THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, N.Y. 12234

OFFICE OF PROFESSIONAL DISCIPLINE
ONE PARK AVENUE, NEW YORK, NEW YORK 10016-5802

Ming Kow Hah, Physician
94-33 58th Avenue
Elmhurst, N.Y. 11373

July 31, 1991

Re: License No. 112144

Dear Dr. Hah:

Enclosed please find Commissioner's Order No. 11953. This Order goes into effect five (5) days after the date of this letter.

If the penalty imposed by the Order in your case is a revocation, surrender, or a actual suspension (suspension which is not wholly stayed) of your license, you must deliver your license and registration to this Department within ten (10) days after the date of this letter. Your penalty goes into effect five (5) days after the date of this letter even if you fail to meet the time requirement of delivering your license and registration to this Department.

If the penalty imposed by the Order in your case is a revocation or a surrender of your license, you may, pursuant to Rule 24.7 (b) of the Rules of the Board of Regents, a copy of which is attached, apply for restoration of your license after one year has elapsed from the effective date of the Order and the penalty; but said application is not granted automatically.

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By: Gustave Martine

GUSTAVE MARTINE
Supervisor

DJK/GM/er

CERTIFIED MAIL - RRR

cc: Neal S. Simon, Esq.
275 Madison Avenue, Suite 903
New York, N.Y. 10016

REPORT OF THE
REGENTS REVIEW COMMITTEE

MING KOW HAH

CALENDAR NO. 11953

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

MING KOW HAH **No. 11953**

who is currently licensed to practice
as a physician in the State of New York.

REPORT OF THE REGENTS REVIEW COMMITTEE

MING KOW HAH, hereinafter referred to as respondent, was licensed to practice as a physician in the State of New York by the New York State Education Department.

On November 16, 1990 respondent was served with the Health Commissioner's summary suspension order, notice of hearing, and statement of charges dated November 14, 1990. A copy of such order, notice of hearing, and statement of charges, with the exception of the appendix of patient names, is annexed hereto, made a part hereof, and marked as Exhibit "A". Accordingly, this disciplinary proceeding was duly commenced.

The Commissioner of Health determined that the continued practice of medicine in the State of New York by respondent constitutes an imminent danger to the health of the people of this State and, pursuant to Public Health Law §230(12), that, effective

immediately, respondent shall not practice medicine in the State of New York.

On eleven sessions, including pre-hearing conferences, from November 21, 1990 through January 17, 1991 a hearing was held before a hearing committee of the State Board for Professional Medical Conduct. On January 17, 1991, having heard both petitioner's and respondent's entire case, the hearing committee recommended that the Commissioner of Health continue his summary order.

On February 26, 1991 the hearing committee rendered a report of its findings, conclusions, and recommendation, a copy of which is annexed hereto, made a part hereof, and marked as Exhibit "B". The hearing committee concluded that respondent was guilty of the first, sixth, eighth, ninth, and seventeenth specifications of the charges to the extent indicated in its report and not guilty of the remaining specifications and charges. The hearing committee recommended that respondent's license to practice as a physician in the State of New York be revoked.

On April 8, 1991 the Commissioner of Health recommended to the Board of Regents that the findings of fact and conclusions of the hearing committee be accepted in full, and that its recommendation as to penalty also be accepted. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On May 17, 1991, the scheduled date of our hearing, respondent appeared before us in person and was represented by his attorney, Neal S. Simon, Esq., who presented oral argument on behalf of respondent. Dianne Abeloff, Esq., presented oral argument on behalf of the Department of Health.

Petitioner's written recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was revocation.

Respondent submitted no written recommendation as to the measure of discipline to be imposed, should respondent be found guilty.

We have considered the record as transferred by the Commissioner of Health in this matter, as well as respondent's brief to the Regents Review Committee. Such review has also included the transcripts from pre-hearing conferences of November 21 and November 26, 1990.

We note that the Commissioner of Health, who reviewed the record which reflects the existence of the transcripts of the pre-hearing conferences, did not, in fact, review these transcripts. We do not view the absence of review of these transcripts, to which the Commissioner of Health had access, to indicate a failure by the Commissioner of Health to fulfill his statutory duties with regard to this disciplinary matter. See, Matter of Smith, Cal. No. 11657. Cf., DiMarsico v. Ambach, 424 N.Y.S.2d 107, reargument denied 425 N.Y.S.2d 1029, on remand 425 N.Y.S.2d 894.

In our unanimous opinion, with the exception of the last paragraph of the General Conclusions on page 17 of the hearing committee's report, which we do not pass or rely upon, the hearing committee's decision, viewed as a whole, appropriately addresses the charges based on the evidence in the record and the hearing committee properly evaluated the evidence under appropriate medical and legal standards.

With regard to respondent's stipulation as to Patient F, we agree with the hearing committee that the stipulation was intended to cover the allegations in paragraphs F2 and F4 on page 9 of the statement of charges. Furthermore, even were we to interpret the stipulation more narrowly, we believe that the record clearly supports the hearing committee's findings of fact and conclusions of guilt with regard to Patient F.

We unanimously recommend the following to the Board of Regents:

1. The hearing committee's findings of fact, conclusions as to guilt, and recommendation as to the penalty to be imposed, as well as the Commissioner of Health's recommendation as to those findings, conclusions, and recommendation be accepted, except that the last paragraph of the General Conclusions on page 17 of the hearing committee's report not be accepted;
2. Respondent be found guilty, by a preponderance of the

evidence, of the first, sixth, eighth, ninth, and seventeenth specifications of the charges to the extent indicated in the hearing committee report; and

3. Respondent's license to practice as a physician in the State of New York be revoked upon each specification of the charges of which we recommend respondent be found guilty, as aforesaid.

Respectfully submitted,

EMLYN I. GRIFFITH

SIMON J. LIEBOWITZ

JOHN T. McKENNAN

Chairperson

Dated: 6/27/91

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

IN THE MATTER	:	STATEMENT
OF	:	OF
Ming Kow Hah, M.D.	:	CHARGES

Ming Kow Hah, M.D., the Respondent, was authorized to practice medicine in New York State on May 15, 1972 by the issuance of license number 112144 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, 1989 through December 31, 1991 from 94-33 58 Avenue, Elmhurst, New York.

FACTUAL ALLEGATIONS

A. On or about April 24, 1990, Patient A (the patients' identities are contained in the attached appendix) went to Respondent's office at 94-33 58th Avenue, Elmhurst, New York for an abortion. Respondent placed eight laminaria in Patient A's cervix.

At or about 4:30 p.m. on April 25th, at Econo-Surgi-Center, 87-08 Justice Avenue, Queens, N.Y., Respondent began the procedure and removed the ...

laminaria, ruptured the membranes, removed the fetus in pieces with the exception of the head, which separated from the rest of the body and remained somewhere inside the patient.

During the course of the D & E Patient A began to bleed. Respondent, realizing that he had lacerated the uterus, attempted to suture the uterine laceration, but was unable to control Patient A's bleeding. Finally, at or about 6:15 p.m., Respondent and/or the anesthesiologist called an ambulance.

By the time the Emergency Medical Service personnel (EMS) arrived at Econo-Surgi-Center, Patient A had already lost approximately 2 liters of blood. Patient A was transferred to Elmhurst General Hospital (Elmhurst), Queens, N.Y, where a surgical team found 2500 cc. of blood in the peritoneal cavity, a lacerated uterus, a severed left infundibular ligament with bleeding from that area and from the right adnexa, and a lacerated bladder. The Elmhurst surgical team performed a hysterectomy, a right oophorectomy, a salpinectomy, bladder repair, and removed the normal 24-27 week fetal brain and skull from the patient's abdomen.

1. Respondent failed to perform or obtain the results of a sonogram prior to performing a D & E on Patient A.

2. Respondent failed to accurately measure the size of Patient A's uterus prior to performing a D & E on Patient A.

3. Respondent failed to accurately determine that the fetus was alive prior to performing a D & E on Patient A.

4. Respondent lacerated the uterus and then failed to terminate the surgery and immediately transfer Patient A to the hospital when he realized he had lacerated the uterus.

5. Respondent failed to perform or order the following pre-operative tests prior to performing an evacuation of the uterus for fetal demise: pt; ptt; platelet; CBC; fibrinogen.

6. Respondent inappropriately performed an evacuation of the uterus for fetal demise and

did so in an outpatient facility rather than in the hospital.

7. Respondent failed to note in his records for Patient A the size and type of laminaria inserted into Patient A's cervix.

8. Respondent failed to cross match Patient A's blood and to have blood available prior to performing an evacuation of uterus for fetal demise.

9. Respondent delivered Patient A's uterus into her vagina and caused injuries to the bladder and right adnexa.

10. Respondent attempted to close the laceration in the uterus without locating and removing the fetal head from Patient A's abdomen.

11. Respondent inappropriately attempted to direct the ambulance to Booth Memorial Hospital, Queens, N.Y., which was not the closest hospital.

12. Respondent failed to accurately inform the EMS personnel regarding the nature of the procedure he performed on Patient A.

13. Respondent knowingly made the following false representations: Respondent noted a pre-operative diagnosis of fetal demise when he knew that there was no fetal demise. Respondent also noted in the chart that he advised the patient to obtain a sonogram when he did not so advise the patient. Respondent told the EMS personnel that he had performed a tubal ligation when in fact he had performed an abortion.

B. On or about June 18, 1990, Patient B went to Respondent's office for an abortion. Respondent performed a pelvic examination on Patient B and noted in his record that Patient B had multiple condyloma and severe cervicitis. At the completion of the pelvic examination Respondent performed an abortion. Respondent sent the tissue for pathological examination. The pathological report showed "extensive hydropic degeneration of chorionic villi." Respondent's care and treatment of Patient B deviated from acceptable medical standards in that:

1. Respondent failed to treat the severe cervicitis and condyloma prior to performing an abortion on Patient B.

2. Respondent failed to follow the patient for possible gestational trophoblastic disease by obtaining weekly pregnancy tests for Patient B until the tests results indicated that she was no longer pregnant, or sending her for chemotherapy if required.

3. Respondent failed to perform a serologic test for syphilis on Patient B.

4. Respondent failed to examine the fetal tissue subsequent to the abortion and/or document in the chart that he removed all products of conception and examined them.

C. On or about June 1, 1990, Patient C went to Respondent's office with complaints of post menopausal bleeding, abnormal itching and bumps in the vagina. Respondent's pelvic exam showed condyloma and chronic cervicitis. Respondent's

physical examination of Patient C showed that the patient was "post left mastectomy." Respondent performed a Pap smear on June 1, 1990. On that same day Respondent excised the condyloma and cauterized the cervix. Respondent's care and treatment of Patient C deviated from accepted medical standards in that:

1. Respondent cauterized Patient C's cervix prior to receiving the report of the Pap smear.

2. Respondent failed to perform a D&C to rule out cancer as a cause of Patient C's post-menopausal bleeding.

3. Respondent failed to perform or order a blood test for syphilis, given the diagnosis of condyloma.

D. On or about June 18, 1990, Patient D went to Respondent's office with complaints of irregular menstruation and fertility problems. On or about June 20, 1990, Respondent performed a Dilatation and Curettage (D & C) on Patient D to evaluate her fertility status. Respondent's care and

treatment of Patient D deviated from accepted medical standards in that:

1. Respondent performed a D & C on Patient D to evaluate her fertility status. This procedure is not indicated for this diagnostic purpose. This procedure is contraindicated for a patient with these complaints.

E. On or about May 15, 1990, Patient E went to Respondent's office with complaints of abnormal uterine bleeding for approximately three weeks and abdominal cramps. Respondent obtained a consent from Patient E for an endometrium biopsy; however, he performed a D & C. Respondent's care and treatment of Patient E failed to meet accepted medical standards in that:

1. Respondent performed a D & C on Patient E without medical justification.

2. Respondent failed to obtain the patient's consent for the operation that he performed.

F. On or about October 31, 1989, Patient F went to Respondent's office with complaints of mild bleeding, nausea and spotting for the past two weeks. Respondent performed a pelvic

examination and determined that the uterus was approximately 6 week size, that the patient suffered from severe chronic cervicitis, as well as condyloma in the perineal area. Respondent's preoperative diagnosis was "threatened abortion, rule out incomplete abortion." On or about October 31, 1989, Respondent performed a suction curretage. Respondent's care and treatment of Patient F deviated from accepted medical standards in that:

1. Respondent failed to perform and document a complete physical examination of Patient F.

2. Respondent administered 20 mgm. Valium and ~~45~~ 75 mgm. Demerol to Patient F, which was an excessive amount.

3. When Respondent administered the Demerol to Patient F, the Respondent's DEA number had been revoked.

4. Respondent administered Demerol and Valium without the assistance of a nurse anesthetist or an anesthesiologist.

5. Respondent failed to perform a syphilis blood test, given Respondent's findings of perineal condyloma.

6. Respondent failed to perform a gonorrhea and chlamydia screen prior to the suction curettage, given the fact that chronic cervicitis was noted.

7. Respondent's record failed to document the justification for performing suction curettage on Patient F.

G. On or about January 23, 1990, Patient G went to Respondent's office for an abortion. Respondent performed a pelvic examination and determined that Patient G's uterus was the size of a 10 week pregnancy. Respondent's pre-abortion examination of Patient G indicated that her cervix was normal; however, the operative note and the note dated February 5, 1990, stated that Patient G had cervicitis. Respondent sent the tissue he removed from Patient G's uterus for a pathology review. The pathology report reveals placental tissue measuring 2.5 cm. x 1.0 cc. Respondent's care and treatment of Patient G deviated from accepted medical standards in that:

1. Respondent failed to examine the tissue he removed after the abortion to determine whether or not he had the appropriate amount of products of conception for a 10-week pregnancy.

2. Respondent failed to document in his operative note that only scant tissue was removed.

SPECIFICATION OF CHARGES

FIRST THROUGH SEVENTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with gross negligence within the meaning of N.Y. Educ. Law section 6509(2) (McKinney 1985) in that Petitioner charges:

1. The facts in paragraphs A and A1 through A12.

2. The facts in paragraphs B and B1 through B4.

3. The facts in paragraphs C and C1 through C3.

4. The facts in paragraphs D and D1.

5. The facts in paragraphs E and E1 through E2.

6. The facts in paragraphs F and F1 through F7.

7. The facts in paragraphs G and G1 through G2.

EIGHTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion within the meaning of N.Y. Educ. Law Section 6509(2) (McKinney 1985) in that Petitioner charges that Respondent committed two or more of the following:

8. The facts in paragraphs A, A1 through A12, B, B1 through B4, C, C1 through C3, D, D1,

E, E1 through E2, F, F1 through F7 and/or G, G1 through G2.

NINTH THROUGH FIFTEENTH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with gross incompetence within the meaning of N.Y. Educ. Law section 6509(2) (McKinney 1985), in that the Petitioner charges:

9. The facts in paragraphs A and A1 through A12.

10. The facts in paragraphs B and B1 through B4.

11. The facts in paragraphs C and C1 through C3.

12. The facts in paragraphs D and D1.

13. The facts in paragraphs E and E1 through E2.

14. The facts in paragraphs F and F1 through F7.

15. The facts in paragraphs G and G1 through G2.

SIXTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with incompetence on more than one occasion within the meaning of N.Y. Educ. Law section 6509(2) (McKinney 1985), in that the Petitioner charges that Respondent committed two or more of the following:

16. The facts in paragraphs A, A1 through A12, B, B1 through B4, C, C1 through C3, D, D1, E, E1 through E2, F, F1 through F7 and/or G, G1 through G2.

SEVENTEENTH SPECIFICATION

FRAUD

Respondent is charged with practicing the profession fraudulently within the meaning of N.Y. Educ. Law Section 6509(2) (McKinney 1985), in that Petitioner charges the following:

17. The facts in paragraphs A and A13.

EIGHTEENTH THROUGH NINETEENTH SPECIFICATIONS

EXCESSIVE TREATMENT

Respondent is charged with committing unprofessional conduct within the meaning of N.Y. Educ. Law section 6509(9) (McKinney 1985), in that he committed unprofessional conduct within the meaning of 8 N.Y.C.R.R.29.2(a)(7) (1989) when he ordered excessive tests and/or treatment not warranted by the condition of the patient, in that Petitioner charges:

18. The facts in paragraphs D and D1.

19. The facts in Paragraphs E and E1 and E2.

DATED: New York, New York
November 14, 1990

Chris Stern Hyman
Counsel
Bureau of Professional Medical
Conduct

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

IN THE MATTER	:	REPORT OF
	:	
OF	:	THE HEARING
	:	
MING KOW HAH, M.D.	:	COMMITTEE

TO: The Honorable David Axelrod, M.D.
Commissioner of Health, State of New York

Mr. Robert M. Briber, Chairperson, Dr. Jean M. Chin, M.D. and Dr. Jerry Waisman, M.D., 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 Section 230(10)(e) of the Public Health Law. Tyrone Thomas Butler, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this report.

SUMMARY OF PROCEEDINGS

Service of Commissioner's Summary Order, Notice of Hearing and Statement of Charges:	November 16, 1990
Prehearing Conferences:	November 21, 1990
	November 26, 1990

EXHIBIT "B"

Hearing Dates: November 26, 1990
November 29, 1990
December 3, 1990
December 4, 1990
December 11, 1990
(Adjourned - Respondent)
December 13, 1990
(Adjourned - Respondent)
*December 17, 1990
December 19, 1990
January 3, 1991
January 17, 1991

* Dr. Chin was absent from the hearing on this date. However, she attests that she has read the transcript of this proceeding and has thoroughly familiarized herself with the testimony and evidence received in her absence.

Interim Report(s):
"Imminent Danger" January 17, 1991
(On the record)

Motions:
Move that the Committee decide Imminent Danger issue at end of Department's case: December 3, 1990
Denied: December 3, 1990

Move that the Committee decide Imminent Danger issue on closing of the record: January 17, 1991
Granted: January 17, 1991

Deliberations were held on: February 4, 1991

Place of Hearing(s): 8 East 40th Street
New York, NY 10016

1515 Broadway, 51st. Floor
New York, NY 10036

Department of Health

Appeared By: Peter J. Millock, Esq.,
General Counsel by:
Dianne Abeloff, Esq.,
Associate Counsel
Office of Professional
Medical Conduct
8 East 40th Street
New York, NY 10016

Respondent appeared by: Polatsek and Sclafani
by:
Neal S. Simon, Esq.,
of counsel,
275 Madison Avenue
Suite 903
New York, NY 10016

Witnesses for the Department of Health:

Patient A, Fact Witness
Camille Codoluto, Fact Witness
Felix McClymont, M.D., OB, GYN, Fact/Expert Witness
Angeline R. Mastri, M.D., Neuropathologist, Expert Witness
E. Hakim-Elahi, M.D., OB, GYN, Expert Witness

Witnesses for the Respondent:

Patient F, Fact Witness
Rosa Camacho, Fact Witness
Richard Livingston Berman, M.D., OB, GYN, Expert Witness
Satty Gill Keswani, M.D., OB, GYN, Expert Witness
Ming Kow Hah, M.D., Respondent
Kumudini Dinbandhu Shah, M.D., Pediatric Pathologist, Expert Witness

Department filed Proposed Findings
of Fact, Conclusions of Law: January 31, 1991

Respondent filed Proposed Findings
of Fact, Conclusions of Law: January 31, 1991

On November 16, 1990, the Respondent was served with the Commissioner's Summary Order, Notice of Hearing and Statement of Charges (Department's Exhibit #1). The Department of Health and the Respondent presented their entire case and the record was closed on January 17, 1991. On December 3, 1990, a motion to consider the issue of imminent danger was denied and on January 17, 1991, a repeat motion to consider the issue of imminent danger was granted. The hearing committee considered the issue of imminent danger on January 17, 1991 and issued its report, re: imminent danger, on the record. On February 4, 1991, the hearing committee met to deliberate the entire case.

SUMMARY OF CHARGES

In the Statement of Charges (Dept's Ex. #1 - copy attached), the Respondent, Ming Kow Hah, M.D., is charged with professional misconduct pursuant to Education Law §6509. The specific charges are: practicing the profession with gross negligence (First through Seventh Specification), practicing the profession with negligence on more than one occasion (Eighth Specification), practicing the profession with gross incompetence (Ninth through Fifteenth Specification), practicing the profession with incompetence on more than one occasion (Sixteenth Specification), practicing the profession fraudulently (Seventeenth Specification), and ordering excessive tests and/or treatment [8 N.Y.C.R.R. 29.2(a)(7) (1989)] (Eighteenth through Nineteenth Specification).

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record. 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 the cited evidence. The pre-hearing transcripts were not made available to the Hearing Committee at the time of deliberations.

1. Ming Kow Hah, M.D., the Respondent, was authorized to practice medicine in New York State on May 15, 1972 by the issuance of license number 122144, by the New York State Education Department. (Ex. 1)

2. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1989 through December 31, 1991, from 94-33 58th Avenue, Elmhurst, New York. (Ex. 1)

FINDINGS OF FACT - PATIENT A

3. Patient A went to the Respondent's office on April 23, 1990 for an abortion. The Respondent examined Patient A and wrote in his records that she was 18-19 weeks pregnant. The Respondent told Patient A to return the following day for the abortion. When she returned to his office he told her that she was too big for him to perform the procedure in his office that day. He inserted laminaria and directed Patient A to meet him the next day at the Econo Surgi-Center for the abortion. (Ex. 3, T. 231, 555, 616-617, 867, 872)

4. The Respondent failed to perform or obtain the results of a sonogram, for Patient A, prior to performing a Dilatation and Extraction (D & E) on Patient A. (Ex. 3, T. 23, 203, 611, 868-870)

5. The Respondent noted in his office records that he advised Patient A to obtain a sonogram. (Ex. 3)

6. The Respondent performed a physical examination on Patient A in order to determine gestational age. (Ex. 3, T. 868)

7. Patient A reported irregular menses to the Respondent. The Respondent did not record this in his office record. (Ex. 3, T. 39)

8. Prior to performing the D & E the Respondent determined that there was fetal demise. He recorded "...no fetal heart tone...", in his physical examination, and in the operative note, he records "...fetal death..." and "...Missed abortion...". (Ex. 3)

9. Pre-operatively, the Respondent, performed a CBC and platelet count but he did not order a PT, PTT and fibrinogen. The Respondent failed to cross match Patient A's blood and he failed to have blood available at the Econo Surgi-center at the time of the performance of the D & E. (Ex. 3, T. 946, 950-951)

10. The Respondent noted in his office records, for Patient A, that 8 laminaria were inserted on April 24, 1990. (Ex. 3)

11. On April 25, 1990, at the Econo Surgi-Center, when the Respondent ruptured Patient A's amniotic sac cloudy green amniotic fluid came out of her cervix. (Ex. 3, T. 874)

12. During the performance of the D & E, on Patient A, at the Econo Surgi-Center, on April 25, 1990, the Respondent lacerated her uterus. He then delivered the uterus into the vagina through an anterior incision and sutured the laceration. In delivering the uterus into the vagina he tore it from the right pelvic side-wall attachments. He was unsuccessful in replacing the uterus afterwards. (Ex. 3, T. 102, 127, 224, 289, 638, 907, 939)

13. The Respondent was aware that he had not removed the fetal head when he sutured the laceration in Patient A's uterus. (Ex. 3, 5, T. 874-875)

14. Patient A was transferred to Elmhurst Hospital where she underwent a total abdominal hysterectomy, a right salpingo/oophorecty, bladder laceration repair and urethral replacement, right and left sides. (Ex. 5, 5A, T. 102-109)

15. When the emergency service personnel were preparing to remove Patient A from the Econo Surgi-Center to Elmhurst Hospital, the Respondent requested the ambulance driver to transport her to Booth Memorial Hospital instead of Elmhurst, which was closer. (T. 55, 889)

CONCLUSIONS - PATIENT A

Patient A visited the Respondent at his office on April 23, 1990, and requested an abortion. The Respondent examined Patient A. He performed a physical examination and determined that there was an 18 - 19 week sized uterus and no fetal heart tone. He diagnosed "...second trimester pregnancy...missed abortion...". (FF #1,6,8, Allegation A1,A2)

In order to proceed safely with the performance of an abortion on this patient a reasonable and prudent physician must obtain a sonogram, necessary to corroborate fetal demise and gestational age. The Respondent's physical examination was adequate to measure uterine size but he failed to obtain a sonogram which is an objective measure of gestational age. The failure to obtain a sonogram, under these circumstances, constituted gross negligence by the Respondent.
(FF #3,4,6,8, Allegation A1, A3)

The recognition of fetal demise necessitated the transfer of Patient A to an in-patient facility for the abortion procedure. Further, the Respondent's failure to obtain pre-operative blood testing to determine Patient A's coagulation status and to have

blood available in case of hemorrhage further compromised the safety and well-being of Patient A. The Respondent's failures in this regard demonstrate gross incompetence in his care and treatment of Patient A.
(FF #3,8,9,11,12, Allegation A5, A8)

On April 24, 1990, the Respondent inserted 8 laminaria in Patient A's cervix for the purpose of passive dilatation, he noted this procedure in his office records. The Committee finds that this was not a deviation from standard medical practice.
(FF #3,10, Allegation A7)

On April 25, 1990, Patient A reported to the Econo Surgi-Center, an out-patient facility to undergo a termination of pregnancy to be performed by the Respondent. The Respondent was to be assisted in this procedure by an anesthesiologist and a nurse.
(FF #3,11, Allegation A6)

Patient A was administered intravenous Brevitol. The Respondent removed the laminaria and injected 1% Lidocaine. This was a deviation from the normal procedure, however, the Respondent acted upon the advice of the anesthesiologist (T. 948). When the amniotic membrane was ruptured a quantity of cloudy green amniotic fluid was noted. This discoloration of the amniotic fluid is an indication of fetal distress and possible demise.
(FF #11, Allegation A5, A6)

The Respondent proceeded to perform the evacuation and extraction of fetal parts and placenta from the patient. During this process he realized that he had not removed the fetal skull and in his attempt to recover the skull he noted a uterine laceration. The Respondent delivered the uterus into the vagina through the anterior vaginal wall and in the process he further compounded Patient A's injuries. He then sutured the uterine laceration without retrieving the fetal skull. The Respondent alleges that there was an inadvertent eversion of the uterine wall and uterine laceration. The Committee in its reconstruction of the events, as supported by the credible evidence in the record, at the

time of surgery, concludes that it was not an "inadvertent eversion of the uterine wall" but rather, the uterine fundus was delivered into the vagina through a separate opening in the vaginal wall. (FF #12,13, Allegation A4, A9, A10)

A reasonable and prudent physician faced with a uterine laceration in an out-patient facility would have terminated the procedure immediately upon detecting the lacerated uterus and transferred the patient to the nearest hospital setting where the repair of the laceration would have performed through an abdominal incision. The retrieval of the fetal skull necessitated a laparotomy which could not be performed in an out-patient facility. (FF #3,11,12,13,14,15, Allegation A4, A6, A10)

The Committee concludes that the repair of the lacerated uterus signifies that the procedure was not immediately terminated and Patient A transferred to the nearest hospital. The failure to immediately terminate the procedure and the persistent attempt to repair the laceration in an out-patient facility led to the significant injuries sustained by Patient A as a result of the Respondent's gross incompetence in his handling of the initial complications that developed during the abortion procedure. (FF #12,13,14, Allegation A4)

The Committee agrees that the credible evidence indicates that the Respondent requested the transporting ambulance to take Patient A to Booth Memorial Hospital which was further from the Econo Surgi-Center than Elmhurst General Hospital. However, we do not feel that this was professional misconduct but merely an attempt, by the Respondent, to go to a facility with which he was familiar. (FF# 15, Allegation A11)

The record does not support the allegation that it was the Respondent who informed the responding EMS personnel regarding the nature of the procedure being performed on Patient A. Rather, the evidence tends to support, and we believe, that it was the anesthesiologist who spoke with the EMS attendant. (T. 948, FF #15, Allegation A12, A13)

The Committee found Patient A to be a credible witness and we accept her testimony that the Respondent did not advise her to obtain a sonogram prior to the termination of her pregnancy as he noted in his office record.
(FF #4,5,7, Allegation A13)

The Committee unaminously sustains Allegations A1, A3, A4, A5, A6, A8, A9, A10 and A13. We do not sustain Allegations A2, A7 and A12. Allegation A11 is sustained, however, the Committee does not find that the Respondent's conduct to be professional misconduct as regards his communication with the EMS driver. We sustain Allegation A13, in part, as regards the Respondent's notation in the office chart that he advised Patient A to obtain a sonogram. We do not find that he made false representations when he noted a diagnosis of fetal demise and we do not believe that he was the doctor who communicated with the responding ambulance personnel.

FINDINGS OF FACT - PATIENT B

16. On June 18,1990, Patient B presented at the Respondent's office with complaints of "abdominal pain and possible miscarriage". (Ex. 7)

17. The Respondent noted, on physical examination, multiple condyloma, accumita of her vagina and perineum, and severe cervicitis. (Ex. 7)

18. The Respondent performed dilatation and suction curettage of her uterus for the purpose of aborting her pregnancy. (Ex. 7)

19. The tissue removed during the procedure was examined by a pathologist and revealed extensive hydropic degeneration. (Ex. 7)

20. The Respondent failed to treat the severe cervicitis and condyloma accuminateus prior to performing the abortion. (Ex. 7, T. 978)

21. The Respondent did not perform weekly pregnancy tests and follow-up Patient B for possible gestational trophoblastic disease after the abortion. (Ex. 7, T. 979-980)

22. The Respondent did not order a serologic test for syphilis for Patient B. (Ex. 7, T. 978)

23. The Respondent examined the fetal tissue subsequent to the abortion and documented his findings in the patient's office record. (Ex. 7, T. 981)

CONCLUSIONS - PATIENT B

The Committee finds that the Respondent's care and treatment of Patient B did not evidence either gross negligence or gross incompetence. We find that there was not significant deviation from the accepted standards of practice to warrant substantiating either of the above charges for Patient B.
(FF # 19, 20, Allegation B1)

It is a fact that the Respondent did not treat the severe cervicitis, condyloma, failed to follow the patient for possible trophoblastic disease and failed to perform a serologic test for syphilis. Cervicitis and condyloma are not diseases that necessarily require treatment before performing an abortion and may spontaneously regress after the procedure. The presence of hydropic degeneration of villi is not diagnostic of trophoblastic disease and the subsequent pathology did not necessitate treatment or reveal trophoblastic disease. It is the Committee's impression from the testimony presented that it is not routine practice in the community to test all patients for condyloma and syphilis.
(FF # 19 through 22, Allegations B1, B2 and B3)

The hearing record indicates that the Respondent did, in fact, examine the fetal tissue subsequent to the abortion and documented same in his office records.
(FF # 23, Allegation B4)

Therefore, the Committee concludes that in his care and treatment of Patient B, the Respondent, did not act with Gross Negligence, Gross Incompetence and/or Negligence or Incompetence on this occasion. The Committee votes unaminously not to sustain Allegations B1 through B4.

FINDINGS OF FACT - PATIENT C

24. On June 1, 1990, the Respondent saw Patient C who complained of post menopausal bleeding, itching, lumps in her vagina and requested a Pap smear. (Ex. 8, T. 997)

25. The Respondent's examination noted a left mastectomy scar, vaginal condyloma and chronic cervicitis. (Ex. 8, T. 997)

26. The Respondent obtained cervical and vaginal smears for a Pap test and subsequently excised the condyloma and cauterized the uterine cervix. (Ex. 8, T. 998)

27. The Respondent cauterized Patient C's cervix prior to receiving the report of the Pap smears. (Ex. 8, T. 998, 1011)

28. The Respondent did not perform a D & C on Patient C. (Ex. 8, T. 998-999, 1009-1010)

29. The Respondent did not perform or order a test for syphilis. (Ex. 8)

CONCLUSIONS - PATIENT C

The Committee finds that the Respondent's failure to obtain the Pap smear results prior to cauterization of Patient C's cervix was a fundamental error and deviates from accepted standards of medical care and constitutes negligence on this occasion. (FF #26, 27, Allegation C1)

The Respondent's failure to perform a D & C to rule out cancer as a cause of Patient C's post menopausal bleeding also constituted negligence on this occasion.
(FF #25, 28, Allegation C2)

As discussed, supra, in the matter of Patient B, to routinely test for condyloma and syphilis is not common practice in the medical community.
(FF #25, 29, Allegation C3)

FINDINGS OF FACT - PATIENT D

30. Patient D, a 29 year old woman, came to the Respondent's office on June 18, 1990, complaining of irregular vaginal bleeding, over the past six (6) months, and infertility. Patient D had been married for one year. (Ex. 9, T. 1034)

31. The Respondent examined Patient D and obtained a negative test for pregnancy. (Ex. 9)

32. On June 20, 1990, the Respondent performed a dilatation and curettage on Patient D in his office. (Ex. 9, T. 1035)

33. The Respondent performed the D & C on Patient D to address her vaginal bleeding. (Ex. 9, T. 714, 810, 1035)

CONCLUSIONS - PATIENT D

The Committee finds that Patient D presented to the Respondent complaining of irregular menstruation and infertility. The proper procedure for the treatment of irregular menstruation could be a D & C. However, a D & C is contraindicated as a primary diagnostic procedure for the evaluation of infertility.

As the patient's chart indicates that the D & C was done for irregular bleeding we do not find that the Respondent's care and treatment of Patient D constituted professional misconduct in this instance.
(FF # 32, 33, Allegation D1)

FINDINGS OF FACT - PATIENT E

34. On May 15, 1990, Patient E, a 40 year old female, went to The Respondent's office with complaints of abnormal uterine bleeding, for approximately three weeks, and abdominal cramps. A pregnancy test was performed with negative results. Although, the Respondent obtained consent from the patient to perform an endometrium biopsy, he performed a D & C. (EX. 10, T. 1054-1055)

CONCLUSIONS - PATIENT E

The Committee finds that in a 40 year old patient with irregular bleeding, an enlarged uterus and a negative pregnancy test requires a D & C for diagnosis.
(FF #34, Allegation E1)

We agree that the Respondent obtained the patient's consent for an endometrium biopsy when in fact he performed a D & C. This conduct constitutes simple negligence on this occasion.
(FF #34, Allegation E2)

FINDINGS OF FACT - PATIENT F

35. On October 31, 1989, Patient F went to the Respondent's office with complaints of mild bleeding, nausea and spotting for the past two weeks. The Respondent performed a pelvic examination and determined that the uterus was approximately six weeks size. In addition, he diagnosed the patient as suffering from severe chronic cervicitis and condyloma in the perineal area. (Ex. 11)

36. The Respondent administered 20 mg. of Valium and 75 mg. of Demerol to Patient F. (Ex. 11, T. 412, 741, 840)

37. The Respondent administered 20 mg. of Valium and 75 mg. of Demerol without the assistance of any medically trained personnel. (T. 414)

38. The Respondent did not deny that he administered 20 mg. of Valium and 75 mg. of Demerol to Patient F. The Valium and Demerol administered to the patient was excessive. (EX. 11, T. 412, 415)

39. A physician needs a valid DEA number in order to administer Demerol. The Respondent's DEA number was revoked at the time that he administered Demerol to Patient F. (Ex.13, T. 414-415)

CONCLUSIONS - PATIENT F

The Committee finds that the Respondent performed and documented a physical examination of Patient F. Therefore, Allegation F1 is not substantiated.
(FF # 35, Allegation F1)

The Respondent has stipulated to all of the charges re: administration of Valium and Demerol, and that no anesthesiologist or nurse anesthetist was present when these drugs were administered. In addition, the stipulation covers the fact that these drugs were administered in an excessive amount.
(FF #36, 37, 38, T. 414, Allegation F2, F4,)

The Respondent did not controvert the Department's allegation that he administered Demerol, to Patient F, after his DEA number had been revoked.
(FF #39, Allegation F3)

The Committee reiterates its findings, supra, re: Patients B and C it is not necessary, in this context, to test for syphilis and other sexually transmitted diseases. We also find that the Respondent did document the justification for performance of a suction curettage on Patient F.
(Ex. 11, FF # 35, Allegation F5, F6, F7)

The Committee concludes that the Respondent acted with gross negligence in his care and treatment of Patient F. Specifically, his administration of Valium and Demerol at the noted high doses, in combination and without appropriate medical backup and assistance.
(FF # 36, 37, 38, Allegation F2)

FINDINGS OF FACT - PATIENT G

40. On January 23, 1990, Patient G went to the Respondent's office for an abortion. The Respondent performed a pelvic examination and diagnosed that Patient G was 10 weeks pregnant. (Ex. 12)

41. The Respondent noted, grossly, the placental tissue removed from Patient G. (Ex. 12, T. 1077-1079, 1081)

42. The Respondent did not document the amount of placental tissue removed in his operative note. (Ex. 12, 1082)

CONCLUSIONS - PATIENT G

The Committee has thoroughly reviewed the record and we do not find that there was any deviation from the acceptable standards of medical practice in the Respondent's care and treatment of Patient G.
(FF #40, 41, 42, Allegation G1, G2)

GENERAL CONCLUSIONS

The Committee finds that the Respondent, Dr. Ming Kow Hah, was guilty of professional misconduct in that:

He is guilty of Gross Incompetence - Allegations: A5, A8.

He is guilty of Gross Negligence - Allegations: A1, A3, A4, A6, A9, A10, F2, F3, F4.

He is guilty of Negligence on more than one occasion - Allegations: A1, A3, A4, A6, A9, A10, C1, C2,E2, F2, F3, F4.

He is guilty of Practicing the Profession Fraudulently - Allegation: A13.

We do not find that the Respondent is guilty of "Incompetence On More Than One Occasion" or that he is guilty of "Excessive Treatment".

The Committee was very disturbed by the apparent lack of medical knowledge exhibited by the Respondent in his responses to medical questions posed to him by the panel. Finally, and consistently alarming, has been the apparent discrepancies noted in the medical records offered and certified by the Respondent for his defense. There were two instances where certified records, in evidence, were found to lack notations present in copies of the same documents supplied to defense witnesses. These events reflected negatively upon the Respondent's credibility.

RECOMMENDATION

The Committee recommends, unaminously, to the Commissioner of Health, that the Respondent's license to practice medicine, in the State of New York, be REVOKED.

DATED: New York, N.Y.
February 26 1991

Respectfully submitted

Mr. Robert M. Briber
Chairperson
Dr. Jean M. Chin, M.D.
Dr. Jerry Waisman, M.D.

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

IN THE MATTER :

OF :

MING KOW HAH, M.D. :

COMMISSIONER'S RECOMMENDATION

TO: Board of Regents
New York State Education Department
State Education Building
Albany, New York

A hearing in the above-entitled proceeding was held on November 26, 1990, November 29, 1990, December 3, 1990, December 4, 1990, December 11, 1990, December 13, 1990, December 17, 1990, December 19, 1990, January 3, 1991, January 17, 1991. Respondent, Ming Kow Hah, M.D. appeared by Neal S. Simon, Esq. The evidence in support of the charges against the Respondent was presented by Dianne Abeloff, Esq.

NOW, on reading and filing the transcript of the hearing, the exhibits and other evidence, and the findings, conclusions and recommendation of the Committee,

I hereby make the following recommendation to the Board of Regents:

A. The Findings of Fact and Conclusions of the Committee should be accepted in full;

B. The Recommendation of the Committee should be accepted; and

C. The Board of Regents should issue an order adopting and incorporating the Findings of Fact and Conclusions and further adopting as its determination the Recommendation described above.

EXHIBIT "C"

The entire record of the within proceeding is transmitted with this Recommendation.

DATED: Albany, New York
April 7, 1991

ALFRED GELLHORN, M.D.
Director of Medical Affairs
New York State Department of Health

The University of the State of New York

IN THE MATTER

OF

MING KOW HAH
(Physician)

DUPLICATE ORIGINAL VOTE AND ORDER NO. 11953

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 11953, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (July 26, 1991): That, in the matter of MING KOW HAH, respondent, the recommendation of the Regents Review Committee be accepted as follows:

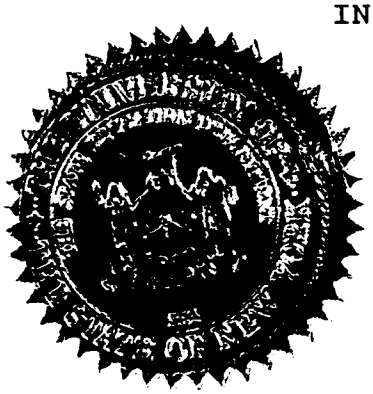
1. The hearing committee's findings of fact, conclusions as to guilt, and recommendation as to the penalty to be imposed, as well as the Commissioner of Health's recommendation as to those findings, conclusions, and recommendation be accepted, except that the last paragraph of the General Conclusions on page 17 of the hearing committee's report not be accepted;
2. Respondent is guilty, by a preponderance of the evidence, of the first, sixth, eighth, ninth, and seventeenth specifications of the charges to the extent indicated in the hearing committee report; and
3. Respondent's license to practice as a physician in the State of New York be revoked upon each specification of the charges of which respondent was found guilty, as aforesaid;

and that the Commissioner of Education be empowered to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote;

and it is

ORDERED: That, pursuant to the above vote of the Board of Regents, said vote and the provisions thereof are hereby adopted and **SO ORDERED**, and it is further

ORDERED that this order shall take effect as of the date of the personal service of this order upon the respondent or five days after mailing by certified mail.



IN WITNESS WHEREOF, I, Thomas Sobol, Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 26th day of July, 1991.

Thomas Sobol

Commissioner of Education