STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson E. Rockefeller Empire State Plaza Albany, New York 12237

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

May 9, 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Michael Hiser, Esq.
NYS Department of Health
Corning Tower-Room 2438
Empire State Plaza
Albany, New York 12237

Joseph G. Rende, Esq.
Rende, Ryan & Downes
202 Mamaroneck Ave.
White Plains, New York 10601

Moises Salama, M.D.
Oscawanna Lake Road
Putnam Valley, New York 10579

RE: In the Matter of Moises Salama, M.D.

EFFECTIVE DATE: 05/16/95

Dear Mr. Hiser, Mr. Rende and Dr. Salama:

Enclosed please find the Determination and Order (No. 95-98) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

Office of Professional Medical Conduct
New York State Department of Health
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

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

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

Request for review of the Committee's determination by the Administrative Review Board stays all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

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

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

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

MOISES SALAMA, M.D.

DETERMINATION

AND

ORDER

BPMC 95-98

WILLIAM W. FALOON, M.D., CHAIRMAN, JOHN H. MORTON, M.D., and **MR. JOHN T. VERNIEU**, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) of the Public Health Law. **MICHAEL P. MCDERMOTT, ESQ.**, Administrative Law Judge, served as Administrative Officer for the hearing Committee.

After consideration of the entire record, the Hearing Committee submits this DETERMINATION AND ORDER.

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges:	July 6, 1994
Pre-Hearing Conference:	September 15, 1994
Hearing Dates:	December 9, 1994 December 16, 1994 January 5, 1995 February 9, 1995

Place of Hearing:	NYS Department of Health Corning Tower Albany, New York on December 9, 1994 and December 16, 1994 NYS Department of Health 584 Hugenot Street New Rochelle, New York on January 5, 1995 NYS Department of Health 5 Penn Plaza New York, New York on February 9, 1995
Date of Deliberations:	April 13, 1995 April 28, 1995
Petitioner Appeared By:	Peter J. Millock, Esq. General Counsel NYS Department of Health BY: Michael Hiser, Esq. Associate Counsel
Respondent Appeared By:	Rende, Ryan & Downes 202 Mamaroneck Ave. White Plains, New York 10601 BY: Joseph G. Rende, Esq.

STATEMENT OF CHARGES

The Statement of Charges charges the Respondent with negligence on more than one occasion; incompetence on more than one occasion and failing to maintain records.

NOTE: During the course of the hearings, those charges specified in Paragraphs E2, F3 and G1 of the Statement of Charges were WITHDRAWN by the Petitioner.

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part of this DETERMINATION AND ORDER.

WITNESSES

For the Petitioner:

1) Kirk Pannenton, M.D.
2) C. Maynard Guest, M.D.

For the Respondent:

1) Moises Salama, M.D., the Respondent
2) Marvin Moser, M.D.

FINDINGS OF FACT

Numbers in parenthesis refer to transcript pages or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. All hearing Committee findings were unanimous unless otherwise specified.

GENERAL FINDINGS

1. Moises Salama, M.D., the Respondent, was authorized to practice medicine in New York State on September 30, 1965, by the issuance of license number 095562 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1995 through December 31, 1996, from Oscawanna Lake Road, Putnam Valley, New York 10579 (Pet's. Ex. 1 and 2).

FINDINGS AS TO PATIENT A

2. The Respondent provided medical treatment to Patient A, a 79 year old female, from October 23, 1993 through July 1990 at his office at Oscawanna Lake Road, Putnam Valley, New York, 10579 (hereafter, "Respondent's office")(Pet's Ex. 3, p.4).

3. The Respondent saw Patient A on October 23, 1989, for an initial visit, including initial history and physical examination. Patient A had an initial complaint of several falls, and incontinence. She was also taking Lopressor with a diuretic at that time (Pet's. Ex. 3, p. 4).

4. An adequate initial history of the patient should identify the chief complaint, as well as a more detailed history of that complaint. It should also include a family history and social history (Tr. 31-43).

5. The Respondent's record did not reflect an adequate history of the patient's complaints. There is no indication how long the patient had been on Lopressor; under what circumstances the patient fell; how many times the patient fell; the results of the falls; how long the patient had been incontinent at night; or whether the incontinence was related to the diuretic therapy (Tr. 633, 641, 645-647).

6. The Respondent's medical records for Patient A note a diagnosis of leg ulcer, but do not report any findings as to the Patient's extremities or vascular system (Pet's. Ex.3 and Ex. 3A, p.4).

