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

June 7, 2001

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Dianne Abeloff, Esq.
NYS Department of Health
5 Penn Plaza – 6th Floor
New York, New York 10001

Nathan L. Dembin, Esq.
225 Broadway
Suite 1400
New York, New York 10007

Abraham Solomon, M.D.

Abraham Solomon, M.D.
29-27 41st Street
Suite 509
Long Island City, New York 11103

RE: In the Matter of Abraham Solomon, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 01-140) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

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

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

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

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

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

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

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

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah
Enclosure

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

COPY

IN THE MATTER : HEARING COMMITTEE

OF : DETERMINATION

ABRAHAM SOLOMON : AND ORDER

----------X BPMC #01-140

BENJAMIN WAINFELD, M.D., CHAIRPERSON, ERWIN LEAR, M.D. AND PEGGY MURRAIN, ED.D., duly designated members of the State Board of 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) and 230 (12) of the Public Health Law. **STEPHEN BERMAS, ESQ.,** Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

Dr. Wainfeld was not present at a portion of the hearing session conducted on February 12, 2001. Dr. Wainfeld duly affirmed that he had read and considered the transcript of proceedings and the evidence received at such hearing session prior to the deliberations in this matter on May 14, 2001. See Appendix A.

After consideration of the entire record, the Hearing Committee submits this Determination and Order.

SUMMARY OF THE PROCEEDINGS

Notice of Hearing dated:	November 29, 2000
Amended Statement of Charges dated:	February 1, 2001
Hearing Dates:	December 7, 2000; February 12, 14, 22, 26; March 9, 19; April 5, 16, 2001
Deliberation Date:	May 14, 2001
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York

Petitioner Appeared By: Dianne Abeloff, Esq.
Associate Counsel
Bureau of Professional Medical Conduct
NYS Department of Health

Respondent Appeared By: Nathan L. Dembin, Esq.

STATEMENT OF CHARGES

The amended Statement of Charges has been marked as Petitioner's Exhibit 1-A and attached hereto as Appendix B.

FINDINGS OF FACT

Numbers in parentheses refer to transcript page numbers 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 cited evidence. All findings are unanimous.

PATIENT A

1. Patient A was a 62 year old male who presented to the emergency room of Maimonides Hospital on April 8, 1999 at approximately 8:05 p.m., complaining of some chest pain and trouble breathing. Recorded in the triage note was back pain and some abdominal pain. His vital signs were significant for an elevated pulse. He was tachycardic, with a heart rate of 116. He had an abnormally low blood pressure and a low oxygen saturation of 70. The patient was in a state of shock. (Pet. Exh. 3; T. 46, 48, 62).

2. Respondent took a history of Patient A, but it was not adequate. Respondent failed to fully address the chief complaint of abdominal pain. He failed to inquire whether the patient was nauseated, had vomited, had diarrhea, had constipation or had a fever. He did not investigate the location of the abdominal pain. (T. 56).

3. Respondent believed that Patient A was experiencing cardiogenic shock, although the clinical and laboratory findings indicated that he was not, and the physicians from CCU told Respondent that the problem was not cardiac because the EKG and cardiac enzymes were normal. (T. 701, 703, 735; Pet. Exh.

3).

4. Respondent's physical examination of Patient A was inadequate. Respondent failed to perform a rectal examination to determine whether or not there was blood in the stool. Patient A had chest pain; however, Respondent's only note was that the heart had a regular rate and rhythm. The neurological examination was also inadequate. Respondent noted that Patient A's mentation was low secondary to hypotension; however, there were no other focal aspects to the examination, i.e., any motor deficits or muscle weakness, sensory problems or anything else. (T. 65-67, 280).

5. Respondent never adequately assessed the cause of Patient A's hypotension. He treated the hypotension with Dopamine and normal saline IV fluid. This action helps with the low blood pressure; however, Respondent never determined the cause of the low blood pressure. (T. 70, 71).

6. The paramedics, the triage nurse who saw the patient two minutes before Respondent and the MICU physician who examined the patient several hours after Respondent when the patient's blood pressure was considerably lower than when he was examined by Respondent, were all able to obtain full histories from Patient A. (Pet. Exh. 3, T. 244, 591, 592).

7. Dr. Alaveris Molina, a fellow in the MICU at Maimonides Hospital on April 8, 1999, was the first physician from MICU to examine Patient A at or about 11:30 p.m.

