks, alternatives and benefits. The Committee found further that, when Respondent learned that the Patient's attorney had already received an unaltered copy of the Patient's chart, the Respondent altered the record by whiting out the sentence he added previously. The Committee determined that such conduct constituted fraud in practice. The Committee also found that the Respondent lied in an application for re-appointment to the staff as Beth Israel Medical Center. The Committee concluded that conduct amounted to practicing fraudulently and engaging in conduct that evidenced moral unfitness. The Committee made no findings on the allegations charging filing false records.

In making their findings, the Committee rejected testimony by the Respondent, finding the Respondent repeatedly deceitful and finding his testimony about the record for Patient F incredulous. The Committee gave no credit to the testimony by the Respondent's expert Mark G. Lazansky, M.D. due to Dr. Lazansky's long-term friendship with the Respondent. Dr. Lazansky also lost his position as medical coordinator for the Office of Professional Medical Conduct (OPMC) because he reviewed one of the cases at issue in the hearing, without informing OPMC about his friendship with the Respondent. The Committee found the Petitioner's expert, Gilbert H. Young, M.D. credible on general medical practice, surgery and record keeping, but gave Dr. Young's testimony minimal weight in discussing the surgeries on Patient A, C, D and E, due to Dr. Young's inexperience in the surgeries those cases involved.

The Committee voted to suspend the Respondent's License for three years, to stay two years and to fine the Respondent $50,000.00. The Committee also placed a monitor on the Respondent's record keeping for two years following the actual suspension.

Review History and Issues

This proceeding commenced on April 23, 2001, when the ARB received the Petitioner's Notice requesting a Review. The record for review contained the Committee's Determination, the hearing record, the Petitioner's brief and response brief and the Respondent's brief and response brief. The record closed when the ARB received the Respondent's response brief on or about June 1, 2000.

The Petitioner argues that the Committee imposed an inadequate sanction and asks that the ARB revoke the Respondent's License. In the alternative, the Petitioner requests that the ARB impose five years probation, with supervision, under conditions that the Petitioner's brief suggests in the attachment to the brief. In response to the Petitioner, the Respondent argues that the Petitioner's brief restates multiple erroneous findings and conclusions by the Committee without a single reference to the hearing record.

In the Respondent's main brief, he argues that the only finding on sub-standard care came in Patient B's case, which was fifteen years old when the case came to hearing. The Respondent claims that the fifteen-year delay resulted in an inability to defend fully against the charges relating to Patient B. The Respondent argues further that the Committee erred in rejecting the testimony by the Respondent and Dr. Lazansky and that the Committee misrepresented the Respondent's testimony. As to the Beth Israel Application, the Respondent argued that the re-application mistake resulted from a staff error, that the Respondent had no intent to deceive and the Committee failed to find all elements necessary to prove fraud, by making no finding that the

Respondent intended to deceive. The Respondent asks that the ARB dismiss the charges or reduce the sanction.

Determination

The ARB has considered the record and the parties' briefs. We affirm the Committee's Determination that the Respondent practiced with fraud and gross negligence, that the Respondent engaged in conduct that evidenced moral unfitness and that the Respondent failed to maintain accurate records. We hold that the Committee failed to impose a penalty consistent with their findings and conclusions concerning the Respondent's repeated, varied and serious misconduct. Under our authority from Pub. Health Law § 230-c(4)(a), in reviewing a hearing committee determination, the ARB determines whether a Committee rendered an appropriate penalty and a penalty consistent with their findings and conclusions. The courts have interpreted the statute to mean that the ARB may substitute our judgment for that of the Committee in deciding upon a penalty Matter of Bogdan v. Med. Conduct Bd., 195 A.D.2d 86, 606 N.Y.S.2d 381 (3rd Dept. 1993) and in determining guilt on the charges, Matter of Spartalis v. State Bd. for Prof. Med. Conduct 205 AD 2d 940, 613 NYS 2d 759 (3rd Dept. 1994). The ARB may also choose to substitute our judgement and amend a Committee Determination on our own motion, Matter of Kabnick v. Chassin, 89 N.Y.2d 828 (1996). We elect to exercise the authority to substitute our judgement in this case. We overturn the Committee and vote to revoke the Respondent's License.

