STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

OFFICE OF PUBLIC HEALTH
Lloyd F. Novick, M.D., M.P.H.
Director
Diana Jones Ritter
Executive Deputy Director

April 25, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Terrence Sheehan, Esq.
Associate Counsel
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

David W. Windley, Esq.
224 Atlantic Avenue
Brooklyn, New York 11201

Raymond Nadell, M.D.
53 Marlborough Road
Brooklyn, New York 11226

RE: In the Matter of Raymond Nadell, M.D.

Dear Mr. Sheehan, Mr. Windley and Dr. Nadell:

Enclosed please find the Determination and Order (No. BPMC 94-54) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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 than 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), "(t)he 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
Corning Tower - Room 2503
Empire State Plaza
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.

Very truly yours,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mmn
Enclosure

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

IN THE MATTER	DETERMINATION
OF	AND
RAYMOND NADELL, M.D.	ORDER

NO. BPMC-94-54

A Commissioner's Order and Notice of Hearing, dated November 2, 1993, and a Statement of Charges, dated October 26, 1993, were served upon the Respondent, Raymond Nadell, M.D. **BENJAMIN WAINFELD, M.D. (Chair), SUMNER SHAPIRO, and NORTON SPRITZ, M.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer. The Department of Health appeared by Terrence Sheehan, Esq., Associate Counsel. The Respondent appeared by David W. Windley, Esq. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Service of Commissioner's Order, Notice of Hearing and Statement of Charges;	November 2, 1993
Answer to Statement of Charges:	None
Pre-Hearing Conference:	November 8, 1993
Dates of Hearings:	November 12, 1993 November 23, 1993 December 28, 1993
Received Petitioner's Proposed Findings of Fact, Conclusions of Law:	March 11, 1994
Received Respondent's Proposed Findings of Fact, and Conclusions of Law:	March 15, 1994
Witnesses for Department of Health:	Robert Campbell, M.D. Patient H
Witnesses for Respondent:	Shari Nadell Raymond Nadell, M.D.
Hearing Committee's Report on Imminent Danger:	December 28, 1993
Date of Commissioner's Interim Order to Continue Summary Suspension:	January 13, 1994
Deliberations Held:	March 24, 1994

STATEMENT OF CASE

By an Order dated November 2, 1993, the Commissioner of Health summarily suspended the medical license of the Respondent, Raymond Nadell, M.D., upon a finding that his continued practice of medicine would constitute an imminent danger to the health of the people of this state. More specifically, the accompanying Statement of Charges alleged twenty-six specifications of professional misconduct, including allegations of the fraudulent

practice of medicine, gross negligence, negligence on more than one occasion, failure to maintain adequate records, and moral unfitness. Following the hearings on this matter, which commenced on November 12, 1993 and concluded on December 28, 1993, the Hearing Committee issued its report on imminent danger, on the record. The Hearing Committee recommended that the summary suspension of Respondent's license be maintained pending the ultimate resolution of the case. By an Order dated January 13, 1994, the Commissioner ordered that the summary suspension be continued.

A copy of the Statement of Charges is attached to this Determination and Order in Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent 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.

1. Raymond Nadell, M.D. (hereinafter "Respondent"), was authorized to practice medicine in New York State in 1936 by the issuance of license number 32586 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994 at 53 Marlborough Road, Brooklyn, New York 11226. (Not Contested).

2. Petitioner presented expert testimony by Robert

Campbell, M.D. Dr. Campbell is the Director of Gracie Square Hospital, a private psychiatric hospital in New York City which is affiliated with Cornell Medical Center. He has been the vice-president of the American Psychiatric Association and is on the faculty of New York University Medical Center and Columbia University College of Physicians and Surgeons. (106-109).

Patient A

3. Between on or about November 8, 1983 and on or about June 22, 1993 Respondent treated Patient A at his office located at 53 Marlborough Road, Brooklyn, New York. (Pet. Ex. #2).

4. Dr. Campbell testified that when a psychiatrist sees a patient for the first time, it is necessary to take and record a personal, medical and psychiatric history. This is necessary in order to create a baseline from which the treating psychiatrist can determine whether or not his treatment is progressing adequately. Dr. Campbell further testified that the history recorded by Respondent for this patient did not meet minimally accepted standards of practice. Respondent made no attempt to uncover any emotional or physical difficulties the patient experienced. Respondent failed to contact the patient's previous therapist and failed to follow-up on the patient's history of being treated at a sleep clinic. (131-134; Pet. Ex. #2).

5. Respondent prescribed a number of psychotropic drugs and other controlled substances to Patient A. More specifically, Respondent prescribed 82 prescriptions for Valium, 44 prescriptions for Noludar, 7 prescriptions for Doriden, 48 prescriptions for Fiorinal, 11 prescriptions for Placidyl, 4

prescriptions for Emperin with Codeine, 29 prescriptions for Didrex, 35 prescriptions for Lotusate, 19 prescriptions for Phrenilin, 8 prescriptions for Chloral Hydrate, and 15 prescriptions for Talwin. None of these medications were medically indicated for the patient. (114-115; Pet. Ex. #2; Pet. Ex. #15).

6. Dr. Campbell testified that there should be a reason for prescribing controlled substances. He further testified that there was no indication of any symptoms or other complaints that would justify the drugs which were prescribed by Respondent. (115).

7. The drugs prescribed for Patient A by Respondent are potentially habit forming or addictive. Dr. Campbell testified that in order to prevent addiction or habituation, physicians should take certain precautions. These precautions included beginning at the lowest effective dosage, and limiting the duration for which the drug is prescribed. None of these precautions were observed by Respondent. (116-117).

8. Patient A was able to tolerate an extremely high level of drugs from the very beginning of his treatment by Respondent. For example, Respondent prescribed Valium, 10 mg. Dr. Campbell testified that it was apparent that the Patient had been on Valium before beginning treatment with Respondent, given his ability to tolerate such a high dosage of the drug. It was therefore obvious that the patient was already either addicted or habituated to this level of drug use. As a result, Respondent's treatment on Patient A constituted a perpetuation of a pre-existing habituation or addiction by Patient A to those

medications. (116-117).

9. Dr. Campbell testified that generally accepted standards of medical record-keeping, as practiced by psychiatrists, require that psychiatric records disclose the justification for the prescription of psychotropic drugs. Respondent's records for Patient A failed to disclose such information. (115-116; Pet. Ex. #2).

