



**New York State Board for Professional Medical Conduct**

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

Barbara A. DeBuono, M.D., M.P.H.  
Commissioner of Health

Charles J. Vacanti, M.D.  
Chair

March 25, 1997

**PUBLIC**

**CERTIFIED MAIL-RETURN RECEIPT REQUESTED**

William Longaker, M.D.  
103 West Seneca Street  
Suite 206  
Ithaca, New York 14850

RE: License No. 046863

Dear Dr. Longaker:

Enclosed please find Order #BPMC 97-73 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect upon receipt of this letter or seven (7) days after the date of this letter, whichever is earlier.

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.

Board for Professional Medical Conduct  
New York State Department of Health  
Hedley Park Place, Suite 303  
433 River Street  
Troy, New York 12180

Sincerely,

Charles Vacanti, M.D.  
Chair  
Board for Professional Medical Conduct

Enclosure

cc: George Awad, Esq.  
171 Main Street  
PO Box 507  
Owego, New York 13827

Karen Eileen Carlson, Esq.



a limitation on my ability to prescribe in that I may not prescribe any substances, controlled substances or non-controlled substances during the five year term of probation;

a five year term of probation, to run concurrently to the two year stayed suspension;

the probation terms, annexed hereto, made a part hereof, and marked as Exhibit B, including quarterly meetings with probation, and regular review of my records.

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

I understand that, in the event that the Board does not grant this application, 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 final determination by the Board pursuant to the provisions of the Public Health Law.

I agree that, in the event the State Board for Professional Medical Conduct grants my application, an order of the Chairperson of the Board shall be issued in accordance with same.

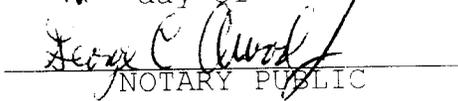
I make this application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner.

  
WILLIAM LONGAKER, M.D.  
Respondent

Sworn to before me this

12<sup>th</sup> day of March

, 1997

  
NOTARY PUBLIC

GEORGE C. ANAG, JR.  
Notary Public, State of New York  
Qualified in Tioga County  
Commission Expires April 30, 1999

AGREED TO:

DATE: 3.11.97

  
\_\_\_\_\_  
GEORGE AWAD, ESQ.  
Attorney for Respondent

DATE: 3/14/97

  
\_\_\_\_\_  
KAREN EILEEN CARLSON  
Assistant Counsel  
Bureau of Professional  
Medical Conduct

DATE: March 19, 1997

  
\_\_\_\_\_  
ANNE F. SAILE  
Director  
Office of Professional Medical  
Conduct

ORDER

Upon the application of William Longaker, M.D. for a consent order, which is agreed to and made a part hereof, it is

ORDERED, that the agreement and the provisions thereof are hereby adopted; and it is further

ORDERED, that this order shall take effect as of the date of personal service upon Respondent, upon receipt by Respondent of this order by certified mail, or seven days after mailing of this order by certified mail, whichever is earliest.

DATE: 20 March 1997

Charles J. Vacanti

Charles J. Vacanti, M.D.  
Chairperson  
State Board for Professional  
Medical Conduct

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

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IN THE MATTER : STATEMENT  
 OF : OF  
 WILLIAM LONGAKER, M.D. : CHARGES

-----X

William Longaker, M.D., the Respondent, was authorized to practice medicine in New York State on October 9, 1947 by the issuance of license number 046863 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine.

**FACTUAL ALLEGATIONS**

- A. Respondent provided psychiatric care to Patient A [all patients are identified in Appendix] from on or about May 24, 1986 through on or about August, 1992 in his office at 46 Riverside Drive, Binghamton, New York [hereafter "Respondent's office"].
  - 1. Respondent failed to perform and/or document an adequate initial evaluation and/or mental status examination of Patient A.
  - 2. Respondent failed to prepare and/or document an adequate treatment plan for Patient A.
  - 3. Respondent prescribed Demerol to Patient A in excessive amounts.

4. Respondent prescribed Fiorinal to Patient A in excessive amounts.
5. Respondent, at various times, treated Patient A with Valium and Xanax simultaneously which was not medically indicated.
6. Respondent prescribed controlled substances to Patient A while knowing Patient A to be a substance abuser.
7. Respondent treated and/or prescribed medication for migraine headaches for Patient A without adequate medical justification.
8. Respondent failed to make adequate referrals for Patient A.
9. Respondent failed to maintain medical records which adequately reflect the care and treatment of Patient A.