8. The 8:44 p.m. time with the handwritten MICU in the stamped part of Page 3 of Pet. Exh. 3 was written by Respondent. Patient A had not been accepted by MICU at that time because he had not yet been evaluated by an MICU fellow. (T. 1420-1425)

9. A patient could not be admitted to MICU without a examination by an MICU fellow. (T. 602, 1415, 1419, 1420).

10. Respondent was responsible for the care and treatment of Patient A until 12:30 a.m. when the next emergency department physician accepted the case from Respondent. (Pet. Ex. 3, page 6; T. 1426, 1427).

PATIENT B

11. Patient B, an 80 year old woman, came by ambulance to the emergency room of Marmonides Hospital on April 2, 1999. Patient B had a history of abdominal pain and vomiting three times. She had a blood pressure of 106/63, and a heart rate of 111. (Pet. Exh. 4; T. 82).

12. Respondent's documented history of Patient B failed to meet accepted medical standards. Respondent did not address the timing of the abdominal pain, palliative and provocative factors, description of the vomitus or if it was blood, food or bile. He also failed to ask about fever, chills, alcohol use, previous history of other conditions that could cause her problem, such as pancreatitis, cholecystitis. (T. 82, 83).

13. Patient B was accompanied by family who could have provided some of the information if the patient was too short of breath to speak. (Pet. Exh. 4).

14. Respondent's physical exam of Patient B failed to meet accepted medical standards. He did not perform a rectal examination, which is considered a basic component of a physical examination on an elderly person with abdominal pain and vomiting because it can tell the physician whether the problem is ischemic bowel versus other etiologies. (T. 85, 1621, 1622).

15. Exhibit 5B shows outlines of the outer wall of the intestine which is highly suggestive of air within the cavity of the abdomen. (Pet. Exh. 5B; T. 90, 336, 337, 339, 341).

16. Physicians who work in the emergency room are expected to recognize free air within the abdomen on reading a plain x-ray. (T. 90, 92, 93).

17. Free air in the abdomen is an emergency condition, which requires a prompt surgical consult with the expectation that the patient is going to the operating room. The suspicion alone is enough to trigger a surgical consultation. (T. 91, 1524).

18. Respondent failed to obtain a stat surgical consult for Patient B. This failure deviates from accepted medical standards. (T. 97).

19. Patient B was an 80 year old woman with a resting heart rate of 111. A physician should monitor that patient with a cardiac monitor and find the cause for the underlying rapid heart beat. (T. 97).

20. Respondent failed to order and ensure that a cardiac monitor was positioned on Patient B while she was in the emergency room. (Pet. Exh. 4; T. 98, 99, 846).

PATIENT C

21. Patient C, a 27 year old male, arrived at Maimonides Hospital on March 10, 1999 at about 1:50 a.m. with a complaint of palpitations starting 40 minutes prior to arrival. His pulse was around 176. Patient C had already been treated with Adenosine in the ambulance on the way to the hospital. (T. 104, 107; Pet. Exh. 6).

22. Even though Patient C arrived at the hospital in obvious need of emergency care, acceptable medical standards required that an adequate history be documented, which Respondent failed to do. Respondent failed to elicit information about precipitating factors prior to the onset of the arrhythmia, whether or not there was history of illicit drug use, as well as a history of previous work-up or previous diagnosis of his type of arrhythmia. (T. 108; Pet. Exh. 6).

23. Nothing in Patient C's record indicated that he was physically incapable of communicating during the time Respondent obtained the history. (T. 108, Pet. Exh. 6).

24. Respondent placed Patient C on a cardiac monitor, a strip of which was attached to Petitioner's Exhibit 6 on page 3. This strip demonstrates that the heart was beating faster than it normally should. The strip also shows that the heart was beating at an irregular rate. (Pet. Exh. 6, 23; T. 109, 110, 370, 1415).

25. Respondent treated Patient C as if he had only a supraventricular tachycardia. However, the important aspect of this patient's rhythm was the atrial fibrillation with WPW or Wolff-Parkinson White Syndrome. Channel blockers were contraindicated. (T. 370-373).

26. Even though Patient C at some previous time had been prescribed Cardiazem, Respondent failed to ascertain the reason it had been prescribed. (T. 116, 117, 1413).