10. The medical record for Patient A maintained by Respondent does not reflect any understanding as to why this patient was given particular medications, how they were affecting the patient's condition, and what future steps Respondent contemplated with respect to this patients's care. The medical record does not comport with the minimally acceptable standards of medical record-keeping. (123-124; Pet. Ex. #2).

Patient B

11. Between on or about April 8, 1992, and on or about June 18, 1993, Respondent treated Patient B. On the patient's first visit, Respondent failed to obtain an adequate history. Such history as is recorded is confusing. At one point it states that the patient was married to "Laura", aged 17, when he was 19. At another point, the record states that the patient was married to "Donna", aged 18, when he was 19. The history states that the patient has an older sister, yet a progress note states that he is an only child. Respondent also failed to record a mental status examination. Such an examination should be performed on a patient's first visit to a psychiatrist. Respondent also failed to perform a physical examination. (131-132; Pet. Ex. #3; Pet. Ex. #15).

12. During the course of his treatment of Patient B, Respondent issued approximately 25 prescriptions for Xanax, 21 prescriptions for Elavil, 22 prescriptions for Catapres, and 1[illegible] prescriptions for Valium. These prescriptions were issued to Patient B without documented medical indication. (131-136; Pet. Ex. #3; Pet. Ex. #15, pp. 16-17).

13. By continually prescribing these drugs to Patient B over a fourteen month period, Respondent risked perpetuating the patient's addiction or habituation to them. (134-136; Pet. Ex. #15).

14. Respondent's pattern of prescribing dangerous drugs to patients is exemplified by his willingness to issue replacement prescriptions to Patient B. According to the progress notes, almost every prescription given this patient over a fourteen month period was confiscated. No matter how bizarre the patient's story about how he lost, marred, or had his prescription stolen or confiscated, Respondent issued replacement prescriptions. (134-136; Pet. Ex. #3; Pet. Ex. #15).

15. Despite the fact that such stories of lost prescriptions are one of the major indications of drug-seeking behavior, Respondent issued a replacement prescription on each occasion. (134-136).

16. The medical record maintained for Patient B by Respondent does not meet accepted standards of practice. There is no treatment plan, and no objective evidence to warrant the diagnosis recorded. (134-135, 137; Pet. Ex. #3; Pet. Ex. #15, p. 16).

Patient C

17. Respondent treated Patient C at his office between on or about April 14, 1991 and on or about June 2, 1993. No mental status examination was recorded. The only physical examination findings reported are blood pressure, pulse, height, and weight. No diagnosis was recorded, nor were any medical indications documented that would justify the medications prescribed by Respondent. Respondent failed to follow-up on Patient C's reported history of drug and alcohol problems or his reported prior treatment. (143-144; Pet. Ex. #4; Pet. Ex. #15, p. 19).

18. Although there were multiple visits to Respondent by this patient over a two-year period, no diagnosis was ever recorded by Respondent. There is a five-month hiatus in the patient's visits - from October, 1991 to March, 1992 - as well as a two- month gap between March, 1993 and May, 1993. Neither of these gaps in treatment are explained in the record. (144; Pet. Ex. #4; Pet. Ex. #15, p. 19).

19. Respondent issued to Patient C approximately 14 prescriptions for Xanax, 9 prescriptions for Valium, 4 prescriptions for Elavil and 3 prescriptions for Darvocet N-100. The prescriptions were issued to Patient C under three different names. No medical indications for the use of any of these medications were documented in the medical record. (145-146; Pet. Ex. #4; Pet. Ex. #15, pp. 19-20).

20. Respondent's prescription of these medications risked causing or perpetuating an addiction or habituation to these drugs by Patient C. Respondent took no precautions to prevent that from happening. (146-147).

Patient D

21. Respondent treated Patient D between on or about May 1, 1991 and on or about January 27, 1993. Although a history was recorded by Respondent, it contains contradictory entries. For instance, the patient's mother is reported to have died in September, 1991, at one point in the record. Elsewhere, she is reported to have died in 1982. There is no mention initially about the existence of any siblings of this patient, yet a year later the progress notes indicate that the patient had brothers. According to the history given by the patient, it also appears that he was simultaneously married to two different women. (153-155; Pet. Ex. #5; Pet. Ex. #15).

22. The patient complained about panic attacks, yet there is no evidence that Respondent attempted to investigate or treat this condition. The only coded diagnosis is 300.0 (generalized anxiety disorder). Respondent notes that on two occasions the patient was hospitalized, but there is no evidence of any follow-up concerning the nature of these hospitalizations. (153-155; Pet. Ex. #5; Pet. Ex. #15).

23. Respondent issued to Patient D approximately 12 prescriptions for Xanax, 11 prescriptions for Elavil, 11 prescriptions for Valium, 6 prescriptions for Darvocet N-100, 3 prescriptions for Placidyl and 2 prescriptions for Fastin. None of these prescriptions were indicated for the treatment of this patient. (155; Pet. Ex. #5; Pet. Ex. #15).

24. The prescriptions which Respondent issued to Patient D unnecessarily risked causing or perpetuating an addiction or habituation to these drugs by the patient. (155).

25. The patient also exhibited typical drug-seeking behavior, such as repeated requests for replacement prescriptions based upon claimed loss or destruction of the originals, yet Respondent continued to write prescriptions for him. (155; Pet. Ex. #5; Pet. Ex. #15, pp. 23-24).

26. At one point, Patient D told Respondent that he had suffered a skull fracture and had a brain tumor. Dr. Campbell testified that Respondent should have referred the patient to a neurologist for evaluation. Instead, he continued to prescribe psychotropic medications for the patient. (159-161; Pet. Ex. #5; Pet. Ex. #15).

Patient E

27. Respondent treated Patient E at his office between on or about November 23, 1990 and on or about April 20, 1993. Patient E's wife, Patient F was also treated by Respondent. Patient E admitted being addicted to heroin between the ages of 21 and 30, and gave a history of treatment in a methadone program. Dr. Campbell testified that when dealing with a patient with an admitted history of drug addiction, a psychiatrist should be especially circumspect in prescribing psychotropic medications. Respondent did not follow this principle. On the very first patient visit, he prescribed 90 Xanax pills for Patient E. (162-163; Pet. Ex. #6; Pet. Ex. #15).

