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

IN THE MATTER

OF

RAYMOND NADELL, M.D.

: COMMISSIONER'S ORDER AND NOTICE OF HEARING

TO: RAYMOND NADELL, M.D.
53 Marlborough Road
Brooklyn, New York 11226

The undersigned, Mark R. Chassin, M.D., Commissioner of Health of the State of New York, after an investigation, upon the recommendation of a committee on professional medical conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by RAYMOND NADELL, M.D., the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law Section 230(12) (McKinney Supp. 1993), that effective immediately RAYMOND NADELL, M.D., Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law Section 230(12) (McKinney Supp. 1993).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1993), and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1993). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 12th day of November, 1993 at 10:00 a.m. at 5 Penn Plaza, 6th Floor, New York, NY 10001 and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to issue or have subpoenas issued on his behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against him. A summary of the Department of Health Hearing Rules is enclosed. Pursuant to Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified

interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the Administrative Law Judge's Office, Empire State Plaza, Corning Tower Building, 25th Floor, Albany, New York 12237-0026 and by telephone (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty or sanction to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a (McKinney Supp. 1993). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
November 2, 19

MARK R. CHASSIN, M.D.
Commissioner of Health

Inquiries should be directed to:
Terrence Sheehan
Associate Counsel
N.Y.S. Department of Health
5 Penn Plaza - 6th floor
New York, New York 10001

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

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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
19 prescriptions for Phrenilin
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.

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