27. A cardiologist evaluated Patient C at or about 2:47 a.m. Pronestyl was administered at 3:05 a.m., after Respondent administered Cardiazem and Verapamil and cardioverted Patient C.

PATIENT D

28. Patient D, an 86 year old woman, was brought to the Maimonides Hospital emergency room on March 10, 1999 at or about 1:10 a.m., with shortness of breath. She arrived approximately 40 minutes prior to the arrival of Patient C to the Maimonides emergency room. (Pet. Exhs. 7, 8).

29. Respondent failed to document an adequate history, which would help him know what direction to go with the rest of his work-up. (T. 122, 123, 401-405).

30. Respondent's physical examination documentation, particularly with respect to the description of the neck examination, failed to meet accepted medical standards. Respondent failed to address whether there was jugular venous distention or other signs of congestive heart failure. (T. 124).

31. Respondent determined that Patient D suffered from pulmonary edema, CHF, and renal failure. (T. 125, Pet. Exh. 7).

32. He treated Patient D with Proventil as a nebulizer and an inhaled mist. This was the wrong treatment for pulmonary edema and contraindicated in a setting of cardiac ischemia since it increases the work load of the heart by increasing the heart rate. (T. 125, 128, 129, 379, 383, 384).

33. Respondent failed to treat Patient D appropriately with IV nitroglycerin, Lasix and morphine. (T. 130, 1459).

PATIENT E

34. Patient E, a 83 year old male, was brought to Maimonides Hospital on March 1, 1999. He was brought in by ambulance, having been found by home attendant on the floor disoriented, incontinent of urine, with redness to the right side of the face and a black and blue ecchymosis to the right eye. The patient presented with altered mental status, a fall, and evidence of head trauma. (Pet. Exh. 8).

35. Respondent failed to document an adequate history. Respondent did not address headache, visual changes, other neurologic complaints, chest pain, palpitations or other possible causes of this event. (T. 131-133).

36. Respondent noted that the patient was demented. Nothing in the record indicates whether or not the patient was able to describe what happened. If he was not able to relay that kind of information, Respondent should have included that information in the chart. Respondent also noted that "the patient is cooperative, slight decrease in mentation". The patient's son was present in the hospital and translated for his father. Nevertheless, Respondent failed to address with the son the critical issue of whether there was any change in the father's dementia or level of thinking. (Pet. Exh. 8; T. 135, 420, 422, 424, 425).

37. Respondent failed to perform an adequate physical examination, especially to perform a more complete neurologic examination. (T. 136, 144, 167).

PATIENT F

38. Patient F, a 37 year old woman, came to the emergency room at Maimonides Hospital on March 4, 1999, with complaints of lower abdominal and right flank pain with urinary frequency. (Pet. Exh. 9).

39. Respondent's documented history of Patient F was inadequate. He failed to address the onset or timing of the pain, palliative or provocative measures, whether the pain radiated and the gynecological history. (T. 145).

40. Respondent failed to perform an adequate physical examination. The patient presented with abdominal pain and flank pain according to the nurse's notes. Respondent did not perform either an abdominal examination or a gynecological examination. (T. 146, 147)

41. A urinalysis is the clinical standard by which the diagnosis of a urinary tract infection can be made. (Pet. Exh. 9).

42. Respondent failed to order a urine analysis. If this showed blood, and white cells, Respondent would have had to pursue a work up of possible kidney stone, which he failed to do. (T. 152-155, 477, 490, 491).

PATIENT G

43. Patient G, a 72 year old woman, came to the emergency room at Nathan Littauer Hospital at or about 2:55 a.m. on September 26, 1997, with complaints of right arm pain for one day progressively worsening but without a history of injury. (Pet. Exh. 10).

44. Respondent did not elicit an adequate history. Respondent noted the presence of right shoulder bursitis with episode of focal right shoulder pain. He failed to inquire how long the pain had been there, whether the pain radiated or whether it was associated with shortness of breath. (T. 156, 157).

45. Respondent did not document a physical examination. (T. 157, 158, 502, 507, 508, 509).

46. Respondent failed to appropriately assess Patient G. Right shoulder pain could represent a number of different conditions, such as bursitis or cardio pulmonary disease. (T. 158, 159; Pet. Exh. 10).

47. Respondent did not document that he ever considered Patient G's cardiac history when he evaluated Patient G. Given the medications she was on, Respondent should have performed an EKG. (T. 160, 161).

