In The Matter Of:

Board of Registration in Medicine v. Padmanabhan, M.D.

Bharanidharan Padmanabhan, M.D.

January 12, 2015

Jones & Fuller Reporting
10 High Street, Suite 702
Boston, MA 02110

Original File 0112Padmanabhan.txt

Min-U-Script®

VOLUME: I
PAGES: 1 - 124
EXHIBITS: Index

COMMONWEALTH OF MASSACHUSETTS

DIVISION OF ADMINISTRATIVE LAW APPEALS

- - - - - - - - - - - - - - - - - -x

BOARD OF REGISTRATION IN MEDICINE

v DOCKET NO.

BHARANIDHARAN PADMANABHAN, M.D. RM-14-363

- - - - - - - - - - - - - - - - - -x

BEFORE: Kenneth Bresler
Administrative Magistrate

Held at

Office of the Civil Service Commissioner

One Ashburton Place - Room 503

Boston, Massachusetts 02108

Monday, January 12, 2015

9:02 a.m. - 11:53 a.m.

Reporter: Carole M. Wallace, CSR

APPEARANCES:

James Paikos, Complaint Counsel
Board of Registration in Medicine
200 Harvard Mill Square - Suite 330
Wakefield, Massachusetts 01880
(781) 876-8200 jim.paikos@state.ma.us
On behalf of the Petitioner

Bharanidharan Padmanabhan, MD
30 Gardner Road - Unit 6A
Brookline, Massachusetts 02445
(617) 566-6047 scleroplex@gmail.com
Pro Se

ALSO PRESENT:
Loretta Cooke, Nurse Investigator

THE MAGISTRATE RETAINED THE ORIGINAL EXHIBITS

OPENING STATEMENTS

INDEX

PETITIONER'S EXHIBITS

No.	Description	Evid.
Exhibit 1	Statement of Allegations	11
Exhibit 2	Records for Patient A	11
Exhibit 3	Records for Patient B	11
Exhibit 4	Records for Patient C	11
Exhibit 5	Records for Patient D	11
Exhibit 6	Records for Patient E	11
Exhibit 7	Records for Patient F	11
Exhibit 8	Records for Patient G	11
Exhibit 9	Records for Patient H	11
Exhibit 10	Records for Patient I	11
Exhibit 11	CV of Barry Levin, MD	11
Exhibit 12	CV of Steven Horowitz, MD	11
Exhibit 13	Report of Dr. Horowitz	11
Exhibit 14	Prescription from CVS	11
Exhibit 15	Massachusetts Controlled Substance Registration Credentialing Verification document	11
Exhibit 16	Department of Public Health registration information	11
Exhibit 17	Massachusetts Prescribing Registration	11

No.	Description	Evid.
Exhibit 18	Application of Massachusetts Controlled Substance Registration Credentialing Verification	12
Exhibit 19	Copy of Output	12
Exhibit 20	Cambridge Health Alliance appointment letter	12
Exhibit 21	Cambridge Health Alliance suspension letter	12
Exhibit 22	Request to the Cambridge Health Alliance and suspension and termination	12
Exhibit 23	Articles and references with sub-exhibits A - F	12
Exhibit 24	Radiographic images for Patient G	12
Exhibit 25	Radiographic images for Patient I	12
Exhibit 26	Records related to Patient D	35
Exhibit 27	Greeley report	35

RESPONDENT'S EXHIBITS

No.	Description	Evid.
Exhibit 2	Testimony of Carol Wakefield, MD	18
Exhibit 3	2011 letter from Nancy Lian Re: Massachusetts Controlled Substance Registration	18
Exhibit 4	Amended Information Form, MCSR	18
Exhibit 5	FAQs from Executive Office of Health and Human Services' website	18
Exhibit 6	Affidavit of Patient A	22
Exhibit 8	Fraudulent termination letter from Cambridge, November 11, 2011	23
Exhibit 9	Open e-mail from Dr. Rachel Nardin	23
Exhibit 10	E-mails from BORM	23

THE MAGISTRATE: Today is January 12, 2015. We are conducting the hearing before the Division of Administrative Law Appeals. The physical location is One Ashburton Place, Boston Massachusetts, at the Offices of the Civil Service Commission. This appeal has been assigned Docket No. RM-14-363. The hearing is being held under the provision of General Laws Chapters 112 Section 5 and 243 CMR 1.03. The petitioner is the Board of Registration in Medicine, the respondent is Bharanidharan Padmanabhan.

Have I pronounced your name correctly?

DR. PADMANABHAN: (Nodding).

THE MAGISTRATE: I am Administrative Magistrate Kenneth Bresler. James Paikos, Esq. represents the petitioner and the doctor represents himself. The parties' representatives are present and have previously filed notices of appearance.