28. Dr. Campbell testified that Respondent failed to take an adequate history for this patient. Respondent failed to perform a mental status examination or a physical examination. Respondent recorded diagnoses of 300.02 (generalized anxiety disorder) and 300.4 (neurotic depression). No differential

diagnosis was entered, and no justification for the diagnoses made was documented by the record. (163; Pet. Ex. #6; Pet. Ex. #15).

29. The progress notes do not meet acceptable standards of practice. They do not describe how the patient's addictive personality is being addressed, the patient's response to his medications, or what events were occurring in the patient's life. There is no evidence of any treatment plan or goals for this patient. (163-164; Pet. Ex. #6; Pet. Ex. #15).

30. Respondent issued to Patient E approximately 11 prescriptions for Xanax, 10 prescriptions for Elavil, 2 prescriptions for Darvon, 2 prescriptions for Placidyl and 2 prescriptions for Valium. There is no evidence that these drugs were indicated in the treatment of this patient. (163-164; Pet. Ex. #6; Pet. Ex. #15).

31. By prescribing these medications to a patient with an admitted history of addiction problems, Respondent risked causing or perpetuating an addiction or habituation by the patient. Respondent did not indicate in the record whether or not he believed that the patient was an addict during the course of treatment. Dr. Campbell testified that a review of the chart supports the proposition that Patient E was, in fact, addicted to drugs during the entire course of his treatment by Respondent. (164-165; Pet. Ex. #6).

32. Respondent's progress notes document the fact that Patient E developed AIDS while under Respondent's care. There is no indication in the record that Respondent coordinated his management of this patient with those physicians, if any, who

were treating the patient for this condition. (167-168; Pet. Ex. #6).

Patient F

33. Respondent treated Patient F, the wife of Patient E, at his office between on or about April 22, 1991 and on or about November 23, 1992. (171; Pet. Ex. #7).

34. Respondent failed to perform an adequate mental status examination for this patient. In addition, there is no recorded physical examination except for one blood pressure recording. There is some evidence of a family history. No history of physical complaints or past illnesses was recorded. There is no mention of post-partum depression or electroconvulsive therapy, which are recorded in the husband's chart. A diagnosis of generalized anxiety disorder related to external stress from family problems and concern over children was recorded. There is no further explanation of either the family problems or the patient's concern over her children. (172; Pet. Ex. #7; Pet. Ex. #15, p. 10).

35. Dr. Campbell testified that Respondent failed to record a differential diagnosis, and that the diagnosis entered was not justified by those findings which were recorded. (172-173; Pet. Ex. #15, p. 10).

36. Respondent issued to Patient F approximately 10 prescriptions for Xanax, 3 prescriptions for Elavil, 1 prescription for Darvon, and 1 prescription for Valium. Respondent also prescribed Sinequan for Patient F although she had told him that she had taken it in the past and had "a hard time" with the drug. No reason for prescribing Sinequan was

given. Dr. Campbell testified that there was no medical indication for the use of these drugs by Patient F. (172-173; Pet. Ex. #7; Pet. Ex. #15).

37. By prescribing these medications for Patient F Respondent risked causing an habituation or addiction to the drugs. Respondent's prescription of Xanax, 1 mg. four times a day for Patient F is over 5 times the generally recommended initial dose. (172-173; Pet. Ex. #7; Pet. Ex. #15, p. 10).

Patient G

38. Respondent treated Patient G at his office between on or about September 6, 1991 and on or about June 20, 1992. At the first visit, Patient G was a 27 year-old male with complaints of anxiety, nervousness, and insomnia which developed in relation to his mother's illness. Patient G was his mother's primary caregiver. The patient gave a history of past treatment for depression with imipramine. Respondent recorded a mental status examination which indicated that the patient had no fears or phobias. Respondent recorded an initial diagnosis of 300.02 (generalized anxiety disorder) and 300.4 (neurotic depression). However, on November 11, 1991, Respondent recorded a diagnosis of 300.23 (social phobia). This contradiction with the patient's mental history was not explained. No physical examination was recorded, nor were a treatment plan or goals for the patient noted. (176; Pet. Ex. #8; Pet. Ex. #15, p. 14).

39. Patient G appeared to be depressed during much of the time he was seen by Respondent. Respondent prescribed Xanax. Dr. Campbell testified that this was not appropriate in a patient suffering from depression. He stated that it was particularly

dangerous in this instance because the patient admitted a history of alcohol use. A combination of Xanax and alcohol can be lethal. The medical record indicates that on the first occasion at which the patient spoke about his drinking (March 14, 1992), Respondent gave him a prescription for Xanax without any warning about its use in combination with alcohol. (177-178; Pet. Ex. #8; Pet. Ex. #15, p. 15).

40. Respondent admitted that he was aware that Xanax should not be used in combination with alcohol, but stated that he did not warn the patient about the danger of mixing the two drugs. (580-582).

41. Respondent issued to Patient G approximately 7 prescriptions for Xanax, 7 prescriptions for Chloral Hydrate, and 1 prescription for Darvocet N-100. Dr. Campbell testified that there was no medical indication for the use of any of these prescriptions by Patient G. By issuing these prescriptions, Respondent risked causing or perpetuating an addiction or habituation to Xanax and Chloral Hydrate by Patient G. (178-179; Pet. Ex. #8).

42. Respondent's medical record for Patient G did not accurately reflect the patient's complaints, history, examination, diagnoses, progress notes and treatment plan. (176-179; Pet. Ex. #3).

Patient H

43. Respondent treated Patient H at his office from on or about sometime in the beginning of 1991 until on or about January 4, 1993. Patient H testified about her history of addiction to heroin. She also testified that while being treated in an

outpatient methadone program in Brooklyn in 1989, she began using Xanax and Elavil which she purchased from people on the street. Patient H stated that Elavil was used to help her sleep at night, and that she took Xanax because it gave her a relaxed feeling. (14-16).

44. Patient H testified that she first went to Respondent's office in sometime in the beginning of 1991. She stated that she went to Respondent's office on the recommendation of the people from whom she was buying her drugs. (14-18).

45. Patient H testified that when she would go to Respondent's office, 10 or 15 people would sometimes be in the waiting room or on the porch outside. She stated that she recognized these people from the methadone program. She also stated that she knew that these individuals were there to get Xanax and Elavil prescriptions because she discussed the fact with them, and also because on occasion she would buy her drugs from these individuals. (21-23).