PATIENT H

48. Patient H, a 44 year old woman, arrived at the Nathan Littauer Hospital emergency room at or about 3:15 p.m., on or about September 26, 1997, with complaints of diffuse abdominal pain and discomfort and feeling bloated. (Pet., Exh. 11).

49. Respondent's documented history of Patient H was inadequate. The history failed to address the timing or onset of the patient's pain, or any palliative or provocative aspects of the pain. No inquiry was made as to associated symptoms such as nausea, vomiting, fevers or urinary symptoms. (T. 163).

50. Respondent failed to perform an adequate physical examination. All of Patient H's symptoms were focused on the gastrointestinal tract, but Respondent never performed a complete GI examination. Respondent also failed to perform or request a pelvic examination on a 44 year old woman with complaints of abdominal pain. (T. 163-165, 1729).

51. Respondent did not appropriately assess Patient H's condition and simply determined that the patient suffered from constipation. He did not adequately evaluate and consider other possibilities, partly because he failed to order the correct tests. (T. 166, 167, 532, 534, 535, 556).

52. Respondent inappropriately prescribed magnesium citrate without fully ruling out the possibility of small bowel obstruction. (T. 169) Although this patient was able to pass loose stool, this does not exclude a diagnosis of partial bowel obstruction. (T. 550, 554; Pet. Exh. 11).

53. A subsequent treating emergency department doctor ordered a flat and upright film of Patient H's abdomen and pursued a working diagnosis of small bowel obstruction. (Pet. Exh. 11; T. 168, 533) The subsequent treating physician inserted a nasogastric tube at or about 10:20 a.m. This tube seems to have decompressed the obstruction with resolution of the abnormal findings or air fluid levels on x-ray. (T. 551-552).

PATIENT I

54. Patient I, a 72 year old woman, presented at 11:55 a.m. on or about September 24, 1997, at Nathan Littauer Hospital, with complaint of right lower quadrant pain for approximately 24 hours. (Pet. Exh. 12).

55. Respondent's documented history of Patient I was not adequate. Respondent did not ascertain any information about the nature of Patient I's abdominal pain, i.e., when did the pain begin, was it constant, intermittent, worsening, improving; what made that pain worse; did the pain radiate; were there associated symptoms of nausea, vomiting or fever. (T. 171).

56. Respondent's physical examination was not adequate. Respondent failed to document the performance of or request for a gynecological examination. He also failed to document an examination of the heart, lungs or anything besides a rudimentary examination of the abdomen. (T. 172, 173, 175).

57. Respondent did not appropriately assess this patient. He failed to determine the cause of the abdominal pain. One cause of abdominal pain could be ischemic bowel. Respondent made a functional diagnosis of constipation without ever considering what caused this condition and without excluding life threatening conditions. (T. 174-176, 1729)

58. Magnesium citrate was the wrong treatment for this patient. Magnesium citrate is quite dangerous for patients with possible or suspected intestinal obstruction. (T. 175, 177-179).

PATIENT J

59. Patient J arrived by ambulance at Columbia Memorial Hospital at or about 10:30 p.m. on or about March 15, 1999, with complaints of intermittent chest pain. While in the ambulance, EMS gave him IV and oxygen and placed him on a cardiac monitor which showed a sinus rhythm with inverted T-waves in lead 3 and AVF, indicating cardiac ischemia. (Pet. Exh. 14).

60. The EKG in the ambulance demonstrated ischemia. These findings were not present on the EKG taken in the emergency room, which is highly suggestive of active, unstable angina. (Pet. Exh. 14; T. 202, 203).

61. Respondent's documented history of Patient J was not adequate. Respondent failed to describe the nature of the pain. He failed to inquire about associated symptoms, such as, nausea, shortness of breath and diaphoresis in connection with chest pain. (T. 205-208).

62. Respondent placed Patient J on a 12 lead EKG. The print-out shows ST segment depressions in V-3, V-4, V-5 and V-6. ST segment depressions can be caused by ischemia. (Pet. Exh. 14; T. 210).

63. Respondent did not appropriately diagnose the patient's ischemia, which was clear from the ST depressions in V-3, V-4, V-5 and V-6. Respondent diagnosed anxiety and atypical chest pains. An emergency room physician should be able to interpret this EKG. (T. 210-214, 568).

