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

December 29, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ehud Arbit, M.D.
166 Elm Road
Englewood, NJ 07631

Anthony Z. Scher, Esq.
Wood & Scher
The Harwood Building
Scarsdale, NY 10583

Dianne Abeloff, Esq.
NYS Department of Health
5 Penn Plaza – Sixth Floor
New York, NY 10001

RE: In the Matter of Ehud Arbit, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 00-369) 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.

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.

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,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

IN THE MATTER OF EHUD ARBIT, M.D.	DETERMINATION AND ORDER BPMC 00 - 369

THEA GRAVES PELLMAN (Chair), **DAVID HARRIS, M.D.**, and **JOHN B. WALDMAN, M.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) of the Public Health Law.

MARC P. ZYLBERBERG, ESQ., ADMINISTRATIVE LAW JUDGE, ("ALJ") served as the Administrative Officer.

The Department of Health appeared by **DIANNE ABELOFF, ESQ.**, Associate Counsel.

Respondent, **EHUD ARBIT, M.D.**, appeared personally and was represented by **WOOD & SCHER** by **ANTHONY Z. SCHER, ESQ.**, of Counsel.

Evidence was received and examined, including witnesses who were sworn or affirmed. Transcripts of the proceeding were made. After consideration of the record, the Hearing Committee issues this Determination and Order pursuant to the Public Health Law and the Education Law of the State of New York.

PROCEDURAL HISTORY

Date of Notice of Hearing:	June 7, 2000
Date of Statement of Charges:	June 7 and 28, 2000
Letter authorizing Service of Notice of Hearing and Statement of Charges:	June 5, 2000
Date of Answer to Charges:	June 28, 2000
Date of Amended Statement of Charges:	August 9, 2000
Pre-Hearing Conference Held:	June 27, 2000
Hearings Held: - (First Hearing day):	July 6, 2000

August 10, 2000; August 30, 2000; August 31, 2000; September 15, 2000; October 12, 2000; October 19, 2000; October 20, 2000

Intra-Hearing Conferences Held:	July 6, 2000

July 20, 2000; August 10, 2000; August 30, 2000

Department's Summation, Proposed Findings of Fact, Conclusions of Law and Sanction:	Dated, November 22, 2000
Respondent's Post-Hearing Memorandum	Dated, November 24, 2000

Witnesses called by the Petitioner, Department of Health:
Arnold Goran, M.D.; Marina L. Perazzo, P.A.; Paul McCormick, M.D.; Jeanette Comuniello

Witnesses called by the Respondent, Ehud Arbit, M.D.:
Ehud Arbit, M.D.; George Krol, M.D.; Shelley E. Wertheim, M.D.; Russel H. Patterson, Jr., M.D.; Patient H [1]; Patrick S. O'Leary, M.D.; Fred Epstein, M.D.

The record remained open (request of Respondent) for the receipt of copies of Respondent's Exhibits # N, N-1, N-2, N-3, O, O-1, P, P-1 (imaging studies of Patient C):

Copies received: November, 2000;

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[1] All patients are identified in the Appendix annexed to the Amended Statement of Charges (Department's Exhibit # 1-B).

The record remained open (request of the Respondent) for the receipt of Respondent's Exhibit # Q (MRI Report of Patient D):

Received and accepted in evidence:	November 15, 2000
Deliberations Held: (last day of Hearing)	November 30, 2000 and December 1, 2000

STATEMENT OF CASE

The State Board for Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York (§230 et seq. of the Public Health Law of the State of New York ["**P.H.L.**"]).

This case was brought by the petitioner, New York State Department of Health, Bureau of Professional Medical Conduct ("**Department**") pursuant to §230 of the P.H.L.

EHUD ARBIT, M.D., ("**Respondent**") is charged with twenty specifications of professional misconduct, as delineated in §6530 of the Education Law of the State of New York ("**Education Law**").

Respondent is charged with professional misconduct by reason of: (1) practicing the profession with gross negligence[2]; (2) practicing the profession with negligence on more than one occasion[3]; (3) practicing the profession with gross incompetence[4]; and (4) practicing the profession with incompetence on more than one occasion[5].

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[2] Education Law §6530(4) and see also the First through Ninth Specifications of the Amended Statement of Charges (Department's Exhibit # 1-B).

[3] Education Law §6530(3) and see also the Tenth Specification of the Amended Statement of Charges (Department's Exhibit # 1-B).

[4] Education Law §6530(6) and see also the Eleventh through Nineteenth Specifications of the Amended Statement of Charges (Department's Exhibit # 1-B).

[5] Education Law §6530(5) and see also the Twentieth Specification of the Amended Statement of Charges (Department's Exhibit # 1-B).

These Charges and Specifications of professional misconduct result from Respondent's alleged conduct in the care and treatment of eleven patients.

Respondent admits some of the factual allegations but denies that his actions deviated from accepted medical standards and denies all specifications of misconduct.

A copy of the Amended Statement of Charges and the Answer is attached to this Determination and Order as Appendix I and II respectively.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. These facts represent documentary evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Where there was conflicting evidence the Hearing Committee considered all of the evidence presented and rejected what was not relevant, believable or credible in favor of the cited evidence. The Department, which has the burden of proof, was required to prove its case by a preponderance of the evidence. The Hearing Committee unanimously agreed on all Findings of Fact, unless otherwise noted. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

1. Respondent was licensed to practice medicine in New York State on May 7, 1982 by the issuance of license number 149975 by the New York State Education Department (Department's Exhibits # 1-B & # 2); (Respondent's Exhibit # B)[6].

[6] Refers to exhibits in evidence submitted by the New York State Department of Health (Department's Exhibit #) or by Dr. Ehud Arbit (Respondent's Exhibit #).

2. Respondent is currently registered with the New York State Education Department to practice medicine for the period of January 1, 2000 through December 31, 2001 (Department's Exhibit # 2).

3. The State Board for Professional Medical Conduct has obtained personal jurisdiction over Respondent (determination made by the ALJ; Respondent had no objection regarding service effected on him); (P.H.L. §230[10][d]); [P.H.T-43-44][7].

PATIENT A

4. Patient A had a 3.5 x 5.7 centimeter ("**cm**") right cerebellar mass with significant mass effect. (Department's Exhibits # 3, # 4-A & # 4-B); [T-252, 1258].

5. Patient A's tumor was so large that it was partially occupying the left posterior fossa. In effect, Patient A's right cerebellar hemisphere was so large that it was occupying both sides of the posterior fossa (Department's Exhibits # 3, # 4-A & # 4-B); [T-252, 1256, 1261-1262].

6. Patient A's tumor was causing pressure on his brain stem. Respondent, saw Patient A on January 31, 2000, in the hospital on an emergency basis, and decided that the tumor needed to be removed to decompress the pressure on the brain stem. The cerebral spinal fluid was obstructed because of midline pressure on the brain stem [T-253, 549, 556, 561].

7. Respondent's plan was to do a large, wide suboccipital craniectomy including the midline, on Patient A. Patient A was placed in the prone position. Respondent first marked the incision site, which was 1 ½ to 2 cm left of the midline; then he made the longitudinal incision in that location. Respondent and his first assistant put a retractor in and opened up the area for good visibility. At that point they reached the skull and Respondent started to drill along the incision site and the physician assistant, Ms. Perazzo, suctioned (Department's Exhibit # 3); [T-380-383, 554-559].

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[7] Numbers in brackets refer to Hearing transcript page numbers [T-]; to Pre-Hearing transcript page numbers [P.H.T-] or to Intra-Hearing transcript page numbers [I.H.T-]. The Hearing Committee did not review the Pre-Hearing transcripts, the Intra-Hearing transcripts or the ALJ Exhibits (except for ALJ Exhibit # 1).

8. Ms. Perazzo stood to Respondent's right when she was at the operating table [T-379].

9. At the point that Respondent drilled the incision line and made two small holes, Ms. Perazzo looked up to check the CT scans. Ms. Perazzo realized the CT scans were not in the operating room. She asked Respondent if he wanted her to get them. Respondent said yes and she did. When Ms. Perazzo returned, she put the CT scans up and commented that the lesion was on the right side. Respondent acknowledged her. Ms. Perazzo then scrubbed and rejoined Respondent at the head of the operating table about 5 minutes later [T-382-387, 406-408, 418, 428, 439-440, 585, 619-620, 1075-1076, 1082, 1091, 1145-1146].

10. When Ms. Perazzo returned to the operating table, she saw that Respondent had extended the incision out, up and over in the shape of a reverse hockey stick or the reverse of the number "7". Respondent had also opened and made a dura flap in the area which had been drilled. Respondent told Ms. Perazzo that there wasn't anything conclusive in this area so he extended the incision. Once Ms. Perazzo scrubbed back in, she irrigated and suctioned while Respondent drilled out the skull under the incision which had been extended over the right side [T-388-389, 393, 409-410, 441-442, 593-594, 1077-1078, 1083, 1096-98, 1101-1104, 1145-1147]. VOTE OF 2 TO 1.

11. Once Respondent opened the dura, the area was under a great deal of pressure. The tumor just "popped like a pimple". The tumor was necrotic and foul smelling. Ms. Perazzo was present at the head of the operating room table with and assisted Respondent when he found and removed the tumor [T-390, 1098, 1099].

12. There were areas that had been coagulated with the bipolar coagulator. The dura was opened and the area was looked at [T-389, 391-392, 593, 602, 1086].

13. The incision made by Respondent was an acceptable approach and did not constitute a departure from accepted standards of practice [T-254-257, 265, 269, 270, 272, 1416, 1418, 1423,1430].

14. Respondent began the operation on Patient A without the presence of the patient's CT scan in the operating room (Respondent's Exhibit # A); [T-254, 265].

15. Respondent saw the CT scan on the computer, in the Radiology Department of Staten Island University Hospital ("**SIUH**"), not more than 2 hours prior to surgery, and wrote a note in Patient A's medical records indicating that the tumor was in the right cerebellar hemisphere (Department's Exhibit # 3); (Respondent's Exhibit # A); [T-550-552, 562, 599, 1244-1245].

16. Respondent met with Dr. Shelly Wertheim, the radiologist who had interpreted the CT scans of Patient A and discussed Patient A's CT scans with her [T-552, 1244-1245, 1259, 1265, 1269].

17. There was no evidence presented that indicated that Respondent was **in** or actually "**explored**" Patient A's left cerebellar hemisphere [T-424-425, 567-568].

18. The operative note accurately reflects the care and treatment rendered to Patient A (Department's Exhibit # 3); [T-258-259, 625-626].

PATIENT B

19. Patient B went to Respondent with pain in her neck, paraesthesia in her left, upper extremity and radicular pain in her upper extremities (Department's Exhibit # 5); [T-27].

20. On June 22, 1999 Respondent performed a two-level corpectomy at C5 and C6 with excision of the intervening intervertebral discs (Department's Exhibit # 5); [T-27-28].

21. The Department's expert did not agree that Respondent's conduct deviated from accepted medical standards regarding the June 22, 1999 procedure performed on Patient B [T-109].

22. After reviewing the post surgical imaging studies of Patient B's graft, Respondent decided that the patient had to be taken back to the operating room to improve the position of the plate and the screws (Department's Exhibit # 5); [T-60, 89-90].

23. On June 28,1999, Patient B returned to the operating room for Respondent to resite the screws and plates which he had used in the June 22, 1999 operation (Department's Exhibit # 5); [T-60].

24. At the June 28th operation, Respondent first attempted to place the screw that had come loose back in to the original screw hole in order to obtain a good purchase. After several attempts, Respondent was unable to achieve a good purchase. Respondent then tried a longer screw but this also did not work. Respondent noted that "attempt to replace this screw with a longer screw at this junction seem to encounter a very weak underlying bone" (Department's Exhibit # 5 at p. 29); [T-639-640].

25. Respondent then changed the position of the plate itself and when this did not work, he tried a larger plate. Eventually, Respondent was able to secure the plate in a position which, while not ideal, was adequate. The operative report notes "intra-operative x-rays (fluoroscopy) were performed and showed a good alignment of the plate and a good purchase of the screw" (Department's Exhibit # 5 at p. 29); [T-95-96].

26. When placing a screw into the vertebrae if the screw is partly in bone and partly in disk, it can feel like its tight [T-100].

27. Intra-operative x-rays (fluoroscopy) are used to confirm the physician's tactile feel [T-100].

28. Respondent did not make a hard copy of the intra-operative x-rays (fluoroscopy) image taken, but did note the fact that they were taken in the operative note of Patient B's medical records (Department's Exhibit # 5 at p. 29); [T-662-663].

29. The post-operative imaging studies, taken on June 29, 1999, showed that the screws securing the metallic plate were neither perfect nor ideal but were acceptable, as was the position of the plate (Department's Exhibits # 6J & # 6K); [T-653-655, 1324-1325].

PATIENT C

30. On May 20, 1999, at SIUH, Respondent planned to perform a decompressive cervical laminectomy from C2 through C7 on Patient C. Due to extensive bleeding Respondent only performed a decompressive laminectomy from C2 through C5. Although Patient C improved, she continued to have significant left upper extremity pain (Department's Exhibits # 7 & # 8); [T-186,187, 670-671, 674-675].

31. On November 9, 1999, Patient C was readmitted to SIUH for further surgery. Respondent encountered extensive (about two liters) bleeding during the second operation on Patient C (Department's Exhibit # 8); [T-187, 190, 675].

32. Respondent did not obtain a consultation with a hematologist following the first operation or before the second operation on Patient C (Respondent's Exhibit # A); [T-188, 678, 1359-1360].

33. Patient C experienced neurological deficit following the November 9, 1999 surgery. Patient C's post-operative neurological deficit was more likely to be from nerve root damage than from cord damage (Department's Exhibit # 8 at p. 48-50); (Respondent's Exhibits # N, N-1, N-2, N-3, O, O-1, P, & # P-1); [T-191, 225-227, 686-687, 1200-1209].

34. Respondent did not dictate a discharge summary for the November, 1999 hospitalization for Patient C (Department's Exhibit # 8); [T-196, 235, 628-629].

35. At SIUH, discharge summaries in neurosurgery are dictated by physician's assistants [T-629]. After dictation by a physician's assistant, the discharge summary would eventually be routed to the neurosurgeon for signature [T-708-709]. Although the physician has the responsibility to maintain adequate records by insuring that a discharge summary is included in the patient's medical records, under the circumstances present here, the hospital (SIUH) also has a responsibility to notify the physician that a discharge summary is not in the patient's medical records [T-204].

PATIENT D

36. Patient D was admitted to SIUH on August 10, 1999, for a corpectomy, C6 partial, C5 and C7 with bone graft with decompression of spinal cord and nerve roots. Respondent performed said surgery on Patient D on August 10, 1999 (Department's Exhibit # 11); [T-135, 444-445, 801-803].

37. Respondent failed to include an adequate preoperative history and neurological examination in the hospital records prior to performing surgery on Patient D. There is an undated and unsigned record from the Nalitt building at SIUH for Patient D. That record, being undated, unsigned and not in the hospital record does not constitute proof or evidence of an adequate pre-operative history for Patient D prior to surgery (Department's Exhibits # 11 & # 11); (Respondent's Exhibit # I); [T-130-135, 977-979].

38. During the August 10, 1999 surgery on Patient D, Respondent used a Cobb Elevator (a surgical instrument - Department's Exhibit # 23); [T-449-452, 804-805, 960-962, 1143]. The use of a Cobb Elevator, during the course of a corpectomy and bone graft, is not inappropriate {T-1376-1378].

39. During the August 10, 1999 surgery on Patient D, Respondent lacerated the dura outside of Patient D's spinal cord area. Respondent then repaired the dura tear (durotomy) (Department's Exhibit # 11); (Respondent's Exhibit # A); [T-140-143, 174-176, 809-812].

40. The dural laceration occurred before the insertion of the bone plug and before the use of the Cobb Elevator (Department's Exhibit # 11); [T-1392-1393].

41. During the August 10, 1999 surgery on Patient D, Respondent injured Patient D's spinal cord because he exerted force in an effort to remove adherent disc fragments (Department's Exhibit # 11); (Respondent's Exhibit # A); [T-808, 814, 1138, 1141-1142].

42. As a result of the contusing of Patient D's spinal cord, the patient experienced significant neurological deficits, post-operatively (Department's Exhibit # 11); (Respondent's Exhibit # A).

43. On August 12, 1999, a CT scan of Patient D's cervical spine was performed (Department's Exhibit # 11); [T-147-148].

44. The report of the radiologist indicates that "with continued clinical concern for intra spinal contents, an MRI is recommended" to be performed (Department's Exhibit # 11 at p. 63); [T-148, 815-816].

45. Patient D was discharged to the inpatient rehabilitation floor on August 12, 1999. Respondent did not order that an MRI be performed on Patient D (Department's Exhibit # 11); [T-815-818].

46. Given the clinical presentation of Patient D, Respondent's knowledge of what occurred during the surgical procedure, and the CT scan results, Respondent's judgment not to obtain an MRI was not a departure from accepted standards [T-815-818, 1384-1385].

PATIENT E

47. The Department withdrew the Factual Allegations and Specifications of Misconduct as they relate to Patient E [T-337].

PATIENT F

48. Patient F suffered from tic douloureux, also known as trigeminal neuralgia. On May 21, 1996, Respondent performed a micro-vascular decompression of the left trigeminal nerve, an operation in the back of the brain on the left side. The procedure involved the area between the brain stem and the bony openings into the skull where the nerves coming out of the brain stem exit from the cranial cavity (Department's Exhibits # 15 & # 16); [T-339-340].

49. After the surgery, Patient F had multiple cranial nerve deficits involving the left 3rd, the right 6th, 7th and 12th cranial nerves, and transitory hemiparesis involving the right arm and leg, spasticity and diplopia in all directions. Patient F's post-operative condition was considerably different than her pre-operative condition. Prior to surgery she did not have any cranial nerve palsies. On May 24, 1996, Patient F was discharged from the hospital with multiple cranial nerve palsies (Department's Exhibits # 15 & # 16); [T-340-341].

50. During the course of the May 21st surgery, Respondent caused a vascular injury or an injury to the brain stem [T-342-347, 729-730, 738, 1295)

51. A vascular injury or an injury to the brain stem is a result or complication which does not necessarily demonstrate a departure or deviation from accepted medical standards [T-344, 347, 1295].

52. Respondent did not order a post-surgical MRI for Patient F (Department's Exhibits # 15 & # 16); [T-342].

53. Respondent ordered a CT scan for Patient F soon after the May 21, 1996 surgery (Department's Exhibits # 15 & # 16); [T-730]. The CT scan was an adequate medical test under the circumstances [T-731-737, 1296-1298].

PATIENT G

54. On April 20, 1994, Respondent performed a right frontal craniotomy and arachnoid cyst deroofing on Patient G at Memorial Sloan-Kettering Hospital. During Patient G's post-operative care, Respondent ordered an MRI scan for Patient G. The MRI scan was performed on Patient G on July 16, 1994. A copy of the MRI report was sent to Respondent (Department's Exhibit # 17); (Respondent's Exhibit # D); [T-768].

55. There is no indication in Patient G's medical records that Respondent reviewed the MRI or the MRI report (Department's Exhibit # 17); (Respondent's Exhibit # D); [T-279, 316- 318, 768].

56. Respondent's office chart for Patient G contains a copy of the MRI report performed on July 16, 1994 on Patient G (Respondent's Exhibit # D).

57. Based on Respondent's habits and office practice, the fact that Patient G's MRI report is in the patient's medical records is a probable indication that Respondent reviewed the MRI report [T-768-771, 782].

58. Patient G had a very large arachnoid cyst which was causing him severe headaches. Respondent advised Patient G and his family that following the operation, the headaches would not stop abruptly. The patient was advised to see Respondent post-operatively and did so on May 2, 1994. Patient G reported that while he still had headaches, they were diminished in severity and frequency. Patient G was advised to have an MRI done and that he would be contacted if there were any abnormalities. Patient G was also advised to contact Respondent in the event his headaches returned or got worse (Department's Exhibit # 17 at p. 5, 7); [T-757-759, 794-795].

59. Respondent's follow-up of Patient G's post-operative care was adequate (Department's Exhibit # 17); [T-757-759, 794-795, 1144-1145, 1159-1161, 1441-1443].

PATIENT H

60. Patient H was seen by Respondent in May of 1998. On the basis of Respondent's clinical evaluation, history, and a May, 1998 MRI of the cervical spine, Respondent identified that Patient H had C7 nerve root syndrome (Department's Exhibits # 18 & # 29A); (Respondent's Exhibit # J); [T-843-849].

61. The following clinical symptoms of C6-C7 disc herniation are documented in Patient H's medical records of May 15, 1998: pain down the back of the arm, over the triceps, down into the forearm and into the middle finger. At the May 15th visit, Respondent suggested to Patient H that he try a course of Decadron and physical therapy. Respondent also mentioned the surgical option of a discectomy and decompressing of the nerve root at C7 (Department's Exhibit # 18); [T-850, 851].

62. On November 5, 1998 Patient H returned to Respondent's office with complaints consistent with C7 nerve root dysfunction or radiculopathy; weakness in the triceps muscles, diminished triceps reflex and decreased sensation in the C7 nerve root distribution. These complaints were the same as the patient experienced back in May; consequently, the initial surgical approach of a C6-C7 decompression was still appropriate (Department's Exhibit # 18); [T-852, 853].

63. C5-C6 symptoms are generally more in the front over the biceps. The pain would be distributed in the forearm in a manner very difficult to distinguish from C6-C7, but as you travel into the hand it's more likely to affect the thumb and index finger. Respondent's entries for November were silent about location of pain in the hand. A complaint of pain in the shoulder does not assist a surgeon in distinguishing between C5-C6 and C6-C7. In order to differentiate location of nerve root, the physician needs to look at changes in the distal symptoms, not the proximal (Department's Exhibits # 18 & # 19); (Respondent's Exhibit # J); [T-862, 864, 865,887].

64. All the information in Respondent's office record of Patient H, and in Patient H's hospital record prior to the operative report, indicated that Respondent intended to operate on C6-C7 (Department's Exhibits # 18 & # 19); (Respondent's Exhibit # J).

65. On November 11, 1998, at SIUH, Respondent performed a C5-C6 decompression on Patient H without explaining anywhere in the record the reason he changed his prior operative plan of decompressing C6-C7 (Department's Exhibit # 19); [T-857, 858, 884, 1000].

66. Based on the operative note, which was dictated on the same date of the operation, and the patient's medical records, one is unable to know for sure that the operation on Patient H's C5-C6 disc was planned [T-866, 873].

67. The May 1998 MRI study of Patient H identify the more pronounced bulge at the C6-C7 level and to a much lesser extent there a small defect at the C5-C6 level (Department's Exhibit # 18 at p. 19-20); (Department's Exhibits # 29-A through 29-D); [T-846-849, 1303-1304].

68. Patient H's symptoms were not alleviated by the C5-C6 surgery. Patient H had another operation on December 1, 1998 at C6-C7. After the second surgery, at the C6-C7 location, Patient H's symptoms were alleviated (Department's Exhibits # 18 & # 19); [T-858].

PATIENTS I, J, K

69. From January 1, 1996 through December 31, 1997, Respondent performed 35 discectomies at SIUH. In 3 of the 35 patients (Patients I, J, K) Respondent caused a dural tear with subsequent cerebral spinal fluid leaks which required re-operations for repair of the tears (Department's Exhibits # 24 through 28).

70. Dural tear with a spinal fluid leak is a known complication and inherent risk of discectomies. The occurrence of dural tears depend on numerous factors, including: the complexity of the case, if it is a redo operation; age of the patient; general health of the patient; and other disease present with the patient [T-900, 938-939, 1396-1397].

71. Complication rates are evidence of results not cause or conduct [T-938-939].

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions as to the allegations contained in the Amended Statement of Charges were by a unanimous vote of the Hearing Committee unless otherwise noted.

The Hearing Committee concludes that the following Factual Allegations, in the August 9, 2000 Amended Statement of Charges are **SUSTAINED:**[8]

Paragraph A.	partially	:	(4 - 13)
Paragraph A.2.		:	(4 -6, 14)
Paragraph B.	partially	:	(19 - 20)
Paragraph B 2.	partially	:	(22 - 28)
Paragraph C.	partially.	:	(30 - 31)
Paragraph D.	partially	:	(36 - 37)
Paragraph D.1.		:	(36 - 37)
Paragraph D.3.		:	(36 - 37, 39)
Paragraph D.4.		:	(36 - 37, 41)
Paragraph D.5.	partially	:	(43 - 45)
Paragraph F.	partially	:	(48)
Paragraph F.1.		:	(48 - 50)
Paragraph G.	partially	:	(54)
Paragraph G.1.	partially	:	(54)
Paragraph H.		:	(60 - 68)
Paragraph H.1.	partially	:	(60 - 67)
Paragraph H.2.		:	(60 - 67)
Paragraph I		:	(69)

[8] The numbers in parentheses refer to the Findings of Fact previously made herein by the Hearing Committee and support each Factual Allegation contained in the Amended Statement of Charges. The Factual Allegations and the Hearing Committee's rationale are more fully explained below.

The Hearing Committee concludes that the following Factual Allegations, in the August 9, 2000, Amended Statement of Charges, are **NOT SUSTAINED:**

Paragraph A.	partially	:	(4 - 13)
Paragraph A.1.	VOTE OF 2 TO 1:		(4 - 13, 17)
Paragraph A. & A.2.		:	(4 - 6, 14 - 16)
Paragraph A.3.		:	(4 - 6, 17 - 18)
Paragraph B.	partially	:	(19 - 21)
Paragraph B.1.		:	(19 - 21)
Paragraph B 2.	partially	:	(22 - 28)
Paragraph B. & B.2.		:	(22 - 28)
Paragraph C.	partially	:	(30 - 35)
Paragraph C.1.		:	(30 - 33)
Paragraph C.2.		:	(30 - 33)
Paragraph C.3.		:	(30 - 35)
Paragraph D.	partially	:	(36 - 46)
Paragraph D.2		:	(36 - 38)
Paragraph D. & D.5.		:	(36 - 46)
Paragraph E.		:	(Withdrawn)
Paragraph E.1.		:	(Withdrawn)
Paragraph E.2.		:	(Withdrawn)
Paragraph F.	partially	:	(48 - 52)
Paragraph F. & F.1.		:	(48 - 51)
Paragraph F.2.		:	(48 - 53)
Paragraph G.	partially	:	(54 - 59)
Paragraph G.1.	partially	:	(54 - 59)
Paragraph H.1.	partially	:	(67)
Paragraph I.		:	(69 - 71)

Based on the above, the complete Findings of Fact, and the Discussion that follows, the Hearing Committee unanimously concludes that the EIGHTH SPECIFICATION contained in the Amended Statement of Charges is **SUSTAINED**.

The Hearing Committee concludes, by a vote of 2 to 1, that the TENTH SPECIFICATION contained in the Amended Statement of Charges is **NOT SUSTAINED**.

The Hearing Committee unanimously concludes that the FIRST through SEVENTH, the NINTH, and the ELEVENTH through TWENTIETH SPECIFICATIONS contained in the Amended Statement of Charges are **NOT SUSTAINED**.

The rationale for the Hearing Committee's conclusions is set forth below.

DISCUSSION

Respondent is charged with twenty specifications alleging professional misconduct within the meaning of §6530 of the Education Law. §6530 of the Education Law sets forth a number and variety of forms or types of conduct which constitute professional misconduct. However §6530 of the Education Law does not provide definitions or explanations of many of the types of misconduct charged in this matter.

The ALJ provided to the Hearing Committee definitions of medical misconduct as alleged in this proceeding. These definitions were obtained from a memorandum, prepared by the New York State Department of Health[9], entitled: Definitions of Professional Misconduct under the New York Education Law, ("**Misconduct Memo**"). During the course of its deliberations on these charges, the Hearing Committee consulted the relevant definitions contained in the Misconduct Memo, which are as follows:

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[9] A copy of this memorandum was made available to Respondent [P.H.T-105-106] and was marked as ALJ Exhibit # 4.

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee (physician) under the circumstances.

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad. Gross Negligence may consist of a single act of negligence of egregious proportions. Gross Negligence may also consist of multiple acts of negligence that cumulatively amount to egregious conduct. Gross Negligence does not require a showing that a physician was conscious of impending dangerous consequences of his conduct.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Gross Incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine. Gross Incompetence may consist of a single act of incompetence of egregious proportions or multiple acts of incompetence that cumulatively amount to egregious conduct.

The Hearing Committee was told that the term "egregious" means a conspicuously bad act or an extreme, dramatic or flagrant deviation from standards. The Hearing Committee used ordinary English usage and understanding for all other terms, allegations and charges.

The Hearing Committee was aware of its duty to keep an open mind regarding the allegations and testimony. With regard to the testimony presented herein, including Respondent's, the Hearing Committee evaluated each witness for possible bias. The witnesses were also assessed according to their training, experience, credentials, demeanor and credibility. The Hearing Committee understood that as the trier of fact they may accept so much of a witnesses testimony as is deemed true and disregard what is found to be false.

Petitioner's expert witnesses, Dr. Arnold Goran and Dr. Paul McCormick, were fair and generally credible witnesses. Neither expert knew Respondent personally, or as referring physicians prior to the Hearing. Their testimony was based on the records and imaging studies. During the course of Dr. Goran's testimony on more than one occasion, he acknowledged the difficult medical situation Respondent encountered with the patients. Many of the Factual Allegations were not sustained based on Dr. Goran's explanations that Respondent's actions did not necessarily deviate from accepted medical standards. Some of the Factual Allegations were not sustained because Dr. Goran was inconclusive and at times ambivalent.

Overall, Respondent's experts, Dr. Russel Patterson, Dr. Shelley Wertheim, Dr. Patrick O'Leary, Dr. George Krol and Dr. Fred Epstein, were generally credible, well credentialed witnesses. Dr. Patterson trained Respondent and worked with him for many years and was familiar with Respondent's abilities. Dr. Wertheim was very forthright regarding her assessments of the imaging studies and her colleagues interpretations of the studies. Dr. Epstein provided fair and very definitive responses to questions posed by all.

Ms. Marina Perazzo was very sincere and forthcoming with no hidden agenda for her testimony. It was clear, however, that her recollection of the synchronization of the events of the surgery on Patient D was inaccurate because of physical anatomy. When the inaccuracy was pointed out to the witness, she paused and realized her mistake. As to her testimony regarding Patient A, we believe that it was not inconsistent with Respondent's recollection of the events. It was Ms. Perazzo who was unclear as to the location of the tumor, not the Respondent. Ms. Perazzo never indicated that she observed Respondent explore the patient's left cerebellar hemisphere.

Obviously Respondent had the greatest amount of interest in the result of this proceeding. The Hearing Committee found Respondent to be mostly credible, except as to Patient H. Many of Respondent's explanations as to the medical treatments provided were supported by his experts as well as the Department's experts. Respondent was frank and candid in admitting some of his errors such as the laceration of the dura and contusion of the spinal cord of Patient D. Respondent's testimony concerning his care and treatment of Patient H was evasive and confusing. The Hearing Committee found that Respondent had no medical rationale to support his actions with regard to Patient H.

PATIENT A

Factual Allegations A. and A.1. allege that:

> *On or about January 31, 2000, at Staten Island University Hospital, ("**SIUH**"), Staten Island, N.Y., Respondent performed a craniotomy on Patient A. Respondent's conduct deviated from accepted medical standards, in that:*
>
> *1. Respondent inappropriately explored the left cerebellar hemisphere when there was no tumor in the left cerebellar hemisphere.*

The Hearing Committee determines, by a vote of 2 to 1, that the Department has not proven, by a preponderance of the evidence, that Respondent ever explored the left cerebellar hemisphere. There was no inappropriate exploration of the left cerebellar hemisphere. The testimony of Ms. Perazzo and Respondent are not inconsistent when examined thoroughly. Furthermore, because of the very large size of the tumor and the location of the incision so close to the midline, the mass effect was such that the right cerebellar hemisphere had shifted to the left and would be under the incision. In other words, it would have been almost impossible to explore the left cerebellar hemisphere through the incision that Dr. Arbit made. As Dr. Wertheim indicated, a portion of the right hemisphere had moved across the midline such that the tumor, which was technically still in the right cerebellum, was now across the midline because a portion of the right cerebellar hemisphere had moved across the midline.

The Hearing Committee agrees with Dr. Epstein that the incision made was not a departure from accepted standards of practice and was perfectly acceptable. We also agree that if Respondent thought the tumor were on the left, it would have been more probable for him to make his incision over the mass of the tumor, about 4 or 5 cm to the left of the midline

To explore an area is to travel into or wander through for the purpose of discovery. Ms. Perazzo's testimony did not establish that Respondent explored the left cerebellar hemisphere as alleged in the charges. What Ms. Perazzo saw regarding the left cerebellum area was that the dural flap was raised, over exposing it's surface, and that there was some evidence of electro coagulation in tissue of the left cerebellum. Ms. Perazzo did not see the left cerebellar hemisphere being "explored".

In a 2 to 1 vote the Hearing Committee did not sustain the above allegation. In a dissenting opinion, one member of the Hearing Committee found the testimony of witness Marina Perazzo to be compelling regarding the comment made to her by Respondent when she had returned to the operating table, had placed the CT scans up, had re-scrubbed and rejoined Respondent at the operating table. At that point, Respondent said to Ms. Perazzo "there really wasn't anything conclusive in this area" and he had extended the incision out like a reverse hockey stick and was proceeding to the right [T-387-388, 442-443, 1077]. Ms. Perazzo testified to this comment three times, twice at her initial appearance before the Hearing Committee on August 10, 2000 and again when she returned on October 10, 2000. At no point was Ms. Perazzo's testimony challenged on this issue by the Respondent.

Factual Allegation A. is sustained only to the extent that on January 31, 2000 at SIUH, Respondent performed a craniotomy on Patient A. The remainder of Factual Allegations A. and A.1. are not sustained by a vote of 2 to 1.

Factual Allegations A. and A.2. allege that:

Respondent's conduct deviated from accepted medical standards, in that:

2. Respondent began the operation without the presence of the patient's CT scan in the operating room.

When Respondent began to operate on Patient A, the CT scans were not in the operating room. It is desirable to have the relevant imaging studies in the operating room. Respondent was aware that when he started the operation the CT scans were not in the operating room. SIUH was in the process of changing to a filmless system. Under the new system, no automatic hard copy would be created. At the time in question, the monitors in the operating room were not yet operational. However, Respondent had reviewed the CT scans in the Radiology Department shortly prior to the emergency surgery. He discussed them with Dr. Wertheim and his consultation note written at 12:30 p.m. on January 31st reflects his review of the CT scans and his understanding that the tumor was on the right side.

Factual Allegation A.2. is sustained. However it was not a deviation from accepted medical standards.

Factual Allegations A. and A.3. allege that:

Respondent's conduct deviated from accepted medical standards, in that:

3. Respondent failed to maintain a record which accurately reflected the care and treatment rendered.

Here, the Department's allegations are two fold. First, Respondent failed to accurately report where and what type of incision was made. Second, the operative report is incorrect because it fails to reflect an exploration of the left cerebellar hemisphere looking for a tumor which was actually on the right side.

The Hearing Committee determines that the operative report accurately describes the type of incision made and its location. Since we have already determined that there was no exploration of the left cerebellar hemisphere, the Department's second argument is incorrect.

Factual Allegation A.3. is not sustained.

PATIENT B

Factual Allegations B. and B.1. allege that:

> *On or about June 22, 1999, at SIUH, Respondent performed a two-level corpectomy at C5 and C6 with excision of the intervening intervertebral discs. Respondent's conduct deviated from accepted medical standards, in that:*
>
> *1. Respondent terminated the June 22, 1999 procedure without ensuring that the metallic plate was properly seated on the spine.*

The Hearing Committee determines that the Department has not proven, by a preponderance of the evidence, that Respondent terminated the June 22, 1999 procedure without ensuring that the metallic plate was properly seated on the spine. The Department's own expert indicated that he did not think that the allegation was true.

Factual Allegation B. is sustained only to the extent that on June 22, 1999, at SIUH, Respondent performed a two-level corpectomy at C5 and C6 with excision of the intervening intervertebral discs.

The remainder of Factual Allegations B. and B.1. are not sustained.

Factual Allegations B. and B.2. allege that:

> *Respondent's conduct deviated from accepted medical standards, in that:*
>
> *2. On or about June 28,1999, Patient B returned to the operating room for Respondent to resite the screws and plates which he had used in the earlier operation. Again, Respondent terminated the procedure without ensuring that the metallic plates and screws were properly seated.*

Respondent testified that he took an intra-operative x-ray (fluoroscopy) and it showed that the screws and plate were seated properly. Respondent's testimony is supported by the operative note in the medical records of Patient B. The fact that one of the screws partially came out, as shown in the next day's imaging studies, may be indicative of different reasons. First, the screw was not seated properly; second, the screw came out after the procedure due to the patient's weak bones or some other scenario. The Hearing Committee cannot infer, from the proof presented, that the Respondent terminated the procedure without ensuring that the metallic plates and screws were properly seated. There was no direct evidence that at the time that Respondent finished the procedure on Patient B, the screws and plate were not properly seated.

Respondent recognized the problem after the first surgery. He tried the same screws; he tried longer screws; he changed the position of the plate; he then tried a longer plate. When he obtained what he thought was a secure position he did a fluoroscopy which indicated that it was a good alignment. After bringing the patient back a second time, it is certainly likely that he did not want to bring her back a third time.

Factual Allegation B.2. is sustained only to the extent that on June 28, 1999, Patient B returned to the operating room for Respondent to resite the screws and plates which he had used in the earlier operation.

The remainder of Factual Allegations B. and B.2. are not sustained.

PATIENT C

Factual Allegations C. and C.1. allege that:

> *On or about May 20, 1999, Respondent performed a laminectomy C2-C5 on Patient C at SIUH; having intended to perform a decompression as far as C7. The surgery was abbreviated due to extensive bleeding. On or about November 9, 1999, Patient C was readmitted to SIUH for further surgery. Respondent encountered extensive bleeding during the second operation. Respondent's conduct deviated from accepted medical standards, in that:*

1. Respondent failed to obtain a consultation with a hematologist following the first operation or before the second operation on Patient C.

The Hearing Committee determines that the Department has not proven, by a preponderance of the evidence, that the failure to obtain a hematology consultation, after the first operation, was a deviation from accepted medical standards under the circumstance presented.

The Hearing Committee agrees with the Department that if Respondent thought that Patient C had a hematological disorder (ie: coagulopathy), then, certainly, a consultation with a hematologist would have been appropriate and proper. The credible evidence indicates that Respondent did not believe that Patient C had a coagulation problem after the first operation. Respondent's belief that Patient C's excessive bleeding was due to her positioning, combined with the patient's past surgical histories without bleeding problems, no hematoma following the surgery, no blood accumulation under the skin, and that Patient C clotted as soon as she was off the operating table, is reasonable and indicative that the patient did not have coagulopathy.

The Hearing Committee looked at Respondent's behavior and conduct at the time of the surgeries not at the outcome of the surgery. Respondent's rationale was perfectly reasonable when looking at this case as it presented and as the events unfolded.

Factual Allegation C is sustained only to the extent that on May 20, 1999, Respondent performed a laminectomy C2-C5 on Patient C at SIUH, having intended to perform a decompression as far as C7. The surgery was abbreviated due to extensive bleeding. On or about November 9, 1999, Patient C was readmitted to SIUH for further surgery. Respondent encountered extensive bleeding during the second operation.

The remainder of Factual Allegations C. and C.1. that allege that it was a deviation from accepted medical standards to fail to obtain a consultation with a hematologist following the first operation or before the second operation on Patient C. are not sustained.

Factual Allegations C. and C.2. allege that:

> *Respondent's conduct deviated from accepted medical standards, in that:*
>
> *2. During the course of the November 9, 1999 [surgery], Respondent injured Patient C's cervical spinal cord.*

The Hearing Committee does not believe that the Department has shown, by a preponderance of the evidence, that Respondent injured Patient C's cervical spinal cord during the course of the November 9, 1999 surgery.

The Department's contention that Respondent injured Patient C's cervical spinal cord is mostly based on the MRI report that interpreted films taken post-operatively (Department's Exhibit # 8 at p. 48-50). Dr. Goran, the Department's expert, testified about the patient's post-operative neurological deficit, but it was clear from his testimony that the neurological deficit experienced by Patient C could have been from damage to nerve roots or from damage to the cord itself. Patient C's post-operative neurological deficit was primarily in the left upper extremity. Usually, this will occur when there is nerve root damage rather than a central cord syndrome. Based on the nature of Patient C's post-operative neurological deficit, it would be improbable that Respondent injured her spinal cord during the November 9th surgery. The Hearing Committee agrees with Respondent that if there had been damage to the cord the patient's neurological deficit would have been far greater, especially because the cord was so compromised prior to the surgery.

Dr. Wertheim's testimony was clear and concise. She had reviewed the MRI films of Patient C taken in September 1999 and December 1999 as well as the films taken on November 11, 1999. Dr. Wertheim indicated that there was no cord contusion and there was no cord expansion. Unlike Dr. Wertheim, Dr. Fine, the radiologist who wrote the report at page 48-50 of Department's Exhibit # 8, was not able to compare the post-operative films and the subsequent films when he wrote his report. Patient C had a severely "dreadful" stenosed spinal canal. Dr. Goran admitted that a severely stenosed spinal canal increases the risk of damage to the nerve roots themselves, as well as to the cord itself. Dr. Goran further acknowledged that even in the best of hands, given the severity of Patient C's stenosis, nerve root injury or even cord injury could occur.

The Hearing Committee believes that in this case, there was nerve root damage that took place which, given the severely stenosed spinal canal, was not an unexpected complication. We do not conclude that there was cord injury or that there was a deviation from accepted medical standards by Respondent.

Factual Allegation C.2. is not sustained.

Factual Allegations C. and C.3. allege that:

> *Respondent's conduct deviated from accepted medical standards, in that:*
>
> *2. Respondent failed to dictate a discharge summary for the November hospitalization for Patient C.*

The Hearing Committee agrees that Respondent did not dictate a discharge summary. However, the Hearing Committee does not agree that not dictating a discharge summary is a failure which deviates from accepted medical standards. Based on the testimony presented, the responsibilities of discharge summaries are shared amongst physician assistants, attending physicians and the hospital. As Dr. Goran indicated, this factual allegation is "not directed towards Dr. Arbit.

The comment is directed towards the hospital and whoever is responsible for that". This is not a situation where the hospital notified an attending to complete a medical record and the physician refused or failed to do so after being notified.

Finally we note that, inexplicably, the Amended Statement of Charges does not include a Specification alleging a violation of §6530(32) (failing to maintain a record for a patient which accurately reflects the care and treatment of the patient). Therefore, even if this factual allegation could be sustained on the facts presented, it would not constitute negligence or incompetence by Respondent.

Factual Allegations C. and C.3. that allege that it was a deviation from accepted medical standards to fail to dictate a discharge summary for the November hospitalization of Patient C is not sustained.

PATIENT D

Factual Allegations D. and D.1. allege that:

> *On or about August 10, 1999, Respondent performed a "C6 and partial C5 and C7 corpectomy and bone graft with decompression of spinal cord and nerve roots," on Patient D at SIUH. Respondent's care deviated from accepted medical standards, in that:*
>
> *1. Respondent failed to perform and document an adequate pre-operative history prior to surgery.*

The Hearing Committee did not accept Respondent's undated and unsigned note "found" from the records of the "Nalitt" building at SIUH. This note was not in the hospital records and there was no showing made that Respondent, or any other hospital health care provider, actually had immediate access to the note or its contents. The note should have been a part of the hospital records.

The Hearing Committee, while unanimously sustaining allegation D. and D.1. as to the pre-operative medical records maintained by Respondent on Patient D, by a vote of 2 to 1 did not find this deviation to rise to the level of negligence (see discussion below at page 42-43). In a dissenting opinion, one member of the Hearing Committee believed that such a deviation in such a complicated case posed a serious threat to the health and well-being of the patient and that such deviation amounted to negligence on one occasion.

Factual Allegations D. and D.1. are sustained.

Factual Allegations D. and D.2. allege that:

Respondent's conduct deviated from accepted medical standards, in that:

2. Respondent inappropriately used a Cobb Elevator during the August 10, 1999 surgery.

The Hearing Committee determines that it was likely that Respondent did utilize a Cobb Elevator at some point during the operation performed on Patient D in August, 1999. However, it is clear that the use of the Cobb Elevator occurred after the dura tear and spinal cord contusion when Respondent was positioning or repositioning the bone plug. This scenario is also supported by the operative report dictated by Respondent. We determine that Respondent did not use a Cobb Elevator inappropriately during the course of the August 10, 1999 surgery on Patient D.

Factual Allegation D.2. is not sustained.

Factual Allegations D. and D.3. allege that:

Respondent's conduct deviated from accepted medical standards, in that:

3. During the course of the August 10th surgery, Respondent lacerated the dura.

The Hearing Committee found Respondent's explanation of the events to be credible, reasonable and more probable to have occurred as articulated by Respondent. In an effort to remove one final remnant fragment of disc, Respondent used an instrument (probably a curette) to elevate the disc fragment and when Respondent did this he caught and tore Patient D's dura. This dura tear occurred before the bone plug was placed (and before the use of the Cobb Elevator) and it is more probable than not that the cord was contused at the same time that the dura was torn. The force that Respondent used to remove the adherent disc fragment was too great and he injured the dura and spinal cord of Patient D. Under the circumstance, the laceration of the dura is a not found to be a deviation from accepted medical standards. Obviously it is not the desired result; however, it is a complication which can and does occur even in the best of hands and despite acceptable surgical techniques.

Factual Allegation D.3. is sustained. Factual Allegations D. and D.3. together are not sustained.

Factual Allegations D. and D.4. allege that:

Respondent's conduct deviated from accepted medical standards, in that:

4. During the course of the August 10th surgery, Respondent injured the spinal cord.

Respondent admitted that he caused a tear of Patient D's dura and an injury to her spinal cord. As stated in the discussion of Factual Allegation D.3. above, the injury occurred as a result of Respondent's attempt to remove adherent disc fragments. The injury to Patient D's spinal cord is a not deviation from accepted medical standards. See discussion above.

Factual Allegation D.4. is sustained. Factual Allegations D. and D.4. together are not sustained.

Factual Allegations D. and D.5. allege that:

Respondent's conduct deviated from accepted medical standards, in that:

5. On or about August 12, 1999, a CT scan of Patient D's cervical spine was performed. The radiologist recommended to Respondent that an MRI be performed. Respondent failed to ensure that the examination was performed prior to Patient D's discharge from SIUH.

Respondent explained that he did not have a continuing concern for intra spinal contents and, therefore, did not feel that an MRI was needed. Given the context of the patient's clinical situation, her neurological problems, Respondent knowledge of what occurred during the operation, and no evolution or worsening after the surgery, the CT scan was adequate to assess that there was nothing there that needed to be evacuated, or changed, or realigned. The CT scan was adequate for the purposes of ruling out an acute neurosurgical process.

Dr. O'Leary agreed that the recommendation of the radiologist left it to the surgeon to make the judgment as to whether there was a continuing clinical concern and that, accordingly, not obtaining an MRI would not constitute a departure from accepted standards. A qualified recommendation from a colleague is not a mandate.

The Hearing Committee determines that the first two sentences of Factual Allegation D.5 are true but the last sentence is not true and therefore Factual Allegations D. and D.5. are not sustained.

PATIENT E

The Department withdrew the Factual Allegations and Specifications of Misconduct as they relate to Patient E [T-337].

PATIENT F

Factual Allegations F. and F.1. allege that:

> *On or about May 21, 1996, Respondent performed a microvascular decompression of the trigeminal nerve for tic douloureux on Patient F at SIUH. Respondent's care deviated from accepted medical standards, in that:*
>
> *1. During the course of the May 21st surgery, Respondent caused a vascular injury or an injury to the brain stem.*

Patient F suffered a vascular injury during the course of the May 21, 1996 surgery. The Department's expert witness, Dr. Goran, was somewhat equivocal on whether the complication that occurred to Patient F from the type of surgery performed was negligence or a departure from accepted standards. There is no question that the outcome was not the desired result. Respondent's expert, Dr. Patterson, indicated that the outcome was a very infrequent risk of the surgery but does not necessarily mean that there was a departure from good surgical technique. The Hearing Committee determined that again, the Department presented a case where there was a bad outcome without proving, by a preponderance of the evidence, that Respondent's conduct was a departure from minimal accepted standards of care.

Factual Allegations F. and F.1. are sustained to the extent that the events occurred. Factual Allegations F. and F.1. are not sustained to the extent that they allege that Respondent's care deviated from accepted medical standards.

Factual Allegations F. and F.2. allege that:

> *Respondent's care deviated from accepted medical standards, in that:*
>
> *2. Respondent failed to order a post-operative MRI.*

Respondent did not order a post-operative MRI and the Hearing Committee agrees with Respondent that a CT scan was adequate under the circumstances. The main reason to obtain post-operative imaging was to ascertain whether there was a treatable condition which was causing the post-operative cranial nerve deficits and hemiparesis in Patient F. As Dr. Goran explained, the treatable possibilities were accumulation of blood, fluid or air. The alternative, and far more likely, cause of the patient's post-operative condition was a non-treatable vascular injury.

Dr. Goran admitted that the CT scan that was performed would have shown an accumulation of fluid or air. As Dr. Patterson explained, a hematoma (accumulation of blood) would also show up on a CT scan. The CT scan that was performed in this case, especially when considered in the context of Patient F's clinical condition, eliminated any treatable cause of the patient's post-operative condition. While an MRI would probably have given more information on the nature of the vascular injury, this would not have affected the management of the patient. The Hearing Committee determines that the "failure" to obtain an MRI did not constitute a departure from accepted medical standards.

Factual Allegation F.2. is not sustained.

Factual Allegations G. and G.1. allege that:

> *On or about April 20, 1994, Respondent performed a right frontal craniotomy and arachnoid cyst deroofing on Patient G at Memorial Sloan-Kettering Hospital, N.Y., N.Y. Respondent ordered an MRI scan for Patient G, a scan which was performed on July 16, 1994. Respondent's care deviated from accepted medical standards, in that:*
>
> *1. Respondent ordered an MRI and never reviewed the scan, nor did he appropriately follow-up with this patient's post-operative care.*

The Hearing Committee determined that Respondent did order an MRI for Patient G, that Respondent did review the scan and/or the report and that Respondent adequately followed-up with Patient G's post-operative care.

George Krol, the Chief of Neuroradiology at Memorial Sloan-Kettering Cancer Center, reported on the MRI of July 16, 1994. Dr. Krol's report indicates that there was no change in the size of the cyst as compared to a CT scan taken immediately post-operatively on April 21, 1994. In addition, Dr. Krol indicated in his report that there was a left subdural or subarachnoid hygroma present. The Hearing Committee agrees with Dr. Epstein that such cysts are not routinely reduced in size following a lysis of membranes. When an arachnoid cyst is opened by the lysing of membranes, the cyst may stay about the same size. As Dr. Epstein noted, the radiologist's statement of "no interval change" was based on a comparison with a CT scan taken post-operatively, this result was an ideal result. Thus, the radiologist's report was not an alarming report or a report which indicated that the operation had failed. With respect to the hygroma reported by Dr. Krol, Dr. Epstein indicated that these occur commonly, perhaps in half or more of the patients who undergo the type of operation performed by Respondent on Patient G. Furthermore, when the cyst is drained, most of the time the size of the cyst does not change. In fact, when the July, 1994 MRI films are scrutinized carefully and compared to the April 21, 1994 post-operative CT scans, it can be seen that there probably is a small reduction in the size of the cyst. This can be seen by the fact that there is a small midline shift toward the cyst which indicates some shrinkage in the size of the cyst. Patient G was instructed by Respondent to call in the event his headaches returned or got worse.

The existence of a hygroma was almost a guarantee when the arachnoid cyst was decompressed. The Hearing Committee does not condone Respondent's standard practice, with respect to routine follow-up of imaging studies, to advise the patient that if there were any abnormalities he would contact the patient. Obviously, the better practice is to contact the patient and advise the results. However failure to do so, in light of no abnormality, is not a deviation from accepted medical standards.

Although there is no concrete proof that Respondent reviewed the MRI report or the actual scans, the Hearing Committee found Respondent's explanation credible. Furthermore, although it is certainly far from ideal, the practice explained by Respondent is not uncommon. It is more likely than not that Respondent reviewed both the MRI report and possibly the scans themselves of the MRI performed on Patient G in July, 1994. The Department did not present persuasive evidence to the contrary.

The Hearing Committee notes that Respondent complained that it was difficult to recall certain events because so many years have elapsed (six years). If Respondent maintained appropriate and accurate records, made notes where necessary, initialed reports reviewed and made his intentions and rationale clear, then there would be no need to have great recall or even defend himself in a case such as was presented by the Department with Patient G.

Factual Allegation G is sustained except to the extent that they allege that Respondent's care was a deviation from accepted medical standards. Factual Allegation G.1. is not sustained except that Respondent did order an MRI.

Factual Allegations H. and H.1. allege that:

> *On or about May 15, 1998, Respondent after a clinical evaluation of Patient H, in his office, and a review of an MRI of the cervical spine dated May 7, 1998, Respondent determined that a discectomy and decompression of the nerve root at C-7 may be necessary. On or about November 11, 1998, at SIUH, Respondent performed a discectomy at C5, C6. Respondent's care deviated from accepted medical standards, in that:*
>
> *1. Respondent operated on the C5-C6 disc without sufficient explanation and/or documentation in the record as to his rationale for not operating at the C6-C7, the location of the pathology identified in the imaging studies and the office record.*

The Hearing Committee determined that this case was much more than just a record keeping violation. After re-reviewing all of the testimony and medical records for this patient, the

Hearing Committee is convinced that one of two probable scenarios occurred in the care and treatment Respondent provided to Patient H. First, Respondent made an error and operated on the wrong level (possibly because he did not remember what level he was supposed to be operating on); second, Respondent operated on the C5-C6 level on purpose, but he did so without any documentation and without sufficient medical justification. Either scenario is egregious and unacceptable conduct which had the potential of, and actually did cause, patient harm.

All of Respondent's notes, in Patient H's office record and the hospital record prior to the operative report, indicate that Respondent intended to perform surgery at the C6-C7 level. Respondent's answers to questions concerning when he changed his operative plan were evasive. For example, Respondent testified that sometime between his examination of Patient H on November 5, 1998 and the time of surgery he "must have made [my] decision to operate on the C5-C6 level." If Respondent made his decision to operate at C5-C6 on or after November 5, then any reasonable, prudent physician would have noted such change and the rationale in the medical records. Respondent then testified that "I make my final decision right there before surgery. I examine them sometimes, most of the time it is too anxious provoking issue, so I don't examine them." In response to the following question "On November 10, where did you intend to do the surgery, what level?" Respondent stated "I don't–I cannot say that I have– I don't– November 10? No, I cannot find–cannot pinpoint to exact plan. I cannot pinpoint to that."

Everyone agreed that the greater pathology was located at the C6-C7 level. Even though the May, 1998 MRI (and its report) identify a small defect at the C5-C6 level, there is no documentation by Respondent that Patient H had a C5-C6 radiculopathy.

Respondent acknowledged that there was nothing in the record to support his recollection that the patient's symptoms required a change in the operative location and that the decision to change the operative location to C5-C6 was made between November 5, 1998 and the actual operation.

Patient H testified that when he visited Respondent about two or three weeks before the surgery, Respondent told him "it is a different area that he believes was affected, that was associated with the pain". Patient H's medical records indicate that Respondent saw Patient H on November 5, 1998, about 6 days before the surgery. There is nothing which indicates that on that date Respondent changed the procedure. To the contrary, Respondent's notes for the November 5, 1998 visit reinforces a C6-C7 procedure.

Respondent did document in the operative note that he operated on the C5-C6 level. A metallic marker was placed intra-operatively and the x-ray revealed that the marker was located at the C5-C6 level. Therefore it would appear that Respondent intended to operate at the C5-C6 level. Was this an error in judgment, a mistake, a lapse, or carelessness because there was no documentation by Respondent to tell him what level he should be operating? Did Respondent look at the May, 1998 MRI which showed some pathology at both level C5-C6 and C6-C7 and the notes of the examination performed at the hospital, just before surgery, by his physician's assistant which indicated C5-C6 problems? Why did Respondent change the operation from the one contemplated in May and November 1998 (C6-C7) when he operated on November 11, 1998 on the C5-C6 disc? The Hearing Committee can not determine the answers to the above questions. Neither can Respondent and even more importantly, neither can future medical care providers for Patient H.

We disagree with Dr. Patterson that Respondent's decision to operate on the C5-C6 level was not unreasonable. Dr. Patterson opined that the decision to operate on C5-C6 was based on clinical judgment. Since there is nothing in Patient H's medical records which indicates what Respondent's clinic judgment was, then Dr. Patterson's opinion was mere conjecture. Without valid clinical judgment, Respondent decision to operate on the C5-C6 level was unreasonable.

The Hearing Committee does determine that Respondent operated on the C5-C6 disc of Patient H without sufficient explanation or medical justification. Respondent also operated on the C5-C6 disc of Patient H without sufficient documentation as to his rationale for not operating at the C6-C7 level. Patient H suffered harm because he was exposed to a second surgical procedure and anesthesia risks solely due to Respondent's gross error in operating on the wrong disc. The Hearing Committee determined that operating on the wrong disc is no different in substance and egregiousness to operating on the wrong limb.

Factual Allegations H. and H.1. are sustained to the extent that on May 15, 1998, Respondent, after a clinical evaluation of Patient H in his office and a review of an MRI of the cervical spine dated May 7, 1998, determined that a discectomy and decompression of the nerve root at C-7 may be necessary. On November 11, 1998, at SIUH, Respondent performed a discectomy at C5-C6. Respondent's care deviated from accepted medical standards, in that Respondent operated on the C5-C6 disc without sufficient explanation and/or documentation in the record as to his rationale for not operating at the C6-C7.

Factual Allegations H. and H.2. allege that:

> *Respondent's care deviated from accepted medical standards, in that:*
>
> *2. Respondent failed to perform surgery at the C6-C7 level given the clinical findings and imaging studies.*

On November 11, 1998, Respondent did not perform surgery at the C6-C7 level on Patient H. Given the clinical findings and the May, 1998 imaging study of Patient H, there is no valid, credible explanation as to why Respondent did not perform surgery at the C6-C7 level. See discussion above.

Factual Allegations H. and H.2. are sustained.

Factual Allegation I. alleges that:

> *From on or about January 1, 1996 through on or about December 31, 1997, Respondent performed 35 discectomies at SIUH. In at least 3 of the 35 patients (Patients I, J, K) Respondent caused a dural tear with subsequent cerebral spinal fluid leaks which required reoperations for repair of the tears. This high complication rate deviated from accepted medical standards.*

This factual allegation and its consequential Charges was very disturbing to the Hearing Committee who serve on a Board for Professional Medical **Conduct** not a Board of statistical outcome. The law and our directions have always been clear that bad outcomes do not necessarily arise out of "bad", negligent, or incompetent conduct. No evidence was presented by the Department that Respondent failed to exercise the care (for Patients I and J and K) that a reasonably prudent physician would exercise under the circumstances. No evidence was presented by the Department that in the care and treatment of Patients I and J and K Respondent lacked the skill or knowledge necessary to practice the profession.

This is the first time that we have been presented with this type of allegation. Although we would agree that statistical high complication rates may be a reason to conduct a further investigation and review of a physician's practice, the use of statistical complication rates. with an arbitrary time period, is an invalid attempt to show a deviation without producing relevant probative

evidence regarding the cause and circumstances present. A statistical analysis of outcome, in and of itself, cannot establish causation, nor is it proof of medical misconduct by any individual. Each case must be reviewed and evaluated on its own merits. The Hearing Committee also believes that the inclusion of this Factual Allegation and other "result" Factual Allegations rather than conduct Factual Allegations had the effect of weakening the Department's position and lengthening the presentation, defense, and resolution of this Hearing.

The Hearing Committee determines that the Department has not proven, by any evidence, that Respondent's complication rate is a deviation from accepted medical standards.

Factual Allegation I. is not sustained.

CONCLUSIONS WITH REGARD TO:

THE FIRST, TENTH, ELEVENTH, and TWENTIETH SPECIFICATIONS

The only substantive Factual Allegation which is sustained is A.2. The Hearing Committee determines that the failure to bring the patient's CT scan in the operating room, under the circumstances and proof presented, is not a deviation from accepted medical standards. Therefore Respondent did not commit gross negligence, negligence (vote of 2 to 1 [see discussion on Factual Allegations A. and A.1]), gross incompetence or incompetence in the care and treatment that he provided to Patient A. These Specifications are not sustained. The Hearing Committee concludes that the Department of Health has not shown by a preponderance of the evidence that Respondent's conduct constituted professional misconduct under §6530(4) or (3) or (6) or (5) of the Education Law.

THE SECOND, TENTH, TWELFTH, and TWENTIETH SPECIFICATIONS

No substantive (deviation) Factual Allegations are sustained as to Patient B. The Hearing Committee determines that Respondent's conduct, under the circumstances and proof presented, is not a deviation from accepted medical standards. Therefore, Respondent did not commit gross negligence, negligence, gross incompetence or incompetence in the care and treatment that he provided to Patient B. These Specifications are not sustained. The Hearing Committee concludes that the Department of Health has not shown by a preponderance of the evidence that Respondent's conduct constituted professional misconduct under §6530(4) or (3) or (6) or (5) of the Education Law.

THE THIRD, TENTH, THIRTEENTH, and TWENTIETH SPECIFICATIONS

No substantive (deviation) Factual Allegations are sustained as to Patient C. The Hearing Committee determines Respondent's conduct, under the circumstances and proof presented, is not a deviation from accepted medical standards. Therefore, Respondent did not commit gross negligence, negligence, gross incompetence or incompetence in the care and treatment that he provided to Patient C. These Specifications are not sustained. The Hearing Committee concludes that the Department of Health has not shown by a preponderance of the evidence that Respondent's conduct constituted professional misconduct under §6530(4) or (3) or (6) or (5) of the Education Law.

THE FOURTH, TENTH, FOURTEENTH, and TWENTIETH SPECIFICATIONS

The substantive Factual Allegations which are sustained are D.1, D.3 and D.4. The Hearing Committee, by a vote of 2 to 1, determines that the failure to document an adequate pre-

operative history prior to surgery, under the circumstances and proof presented, was not a deviation from accepted medical standards which reaches the level of negligence. It is a failure to maintain records for a patient which shows the actual care and treatment provided to the patient. Said failure however does not rise to the level of gross negligence, negligence (by a vote of 2 to 1), gross incompetence or incompetence in the care and treatment of Patient D. Similarly, the Hearing Committee determines that the laceration of the dura and the injury to the spinal cord, under the circumstances and proof presented, did not rise to the level of gross negligence, negligence, gross incompetence or incompetence in the care and treatment of Patient D. Sometimes in surgery complications and unintended results occur. The issue is not always the event but how the event occurred, why did it occur and how did the physician contend with the complication. The Department has not shown that Respondent's conduct, under the circumstances presented in Patient D was a departure from minimally accepted medical standards. Therefore these Specifications are not sustained. The Hearing Committee concludes that the Department of Health has not shown by a preponderance of the evidence that Respondent's conduct constituted professional misconduct under §6530(4) or (3) or (6) or (5) of the Education Law.

THE FIFTH, TENTH, FIFTEENTH, and TWENTIETH SPECIFICATIONS

These Factual Allegations and Specifications were withdrawn by the Department.

THE SIXTH, TENTH, SIXTEENTH, and TWENTIETH SPECIFICATIONS

No substantive (deviation) Factual Allegations are sustained as to Patient F. The Hearing Committee determines that Respondent's conduct, under the circumstances and proof presented, is not a deviation from accepted medical standards. Therefore, Respondent did not commit gross

negligence, negligence, gross incompetence or incompetence in the care and treatment of Patient F. These Specifications are not sustained. The Hearing Committee concludes that the Department of Health has not shown by a preponderance of the evidence that Respondent's conduct constituted professional misconduct under §6530(4) or (3) or (6) or (5) of the Education Law.

THE SEVENTH, TENTH, SEVENTEENTH, and TWENTIETH SPECIFICATIONS

No substantive (deviation) Factual Allegations are sustained as to Patient G. The Hearing Committee determines that Respondent's conduct, under the circumstances and proof presented, is not a deviation from accepted medical standards. Therefore, Respondent did not commit gross negligence, negligence, gross incompetence or incompetence in the care and treatment of Patient G. These Specifications are not sustained. The Hearing Committee concludes that the Department of Health has not shown by a preponderance of the evidence that Respondent's conduct constituted professional misconduct under §6530(4) or (3) or (6) or (5) of the Education Law.

THE EIGHTH, TENTH, EIGHTEENTH, and TWENTIETH SPECIFICATIONS

The Hearing Committee determines that Respondent did commit gross negligence with regards to the care and treatment of Patient H. This case is the equivalent of operating on the wrong limb or organ. As discussed above, either Respondent had no idea what level he was supposed to operate on or he operated on the wrong level. Either scenario is egregious. There is no medical justification for the procedure performed by Respondent. Patient H was subjected to an additional operation, with all of its risks and ordeals, due to Respondent's carelessness and defective conduct.

The Hearing Committee also determines that Respondent committed negligence with regards to the care and treatment of Patient H. Therefore, Respondent did commit gross negligence

and negligence on one occasion in the care and treatment of Patient H. The Specification of gross negligence is sustained. Since there is only one act of negligence, the Specification of negligence on more than one occasion is not sustained. The Hearing Committee concludes that the Department of Health has shown by a preponderance of the evidence that Respondent's conduct constituted professional misconduct under §6530(4) of the Education Law. The Hearing Committee concludes, by a vote of 2 to 1, that the Department of Health has not shown by a preponderance of the evidence that Respondent's conduct constituted professional misconduct under §6530(3) of the Education Law.

There was no proof presented that Respondent lacked the skill or knowledge to perform the correct procedure or practice the profession. Respondent is a Board Certified Neurosurgeon with training in the surgical treatment of oncological and degenerative diseases. Respondent has performed a significant number of spine surgeries. Respondent had previously been involved in the treatment of oncological disease involving the spine. The treatment or surgery of oncological disease is similar, if not more difficult, then the treatment or surgery of degenerative disease.

Respondent did not commit gross incompetence or incompetence in the care and treatment of Patient H. These Specifications are not sustained. The Hearing Committee concludes that the Department of Health has not shown by a preponderance of the evidence that Respondent's conduct constituted professional misconduct under §6530(6) or (5) of the Education Law.

THE NINTH, TENTH, NINETEENTH, and TWENTIETH SPECIFICATIONS

No substantive (deviation) Factual Allegations are sustained as to Patients I, J and K. The Hearing Committee determines that Respondent's conduct, under the circumstances and proof presented, is not a deviation from accepted medical standards. Therefore, Respondent did not

commit gross negligence, negligence, gross incompetence or incompetence in the care and treatment of Patients I, J and K. These Specifications are not sustained. The Hearing Committee concludes that the Department of Health has not shown by a preponderance of the evidence that Respondent's conduct constituted professional misconduct under §6530(4) or (3) or (6) or (5) of the Education Law.

DETERMINATION AS TO PENALTY

The Hearing Committee pursuant to the Findings of Fact, Conclusions of Law and Discussion set forth above determines that Respondent's license to practice medicine in New York should be SUSPENDED FROM THE DATE HE STOPPED PRACTICING IN FEBRUARY, 2000 TO THE EFFECTIVE DATE OF THIS DETERMINATION AND ORDER. In addition Respondent should be placed on PROBATION FOR A PERIOD OF 3 YEARS FROM THE EFFECTIVE DATE OF THIS DETERMINATION AND ORDER with the standard terms of probation (see attached Appendix III) plus the requirement that Respondent enroll in a medical RECORD KEEPING COURSE, acceptable to the Office of Professional Medical Conduct ("**OPMC**"), and the requirement that Respondent only practice surgery in an Article 28 facility or government facility during the period of probation with a PRACTICE MONITOR, acceptable to the OPMC, supervising Respondent's practice of surgery.

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. § 230-a, including:

(1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6)

Limitations; (7) the imposition of monetary penalties; (8) a course of education or training; (9) performance of public service and (10) probation.

Respondent informed the Hearing Committee that he has not been practicing since February 2000 [T-484]. There is no question that Respondent's misconduct involving Patient H was serious. In addition, although the Hearing Committee did not sustain misconduct charges for the other patients, Respondent's conduct as to those patients shows a pattern of poor documentation and inattention to details of good clinical practice (for example, CT scans not in operating room, not initialing records reviewed nor acknowledging the reading of laboratory reports, not calling patients with result of MRI). Respondent was disciplined by the New York State Board for Professional Medical Conduct four years ago. In that case, Respondent never adequately examined the patient's chart, MRI's, or even the patient before surgery. One would expect that the experience of four years ago would have sufficiently chastened Respondent to ensure the utmost caution, documentation and patient attention to prevent a reoccurrence of misconduct. Apparently that was not the case for the November, 1998 surgery on Patient H. Respondent provided absolutely no documentation regarding his rationale or medical justification for changing the surgery. The Hearing Committee believes that Respondent's care and treatment of Patient H is the equivalent of operating on the wrong body part.

The Hearing Committee decided that community service was not appropriate because there was no general harm to the community nor fraud nor abrogation of people's rights charged. A fine was not appropriate again because no fraud was alleged and Respondent did not profit from the misconduct found. The Hearing Committee did not revoke Respondent's license because we believe that Respondent has the talent and skills necessary to provide good surgical care. With practice monitoring, the Hearing Committee believes that Respondent should be able to provide safe medical care to his surgical patients. The Hearing Committee notes that the actual suspension of

Respondent's license for almost a full year is a heavy penalty for one sustained charge of gross negligence, however based on Respondent's past discipline and his apparent failure to learn from it, we determine the above suspension, probation and terms to be necessary for the protection of the public. We also believe that Respondent has now been sufficiently disciplined in regards to actual suspension and should be allowed to begin the process of reentry to patient care and surgery with the conditions imposed in this Determination and Order.

Taking all of the facts, details, circumstances and particulars in this matter into consideration, the Hearing Committee determines that the above is the appropriate sanction under the circumstances. The Hearing Committee concludes that the sanction imposed strikes the appropriate balance between the need to punish Respondent, deter future misconduct, and protect the public.

All other issues raised by both parties have been duly considered by the Hearing Committee and would not justify a change in the Findings, Conclusions or Determination contained herein.

By execution of this Determination and Order, all members of the Hearing Committee certify that they have read and considered the complete record of this proceeding.

ORDER

Based on the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The EIGHTH SPECIFICATION contained in the Amended Statement of Charges (Department's Exhibit # 1-B) is **SUSTAINED**; and

2. All other SPECIFICATIONS contained in the Amended Statement of Charges (Department's Exhibit # 1-B) are **NOT SUSTAINED**; and

3. Respondent's license to practice medicine in the State of New York is hereby SUSPENDED FROM THE DATE HE STOPPED PRACTICING IN FEBRUARY, 2000 TO THE EFFECTIVE DATE OF THIS DETERMINATION AND ORDER; and

4. Respondent is placed on PROBATION FOR A PERIOD OF 3 YEARS FROM THE EFFECTIVE DATE OF THIS DETERMINATION AND ORDER with the standard terms of probation plus the requirement that Respondent enroll in a medical record keeping course, acceptable to the Office of Professional Medical Conduct ("**OPMC**") (see attached Appendix III - which Terms and Conditions are incorporated herein); and

5. The requirement that Respondent only practice surgery in an Article 28 facility or government facility during the period of probation with a practice monitor, acceptable to the OPMC, supervising Respondent's practice of surgery; and

6. This Order shall be effective on personal service on the Respondent or 7 days after the date of mailing of a copy to Respondent by certified mail or as provided by P.H.L. §230(10)(h).

DATED: **New York**
December, 28 **2000**

THEA GRAVES PELLMAN
DAVID HARRIS, M.D.
JOHN B. WALDMAN, M.D.

To:

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APPENDIX I

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

IN THE MATTER

OF

EHUD ARBIT, M.D.

AMENDED STATEMENT OF CHARGES

EHUD ARBIT, M.D., the Respondent, was authorized to practice medicine in New York State on or about May 7, 1982, by the issuance of license number 149975 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about January 31, 2000, at Staten Island University Hospital,(SIUH), Staten Island, N.Y., Respondent performed a craniotomy on Patient A. (The patients are identified in the attached Appendix)
Respondent's conduct deviated from accepted medical standards, in that:

1. Respondent inappropriately explored the left cerebellar hemisphere when there was no tumor in the left cerebellar hemisphere.

2. Respondent began the operation without the presence of the patient's CT scan in the operating room.

3. Respondent failed to maintain a record which accurately reflected the care and treatment rendered.

B. On or about June 22, 1999, at SIUH, Respondent performed a two-level

DEPARTMENTS
EX. 1-B
in evidence
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corpectomy at C5 and C6 with excision of the intervening intervertebral discs. Respondent's conduct deviated from accepted medical standards, in that:

1. Respondent terminated the June 22, 1999 procedure without ensuring that the metallic plate was properly seated on the spine.

2. On or about June 28,1999, Patient B returned to the operating room for Respondent to resite the screws and plates which he had used in the earlier operation. Again, Respondent terminated the procedure without ensuring that the metallic plates and screws were properly seated.

C. On or about May 20, 1999, Respondent performed a laminectomy C2-C5 on Patient C at SIUH; having intended to perform a decompression as far as C7. The surgery was abbreviated due to extensive bleeding. On or about November 9, 1999, Patient C was readmitted to SIUH for further surgery. Respondent encountered extensive bleeding during the second operation. Respondent's conduct deviated from accepted medical standards, in that:

1. Respondent failed to obtain a consultation with a hematologist following the first operation or before the second operation on Patient C.

2. During the course of the November 9, 1999, Respondent injured Patient C's cervical spinal cord.

3. Respondent failed to dictate a discharge summary for the November hospitalization for Patient C.

D. On or about August 10, 1999, Respondent performed a "C6 and partial C5 and C7 corpectomy and bone graft with decompression of spinal cord and nerve roots," on Patient D at SIUH. Respondent's care deviated from accepted medical standards, in that:

1. Respondent failed to perform and document an adequate pre-operative history prior to surgery.

2. Respondent inappropriately used a Cobb Elevator during the August 10, 1999 surgery.

3. During the course of the August 10th surgery, Respondent lacerated the dura.

4. During the course of the August 10th surgery, Respondent injured the spinal cord.

5. On or about August 12, 1999, a CT scan of Patient D's cervical spine was performed. The radiologist recommended to Respondent that an MRI be performed. Respondent failed to ensure that the examination was performed prior to Patient D's discharge from SIUH.

8/10/00 MPZ

E. On or about January 28, 1998, Respondent performed a transphenoidal

WITHDRAWN 8-10-00 MPZ

resection of a pituitary macroadenoma on Patient E at SIUH. Respondent's care deviated from accepted medical standards, in that:

1. Respondent incorrectly penetrated the left cavernous sinus and possibly beyond.

2. The hospital record for Patient E failed to accurately reflect the care and treatment rendered to Patient E.

F. On or about May 21, 1996, Respondent performed a microvascular decompression of the trigeminal nerve for tic douloureux on Patient F at SIUH. Respondent's care deviated from accepted medical standards, in that:

1. During the course of the May 21st surgery, Respondent caused a vascular injury or an injury to the brain stem.

2. Respondent failed to order a post-operative MRI.

G. On or about April 20, 1994, Respondent performed a right frontal craniotomy and arachnoid cyst deroofing on Patient G at Memorial Sloan-Kettering Hospital, N.Y., N.Y. Respondent ordered an MRI scan for Patient G, a scan which was performed on July 16, 1994. Respondent's care deviated from accepted medical standards, in that:

1. Respondent ordered an MRI and never reviewed the scan, nor did he appropriately follow-up with this patient's post-operative care.

H. On or about May 15, 1998, Respondent after a clinical evaluation of Patient H in his office, and a review of an MRI of the cervical spine dated May 7, 1998, Respondent determined that a discectomy and decompression of the nerve root at C-7 may be necessary. On or about November 11, 1998, at SIUH, Respondent performed a discectomy at C5, C6. Respondent's care deviated from accepted medical standards, in that:

1. Respondent operated on the C5-C6 disc without sufficient explanation and/or documentation in the record as to his rationale for not operating at the C6-C7, the location of the pathology identified in the imaging studies and the office record.

2. Respondent failed to perform surgery at the C6-C7 level given the clinical findings and imaging studies.

I. From on or about January 1, 1996 through on or about December 31, 1997, Respondent performed 35 discectomies at SIUH. In at least 3 of the 35 patients (Patients I, J, K) Respondent caused a dural tear with subsequent cerebral spinal fluid leaks which required reoperations for repair of the tears. This high complication rate deviated from accepted medical standards.

SPECIFICATION OF CHARGES

FIRST THROUGH NINTH 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:

1. The facts in Paragraph A and its subparagraphs
2. The facts in Paragraph B and its subparagraphs
3. The facts in Paragraph C and its subparagraphs
4. The facts in Paragraph D and its subparagraphs
5. The facts in Paragraph E and its subparagraphs
6. The facts in Paragraph F and its subparagraphs
7. The facts in Paragraph G and its subparagraphs
8. The facts in Paragraph H and its subparagraphs
9. The facts in Paragraph I.

TENTH 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:

10. The facts in Paragraph A and its subparagraphs; Paragraph B and its subparagraphs; Paragraph C and its subparagraphs; Paragraph D and its subparagraphs; Paragraph E and its subparagraphs; Paragraph F and its subparagraphs; Paragraph G and its subparagraphs; the facts in Paragraph H and its subparagraphs; and/or the facts in Paragraph I.

ELEVENTH THROUGH NINETEENTH SPECIFICATION

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:

11. The facts in Paragraph A and its subparagraphs
12. The facts in Paragraph B and its subparagraphs
13. The facts in Paragraph C and its subparagraphs
14. The facts in Paragraph D and its subparagraphs
15. The facts in Paragraph E and its subparagraphs
16. The facts in Paragraph F and its subparagraphs
17. The facts in Paragraph G and its subparagraphs
18. The facts in Paragraph H and its subparagraphs
19. The facts in Paragraph I.

TWENTIETH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

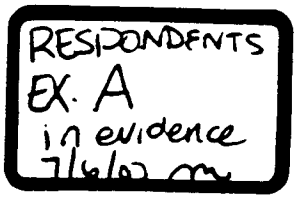
Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 2000) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

20. The facts in Paragraph A and its subparagraphs; Paragraph B and its subparagraphs; Paragraph C and its subparagraphs; Paragraph D and its subparagraphs; Paragraph E and its subparagraphs; Paragraph F and its subparagraphs; Paragraph G and its subparagraphs; the facts in Paragraph H and its subparagraphs; and/or the facts in Paragraph I.

DATED: August 9, 2000
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II



NEW YORK STATE : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT
----------X

IN THE MATTER

OF

EHUD ARBIT, M.D.
----------X

RESPONDENT'S ANSWER TO STATEMENT OF CHARGES

By his attorneys, Wood & Scher, respondent answers the statement of charges as follows:

1. With respect to Paragraph A of the Factual Allegations set forth in the Statement of Charges, respondent respectfully refers the Hearing Committee to the pertinent medical records for a detailed and full description of the treatment rendered to Patient A. Respondent denies that his actions deviated from accepted medical standards.

2. Respondent denies the allegations contained in Paragraph A.1 of the Factual Allegations. Respondent denies that his actions deviated from accepted medical standards.

3. Respondent admits that he began the operation on Patient A without the presence of the patient's CT scan in the operating room as is alleged in Paragraph A.2 of the Factual Allegations, but affirmatively states that he personally reviewed the CT scan directly on the computer screen shortly prior to commencing the operation and was fully apprised as to the exact location of the tumor. Respondent denies that his actions deviated from accepted medical standards.

4. Respondent denies the allegations contained in Paragraph A.3 of the Factual Allegations. Respondent denies that his actions deviated from accepted medical standards.

5. With respect to Paragraph B of the Factual Allegations, respondent respectfully

refers the Hearing Committee to the pertinent medical records for a detailed and full description of the treatment rendered to Patient B. Respondent denies that his actions deviated from accepted medical standards.

6. Respondent denies the allegations contained in Paragraph B.1 of the Factual Allegations. Respondent denies that his actions deviated from accepted medical standards.

7. Respondent denies the allegations contained in Paragraph B.2 of the Factual Allegations. Respondent denies that his actions deviated from accepted medical standards.

8. With respect to Paragraph C of the Factual Allegations, respondent respectfully refers the Hearing Committee to the pertinent medical records for a detailed and full description of the treatment rendered to Patient C. Respondent denies that his actions deviated from accepted medical standards.

9. Respondent admits that he did not obtain a consultation with a hematologist prior to the operation performed on or about November 9, 1999 as alleged in Paragraph C.1 of the Factual Allegations. Respondent objects to the word "failed" as used in Paragraph C.1 and affirmatively states that under all of the facts and circumstances known to respondent such a consultation was not a requisite of good and accepted medical practice. Respondent denies that his actions deviated from accepted medical standards.

10. Respondent denies the allegations contained in Paragraph C.2 of the Factual Allegations. Respondent denies that his actions deviated from accepted medical standards.

11. Respondent denies the allegations contained in Paragraph C.3 of the Factual Allegations. Respondent denies that his actions deviated from accepted medical standards.

12. With respect to Paragraph D of the Factual Allegations, respondent respectfully

refers the Hearing Committee to the pertinent medical records for a detailed and full description of the treatment rendered to Patient D. Respondent denies that his actions deviated from accepted medical standards.

13. Respondent denies the allegations contained in Paragraph D.1 of the Factual Allegations. Respondent denies that his actions deviated from accepted medical standards.

14. Respondent denies the allegations contained in Paragraph D.2 of the Factual Allegations. Respondent denies that his actions deviated from accepted medical standards.

15. Respondent admits that a durotomy occurred during the August 10th surgery as alleged in Paragraph D.3 of the Factual Allegations. Respondent denies that his actions deviated from accepted medical standards.

16. In response to Factual Allegation D.4, respondent admits that during the course of the August 10th surgery pressure was exerted on the spinal cord in an effort to elevate a free disc fragment and that as a result of this pressure the patient experienced some neurological deficit post-operatively. Respondent denies that his actions deviated from accepted medical standards.

17. Respondent denies the allegations contained in Paragraph D.5 of the Factual Allegations and respectfully refers the Hearing Committee to the pertinent medical records for a detailed and full description of the radiologist's recommendation. Respondent denies that his actions deviated from accepted medical standards.

18. With respect to Paragraph E of the Factual Allegations, respondent respectfully refers the Hearing Committee to the pertinent medical records for a detailed and full description of the medical treatment rendered to Patient E. Respondent denies that his actions deviated from accepted medical standards.

19. Respondent denies the allegations contained in Paragraph E.1 of the Factual Allegations. Respondent denies that his actions deviated from accepted medical standards.

20. Respondent denies the allegations contained in Paragraph E.2 of the Factual Allegations. Respondent denies that his actions deviated from accepted medical standards.

21. With respect to Paragraph F of the Factual Allegations, respondent respectfully refers the Hearing Committee to the pertinent medical records for a detailed and full description of the medical treatment rendered to Patient F. Respondent denies that his actions deviated from accepted medical standards.

22. Respondent denies the allegation contained in Paragraph F.1 of the Factual Allegations. Respondent denies that his actions deviated from accepted medical standards.

23. With respect to Paragraph G of the Factual Allegations, respondent respectfully refers the Hearing Committee to the pertinent medical records for a detailed and full description of the medical treatment rendered to Patient G. Respondent denies that his actions deviated from accepted medical standards.

24. Respondent denies the allegations contained in Paragraph G.1 of the Factual Allegations. Respondent denies that his actions deviated from accepted medical standards.

25. With respect to Paragraph H of the Factual Allegations, respondent respectfully refers the Hearing Committee to the pertinent medical records for a detailed and full description of the medical treatment rendered to Patient H. Respondent denies that his actions deviated from accepted medical standards.

26. Respondent denies the allegations contained in Paragraph H.1 of the Factual Allegations. Respondent denies that his actions deviated from accepted medical standards.

27. Respondent denies the allegations contained in Paragraph H.2 of the Factual Allegations. Respondent denies that his actions deviated from accepted medical standards

28. Respondent denies having knowledge or information sufficient to form a belief as to the truth or falsity of the allegation that he performed 35 discectomies at Staten Island University Hospital from January 1, 1996 through December 31, 1997 as alleged in Paragraph I of the Factual Allegations. Respondent also denies having knowledge or information sufficient to form a belief as to the truth or falsity of the allegation that in at least 3 of the 35 patients he caused a dural tear with subsequent cerebral spinal fluid leaks which required reoperations as is also alleged in Paragraph I of the Factual Allegations. Respondent denies the allegations of a high complication rate which deviates from accepted medical standards as alleged in Paragraph I of the Factual Allegations. Respondent asserts that Paragraph I contains an arbitrary time frame and other arbitrary parameters for Respondent's "complication rate" and that as such this is a specious allegation. Respondent denies that his actions deviated from accepted medical standards.

29. With respect to the Specification of Charges contained in the Statement of Charges, respondent denies that he committed any misconduct as alleged therein.

WHEREFORE, respondent respectfully requests that the Hearing Committee issue an Order dismissing all of the charges herein.

Dated: Scarsdale, NY
June 28, 2000

WOOD & SCHER
Attorneys for Respondent Arbit

The Harwood Building
Scarsdale, NY 10583
(914) 723-3500

APPENDIX III

Terms and Conditions of Probation for EHUD ARBIT, M.D.

1. Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his profession. Respondent acknowledges that if he commits professional misconduct as enumerated in New York State Education Law §6530 or §6531, those acts shall be deemed to be a violation of probation and that an action may be taken against Respondent's license pursuant to New York State Public Health Law §230(19).

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct ("**OPMC**"), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Respondent shall fully cooperate with and respond in a timely manner to requests from the OPMC to provide written periodic verification of Respondent's compliance with the terms of the Hearing Committee's Order. Respondent shall personally meet with a person designated by the Director of the OPMC as requested by the Director.

4. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. 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 section 171(27)]; State Finance Law section 18; CPLR section 5001; Executive Law Section 32].

5. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of the OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled on Respondent's return to practice in New York State.

6. Respondent's professional performance may be reviewed by the Director of the OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his staff at practice locations or the OPMC offices.

7. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

8. The period of probation imposed shall commence on the effective date of the Order and shall continue for a period of 36 months thereafter.

9. Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of the OPMC.

(a) Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice or hospital location at each and every location, on a random unannounced basis at least monthly and shall examine a selection (no less than 10) of records maintained by Respondent, including patient records, prescribing information and office or hospital records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to the OPMC.

(b) Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

(c) Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of the OPMC.

(d) Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of the OPMC prior to Respondent's practice after the effective date of this Order.

10. Respondent shall take and complete a course in medical record keeping in the practice of surgery or medicine or equivalent program proposed by Respondent and subject to the prior written approval of the Director of the OPMC. Respondent shall complete the course or program within one hundred eighty (180) days of the effective date of the Hearing Committee's Order, unless the Director of the OPMC approves an extension in writing.

11. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he is subject pursuant to the Hearing Committee's Order and shall assume and bear all costs related to compliance. On receipt of evidence of non-compliance with, or any violation of these terms, the Director of the OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized pursuant to the law.