BEFORE THE

BOARD OF MEDICAL EXAMINERS

STATE OF OREGON

In the Matter of GEORGE FRED WITTKOPP, MD LICENSE NO. MD10695	)))))	FINAL ORDER BY DEFAULT

1.

The Board of Medical Examiners (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including physicians, in the state of Oregon. George Fred Wittkopp, MD (Licensee) is a licensed physician in the state of Oregon.

2.

On February 11, 2005, the Board issued a Complaint and Notice of Proposed Disciplinary Action pursuant to ORS 677.205 for violating the Medical Practice Act, to wit: ORS 677.190(1)(a) unprofessional or dishonorable conduct, as defined in ORS 677.188(4)(a) and ORS 677.190(18) willfully violating a board order. The Notice designated the Board's file on this matter as the record of proceedings for purposes of default and informed Licensee that failure to request a hearing within 21 days of service of the Notice or to appear at any hearing would constitute waiver of the right to a contested case hearing and result in a default order.

3.

In a letter dated February 22, 2005, legal counsel representing Licensee informed the Board that Licensee requested a hearing. But in a subsequent letter dated April 21, 2005, Licensee withdrew his request for hearing. As a result, Licensee stands in default, *see* OAR 137-003-0670(1)(b). The Board elects in this case to designate the record of proceedings, which consists of Licensee's file with the Board, as the record for purposes of proving a prima facie case.

NOW THEREFORE, after considering the Board's file relating to this matter, the Board enters the following Order.

4.

FINDINGS OF FACT

The Board makes the following findings of fact from the record of proceedings, including the investigative files, pertaining to these cases:

4.1 On September 20, 2002, the Board ordered Licensee to undergo an evaluation to assess his competence to practice medicine. The Center for Personalized Education for Physicians (CPEP) conducted the evaluation and prepared an assessment report. This report found that although Licensee demonstrated acceptable medical knowledge, Licensee's patient care documentation was inadequate and that he did not consistently apply his knowledge to medication management, frequency of treatment sessions, re-evaluation of patient responses to treatment, and informed consent. The CPEP report recommended that Licensee engage in continuing education, that he take courses in chart documentation and health law, and that he establish a relationship with an experienced psychiatrist who would serve as his preceptor.

4.2 The Board subsequently took Licensee to formal discipline. Following a contested case hearing, the Board issued a Final Order on October 25, 2004, finding that Licensee had engaged in unprofessional or dishonorable conduct as well as repeated acts of negligence in regard to his care of five patients. The Board found that Licensee's charts revealed a pattern of inadequate chart documentation, that he had failed to obtain informed consent, that he used inappropriate therapies and employed multiple medications without medical justification in his treatment of patients, and that he violated patient boundaries by interposing his own political and religious views into discussions with patients in clinical settings.

4.3 Due to these serious identified shortcomings in Licensee's practice that could adversely impact patient health, the Board suspended Licensee from practice but stayed the suspension conditional upon Licensee's ongoing successful compliance with all the terms of the Final Order. Licensee's terms of probation included the following: "Respondent shall enroll in the Center for Personalized Education for Physicians (CPEP) Educational Intervention Program within thirty (30) days from the date this Order is signed by the Board Secretary. Respondent

shall complete and sign the written Education Plan and initiate participation in identified education activities within 90 days of the effective date of this Order and cause a copy of this Plan to be sent to the Board within 10 days of it being signed." To date, Licensee has failed to comply with these requirements. The terms of probation were designed to bring Licensee's conduct into conformity with the standard of care while allowing the Board to monitor his progress by using a preceptor. On February 3, 2005, Licensee signed an Interim Stipulated Order in which Licensee withdrew from the practice of medicine, and promised that he would not resume practice until he received written permission from the Board. This Interim Stipulated Order noted that Licensee remained in noncompliance with the October 25, 2004 Final Order, by failing to pay his fine, failing to enroll in the CPEP educational intervention program, failing to sign or submit a written education plan and failing to participate in other specified educational activities.

4.4 In addition to the above, which standing alone would justify revocation of his license, the Board has learned that Licensee has engaged in sexual misconduct with Patient A, an adult female. Patient A was referred to Licensee on October 4, 2000 for a mental health consultation. The initial clinic visit occurred on October 20, 2000. Licensee made an Axis I diagnosis of dysthymic disorder, with anxious features, rule out cyclothymic disorder and or mild bipolar disorder, and an Axis II diagnosis of histrionic personality disorder. Patient A returned for 21 subsequent clinical visits. Licensee described his treatment of Patient A as "only supportive psychotherapy of a superficial sort." Review of Licensee's charting for the clinical visits (each of about 45 – 50 minutes in duration) reveals that Licensee provided psychotherapy. In addition, Licensee's progress notes reveal frequent occasions where he described Patient A's disclosures of her relationship problems with men (to include a former spouse, prior boyfriends, and a male roommate). Licensee's chart reflects that he offered interpretations and advice to her on this issue. For instance, on one occasion, Licensee suggested that Patient A's inability to turn her head "might be a symbolism (not daring to look for another man)."

4.5 Licensee reports that his treatment of Patient A ended on May 25, 2001. Contemporaneously or shortly thereafter, Licensee contacted Patient A and entered into a personal relationship with her that soon developed into intimate sexual contact and co-habitation. Licensee's conduct violated well recognized medical ethical standards to include the philosophy statement by this Board regarding sexual misconduct; the Principles of Medical Ethics published by the American Medical Association regarding sexual misconduct and the exploitation of a patient's trust and confidence; as well as Principles of Medical Ethics published by the American Psychiatric Association (2001 Edition with November 2003 amendments), which includes the following statement at section 2: "Sexual activity with a current or former patient is unethical."

4.6 During the course of the investigation, Licensee produced a document dated May 26, 2001, entitled "Document of Understanding" that is signed by Patient A. This document (prepared by and for the benefit of Licensee) acknowledges the possibility that Patient A's feelings for Licensee "may be largely a product of the therapy." It also states that Patient A's feelings toward Licensee may be distorted by the phenomenon of transference, and further states that Patient A "is willing to assume the risks of this factor [transference] and will not assign blame to Licensee." Licensee's use of such a self serving document, regardless of the date it was signed, highlights the disparate power differential between the parties and Licensee's willingness to manipulate his position as a physician to advance his personal interest at the expense of the patient's.

4.7 As a result of the conduct and events described above, the Board invited Licensee to appear before the Board's Investigative Committee on February 3, 2005, pursuant to ORS 677.320(5), for an interview. Licensee appeared before the committee on that date and responded to questions regarding his medical practice, his relationship with Patient A, and his failure to comply with the Board's Final Order. During that interview, Licensee stated that although Patient A was not the first patient to have flirted with him, he decided to "go ahead and have a relationship with [her]" because he was "under attack by the Board" and "[s]he distracted me from my portents of doom at that point. And I decided that the risk/benefit ratio was such

that this is something that I would do." The Board has considered the explanations offered by Licensee during this interview and concludes that Licensee willfully refused to comply with the terms of the Final Order. Further, that Licensee engaged in a sexual relationship with Patient A despite understanding that the ethical standards published by his own professional association flatly prohibits such relationships. Licensee understands the applicable ethical principles as well as the concepts of transference and the disparate power differential between physician and patient, but decided to put his own interests before that of his patient. This once again demonstrates Licensee's willingness to spurn principles of medical ethics that stand in the way of his personal agenda. Based upon these investigations and interview, the Board concludes that Licensee cannot be trusted to practice medicine in the future, and that his continued practice would subject the public to the risk of harm.

5.

CONCLUSIONS OF LAW

5.1 Licensee willfully violated the Board's Final Order by failing to pay $5,000 in costs and failing to comply with the terms of his probation, to include failing to enroll in the CPEP educational intervention program, and failing to sign or submit to the Board a written education plan. Licensee knew the terms of his Final Order and failed to comply with them because he didn't want to.

5.2 Licensee breached well recognized standards of ethics of the medical profession and engaged in conduct that did or might constitute a danger to the health of his patient by engaging in sexual misconduct with an adult female patient. Whether or not this patient was a current or former patient is of no consequence. The American Psychiatric Association's Principles of Medical Ethics, Section 2, 2001 Edition states: "Sexual activity with a current or former patient is unethical." Licensee's conduct was done willfully with full knowledge of applicable ethical standards.

5.3 Licensee's conduct exploited the vulnerability of a mental health patient. Licensee gained knowledge of Patient A's emotional needs and relationship problems with men,

and was able to parlay that information to his advantage. Licensee used his position as a physician to incrementally exploit the trust, knowledge, emotions or influence of this patient derived from his position as a physician for his own selfish ends, to include having Patient A sign a document designed to absolve himself of any responsibility for his own misconduct. Such conduct is both unprofessional and dishonorable.

5.4 The Board finds that upon examination of the record in these cases, that each alleged violation of the Medical Practice Act is supported by reliable, probative and substantial evidence.

6.

ORDER

IT IS HEREBY ORDERED THAT the license of George Fred Wittkopp, MD to practice medicine in the state of Oregon is revoked.

DATED this 14th day of July, 2005.

BOARD OF MEDICAL EXAMINERS
State of Oregon

Joseph J. Thaler MD

JOSEPH J. THALER, MD
BOARD CHAIR

Right to Judicial Review

NOTICE: You are entitled to judicial review of this Order. Judicial review may be obtained by filing a petition for review with the Oregon Court of Appeals within 60 days after the final order is served upon you. See ORS 183.482. If this Order was personally delivered to you, the date of service is the day it was mailed, not the day you received it. If you do not file a petition for judicial review within the 60 days time period, you will lose your right to appeal.

BEFORE THE

BOARD OF MEDICAL EXAMINERS

STATE OF OREGON

In the Matter of:	)	
	)	
GEORGE FRED WITTKOPP, MD	)	BILL OF COSTS
LICENSE NO. MD 10695	)	
	)	

1.

On October 25, 2004, the Board of Medical Examiners (Board) issued a Final Order in the matter of George Fred Wittkopp, MD (Licensee). In this Order, Licensee was assessed the costs, not to exceed $5,000, related to his Contested Case Hearing held on April 6-8, 2004. This $5,000 payment is due within 3 months from the date the Final Order was signed by the Board Secretary.

2.

The State of Oregon, by and through its Board of Medical Examiners, claims costs related to the April 6-8, 2004 Contested Case Hearing in the above-captioned case as follows:

Board Counsel - Warren Foote	$ 12,159.90
Board Consultants-	$ 4,426.28
Illige ($2,731.28)	
Lakovics ($1,000.00)	
Waugh ($695.00)	
Administrative Law Judge - Monica Smith	$ 7,706.78
Court Reporter Appearance - Naegeli Corp	$ 3,333.75
TOTAL COSTS:	$ 27,626.71
TOTAL COSTS DUE:	**$ 5,000.00**

The above costs are certified as a correct accounting of actual costs incurred preparing for and participating in the contested case hearing in this matter.

Dated this 29th of October, 2004

BOARD OF MEDICAL EXAMINERS
State of Oregon

Kathleen Haley

KATHLEEN HALEY,
EXECUTIVE DIRECTOR