64. Discharging this patient with ST segment depressions of 1 millimeter or more in the anterolateral leads, places this patient into the high risk group of unstable angina patients. He should have been admitted, and treated appropriately. (T. 215).

65. Patient J's "anxiety" could have been the sense of impending doom that individuals experience who are about to have a myocardial infarction. (T. 1129-32).

66. It was incumbent upon Respondent to read nurses' notes and the ambulance call reports. Respondent never tried to get records from the ambulance or any other previous history from the nurse. (T. 1121, 1136, 1476, 1481, 1485, 1486).

CREDENTIALING

67. Respondent completed a credential application form for privileges at Nathan Littauer Hospital. He was credentialed at that hospital. He worked there for a few shifts when concerns arose about his care and treatment of various patients at that hospital. His employment with Nathan Littauer terminated in or about October 1997. We find Respondent's explanation of the conditions under which he stopped working at Nathan Littauer Hospital not credible. (Pet. Exh. 17; T. 1195, 1202, 1205).

68. Respondent never received any credit for the time he spent in the emergency medicine residency at Beth Israel Hospital. Respondent acknowledges that he was not given credit for that residency. (Pet. Exhs. 2, 16; T. 1160),

69. Respondent, on his 1998 appointment application to Southside Hospital, did not accurately answer the question: "Have any of the following ever been, or are any currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished?...membership on any hospital medical staff...clinical privileges...other institutional affiliation or status thereat?" (Pet. Exh. 18).

70. Respondent, in his 1998 appointment application to the University Hospital of Brooklyn, did not accurately answer the question: "[H]ave your privileges at any hospital ever been suspended, diminished, revoked or not renewed, or has disciplinary or corrective action ever been instituted?". Respondent knowingly and with intent to deceive failed to disclose the termination of his privileges at Nathan Littauer Hospital on or about October 1, 1997, and the termination without credit from his residency in emergency medicine, at Beth Israel Hospital, on or about December 22, 1994. (Pet. Exh. 19).

71. Respondent, in his 1999 appointment application to Maimonides Medical Center, did not accurately answer the question: "[H]ave your privileges, association, employment, practice or training in any hospital or facility in NYS or elsewhere ever been denied, suspended, diminished, restricted, revoked, terminated, not renewed or otherwise discontinued (including voluntary resignation)?". Respondent

knowingly and with intent to deceive failed to disclose the termination of his privileges at Nathan Littauer Hospital on or about October 1, 1997. (Pet. Exh. 20).

72. On the same 1999 appointment application to Maimonides Medical Center, in response to the directive to list all hospitals at which applicant was affiliated for the past ten years, Respondent did not list his 1997 affiliation with Nathan Littauer Hospital. (Pet. Exh. 20).

DISCUSSION

The Hearing Committee found the Respondent not to be a credible witness because of his evasive, indefinite answers to very specific questions, as well as his general demeanor while testifying. Despite repeated attempts by Petitioner's counsel, members of the Hearing Committee and even, on occasion, Respondent's own counsel, Respondent would not or could not give direct responses to direct questions.

It is the conclusion of the Hearing Committee that although the Respondent is a competent physician, his care and treatment of the patients involved in the proceeding were superficial at best. He responded superficially to the patient's signs and symptoms without any analysis or thought as to the causes of their complaints. This resulted in incorrect diagnosis and improper treatments.

The Committee found Drs. Valladares, Brown and Gouge to be somewhat defensive in their testimony and trying to avoid the weaknesses in Respondent's treatment of his patients. They seemed too ready to excuse any errors made by Respondent, without specifying reasons for such excuses.

The Committee found Drs. Brogan, Molina and Murphy to be fully credible witnesses.

CONCLUSIONS OF LAW

FIRST: Respondent is found to have engaged in professional misconduct by reason of practicing the profession of medicine with gross negligence within the meaning of NY Education Law Section 6530 (4) (McKinney Supp. 2000) as charged in the First, Second, Seventh and Tenth Specifications of Charges, and as set forth in Findings of Fact 1 through 20, 43 through 47 and 59 through 66, supra.

SECOND: Respondent is found not to have engaged in professional misconduct by reason of practicing the profession of medicine with gross negligence within the meaning of NY Education Law Section 6530 (4) (McKinney Supp. 2000) as charged in the Third, Fourth, Fifth, Sixth, Eighth and Ninth Specifications of Charges, and as set forth in Findings of Fact 21 through 42, 48 through 58, supra.

