STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Lorna McBarnette
Executive Deputy Commissioner

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JUL 15 1992
OFFICE OF PROFESSIONAL
MEDICAL CONDUCT

July 13, 1992

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ralph Bavaro, Esq.
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001-1810

Joseph Saltiel, M.D.
462 East 135th Street
Bronx, New York 10451

Martin Gallin, Esq.
Gallin & Newman
860 Grand Concourse
Bronx, New York 10451

RE: In the Matter of Joseph Saltiel, M.D.

Dear Mr. Bavaro, Mr. Gallin and Dr. Saltiel:

Enclosed please find the Determination and Order (No. BPMC 92-57) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

Office of Professional Medical Conduct
New York State Department of Health
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 than 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), "(t)he 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
Corning Tower - Room 2503
Empire State Plaza
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.

Very truly yours,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

--X	
IN THE MATTER :	**DETERMINATION**
OF :	**AND**
JOSEPH SALTIEL, M.D. :	**ORDER**

--X

Order No. BPMC 92-57

The undersigned Hearing Committee consisting of **Thea Graves Pellman, Chairperson, Steven M. Lapidus, M.D.,** and **Phillip N. Fyman, M.D.** was duly designated and appointed by the State Board for Professional Medical Conduct. **Jonathan M. Brandes, Administrative Law Judge,** served as Administrative Officer.

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

The Committee has considered the entire record in the above captioned matter and hereby renders its decision with regard to the charges of medical misconduct.

RECORD OF PROCEEDINGS

Original Notice of Hearing and Statement of Charges dated:	March 3, 1992
Notice of Hearing returnable:	May 11, 1992
Place of Hearing:	5 Penn Plaza New York, NY
Respondent's answer served:	May 11, 1992
The State Board for Professional Medical Conduct appeared by:	Ralph J. Bavaro, Esq. Associate Counsel Bureau of Professional Medical Conduct 5 Penn Plaza New York, NY
Respondent appeared in person and was represented by:	Martin Gallin, Esq. Gallin & Newman 860 Grand Concourse Bronx, New York
Hearings held on:	May 11, 1992
Conferences held on:	May 11, 1992
Closing briefs received:	June 1, 1992
Record closed:	June 1, 1992
Deliberations held:	June 17, 1992

SUMMARY OF PROCEEDINGS

The Statement of Charges alleges Respondent has practiced his profession with negligence on more than one occasion, and kept inadequate patient records. The allegations arise from Respondent's records of some two hundred twenty-five patients in 1990 and 1991. The

allegations are more particularly set forth in the Statement of Charges which is attached hereto as Appendix I.

Respondent denied each of the charges.

The State called these witnesses:

Frank McKeon	Fact Witness
Marie Denise Labbe, R.N.	Fact Witness
George G. Reader, M.D.	Expert Witness

Respondent testified in his own behalf and called no other witnesses.

SIGNIFICANT LEGAL RULINGS

The Administrative Law Judge issued instructions to the Committee with regard to the definitions of medical misconduct as alleged in this proceeding. The Administrative Law Judge instructed the panel that negligence is the failure to use that level of care and diligence expected of a prudent physician and thus consistent with acceptable standards of medical practice in this State.

Inadequate record keeping was defined as a failure to keep records which accurately reflect the evaluation and treatment of a patient. The standard applied would be whether a substitute or future physician or reviewing entity could review a given chart and be able to understand Respondent's course of treatment and basis for same.

The following findings of fact were made after review of the entire record. Numbers in parentheses (T.) refer to transcript pages or numbers of exhibits (Ex.) in evidence. These citations represent evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Evidence or testimony which conflicted with any finding of this Hearing Committee was considered and rejected. Some evidence and testimony was rejected as irrelevant. The Petitioner was required to meet the burden of proof by a preponderance of the evidence. All findings of fact made by the Hearing Committee were established by at least a preponderance of the evidence. All findings and conclusions herein were unanimous unless specifically stated to the contrary.

FINDINGS OF FACT

1. Respondent was authorized to practice medicine in New York State by the issuance of license number 071643 on December 6, 1954 and is currently licensed to practice medicine with the New York State Department of Education.

2. Respondent has maintained an office for the practice of medicine and has treated patients continuously at 462 East 138th Street, Bronx, New York from approximately 1954 to the present. (T. 14, 51, 114-115).

3. Respondent's office consists of a waiting room, an examining room/office and a backroom/examining room. (T: 16-17; 54-56; Ex.3, p 1).

4. In January 1991, the condition of the office was as follows: the lighting was dim; there was dust on the furnishings; there were cobwebs in the corners; electrical wiring were exposed; ceiling tiles were missing; there were many old magazines lying about; there were two used needles and syringes, one on the floor and one in an open drawer; there was no running hot water in the sink; the toilet was filthy and non-functioning; the wooden floor was rotten in some spots; there were no containers for the disposal of medical waste. (T: 17-19; 32-33).

5. Respondent was contacted by the Department of Health regarding the unsanitary condition of his office and given an opportunity to clean up the office. In June 1991, the condition of the office had improved somewhat. The office was neater, the lighting was better and the needles and syringes had been removed. (T: 25, 27-28).

6. By March 1992, the condition of Respondent's office had once again deteriorated. The condition of the office was as follows: the lighting was very dim; one examining table was covered with magazines, books, clothes, etc.; there was exposed electrical wiring; there was an old tire in a backroom; there was an old refrigerator filled with miscellaneous items including bread, books and Respondents' stethoscope and other medical instruments; the sink was filthy with no running water; the toilet was filthy and non-functioning; the radiator was uncovered; the floor was

10. Exhibit 2 is in the form of a chronological log with no organization or means to locate a particular patient entry.

CONCLUSIONS

This case rests upon two factual allegations. The first alleges substandard records. The second allegation is that Respondent's office was unsanitary and unsafe. The Committee unanimously sustains both factual allegations. Clearly, Exhibit 2 and Exhibit C which purport to be Respondent's records for the period in question are utterly inadequate in that they barely identify the patients and provide virtually no medical data. While Respondent states he examines his patients, his records show no evidence of any examination or other data. There is often no diagnosis. There is no way to know what if any treatment was rendered or why. In sum, the records offered by both the State and Respondent lack histories, physical examinations, diagnoses and treatments as charged. The factual allegations in paragraph A are therefore **SUSTAINED**.

Turning now to paragraph B, Respondent is charged with maintaining an unsafe and unsanitary office. Respondent admitted his plumbing was nonfunctional. The State established and, indeed, Respondent did not deny that there existed other conditions, including exposed electrical wiring and used needles and syringes not in appropriate containers during at least one visit to Respondent's office.

Respondent noted mitigating factors in the condition of his office which were considered by the Committee and are addressed later. Based upon the above, the allegations in paragraph B are also **SUSTAINED.**

Having sustained the factual allegations the Committee now turns its attention to the specifications. In the first specification Respondent is charged with negligence on more than one occasion in that Respondent saw patients without establishing a record showing patient history, physical examination, diagnosis and treatment. Respondent is also charged with negligence on more than one occasion by seeing patients in an office which was unsanitary and unsafe.

Utilizing the definitions previously described, the Committee finds that Respondent committed negligence on more than one occasion by providing medical care to over 200 patients without establishing even marginally acceptable records. The Committee finds that regardless of the quality of the care provided, which is not at issue herein, it was a violation of basic standards of care and diligence to treat patients and keep the kind of submarginal records seen here. Therefore, Respondent violated accepted standards of care and diligence and hence acted negligently.

Likewise the Committee finds when Respondent saw numerous patients within the conditions described, he again violated accepted standards of care and diligence expected of a prudent physician in this state and hence committed

negligence on more than one occasion. The Committee finds that a prudent physician exhibiting an acceptable level of care and diligence would not provide medical care in surroundings which are dirty and unsafe to the degree established in this proceeding.

Accordingly, specification one is **SUSTAINED** based upon the allegations in paragraphs A and B.

Specification two alleges Respondent failed to maintain medical records as prescribed by section 6530(32) of the Education law. The standard established by that provision is that each patient must have a record which accurately reflects the care and treatment rendered. As stated previously, the records submitted in evidence by both the State and Respondent fail in any meaningful way to record either the care rendered by Respondent or the basis for same. Accordingly, specification two is **SUSTAINED**.