46. Patient H testified that she went to Respondent's office under four different names. She stated that she would sometimes go as different individuals within the same month. On one occasion, Respondent called her by one of her names and Patient H replied that she was another person. She testified that it was her impression that Respondent was aware that she was using multiple names. (27-28).

47. Patient H further testified that there came a time when the pharmacists she went to told her that Medicaid would no longer pay for prescriptions issued by Respondent. As a result, it was necessary to pay cash for prescriptions. She also stated

that in response, Respondent reduced his fees from $120 to $40. (30-31).

48. On September 20, 1992, Patient H overdosed on Elavil and experienced generalized clonic seizures. She was treated for this condition at Coney Island Hospital, between on or about September 21, 1992 and on or about September 28, 1992. (Pet. Ex. #14).

49. Patient H testified that Respondent prescribed the Elavil on which she overdosed. (35).

50. Patient H further testified that Respondent was known as a "script doctor" by the patients in the methadone program. She defined a script doctor as someone who will give you a prescription as long as you have the money to pay for it. (98).

51. The medical record maintained for Patient H in her real name contains notations for only two visits. No physical examination was recorded and the mental status examination was not done until after she was started on medication. At the second visit, Respondent recorded a diagnosis of 300.02 (generalized anxiety disorder) and 300.4 (neurotic depression). No treatment plan was outlined and no goals were set. Although the patient gave a history of IV heroin addiction, Respondent prescribed Elavil and Xanax for her on both visits. Dr. Campbell testified that there was no medical indication for prescribing either of these drugs. (184-185; Pet. Ex. #9; Pet. Ex. #15, p. 21).

52. By prescribing Xanax and Elavil to a patient with a high addiction potential, Respondent risked causing or perpetuating an addiction to these drugs. (184-185).

Conclusions of Law

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee concluded that the following Factual Allegations should be sustained. The citations in parentheses refer to the Findings of Fact which support each Factual Allegation:

Paragraph A: (3-10);

Paragraph A.1: (4);

Paragraph A.2: (5-6);

Paragraph A.3: (7-8);

Paragraph A.4: (3-8);

Paragraph A.5: (4-10);

Paragraph B: (11);

Paragraph B.1: (11);

Paragraph B.2: (11-12);

Paragraph B.3: (13);

Paragraph B.4: (11-16);

Paragraph B.5: (11-16);

Paragraph C: (17);

Paragraph C.1: (17-18);

Paragraph C.2: (18-19);

Paragraph C.3: (20);

Paragraph C.4: (17-20);

Paragraph C.5: (17-20);

Paragraph D: (21);

Paragraph D.1 except with regard to the mental status

examination, which is not sustained: (21-22);

Paragraph D.2 except with regard to Zantac, which is not sustained: (21-23)

Paragraph D.3 except with regard to Zantac, which is not sustained: (21-23);

Paragraph D.4 except with regard to Zantac, which is not sustained: (21-26);

Paragraph D.5: (21-22);

Paragraph E: (27);

Paragraph E.1 except for the family history, which is not sustained: (27-28);

Paragraph E.2: (30);

Paragraph E.3: (31);

Paragraph E.4: (27-31);

Paragraph E.5: (27-32);

Paragraph F: (33);

Paragraph F.1, except for the family history, which is not sustained: (34-36);

Paragraph F.2: (36);

Paragraph F.3: (36-37);

Paragraph F.4: (33-37);

Paragraph F.5: (33-35);

Paragraph G: (38);

Paragraph G.1: (38, 42);

Paragraph G.2: (39-41);

Paragraph G.3: (39-41);

Paragraph G.4: (38-42);

Paragraph G.5: (38-42);

Paragraph H: (43);

Paragraph H.1: (51);

Paragraph H.2 as to 2 prescriptions of Xanax and 2 prescriptions of Elavil. The remaining prescriptions are not sustained: (51);

Paragraph H.3: (43-52);

Paragraph H.4: (43-51);

Paragraph H.5: (48);

Paragraph H.6: (51).

The Hearing Committee further concluded that the following Specifications should be sustained. The citations in parentheses refer to the Factual Allegations which support each specification:

PRACTICING THE PROFESSION FRAUDULENTLY

First Specification: (Paragraphs A and A.1 through A.4);

Second Specification: (Paragraphs B and B.1 through B.4);

Third Specification: (Paragraphs C and C.1 through C.4);

Fourth Specification: (Paragraphs D and D.1 through D.4);

Fifth Specification: (Paragraphs E and E.1 through E.4);

Sixth Specification: (Paragraphs F and F.1 through F.4);

Seventh Specification: (Paragraphs G and G.1 through G.4);

Eighth Specification: (Paragraphs H and H.1 through H.4);

PRACTICING WITH GROSS NEGLIGENCE

Ninth Specification: (Paragraphs A and A.1, A.2, A.3 and A.5);

Tenth Specification: (Paragraphs B and B.1, B.2, B.3 and B.5);

Eleventh Specification: (Paragraphs C and C.1, C.2, C.3 and C.5);

Twelfth Specification: (Paragraphs D and D.1, D.2, D.3 and D.5);

Thirteenth Specification: (Paragraphs E and E.1, E.2, E.3 and E.5);

Fourteenth Specification: (Paragraphs F and F.1 , F.2, F.3 and F.5);

Fifteenth Specification: (Paragraphs G and G.1, G.2, G.3 and G.5);

Sixteenth Specification: (Paragraphs H and H.1, H.2, H.3, H.5 and H.6);

NEGLIGENCE ON MORE THAN ONE OCCASION

Seventeenth Specification: (Paragraphs A and A.1, A.2, A.3 and A.5, B and B.1, B.2, B.3 and B.5, C and C.1, C.2, C.3 and C.5, D and D.1, D.2, D.3 and D.5, E and E.1, E.2, E.3, and E.5, F and F.1, F.2, F.3 and F.5, G and G.1, G.2, G.3 and G.5, and H and H.1, H.2, H.3, H.5 and H.6);

FAILURE TO MAINTAIN ADEQUATE RECORDS

Eighteenth Specification: (Paragraphs A and A.5);

Nineteenth Specification: (Paragraphs B and B.5);

Twentieth Specification: (Paragraphs C and C.5);

Twenty-First Specification: (Paragraphs D and D.5);

Twenty-Second Specification: (Paragraphs E and E.5);

Twenty-Third Specification: (Paragraphs F and F.5);

Twenty-Fourth Specification: (Paragraphs G and G.5);

Twenty-Fifth Specification: (Paragraphs H and H.6);

MORAL UNFITNESS

Twenty-Sixth Specification: (Paragraphs A and A.1 through A.4, B and B.1 through B.4, C and C.1 through C.4, D and D.1 through D.4, E and E.1 through E.4, F and F.1 through F.4, G and G.1 through G.4, and H and H.1 through H.4)

DISCUSSION

Respondent is charged with twenty-six 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 Peter J. Millock, Esq., 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, incompetence, and the fraudulent practice of medicine.