THIRD: Respondent is found to have engaged in professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion within the meaning of NY Education Law Section 6530 (3) (McKinney Supp. 2000) as charged in the Eleventh Specification of Charges, and as set forth in Findings of Fact 1 through 66, supra.

FOURTH: Respondent is found not to have engaged in professional misconduct by reason of practicing the profession of medicine with gross incompetence within the meaning of NY Education Law Section 6530 (6) (McKinney Supp. 2000) as charged in the Twelfth Specification of Charges, and as set forth in Findings of Fact 1 through 66, supra.

FIFTH: Respondent is found not to have engaged in professional misconduct by reason of practicing the profession of medicine with incompetence on more than one occasion within the meaning of NY Education Law Section 6530 (5) (McKinney Supp. 2000) as charged in the Thirteenth Specification of Charges, and as set forth in Findings of Fact 1 through 66, supra.

SIXTH: Respondent is found not to have engaged in professional misconduct by reason of practicing the profession of medicine fraudulently within the meaning of NY Education Law Section 6530 (2) (McKinney Supp. 2000) as charged in the Fourteenth Specification of Charges.

SEVENTH: Respondent is found to have engaged in professional misconduct by reason of practicing the profession of medicine fraudulently within the meaning of NY Education Law Section 6530 (2) (McKinney Supp. 2000) as charged in the Fifteenth, Sixteenth, Seventeenth and Eighteenth Specifications of Charges, and as set forth in Findings of Fact 67 through 71, supra.

EIGHTH: Respondent is found to have engaged in professional misconduct by reason of violating Section 2805 of the NY Public Health Law as charged in the Nineteenth, Twentieth, Twenty-First and Twenty-Second Specifications of Charges, and as set forth in Findings of Fact 69 through 72, supra.

ORDER

The Hearing Committee determines and orders that Respondent's license to practice medicine in New York State be revoked.

Dated: New York, N.Y.
June , 2001

Benjamin Wainfeld, M.D.
Chairperson

Erwin Lear, M.D.
Peggy Murain, Ed.D.

APPENDIX A

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER	:	AFFIRMATION
OF	:	OF MEMBER OF THE
ABRAHAM SOLOMON, M.D.	:	HEARING COMMITTEE

Benjamin Wainfeld, M.D., a duly designated member of the State Board for Professional Medical Conduct and of the Hearing Committee thereof designated to hear the MATTER OF ABRAHAM SOLOMON, M.D., hereby affirms that he was not present at a portion of the hearing session conducted on February 12, 2001. He further affirms that he has read and considered the transcript of proceedings of, and the evidence received at such hearing day prior to deliberations of the Hearing Committee on the 14th day of May, 2001.

DATED: 6/1/01 New York, New York

Benjamin Wainfeld, M.D.

APPENDIX B

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

IN THE MATTER

OF

ABRAHAM SOLOMON, M.D.

AMENDED STATEMENT OF CHARGES

ABRAHAM SOLOMON, M.D., the Respondent, was authorized to practice medicine in New York State on or about January 10, 1997, by the issuance of license number 205496 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about April 8, 1999, Patient A (the identity of the other patients is contained in the attached appendix) after being in a motor vehicle accident was taken by EMS to Maimonides Medical Center's Emergency Room, Brooklyn, N.Y. Respondent, an emergency room physician at Maimonides, recorded the patient's chief complaint as "diaphoresis, near-syncope." Respondent admitted Patient A to the MICU (medical intensive care unit) with a diagnosis of hypotension and left pleural effusion. Patient A expired early April 9, 1999 while on the operating table for a repair of a leaking abdominal aortic aneurysm.

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

1. Respondent failed to perform and/or document an adequate history of Patient A.
2. Respondent failed to perform and/or document an adequate physical examination of Patient A.

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3. Respondent treated hypotension with a history of trauma without addressing the cause of the hypotension.
4. Respondent failed to appropriately assess the patient's condition.
5. On or about April, 16, 1999, Respondent submitted an interoffice memo concerning his care of Patient A to the chair of the Emergency Department at Maimonides. In this document Respondent knowingly and intentionally made incorrect statements concerning his communications with the CCU (cardiac care unit) and the MICU at Maimonides.

B. On or about April 27, 1999, at or about 10:00 p.m.,Patient B was brought by EMS to the Maimonides emergency room with abdominal pain, vomiting, tachycardia and a low blood pressure. Respondent, an emergency room physician at Maimonides saw Patient B approximately 3 hours later. The patient expired at 5:20 a.m. while awaiting a CT scan.
Respondent's care deviated from accepted medical standards, in that:

1. Respondent failed to perform and /or document an adequate history.
2. Respondent failed to perform and/or document an adequate physical exam.
3. Respondent failed to recognize and document in the patient's record a pnuemoperitoneum on plain abdominal x-ray.
4. Respondent failed to secure appropriate surgical consultation when there was evidence of a pneumoperitoneum on plain abdominal x-ray.

5. Respondent failed to place Patient B on a cardiac monitor and arrange for the review of the cardiac information by appropriate personnel.
6. Respondent's notes in Patient B's chart are inadequate.

C. On or about March 10, 1999, at or about 1:50 a.m., Patient C was brought by EMS to the emergency room at Maimonides with complaints of palpitations. EMS had given Patient C oxygen and Adenosine IV first 6 mg, then 12mg and then another 12 mg. Patient C, a 27 year old male, had a past medical history of suprarventricular tachycardia. He was on Cardizem, but had not been compliant with his medication. In the E.R., Respondent gave Patient C Cardiazem x 2 doses, Verapamil x 1 dose, Adenosine x 2 doses, and Versed. Patient C then went into ventricular arrythmia from which he was defibrillated and converted into normal sinus rhythm. Patient C was admitted to the Cardiac Intensive Care Unit with the diagnosis of Wolf Parkinson White Syndrome.

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

1. Respondent failed to perform and/or document an adequate history.
2. The cardiac medications administered by Respondent were contra-indicated given the patient's clinical condition.

D. On or about March 10, 1999, at or about 1:10 a.m. Patient D arrived at the

emergency room at Maimonides acutely short of breath. Respondent ordered continuous Proventil, blood tests and 40 mg. of Lasix intravenously. Patient D continued to be in distress and at or about 2:00 a.m. was intubated by Respondent and put on a ventilator.

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

1. Respondent failed to perform and/or document an adequate history.
2. Respondent failed to perform and/or document an adequate physical examination.
3. Respondent failed to treat Patient D's pulmonary edema appropriately.
4. Respondent failed to appropriately assess Patient D's condition.

E. On or about March 1, 1999, at or about 11:45 a.m., Patient E was brought by EMS to Maimonides emergency room. Respondent saw Patient E at or about 12:55 p.m. Patient E was brought to Maimonides by ambulance after being found on the floor, disoriented, incontinent of urine and with evidence of trauma.

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

1. Respondent failed to obtain and/ or document an adequate history of Patient E's pain.
2. Respondent failed to obtain and/or document an adequate neurologic examination of Patient E.

F. On or about March 4, 1999, at or about 9:54 p.m., Patient F went to Maimonides emergency room with complaints of lower abdominal pain and frequency of urination. Respondent evaluated and treated Patient F. Respondent's care deviated from accepted medical standards, in that:

1. Respondent failed to perform and/or document an adequate history.
2. Respondent failed to perform and/or document an adequate physical examination.
3. Respondent failed to order appropriate laboratory tests.
4. Respondent failed to appropriately assess the patient's condition.

G. On or about September 26, 1997 at or about 2:55 a.m., Patient G went to the emergency room at Nathan Littauer Hospital, Gloversville, N.Y. with complaints of right arm pain which was getting progressively worse. Patient G had a cardiac history and was on Lanoxin and Calan. Respondent diagnosed the patient with shoulder bursitis and sent the patient home. Respondent's care deviated from accepted medical standards, in that:

1. Respondent failed to perform and/or document an adequate history of Patient G.
2. Respondent failed to perform and/or document any physical examination of Patient G.
3. Respondent failed to appropriately assess Patient G's condition.

H. On or about September 26, 1997 at or about 3:22 a.m., Patient H went to the

emergency room at the Nathan Littauer Hospital with abdominal pain. Respondent diagnosed constipation. Before she left the hospital she was seen by another physician on the next shift. He correctly diagnosed Patient H as having a small bowel obstruction.

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

1. Respondent failed to perform and/or document an adequate history.
2. Respondent failed to perform and/or document an adequate physical examination.
3. Respondent failed to appropriately assess Patient H's condition.