B. Respondent provided psychiatric treatment to Patient B from on or about December 23, 1988 through on or about December 18, 1989 and again from on or about January 15, 1992 through on or about March, 1993 at Respondent's office.

1. Respondent failed to perform and/or document an adequate initial evaluation and/or mental status examination of Patient B.
2. Respondent prescribed excessive amounts of Darvocet to Patient B.
3. Respondent prescribed excessive amounts of Valium to Patient B.
4. Respondent prescribed excessive amounts of Ritalin to

Patient B.

5. Respondent prescribed excessive amounts of Restoril to Patient B.
6. Respondent prescribed Ritalin, Klonopin, ProSom and Restoril, Soma, and/or Plegine without adequate medical justification.
7. Respondent treated Patient B's girlfriend while treating Patient B.
8. Respondent failed to maintain medical records which accurately reflect the care and treatment of Patient B.

C. Respondent provided psychiatric care to Patient C from on or about April 6, 1989 through on or about January 18, 1993, at his office.

1. Respondent failed to prepare and/or document an adequate treatment plan for Patient C.
2. Respondent prescribed Klonopin to Patient C in excessive amounts.
3. Respondent prescribed Ativan to Patient C in excessive amounts.
4. Respondent prescribed Valium to Patient C in excessive amounts.
5. Respondent prescribed Xanax to Patient C in excessive amounts.
6. Respondent prescribed Halcion to Patient C without adequate medical justification.
7. Respondent prescribed Klonopin and Ativan to Patient C

simultaneously.

8. Respondent prescribed Klonopin and Valium to Patient C simultaneously.

9. Respondent prescribed Klonopin and Xanax to Patient C simultaneously.

10. Respondent treated Patient C's sister while treating Patient C.

11. Respondent failed to maintain medical records which accurately reflect the care and treatment of Patient C.

D. Respondent provided psychiatric care to Patient D from on or about September 8, 1981 through on or about February, 1993 at Respondent's office.

1. Respondent failed to perform and/or document an adequate initial evaluation and/or mental status examination of Patient D.

2. Respondent failed to prepare and/or document an adequate treatment plan for Patient D.

3. Respondent prescribed Fiorinal and/or Tylenol with Codeine to Patient D while knowing him to have a history of a drug addiction and/or without medical justification.

4. Respondent failed to maintain medical records which accurately reflect the care and treatment of Patient D.

E. Respondent provided psychiatric care to Patient E from on or

about July 23, 1987 through on or about May 5, 1988 at Respondent's office.

1. Respondent failed to perform and/or document an adequate mental status examination of Patient E.
2. Respondent failed to prepare and/or document an adequate treatment plan for Patient E.
3. Respondent prescribed Klonopin and/or Xanax to Patient E without adequate medical justification.
4. Respondent failed to maintain medical records which accurately reflect the care and treatment of Patient E.

F. Respondent provided psychiatric care to Patient F from on or about May 17, 1984 through on or about June 24, 1986 at Respondent's office.

1. Respondent failed to perform and/or document an adequate mental status examination of Patient F.
2. Respondent failed to prepare and/or document an adequate treatment plan and/or diagnosis for Patient F.
3. Respondent prescribed excessive amounts of Valium to Patient F.
4. Respondent prescribed Valium, a benzodiazepene, to Patient F while knowing Patient F to be a substance abuser.
5. Respondent failed to maintain records which accurately reflect the care and treatment of Patient F.

G. Respondent provided psychiatric care to Patient G from on or about December 31, 1987 through on or about May 30, 1991 at Respondent's office.

1. Respondent failed to perform and/or document an adequate mental status examination of Patient G.
2. Respondent failed to prepare and/or document an adequate treatment plan and/or diagnosis of Patient G.
3. Respondent treated Patient G's girlfriend while treating Patient G.
4. Respondent failed to maintain records which accurately reflect the care and treatment of Patient G.

H. Respondent provided psychiatric care to Patient H from on or about August 9, 1988 through on or about March 14, 1991 at Respondent's office.

1. Respondent failed to perform and/or document an adequate mental status examination of Patient H.
2. Respondent failed to prepare and/or document an adequate treatment plan and/or diagnosis of Patient H.
3. Respondent failed to order and/or document a baseline thyroid study on Patient H.
4. Respondent failed to adequately monitor Patient H's lithium level.
5. Respondent failed to maintain medical records which accurately reflect the care and treatment of Patient H.

I. Respondent provided psychiatric care to Patient I from on or about February 26, 1985 through on or about June 6, 1985 at Respondent's office.

1. Respondent failed to perform and/or document an adequate mental status examination of Patient I.
2. Respondent failed to prepare and/or document an adequate diagnosis or treatment plan on Patient I.
3. Respondent failed to maintain records which accurately reflect the care and treatment of Patient I.

J. Respondent provided psychiatric care to Patient J from on or about May 17, 1988 through on or about December 11, 1990 at Respondent's office.

1. Respondent failed to perform and/or document an adequate mental status examination of Patient J.
2. Respondent failed to prepare and/or document an adequate treatment plan and/or diagnosis of Patient J.
3. Respondent failed to maintain records which accurately reflect the care and treatment of Patient J.

K. Respondent provided psychiatric care to patient M from on or about September 27, 1990 through on or about June 13, 1991 at Respondent's office.

1. Respondent failed to perform and/or document an adequate mental status evaluation for Patient M.

2. Respondent failed to prepare and/or document an adequate treatment plan for Patient M.
  3. Respondent failed to maintain records which accurately reflect the care and treatment of Patient M.
- L. Respondent provided psychiatric care to Patient K on or about October 9, 1990 through on or about January 31, 1991 at Respondent's office. Respondent failed to maintain records which accurately reflect the care and treatment of Patient K.
- M. Respondent provided psychiatric care to Patient L from on or about May 6, 1986 through on or about August 10, 1989 at Respondent's office. Respondent failed to maintain records which accurately reflect the care and treatment of Patient L.
- N. Respondent provided psychiatric care to Patient N from on or about May 1, 1986 through on or about April 6, 1989 at Respondent's office. Respondent failed to maintain records which accurately reflect the care and treatment of Patient N.
- O. Respondent provided psychiatric care to Patient O from on or about May 19, 1987 through on or about July 23, 1987 at Respondent's office. Respondent failed to maintain records which accurately reflect the care and treatment of Patient O.

P. Respondent provided psychiatric care to Patient P from on or about July 7, 1988 through on or about October 11, 1988 at Respondent's office. Respondent failed to maintain records which accurately reflect the care and treatment of Patient P.

### SPECIFICATIONS

#### FIRST THROUGH THIRD SPECIFICATIONS

##### PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with professional misconduct under N.Y. Educ. Law section 6530(4) by reason of his having practiced the profession with gross negligence on a single occasion in that Petitioner charges:

1. The facts in paragraphs A and A.3, A and A.4, A and/or A.5.
2. The facts in paragraphs B and B.2, B and B.3, B and B.4, B and B.5 and/or B and B.6.
3. The facts in paragraphs C and C.2, C and C.3, C and C.4 and/or C and C.5.

#### FOURTH THROUGH SIXTH SPECIFICATIONS

##### PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with professional misconduct under

N.Y., Educ. law section 6530(6) by reason of his having practiced the profession with gross incompetence in that Petitioner charges:

4. The facts in Paragraphs A and A.3, A and a.4, and/or A and A.5.
5. The facts in Paragraphs B and B.2, B and B.3, B and B.4 B and B.5, and/or B and B.6.
6. The facts in Paragraphs C and C.2, C and C.3 and C.4 and/or C and C.5.

#### SEVENTH SPECIFICATION

#### NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y., Educ. law section 6530(3) by reason of his having practiced the profession with negligence on more than one occasion in that Petitioner charges:

7. 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, A and A.7, A and A.8, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, C and C.1 C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, C and C.8, C and C.9, C and C.11 C and C.11, D and D.1, D and D.2 D and D.3, D and D.4, 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, F and F.4, F and F.5, 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, H and H.4, H and H.5, I and I.1, I and I.2, I and I.3, J and J.1, J and J.2, J and J.3, K and K.1, K and K.2, K and K.3, L, M, N, O and/or P.

#### EIGHTH SPECIFICATION

#### INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under

N.Y. Educ. Law section 6530(5) by reason of his having practiced the profession with incompetence on more than one occasion in that Petitioner charges:

8. 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, A and A.7, A and A.8, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, C and C.7, C and C.8, C and C.9, C and C.11, C and C.11, D and D.1, D and D.2, D and D.3, D and D.4, 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, F and F.4, F and F.5, 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, H and H.4, H and H.5, I and I.1, I and I.2, I and I.3, J and J.1, J and J.2, J and J.3, K and K.1, K and K.2, K and K.3, L, M, N, O and/or P.

**NINTH THROUGH TWENTY-FOURTH SPECIFICATIONS**

**INADEQUATE RECORD KEEPING**

Respondent is charged with professional misconduct under N.Y. Educ. Law section 6530(32) by reason of his having failed to maintain a record for each patient that accurately reflects the care and treatment given to each patient in that Petitioner charges:

9. The facts in Paragraphs A and A.1, A and A.2, and/or A and A.9.
10. The facts in Paragraphs B and B.1, and/or B and B.8.
11. The facts in Paragraphs C and C.1, and/or C and C.11.
12. The facts in Paragraphs D and D.1, D and D.2, and/or D and D.4.
13. The facts in Paragraphs E and E.1, E and E.2, and/or E and E.4.

14. The facts in Paragraphs F and F.1, F and F.2, and/or F and F.5.
15. The facts in Paragraphs G and G.1, G and G.2, and/or G and G.4.
16. The facts in Paragraphs H and H.1, H and H.2, and/or H and H.5.
17. The facts in Paragraphs I and I.1, I and I.2, and/or I and I.3.
18. The facts in Paragraphs J and J.1, J and J.2, and/or J and J.3.
19. The facts in Paragraphs K and K.1, K and K.2, and/or K and K.3.
20. The facts in Paragraph L.
21. The facts in Paragraph M.
22. The facts in Paragraph N.
23. The facts in Paragraph O.
24. The facts in Paragraph P.

*March 17, 1997*  
Albany, New York

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

EXHIBIT B

TERMS OF PROBATION

1. William Longaker, M.D, hereafter referred to as Respondent, during the period of probation, shall conduct himself in all ways 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 submit written notification to the New York State Department of Health (NYSDOH), addressed to the Director, Office of Professional Medical Conduct, New York State Department of Health, Hedley Park Place, 4th Floor, 433 River Street, Troy, New York 12180-2299 of any employment and practice, of Respondent's residence and telephone number, of any change in Respondent's employment, practice, residence, or telephone number within or without the State of New York (a post office box is unacceptable as an address);
3. Respondent shall submit written proof from the Division of Professional Licensing Services (DPLS), New York State Education Department (NYSED), that Respondent has paid all registration fees due and owing to the NYSED and Respondent shall cooperate with and submit whatever papers are requested by DPLS in regard to said registration fees, said proof from DPLS to be submitted by Respondent to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, no later than the first three months of the period of probation;
4. Respondent shall submit written proof to the NYSDOH, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, that 1) Respondent is currently registered with the NYSED, unless Respondent submits written proof that Respondent has advised DPLS, NYSED, that Respondent is not engaging in the practice of Respondent's profession in the State of New York and does not desire to register, and that 2) Respondent has paid any fines which may have previously been imposed upon Respondent by the Board or by the Board of Regents; said proof of the above to be submitted no later than the first two months of the period of probation;
5. Respondent shall cooperate with a Medical Coordinator of OPMC or other physician designated by OPMC who may quarterly during the period of probation, or more often if deemed necessary by OPMC, review Respondent's practice of medicine. Such reviews may include, without limitation and at the discretion of the Medical Coordinator or other physician, interviews with Respondent, random review of Respondent's patient records, observation of Respondent's treatment of patients or any reasonable means of reviewing Respondent's practice of medicine.

6. Respondent's practice of prescribing, within his practice of medicine, is restricted such that Respondent may not at any time prescribe any substances, until such time as Respondent has completed probation. Respondent may not prescribe controlled or non-controlled substances.

Respondent shall attest to compliance with the prescribed practice restriction by signing and submitting to the Director of OPMC a Practice Restriction Declaration, as directed by the Director.

Respondent shall cause the administrator(s) of all hospitals and other health care facilities or practices with which Respondent is affiliated to submit a letter to the Director of OPMC attesting to Respondent's compliance with the specified restriction at each location.

7. Respondent shall comply with all terms, conditions, restrictions, and penalties to which he is subject pursuant to the order of the Board;
8. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by the State of New York. 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, .
9. So long as there is full compliance with every term herein set forth, Respondent may continue to practice his or her aforementioned profession in accordance with the terms of probation; provided, however, that upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of the Office of Professional Medical Conduct and/or the Board may initiate a violation of probation proceeding and/or such other proceeding against Respondent as may be authorized pursuant to the Public Health Law.
10. Respondent shall assume and bear all costs related to compliance with the terms of probation.