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 reasonably 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.

Fraudulent Practice of the Profession is an intentional misrepresentation or concealment of a know fact. An individual's knowledge that he/she is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts. A licensee may be found to have

fraudulently practiced the profession if he or she has prescribed controlled substances for other than a good faith medical purpose. (**See**, Katz v. Ambach, 72 A.D.2d 894, 422 N.Y.S.2d 159 (3rd Dept. 1979); Kenna v. Ambach, 61 A.D.2d 1091, 403 N.Y.S.2d 351 (3rd Dept. 1978)).

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee unanimously concluded, by a preponderance of the evidence, that the twenty-six specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions is set forth below.

At the outset, the Hearing Committee made a determination as to the credibility of the various witnesses presented by the parties. The Department presented two witnesses: Robert Campbell, M.D. and Patient H. Dr. Campbell is the director of Gracie Square Hospital, a private psychiatric hospital affiliated with Cornell Medical Center. He has been the vice-president of the American Psychiatric Association and is on the faculty of New York University Medical Center and Columbia University College of Physicians and Surgeons. Dr. Campbell testified in a direct and forthright manner. He has no stake in the outcome of these proceedings and no motive for falsification or fabrication of his testimony was alleged or proven. The Hearing Committee found Dr. Campbell to be an eminently credible witness and gave his testimony great weight.

The Hearing Committee also gave credence to the testimony of Patient H. She testified convincingly as to her experiences with Respondent. Her testimony was unshaken during cross-examination. More importantly, many factual components of her

testimony were corroborated by Respondent.

In contrast, Respondent presented testimony by himself and by Mrs. Nadell. Both have an obvious stake in the outcome of this hearing. Respondent was continually evasive during his cross-examination by Counsel for the Department, and frequently engaged in verbal fencing with him. (**See**, e.g., Tr., pp. 504, and 509-510). Respondent presented no independent corroboration for his opinions regarding the medical care rendered to his patients. As a result, the Hearing Committee gave little weight to his testimony.

Practicing the Profession Fraudulently

The fraudulent practice of medicine, as noted above, has been defined to include situations where a licensee prescribed controlled substances for other than a good faith medical purpose. (**See**, Katz v. Ambach, 72 A.D.2d 894, 422 N.Y.S.2d 159 (3rd Dept. 1979); Kenna v. Ambach, 61 A.D.2d 1091, 403 N.Y.S.2d 351 (3rd Dept. 1978)). The Hearing Committee concluded, by a preponderance of the evidence, that Respondent repeatedly prescribed controlled substances for each of Patients A through H for other than a good faith medical purpose.

Respondent's records clearly revealed that he had little or no interest in actually exploring any psychiatric problems which his patients might have. He rarely performed mental status examinations, took complete histories, or performed physical examinations on any of these patients. Where his records do indicate evidence of relevant historical findings, there was absolutely no effort made to follow-up and appropriately treat the problems. For example, Patient G admitted a history of crack

abuse. Nevertheless, Respondent made no attempt to elicit information about the nature and severity of the patient's drug history. When asked about this failure to explore the patient's crack abuse, Respondent merely stated "Well, it's not a medication I prescribed." (**See**, Tr. p. 577).

Dr. Campbell's review of Respondent's medical records for Patients A through H revealed that in virtually all cases, Respondent recorded the same diagnoses - generalized anxiety disorder and neurotic depression. In one case - Patient C, who was seen by Respondent over a two-year period - Respondent did not record any diagnosis. Dr. Campbell testified that in each of these cases, Respondent failed to record any relevant information which would justify the diagnoses or treatment prescribed.

Respondent's treatment for each of the named patients was essentially the same. He prescribed Xanax or Valium, in combination with Elavil. On occasion, he also prescribed various pain-killers such as Darvon or Darvocet, as well as amphetamines. The dosages and frequency of administration of these drugs did not vary greatly between patients, nor did Respondent make any attempt to determine whether the drugs were working appropriately, or whether lower dosages would be appropriate.

Respondent ignored clear indications that his patients were merely seeking to obtain controlled substances for improper purposes. One of the major indicators of drug-seeking behavior on the part of addicts is the repeated request for "replacement" prescriptions because the original prescription was lost or destroyed. The records for Patients A through H reveal numerous

instances where patients requested such "replacement" prescriptions. For example, 34 prescriptions - nearly all of the prescriptions given by Respondent to Patient B over a fourteen month period - were reported as stolen or confiscated. No matter how bizarre the patient's story about how he lost, marred, or had his prescription stolen or confiscated, Respondent issued replacements. During the period June 27, 1992 through July 8, 1992, Respondent issued prescriptions to Patient B for 360 Xanax tablets (an average of 36 per day). When asked to explain this, Respondent merely stated that the patient "told me that the prescriptions were lost. Or confiscated. And I chose to believe him at that particular time." (**See**, Tr. p. 486).

Most telling of all, was the testimony of Patient H. Patient H, a recovering heroin addict, testified that she began using Xanax and Elavil which she purchased on the street while attending a methadone program in Brooklyn. She testified that she went to Respondent's office on the recommendation of the people from whom she was buying her drugs. During a period commencing in early 1991 through January 4, 1993, Patient H was treated by Respondent. She testified that during that period, she used four different names in order to obtain more drugs from Respondent. She stated that she used various borrowed Medicaid identification cards to verify her different identities.

Patient H also testified that when she would go to Respondent's office, there would sometimes be up to 10 or 15 people in the waiting room or on the porch. She further testified that she recognized these people as patients in the methadone program, and that she had purchased drugs from some of

the individuals. Patient H also testified that there came a time when the local pharmacists told her that Medicaid would no longer pay for prescriptions issued by Respondent. When, informed of this, Respondent reduced his customary fee of $120.00 down to $40.00.

Ultimately, Patient H overdosed on Elavil which she obtained through a prescription issued by Respondent. She was treated at Coney Island Hospital between September 21, 1992 through September 28, 1992.

Based upon the totality of the evidence, the Hearing Committee unanimously concluded that Respondent knowingly prescribed controlled substances to Patients A through H for other than a good faith medical purpose. As a result, the Committee further concluded that Respondent's conduct constituted the fraudulent practice of medicine and voted to sustain the First through Eighth Specifications.

Gross Negligence

Gross negligence has been defined as 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. The record clearly established the fact that Respondent repeatedly failed to meet the appropriate standards of care with respect to each of Patients A through H. As was noted previously, Respondent failed to take adequate histories, or perform appropriate mental status or physical examinations.

Respondent prescribed controlled substances without clear medical indication, and made no attempt to verify whether the

dosages were excessive. Moreover, Respondent indiscriminately prescribed controlled substances to Patients E, G and H despite their admitted histories of drug or alcohol abuse. Respondent also ignored important information about problems reported by his patients. For example, Patient D reported that he had suffered a skull fracture and had a brain tumor. Dr. Campbell testified that Respondent should have referred the patient to a neurologist for follow-up. Instead, Respondent continued to prescribe psychotropic drugs for the patient, despite the fact that such drugs may have masked any neurological deficits exhibited by the patient. Respondent noted in his record for Patient E that the patient was suffering from AIDS. However, he made no attempt to coordinate his "treatment" of the patient with any providers dealing with the patient's other problems.

Respondent cynically attempted to justify his indiscriminate prescription of potentially dangerous drugs. He claimed that his patients have a "biological necessity" for Xanax and Elavil to treat chronic anxiety. He compared his prescription of psychotropic drugs for his patients to the prescription of insulin for diabetics. When asked if Patient B was addicted or habituated to the drugs prescribed by Respondent he stated: "No. If a patient has a biological necessity for a medication and it was necessary to maintain normal physiological functioning, I don't believe you can call it an addiction, any more than you can say that ... a diabetic was addicted to insulin." (**See**, Tr., pp. 471-472).

The Hearing Committee categorically rejects Respondent's contention. It is a smokescreen intended to divert attention

from the fact that Respondent is simply prescribing large quantities of controlled substances to maintain the comfort of patients who are addicted to, or at substantial risk of addiction, to those substances.

Respondent's lack of concern for the well-being of his patients was most clearly demonstrated in his own testimony. The record established that several of his patients admitted that they shared their drugs with family members and friends. When the Chair asked Respondent whether there was anything wrong with patients sharing psychotropic medications with members of their family, Respondent stated "I don't think there's anything wrong. **If they share the bed together, I think they could share the medication.**" (Tr., pp. 536-537; Emphasis supplied).

The Hearing Committee unanimously concluded that Respondent's conduct regarding Patients A through H constituted an especially egregious failure to exercise the care that would be exercised by a reasonably prudent physician. As a result, the Committee voted to sustain the Ninth through Sixteenth Specifications of professional misconduct.

Negligence on More Than One Occasion

As noted above, the Hearing Committee voted to sustain eight specifications of gross negligence. Therefore, it is axiomatic that his conduct also constituted negligence on more than one occasion. As a result, the Hearing Committee voted to sustain the Seventeenth Specification.

Failure to Maintain Adequate Records

The Department also alleged that Respondent failed to maintain accurate medical records for Patients A through H.

The evidence clearly established that Respondent's medical records were woefully inadequate. They contained little or no information relevant to the medical and psychiatric histories of the patients. The progress notes consisted of little more than recitations of prescriptions issued and fees paid. Respondent attempted to rationalize his failure to properly document the care rendered to his patients by claiming that psychiatric records present a unique need for confidentiality. As a result, he would only record "key words" in the chart. He also claimed that, since the records were for his use, it was not necessary to have greater detail in the charts. **See**, e.g., Tr., pp. 279, 282). The Hearing Committee specifically rejected this contention.

Physicians do not practice in a vacuum. It is essential that medical records contain sufficient information that a subsequent treating physician can obtain a working knowledge of the medical history of a patient. The Hearing Committee strongly agreed with the opinion of Dr. Campbell on the inadequacy of Respondent's records. Dr. Campbell testified that a medical record that does not indicate why a medication is being prescribed, what the reaction to the medication is, whether or not there are any alternatives, and whether or not the patient is responding as anticipated, is inadequate.

It is clear that Respondent's medical records do not pass such scrutiny. As was noted previously, they uniformly contained inadequate documentation of medical and psychiatric histories. Based upon the sparse information contained in the charts, there was no medical indication for any of the prescriptions issued by

Respondent. As a result, the Hearing Committee concluded that Respondent failed to maintain medical records for Patients A through H which accurately reflected the medical care and treatment rendered to those patients. Therefore, the Committee voted to sustain the Eighteenth through Twenty-Fifth Specifications of professional misconduct.

Moral Unfitness

Respondent is charged with practicing the profession in a manner which evidences moral unfitness to practice medicine in violation of Education Law §6530(20). Conduct which evidence moral unfitness can arise either from conduct which violates a trust related to the practice of the profession or from activity which violates the moral standards of the professional community to which the Respondent belongs. The Hearing Committee unanimously concluded that Respondent's actions constituted an egregious violation of professional trust.

The evidence clearly established that Respondent repeatedly wrote prescriptions for potentially dangerous controlled substances without clear medical indication. He prescribed to patients known to be drug addicts and further risked addiction or habituation to the drugs which he prescribed. When confronted with his conduct, Respondent cynically attempted to defend his actions by claiming that he was simply treating the patient's "biological necessity" for psychotropic drugs, claiming that it was no different than prescribing insulin for a patient suffering from diabetes. The Hearing Committee unanimously concluded that Respondent's conduct demonstrated a violation of his professional trust and the ethical standards of the medical

community. Accordingly, the Hearing Committee concluded that the Twenty-Sixth Specification should be 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 revoked. In addition, the Committee further determined that a fine in the amount of Ten Thousand Dollars ($10,000.00) should be assessed as well. 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.

The record in this case clearly established that Respondent repeatedly issued prescriptions for potentially dangerous controlled substances without valid medical indication. By doing so, he risked creating or exacerbating his patients' addiction to those drugs. Respondent demonstrated gross negligence and engaged in the fraudulent practice of medicine.

Any individual who receives a license to practice medicine is placed into a position of public trust. Respondent essentially sold his right to that public trust, by selling prescriptions to anyone with the money to pay for an office visit. In doing so, Respondent abdicated his responsibility to exercise his skill and judgment for the benefit of his patients. His attempt to justify his conduct by claiming that prescribing large quantities of psychotropic drugs for his patients was no

different than prescribing insulin for a diabetic was a cynical smokescreen.

Under the totality of the circumstances, the Hearing Committee unanimously determined that no sanction short of revocation would adequately protect the public. Respondent refused to see any deficiencies in his conduct and claimed that he would continue to prescribe drugs for these patients without limit. (**See**, e.g., Tr., pp. 295-296). As a result, the Hearing Committee determined that a period of suspension combined with retraining would be futile. The Committee further determined that a $10,000.00 fine was warranted. Respondent sold prescriptions for controlled substances. As a result, he should not be allowed to profit from his unlawful conduct.

ORDER

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

1. The First through Twenty-Sixth Specifications of professional misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit #1) are **SUSTAINED**;

2. Respondent's license to practice medicine in New York State be and hereby is **REVOKED**;

3. A fine in the amount of **TEN THOUSAND DOLLARS ($10,000.00)** be and hereby is imposed against Respondent. Payment of the aforesaid sum shall be made to the Bureau of Accounts Management, New York State Department of Health, Erastus Corning Tower Building, Room 1245, Empire State Plaza, Albany, New York 12237 within thirty (30) days of the effective date of this Order;

4. 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 §171(27); State Finance Law §18; CPLR §5001; Executive Law §32).

DATED: Albany, New York
April 20, 1994

BENJAMIN WAINFELD, M.D. (CHAIR)

SUMNER SHAPIRO
NORTON SPRITZ, M.D.

TO: Terrence Sheehan, Esq.
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APPENDIX I

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

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IN THE MATTER	:	STATEMENT
OF	:	OF
RAYMOND NADELL, M.D.	:	CHARGES

----------X

RAYMOND NADELL, M.D., the Respondent, was authorized to practice medicine in New York State in 1936 by the issuance of license number 32586 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 January 1, 1993 through December 31, 1994 at 53 Malborough Road, Brooklyn, New York 11226.

FACTUAL ALLEGATIONS

A. Between on or about November 8, 1983 and on or about June 22, 1993 Respondent, a psychiatrist, treated Patient A at his office located at 53 Marlborough Road, Brooklyn, New York 11226. (Patient names are contained in the attached Appendix).

1. Respondent failed to perform adequate physical and mental status examinations and failed to obtain

adequate medical, family, personal and psychiatric histories.

2. During this period, Respondent issued to Patient A the following prescriptions which were not medically indicated:

82 prescriptions for Valium
44 prescriptions for Noludar
7 prescriptions for Doriden
48 prescriptions for Fiorinal
11 prescriptions for Placidyl
4 prescriptions for Emperin w/Codeine
29 prescriptions for Didrex
35 prescriptions for Lotusate
19 prescriptions for Phrenilin
8 prescriptions for Chloral Hydrate
15 prescriptions for Talwin

3. By issuing these prescriptions, Respondent risked causing or perpetuating an addiction by Patient A to these medications.

4. Respondent issued these prescriptions not in good faith and not in the course of regular professional practice.

4. Respondent issued these prescriptions not in good faith and not in the course of regular professional practice.

5. Respondent failed to maintain a medical record for Patient A which accurately reflects the patient complaints, history, examination, diagnosis, progress notes and treatment plan.

B. Between on or about April 8, 1992, and on or about June 18, 1993, Respondent treated Patient B at his office.

1. Respondent failed to perform adequate physical and mental-status examination and failed to obtain adequate medical, family, personal and psychiatric histories.

2. Respondent issued to Patient B approximately 25 prescriptions for Xanax; 21 prescriptions for Elavil; 22 prescriptions for Catapres; and 11 prescriptions for Valium. These prescriptions were issued without medical indication.

3. By issuing these prescriptions, Respondent risked causing or perpetuating an addiction by Patient B to Xanax, Elavil and/or Valium.

4. Respondent issued these prescriptions not in good faith and not in the course of regular professional practice.

5. Respondent failed to maintain a medical record for Patient B which accurately reflects the patient complaints, history, examination, diagnosis, progress notes and treatment plan.

C. Between on or about April 14, 1991, and on or about June 2, 1993, Respondent treated Patient C at his office.

1. Respondent failed to perform adequate physical and mental-status examinations and failed to obtain adequate medical, family, personal and psychiatric histories.

2. Respondent issued to Patient C approximately 14 prescriptions for Xanax; 9 prescriptions for Valium; 4 prescriptions for Elavil and 3 prescriptions for Darvocet N100. These

prescriptions were issued without medical indication.

3. By issuing these prescriptions, Respondent risked causing or perpetuating an addiction by Patient C to Xanax, Valium, Elavil and/or Darvocet N100.

4. Respondent issued these prescriptions not in good faith and not in the course of regular professional practice.

5. Respondent failed to maintain a medical record for Patient C which accurately reflects the patient complaints, history, examination, diagnosis, progress notes and treatment plan.

D. Between on or about May 1, 1991, and on or about January 27, 1993, Respondent treated Patient D at his office.

1. Respondent failed to perform adequate physical and mental-status examinations and failed to obtain adequate medical, family, personal and psychiatric histories.

2. Respondent issued to Patient D approximately 12 prescriptions for Xanax; 11 prescriptions for

Elavil; 11 prescriptions for Valium; 6 prescriptions for Darvocet N100; 3 prescriptions for Zantac; 3 prescriptions for Placidyl; and 2 prescriptions for Fastin. These prescriptions were issued without medical indication.

3. By issuing these prescriptions, Respondent risked causing or perpetuating an addiction by Patient D to these medications.

4. Respondent issued these prescriptions not in good faith and not in the course of regular professional practice.

5. Respondent failed to maintain a medical record for Patient D which accurately reflects the patient complaints, history, examination, diagnosis, progress notes and treatment plan.

E. Between on or about November 23, 1990,and on or about April 20, 1993, Respondent treated Patient E at his office.

1. Respondent failed to perform adequate physical and mental status examinations and failed to obtain

adequate medical, family, personal and psychiatric histories.

2. Respondent issued to Patient E approximately 11 prescriptions for Xanax; 10 prescriptions for Elavil; 2 prescriptions for Darvon; 2 prescriptions for Placidyl; and 2 prescriptions for Valium. These prescriptions were issued without medical indication.

3. By issuing these prescriptions, Respondent risked causing or perpetuating an addiction by Patient E to these medications.

4. Respondent issued these prescriptions not in good faith and not in the course of regular professional practice.

5. Respondent failed to maintain a medical record for Patient E which accurately reflects the patient complaints; history, examination, diagnosis, progress notes and treatment plan.

F. Between on or about April 22, 1991, and on or about November 23, 1992, Respondent treated Patient F at his office.

1. Respondent failed to perform adequate physical and mental status examinations and failed to obtain adequate medical, family, personal and psychiatric histories.

2. Respondent issued to Patient F approximately 10 prescriptions for Xanax; 3 prescriptions for Elavil; 1 prescription for Darvon; and 1 prescription for Valium. These prescriptions were issued without medical indication.

3. By issuing these prescriptions Respondent risked causing or perpetuating an addiction by Patient F to these medications.

4. Respondent issued these prescriptions not in good faith and not in the course of regular professional practice.

5. Respondent failed to maintain a medical record for Patient F which accurately reflects the patient complaints, history, examination, diagnosis, progress notes and treatment plan.

G. Between on or about September 6, 1991 and on or about June 20, 1992 Respondent treated Patient G at his office.

1. Respondent failed to perform adequate physical and mental status examinations and failed to obtain adequate medical, family, personal and psychiatric histories.

2. Respondent issued to Patient G approximately 7 prescriptions for Xanax; 7 prescriptions for chloral hydrate; and one prescriptions for Darvocet N100. These prescriptions were issued without medical indication.

3. By issuing these prescriptions, Respondent risked causing or perpetuating an addiction by Patient G to Xanax and chloral hydrate.

4. Respondent issued these prescriptions not in good faith and not in the course of regular professional practice.

5. Respondent failed to maintain a medical record for Patient G which accurately reflects the patient complaints, history, examination, diagnoses, progress notes and treatment plan.

H. Between on or about April 5, 1991 and on or about January 4, 1993. Respondent treated Patient H at his office.

1. Respondent failed to perform adequate physical and mental-status examinations and failed to obtain adequate medical, family, personal and psychiatric histories.

2. Respondent issued to Patient H approximately 10 prescriptions for Xanax and 11 prescriptions for Elavil. These prescriptions were issued without medical indication.

3. By issuing these prescriptions, Respondent risked causing or perpetuating an addiction by Patient H to Xanax and/or Elavil.

4. Respondent issued these prescriptions not in good faith and not in the course of regular professional practice.

5. On September 21, 1992, Patient H overdosed on Elavil and experienced generalized clonic seizures. She was treated for this condition at Coney Island Hospital, Coney Island, N.Y., between on or about September 21, 1992 and on or about September 28, 1992.

6. Respondent failed to maintain a medical record for Patient H which accurately reflects the patient complaints, history, examination, diagnoses, progress notes and treatment plan.

SPECIFICATION OF CHARGES

FIRST THROUGH EIGHTH SPECIFICATIONS

PRACTICING THE PROFESSION FRAUDULENTLY

Respondent is charged with practicing the profession fraudulently under N.Y. Educ. Law Section 6530(2)(McKinney Supp. 1993), in that Petitioner charges:

1. The facts in paragraphs A and A.1 through A.4.

2. The facts in paragraphs B and B.1 through B.4.

3. The facts in paragraphs C and C.1 through C.4.

4. The facts in paragraphs D and D.1 through D.4.

5. The facts in paragraphs E and E.1 through E.4.

6. The facts in paragraphs F and F.1 through F.4.

7. The facts in paragraphs G and G.1 through G.4.

8. The facts in paragraphs H and H.1 through H.4.

NINTH THROUGH SIXTEENTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with practicing the profession with gross negligence under N.Y. Educ. Law Section 6530(4)(McKinney Supp. 1993), in that Petitioner charges:

9. The facts in paragraphs A and A.1, A.2, A.3 and A.5.

10. The facts in paragraphs B and B.1, B.2, B.3 and B.5.

11. The facts in paragraphs C and C.1, C.2, C.3 and C.5.

12. The facts in paragraphs D and D.1, D.2, D.3 and D.5.

13. The facts in paragraphs E and E.1, E.2, E.3 and E.5.

14. The facts in paragraphs F and F.1, F.2, F.3 and F.5.

15. The facts in paragraphs G and G.1, G.2, G.3 and G.5.

16. The facts in paragraphs H and H.1, H.2, H.3, H.5 and H.6.

SEVENTEENTH SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6530(3)(McKinney Supp. 1993) in that Petitioner charges at least two of the following:

17. The facts in paragraph A and A.1, A.2., A.3 and A.5, B and B.1, B.2, B.3 and B.5, C and C.1, C.2, C.3 and C.5, D and D.1, D.2, d.3 and d.5, E and E.1, E.2, E.3 and E.5, F and F.1, F.2, F.3 and F.5, G and G.1, G.2, G.3 and G.5 and/or H and H.1, H.2, H.3, H.5 and H.6.

EIGHTEENTH THROUGH TWENTY-FIFTH SPECIFICATIONS

FAILURE TO MAINTAIN ADEQUATE RECORDS

Respondent is charged with professional misconduct under N.Y. Educ. Law Section 6530(32)(McKinney Supp. 1993), in that he failed to maintain records for patients which accurately reflect the evaluation and treatment of the patients. Petitioner charges:

18. The facts in paragraphs A and A.5.

19. The facts in paragraphs B and B.5.

20. The facts in paragraphs C and C.5.

21. The facts in paragraphs D and D.5.

22. The facts in paragraphs E and E.5.

23. The facts in paragraphs F and F.5.

24. The facts in paragraphs G and G.5.

25. The facts in paragraphs H and H.6.

TWENTY-SIXTH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with practicing the profession in a manner which evidences moral unfitness to practice medicine under N.Y. Educ. Law Section 6530(20)(McKinney Supp. 1993), in that Petitioner charges:

26. The facts in paragraphs A and A.1 through A.4, B and B.1 through B.4, C and C.1 through C.4, D and D.1 through D.4, E and E.1 through E.4, F and F.1 through F.4, G and G.1 through G.4 and/or H and H.1 through H.4.

DATED: New York, New York
October 26, 1993

CHRIS STERN HYMAN
COUNSEL
Bureau of Professional Medical
Conduct