Determination on the Charges: In making their Determination that the Respondent practiced with gross negligence in caring for Patient B, the Committee relied on testimony by Dr. Young and they rejected contrary testimony by the Respondent and Dr. Lasansky. The

Committee held the testimony by all the experts to strict scrutiny, as they gave minimal weight to Dr. Young's testimony concerning the care for the other Patients. The Committee rejected the Respondent's testimony. In weighing witness credibility, the Committee may consider prior deceitful conduct by a witness. The Committee found that the Respondent engaged in repeated deceitful conduct by falsifying the record for Patient F and by submitting the knowingly false re-application to Mount Sinai. The Committee also specified testimony by the Respondent they found incredulous. Although the Committee made incorrect statements about issues in the record, such as whether the Respondent authored certain articles, the Committee cited sufficient accurate grounds on which to reject the Respondent's testimony. The Committee may also consider possible bias in assessing witness credibility. The Committee considered and found bias in the testimony by Dr. Lasansky, the Respondent's long time friend. The Committee also found that Dr. Lasansky lost his position with OPMC for failing to reveal that friendship before reviewing a patient case on issue in this proceeding. Again the Committee cited sufficient grounds for rejecting Dr. Lasansky's testimony.

The ARB owes the Committee as the fact finder deference in their Determination on credibility, as the Committee saw the testimony by the witnesses. We see no reason to overturn the Committee's judgement on credibility in this case. The evidence the Committee found credible showed that the Respondent exposed Patient B to unnecessary, life threatening surgery and that the Respondent failed to address the malignant Histiocytoma. The Respondent also exposed the Patient to risk by making no note of the Patients' malignancy and a lesion that appeared in pre-operative x-rays. The Respondent's conduct demonstrated carelessness and a disregard for this Patient's health. We affirm the Committee's Determination that the Respondent's care for Patient B constituted practice with gross negligence.

The Respondent also challenged the Determination on Patient B due to the passage in time from the care to the hearing. We leave the Respondent to raise that legal issue with the Courts. We saw nothing in the Respondent's testimony on that case, however, to indicate that the Respondent experienced any difficulty in remembering the case.

The Committee also found that the Respondent failed to maintain accurate records for Patients A-E. We hold the evidence on the Respondent's record keeping proved that the Respondent failed to maintain accurate records for the Patients. For example, at Finding of Fact (FF) 7, the Committee found that the Respondent failed to note the malignancy or the lesion in Patient B's chart. That omission clearly amounted to inadequate record keeping. The Respondent's brief also conceded the Respondent's responsibility for poor documentation in the cases at issue here (Respondent's Brief page 17).

The Committee found that the Respondent altered the record for Patient F intentionally, with intent to deceive. The Committee found that conduct constituted fraud in practice. The Committee also found that the Respondent deliberately lied on the application to Beth Israel. The Committee determined that the deliberate lie constituted fraud and evidenced moral unfitness. In order to sustain a charge that a physician practiced medicine fraudulently, a hearing committee must find that (1) the physician made a false representation, whether by words, conduct or by concealing that which the licensee should have disclosed, (2) the physician knew the representation was false, and (3) the physician intended to mislead through the false representation, Sherman v. Board of Regents, 24 A.D.2d 315, 266 N.Y.S.2d 39 (3rd Dept. 1966), aff'd, 19 N.Y.2d 679, 278 N.Y.S.2d 870 (1967). A committee may infer a respondent's knowledge and intent properly from facts that such committee finds, but the committee must state specifically the inferences it draws regarding knowledge and intent, Choudhry v. Sobol, 170

A.D.2d 893, 566 N.Y.S.2d 723 (3rd Dept. 1991). A committee may reject a respondent's explanation for a misrepresentation and draw the inference that the respondent intended or was aware of the misrepresentation, with other evidence as the basis, Matter of Brestin v. Comm. of Educ., 116 A.D.2d 357, 501 N.Y.S.2d 923 (3rd Dept. 1986). A physician evidences moral unfitness in practice by violating the trust the public bestows on the medical profession and/or violating the medical profession's moral standards.