7. The Respondent's records for Patient A are inadequate in that there is no family history, no past history, no indication as to how long the patient was on Lopressor, no patient history regarding falls and no history of the patient's incontinence (Pet's. Ex. 3).

8. The initial physical examination should include blood pressure as a base line, even if normal; extra heartbeats or irregularities; that the lungs are clear or have certain findings; whether a liver is palpable or just the word "negative"; and whether the spleen is palpable or just the word "negative". Additionally, if peripheral vascular disease with ulcers were a part of history, there should have been a note that the peripheral pulses were palpable or decreased or absent (Tr. 593-594, 647-649).

9. The Respondent's physical examination of Patient A, as documented by the Respondent, was inadequate (Pet's. Ex. 3; Tr. 40, 113).

10. The Respondent's medical record for Patient A indicated that the patient was taking Lopressor, 100/25. Lopressor is in a family of beta blockers and it is often used in the treatment of hypertension and other forms of heart disease. Lopressor 100/25 refers to Lopressor being given with 25 milligrams of an added diuretic (Pet's. Ex. 3, p.4; Tr. 34, 44).

11. Congestive heart failure is a failure of the heart to pump the blood forward. As a result, there is back pressure with resultant fluid in the lungs, and sometimes elsewhere in the body. If untreated, congestive heart failure can lead to shortness of breath and organ failure (Tr. 51-52).

12. There is much dispute in the record as to whether or not Patient A had congestive heart failure. Congestive heart failure is suggested by the Respondent's documented findings of an enlarged heart, left ventricular hypertrophy, and lungs with bronchial rales. The record however, does not indicate significant symptoms of congestive heart failure (Pet's. Ex. 3, p.5, Ex. 3A, p.1; Tr. 51).

13. The Respondent signed a physician statement of medical necessity, dated 6/1/90, which contained two (2) diagnoses for Patient A. The first diagnosis is congestive heart failure and the second is decubitus ulcer. The Respondent signed the document but did not strike out the erroneous diagnosis of congestive heart failure due to oversight (Pet's. Ex. 3B; Tr. 51-63, 364-365).

14. Chronic dependent leg ulcers are breakdowns of skin in the lower extremities (Tr. 63).

15. There is substantial evidence in the record that Patient A had chronic dependent leg ulcers on her left leg from about October 1989 through March 1990. This condition was noted as early as October 1989, when the Respondent performed an initial examination of Patient A and noted a diagnosis of "peripheral vascular disease with ulcer". It is also indicated by the fact that the Respondent claimed to see a sore on the patient's left foot, which was treated in January 1990 with bacitracin. He also noted that in March 1990 the pain was in the left foot, that the foot was swollen, sore and red; and he prescribed neosporin ointment (Pet's. Ex. 3, p.4; Tr. 63-71).

16. This 79 year old patient with left ventricular hypertrophy, cardiomegaly, rales on examination, and ultimately sores on her left foot, obviously had circulatory problems (Tr. 71-72).

17. There is no evidence in the record as to why this patient had circulatory difficulty, either arterial or venous. Some type of evaluation or description of the blood flow in her legs would be necessary for such a determination (Pet's. Ex. 3; Tr. 72-73, 628-629).

18. There should have been some resolution in the treatment of the ulcers in the first six to eight weeks in terms of proper healing and epithelialization (Tr. 74, 121).

CONCLUSIONS AS TO PATIENT A

1. The Respondent failed to maintain adequate records concerning Patient A.

2. Patient A did not suffer from congestive heart failure and the Respondent's signing of a health care requisition indicating congestive heart failure was an oversight.

3. Patient A did have a leg ulcer and the Respondent's treatment of this condition solely with Bacitracin ointment or neosporin ointment over a period of five months was insufficient.

4. The Respondent failed to do a vascular evaluation of patient A despite the patient's ongoing circulatory problems.

FINDINGS AS TO PATIENT B

19. The Respondent provided medical care to Patient B, a 35 year old male, from November 1979 through 1991 at his office. On or about September 11, 1989, Patient B presented with physical symptoms including heart palpitations every night, and occasionally every day (Pet's. Ex. 4, p. 15-16).

20. "Heart palpitation" is a clinical term that refers to a heart rate that is either irregular or too fast. Palpitations can be very simple and benign in that the heart rate is simply accentuated and fast; they can also be severe and life threatening (Tr. 127).

21. In recording the September 11, 1989 palpitations, the Respondent recorded the patient's weight; made notations that the palpitations occurred every night and occasionally every day; measured the blood pressure; examined the heart sufficient to identify a regular sinus rhythm, and noted that the lungs were clear (Pet's. Ex. 4, p. 15).