CONCLUSIONS WITH REGARD TO PENALTY AND ORDER

The Committee has sustained each of the facts and specifications charged. In reaching a penalty the Committee must weigh both the charges sustained, which are serious, as well as what the Committee considers to be significant mitigation. On the one hand Respondent's records are abysmal. His office lacked basic plumbing and was filthy. Yet this is a physician who has voluntarily limited his

practice at the end of 35 years of providing care to an impoverished inner city neighborhood. Respondent even provided house calls (and was seriously assaulted) until fairly recently. It is also to be noted that Respondent had difficulty with his landlord who compromised his ability to keep his office in repair. Furthermore, the Committee finds it significant that Respondent fled Nazi tyranny in World War II to serve as a physician to guerrilla fighters. Given the magnitude of the charges sustained balanced against an otherwise blemish-free career and substantial mitigation the Committee hereby finds and orders:

The license of Respondent to practice medicine in the State of New York **be SUSPENDED** for a period of one year and that said suspension shall be **STAYED IN FULL** in lieu of **PROBATION** for a period of not less than three years. The said probation shall include the following terms:

Respondent shall, for a period of three years from the effective date of this Order:

1. Be reviewed in his professional performance by submitting office records, patient records and hospital charts as randomly selected by the Director of the Board for Professional Medical Conduct and shall;

2. Make periodic visits to a member of the State Board for Professional Medical Conduct or an employee of the Office of Professional Medical Conduct as selected by the Director of the Board for Professional Medical Conduct and

at intervals set by said Director and shall;

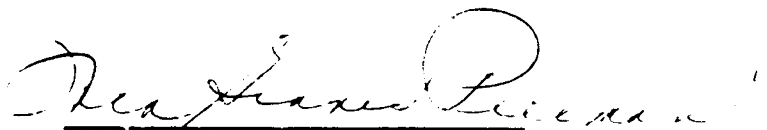
3. Obtain an appropriate monitor of his practice as approved by, and upon terms and conditions set forth by the Director of the Board for Professional Medical Conduct and shall;

Comply with the malpractice insurance provisions set forth in section 230(18)(b) of the Public Health Law and shall;

Be subject to the provisions of section 230(19) of the Public Health Law.

This Order shall be effective 30 days after service upon Respondent or his attorney by personal service, registered or certified mail.

DATED: New York, New York
July 6, 1992



THEA GRAVES PELLMAN
Chairperson

STEVEN M. LAPIDUS, M.D.
PHILLIP N. FYMAN, M.D.

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

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IN THE MATTER OF JOSEPH SALTIEL, M.D.	: STATEMENT : OF : CHARGES

---X

JOSEPH SALTIEL, M.D., the Respondent, was authorized to practice medicine in New York State on December 6, 1954 by the issuance of license number 076143 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991 through December 31, 1992 at 462 East 135th Street, Bronx, New York 10451.

FACTUAL ALLEGATIONS

A. Between November 1990 and June 1991, more than 200 patients sought medical care from Respondent at Respondent's office located at 462 East 138th Street, Bronx, New York (all patients are identified in Appendix A). Respondent, in his evaluation of each patient throughout that period, failed to perform and note one or more of the following: history, physical examination, diagnosis and treatment.

B. Between on or about December 1990 and January 1991 Respondent maintained his office in an unsanitary and unsafe condition in that, among other things, the office was unkempt, and contained exposed electrical wiring, used needles and syringes strewn about, and nonfunctional plumbing.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law, Section 6530(3), (McKinney Supp. 1992), in that Petitioner charges:

1. The facts contained in Paragraph A as they pertain to each of Patients 1 through 225 and/or Paragraph B.

SECOND SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with professional misconduct under N.Y. Educ. Law, Section 6530(32), (McKinney Supp. 1992) in that he failed to maintain a record for each patient which

accurately reflected the evaluation and treatment of the patients. Petitioner charges:

2. The facts contained in Paragraph A, as they pertain to each of Patients 1 through 225.

DATED: New York, New York
March 31, 1992

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical Conduct