I. On or about September 24, 1997, at or about 12:15 p.m., Patient I went to Nathan Littauer emergency room with complaints of lower quadrant pains in her abdomen for approximately 12 hours. Respondent diagnosed Patient I with constipation.

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

1. Respondent failed to perform and/or document an adequate history of Patient I.
2. Respondent failed to perform and/ or document an adequate physical examination of Patient I.
3. Respondent's treatment of magnesium citrate is not appropriate treatment for constipation.
4. Respondent failed to appropriately assess Patient I's condition.

J. On or about March 15, 1999, at or about 10:00 p.m., Patient J was brought by

EMS to the Columbia Memorial Hospital, Hudson, New York with chest pains and discomfort. Respondent examined the patient, obtained an EKG, diagnosed the patient with anxiety and discharged the patient. Respondent's care deviated from accepted medical standards, in that:

1. Respondent failed to obtain and/or document an adequate history.
2. Respondent failed to obtain and/or document an adequate physical examination.
3. Respondent failed to appropriately diagnose abnormalities on the EKG.
4. Respondent failed to diagnose and treat unstable angina.

K. Respondent, in his 1998 appointment application to Southside Hospital, in response to the question: "[H]ave any of the following ever been, or are any currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished?...membership on any hospital medical staff,.. clinical privileges ...other institutional affiliation or status thereat," knowingly and with intent to deceive failed to disclose the termination of his privileges at Nathan Littauer Hospital on or about October 1, 1997, and the termination without credit from his residency in emergency medicine, at Beth Israel Hospital, on or about December 22, 1994.

L. Respondent, in his 1998 appointment application to University Hospital of Brooklyn, in response to the question: "[H]ave your privileges at any hospital

ever been suspended, diminished, revoked or not renewed, or has disciplinary or corrective action ever been instituted?", knowingly and with intent to deceive failed to disclose the termination of his privileges at Nathan Littauer Hospital on or about October 1, 1997, and the termination without credit from his residency in emergency medicine, at Beth Israel Hospital, on or about December 22, 1994.

M. Respondent, in his 1999 appointment application to Maimonides Medical Center, in response to the question: "[H]ave your privileges, association, employment, practice or training in any hospital or facility in NYS or elsewhere ever been denied, suspended, diminished, restricted, revoked, terminated, not renewed, or otherwise discontinued (including voluntary resignation)?", knowingly and with intent to deceive failed to disclose the termination of his privileges at Nathan Littauer Hospital on or about October 1, 1997.

N. On the same 1999 appointment application to Maimonides Medical Center, in response to the directive to list all hospitals at which applicant was affiliated for the past ten years, Respondent knowingly and with intent to deceive failed to list his 1997 affiliation with Nathan Littauer Hospital.

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SPECIFICATION OF CHARGES

FIRST THROUGH ~~NINTH~~ TENTH 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. Paragraph A and its subparagraphs
2. Paragraph B and its subparagraphs
3. Paragraph C and its subparagraphs
4. Paragraph D and its subparagraphs
5. Paragraph E and its subparagraphs
6. Paragraph F and its subparagraphs
7. Paragraph G and its subparagraphs
8. Paragraph H and its subparagraphs
9. Paragraph I and its subparagraphs
10. Paragraph J and its subparagraphs

ELEVENTH 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:

11. 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; Paragraph H and its subparagraphs; Paragraph I and its subparagraphs; and/or Paragraph J and its subparagraphs.

TWELFTH 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:

12. 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; Paragraph H and its subparagraphs; Paragraph I and/or Paragraph J and its subparagraphs.

THIRTEENTH 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:

13. 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; Paragraph H and its subparagraphs; Paragraph I

and its subparagraphs; and/or Paragraph J.

FOURTEENTH THROUGH EIGHTEENTH SPECIFICATIONS

FRAUDULENT PRACTICE

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

14. Paragraph A 5.
15. Paragraph K
16. Paragraph L
17. Paragraph M
18. Paragraph N.

NINETEENTH THROUGH TWENTY SECOND SPECIFICATION

VIOLATION OF §2805-k of the PUBLIC HEALTH LAW

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(14)(McKinney Supp. 2000) by violating section twenty-eight hundred five-k of the Public Health Law, as alleged in the facts of:

19. Paragraph K
20. Paragraph L
21. Paragraph M
22. Paragraph N.

DATED: February / , 2001
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct