New York State Board for Professional Medical Conduct

433 River Street, Suite 303 Troy, New York 12180-2299 • (518) 402-0863

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Office of Professional Medical Conduct

William P. Dillon, M.D.
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Vice Chair
Ansel R. Marks, M.D., J.D.
Executive Secretary

May 1, 2000

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Salomon Epstein, M.D.
6910 Avenue U
Brooklyn, NY 11234

RE: License No. 129491

Dear Dr. Epstein:

Enclosed please find Order #BPMC 00-131 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect **May 1, 2000.**

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order to Board for Professional Medical Conduct, New York State Department of Health, Hedley Park Place, Suite 303, 433 River Street, Troy, New York 12180.

Sincerely,

Ansel R. Marks, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure
cc: Robert Asher, Esq.
295 Madison Avenue
New York, NY 10017

Kevin P. Donovan, Esq.

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

IN THE MATTER	CONSENT
OF	ORDER
SALOMON EPSTEIN, M.D.	BPMC 00-131

Upon the proposed agreement of SALOMON EPSTEIN, M.D., (Respondent) for Consent Order, which application is made a part hereof, it is agreed to and

ORDERED, that the application and the provisions thereof are hereby adopted and so ORDERED, and it is further

ORDERED, that this order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Consent Order to Respondent at the address set forth in this agreement or to Respondent's attorney by certified mail, or upon transmission via facsimile to Respondent or Respondent's attorney, whichever is earliest.

SO ORDERED.

DATED: 4/28/00

William P. Dillon, M.D.
WILLIAM P. DILLON, M.D.
Chair
State Board for Professional
Medical Conduct

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

IN THE MATTER

OF

SALOMON EPSTEIN, M.D.

CONSENT

AGREEMENT

AND

ORDER

Salomon Epstein, M.D., (Respondent) says that:

On or about December 3, 1976, I was licensed to practice as a physician in the State of New York, having been issued License No. 129491 by the New York State Education Department.

My current address is 6910 Avenue U, Brooklyn, New York 11234, and I will advise the Director of the Office of Professional Medical Conduct of any change of my address.

I understand that the New York State Board for Professional Medical Conduct has charged me with thirty-six specifications of professional misconduct.

A copy of the Statement of Charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

I admit guilt to the twenty-fifth through thirty-sixth specifications, in full satisfaction of the charges against me. I hereby agree to the following penalty: a five year suspension of my license to practice medicine in New York State, which suspension shall be stayed in its entirety conditioned on my full compliance with the Terms of Probation attached hereto as Exhibit B for a probationary period of five years.

I further agree that the Consent Order for which I hereby apply shall impose the following

conditions:

That, except during periods of actual suspension, Respondent shall maintain current registration of Respondent's license with the New York State Education Department Division of Professional Licensing Services, and pay all registration fees. This condition shall be in effect beginning thirty days after the effective date of the Consent Order and will continue while the licensee possesses his license; and

That Respondent shall fully cooperate in every respect with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Order and in its investigation of all matters regarding Respondent. Respondent shall respond in a timely manner to each and every request by OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall meet with a person designated by the Director of OPMC as directed. Respondent shall respond promptly and provide any and all documents and information within Respondent's control upon the direction of OPMC. This condition shall be in effect beginning upon the effective date of the Consent Order and will continue while the licensee possesses his license.

I hereby stipulate that any failure by me to comply with such conditions shall constitute misconduct as defined by New York State Education Law §6530(29).

I agree that in the event I am charged with professional misconduct in the future, this agreement and order shall be admitted into evidence in that proceeding.

I hereby make this Application to the State Board for Professional Medical Conduct (the Board) and request that it be granted.

I understand that, in the event that this Application is not granted by the Board, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged or charged against me, such Application shall not be used against me in any way and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary proceeding; and such denial by the Board shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by the Board pursuant to the provisions of the Public Health Law.

I agree that, in the event the Board grants my Application, as set forth herein, an order of the Chairperson of the Board shall be issued in accordance with same. I agree that such order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Consent Order to me at the address set forth in this agreement, or to my attorney, or upon transmission via facsimile to me or my attorney, whichever is earliest.

I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner. In consideration of the value to me of the acceptance by the Board of this Application, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive any right I may have to contest the Consent Order for which I hereby apply, whether administratively or judicially, and ask that the Application be granted.

AFFIRMED:

DATED 4/14/00

SALOMON EPSTEIN, M.D.
RESPONDENT

The undersigned agree to the attached application of the Respondent and to the proposed penalty based on the terms and conditions thereof.

