



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

PUBLIC

August 28, 1995

OFFICE OF MEDICAL CONDUCT
AUG 29 1995

RECEIVED

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Michael A. Hiser, Esq.
Associate Counsel
NYS Department of Health
Corning Tower-Room 2438
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

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

Dear Mr. Hiser, Mr. Marcus and Dr. Go:

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

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza

Albany, New York 12237

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

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

Request for review of the Committee's determination by the Administrative Review Board stays all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

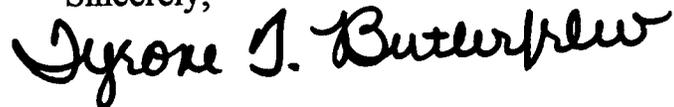
The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

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

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

Sincerely,

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

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:rlw
Enclosure

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

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

**DETERMINATION
AND
ORDER
BPMC-95-189**

A Notice of Hearing and Statement of Charges, each dated March 22, 1995, was served upon the Respondent **JAIME YU GO, M.D.** **JOHN H. MORTON, M.D.**, Chairperson, **JOSEPH E. GEARY, M.D.** and **ANTHONY C. BIONDI**, 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 Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) of the Public Health Law. **JEFFREY ARMON, ESQ.** served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF PROCEEDINGS

Date of Service of the Notice
of Hearing and Statement of Charges:

March 23, 1995

Dates of Hearing:

April 25, 1995
June 15, 1995

Department of Health
appeared by:

Jerome J. Jasinski, Esq.
Acting General Counsel
NYS Department of Health
BY: Michael A. Hiser, Esq.
Associate Counsel

Respondent appeared by:

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

Witnesses for the Department
of Health:

David A. Taylor, M.D.
Sally A. Keefer

Witnesses for the Respondent:

Min-Chung Lin, M.D.
Jaime Yu Go, M.D. (Respondent)

A copy of the Statement of Charges is attached hereto as Appendix I and is made a part of this Determination and Order.

FINDINGS OF FACT

Numbers in parenthesis refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. All Hearing Committee findings were unanimous unless otherwise specified.

NOTE: Petitioner's Exhibits are designated by Numbers.

Respondent's Exhibits are designated by Letters.

T = Transcript

GENERAL FINDINGS

The Respondent was authorized to practice medicine in New York State on November 5, 1976 by the issuance of license number 129186 by the New York State Education Department. The Respondent is registered with the New York State Education Department to practice medicine through the period ending November 30, 1997. (Ex. 2)

FINDINGS RELATED TO PATIENT A

1. Respondent provided general anesthesia to Patient A, a 47 year old female, on or about February 5, 1992, at the Ira Davenport Memorial Hospital, Bath, New York. Patient A was admitted for out-patient surgery to correct carpal tunnel syndrome. (Ex. 3, p. 10; Ex. 8)
2. Patient A's height was recorded as five feet one inch and weight as 224 pounds at the time of surgery. She was noted to have a history of hypertension, to be taking medication for such condition, to have an elevated blood pressure, diabetes mellitus and a history of peripheral vascular disease. (Ex. 3, pp. 8-9, 59)
3. Patient A was designated an American Society of Anesthesiologists ("ASA") Physical Status 3. That means that the patient had severe systemic disease that was functionally limiting. (Ex. 3, p. 59; T. 33)
4. Patient A underwent general anesthesia from approximately 10:30 A.M. through 11:45 A.M. on February 5, 1992. The patient was intubated during the procedure which consists of the placement of a breathing tube into a patient's wind pipe or trachea after the patient is rendered unconscious by the anesthetic medication. The placement of such a tube requires administration of a muscle relaxant designed to temporarily paralyze the patient. (Ex. 3, p. 59; T. 36-7)
5. A breathing tube should be placed in a patient's trachea and not the esophagus to prevent a low level of oxygen in the bloodstream, which can lead to brain damage. (T. 37-40)
6. New York State Health Department regulations in effect from 1989 provide that "all patient's ventilation shall be continuously monitored during the conduct of anesthesia. . . . For every

patient receiving general anesthesia with a endotracheal tube, the quantitative carbon dioxide content of expired gases shall be monitored through the use of end tidal carbon dioxide analysis or superior technology." (10 NYCRR 405.13(b)(2)(iii)(e))

7. The ways to identify carbon dioxide in the expired gas is through end tidal capnometry. The methods are the capnograph, the capnometer, and a device that will identify whether carbon dioxide is present or not with a color change. (T. 44)

8. A capnograph is a device which continuously measures the carbon dioxide exhaled by a patient. Reasons for the use of a capnograph are to guarantee that the endotracheal tube has been properly placed in the trachea and to receive continuous and immediate feedback if the tube should become displaced. It also provides an estimation of the functioning of the heart and lungs of a patient by the measurement of carbon dioxide released into the lungs.
(T. 38-41)

9. Respondent failed to use and or record the use of a carbon dioxide monitor (capnograph) during his provision of general anesthesia to Patient A. The capnograph was available for Respondent's use on Patient A at the time of Patient A's surgery. (Ex. 8, Paragraph 3)

10. A pulse oximeter is a device that shines a light through the nail bed and gives a continuous number reflecting the oxygenation of the patient's blood. It consists of a clip that can be put over the finger. (T. 48)

11. New York State Health Department regulations require monitoring of patients under general anesthesia with a pulse oximeter and state that "during the administration and conduct of all anesthesia, the patient's oxygenation shall be continuously monitored to ensure adequate oxygen concentration in the inspired gas and the blood through the use of a pulse oximeter

or superior equipment". There is no indication in the record that superior equipment other than a pulse oximeter was used for Patient A. (10 NYCRR 405.13(b)(2)(iii)(d); Ex. 3; T. 50)

12. The American Society of Anesthesiologists' recommended Standards for Basic Intra-operative Monitoring, in effect in February, 1992, provided that "during all anesthetics, a quantitative method of assessing oxygenation such as pulse oximetry shall be employed." This standard could be waived under extenuating circumstances. In such cases, it was recommended that the anesthesiologist so state in the patient's medical record, and include the reasons for waiving the standard. (Ex. 9)
13. Extenuating circumstances are considered to be an emergency situation or a malfunction or unavailability of a unit. There is nothing in the record to indicate there were any extenuating circumstances in Patient A's case. (Ex. 3; T. 49-50)
14. Respondent failed to use and/or record the use of a pulse oximeter during his provision of general anesthesia to Patient A. The pulse oximeter was available for Respondent's use with Patient A at the time of the patient's surgery. (Ex. 8, Paragraph 4)
15. Respondent ordered an oximetry reading for Patient A by approximately 12:00 P.M. The patient's medical record notes "oximeter 55" which indicates that her oxygen saturation was 55 percent. (Ex. 3, p. 73)
16. Dr. Taylor testified that such level of oxygenation was extremely low, placing the patient at risk of developing brain damage or other organ tissue damage. He further testified that the failure to use a pulse oximeter during Patient A's surgical procedure was not in accordance with accepted standards of practice. (T. 51-3)

17. The purpose of documentation in the intraoperative anesthetic record is to allow evaluation of the patient's course and the care rendered to the patient, as well as to document the medications given and the effects of the medications. This information can be used by the anesthesiologist or other physicians. (T. 54)
18. Dr. Taylor testified that during the anesthetic, the anesthesiologist should document not only the blood pressure and the heart rate, but also the status of the electrocardiogram. He stated that electrocardiogram readings should be documented because anesthetics are potent enough to depress the electrical function of the heart. Documentation of the readings of the electrocardiogram would ordinarily include the heart rhythm, which would typically be the sinus rhythm. (T. 53-55)
19. Respondent failed to indicate the status of the electrocardiogram in the intraoperative anesthesia record for Patient A. There was also no indication of the results of pulse oximetry and end-tidal carbon dioxide monitors. Respondent recorded "EKG-NSR", representing "normal sinus rhythm" in the "remarks" section of the anesthetic record. Dr. Taylor testified that such notation represented the pre-operative evaluation or pre-operative medical history of the patient and not the intraoperative notation of the electrocardiogram. (T. 55-56)
20. Respondent used two muscle relaxants with Patient A to enable placement of the breathing tube and to relax the patient's muscles during the operation. One relaxant was Anectine, considered to be a short acting relaxant of about five to seven minutes. The second relaxant was d- tubocurarine (dTc). (Ex. 3, p. 59; T. 57-59)
21. Dr. Taylor testified that Patient A's surgery to correct carpal tunnel syndrome would typically be expected to have an operating time of approximately 30-40 minutes. (T. 59)

22. Dr. Taylor testified that a fair estimate of the duration of action of dTC could range from 25 to 90 minutes and that a long-acting relaxant would be a medication that has an effect for 45 minutes or longer. (T. 58, 97)
23. Respondent testified that, based on his experience, he considered dTC to be an intermediate-acting muscle relaxant of approximately 30-45 minutes duration. He further testified that he used such medication for its effect in lowering blood pressure because Patient A had a history of hypertension. (T. 265, 269)
24. A nerve stimulator is a device that provides an electrical stimulation to stimulate the nerves, typically on the wrist. The stimulator provides an estimate of how paralyzed a patient's muscles are. From that information, a determination can be made as to whether a patient has enough muscular strength to adequately breathe. It can also determine the extent of a patient's paralysis. This is important because the effects of long acting neuromuscular blockers can only be reversed by the administration of reversal medications if there is some muscular function present. (T. 62-63)
25. Dr. Taylor testified that it is prudent to use a nerve stimulator when a patient is undergoing general anesthesia with a long acting neuromuscular blocker in a short surgical procedure because of variable lengths of duration depending on the patient's physical status and the anesthetics that are used. He stated that a nerve stimulator would enable the anesthesiologist to gauge at what stage of the course of the relaxant the patient was at by the end of the surgery. (T. 60-61)
26. Respondent treated Patient A with twenty milligrams of Reganol, a reversal agent, intravenously at approximately 11:35 A.M. in the operating room. He subsequently

administered ten milligrams of Reganol at approximately 12:00 P.M. and again at about 12:45 P.M. to the patient in the recovery room. (Ex. 3, pp. 59, 61, 73)

27. Patient A was observed to have great difficulty in breathing on her own following the completion of her surgery. At approximately 1:30 P.M., she was transferred to the intensive care unit for ventilation assistance with her respiration. (Ex. 3, pp. 10, 61)
28. At approximately 9:40 P.M., Patient A was transferred to another medical facility to evaluate the condition of her left hand due to the presence of cyanosis in her fingers. At that time, the patient remained on the assistance of a ventilator for her respiration. (Ex. 3, pp. 10-11)
29. Respondent failed to monitor the degree of paralysis or muscular relaxation of Patient A by use of a nerve stimulator. (Ex. 8, Paragraph 5)
30. The photocopied medical record of Patient A, which accompanied her to the receiving medical facility approximately ten hours after her surgery, lacked any documentation by Respondent related to his pre-anesthesia evaluation, intraoperative anesthesia record and postoperative anesthesia-related complications. (Ex. 10)
31. The medical record of Patient A received in evidence contains documentation by Dr. Go of the pre-anesthesia evaluation, dated and timed February 5, 1992 at 10:25 A.M., the intra-operative anesthesia record from approximately 10:30 through 11:30 A.M., a post-anesthetic note timed 11:50 A.M., and a post-anesthetic follow-up note timed 2:30 P.M.
(Ex. 3, pp. 59-61)
32. A meeting between hospital administrators and Respondent was held on February 13, 1992 to address the necessity for timely documentation in the medical record of all anesthesia

observations, assessments, decisions and services. Respondent was counseled to correct his documentation practices and to enter into Patient A's record a note which would accurately clarify what his actions regarding his documentation of such record had been. (Ex. 10)

33. The memorandum of such meeting indicates Respondent expressed his intention to continue his method of documentation without change. Respondent did not deny allegations of backdating Patient A's medical records and signed his name to the memorandum without additional notation. (Ex. 10)

34. Dr. Taylor testified that the purpose of an anesthesia record is to reflect intraoperative events which should be noted concurrently with the operative course. He stated that there was nothing in the medical record to indicate the presence of circumstances that would have prevented Respondent from contemporaneously documenting the intraoperative anesthesia record. Dr. Taylor also testified that it is not standard medical practice to antedate a pre-operative and a post-operative anesthesia note. (T. 67-68)

FINDINGS RELATED TO PATIENT B

35. Respondent provided anesthesia to Patient B, a 42 year old female, who was admitted to the Hospital for an elective cholecystectomy, on October 22, 1991. (Ex. 8, Paragraph 6)

36. Patient B had a history of asthma and used an inhaler to control her disease. She was also noted as being a smoker. This was significant in that persons with asthma may experience an attack during the operation or during placement of the breathing tube.

