New York State Board for Professional Medical Conduct

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

Antonia C. Novello, M.D., M.P.H.
Commissioner
NYS Department of Health
Dennis P. Whalen
Executive Deputy Commissioner
NYS Department of Health
Anne F. Saile, Director
Office of Professional Medical Conduct

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

January 7, 2000

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

William Wittlin, M.D.
REDACTED

RE: License No.: 174719

Dear Dr. Wittlin:

Enclosed please find Order #BPMC 00-6 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect **January 7, 2000.**

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

Sincerely,

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

Enclosure
cc: George F. Mould, Esq.
Martin, Ganotis, Brown, Mould & Currie, P.C.
5790 Widewaters Parkway
DeWitt, NY 13214

Michael Hiser, Esq.

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

IN THE MATTER

OF

WILLIAM A. WITTLIN, M.D.

CONSENT
AGREEMENT
AND
ORDER
BPMC# 00-6

WILLIAM A. WITTLIN, M.D., (Respondent) says:

That on or about June 30, 1988, I was licensed to practice as a physician in the State of New York, having been issued License No. 174719 by the New York State Education Department.

My current address is REDACTED and I will advise the Director of the Office of Professional Medical Conduct of any change of my address.

I understand that the New York State Board for Professional Medical Conduct has charged me with 23 specifications of professional misconduct.

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

In full satisfaction of the charges against me, I admit guilt to the Twentieth Specification insofar that I admit (a) that I failed to record the necessary information as set out in Factual Allegations A.1, B.1, D.1, G.1, and H.1; (b) that I failed to record the necessary information as set out in Factual Allegations B.2, C.1, D.2, E.2, F.1, and H.2. I also do not contest the Second Specification. I hereby agree to the following penalty:

That my license shall be suspended for a period of two years from the effective date of the Order herein, but that the suspension shall be stayed pending my compliance with the further terms of this agreement and the Terms of Probation

attached hereto as Exhibit B, which Terms are made a part hereof by reference. My practice of medicine will be monitored for a period of five years from the effective date of the Order herein. Finally, my license to practice medicine in New York shall be permanently limited to require me to remain in treatment for the medical condition at issue in this proceeding, i.e., REDACTED so long as I continue to practice medicine.

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

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

That Respondent shall fully cooperate in every respect with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Order and in its investigation of all matters regarding Respondent. Respondent shall respond in a timely manner to each and every request by OPMC to provide written periodic verification

of Respondent's compliance with the terms of this Order. Respondent shall meet with a person designated by the Director of OPMC as directed. Respondent shall respond promptly and provide any and all documents and information within Respondent's control upon the direction of OPMC. This condition shall be in effect beginning upon the effective date of the Consent Order and will continue while the licensee possesses his/her license.

I hereby stipulate that any failure by me to comply with such conditions shall constitute misconduct as defined by New York State Education Law §6530(29)(McKinney Supp 1999).

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

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

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

I agree that, in the event the Board grants my Application, as set forth

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

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

AFFIRMED:

DATED 12.24.99

REDACTED

WILLIAM A. WITTLIN, M.D.
RESPONDENT

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

DATE: 12/29/99

REDACTED

GEORGE F. MOULD, ESQ.
Attorney for Respondent

DATE: 12/30/99

REDACTED

MICHAEL A. HISER
ASSOCIATE COUNSEL
Bureau of Professional
Medical Conduct

DATE: 12/31/99

REDACTED

ANNE F. SAILE
Director
Office of Professional
Medical Conduct

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

IN THE MATTER

OF

WILLIAM A. WITTLIN, M.D.

CONSENT

ORDER

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

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

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

SO ORDERED.

DATED: 1/4/00

REDACTED

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

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	**:**	**FIRST AMENDED**
OF	**:**	**STATEMENT**
WILLIAM A. WITTLIN, M.D.	**:**	**OF CHARGES**

----------X

William A. Wittlin, M.D., the Respondent, was authorized to practice medicine in New York State on June 30, 1988, by the issuance of license number 174719 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 July 1, 1997, through June 30, 1999 with an office address of 107 Cayuga Heights Road, Ithaca, New York 14850.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (patients are identified in the Appendix), a female born 2/24/75, on two occasions in May 1997. Patient A was treated at Respondent's office at 107 Cayuga Heights Road, Ithaca, New York 14850 (hereafter "the office"). Patient A thereafter had contact with Respondent on two occasions in August 1997. Respondent's care of Patient A and his subsequent contact with her were below accepted standards of medical practice as follows:

1. Respondent failed to obtain and or record an adequate history, mental status evaluation, diagnosis, treatment plan, and/or termination note, for Patient A.

2. Respondent violated appropriate and therapeutic professional boundaries with Patient A by, among other things:

    a. Approaching her at a public place on or about August 3, 1997 and, despite the patient's explanations, repeatedly and falsely accusing her of not paying a bill for the two sessions of treatment with Respondent, demanding payment, and acting in a hostile manner.

b. Approaching her at her public place of employment on or about August 9, 1997, and again repeatedly and falsely accusing her of not paying a bill for the two sessions of treatment with Respondent, demanding payment, and acting in a hostile manner.

Respondent did this on the second occasion despite Patient A having sent a receipt to the Respondent after the first occasion showing that no balance was owed to him on her account.

3. Respondent, in a letter to Patient A dated 8/11/97, intentionally and falsely stated that his contact with her had been "a case of mistaken identity on [Respondent's] part", and that he "confused [Patient A's] case with another young lady". In fact, there was no other such patient.

4. Respondent, in his treatment sessions with Patient A, advised Patient A that her parents were both suicidal, even though Respondent had neither treated nor even met Patient A's parents.

5. Respondent's medical record of his care of Patient A fails to accurately reflect his evaluation and treatment of the patient.

B. Respondent treated Patient B, a female patient born 9/26/54, on several occasions from February through April 1998, at the Respondent's office in Ithaca, New York. Respondent's care of Patient B was below accepted standards of medical practice as follows:

1. Respondent failed to obtain and or record an adequate history, mental status evaluation, diagnosis and/or treatment plan for Patient B.

2. Respondent failed to consider and/or record the consideration of the nature of the treatment undertaken, the patient's response to the treatment, consideration of alteration in diagnosis or treatment as indicated by the patient's response to treatment or new information, information essential to the termination of the patient's treatment, and the evaluation or management of psychiatric risk.

3. Respondent included confidential patient information relating to Patient B's husband in Patient B's chart, thereby compromising the confidentiality of Patient B's husband medical information.

C. Respondent treated Patient C, a male patient born 8/25/76, on several occasions in April 1998, at the Respondent's office in Ithaca, New York. Respondent's care of Patient C was below accepted standards of medical practice as follows:

1. Respondent failed to consider and/or record the consideration of the nature of the treatment undertaken, the patient's response to the treatment, consideration of alteration in diagnosis or treatment as indicated by the patient's response to treatment or new information, information essential to the termination of the patient's treatment, and the evaluation or management of psychiatric risk.

2. Respondent failed to adequately respond to the indications of Patient C's substance dependence and/or abuse.

3. Respondent failed to obtain appropriately informed consent prior to prescribing Trazadone to Patient C.

D. Respondent treated Patient D, a female patient born 7/15/67, on several occasions from November 1997 through January 1998, at the Respondent's office in Ithaca, New York. Respondent's care of Patient D was below accepted standards of medical practice as follows:

1. Respondent failed to perform and/or record the performance of an adequate mental status exam.

2. Respondent failed to consider and/or record the consideration of the nature of the treatment undertaken, the patient's response to the treatment, consideration of alteration in diagnosis or treatment as indicated by the patient's response to treatment or new information, and/or information essential to the termination of the patient's treatment.

E. Respondent treated Patient E, a female patient born 5/12/76, on several occasions from October 1997 through April 1998, at the Respondent's office in Ithaca, New York. Respondent's care of Patient E was below accepted standards of medical practice as follows:

1. Respondent failed to perform and/or record the performance of an adequate mental status exam.

2. Respondent failed to consider and/or record the consideration of the nature of the treatment undertaken, the patient's response to the treatment, consideration of alteration in diagnosis or treatment as indicated by the patient's response to treatment or new information, and the evaluation or management of psychiatric risk.

3. Respondent failed to adequately evaluate Patient E for suicide potential.

4. Respondent failed to protect Patient E's confidentiality in that Respondent spoke to the patient's mother regarding the patient's condition without proper authorization.

F. Respondent treated Patient F, a male patient born 2/17/64, on several occasions from March through April 1998, at the Respondent's office in Ithaca, New York. Respondent's care of Patient F was below accepted standards of medical practice as follows:

1. Respondent failed to consider and/or record the consideration of the nature of the treatment undertaken, the patient's response to the treatment, consideration of alteration in diagnosis or treatment as indicated by the patient's response to treatment or new information, and/or information essential to the termination of the patient's treatment.

2. Respondent failed to appropriately assess and/or record an appropriate assessment of Patient F for suicide potential.

3. Respondent failed to adequately respond to indications of Patient F's substance dependence and/or abuse.

G. Respondent treated Patient G, a female patient born 12/2/75, on at least one occasion in April 1998 at the Respondent's office in Ithaca, New York. Respondent's care of Patient G was below accepted standards of medical practice as follows:

1. Respondent failed to obtain and/or record an adequate history and/or mental status evaluation for Patient G.

2. Respondent inappropriately prescribed klonopin as medication to treat what Respondent diagnosed as the patient's panic attacks, then discontinued treatment four days later without informing the patient of either the nature and potential side effects of the medication or a safe protocol for its discontinuation.

3. Respondent failed to prepare an adequate termination note regarding his termination of treatment of the patient, including the patient's response to treatment, whether Respondent agreed with the decision to terminate treatment, what risks the patient might assume by terminating treatment prematurely, and what attempts Respondent made to explain these factors to the patient.

4. Respondent failed to consider and/or record the consideration of the nature of the treatment undertaken, the patient's response to the treatment, consideration of alteration in diagnosis or treatment as indicated by the patient's response to treatment or new information, and the evaluation or management of psychiatric risk.

H. Respondent treated Patient H, a female patient born 8/17/81, on several occasions in April 1998, at the Respondent's office in Ithaca, New York. Respondent's care of Patient H was below accepted standards of medical practice as follows:

1. Respondent failed to obtain and/or record an adequate history and/or mental status evaluation for Patient H.

2. Respondent failed to consider and/or record the consideration of the nature of the treatment undertaken, the patient's response to the treatment, and/or consideration of alteration in diagnosis or treatment as indicated by the patient's response to treatment or new information.

3. Respondent failed to adequately respond to the indications of Patient H's substance dependence and/or abuse.

4. Respondent failed to appropriately assess and manage and/or record the assessment and management of Patient H's risk of suicide.

SPECIFICATIONS OF MISCONDUCT

FIRST SPECIFICATION

WILFUL HARASSMENT, ABUSE OR INTIMIDATION OF PATIENT

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(31) (McKinney Supp. 1999) by wilfully harassing, abusing, or intimidating a patient either physically or verbally, as alleged in the facts of the following:

1. Paragraphs A and A.2.a and/or A and A.2.b.

SECOND SPECIFICATION

PRACTICING WHILE ABILITY IMPAIRED

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(7) (McKinney Supp. 1999) by practicing the profession while impaired by physical or mental disability, as alleged in the facts of the following:

2. Paragraphs A and A.2.a and/or A and A.2.b.

THIRD SPECIFICATION

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(2) (McKinney Supp. 1999) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

3. Paragraphs A and A.3.

FOURTH THROUGH ELEVENTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(4) (McKinney Supp. 1999) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

4. Paragraphs A and A.1, A and A.4, and/or A and A.5.
5. Paragraphs B and B.1 and/or B and B.2.
6. Paragraphs C and C.1, C and C.2, and/or C and C.3.
7. Paragraphs D and D.1 and/or D and D.2.
8. Paragraphs E and E.1, E and E.2, E and E.3 and/or E and E.4.
9. Paragraphs F and F.1, F and F.2, and/or F and F.3.
10. Paragraphs G and G.1, G and G.2, G and G.3, and/or G and G.4.
11. Paragraphs H and H.1, H and H.2, H and H.3, and/or H and H.4.

TWELFTH THROUGH NINETEENTH SPECIFICATIONS
GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(6) (McKinney Supp. 1999) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

12. Paragraphs A and A.1, A and A.4, and/or A and A.5.

13. Paragraphs B and B.1 and/or B and B.2.

14. Paragraphs C and C.1, C and C.2, and/or C and C.3.

15. Paragraphs D and D.1 and/or D and D.2.8.

16. Paragraphs E and E.1, E and E.2, E and E.3 and/or E and E.4.

17. Paragraphs F and F.1, F and F.2, and/or F and F.3.

18. Paragraphs G and G.1, G and G.2, G and G.3, and/or G and G.4.

19. Paragraphs H and H.1, H and H.2, H and H.3, and/or H and H.4.

TWENTIETH SPECIFICATION
NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(3) (McKinney Supp. 1999) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

20. Paragraphs A and A.1, A and A.4, A and A.5, 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, E and E.1, E and E.2, E and E.3, E and E.4, F and F.1, F and F.2, F and F.3, G and G.1, G and G.2, G and G.3, G and G.4, H and H.1, H and H.2, H and H.3, and/or H and H.4.

TWENTY-FIRST SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined by New York Education Law §6530(5) (McKinney Supp. 1999) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

21. Paragraphs A and A.1, A and A.4, A and A.5, 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, E and E.1, E and E.2, E and E.3, E and E.4, F and F.1, F and F.2, F and F.3, G and G.1, G and G.2, G and G.3, G and G.4, H and H.1, H and H.2, H and H.3, and/or H and H.4.

TWENTY-SECOND SPECIFICATION
FAILURE TO MAINTAIN ACCURATE RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32) (McKinney Supp. 1999) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of:

22. Paragraph A and A.1, A and A.5, B and B.1, B and B.2, C and C.1, D and D.1, D and D.2, E and E.1, E and E.2, F and F.1, F and F.2, G and G.1, G and G.4, H and H.1, H and H.2, and/or H and H.4.

TWENTY-THIRD SPECIFICATION
BREACH OF CONFIDENTIALITY

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(23) (McKinney Supp. 1999) by revealing information obtained in a professional capacity without the prior consent of the patient, except as authorized or required by law, as alleged in the facts of:

23. Paragraph B and B.3 and/or E and E.4.

DATED: Dec 30, 1999

Albany, New York

REDACTED

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

EXHIBIT "B"

Terms of Probation

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

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

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

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

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

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

7. Respondent shall practice medicine only when monitored by a licensed physician, board certified in psychiatry, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC. The monitor shall be provided with a copy of this agreement. Approval of

a monitor or supervisor is a condition precedent to the Respondent's further practice of medicine and any practice of medicine without a pre-approved monitor is unauthorized within the meaning of N.Y. Educ. Law §6512, and may lead to criminal prosecution.

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

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

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

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

8. Respondent shall enroll (or continue enrollment) in the Committee for Physicians' Health (CPH) and shall engage in a contract with CPH which fully describes the terms, conditions and duration of a recovery program. Respondent shall fully comply with the contract.

Respondent shall provide a written authorization for CPH to provide to the Director of OPMC with any/all information or documentation requested by OPMC to determine whether Respondent is in compliance with the contract.

Respondent shall cause CPH to report to OPMC if Respondent refuses to comply with the contract, refuses to submit to treatment or whose impairment is not substantially alleviated by treatment. CPH shall report immediately to OPMC if Respondent is regarded at any time to be an imminent danger to the public.

9. Respondent agrees that he will not treat patients at his home, and that any private practice he undertakes will be conducted in an office setting shared with an active counselling group or an active group of health care providers.

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