STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Lorna McBarnette
Executive Deputy C issioner

February 19, 1992

UPS NEXT DAY AIR

Abu Hayat, M.D.
9 Avenue A
New York, New York

Diane Abeloff, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza - Sixth Floor
New York, New York 10001-1810

RE: In the Matter of Abu Hayat, M.D.

Dear Dr. Hayat and Ms. Abeloff:

Enclosed please find the Determination and Order of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

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 of the Hearing Committee's Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to the New York State Department of Health, Bureau of Adjudication, Corning Tower - Room 2503, Empire State Plaza, Albany, New York 12237-0030, **Attention: James F. Horan, Esq., Administrative Law Judge**. The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

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

Very truly yours,

Tyrone T. Butler

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nam
Enclosure

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

IN THE MATTER	:	**DETERMINATION**
OF	:	**AND**
ABU HAYAT, M.D.	:	**ORDER**

Jerry Waisman, M.D., Chairman, Robert J. O'Connor, M.D. and **Ms. Eugenia Herbst** duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Sections 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. **Michael P. McDermott, Esq.**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF THE PROCEEDINGS

Notice of Hearing dated:	November 22, 1991
Statement of Charges dated:	November 21, 1991
Pre-hearing conferences:	December 2, 1991
Hearing dates:	December 3, 1991 December 4, 1991 December 17, 1991
Deliberation dates:	January 9, 1992 February 4, 1992
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York

Petitioner appeared by: Peter J. Millock, Esq.
General Counsel
NYS Department of Health
By: Diane Abeloff, Esq.
Associate Counsel

The Respondent failed to appear.

Motions: November 27, 1991 - Pre-hearing motion for an adjournment on behalf of the Respondent by Amelio Marino, Esq.

MOTION DENIED

WITNESSES

For the Petitioner:

1) Patient A (Nancy I. Adler - Spanish interpreter)
2) Patient D (Nancy I. Adler - Spanish interpreter)
3) Patient B (Jessy Pierre-Louise - Haitian Creole interpreter)
4) Patient B's husband (Jessy Pierre-Louise - Haitian Creole interpreter)
5) Michelle Flemings, M.D.
6) Patricia Harding, M.D.
7) Margie Miranda
8) Peter Sailon, M.D.
9) Marjorie Andrade
10) Albert Baldassari

For the Respondent:
NONE

STATEMENT OF CHARGES

A Commissioner's Order and Notice of Hearing, dated November 22, 1991, advises that a determination had been made that the continued practice of medicine in the State of New York by the Respondent constitutes an imminent danger to the health of the people of the State and ordered that effective immediately the Respondent shall not practice medicine in the State of New York and that the Order shall remain in effect

unless modified or vacated by the Commissioner of Health pursuant to New York Public Health Law Section 230(12), as amended by Ch. 606, Laws of 1991.

The Statement of Charges essentially charges the Respondent with professional misconduct by reason of practicing the profession of medicine with gross negligence; with negligence on more than one occasion; with violation of State Law governing the practice of medicine; with moral unfitness in the practice of medicine, with abandonment of a patient; with fraudulent practice, with failing to maintain accurate records and with excessive tests not indicated clinically.

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

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 the cited evidence.

GENERAL FINDINGS

1. Abu Hayat, M.D., the Respondent, was authorized to practice medicine in New York State on September 6, 1973 by the issuance of license number 117511 by the New York State Education Department (Pet's. Ex. 2).

2. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991 through December 31, 1992 from Medico-Ways Building, 9 Avenue A, New York, NY 10009 (Pet's. Ex. 2).

FINDINGS OF FACT AS TO PATIENT A

3. On October 25, 1991 in response to a newspaper advertisement, Patient A went to 296 Broadway, Brooklyn, N.Y. for an abortion (Tr. 14-16).

4. At the 296 Broadway address, Patient A met and was examined by Margie Miranda who then took her to the Respondent's office at 9 Avenue A, New York, N.Y. (Tr. 16, 252-259).

5. During her testimony Patient A described the Respondent's physical characteristics and then identified him from two photographs (Pet's. Exs. 20 and 21; Tr. 44-46).

6. The Respondent told Patient A that the fee for the abortion was $1500 cash. Patient A told the Respondent that she only had $1,000 cash with her. The Respondent accepted the $1,000 and also took her passport, residency (green) card, and a gold and diamond ring as collateral for the remaining $500 (Tr. 30-31).

7. The Respondent then examined Patient A, who was put to sleep. Her abdomen was injected, and laminaria was inserted into her cervix as part of an abortion (Tr. 18-20).

8. The Respondent told Patient A to return to his office the next day, October 26, 1991. He also told her

that if she had any problems she should call Margie and not go to any hospital (Tr. 21).

9. At about 9:40 a.m. on October 26, 1991, Patient A went with Margie to the Respondent's office. Patient A told the Respondent that she did not want to continue the procedure. The Respondent told her that at this point she had to proceed with the abortion (Tr. 21, 259).

10. The Respondent gave Patient A an injection in the arm, which tranquilized her. When she recovered, the Respondent told her that he had removed the "old medication" and inserted some more (Tr. 24).

11. The Respondent told Patient A to return to his office on the next day, October 27, 1991. He also told her to go home; not to go to any hospital; not to inform anyone; but if she felt badly she should call Margie (Tr. 25).

12. That night, October 26, 1991, Patient A experienced severe abdominal pain and contractions (Tr. 32, 34, 261-262).

13. Patient A called Margie and told her about the pain and contractions. Margie told her that she would call the Respondent. Margie called the Respondent, who said that Patient A was not yet ready and should wait until the next day (Tr. 32-33, 261).

14. Patient A called Margie a second time complaining of pain. Margie told Patient A the Respondent had said that this was normal, not to get desperate. Margie then told Patient A to come to her house, and she would take care of

her (Tr. 33, 261).

15. The pain finally became too severe for Patient A, and she told her mother that she was pregnant and in a lot of pain (Tr. 34).

16. A family friend called an ambulance for Patient A. The ambulance took her to Jamaica Hospital, 89th Avenue and Van Wyck Expressway, Jamaica, N.Y. At about 8:10 a.m. on October 27, 1991, in the emergency room of Jamaica Hospital, Patient A delivered a live 30-32 week old (1400 Gm.) baby girl with a missing right arm (Pet's Exs. 3 and 4; Pet's Ex. 5, Pgs. 3-4; Tr. 35-37).

17. The physicians at Jamaica Hospital performed a D&C, an abdominal x-ray and a pelvic sonogram, and failed to locate the baby's missing arm (Pet's Ex. 4, pgs. 18, 19, 49 and 50; Tr. 315).

18. The Respondent never weighed or measured Patient A; never performed a sonogram on her; never took her temperature; never discussed with her that her pregnancy was greater than 24 weeks; never discussed the need for prenatal care; never discussed adoption or foster care with her, and never obtained written consent (Tr. 28-29).

19. The performance of an abortion on a woman who is 30-32 weeks pregnant when her health is not in jeopardy violates N.Y.S. Law (Penal Law Section 125.45; Tr. 309, 313).

20. The Respondent knew that performing an abortion on a woman without medical complication whose pregnancy is

greater than 24 weeks, violates the law (Tr. 423).

21. In the case of Patient A, the Respondent attempted a third trimester abortion in his office. A termination this late in the pregnancy must be performed in an adequately staffed and equipped facility (Tr. 309, 318-320).

CONCLUSIONS AS TO PATIENT A

1. The Respondent saw Patient A on several occasions and attempted to abort a third trimester pregnancy in his office.

2. The Respondent failed to obtain a complete medical history and failed to perform a complete physical examination on this patient. The Respondent also failed to obtain those tests necessary to confirm the pregnancy and, more importantly, its duration.

3. The Respondent's facilities and supporting staff were inadequate to safely perform third trimester abortions (Pet's. Ex. 27).

4. The Respondent's follow up procedures were inadequate to insure the safety of the patient following the attempted abortion and including his failure to respond to Patient A's subsequent calls of distress.

5. The Respondent's medical records for Patient A are not credible and are incomplete with regards to the initial evaluation, treatment and follow up of the patient. There also was not record of informed consent.

6. The Respondent's financial arrangements with Patient A were irregular and highly questionable.

FINDINGS OF FACT AS TO PATIENT B

1. Patient B went to Respondent's office, 9 Avenue A, New York, N.Y., for an abortion on March 17, 1991 (Tr. 112, 149, 268-270).

2. Patient B and her husband identified the Respondent from three photographs as the physician who began the abortion on Patient B on the second floor of his facility (Pet's. Exs. 20, 21 and 22; Tr. 112, 137-138).

3. During the course of the abortion, the Respondent left Patient B and went downstairs to the waiting room to speak to Patient B's husband. The Respondent informed Patient B's husband that Patient B's pregnancy was more advanced than he had originally thought (Tr. 143).

4. The Respondent demanded an additional $500.00 from Patient B's husband and told him that if he didn't immediately pay the additional money he would not complete the abortion and Patient B's husband would have to take his wife home (Tr. 119, 133, 143-144, 284-285).

5. Patient B's husband did not have the additional money. He pleaded with the Respondent to finish the procedure and said that he would bring the additional $500.00 the following afternoon. The Respondent refused to complete the procedure and sent Patient B home, while she was bleeding heavily and still under sedation. The Respondent

and one of his assistants physically assisted Patient B downstairs (Tr. 115-116, 121, 144-149).

6. Patient B had severe abdominal pains and bleeding, which continued from the time of discharge from the Respondent's office until the next day (Tr. 117, 151-152).

7. On the next day, March 18, 1991, at 11:45 pm Patient B's husband took her to St. Luke's Hospital, Amsterdam Avenue at 114th Street, New York, N.Y. (Pet's Ex. 8, pgs.2 and 8; Tr. 152-170).

8. Dr. Michelle Flemmings examined Patient B upon her admission to the hospital. Dr. Flemmings found that Patient B had a distended abdomen, was febrile to 103°F, was tachycardic, and had a foul-smelling dark bloody discharge with little pieces of fetal tissue and laminaria protruding from her cervix (Pet. Ex. 8 pg. 4; Tr. 170-171).

9. Patient B's husband gave Dr. Flemings the history that Patient B had gone to the Respondent for an abortion and that the Respondent failed to complete the abortion because the patient's husband was unable to pay the additional $500.00 demanded by the Respondent (Tr. 173).

10. The abortion was completed at St. Luke's Hospital, and the patient was treated for sepsis (Pet's. Ex. 8, pgs. 3, 4 and 6).

11. Jeffrey Rubin, Esq. the Respondent's attorney at the time, submitted a letter, dated July 23, 1991, wherein he states that the Respondent is unaware of any treatment he

rendered to Patient B and is unfamiliar with her name and has no record of ever treating her. However, Margie Miranda, who was employed by the Respondent at the time, specifically remembers Patient B and her family in the clinic on several occasions (Pet's Ex. 7; Tr. 268-270).

12. The Respondent failed to maintain a medical record that accurately reflected his treatment of Patient B (Pet's Ex. 7).

CONCLUSIONS AS TO PATIENT B

1. On March 17, 1991, the Respondent began a second trimester abortion on Patient B. He refused to complete the procedure because the Patient's husband was unable to immediately pay an additional $500.00, which the Respondent demanded.

2. The Respondent's willful refusal to complete the abortion, complicated by hemorrhage, led to infection requiring hospitalization, intensive treatment for infection,and dilatation and curettage to complete the abortion.

3. The Respondent failed to maintain a medical record, which accurately reflected his evaluation and treatment of Patient B.

FINDINGS OF FACT AS TO PATIENT C

1. In September, 1990, Patient C was referred to Respondent's office at 9 Avenue A, New York N.Y. for an abortion by a clinic at 165 Willoughby Avenue, Brooklyn, N.Y.

Patient C was accompanied to the Respondent's office by her mother and the husband of the operator of the Willoughby Avenue Clinic. She was examined by the Respondent, given a prescription for antibiotics, and told to return (Tr. 223-224, 262-268).

2. On September 18, 1990, Patient C and her mother returned to the Respondent's office. Patient C was given an intravenous infusion, which put her to sleep. She was kept for about four hours and then given another prescription for antibiotics (Tr. 224, 264-265).

3. Later in the evening of September 18, 1990, Patient C complained of vaginal bleeding, abdominal pain, and difficulty breathing. On September 19, 1990, she was admitted to Kings County Medical Center, 451 Clarkson Avenue, Brooklyn, N.Y. (Pet's Ex. 11, pg. 25; Tr. 222-224).

4. The diagnosis for Patient C was sepsis secondary to a perforated uterus from an abortion. The surgeons at Kings County performed an exploratory laparotomy, discovered that the uterus was perforated in the posterior lower segment, and removed the uterus and the left adnexa (Pet's Ex. 11, pgs. 27 and 34; Tr. 229).

5. As a result of the sepsis, Patient C developed disseminated intravascular coagulation, which was evident upon admission to the hospital (Pet's Ex. 11, pg. 35; Tr. 233-234).

6. Patient C died of septic shock on September 26,

1990 at Kings County Hospital (Pet's Ex. 11, pg. 85).

7. Jeffrey Rubin, Esq., the Respondent's attorney at the time, submitted two letters, dated April 30, 1991 and July 23, 1991, wherein he states that the Respondent claims that he never treated Patient C at his clinic at 9 Avenue A, New York, N.Y., and that he never performed an abortion on her. Mr. Rubin also reported that the Respondent claims that he does not have nor did he ever have possession of a patient chart concerning the treatment of Patient C (Pet's Exs. 7 and 9).

8. Dr. Patricia Harding was the chief resident responsible for Patient C's medical care at Kings County Hospital. She identified Patient C from a photograph (Pet's Ex. 24; Tr. 222).

9. Dr. Harding asked Patient C's mother for the name of the physician who treated her daughter. Patient C's mother told Dr. Harding that it was the Respondent. Dr. Harding asked Patient C's mother to have the Respondent call her at the hospital. The Respondent called Dr. Harding at Kings County Medical Center and told her that Patient C had delivered a fetus at home and came to him with complaints of abdominal pain and bleeding and that he sent her straight to the hospital (Pet's Ex. 11, pgs. 6 and 54; Tr. 236-237).

10. Margie Miranda, who was employed by the Respondent at the time, identified Patient C from a photograph. She testified that Patient C, accompanied by her mother, was seen

twice at the 9 Avenue A office in September 1990 and that subsequent to the second visit, Patient C's mother phoned the Respondent and was hysterical and crying at that time (Pet's ex. 24; Tr. 262-268).

11. Margie Miranda also testified that there had been a record on Patient C at the Respondents office and that at the time of Patient C's first visit, the Respondent argued with the operator of the referring clinic about payments relative to Patient C (Tr. 266-283).

CONCLUSIONS AS TO PATIENT C

1. On September 18, 1990, the Respondent performed an abortion on Patient C. During the course of the abortion, the Respondent perforated the uterus.

2. On the following day, September 19, 1990, Patient C was admitted to Kings County Hospital where the diagnosis was sepsis secondary to a perforated uterus from an abortion. She developed disseminated intravascular coagulation as a result of the sepsis and died on September 26, 1990 as a result of the coagulopathy.

3. The Respondent failed to transfer or make arrangements for the transfer of Patient C to the hospital after her uterus had been perforated.

4. The Respondent failed to maintain a medical record, which accurately reflected his evaluation and treatment of Patient C.

FINDINGS OF FACT AS TO PATIENT D

1. On July 14, 1988, Patient D went to the Respondent's office at 9 Avenue A, New York, N.Y. for termination of an approximate 17 week pregnancy. The Respondent started the abortion process (Pet's Ex. 14, pgs. 15 and 20; Tr. 76).

2. Patient D identified the Respondent from two photographs as the physician who performed the abortion (Pet's Exs. 20 and 21; Tr. 76-77).

3. On July 17, 1988, in the room on the second floor of the Respondent's Avenue A office, the Respondent performed an abortion on Patient D. After the procedure, Patient D came downstairs and was hemorrhaging. The Respondent told Patient D that the bleeding was normal and that she should go home. He did not tell her it was necessary to return for a follow-up examination. (Tr. 83-84).

4. Subsequent to the abortion, Patient D remained in extreme pain and returned to the Respondent's office on July 19, 1988. The Respondent resuctioned Patient D. After the procedure Patient D was again bleeding, and the Respondent told Patient D's girlfriend that Patient D could go home, that everything was going to be okay (Tr. 84-91).

5. Twelve hours after the Respondent resuctioned Patient D, she started defecating fecal matter through her vagina (Tr. 91).

6. After talking with a girlfriend about her medical

problems, Patient D went to see her girlfriend's physician who sent her to North Central Bronx Hospital (Tr. 92).

7. Patient D was admitted to North Central Bronx Hospital at 9:13 PM on August 3, 1988 (Pet's Ex. 14, pg. 1).

8. The emergency room physicians found parts of a fetal skull in Patient D's cervix (Pet's Ex. 14, pg. 7).

9. Patient D was diagnosed as having an uterocolic fistula and was operated for that condition on August 5, 1988 (Pet's Ex. 14, pg. 48).

10. In an affidavit, dated November 29, 1989, the Respondent denied that he ever examined or treated Patient D and claimed that he had no medical records regarding this patient (Pet's Ex. 13, pg. 3).

CONCLUSIONS AS TO PATIENT D

1. During the course of performing a second trimester abortion on Patient D, the Respondent perforated her uterus in two places. These perforations caused a uterocolic fistula.

2. The Respondent failed to transfer or arrange for the transfer of Patient D to the hospital.

3. The Respondent failed to completely evacuate the fetal parts from Patient D's uterus prior to sending her home from his office.

4. The Respondent failed to maintain a medical record, which accurately reflected his evaluation and treatment of

Patient D.

FINDINGS OF FACT AS TO PATIENT E

1. On March 24, 1989, Patient E went to the Respondent's office at 9 Avenue A, New York, N.Y., for an abortion. The Respondent billed Group Health Insurance (GHI) for the performance of this abortion (Pet's. Exs. 16 and 17).

2. The Respondent failed to perform and document a complete physical examination of Patient E (Pet's Ex. 16; Tr. 368).

3. The Respondent failed to take and document an adequate general medical history of Patient E (Pet's Ex. 16; Tr. 369).

4. The Respondent failed to include in Patient E's chart an operative report of the abortion (Pet's Ex. 17; Tr. 370-371).

CONCLUSIONS AS TO PATIENT E

1. The Respondent failed to perform and/or document a complete physical examination of Patient E.

2. The Respondent failed to take and document an adequate general medical history of Patient E.

3. The Respondent failed to include in Patient E's chart an operative report of the abortion.

4. The Respondent's record for Patient E fails to accurately reflect his evaluation and treatment of this

patient.

FINDINGS OF FACT AS TO PATIENT F

1. On July 22, 1988, Patient F went to Respondent's office at 9 Avenue A, New York, N.Y., for an abortion, which the Respondent performed on that date (Pet. Ex. 18).

2. The Respondent failed to perform and document a pelvic examination of Patient F (Pet. Ex. 18; Tr. 377).

3. The Respondent failed to perform a pregnancy test or sonogram on Patient F prior to performing the abortion (Pet's Ex. 18; Tr. 378- 379).

4. The Respondent ordered or performed cardiac and pulmonary function tests on Patient F. Patient F had no known history of pulmonary or cardiac problems (Tr. 380).

5. The Respondent failed to include in Patient F's chart an operative report of the abortion procedures (Pet's Ex. 18; Tr. 379).

CONCLUSIONS AS TO PATIENT F

1. The Respondent failed to perform and document a pelvic examination of Patient F.

2. The Respondent failed to perform a pregnancy test or sonogram on Patient F prior to performing the abortion.

3. The Respondent failed to include in Patient F's chart an operative report of the abortion procedure.

4. The Respondent ordered or performed cardiac and

pulmonary tests without medical justification.

5. The Respondent's record for Patient F fails to accurately reflect his evaluation and treatment of this patient.

FINDINGS OF FACT AS TO PATIENT G

1. On March 3, 1989, Patient G went to Respondent's office at 9 Avenue A, New York, N.Y. for an abortion, which the Respondent performed on that date (Pet's Ex. 19).

2. The Respondent failed to perform and document an adequate history and physical examination on Patient G (Tr. 385-387).

3. The Respondent failed to perform a pregnancy test or sonogram prior to performing the abortion (Tr. 387).

4. The Respondent failed to determine and document Patient G's blood type or RH factor prior to performing the abortion (Tr. 373-374, 387).

5. The Respondent failed to include in Patient G's chart an operative report of the abortion procedures (Pet's Ex. 19; Tr. 388).

CONCLUSIONS AS TO PATIENT G

1. The Respondent failed to perform and document an adequate history and physical examination on Patient G.

2. The Respondent failed to perform a pregnancy test or sonogram prior to performing the abortion on Patient G.

3. The Respondent failed to determine and document Patient G's blood type or RH factor prior to performing the abortion.

4. The Respondent failed to include in Patient G's chart an operative report of the abortion procedure.

5. The Respondent failed to maintain a medical record for Patient G, which accurately reflected his evaluation and treatment of this patient.

FINDINGS OF FACT AS TO PATIENT H

1. On October 11, 1991, Patient H went to the Respondent's office at 9 Avenue A, New York, N.Y., for a post-abortion follow-up examination (Tr. 185).

2. Patient H identified the Respondent from three photographs as the physician, who had performed the abortion on October 4, 1991 (Pet's Exs. 20, 21 and 22; Tr. 183-184).

3. During the course of the examination on October 11, 1991, Patient H was lying prone on the examining table. The Respondent simultaneously placed his fingers in Patient H's anus and vagina, while his other hand was on her buttocks. He then moved the hand, which he had on her buttocks, and tucked it under her breast and left it there (Tr. 191).

4. A physician cannot properly perform a breast examination and a pelvic examination simultaneously (Tr. 394).

5. The Respondent denies treating Patient H despite the

fact that Exhibit 23 is a prescription signed by him to this patient (Pet's Ex. 32; Tr. 453).

CONCLUSIONS AS TO PATIENT H

1. The Respondent treated Patient H despite his denials to the contrary.

2. During the course of an examination on October 11, 1991 the Respondent inappropriately performed a simultaneous pelvic and breast examination on Patient H.

HEARING COMMITTEE CONCLUSION WITH REGARD TO THE RESPONDENT'S DENIALS OF TREATING PATIENTS B, C, D AND H

Hearings in this matter were held on December 3, 1991, December 4, 1991 and December 17, 1991. The Respondent failed to appear in person or by counsel on any of the hearing dates, despite the very serious charges against him.

The record indicates that the Respondent denies treating Patients B, C, D and H.

The Hearing Committee has reviewed the entire record and based upon a preponderance of the evidence, the Hearing Committee concludes that the Respondent did in fact treat these patients despite his denials to the contrary.

The Hearing Committee further concludes that the Respondent's denials constitute misrepresentations deliberately intended to conceal the fact that he treated

these patients.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous (3-0) unless otherwise indicated)

The Hearing Committee has noted two typographical errors in the Specification of Charges:

1. Specification 9 cites paragraph G.
   It should cite paragraph H.

2. Specification 24 cites paragraphs F-F5.
   It should cite paragraph F-F4.

The Hearing Committee has made the appropriate corrections.

FIRST THROUGH FOURTH SPECIFICATIONS:
(Gross Negligence)

SUSTAINED AS TO PARAGRAPHS: A-A1, A-A2, B-B1, B-B2, B-B4, C-C1, C-C3, D-D1, D-D2.

NOT SUSTAINED AS TO PARAGRAPHS: A-A3, B-B3, C-C2, D-D3.

FIFTH SPECIFICATION:
(Negligence on more than one occasion)

SUSTAINED as to paragraphs: A-A1, A-A2, B-B1, B-B2, B-B4, C-C1, C-C3, D-D1, D-D2, E-E1, E-E2, E-E3, F-F1, F-F2, F-F3, F-F5, G-G1, G-G2, G-G3, G-G4, G-G5.

NOT SUSTAINED AS TO PARAGRAPHS: A-A3, B-B3, C-C2, F-F4.

SIXTH SPECIFICATION
(Violation of state law governing the practice of medicine)

SUSTAINED as to paragraph: A-A1

SEVENTH THROUGH NINTH SPECIFICATION
(Moral unfitness in the practice of medicine)

SUSTAINED as to paragraphs: A-A1, A-A2, A-A3, B-B1, B-B2, B-B3, H-H1, H-H2.

NOT SUSTAINED as to paragraph B4.

TENTH THROUGH TWELFTH SPECIFICATIONS
(Abandonment of a patient)

SUSTAINED as to paragraph B-B1, C-C1, D-D1.

THIRTEENTH THROUGH SIXTEENTH SPECIFICATIONS:
(Fraudulent practice)

SUSTAINED as to paragraphs: A-A3, B-B3, C-C2, D-D3.

SEVENTEENTH THROUGH TWENTY THIRD SPECIFICATIONS
(Failing to maintain accurate records)

SUSTAINED as to paragraphs: A-A3, B-B4, C-C3, D-D4, E-E1, E-E2, E-E3, E-E4, F-F1, F-F2, F-F3, F-F4, F-F5, G-G1, G-G2, G-G3, G-G4, G-G5.

TWENTY FOURTH SPECIFICATION
(Excessive tests)

SUSTAINED as to paragraph F-F4.

HEARING COMMITTEE DETERMINATION WITH REGARD TO THE ISSUE OF IMMINENT DANGER

The Hearing Committee has reviewed the entire record in the case and unanimously determines that the continued practice of medicine in the State of New York by the Respondent constitutes an imminent danger to the health of the people of the State and the Summary Order issued by the Commissioner of Health shall remain in effect.

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee unanimously determines that the Respondent's license to practice medicine in the State of New York should be **REVOKED.**

ORDER

Based upon the forgoing, **IT IS HEREBY ORDERED THAT:**

1. Respondent's license to practice medicine in the State of New York is **REVOKED**.

DATED: New York, New York
February 11, 1992

JERRY WAISMAN, M.D.
Chairperson

ROBERT O'CONNOR, M.D.
MS. EUGENIA HERBST

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
ABU HAYAT, M.D.	:	CHARGES

----------X

ABU HAYAT, M.D., the Respondent, was authorized to practice medicine in New York State on September 6, 1973 by the issuance of license number 117511 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991 through December 31, 1992 from Medico-Ways Building, 9 Avenue A, New York, NY 10009.

FACTUAL ALLEGATIONS

A. On or about October 25, 1991, Patient A (the identity of Patient A and the other patients is contained in the attached appendix), went to Respondent's office, 9 Avenue A, New York, N.Y., for an abortion.

Patient A was informed that the fee for the abortion was $1500 cash. Patient A said that she only had $1,000 cash. He accepted that and took her passport, residency (green) card, and a gold and diamond ring as collateral for the remaining

$500. Respondent then examined Patient A, injected her abdomen with an unknown solution to cause the termination of the pregnancy and inserted laminaria into her vagina. Respondent told Patient A to return to his office on October 26, 1991. At or about 9:00 a.m. on October 26, 1991, Patient A returned to Respondent's office. She told Respondent that she did not want to continue the procedure. Respondent told Patient A that at this point she had to proceed with the abortion. Respondent gave her an injection in her arm which put her to sleep. When Patient A regained consciousness, Respondent told her that he had removed the old laminaria and inserted additional laminaria. Respondent informed Patient A that she should return to his office the next day, October 27, 1991.

That night, October 26th, Patient A experienced severe abdominal pain, fever, and vaginal bleeding. Patient A's mother called an ambulance for Patient A. The ambulance took her to Jamaica Hospital, 89th Avenue and Van Wyck Expressway, Jamaica, N.Y. At or about 8:00 a.m. on October 27, 1991, in the emergency room of Jamaica Hospital, Patient A delivered a 30-32 week old baby girl with a missing right arm.

1. Respondent began an abortion procedure on Patient A, a woman who was 30-32 weeks pregnant.

2. Respondent injected Patient A's abdomen with a solution to cause an abortion and inserted laminaria in a patient who was 30-32 weeks pregnant. The Respondent attempted this abortion in his office, not in a hospital.

3. Respondent's medical record for Patient A fails to accurately reflect his treatment of Patient A.

B. On or about March 15, 1991, Patient B went to Respondent's office, 9 Avenue A, New York, N.Y. for an abortion. Respondent examined Patient B. Patient B returned to Respondent's office for an abortion on March 17, 1991. During the course of the abortion, Respondent left Patient B and went out to the waiting room to speak to Patient B's husband. Respondent informed Patient B's husband that Patient B was later in her pregnancy than he originally thought. He demanded an additional $500 from Patient B's husband. He told Patient B's husband that if he did not pay the additional money he must take his wife home. Patient B's husband did not have the money. Respondent refused to complete the procedure and sent Patient B home.

Patient B had severe abdominal pains and bleeding from the time of discharge from Respondent's office. Patient B's

husband took her to St. Luke's - Roosevelt Hospital, Amsterdam Avenue at 114th Street, New York, N.Y., on or about March 18, 1991.

1. On or about March 17, 1991, Respondent began an abortion on Patient B which he failed to complete due to the patient's lack of funds.

2. Respondent performed an incomplete abortion which caused Patient B to suffer a septic abortion.

3. Respondent denies treating Patient B.

4. Respondent failed to maintain a medical record which accurately reflected his treatment of Patient B.

C. On or about September 18, 1990, Patient C went to Respondent's office, 9 Avenue A, New York, N.Y., for an abortion and then left his office. During the course of the evening of September 18, 1990, Patient C complained of vaginal bleeding, abdominal pain and difficulty breathing. On or about September 19, 1990, Patient C went to and was admitted to Kings County Medical Center, 451 Clarkson Avenue, Brooklyn, N.Y. The diagnosis was sepsis secondary to a perforated

uterus from an abortion. She died at that hospital on September 26, 1990.

1. On or about September 18, 1990, Respondent, during the course of performing an abortion on Patient C, perforated her uterus and failed to transfer/and or make arrangements for her transfer to a hospital.

2. Respondent denies performing an abortion on Patient C.

3. Respondent failed to maintain a medical record for Patient C which accurately reflected his treatment of Patient C.

D. On or about July 19, 1988, Patient D went to Respondent's office, 9 Avenue A, New York, N.Y., for termination of an approximately 17 week pregnancy. From the date of the abortion, July, 19, 1988, until August 3, 1988, when Patient D was admitted to North Central Bronx Hospital, 3424 Kossuth Avenue, Bronx, N.Y., Patient D's fecal matter exited through her vagina. During the course of examination of Patient D in the emergency room of North Central Bronx Hospital, parts of the fetal skull were removed from the patient's uterus.

1. During the course of performing a second trimester abortion, Respondent perforated Patient D's uterus in two places. These perforations caused a recto-uterine fistula. Respondent failed to transfer and/ or arrange for the transfer of Patient D to the hospital.

2. Respondent failed to completely evacuate the fetal parts from Patient D's uterus prior to sending her home from his office.

3. Respondent denies treating Patient D.

4. Respondent failed to maintain a medical record for Patient D which accurately reflected his treatment of Patient D.

E. On or about March 24, 1989, Patient E went to Respondent's office, 9 Avenue A, New York, N.Y., for an abortion. Respondent billed Group Health Insurance (GHI) for performance of an abortion upon Patient E.

1. Respondent failed to perform and/or document a physical examination of Patient E.

2. Respondent failed to take and/or document a history of Patient E.

3. Respondent failed to write and/or document in Patient E's chart an operative report of the abortion procedure.

4. Respondent's record for Patient E fails to accurately reflect his care and treatment of Patient E.

F. On or about July 22, 1988, Patient F went to Respondent's office, 9 Avenue A, New York, N.Y., for an abortion. On that date, Respondent performed an abortion on Patient F.

1. Respondent failed to perform and/or document a pelvic examination of Patient F.

2. Respondent failed to perform a pregnancy test on Patient F and/or document the results of a pregnancy test on Patient F prior to performing the abortion.

3. Respondent failed to write and/or include in Patient F's chart an operative report of the abortion procedure.

4. Respondent ordered and/or performed an EKG and pulmonary function test without medical justification.

5. Respondent's record for Patient F fails to accurately reflect his care and treatment of Patient F.

G. On or about March 3, 1989, Patient G went to Respondent's office, 9 Avenue A, New York, N.Y. for an abortion, which Respondent performed on that date.

1. Respondent failed to perform and/or document a physical, breast or pelvic examination on Patient G.

2. Respondent failed to perform a pregnancy test and/or document the results of the pregnancy test prior to performing the abortion on Patient G.

3. Respondent failed to perform and/or document Patient G's blood type or RH factor prior to performing the abortion.

4. Respondent failed to write and/or document in Patient G's chart an operative report of the abortion procedure.

5. Respondent failed to maintain a medical record for Patient G which accurately reflected his treatment of Patient G.

H. On or about October 11, 1991, Patient H went to Respondent's office, 9 Avenue A, New York, N.Y. for a post-abortion follow-up examination.

1. During the course of that alleged examination, Respondent inappropriately performed a simultaneous pelvic and breast examination.

2. Respondent denies treating Patient H.

SPECIFICATION OF CHARGES

FIRST THROUGH FOURTH SPECIFICATIONS

GROSS NEGLIGIEGENCE

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 6530 (4), as added by ch. 606, laws of 1991,in that Petitioner charges:

1. The facts in paragraphs A and A1 through A 3.

2. The facts in paragraphs B and B1 through B 4.

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

4. The facts in paragraphs D and D1 through D 3.

FIFTH 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 6530 (3), as added by ch. 606, laws of 1991, in that Petitioner charges that Respondent committed two or more of the following:

5. The facts in paragraphs A, A1 through A 3, B, B1 through B4, C, C1 through C 3, D, D1 through D 2, E, E 1 through E3, F, F1 through F5, and/or G, G1 through 5.

SIXTH SPECIFICATION

VIOLATION OF STATE LAW GOVERNING THE PRACTICE OF MEDICINE

Respondent is charged with committing unprofessional conduct within the meaning of N.Y. Educ. Law Section 6530 (16), as added by chap.606, laws of 1991, when he willfully failed to comply with N.Y. Penal Law sec. 125.45 (McKinney 1987) abortion in the first degree, in that Petitioner charges:

6. The facts in Paragraph A and A1.

SEVENTH THROUGH NINTH SPECIFICATIONS

MORAL UNFITNESS IN THE PRACTICE OF MEDICINE

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6530 (20), as amended by ch. 606, laws of 1991, when he engaged in conduct in the practice of medicine which evidences moral unfitness to practice the profession, in that Petitioner charges:

7. The facts in paragraph A and A 1 through A 3.

8. The facts in paragraph B and B 1 through B 4.

9. The facts in paragraph G.

TENTH THROUGH TWELFTH SPECIFICATIONS

ABANDONMENT OF A PATIENT

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6530 (30),as amended by ch. 606, laws of 1991, when he abandoned a patient under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care, in that Petitioner alleges:

10. The facts in Paragraph B and B1.

11. The facts in Paragraph C and C1.

12. The facts in Paragraph D and D1.

THIRTEENTH THROUGH SIXTEENTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6530 (20), as amended by ch. 606, laws of 1991, when he practiced the profession fraudulently, in that Petitioner charges:

13. The facts in Paragraphs A 3.

14. The facts in Paragraphs B 3.

15. The facts in Paragraphs C 2.

16. The facts in Paragraphs D 3.

SEVENTEENTH THROUGH TWENTY-THIRD SPECIFICATIONS

FAILING TO MAINTIAN ACCURATE RECORDS

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6530 (32), as amended by ch. 606, laws of 1991, when he failed to maintain a record for each patient which accurately reflected his evaluation and treatment of the patient, in that Petitioner charges:

17. The facts in Paragraph A and A3.

18. The facts in Paragraph B and B4.

19. The facts in Paragraph C and C3.

20. The facts in Paragraph D and D4.

21. The facts in Paragraph E, E1, E2, E3 and E4.

22. The facts in Paragraph F, F1, F2, F3, F4 and F5.

23. The facts in Paragraph G, G1, G2, G3, G4 and G5.

TWENTY-FOURTH SPECIFICATION

EXCESSIVE TESTS

Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law Section 6530 (35), as amended by ch. 606, laws of 1991, when he performed excessive tests not warranted by the condition of the patient, in that Petitioner charges:

24. The facts in Paragraphs F and F5.

DATED: New York, New York
November 21, 1991

Chris Stern Hyman
Counsel
Bureau of Professional Medical
Conduct