(Ex. 4, p. 87; T. 140-1)

37. Respondent failed to use and/or record the use of a carbon dioxide monitor (capnograph) during his provision of general anesthesia to Patient B. The capnograph was available for Respondent's use on Patient B at the time of Patient B's surgery. There is no indication from the record that there were any extenuating circumstances that would indicate there was a reason not to use the capnograph. Dr. Taylor testified that the failure to use the capnograph under such circumstances was contrary to accepted standards of practice.
(Ex. 4, p. 87, Ex. 8, Paragraph 7; T. 142)
38. Pursuant to Ira Davenport Hospital quality improvement procedures in effect at that time, the pre-anesthesia note and anesthesia record were required to have been on the patient's record no more than 24 hours after the operation. The post-anesthetic notes were required to be on the patient's record no less than three (3) nor more than 48 hours after the operation.
(T. 192-3)
39. Patient B's chart would have been reviewed by the hospital's quality improvement personnel as part of a daily, ongoing assessment to see if the pre-anesthesia note, anesthetic record, and post-anesthetic notes were on the chart at the required times. Neither the pre-anesthetic evaluation nor anesthesia records were on the patient's chart at least 24 hours after the operation. The post-anesthetic notes were not on her chart no less than three (3) nor more than 48 hours after the operation. Accordingly, the hospital reviewers submitted a report to the quality assurance manager. A "patient occurrence" report resulted.
(Ex. 11; T. 188-91, 203-7)
40. Respondent's pre-anesthesia evaluation for Patient B purports to have been prepared at 8:10 A.M. on October 22, 1991. His post-anesthesia notes purport to have been prepared at 9:40 A.M. and 2:00 P.M., respectively, on October 22, 1991. (Ex. 4, pp. 87-88)

41. Respondent's pre-anesthesia evaluation, anesthesia record, and post-anesthetic notes, dated October 22, 1991, were not placed in the medical record of Patient B until after October 22, 1991. (T. 203-207)
42. Dr. Taylor testified that Respondent's antedating of the pre-anesthesia evaluation, post-anesthetic evaluation, and anesthesia record was not in accordance with the accepted standard of practice. (T. 143-144)
43. The intraoperative anesthesia record made no reference to either end-tidal capnometry or the use of an oxygen analyzer, which measures the oxygen concentration in the anesthesia machine. There was also no documentation as to the status of the patient's electrocardiogram. (Ex. 4, p. 87)
44. Dr. Taylor testified that Respondent's documentation on Patient B's anesthesia record did not meet generally accepted standards of medical practice. (T. 145-146)

FACTS RELATED TO PATIENT C

45. Respondent provided anesthesia to Patient C, a 62 year old female, at the hospital on or about October 31, 1991, during the patient's surgical procedure, which consisted of an exploratory laparotomy, appendectomy, and cholecystectomy. (Ex. 8, Paragraph 8)
46. Patient C underwent emergency surgery, involving an extensive abdominal procedure, which necessitated the use of muscle relaxants and an endotracheal tube. She also had a history of smoking. (Ex. 5, pp. 12-3; T. 152)

47. Respondent failed to use and or record the use of a carbon dioxide monitor (capnograph) during his provision of general anesthesia to Patient C. The capnograph was available for Respondent's use on Patient C at the time of Patient C's surgery. (Ex. 8, Paragraph 9)

48. Dr. Taylor testified that Respondent's failure to use the capnograph on the patient who was undergoing general anesthesia when the capnograph was available was not in accordance with generally accepted standards of medical practice. There was no indication from the record that there were any extenuating circumstances that would indicate that there was a reason not to use the capnograph, such as the fact that Patient C was undergoing emergency surgery. (Ex. 5, pp. 238-239; T. 142)

49. Patient C underwent emergency abdominal surgery which increased her risk to aspirate the contents of her stomach into her mouth and windpipe. This made it imperative that the endotracheal tube be placed properly on the first attempt. (T. 155)

50. Dr. Taylor testified that Respondent's documentation of Patient C's anesthesia record did not meet the accepted standard of medical care in that there was no reference to the use of end-tidal capnometry or to the status of the patient's electrocardiogram.
(Ex. 5, pp. 238-9; T. 156-7)

51. Pursuant to Ira Davenport Hospital quality improvement procedures in effect at that time, the pre-anesthesia note and anesthesia record were required to have been on the patient's record no more than 24 hours after the operation. The post-anesthetic notes were required to be on the patient's record no less than three (3) nor more than 48 hours after the operation.
(T. 192-193)

52. Patient C's chart would have been reviewed by the hospital's quality improvement personnel as part of a daily, ongoing assessment to see if the pre-anesthesia note, anesthetic record, and post-anesthetic notes were on the chart at the required times. Neither the pre-anesthetic evaluation nor anesthesia records were on the patients chart at least 24 hours after the operation. The post-anesthetic notes were not on her chart no less than three (3) or more than 48 hours after the operation. Accordingly, the hospital reviewers submitted a report to the quality assurance manager. A "patient occurrence" report resulted. (Ex. 11; T. 188-191, 209-212)
53. Respondent's pre-anesthesia evaluation for Patient C purports to have been prepared at 12:50 p.m. on October 31, 1991. His anesthesia record purports to have been prepared between approximately 1:00 p.m. and 3:45 p.m. on October 31, 1991. His post-anesthesia note purports to have been prepared at 4:00 p.m. on October 31, 1991. (Ex. 5, pp. 237-239)
54. Respondent's pre-anesthesia evaluation, anesthesia record, and post-anesthetic notes, dated October 31, 1991, were not placed in the medical record of Patient C until after October 31, 1991. (T. 209-212)
55. Dr. Taylor testified that Respondent's antedating of the pre-anesthesia evaluation, anesthesia record and post-anesthesia notes was not in accordance with accepted standards of medical practice. (T. 157-158)

FACTS RELATED TO PATIENT D

56. Respondent provided anesthesia to Patient D, an 85 year old female, at the hospital on or about January 29, 1992, during Patient D's elective surgical procedure for ventral hernia repair and abdominoplasty. (Ex. 8, Paragraph 10)

57. Patient D had a history of a hiatal hernia which made her prone to suffer regurgitation, with a resultant risk of aspiration. The patient also had a pacemaker. (Ex. 6, p. 12; T. 164-165)
58. Respondent failed to use and or record the use of a carbon dioxide monitor (capnograph) during his provision of general anesthesia to Patient D. The capnograph was available for Respondent's use on Patient D at the time of Patient D's surgery. There was no documentation in the medical record to indicate the presence of extenuating circumstances which would eliminate the need to use a capnograph. (Ex. 8, Paragraph 11; T. 168)
59. Dr. Taylor testified that Respondent's failure to use or record the use of a carbon dioxide monitor or capnograph during his provision of general anesthesia to the patient, when the capnograph was available for his use on the patient, was contrary to the accepted standard of medical practice. (T. 168)
60. Dr. Taylor testified that Respondent's documentation of Patient D's anesthesia record did not meet the accepted standard of medical practice in that there was no reference to the use of end-tidal capnometry or to the status of the patient's electrocardiogram.
(Ex. 6, p. 182; T. 170-171)
61. Pursuant to Ira Davenport Hospital quality improvement procedures in effect at that time, the pre-anesthesia note and anesthesia record were required to have been on the patient's record no more than 24 hours after the operation. The post-anesthetic notes were required to be on the patient's record no less than three (3) nor more than 48 hours after the operation.
(T. 192-193)
62. Patient D's chart would have been reviewed by the hospital's quality improvement personnel as part of a daily, ongoing assessment to see if the pre-anesthesia note, anesthetic record, and

post-anesthetic notes were on the chart at the required times. The pre-anesthetic evaluation was not on the chart at least 24 hours after the operation. Also, the post-anesthetic notes were not on the chart no less that three (3) nor more than 48 hours after the operation. Accordingly, the hospital reviewers submitted a report to the quality assurance manager. A "patient occurrence" report resulted. (Ex. 12; T. 215-217)

63. Respondent's pre-anesthesia evaluation of Patient D purports to have been prepared at 8:55 a.m. on January 29, 1992. His anesthesia record purports to have been prepared between approximately 9:00 a.m. and 10:00 a.m. on January 29, 1992. His post-anesthesia note purports to have been prepared at 10:30 a.m. on January 29, 1992. (Ex. 6, pp. 182-183)
64. Respondent's pre-anesthesia evaluation, anesthesia record and anesthetic notes, dated January 29, 1992, were not placed in the medical record of Patient D until after January 29, 1992. (T. 216-217)
65. Dr. Taylor testified that Respondent's antedating of the pre-anesthesia evaluation, anesthesia record and post-anesthesia notes was not in accordance with accepted standards of medical practice. (T. 172)

CONCLUSIONS OF LAW

The following Conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from an unanimous vote of the Hearing Committee.

The Hearing Committee concluded that the following Factual Allegations set forth in the Department's Notice of Hearing and Statement of Charges (Ex. 1) should be **SUSTAINED**. The citations in parentheses refer to the Findings of Fact which support each Factual Allegation:

- Paragraph A.: (1);
- Paragraph A.1.: (8-9);
- Paragraph A.2.: (10, 13-14);
- Paragraph A.3.: (18-19);
- Paragraph A.5.: (24-25, 29);
- Paragraph A.6.: (30-34);
- Paragraph B.: (35);
- Paragraph B.1.: (37);
- Paragraph B.2.: (38-42);
- Paragraph B.3.: (43-44);
- Paragraph C.: (45);
- Paragraph C.1.: (47-48);
- Paragraph C.2.: (50);
- Paragraph C.3.: (51-55);
- Paragraph D.: (56);
- Paragraph D.1.: (58-59);
- Paragraph D.2.: (60);
- Paragraph D.3.: (61-65).

The Hearing Committee determined that the following Factual Allegation should **NOT BE SUSTAINED**:

Paragraph A.4.

The Hearing Committee concluded that the following Specification of Charges should be **SUSTAINED** based upon the Factual Allegations which were sustained:

First through Eight Specifications (in their entirety);

Ninth through Tenth Specifications (with the exception of the facts alleged in Paragraph A.4.);
Eleventh through Fifteenth Specifications (in their entirety).

DISCUSSION

Respondent was charged with multiple specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence and incompetence.

The following definitions were utilized by the Hearing Committee during its deliberations:
Negligence is the failure to exercise the care that would be exercised by a reasonable prudent licensee under the circumstances.

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Gross Incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine.

Fraudulent practice of medicine is an intentional misrepresentation or concealment of a known fact.

Using the above definitions as a framework for its deliberations, the Hearing Committee determined that the Department had established, by a preponderance of the evidence, all Factual

Allegations except that alleged in Paragraph A.4. as set out in the Statement of Charges. The Committee further determined to sustain all Specification of Charges, except those related to paragraph A.4.

The Department relied upon the testimony of Dr. David Taylor, a board-certified anesthesiologist, to address the medical issues presented at this proceeding. Dr. Taylor testified that he has been a full time anesthesiologist since 1986 and performs approximately 800 anesthetics annually. (T. 28) The Hearing Committee considered him to be well qualified in his medical specialty and viewed his testimony as objective and authoritative. The Committee accorded his testimony great weight in reaching its determinations. The Respondent offered no expert medical testimony on his behalf. Therefore, the Committee believed Dr. Taylor's testimony related to accepted standards of medical practice to be credible and not rebutted by any conflicting evidence in the record.

The Committee considered Respondent's testimony at times to be inconsistent, contradictory and improbable. He stated that he had performed approximately ten thousand endotracheal tube placements during his career with no adverse complications, (T. 251) He further testified that in about twenty years of practice he had never encountered trouble in terms of intubation and patient outcome. (T. 254, 327-328) The Committee considered these statements to be not worthy of belief in that it felt that patient complications do occur as a part of all medical practices and that the Respondent was less than forthright on this subject. The Respondent was also noted to contradict himself concerning the allegations of backdating medical records. His overall testimony was considered to be of limited credibility and self-serving and it was accorded less weight by the Committee than that of Dr. Taylor.

FAILURE TO USE A CAPNOGRAPH

The panel relied upon Dr. Taylor's testimony to conclude that the appropriate standard of anesthetic practice in 1991-1992 required the use of a capnograph with the administration of general

anesthesia to intubated patients. It was noted that the standards approved by the American Society of Anesthesiologists "encouraged" end tidal carbon dioxide analysis. (Ex. 9) Furthermore, New York State Health Department regulations mandated the use of end tidal carbon dioxide analysis or superior technology. The Committee believed it was clear that Respondent was required to use end tidal carbon dioxide analysis or superior technology to monitor each of the four (4) patients' quantitative carbon dioxide content.

The Committee also noted in the facts stipulated to by the Respondent (Ex. 8), that he agreed that a capnograph was available for his use when he provided general anesthesia to each of the four (4) patients. Respondent testified that he purchased a capnometer in October, 1994 for use in Ira Davenport Hospital. (T. 251) Respondent testified that he did not use the equipment because he was not convinced of its benefits and because of a lack of tubing equipment necessary to use with the capnograph. The Committee rejected these arguments as not providing justification for the failure to use the monitoring equipment. Respondent had a duty to become familiar with the use of new medical devices and it is clear from the record that the use of a capnograph had become accepted in the practice of anesthesiology by October, 1991. He also had a responsibility to obtain all equipment necessary to make the monitor functional. If tubing supplies were unavailable, Respondent should not have proceeded with the administration of anesthesia. The Committee determined to sustain Factual Allegations A.1., B.1., C.1. and D.1.

FAILURE TO DOCUMENT SIGNIFICANT ASPECTS OF THE ANESTHETIC PROCEDURE

Respondent was charged with failing to document significant aspects of the anesthetic procedure, including the status of the electrocardiogram, in the provision of anesthesia to each of the four (4) patients. Respondent's practice was to check the "EKG" on the Anesthesia Record, but not to periodically record what the status of the rhythm was unless it was irregular. (T. 261) Dr. Taylor testified that the recording of the EKG status was in accordance with what he believed to be

accepted standards of anesthetic practice, but also admitted that such documentation was not required by New York State Department of Health regulations. The Committee concluded that not recording the status of the rhythm was not a deviation from accepted standards of care in most instances. However, in the case of Patient D, who had a pacemaker implant, the Committee considered the failure to note the EKG status to be a deviation from accepted standards of care. Dr. Taylor's testimony of the anesthetic risk to a patient with a pacemaker was noted and relied upon by the Committee in its determination that Respondent should have recorded the EKG status of Patient D in the Anesthesia Record. (T. 165)

As a result of failing to utilize a capnograph, Respondent failed to document measurements of end tidal carbon dioxide in the medical records of the four (4) patients. He also failed to document findings of an oxygen analyzer related to measurement of the oxygen concentration of the anesthetic circuit. Respondent further failed to record the findings from a pulse oximeter when he provided anesthesia to Patient A. The Hearing Committee agreed with Dr. Taylor in concluding that recording such information was necessary to permit evaluation of the patient's course and care rendered. It considered the failure to record this information to not be within generally accepted standards of anesthetic practice and determined to sustain Factual Allegations A.3., B.3., C.2. and D.2.

RECORDING MEDICAL CHART INFORMATION

The Committee believed it clear from the record that the Respondent improperly antedated essential medical records and placed those records in the medical chart of each of the four (4) patients. Evidence in the record indicates that Patient A was transferred to another medical facility about ten (10) hours after her surgery and that the medical record which accompanied her lacked the preoperative anesthesia note, intraoperative anesthesia record and post-anesthesia note. The Respondent testified he wrote both the pre-anesthesia and intraoperative notes in either the recovery or intensive care room soon after completion of the surgery and placed both documents in the chart. He further testified he subsequently removed those notes to enable him to complete the post-

anesthesia note and may have misplaced them and not returned all documents to the patient's chart before she was transferred. (T. 279, 282) He stated he could not recall if he wrote the postoperative note on the evening of the patient's transfer or on the following morning. The post-anesthesia note is timed as being written at 2:30 p.m., hours before it was actually prepared. (Ex. 3, p. 61)

The Committee noted Respondent's testimony that his practice of placing his notes on scraps of paper and later rewriting those notes and inserting them in the chart was based on an obsession with neatness driven by a fear of malpractice claims. Respondent testified that he developed this manner of record-keeping early in his career and maintained it until at least 1992. (T. 284) The Committee found this explanation to be unacceptable and to provide no justification for maintaining inaccurate and incomplete records. It was also noted that at the February 13, 1992 meeting held with Respondent and hospital administrators, it was pointed out that the Respondent had been previously advised that his method of record documentation was considered to be unacceptable. (Ex. 10) The Committee considered it essential that all medical records be prepared concurrently with the event or as soon thereafter as practical. Should extenuating circumstances prevent a note from being prepared concurrently, the Committee believed that the acceptable standard of practice required that the true time of the note's creation be recorded along with those circumstances which caused a delay in creation of such note.

The Hearing Committee also concluded that Respondent antedated anesthetic records related to Patients B, C and D. This conclusion was based on Respondent's testimony concerning his record-keeping practices and the testimony of the hospital's utilization review nurse. The hospital's Reports of Patient Occurrences, set forth in Exhibits 11 and 12 provided clear documentation that the anesthetic records were not contained in the charts of those three (3) patients within the timeframes of the facility's quality improvement procedures. The Committee determined to sustain Factual Allegations A.6., B.2., C.3. and D.3.

OTHER FACTUAL ALLEGATIONS RELATED TO PATIENT A

The Committee concluded that the failure to utilize a pulse oximeter during the provision of general anesthesia to Patient A was not in accordance with accepted standards of practice. Standards set by the American Society of Anesthesiologists and New York State Department of Health regulations required the use of a quantitative method of assessing oxygenation, such as a pulse oximeter. The Respondent's explanation for not using the device was rejected as being completely without merit. He stated that he made a conscious decision not to use the pulse oximeter because inflation of the blood pressure cuff would have caused a low oxygen concentration alarm to sound which would have been "annoying" to him and the surgeon. (T. 257-258) In effect, Respondent bypassed the alarm by failing to use the pulse oximeter and as a result avoided two (2) safety features designed to monitor the patient's oxygen saturation. The Hearing Committee determined to sustain Factual Allegation A.2.

Dr. Taylor testified that d-tubocurarine a muscle relaxant used to assist in the placement of Patient A's breathing tube, had a duration of action of approximately 25 to 90 minutes. He also testified that the patient's surgery would be expected to have an operating time of about 30 to 40 minutes. Therefore, the duration of action of the relaxant was clearly of sufficient length for her procedure. The Committee noted Dr. Taylor's opinion that the duration of the relaxant was longer than necessary. (T. 59) However, it considered Respondent's explanation that he used dTC to control Patient A's hypertension to be reasonable. It was also observed that Dr. Taylor stated that "specific durations of effect aren't particularly meaningful." (T.58) The Hearing Committee could not conclude that Respondent used the dTC inappropriately and believed that Respondent used a standard relaxant agent in a standard manner. Factual Allegation A.4. was not sustained.

The Committee believed that it was improper for Respondent to not utilize a nerve stimulator to determine how paralyzed the patient was at the conclusion of her surgery. This belief was based on the fact that the duration of dTC's effect is variable based on the physical status of the patient and the other anesthetics used. Dr. Taylor noted that the use of a stimulator is valuable in assessing

whether the patient has recovered enough muscle function to make the use of a reversal medication effective. He also testified that if sufficient muscle function has not been recovered, the use of a reversal medication may deepen the patient's paralysis. (T. 63-64) The Committee concluded that Patient A's medical history and the additional anesthetics used by Respondent necessitated the use of a nerve stimulator to gauge her recovery at the conclusion of her surgery. Factual Allegation A.5. was sustained.

**NEGLIGENCE ON MORE THAN ONE OCCASION AND
AND GROSS NEGLIGENCE ON A PARTICULAR OCCASION**

Based on its Findings of Fact, the Committee determined that Respondent's failure to use a capnograph, failure to document significant aspects of the anesthetic procedure and the antedating of relevant medical chart information in the provision of anesthesia to the four (4) patients failed to meet the generally accepted standards of anesthetic practice. The same conclusion was made in his failure to utilize a pulse oximeter and muscle nerve stimulator in the treatment of Patient A. The history of all four (4) patients made it essential that the Respondent adequately monitor their condition while under general anesthesia and his failure to do so led the Committee to conclude that he failed to exercise the care that would be expected from an anesthesiologist under the circumstances. The inadequate documentation and postdating of information was also viewed as below the level of care expected under the circumstances. The Committee sustained the Ninth Specification, except for those facts related to Paragraph A.4., in determining that Respondent practiced with negligence on more than one occasion.

The Committee considered Respondent's actions to be particularly egregious when considering the condition of each patient. Patient A was obese with a history of hypertension, diabetes and peripheral vascular disease. Patient B was asthmatic and a smoker. Patient C was undergoing emergency abdominal surgery, which increased her risk of aspiration and made accurate

placement of the endotracheal tube essential. Patient D had a history of a hiatal hernia and a pacemaker implant. Dr. Taylor testified as to the increased anesthetic risks presented by these histories. The Hearing Committee believed Respondent's failure to utilize a capnograph and, in Patient A's case, a pulse oximeter, to be conspicuous failures to exercise the appropriate level of care under the circumstances presented. The First through Fourth Specifications related to the practice of medicine with gross negligence were sustained.

INCOMPETENCE ON MORE THAN ONE OCCASION AND GROSS INCOMPETENCE

The failure to use a capnograph, to document significant aspects of the anesthetic procedure, and to antedate significant portions of the medical chart was determined to evidence Respondent's lack of skill and knowledge necessary to practice. The Respondent's arguments for not using the capnograph, pulse oximeter and nerve stimulator were relied upon by the Committee in reaching this conclusion. He admitted being unaware that the monitoring of the level of carbon dioxide content of expired gases was required by Department of Health regulations. He stated he was not convinced of the usefulness of a capnograph in the context of giving anesthesia. He further testified he failed to use it because of the lack of necessary tubing equipment. The Committee felt these excuses indicated Respondent failed to remain current with developments in his specialty and failed to take actions to ensure that necessary supplies were available to ensure that he could safely provide anesthesia to hospital patients. By not using a pulse oximeter during Patient A's surgery and bypassing the low oxygen content alarm, the Respondent placed a high-risk patient at even greater risk. The risk to Patient A was compounded by the failure to use a nerve stimulator to monitor her recovery from the anesthesia. The documentation practices of the Respondent were viewed as an indication of Respondent's lack of knowledge of the necessity to prepare all anesthesia records concurrently and to include them in the medical chart in a prompt manner. Specification Ten was sustained, except for the facts found in Paragraph A.4. of the Statement of Charges.

The fact that Respondent failed to use a capnograph with these four (4) patients whose histories indicated an elevated anesthetic risk, caused the Committee to conclude that Respondent demonstrated an unmitigated lack of skill or knowledge necessary to practice. The failure to monitor Patient A's oxygenation with a pulse oximeter, in light of her physical condition, was also considered to be incompetence rising to a level of gross incompetence. The Fifth through Eighth Specifications of Charges were sustained.

FAILING TO MAINTAIN ACCURATE RECORDS

It follows that since Respondent failed to utilize a capnograph, he failed to document the carbon dioxide content for each patient's expired gases. In addition the ventilation and pulmonary performance could not be recorded. Respondent also failed to use or record findings from a pulse oximeter or nerve stimulator in the case of Patient A. Dr. Taylor testified such information was essential in following the course of the patient's care. Respondent also failed to record the electrocardiogram readings of Patient D, who had a pacemaker implant. The Committee considered this information essential to evaluate the care of the patient. It also believed that Respondent's habit of copying intraoperative and post anesthesia notes hours after the completion of surgery could easily lead to inaccurate records. The Hearing Committee sustained Specifications Eleven through Fourteen.

FRAUDULENT PRACTICE OF MEDICINE

The Hearing Committee concluded that Respondent's intent in antedating his anesthesia records was to mislead reviewers of the medical charts into believing that those records were prepared concurrently, or close to, the event recorded. This conclusion was based upon the Respondent's own testimony concerning his practice of rewriting his notes and later inserting the

rewritten documents into the medical chart. It was observed that the Respondent admitted preparing the post-anesthesia note related to Patient A either on the evening of the day of her surgery or on the following morning. The time written on that note was 2:30 p.m. Such a antedating is clearly fraud in the practice of medicine. The Committee believed such a practice was common in the Respondent's manner of record-keeping. It considered the information documented in Exhibits 11 and 12 as demonstrating that Respondent's notes were not in the medical records in a timely manner and concluded that the antedating of those records related to the treatment of Patients B, C and D was intended to mislead as to when they were actually prepared. The Fifteenth Specification was sustained.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine in New York State should be suspended until he completes a course of retraining, as described more fully in the Order below. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

Respondent's contention that he has corrected the deficiencies in his practice that were the subject of this proceeding was noted by the Committee. These modifications led the Committee to believe that Respondent would be receptive to additional education and training. However, the Hearing Committee concluded that his actions in providing anesthesia to the four (4) patients demonstrated a lack of skill and judgment which necessitated a significant penalty. It believed that the failure to utilize developing technologies such as the capnograph indicated a failure to remain current in his specialty, notwithstanding the fact that his practice was located at a small hospital in a rural setting. The Hearing Committee felt that the Respondent possessed the basic skills to continue his practice of anesthesiology, but believed that both an update and improvement of the

level of those skills were made necessary by the manner in which the four (4) cases were managed by him. There was also significant concern about Respondent's record-keeping practices which the Hearing Committee felt could most appropriately be addressed through a program of retraining in a supervised setting.

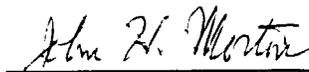
ORDER

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

1. The First through Fifteen Specifications, except for the facts related to Paragraph A.4. in the Ninth and Tenth Specifications, and as set forth in the Statement of Charges (Ex. 1) are **SUSTAINED**; and
2. The license of Respondent, Jaime Yu Go, M.D, shall be **SUSPENDED** until such time as he shall successfully complete a course of retraining in anesthesiology as follows:
 - a. Respondent shall complete a retraining program in the practice of anesthesiology of six months duration in a supervised setting in an institution licensed pursuant to Article 28 of the Public Health Law; and
 - b. Such retraining program shall be subject to the approval of the Office of Professional Medical Conduct. To the extent necessary, the Office of Professional Medical Conduct shall assist Respondent in locating an acceptable retraining program in accordance with the terms of this Order; and
 - c. Respondent shall be permitted to practice medicine to the extent necessary for his completion of the program of retraining; and
 - d. The Office of Professional Medical Conduct shall advise Respondent of the requirements for the selection of a supervisor and of any requirements of said supervisor to submit reports regarding Respondent's quality of medical practice during the course of retraining; and

3. Following Respondent's successful completion of the course of retraining, as determined by the Office of Professional Medical Conduct, Respondent shall be placed on **PROBATION** for a period of two (2) years, in accordance with the terms set out in Appendix II of this Determination and Order.

DATED: Albany, New York
August 24, 1995


JOHN H. MORTON, M.D.
Chairperson

JOSEPH E. GEARY, M.D.
ANTHONY C. BIONDI

APPENDIX I

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

-----X

IN THE MATTER : STATEMENT
OF : OF
JAIME YU GO, M.D. : CHARGES

-----X

JAIME YU GO, M.D., the Respondent, was authorized to practice medicine in New York State on November 5, 1976, by the issuance of license number 129186 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided general anesthesia to Patient A (patients are identified in the Appendix) a 47 year old female, on or about February 5, 1992, at the Ira Davenport Memorial Hospital, Route 54, Bath, New York, 14810 (hereafter "the Hospital"). Patient A was admitted for out-patient surgery to correct carpal tunnel syndrome.

1. Respondent failed to use and/or record the use of a carbon dioxide monitor (capnograph) to evaluate the positioning of the patient's endotracheal tube, whether the patient was being ventilated properly, and the patient's pulmonary performance.

2. Respondent failed to use and/or record the use of a pulse oximeter to monitor the oxygen saturation level of Patient A.
3. Respondent failed to document significant aspects of the anesthetic procedure, including the status of the patient's electro-cardiogram.
4. Respondent made inappropriate use of long acting muscle relaxants with Patient A.
5. Respondent failed to monitor the degree of paralysis or muscular relaxation of Patient A by use of a nerve stimulator.
6. Respondent's pre-anesthesia evaluation, anesthesia record, and post-anesthesia notes, are dated February 5, 1992, when in fact Respondent did not enter that information on the medical record of Patient A until after February 5, 1992.

B. Respondent provided anesthesia to Patient B, a 42 year old female, who was admitted to the Hospital for an elective cholecystectomy, on October 22, 1991.

1. Respondent failed to use and/or record the use of a carbon dioxide monitor (capnograph) to evaluate the positioning of the patient's endotracheal tube, whether the patient was being ventilated properly, and the patient's pulmonary performance.
2. Respondent's pre-anesthesia evaluation, anesthesia record, and post-anesthesia notes, are dated October 22, 1991, when in fact Respondent did not enter that information on the medical record of Patient B until after October 22, 1991.
3. Respondent failed to document significant aspects of the anesthetic procedure, including the status of the patient's electro-cardiogram.

C. Respondent provided anesthesia to Patient C, a 62 year old female, at the Hospital on or about October 31, 1991, during the patient's surgical procedure, consisting of an exploratory laparotomy, appendectomy, and transverse colostomy.

1. Respondent failed to use and/or record the use of a carbon dioxide monitor (capnograph) to evaluate the positioning of the patient's endotracheal tube, whether the patient was being ventilated properly, and the patient's pulmonary performance.
2. Respondent failed to record significant aspects of the anesthetic procedure, including the status of the patient's electrocardiogram.
3. Respondent's pre-anesthesia evaluation, anesthesia record, and post-anesthesia notes, are dated October 31, 1991, when in fact Respondent did not enter that information on the medical record of Patient C until after October 31, 1991.

D. Respondent provided anesthesia to Patient D, an 85 year old female, at the Hospital on or about January 29, 1992, during Patient D's surgical procedure for ventral hernia repair and abdominoplasty.

1. Respondent failed to use and/or record the use of a carbon dioxide monitor (capnograph) to evaluate the positioning of the patient's endotracheal tube, whether the patient was being ventilated properly, and the patient's pulmonary performance.
2. Respondent failed to record significant aspects of the anesthetic procedure, including the status of the patient's electrocardiogram.
3. Respondent's pre-anesthesia evaluation, anesthesia record, and post-anesthesia notes, are dated January 29, 1992, when in fact Respondent did not enter that information on the medical record of Patient D until after January 29, 1992.

SPECIFICATION OF CHARGES

FIRST THROUGH FOURTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with practicing the profession of medicine with gross negligence on a particular occasion under N.Y. Educ. Law §6530(4) (McKinney Supp. 1995) in that Petitioner charges:

- 1. The facts in Paragraphs A and A.1 and/or A and A.2.
- 2. The facts in Paragraphs B and B.1.
- 3. The facts in Paragraphs C and C.1.
- 4. The facts in Paragraphs D and D.1.

FIFTH THROUGH EIGHTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with practicing the profession of medicine with gross incompetence on a particular occasion under N.Y. Educ. Law §6530(6) (McKinney Supp. 1995) in that Petitioner charges:

- 5. The facts in Paragraphs A and A.1 and/or A and A.2.
- 6. The facts in Paragraphs B and B.1.
- 7. The facts in Paragraphs C and C.1.
- 8. The facts in Paragraphs D and D.1.

NINTH SPECIFICATION

NEGLECT ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with negligence on more than one occasion under N.Y. Educ. Law §6530(3) (McKinney Supp. 1995) in that Petitioner

charges that Respondent committed two or more of the following:

- 9. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, C and C.3, D and D.1, D and D.2, and/or D and D.3.

TENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with incompetence on more than one occasion under N.Y. Educ. Law §6530(5) (McKinney Supp. 1995) in that Petitioner charges that Respondent committed two or more of the following:

- 10. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, B and B.1, B and B.2, B and B.3, C and C.1, C and C.2, C and C.3, D and D.1, D and D.2, and/or D and D.3.

ELEVENTH THROUGH FOURTEENTH SPECIFICATIONS

FAILING TO MAINTAIN ACCURATE RECORDS

Respondent is charged with failing to maintain a record for each patient that accurately reflects the evaluation and treatment of the patient under N.Y. Educ. Law §6530(32) (McKinney Supp. 1995) in that Petitioner charges:

- 11. The facts in Paragraphs A and A.1, A and A.2, A and A.3, and/or A and A.6.
- 12. The facts in Paragraphs B and B.1, B and B.2, and/or B and B.3.
- 13. The facts in Paragraphs C and C.1, C and C.2, and/or C and C.3.
- 14. The facts in Paragraphs D and D.1, D and D.2, and/or D and D.3.

FIFTEENTH SPECIFICATION

FRAUD IN PRACTICE OF MEDICINE

Respondent is charged with fraud in the practice of medicine under N.Y. Educ. Law §6530(2) (McKinney Supp. 1995) in that Petitioner charges that Respondent committed one of the following:

15. The facts in Paragraphs A and A.6, B and B.2, C and C.3, and/or D and D.3.

DATED: *March 22*, 1995
Albany, New York

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

APPENDIX II
TERMS OF PROBATION

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

2. Respondent shall comply with all federal, state and local laws, rules and regulations governing the practice of medicine in New York State.

3. Respondent shall submit written notification to the Board addressed to the Director, Office of Professional Medical Conduct ("OPMC"), Empire State Plaza, Corning Tower Building, Room 438, Albany, New York 12237, regarding any change in employment, practice, addresses, (residence or professional) telephone numbers, and facility affiliations within or without New York State, within 30 days of such change.

4. Respondent shall submit written notification to OPMC of any and all investigations, charges, convictions or disciplinary actions taken by any local, state or federal agency, institution or facility, within 30 days of each charge or action.

5. Respondent shall submit written proof to the Director of the Office of Professional Medical Conduct at the address indicated above that he has paid all registration fees due and is currently registered to practice medicine with the New York State Education Department. If he elects not to practice medicine in New York State, then he shall submit written proof that he has notified the New York State Education Department of that fact.

6. In the event that Respondent leaves New York to reside or practice outside the State, he shall notify the Director of the Office of Professional Medical Conduct in writing at the address indicated above, by registered or certified mail, return receipt requested, of the dates of his departure and return. Periods of residence or practice outside New York shall toll the probationary period which shall be extended by the length of residency or practice outside New York.
7. Respondent's probation shall be supervised by the Office of Professional Medical Conduct.
8. Respondent's practice of medicine shall be monitored by a physician monitor ("practice monitor"), board-certified in anesthesiology, who shall be approved in advance in writing by the Director of the Office of Professional Medical Conduct. Respondent may not practice medicine until an approved practice monitor and monitoring program is in place. Any practice of medicine prior to the submission and approval of the proposed practice monitor will be determined to be a violation of probation.
 - a. The practice monitor shall report in writing to the Director of the Office of Professional Medical Conduct or designee thereof, on a schedule to be determined by the Office. The practice monitor shall visit Respondent's medical practice at each and every location on a random basis and shall examine a random selection of records maintained by Respondent, including patient histories, anesthesia records and prescribing information. Respondent will make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall immediately be reported to the Office of Professional Medical Conduct by the monitor.

- b. Any change in practice monitors must be approved in writing, in advance, by the Office of Professional Medical Conduct.
 - c. It shall be the responsibility of the Respondent to ensure that the reports of the practice monitor are submitted in a timely manner. A failure of the practice monitor to submit required reports on a timely basis will be considered a possible violation of the terms of probation.
9. Respondent will maintain legible and complete medical records which accurately reflect evaluation and treatment of patients. Records will contain pre- and postoperative anesthesia notes prepared in a timely manner. Intraoperative anesthesia records will contain documentation of all significant aspects of the anesthetic procedure.
10. All expenses, including but not limited to those of complying with these terms of probation and the Determination and Order, shall be the sole responsibility of the Respondent.
11. Respondent shall comply with all terms, conditions, restrictions, and penalties to which he is subject pursuant to the Order of the Board. A violation of any of these terms of probation shall be considered professional misconduct. On receipt of evidence of non-compliance or any other violation of the terms of probation, a violation of probation proceeding and/or such other proceedings as may be warranted, may be initiated against Respondent pursuant to New York Public Health Law §340(19) or any other applicable laws.