DATE: 4/14/00

ROBERT S. ASHER
Attorney for Respondent

DATE: 4/19/00

KEVIN P. DONOVAN
Associate Counsel
Bureau of Professional
Medical Conduct

DATE: 4/28/00

ANNE F. SAILE
Director
Office of Professional
Medical Conduct

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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IN THE MATTER	:	STATEMENT
OF	:	OF
SALOMON EPSTEIN, M.D.	:	CHARGES

----------X

SALOMON EPSTEIN, M.D., the Respondent, was authorized to practice medicine in New York State on or about December 3, 1976 by the issuance of license number 129491 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, 1999, through December 31, 1999, with a registration address of 6910 Avenue U, Brooklyn, New York 11234.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A (patients are identified in the appendix attached hereto and made a part hereof) from on or about September 2, 1993 at his office at 147 Front Street, Binghamton New York and again on September 15, 1993 via telephone contact. Respondent's care and treatment of Patient A failed to meet acceptable standards of medical care in that:

1. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient A.

2. Respondent failed to give appropriate post-operative instructions to Patient A to follow in the event of an emergency and/or complication.

3. Respondent performed an abortion on Patient A and then failed to be available to provide appropriate care and treatment for Patient A and/or to provide for another appropriate covering physician and/or hospital to treat Patient A for complications of said abortion.

B. Respondent treated Patient B on or about February 10, 1993, at his Binghamton, New York office. Respondent's care and treatment of Patient B failed to meet acceptable standards of medical care in that:

1. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient B.

2. Respondent performed an abortion on Patient B and then failed to be available to provide appropriate care and treatment for Patient B and/or to provide for another appropriate covering physician and/or hospital to treat Patient B for complications of said abortion.

C. Respondent treated Patient C on or about December 9, 1992, at his Binghamton, New York office. Respondent's care and treatment of Patient C failed to meet acceptable standards of medical care in that:

1. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient C.

2. Respondent performed an abortion on Patient C and then failed to be available to provide appropriate care and treatment for Patient C and/or to provide for another appropriate covering physician and/or hospital to treat Patient C for complications of said abortion.

D. Respondent treated Patient D on or about June 2, 1990, at his Bronx, New York office. Respondent's care and treatment of Patient D failed to meet acceptable standards of medical care in that:

1. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient D.

2. Respondent failed to perform or record an appropriate physical examination, including a review of Patient D's medical systems.

3. Respondent failed to properly perform or record a complete pelvic examination of Patient D.

4. Respondent failed to perform a blood pressure check on Patient D, even though Respondent was aware that Patient D was ingesting oral contraceptives.

E. Respondent treated Patient E from June 5, 1990 through on or about October 26, 1990 at his Bronx, New York office. Respondent's care and treatment of Patient E failed to meet acceptable standards of medical care in that:

1. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient E.

2. Respondent failed to take or record an appropriate medical history, including a complete menstrual, obstetrical or surgical history.

3. Respondent failed to perform or record an appropriate physical examination, including a review of Patient E's medical systems.

4. Respondent failed to perform or record a complete pelvic examination of Patient F.

5. Respondent failed to evaluate and treat appropriately for Patient E's anemia.

6. Respondent failed to refer Patient E to a hematologist for followup care and treatment.

7. Respondent failed to obtain or record the results of Patient E's Hepatitis B Surface Antigen test.

8. Respondent failed to note or record the outcome of Patient E's pregnancy.

F. Respondent treated Patient F from on or about July 11, 1995 to on or about July 25, 1995, at his Bronx New York office. Respondent's care and treatment of Patient F failed to meet acceptable standards of medical care in that:

1. Respondent failed to maintain a record which accurately reflects the evaluation and care of Patient F.

2. Respondent failed to order, perform or obtain results of a CBC, blood type and RH and antibody screen prior to preforming a termination of pregnancy on Patient F.

3. Respondent failed to prescribe Rhogam/MicRogham after the termination of pregnancy if Patient F was found to be RH negative.

4. Respondent failed to record accurately Patient F's initial patient history.

5. Respondent failed to administer a proper physical examination of Patient F.

G. Respondent treated Patient G from on or about June 1, 1991, to on or about June 15, 1991, at his Bronx, New York office. Respondent's care and treatment of Patient G failed to meet acceptable standards of medical care in that:

1. Respondent failed to maintain a record which accurately reflects the evaluation and care of Patient G.

2. Respondent failed to order, perform or obtain the results of a CBC, blood type, Rh and antibody screen prior to performing a termination of pregnancy.

3. Respondent failed to prescribe Rhogam/MicRogham after the termination of abortion if Patient G was found to be Rh negative.

4. Respondent failed to record accurately Patient G's initial patient history.

5. Respondent failed to administer a proper physical examination of Patient G.

H. Respondent treated Patient H from on or about December 6, 1985, to on or about July 22, 1988 at his Bronx, New York office. Respondent's care and treatment of Patient H failed to meet acceptable standards of medical care in that:

1. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient H.

2. Respondent failed to perform proper and adequate physical examinations of Patient H prior to performing termination of pregnancies.

3. With respect to termination of pregnancy on December 6, 1985:
   a. Respondent failed to establish appropriately that Patient H was pregnant prior to performing said termination of pregnancy.

   b. Respondent failed to order, obtain or record the results of a urine pregnancy test or BCHG blood test for pregnancy on Patient H.

   c. Respondent failed to rule out an ectopic pregnancy with either sonography or followup blood pregnancy testing after receiving the results of the December, 1985 pathology report.

4. With respect to a termination of pregnancy preformed on July 22, 1988:
   a. Respondent performed an untimely termination of pregnancy when Patient H was only 6.2 weeks pregnant.

   b. Respondent failed to rule out an ectopic pregnancy with either sonography or followup BHCG blood pregnancy testing after receiving the results of the July, 1988 pathology report.

I. Respondent treated Patient I on or about June 14, 1994 to on or about August 5, 1995 at his Bronx, New York office. Respondent's care and treatment of Patient I failed to meet acceptable standards of medical care, in that:

1. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient I.

2. Respondent failed to take or record an appropriate medical history on Patient I.

3. Respondent repeatedly failed to perform or record an appropriate physical examination, including a review of systems on Patient I.

4. Respondent failed to perform or record a complete pelvic examination of Patient I.

5. Respondent failed to perform or record a blood pressure reading on Patient I even though Respondent was aware that Patient I was ingesting oral contraceptives.

6. Respondent failed to perform a PAP smear test on or about March 23, 1988, June 10, 1988 and May 27, 1989 on Patient I.

7. Respondent prescribed and/or provided oral contraceptives to Patient I without obtaining the results of a PAP smear test establishing the status of Patient I's cervix.

8. Respondent failed to followup appropriatel the results of Patient I's April 15, 1993 PAP smear result by informing Patient I of the need to repeat the PAP smear within 6 months.

9. Respondent performed a PAP smear test on or about June 14, 1994 and failed to make appropriate progress notes in the medical records of Patient I.

J. Respondent treated Patient J from on or about December 14, 1993 to on or about September 12, 1994, at his Bronx, New York office. Respondent's care and treatment of Patient J failed to meet acceptable standards of medical care in that:

1. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient J.

2. Respondent failed to take or record an appropriate medical history of Patient J.

3. Respondent failed to perform or record an appropriate physical examination of Patient J, including a review of Patient J's systems.

4. Respondent failed to take or record a complete pelvic examination of Patient J.

5. Respondent failed to take or record a blood pressure reading of Patient J even though Respondent was well aware that Patient J was taking an oral contraceptive.

6. Respondent failed to establish whether or not Patient J was pregnant on or about December 14, 1993 by ordering, preforming or recording the results of a UCG or BHCG pregnancy test.

7. Respondent failed to evaluate appropriately Patient J's period of amenorrhea.

8. Respondent failed to followup appropriately Patient J's elevated blood pressure of 160/118 during the September 12, 1994 visit.

K. Respondent treated Patient K from on or about October 2, 1993 to on or about March 14, 1995 at his Bronx, New York office. Respondent's care and treatment of Patient K failed to meet acceptable standards of medical care in that:

1. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient K.

2. Respondent failed to take or record appropriate medical history on Patient K.

3. Respondent failed to perform or record an appropriate physical examination on Patient K.

4. Respondent failed to evaluate appropriately Patient K's amenorrhea on or about October 2, 1993.

5. Respondent failed to order, perform or obtain results of a urine/blood pregnancy test; provera test; thyroid function tests; and prolactin level on Patient K.

6. Respondent failed to timely followup the results of Patient K's pap smear test in October of 1993.

7. Respondent failed to inform Patient K of the abnormal results of the pap smear test performed in October 1993.

L. Respondent treated Patient L from on or about June 20, 1991 at his Bronx, New York City office. Respondent's care and treatment of Patient L failed to meet acceptable standards of medical care in that:

1. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient L.

2. Respondent failed to take or record an appropriate medical history on Patient L.

3. Respondent failed to perform or record an appropriate physical examination of Patient L.

4. Respondent failed to address Patient L's elevated hemoglobin results.

SPECIFICATIONS

FIRST THROUGH TWELFTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with negligence on more than one occasion a violation of N.Y. Educ. Law Section 6530 (3)(McKinney Supp. 1999) in that Petitioner charges two or more of the following:

1. The facts in Paragraphs A and A.1, A.2 and/or A.3.

2. The facts in Paragraphs B and B.1 and/or B.2.

3. The facts in Paragraphs C and C.1, and/or C.2.

4. The facts in Paragraphs D and D.1, D.2, D.3, and/or D.4.

5. The facts in Paragraphs E and E.1, E.2, E.3, E.4, E.5, E.6, E.7, and/or E.8.

6. The facts in Paragraphs F and F.1, F.2, F.3, F.4, and/or F.5.

7. The facts in Paragraphs G and G.1, G.2, G.3, G.4, and/or G.5.

8. The facts in Paragraphs H and H.1, H.2, H.3a, H.3b, H.3c, H.4a, and/or H.4b.

9. The facts in Paragraphs I and I.1, I.2, I.3, I.4, I.5, I.6, I.7, I.8, and/or I.9.

10. The facts in Paragraphs J and J.1, J.2, J.3, J.4, J.5, J.6, J.7, and/or J.8.

11. The facts in Paragraphs K and K.1, K.2, K.3, K.4, K.5, K.6, and/or K.7.

12. The facts in Paragraphs L and L.1, L.2, L.3, and/or L.4.

THIRTEENTH THROUGH TWENTY-FOURTH SPECIFICATIONS
INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with incompetence on more than one occasion in violation of N.Y. Educ. Law Section 6530(50(McKinney Supp. 1999) in that Petitioner charges two or more of the following:

13. The facts in Paragraphs A and A.1, A.2 and/or A.3.

14. The facts in Paragraphs B and B.1 and/or B.2.

15. The facts in Paragraphs C and C.1, and/or C.2.

16. The facts in Paragraphs D and D.1, D.2, D.3, and/or D.4.

17. The facts in Paragraphs E and E.1, E.2, E.3, E.4, E.5, E.6, E.7, and/or E.8.

18. The facts in Paragraphs F and F.1, F.2, F.3, F.4, and/or F.5.

19. The facts in Paragraphs G and G.1, G.2, G.3, G.4, and/or G.5.

20. The facts in Paragraphs H and H.1, H.2, H.3a, H.3b, H.3c, H.4a, and/or H.4b.

21. The facts in Paragraphs I and I.1, I.2, I.3, I.4, I.5, I.6, I.7, I.8, and/or I.9.

22. The facts in Paragraphs J and J.1, J.2, J.3, J.4, J.5, J.6, J.7, and/or J.8.

23. The facts in Paragraphs K and K.1, K.2, K.3, K.4, K.5, K.6, and/or K.7.

24. The facts in Paragraphs L and L.1, L.2, L.3, and/or L.4.

TWENTY-FIVE THROUGH THIRTY-SIXTH SPECIFICATIONS
RECORDKEEPING

Respondent is charged with failing to maintain a record which accurately reflects the care and treatment of Patients in violation of N.Y. Educ. Law Section 6530(32)(McKinney Supp. 1999) in that Petitioner charges two or more of the following:

25. The facts in Paragraphs A and A.1.

26. The facts in Paragraphs B and B.1.

27. The facts in Paragraphs C and C.1.

28. The facts in Paragraphs D and D.1.

29. The facts in Paragraphs E and E.1.

30. The facts in Paragraphs F and F.1.

31. The facts in Paragraphs G and G.1.

32. The facts in Paragraphs H and H.1.

33. The facts in Paragraphs I and I.1.

34. The facts in Paragraphs J and J.1.

35. The facts in Paragraphs K and K.1.

36. The facts in Paragraphs L and L.1.

DATED: April 19, ~~1999~~ 2000
Albany, New York

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

EXHIBIT "B"

Terms of Probation

1. Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his profession.

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

3. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law section 171(27)]; State Finance Law section 18; CPLR section 5001; Executive Law section 32].

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

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

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

7. Respondent shall create a document for each patient containing the patient's complete history, signs, symptoms, diagnosis, treatment, follow up care and instructions. This document shall be kept on file and available to be promptly provided to any future physicians or facilities to provide treatment to the patient. Respondent shall provide each patient with a copy of this document within one week of each visit by the patient to Respondent.

8. If Respondent maintains any offices outside New York City, such offices shall be staffed during normal business hours. Respondent shall be physically present at such offices a minimum of two days per week.

9. On the days in which Respondent is absent from the area of any of his offices, Respondent shall have available a physician who is qualified to care for the patients Respondent has treated, who has agreed to cover for Respondent in his absence, and a staff person who will be available to contact Respondent or the covering physician so that the patient will be seen in a timely manner.

10. Within thirty (30) days of the effective date of the Order, Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC.

    a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection of no less than 20% and up to 33% of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

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

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

    d. Respondent shall maintain medical malpractice insurance coverage with

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

11. Respondent shall enroll in and complete a continuing education program in the area of obstetrics and gynecology to be equivalent to at least 30 credit hours of Continuing Medical Education, over and above the recommended minimum standards set by the American Board of Obstetrics and Gynecology. Said continuing education program shall be subject to the prior written approval of the Director of OPMC and be completed within the period of probation or as otherwise specified in the Order.

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