



# STATE OF NEW YORK DEPARTMENT OF HEALTH

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

Barbara A. DeBuono, M.D., M.P.H.  
*Commissioner*

Karen Schimke  
*Executive Deputy Commissioner*

December 4, 1995

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

Peter Van Buren, Esq.  
NYS Dept. of Health  
Rm. 2429 Corning Tower  
Empire State Plaza  
Albany, New York 12237

Walter R. Marcus, Esq.  
80 John Street - 20th Floor  
New York, New York 10038

Jaime Yu Go., M.D.  
7246 Mitchellsville Road  
Bath, New York 14810

**PUBLIC**

Effective Date: 12/11/95

**RE: In the Matter of Jaime Yu Go, M.D.**

Dear Mr. Van Buren, Mr. Marcus and Dr. Go :

Enclosed please find the Determination and Order (No. 95-189) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. The Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

Office of Professional Medical Conduct  
New York State Department of Health  
Empire State Plaza  
Corning Tower, Room 438  
Albany, New York 12237

RECEIVED  
DEC 06 1995  
OFFICE OF PROFESSIONAL  
MEDICAL CONDUCT

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

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

A handwritten signature in black ink that reads "Tyrone T. Butler". The signature is written in a cursive style with a large, prominent initial "T".

Tyrone T. Butler, Director  
Bureau of Adjudication

TTB:

Enclosure

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

IN THE MATTER  
OF  
JAIME YU GO, M.D.

ADMINISTRATIVE  
REVIEW BOARD  
DECISION AND  
ORDER NUMBER  
ARB NO. 95-189

The Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board"), consisting of **ROBERT M. BRIBER, SUMNER SHAPIRO, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D.<sup>1</sup>** and **WILLIAM A. STEWART, M.D.** held deliberations on November 10, 1995 to review the Hearing Committee on Professional Medical Conduct's (Hearing Committee) August 28, 1995 Determination finding Dr. Jaime Yu Go (Respondent) guilty of professional misconduct. The Respondent requested the Review through a Notice which the Board received on September 18, 1995. James F. Horan served as Administrative Officer to the Review Board. Walter R. Marcus, Esq. filed a brief for the Respondent, which the Review Board received on October 19, 1995. Michael A. Hiser, Esq. filed a reply brief for the Office of Professional Medical Conduct (Petitioner), which the Review Board received on October 23, 1995.

**SCOPE OF REVIEW**

New York Public Health Law (PHL) §230(10)(i), §230-c(1) and §230-c(4)(b) provide that the Review Board shall review:

- whether or not a hearing committee determination and penalty are consistent with the hearing committee's findings of fact and conclusions of law; and

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<sup>1</sup>Dr. Sinnott participated in the deliberations by telephone.

- whether or not the penalty is appropriate and within the scope of penalties permitted by PHL §230-a.

Public Health Law §230-c(4)(b) permits the Review Board to remand a case to the Hearing Committee for further consideration.

Public Health Law §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board.

**HEARING COMMITTEE DETERMINATION**

The Petitioner charged the Respondent, an anesthesiologist, with practicing medicine with gross negligence, gross incompetence, negligence on more than one occasion, incompetence on more than one occasion, failing to maintain adequate records and fraud in the practice of medicine. The charges arose from anesthesia care which the Respondent rendered, in 1991 or 1992, to four patients, whom the record refers to as Patients A through D. There were three charges common to all the cases: that the Respondent failed to use a capnograph<sup>2</sup> to measure end tidal carbon dioxide to assure safe patient intubation; that the Respondent failed to record significant anesthesia procedures; and, that the Respondent prepared medical records that purported falsely to be prepared at a certain date and time.

On the Specifications charging gross negligence and incompetence and negligence and incompetence on more than one occasion, the Committee found the Respondent guilty. The Committee found that the Respondent failed to use a capnograph to monitor carbon dioxide output in Patient A through D. The Committee found that both appropriate standards of anesthesia practice and Health Department Regulations required the use of a capnograph in all four cases and that a capnograph was available for the Respondent's use for all four patients. The Committee also found the Respondent guilty in all four cases, for failing to document significant aspects of anesthesia

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<sup>2</sup>A capnograph continuously measures carbon dioxide exhaled by a patient. The capnograph guarantees that an endotracheal tube, used during anesthesia, is placed in the trachea and not in the esophagus, to prevent a low level of oxygen in the bloodstream and thereby prevent brain damage (Hearing Committee Findings of Fact 5, 8).

procedure and for antedating relevant medical chart information. The Committee found further that the Respondent failed to use a pulse oximeter<sup>3</sup> for Patient A. The Committee found that Health Department Regulations and standards from the American Society of Anesthesiologists required employing a pulse oximeter in Patient A's case. The Committee found that the Respondent was guilty of negligence in failing to use a muscle nerve stimulator in Patient A's case, to test whether the Patient had sufficient muscular strength to breath adequately following anesthesia.

The Committee found that the Respondent failed to maintain adequate records for Patients A through D. The Committee found that due to the Respondent's failure to use a capnograph for Patients A through D, and a pulse oximeter and muscle nerve stimulator for Patient A, the Patients' records lacked necessary documentation concerning the Patients' conditions. The Committee found further that the Respondent copied intraoperative and post anesthesia notes hours after completing surgery. The Committee found that such a practice could lead easily to inaccurate records.

The Committee found that the Respondent antedated his records, that is, he prepared the records after the date that appears on the record. The Committee concluded that the Respondent's intent in antedating the records was to mislead reviewers into believing that the Respondent prepared the records concurrently with care. The Committee determined that the antedating constituted fraud in the practice of medicine.

In reaching their findings, the Committee relied on testimony by the Petitioner's expert witness, Dr. David Taylor. The Committee noted that the Respondent offered no testimony by a separate expert witness, and stated that they found the Respondent's testimony to be contradictory, self-serving and limited in credibility.

The Committee voted to suspend the Respondent's license to practice medicine until the Respondent completes a course of retraining. The Committee ordered that following retraining, the Respondent shall be on two years probation. The probation terms require a practice monitor<sup>4</sup>. The

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<sup>3</sup>A pulse oximeter gives a continuous number reflecting oxygenation of a patient's blood, to ensure adequate oxygen concentration in inspired gas and blood (Hearing Committee Findings of Fact 10, 11).

<sup>4</sup>Hearing Committee Determination, Appendix II, paragraph 8.

Committee concluded that the Respondent would be receptive to retraining. The Committee concluded that the Respondent had failed to remain current in his specialty and they concluded further that the Respondent demonstrated a lack of skill and judgement which necessitated a significant penalty. The Committee found that an update and improvement in the Respondent's basic skills and in his record keeping practices was necessary.

### REQUESTS FOR REVIEW

RESPONDENT: The Respondent has requested that the Review Board modify the Hearing Committee's penalty, to allow the Respondent to continue in practice during the retraining period.

The Respondent does not agree with all the Committee's conclusions, with the significance they placed on their conclusions or with the inferences which the Committee drew. The Respondent states that he welcomes the opportunity to advance his skills, but argues that suspension during the retraining is a harsh penalty. The Respondent argues that he has since corrected all deficiencies which were the subject of charges.

The Respondent argues that some of the Committee's findings resulted because the Committee misconstrued testimony. The Respondent contends that he would have used a capnograph for Patients A through D, had he known that Health Department regulations required such usage. The Respondent contends that he never had any intent to mislead by antedating his records and that he had developed his practice of antedating to make sure his records were neat and complete, so as to avoid a malpractice suit. The Respondent notes that he is no longer isolated as the only anesthesiologist at Ira Davenport Hospital, and for the past three years has been a member of the Anesthesia Department at Corning Hospital.

The Respondent notes that he is now pursuing Board certification in anesthesiology. He asks the Board to consider the enormous and devastating financial burden which a suspension from practice would cause for the Respondent and his family.

PETITIONER: The Petitioner opposes the Respondent's request that the Review Board stay the suspension of the Respondent's license. The Petitioner argues that the Committee found that the Respondent's care for Patients A through D fell below standards, that the Respondent was neglectful or unaware of basic advances in anesthesiology and that the Respondent was less than fully credible in his hearing testimony.

The Petitioner argues that the Hearing Committee imposed an appropriate penalty by requiring retraining to address the Respondent's lack of knowledge, by imposing a practice monitor during probation to address the Respondent's neglect and by suspending the Respondent's license to penalize his fraud.

### REVIEW BOARD DETERMINATION

The Review Board has considered the entire record below and the briefs which counsel have submitted.

The Review Board votes to sustain the Hearing Committee's Determination finding the Respondent guilty of gross negligence and gross incompetence, negligence and incompetence on more than one occasion, failure to maintain adequate records and fraud. The Committee's Determination is consistent with their findings and conclusions and the Determination is supported by the record. The Review Board finds no merit in the Respondent's contention that certain conclusions by the Committee resulted from misapprehending the Respondent's testimony. The Review Board also rejects the Respondent's contention that the Respondent's testimony concerning his antedating records demonstrates that the Respondent lacked the intent to commit fraud. The Hearing Committee was not bound to accept any testimony by the Respondent and the Committee noted in their Determination that they found the Respondent's testimony to be self-serving and to lack credibility.

The Review Board votes to sustain the Hearing Committee's Determination ordering that the Respondent undergo retraining, approved by the Office of Professional Medical Conduct, and placing the Respondent on two years probation, with a practice monitor, following the retraining. The Committee's findings demonstrate that the Respondent has failed to utilize developing technologies

in anesthesia and that he demonstrated significant deficiencies in his record keeping practices. The Committee's findings show that the Respondent provided substandard care that rose to the level of egregious conduct in the cases of all the Patients, A through D. The Review Board concludes that the Respondent can continue to practice medicine in New York, only if he can correct the serious deficiencies in his practice. The Review Board accepts the Hearing Committee's conclusions that the Respondent would be receptive to retraining and that retraining would correct the deficiencies in the Respondent's skill level and his record keeping practices.

The Review Board sustains the Hearing Committee's Determination to suspend the Respondent's license during the retraining period. The Review Board does not find this suspension to be an overly harsh penalty. The Respondent committed repeated and egregious acts of misconduct, he demonstrated reluctance to learn updated methods which became the standards for practice in anesthesia and he ignored warnings from his former hospital that there were problems with his record keeping practices. The Review Board finds that a severe penalty is warranted in the Respondent's case. The Board believes that a suspension during retraining will assure that the Respondent will concentrate on the retraining only and will assure that the Respondent commences the retraining program as soon as possible. Aside from the need for the Respondent to concentrate on retraining, the Review Board feels that a period of actual suspension is warranted in this case due to the Respondent's fraudulent conduct in antedating patient records. Retraining will not improve a physician's ethics or deter the Respondent or others from fraudulent practice in the future. A period of actual suspension will serve as an appropriate sanction for fraudulent conduct and as a deterrent to such conduct in the future.

**ORDER**

**NOW**, based upon this Determination, the Review Board issues the following **ORDER**:

1. The Administrative Review Board **SUSTAINS** the Hearing Committee on Professional Medical Conduct's August 28, 1995 Determination finding Dr. Jaime Yu Go guilty of professional misconduct.
  
2. The Review Board **SUSTAINS** the penalty which the Hearing Committee imposed in the Respondent's case.

**ROBERT M. BRIBER**

**SUMNER SHAPIRO**

**WINSTON S. PRICE, M.D.**

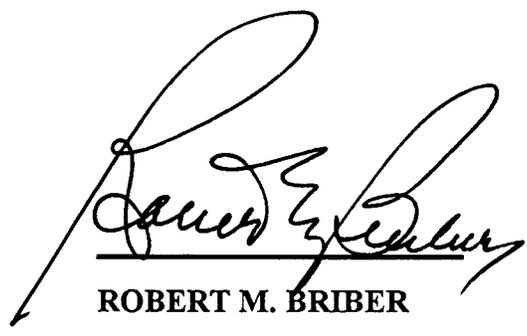
**EDWARD SINNOTT, M.D.**

**WILLIAM A. STEWART, M.D.**

IN THE MATTER OF JAIME YU GO, M.D.

ROBERT M. BRIBER, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Go.

*Schenectady*  
DATED: Albany, New York  
12/1, 1995

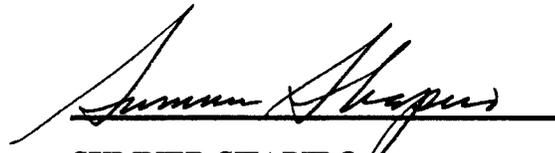
  
ROBERT M. BRIBER

IN THE MATTER OF JAIME YU GO, M.D.

SUMNER SHAPIRO, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Go.

DATED: Delmar, New York

Dec 4, 1995

  
SUMNER SHAPIRO

**IN THE MATTER OF JAIME YU GO, M.D.**

**EDWARD C. SINNOTT, M.D.**, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Go.

**DATED: Roslyn, New York**

*June 25, 1995*



**EDWARD C. SINNOTT, M.D.**

IN THE MATTER OF JAIME YU GO, M.D.

WILLIAM A. STEWART, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Go.

DATED: Syracuse, New York

24 Nov, 1995

A handwritten signature in cursive script that reads "William A. Stewart". The signature is written in black ink and is positioned above the printed name.

WILLIAM A. STEWART, M.D.