22. The record does not indicate how long the patient's palpitations lasted; what type of onset the palpitations had; when they occurred; or under what circumstances they occurred. It would be significant for an evaluation of palpitations if the patient had shortness of breath or pain during the palpitations (Tr. 677-680).

23. Patient B had heart palpitations in 1985, but did not experience any between 1985 and 1989. It could be medically significant that the heart palpitations reoccurred several times a day in September 1989 when the patient did not experience any palpitations for the prior four years (Tr. 675-676).

24. The fact that the patient had a negative Holter Monitoring Test and a negative echocardiogram in 1985 would not eliminate a new cause of the palpitations in September 1989 (Tr. 148).

25. The record does not indicate whether the patient was smoking, drinking alcohol, consuming large amounts of coffee or suffering from high job stress in September 1989 (Tr. 672).

26. Patient B had a stress test in December 1989, which was essentially non-diagnostic (Pet's. Ex. 4, p. 66).

CONCLUSIONS AS TO PATIENT B

The Respondent failed to perform and/or record the performance of adequate diagnostic tests to evaluate Patient B's heart palpitations.

FINDINGS AS TO PATIENT C

27. The Respondent provided medical care to Patient C, a 72 year old male, at his office between May 1987 through 1990. Patient C was treated for an inflamed right knee and chest pain among other things (Pet's. Ex. 5).

28. Patient C had a tender and swollen right knee in August 1987 (Pet's. Ex. 5, p. 9; Pet's. Ex. 5A, p.1)

29. The Respondent diagnosed the patient as having synovitis and arthritis. Synovitis is an inflammation of the synovium, the lining around the knee. Sinovitis and arthritis are both clinical diagnoses made by observation and palpation of the joints (Pet's. Ex. 5A, p.1; Tr. 160-161).

30. The Respondent injected Decadron intra-articularly into the patient's knee, i.e. directly into the joint space. This is the treatment of choice to diminish the swelling and inflammation present in well-diagnosed chronic or acute arthritis (Tr. 157-158).

31. Decadron is a long-acting steroid medication. It is an anti-inflammatory agent meant to take away the inflammation associated with infection or some other cause (Tr. 157-158).

32. There are risks in the intra-articular injection of Decadron in a joint that has not been properly evaluated. The medication could mask further symptoms if the cause of the joint inflammation was infection or crystal-induced arthritis. Further joint destruction can be caused if symptoms of an otherwise undiagnosed arthritis are not revealed. Also, an infected joint can be made worse if Decadron is used, because the steroid impedes the white cell response to the infection. Decadron is contra-indicated for an infected joint (Tr. 158-159, 471, 707-708).

33. The Respondent testified that because of his training and experience he can evaluate the joint fluid by viscosity, i.e., a string test of the joint fluid, and by observing the joint fluid for clarity. However, he failed to record his findings (Tr. 287-288, 451-452).

34. On April 2, 1988, Patient C was noted to have dyspnea (shortness of breath), occasional chest pain and palpitations. However, the Respondent failed to record the patient's pulse and blood pressure (Pet's. Ex. 5, p. 11; Pet's. Ex. 5A, p. 2).

35. Analyzing the causes of occasional chest pain requires that an in-depth history be taken to determine what brings on the chest pain, when it occurs, how severe it is, and what relieves the pain (Tr. 166-167).

36. The Respondent's record for Patient C on April 2, 1988, contains no record of a physical examination having been performed on that date. There is also no documentation that further historical questions were asked (Pet's. Ex. 5, p. 11; Tr. 167-168).

37. The record contains no information about the frequency of the patient's chest pain, the circumstances under which the chest pain occurs, the location of the chest pain, whether the chest pain was related to shortness of breath, under what circumstances the occasional chest pain stopped, the status of the patient's blood pressure and arterial pulses on April 2, 1988. There is also no reference to an examination of the patient's chest, lungs, or abdomen on April 2, 1988 (Tr. 714-717).

38. An Electrocardiogram, performed on April 2, 1988, did not indicate any significant problems. A Holter Monitor Test, performed on May 6, 1988 indicated paroxsymal supraventricular tachycardia (Pet's. Ex. 5, p. 35-37, 41-45).

CONCLUSIONS AS TO PATIENT C

1. The Respondent made an adequate evaluation of patient C's inflamed right knee joint fluid when he injected Decadron into the knee on August 3, 1988, but he failed to record his evaluation.

2. The Respondent's history and physical examination concerning Patient C's chest pain was not adequate. However, an electrocardiagram and Holter monitor test were performed to evaluate these symptoms.

FINDINGS AS TO PATIENT D

39. The Respondent provided medical care to Patient D, a 65 year old female, at his office from August 1977 through 1990 (Pet's. Ex. 6).

40. The Respondent treated this patient for over thirteen years. There is no indication in the record that the Respondent, or any other physician, ever performed or ordered a mammogram, a pelvic examination or a rectal examination, as is recommended for a 65 year old female patient (Pet's. Ex. 6, Ex. 6A; Tr. 189-195, 740-744).

41. On November 18, 1990, Patient D had a tender and swollen right knee. The Respondent injected Kenacort into the right knee via intra-articular injection (Pet's. Ex. 6, p. 5).

42. Kenacort is an adrenal steroid. The treatment employing Kenacort injection intra-articularly has a low risk associated with it. Joint fluid analysis should be performed prior to Kenacort injection (Tr. 198, 505).

43. The risk is that if you inject a joint without proper fluid analysis, you will on occasion encounter a septic joint, or tissue damage in the joint may result from the injection of the steroid if it is done on a repeated basis (Tr. 198-199).

44. If the joint is septic and a steroid is injected into it, the joint could be made worse (Tr. 200, 505).

45. The injection of Kenacort into the knee joint, without fluid evaluation, is in accordance with accepted standards of practice, if the joint fluid, when extracted, was crystal clear; non-turbid; and looking normal to the gross eye (Tr. 202).

46. The Respondent found that Patient D's knee joint fluid was clear, but he failed to record his findings (Tr. 505-506).

CONCLUSIONS AS TO PATIENT D

1. The Respondent failed to perform or record the performance of adequate diagnostic tests, including a mammography, pelvic examination and a rectal examination of Patient D.

2. The Respondent made an adequate evaluation of Patient D's right knee fluid when he injected Kenacort into the knee on November 18, 1980, but he failed to record his evaluation.

FINDINGS AS TO PATIENT E

47. The Respondent provided medical care to Patient E, a 71 year old female, at his office from February 1976 through May 1991 (Pet's. Ex. 7).

48. The records from Patient E fail to document the ordering or performance of a mammography, pelvic examination or rectal examination for this patient. Such testing is medically recommended for female patients of Patient E's age (Pet's. Ex. 7; Tr. 212, 219-221, 521-523, 747-748).

49. It is the responsibility of the physician to either order, perform, or make sure the examinations noted, i.e. pelvic, rectal, and mammography, are performed, either by himself or by some other physician (Tr. 221).

50. Patient E had had a hysterectomy on September 16, 1965, and therefore there was not as great a need for a pelvic examination thereafter (Pet's. Ex. 7, p. 21).

51. Patient E's medical record does not contain any documentation that this patient came into contact with any other physician on a regular basis while being treated by the Respondent during the period February 1976 through May 1991 (Pet's. Ex. 7; Tr. 226).

CONCLUSIONS AS TO PATIENT E

The Respondent failed to perform or record the performance of adequate diagnostic tests, including mammography, pelvic examination and a rectal examination on Patient E.

FINDINGS AS TO PATIENT F

52. The Respondent provided medical care to patient F, a 68 year old female, at his office from August 23, 1980 through August, 1991 (Pet's Ex. 8).

53. When a physician sees a patient for the first time, he should obtain an extensive history of the patient, including past medical history, social history and family history. The significance of such information is to determine a proper evaluation of the patient and a proper treatment plan (Tr. 229-230).

54. The information documented for Patient F in the medical record, (Exhibits 8 and 8A), as an initial history is not in accordance with accepted standards. The blood pressure is the only vital sign recorded. There is a poorly described murmur noted on physical examination . There is no note of a genitalia, rectal or vaginal examination. The Patient's complaint was that she had a rash, which is not described (Tr. 230-231).

55. There is no record that the Respondent ever obtained of a complete history and physical of Patient F at either the Patient's initial visit or at subsequent visits (Pet's Ex. 8).

56. Hypertension is high blood pressure, which has multiple causes. A family history of hypertension is important, as is the history of salt intake and stress. There is an increased incidence of heart disease and stroke associated with untreated hypertension (Tr. 234-235).

57. The Patient had a blood pressure of 160/100 in September 1990, and if persistent this is high (Pet's Ex. 8, p. 12; 8A, p. 3; Tr. 237).

58. A physician evaluates the cause of hypertension first and foremost by an adequate history and physical examination (Tr. 237).

59. Tests that might be performed to evaluate hypertension include electrolyte, urinalysis, blood urea nitrogen, i.e. BUN, creatinine, and EKG (Tr. 237).

60. By failing to perform a urinalysis, a repeat of the BUN, creatinine and electrolytes tests, the care provided by the Respondent for Patient F was below accepted standards of medical practice (Tr. 243).

CONCLUSIONS AS TO PATIENT F

1. The Respondent failed to perform and/or record the performance of an adequate history and physical examination of Patient F on August 23, 1980 or in the Patient's subsequent record through August, 1991.

2. From September 1990 through August 1991, the Respondent failed to perform and/or order adequate diagnostic tests to evaluate Patient F's hypertension.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous unless otherwise indicated)

FIRST SPECIFICATION: (Negligence on more than one occasion)

SUSTAINED as to those charges specified in Paragraphs A1, A3, A4, B1, D1, E1, F1 and F2 of the Statement of Charges.

NOT SUSTAINED as to those charges specified in Paragraphs A2, C1, C2 and D2 of the Statement of Charges.

SECOND SPECIFICATION: (Incompetence on more than one occasion)

NOT SUSTAINED as to any of the charges specified in the Statement of Charges.

THIRD SPECIFICATION: (Failure to maintain records)

SUSTAINED as to those charges specified in Paragraphs A1, B1, C2, D1, E1 and F1 of the Statement of Charges.

(Those charges specified in Paragraphs E2, F3, and G1 of the Statement of Charges were **WITHDRAWN** by the Petitioner.)

DETERMINATION OF THE HEARING COMMITTEE

The Hearing Committee has **SUSTAINED** six charges of failing to maintain records and eight charges of negligence, most of which relate to record keeping. All charges of Incompetence were **NOT SUSTAINED.**

After a review of the entire record in this matter, the Hearing Committee has noted several factors which should also be taken into account in assessing a penalty.

1. The course of the patients reviewed indicates a satisfactory outcome.

2. The Respondent showed a thoughtful concern for his patients, although he was careless in documentation.

3. The Respondent showed a marked improvement in his record keeping after his interview with C. Maynard Guest, M.D., Executive Secretary of the Board for Professional Medical Conduct.

4. The Respondent was cooperative with the Board in its investigation of his medical practice, even to the point of personally copying, in legible fashion, the patient records in issue.

Accordingly, the Hearing Committee has determined that a CENSURE AND REPRIMAND plus a one (1) year period of monitoring as specified hereinafter in the ORDER is the appropriate penalty to be assessed in this case.

ORDER

IT IS HEREBY ORDERED THAT:

1. The Respondent be **CENSURED AND REPRIMANDED.**

2. The Respondent's medical practice be monitored for a period of one (1) year by a board certified internist approved by the Office of Professional Medical Conduct.

3. Every three (3) months, the monitoring physician shall submit a report of a minimum of fifteen (15) of the Respondent's patient records to the Office of Professional Medical Conduct detailing the quality of the Respondent's medical practice including his record keeping.

4. This **ORDER** shall be deemed effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: Pittsford, New York

May 8 **1995**

William W. Faloon M.D.

WILLIAM W. FALOON, M.D.

JOHN H. MORTON, M.D.
JOHN T. VERNIEU

APPENDIX I

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

IN THE MATTER OF MOISES SALAMA, M.D.	NOTICE OF HEARING

TO: MOISES SALAMA, M.D.
Oscawanna Lake Road
Putnam Valley, New York 10579

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1994) and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1994). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 5th day of August, 1994 at 10:00 in the forenoon of that day at Justice Building, 7th Floor, Court of Claims Courtroom #1, Empire State Plaza, Albany, New York 12237 and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You

shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237, (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1994), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, Section 51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. Any answer shall

be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a (McKinney Supp. 1994). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York

July 6, 1994

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel

Inquiries should be directed to: Michael A. Hiser
Assistant Counsel
Division of Legal Affairs
Bureau of Professional
Medical Conduct
Corning Tower Building
Room 2429
Empire State Plaza
Albany, New York 12237

Telephone No.: (518) 473-4282

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

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IN THE MATTER	:	STATEMENT
OF	:	OF
MOISES SALAMA, M.D.	:	CHARGES

----------X

MOISES SALAMA, M.D., the Respondent, was authorized to practice medicine in New York State on September 30, 1965 by the issuance of license number 095562 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994, from Oscawanna Lake Road, Putnam Valley, New York 10579.

FACTUAL ALLEGATIONS

A. Respondent provided medical treatment to Patient A (patients are identified in the attached appendix), a 79 year old female, beginning on or about October 23, 1989, at Respondent's office at Oscawanna Lake Road, Putnam Valley, New York, 10579 (hereafter, "Respondent's office").

1. Respondent failed to perform and/or record the performance of an appropriate initial and/or interval history and physical examinations of Patient A.

2. Respondent maintained Patient A on Lopressor from on or about October 23, 1989 through July, 1990, despite Respondent's diagnosis that Patient A had congestive heart failure.

3. Respondent inappropriately treated Patient A's chronic dependent leg ulcers from on or about October 1989 through March 1990 with Neosporin topical ointments.

4. Respondent failed to do a vascular evaluation of Patient A despite the patient's ongoing circulatory problems.

B. Respondent provided medical care to Patient B, a 35 year old male, from November 1979 through and including 1991 at Respondent's office. On or about September 11, 1989, Patient B presented with physical symptoms including heart palpitations.

1. Respondent failed to perform and/or record the performance of adequate diagnostic tests to evaluate Patient B's heart palpitations.

C. Respondent provided medical care to Patient C, a 72 year old male, at Respondent's office between May, 1987 through and including 1990. Patient C was treated for, among other things, an inflamed right knee and chest pain.

1. Respondent, on or about August 3, 1987, injected Decadron into Patient C's inflamed right knee without adequate evaluation of joint fluid.

2. Respondent, beginning in April 1988, failed to adequately evaluate and/or record the evaluation of Patient C's chest pain by, among other things, implementing specific anti-anginal therapy and/or seeking a cardiology consultation.

D. Respondent provided medical care to Patient D, a 65 year old female, at Respondent's office from August 1977 through and including 1990.

1. Respondent failed to perform and/or record the performance of adequate diagnostic tests, including a mammography, pelvic examination, and/or rectal examination of Patient D.

2. Respondent, on or about November 18, 1980, injected Decadron into Patient D's right knee without adequate evaluation of joint fluid.

E. Respondent provided medical care to Patient E, a 71 year old female, at Respondent's office from on or about February 1976 through and including May 1991.

1. Respondent failed to perform and/or record the performance of adequate diagnostic tests, including mammography, pelvic examination, and/or rectal examination.

2. Respondent, on or about May 13, 1991, injected Decadron into the middle finger of Patient E's left hand without adequate evaluation of joint fluid.

F. Respondent provided medical care to Patient F, a 68 year old female, at Respondent's office from on or about August 23, 1980 through August 1991.

1. Respondent failed to perform and/or record the performance of an adequate history and physical examination of Patient F on August 23, 1980.

2. Respondent, from September 1990 onward, failed to perform and/or order adequate diagnostic tests to evaluate Patient F's hypertension.

3. Respondent, from September 1990 onward, failed to adequately treat Patient F's hypertension.

G. Respondent provided medical treatment to Patient G, a 65 year old female, at the Respondent's office on or about May 29, 1984.

1. Respondent failed to perform and/or record the performance of adequate diagnostic tests, including a mammography, pelvic examination, and/or rectal examination of Patient G.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with negligence on more than one occasion under N.Y. Educ. Law §6530(3) (McKinney Supp. 1994) in that Petitioner charges that Respondent committed two or more of the following:

1. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, B and B.1, C and C.1, C and C.2, D and D.1, D and D.2, E and E.1, E and E.2, F and F.1, F and F.2, F and F.3, and/or G and G.1.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with incompetence on more than one occasion under N.Y. Educ. Law §6530(5) (McKinney Supp. 1994) in that Petitioner charges that Respondent committed two or more of the following:

2. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, B and B.1, C and C.1, C and C.2, D and D.1, D and D.2, E and E.1, E and E.2, F and F.1, F and F.2, F and F.3, and/or G and G.1.

THIRD SPECIFICATION

FAILING TO MAINTAIN RECORDS

Respondent is charged with failing to maintain a record for Patients A through H which accurately reflect the evaluation and treatment of the patients, within the meaning of N.Y. Educ. Law §6530(32) (McKinney Supp. 1994), in that Petitioner charges:

3. The facts in Paragraphs A and A.1, B and B.1, C and C.2, D and D.1, E and E.1, F and F.1, and/or G and G.1.

DATED: Albany, New York
July 6, 1994

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional Medical
Conduct