The evidence demonstrated that the Respondent altered the record for Patient F by adding language to the record several months after the Patient's hospital discharge and then altered the record again by applying white-out to the initial alteration. The Respondent added whiteout after learning that the Patient's lawyer had already obtained an unaltered copy. The alterations in the record show a pattern that leads to the inference that the Respondent altered the patient chart with the intent to deceive, to create a false record showing that the Respondent had advised the Patient thoroughly about risks from a procedure. The evidence at the hearing proved fraud in practice. The evidence also showed that the Respondent provided false information knowingly on the application to Beth Israel by denying that any other hospital was investigating or was not renewing his privileges. The Committee concluded that the Respondent lied in that answer to Beth Israel. In making that conclusion, the Committee exercised their authority in rejecting the Respondent's explanation for the events. The ARB may substitute our judgement for the Committee's. We find that the Respondent lied in the Beth Israel application with the intent to deceive Beth Israel, because the Respondent feared the action by the other hospital might cause problems for the Respondent in remaining on the Beth Israel staff. We hold that the deliberate lie on the Beth Israel application also violated the medical profession's moral standards. Physicians must provide truthful answers on applications for employment and staff credentials, to assure

that the hospital's quality assurance system functions effectively. We hold that the evidence at the hearing established that the Respondent practiced fraudulently and engaged in conduct that evidenced moral unfitness by lying on the Beth Israel application.

Determination on Penalty: The Committee determined that the Respondent engaged in multiple fraudulent acts, that he engaged in conduct that evidenced moral unfitness and that he showed carelessness in treating Patient B, that exposed the Patient to unnecessary surgery and delayed treatment of the Patient's malignancy. Such conduct warrants revocation. The Committee instead chose a one-year suspension, a fine and a record keeping monitor. The Respondent's fraudulent conduct demonstrated that he lacks integrity and no retraining will teach the Respondent integrity. The Committee fails to suggest how the penalty they imposed will provide the Respondent with integrity or deter the Respondent from carelessness and indifference the Respondent displayed in treating Patient B. The Committee found the Respondent technically competent, but the Committee also found the Respondent careless, deceitful and lacking remorse.

The ARB concludes that the Respondent's repeated fraudulent conduct, standing alone, provides sufficient grounds to revoke the Respondent's License. The Respondent's carelessness and indifference in treating Patient B demonstrates deficiencies in patient care as well. Although the Respondent may possess technical competence, he has proved on other grounds his unfitness to hold a medical License in New York.

ORDER

NOW, with this Determination as our basis, the ARB renders the following **ORDER:**

1. The ARB **AFFIRMS** the Committee's Determination that the Respondent committed professional misconduct.
2. The ARB **OVERTURNS** the Committee's Determination to suspend the Respondent's License, to place him on probation and to fine him $50,000.00.
3. The ARB **REVOKES** the Respondent's License.

Robert M. Briber
Thea Graves Pellman
Stanley L. Grossman, M.D.
Therese G. Lynch, M.D.

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

Robert M. Briber, an ARB Member, concurs in the Determination and Order in the Matter of Dr. Pearl.

Dated: July 3, 2001

Redacted Signature

Robert M. Briber

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

Thea Graves Pellman, an ARB Member concurs in the Determination and Order in the Matter of Dr. Pearl.

Dated: 7/3, 200101

Thea Graves Pellman

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

Stanley L. Grossman, an ARB Member concurs in the Determination and Order in the Matter of Dr. Pearl.

Dated: July 5, 2001

Redacted Signature

Stanley L Grossman, M.D.

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

Therese G. Lynch, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Pearl.

Dated: July 4, 2001

Redacted Signature

Therese G. Lynch, M.D.

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
--X

COPY

IN THE MATTER

OF

ORDER # BPMC 01-93

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

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 coagulate-~~positive~~ se-negative 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: ~~August~~ Sept. 5, 2000
New York, New York

Redacted Signature

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct