STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Richard F. Daines, M.D.
Commissioner

Public

November 7, 2007

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

William Eugene Watkins, M.D.
7704 Caminito Sierra
Apartment T 101
Carlsbad, California 92009

William Eugene Watkins, M.D.
P.O. Box 2345
Vita, California 92085-2345

Robert Bogan, Esq.
NYS Department of Health
Hedley Building – 4th Floor
433 River Street
Troy, New York 12180

RE: In the Matter of William Eugene Watkins, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 07-244) 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 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
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

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), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "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 penalties other than suspension or revocation 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
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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,

James F. Horan

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah

Enclosure

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

COPY

IN THE MATTER

OF

WILLIAM EUGENE WATKINS, M.D.

DETERMINATION

AND

ORDER

BPMC #07-244

A hearing was held on November 19, 2004, and October 26, 2007, at the offices of the New York State Department of Health ("the Petitioner"). The lengthy time period between the first day and the second day of the hearing was the result of an adjournment granted to give the Respondent, **William Eugene Watkins, M.D.**, time to petition for restoration of his California medical license, a time consuming process that ultimately proved to be unsuccessful. (The surrender of that license was the basis of this New York State professional medical conduct proceeding). Since December of 2003, the Respondent has been prohibited from the practice of medicine in New York State by a Commissioner's Summary Order (Petitioner's Ex. 1).

A Notice of Referral Proceeding and a Statement of Charges, both dated August 23, 2004, were served upon the Respondent. Pursuant to Section 230(10)(e) of the Public Health Law, **Michael D. Golding, M.D.**, Chairperson, **James D. Hayes II, M.D.**, and **Mr. Irving S. Caplan**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter. **John Wiley, Esq.**, Administrative Law Judge, served as the Administrative Officer.

The Petitioner appeared by **Thomas Conway, Esq.**, General Counsel, by **Robert Bogan, Esq.**, of Counsel. The Respondent appeared at the hearing and represented himself.

Evidence was received and transcripts of these proceedings were made.

After consideration of the entire record, the Hearing Committee issues this Determination and Order.

BACKGROUND

This case was brought pursuant to Public Health Law Section 230(10)(p). The statute provides for an expedited hearing when a licensee is charged solely with a violation of Education Law Section 6530(9). In such cases, a licensee is charged with misconduct based upon a prior criminal conviction in New York State or another jurisdiction, or upon a prior administrative adjudication regarding conduct that would amount to professional misconduct, if committed in New York. The scope of an expedited hearing is limited to a determination of the nature and severity of the penalty to be imposed upon the licensee.

In the instant case, the Respondent is charged with professional misconduct pursuant to Education Law Section 6530(9)(d). Copies of the Notice of Referral Proceeding and the Statement of Charges are attached to this Determination and Order as Appendix 1.

WITNESSES

For the Petitioner: None

For the Respondent: William Eugene Watkins, M.D.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers below in parentheses refer to exhibits, denoted by the prefix "Ex."

These citations refer to evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings were unanimous.

1. William Eugene Watkins, M.D., the Respondent, was authorized to practice medicine in New York State on September 15, 1975, by the issuance of license number 125350 by the New York State Education Department (Petitioner's Ex. 7).

2. On May 20, 2004, the Division of Medical Quality, Medical Board of California, Department of Consumer Affairs ("California Board"), by a Decision ("California Decision"), accepted the surrender of the Respondent's Physician's and Surgeon's Certificate, based on gross negligence, repeated negligent acts, incompetence, failure to maintain adequate records, and aiding and abetting the unlicensed practice of medicine (Petitioner's Ex. 8).

HEARING COMMITTEE CONCLUSIONS

The Hearing Committee concludes that the conduct of the Respondent would constitute professional misconduct under the laws of New York State, had the conduct occurred in New York State, pursuant to:

- New York Education Law Section 6530(3) - "Practicing the profession with negligence on more than one occasion;"

- New York Education Law Section 6530(4) - "Practicing the profession with gross negligence on a particular occasion;"

- New York Education Law Section 6530(5) - "Practicing the profession with incompetence on more than one occasion;"

- New York Education Law Section 6530(6) - "Practicing the profession with gross incompetence;"

- New York Education Law Section 6530(25) - "Delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified, by training, by experience, or by licensure, to perform them;"

- New York Education Law Section 6530(26) – "Performing professional services which have not been duly authorized by the patient or his or her legal representative;"

- New York Education Law Section 6530(31) - "Willfully harassing, abusing, or intimidating a patient either physically or verbally;" and

- New York Education Law Section 6530(32) - "Failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient..."

The Statement of Charges alleged, in addition to the categories of professional misconduct listed above, that the Respondent's conduct, had it occurred in New York State would have constituted moral unfitness, which constitutes professional misconduct under New York Education Law Section 6530(20). The hearing record is unclear as to how the Respondent's conduct constituted moral unfitness and this Hearing Committee, therefore, declines to make such a finding.

VOTE OF THE HEARING COMMITTEE

SPECIFICATION

"Respondent violated New York Education Law Section 6530(9)(d) by having surrendered his license to practice medicine after a disciplinary action was instituted by a duly authorized professional disciplinary agency of another state, where the conduct resulting in the surrender would, if committed in New York state, constitute professional misconduct under the laws of New York state..."

VOTE: Sustained (3-0)

HEARING COMMITTEE DETERMINATION

The Respondent surrendered his California license to practice medicine while a disciplinary proceeding was in progress. Under such circumstances, this Hearing Committee is required by law to consider the charges in the California proceeding to be factually accurate (Public Health Law Section 230[10][p], Education Law Section 6530[9][d]). The California proceeding was based on cosmetic surgery performed by the Respondent on four patients. The surgery in all these cases was performed in the Respondent's office using a local anesthetic. No anesthesiologist or other qualified professional was present before, during or after the surgeries. The quotations, below, in the descriptions of the medical care provided to the four patients, are from the Accusation in the California proceeding (Petitioner's Ex. 8).

The Respondent performed breast implant surgery on Patient F.T. in January of 2001. Two days before the date of the surgery:

> F.T. was shown the operating room. It looked like a kitchen because there was a sink with dishes in it. There were book cases filled with books, and what looked like a dental chair...
>
> [On the day of the surgery] Kim [F.T.'s daughter and the Respondent's employee] told [F.T.] she had sprayed the operating room with disinfectant, and that Veronica, a receptionist Kim was training, would assist in the surgery.

During the surgery, F.T. wore the pants that she had worn to the Respondent's office. There were problems and delays with the surgery. After approximately one hour of surgery:

> ...F.T. was beginning to shake and she heard her daughter say she is going into shock. Respondent told Veronica to give F.T. [a] Valium by putting it under her tongue...

The Respondent had Kim do part of the stitching at the conclusion of the surgery. The outcome of the surgery was unsuccessful.

> F.T.'s breasts developed "double bubbles," with each of them having a distinct additional bulge. Respondent told the patient, massages from her husband would cure the defect...In the latter part of 2001, F.T. consulted with a plastic surgeon who performed additional surgery on F.T. to remove extensive scar tissue and do muscle repair caused by respondent's procedure.

Patient A.B., who previously had breast implant surgery, was scheduled for surgery by the Respondent in March of 2001 for the purpose of centering her breasts. On the day of the surgery, A.B. arrived at the Respondent's office with her friends, J.D. and S.H.

> When respondent discovered that A.B.'s friend S.H. was a surgical technician, he asked her if she could help out with the surgery...S.H. was shown to the operating room. It looked like a kitchen with a dental chair in it...
>
> Respondent began by injecting the anesthetic. When he began to cut, A.B. told him it was very painful and asked him to stop. Respondent just gave the patient more injections and continued...He was leaning on the patient's bladder trying to pull the implant out. At one point, respondent got frustrated and left the room...A.B. asked S.H. to get the implants out and, using gloves, she did. A.B. was in a lot of pain. [At the conclusion of surgery], S.H. commented that the breasts were not centered. Respondent told her they would shift to the middle...After surgery A.B. told respondent she was in a lot of pain. He told her it was anxiety, not pain...
>
> In or about August 2001, A.B. had corrective surgery on her breasts by another plastic surgeon.

Patient M.M. received breast implants from the Respondent in August of 2000. The surgery was performed in the room with the sink and the dental chair.

> Watkins gave M.M. injections of local anesthesia in different areas of her chest. He began cutting under her right breast, and she told him she could feel him cutting. Respondent then pinched her nipples, and when she asked him what he was doing, he said he was seeing if the anesthetic was working. M.M. told him she could still feel him cutting, at which point respondent told her she could not possibly feel it because he had given her so much anesthetic. M.M. complained so much respondent finally agreed to give her morphine...M.M. could feel respondent using his fingers to make a pocket for the implant. The pain was so excruciating that M.M. told respondent she was passing out. Respondent told M.M. to life [sic] up her legs, that he was not going to stop working on her...M.M. found the first implant so painful that she told respondent not to do the second one. Instead, respondent kept working on the second breast, telling her she was tough and that he would be done in two seconds. Respondent again

pinched M.M.'s nipples and she told him to stop. When respondent began using his knife, M.M. started kicking, and respondent told Kim to hold the patient's legs down.

After the surgery, M.M. developed serious problems. The Respondent's response to these problems was totally inadequate.

> Following the surgery M.M. was in such pain that she slept sitting up for 1 ½ months. She woke up with solid bruising from the bottom of her neck to four inches down each thigh. At a post-operative visit respondent told her the bruising would go away. M.M.'s right breast leaked fluid which was bloody with pus in it. Respondent put steri-strips on the area, which M.M. wore for two months...M.M.'s chest muscle pain persisted. Her implants dropped dramatically and her skin began to sag. The implants were causing rippling...In or about July 2001, M.M. underwent revision surgery by another San Diego plastic surgeon...

Patient P.S. received a facelift from the Respondent in March of 2001. The surgery was performed in the room with the dental chair. P.S. slept through much of the surgery. After the surgery:

> ...P.S. noticed that respondent had not done her forehead and that her right earlobe was missing. Having already paid respondent for the surgeries [the face lift and a breast augmentation procedure to be performed on a later date], she underwent another facelift procedure on March 23, 2001. Respondent made an incision on her scalp towards her forehead so forcefully that the knife was forced through her scalp and out through her upper forehead leaving puncture wounds in it. P.S. was in so much pain she told respondent that she wanted morphine even though she was allergic to it...

The Respondent's performance during the breast augmentation surgery in May of 2001 was no better than during the facelifts. The surgery was painful despite the use of a local anesthetic and the result was a right breast that leaked. The Respondent performed surgery again and the patient experienced extreme pain during the surgery. P.S. needed and received corrective surgery on her face and her breasts from another surgeon.

The medical care the Respondent provided to these four patients was shockingly below the acceptable standard of care. He performed surgery in nonsterile conditions and used unqualified persons to assist in the surgery. His use of local anesthetics was

totally inadequate for the type of surgery performed and his refusal to respond competently and humanely to the pain his patients experienced during surgery is inexplicable. He continued to perform surgery when the patients were in extreme pain and even after the withdrawal by a patient of her consent to have the surgery.

The Respondent introduced evidence to prove that he had received over one hundred hours of continuing medical education since he surrendered his California license. This education, however, consisted primarily of Internet courses and similar training involving no classroom or operating room training. This evidence provides no reason to believe that the Respondent has become a more skillful and more responsible surgeon.

The Respondent also presented some evidence of his community service. However, he admitted this community service consisted solely of contributing money to worthy causes. He devoted no time to volunteer work. Even if he had, this could not possibly have outweighed the evidence of grossly negligent and grossly incompetent medical care.

The Petitioner recommended that the Respondent's license to practice medicine be revoked. This Hearing Committee will adopt this recommendation. There is no other penalty sufficient to protect the public from the danger posed by the Respondent.

ORDER

IT IS HEREBY ORDERED THAT:

1. The Respondent's license to practice medicine is revoked.

2. This Order shall be effective upon service on the Respondent in accordance with the requirements of Public Health Law Section 230(10)(h).

DATED: New York, New York
07 November, 2007

Michael R. Golding, M.D.
Chairperson

James D. Hayes II, M.D.
Irving S. Caplan

APPENDIX I

ORIGINAL

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

IN THE MATTER **NOTICE OF**

OF **REFERRAL**

WILLIAM EUGENE WATKINS, M.D. **PROCEEDING**
CO-03-09-4154-A

TO: WILLIAM EUGENE WATKINS, M.D.
7704 Caminito Sierra
Apt. T 101
Carlsbad, CA 92009

PLEASE TAKE NOTICE THAT:

An adjudicatory proceeding will be held pursuant to the provisions of N.Y. Pub. Health Law § 230(10)(p) and N.Y. State Admin. Proc. Act Sections 301-307 and 401. The proceeding will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct (Committee) on the 22nd day of September 2004, at 10:00 in the forenoon of that day at the Hedley Park Place, 433 River Street, 5th Floor, Troy, New York 12180.

At the proceeding, evidence will be received concerning the allegations set forth in the attached Statement of Charges. A stenographic record of the proceeding will be made and the witnesses at the proceeding will be sworn and examined.

You may appear in person at the proceeding and may be represented by counsel. You may produce evidence or sworn testimony on your behalf. Such evidence or sworn testimony shall be strictly limited to evidence and testimony relating to the nature and severity of the penalty to be imposed upon the licensee. Where the charges are based on the conviction of state law crimes in other jurisdictions, evidence may be offered that would show that the conviction would not be a crime in New York state. The Committee also may limit the number of witnesses whose testimony will be received, as well as the length of time any witness will be permitted to testify.

If you intend to present sworn testimony, the number of witnesses and an estimate of the time necessary for their direct examination must be submitted to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 5th Floor, 433 River Street, Troy, New York, ATTENTION: HON. SEAN O' BRIEN, DIRECTOR, BUREAU OF ADJUDICATION, (hereinafter "Bureau of Adjudication") as well as the Department of Health attorney indicated below, on or before September 13, 2004.

Pursuant to the provisions of N.Y. Public Health Law §230(10)(p), you shall file a written answer to each of the Charges and Allegations in the Statement of Charges no later than ten days prior to the hearing. Any Charge of Allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such an answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. You may file a brief and affidavits with the Committee. Six copies of all such papers you wish to submit must be filed with the Bureau of Adjudication at the address indicated above on or before July 12, 2004, and a copy of all papers must be served on the same date on the Department of Health attorney indicated below. Pursuant to Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

The proceeding may be held whether or not you appear. Please note that requests for adjournments must be made in writing to the Bureau of Adjudication, at the address indicated above, with a copy of the request to the attorney for the Department of Health, whose name appears below, at least five days prior to the scheduled date of the proceeding. Adjournment requests are not routinely granted. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation. Failure to obtain an attorney within a reasonable period of time prior to the proceeding will not be grounds for an adjournment.

The Committee will make a written report of its findings, conclusions as to guilt, and a determination. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

SINCE THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT SUSPENDS OR REVOKES YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE AND/OR IMPOSES A FINE FOR EACH OFFENSE CHARGED, YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
8/23, 2004

BRIAN M. MURPHY
Chief Counsel
Bureau of Professional Medical Conduct

Inquiries should be addressed to:

Robert Bogan
Associate Counsel
New York State Department of Health
Office of Professional Medical Conduct
433 River Street – Suite 303
Troy, New York 12180
(518) 402-0828

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

IN THE MATTER	**STATEMENT**
OF	**OF**
WILLIAM EUGENE WATKINS, M.D. **CO-03-09-4154-A**	**CHARGES**

WILLIAM EUGENE WATKINS, M.D., the Respondent, was authorized to practice medicine in New York State on September 15, 1975, by the issuance of license number 125350 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about May 20, 2004, the Division of Medical Quality, Medical Board of California, Department of Consumer Affairs (hereinafter "California Board"), by a Decision (hereinafter "California Decision"), accepted the surrender of Respondent's Physician's and Surgeon's Certificate, based on gross negligence, repeated negligent acts, incompetence, failure to maintain adequate records, and aiding and abetting the unlicensed practice of medicine.

B. The conduct resulting in the California Board disciplinary action against Respondent would constitute misconduct under the laws of New York state, pursuant to the following sections of New York state law:

1. New York State Education Law §6530(3) (negligence on more than one occasion);
2. New York State Education Law §6530(4) (gross negligence);
3. New York State Education Law §6530(5) (incompetence on more than one occasion);
4. New York State Education Law §6530(6) (gross incompetence);
5. New York State Education Law §6530(20) (moral fitness);

6. New York State Education Law §6530(25) (delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified to perform them);

7. New York State Education Law §6530(26) (performing professional services which have not been duly authorized by the patient or his or her legal representative);

8. New York State Education Law §6530(31) (willfully harassing, abusing, or intimidating a patient); and/or

9. New York State Education Law §6530(32) (failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient).

SPECIFICATION

Respondent violated New York State Education Law Section 6530 (9)(d) by having surrendered his license to practice medicine after a disciplinary action was instituted by a duly authorized professional disciplinary agency of another state, where the conduct resulting in the surrender would, if committed in New York state, constitute professional misconduct under the laws of New York state, in that the Petitioner charges:

1. The facts in Paragraphs A and/or B.

DATED: 8/23 ,2004

BRIAN M. MURPHY
Chief Counsel
Bureau of Professional Medical Conduct