I'm going to read 801 CMR 1.01 10(d)1. It has to do with decorum. "All parties, their authorized representatives, witnesses and other persons present at a hearing shall conduct

themselves in a manner consistent with the standards of decorum commonly observed in any court. Where such decorum is not observed, the presiding officer may take appropriate action."

Doctor, this is a hearing and I'm presiding. This is not a three-way hearing where all three sides come to an agreement; if you refuse to agree, you get your way. This is not a three-way meeting in which you are allowed to be sarcastic or uncivil to me or the Board of Registration in Medicine.

Doctor, you will not interrupt me as you did at the prehearing conference. When I start talking, the parties stop. That is the typical decorum in a court, and I will not talk over you.

I sent out an order last week informing you that I had not received your exhibits or witness list. I didn't say that you didn't send them, I said I didn't receive them. That was a notice to you so you could take whatever corrective action was appropriate. It was not an invitation to you to send me a sarcastic fax.

When I located the exhibits in unsorted

mail, I sent you a notice to that effect. That was to save you time in case you were considering sending me another set. I also informed you that DALA's administrative staff had been out sick for two days. Again, this was not an invitation to you to be sarcastic.

You sent me a fax accepting my supposed apology. I did not apologize; I did explain.

Doctor, if your ability to perceive events and interpret communication becomes an issue in this hearing, if it becomes appropriate for me to make a finding about your ability to perceive events and interpret communication and whether or not I have sufficient grounds to make such a finding on the basis of events that are the subject of the hearing, I can potentially make such a finding on the basis of your conduct related to the hearing, just as I can make credibility finding on your conduct in the hearing.

If the possibility of your sarcasm or recognition of appropriate authority becomes an issue in this hearing, I can potentially make such a finding on the basis of your conduct

related to the hearing. I made no such finding yet.

This appeal is about the Board of Registration in Medicine's allegations against you. It is generally not about your allegations against the Board of Registration in Medicine or any hospital as I said at the prehearing conference. It is not about any complaints that the respondent may have against me. I have the responsibility to run a hearing that focuses on the allegations at hand and does not get sidetracked. I have a responsibility to record the due process. I have not exhausted my responsibilities. As the Supreme Court said in Morrissey Vs. Brewer, "due process is flexible and calls for such procedural protections as a particular situation demands."

Do the parties have any response to what I just said? Not to any other issue just yet.

MR. PAIKOS: No.

THE MAGISTRATE: The parties have stipulated to the admissibility of certain documents, and I will now admit certain exhibits. The exhibits will be divided between

petitioner's exhibits and respondent's exhibits.

Petitioner's exhibits: Exhibit 1 the Statement of Allegations.

Exhibit 2, records for Patient A.

Exhibit 3 are records for Patient B.

Exhibit 4 are records for Patient C.

Exhibit 5 are records for Patient D.

Exhibit 6 are records for Patient E.

Exhibit 7 are records for Patient F.

Exhibit 8 are records for Patient G.

Exhibit 9 are records for Patient H.

Exhibit 10 are records for Patient I.

Exhibit 11 is the CV of Dr. Barry Levin.

Exhibit 12 is a CV of Dr. Steven Horowitz.

Exhibit 13 is the report of Dr. Horowitz.

Exhibit 14 is a prescription from CVS.

Exhibit 15 is the Massachusetts Controlled Substance Registration Credentialing Verification Document.

Exhibit 16 is the Department of Public Health registration information.

Exhibit 17 is a Massachusetts Prescribing Registration.

Exhibit 18 application for Massachusetts Controlled Substance Registration Credentialing Verification.

Exhibit 19 is a copy of Output.

Exhibit 20 is a Cambridge Health Alliance appointment letter.

Exhibit 21 is the Cambridge Health Alliance suspension letter.

Exhibit 22 is the request to the Cambridge Health Alliance and suspension and termination.

Exhibit 23 are articles and references with subexhibits A through F.

Exhibits 24 and 25 are on disc, they are radiographic images for patients G and I.

Before we go the respondent's exhibits, Mr. Paikos, how much will the Cambridge Health Alliance's suspension of the doctor be an issue in your case?

MR. PAIKOS: I think it just sets a little background, but the main focus is the records of the patients.

THE MAGISTRATE: Doctor, I'm going through your exhibits.

DR. PADMANABHAN: I have exhibit here.

THE MAGISTRATE: I have the exhibits that you sent.

DR. PADMANABHAN: These are more complete because there are things that I witnessed at the previous motions that you said to bring them into the hearing.

THE MAGISTRATE: But I asked you to submit all exhibits to me before.

DR. PADMANABHAN: You have them with you already, but this is --

THE COURT REPORTER: But this is what, please?

DR. PADMANABHAN: Exhibits in tab form.

THE MAGISTRATE: Ms. Wallace I believe was asking what you said, and I think the words were "convenient format."

I'm looking at Exhibits 1 through 11.

DR. PADMANABHAN: Actually it's 1 through 25.

THE MAGISTRATE: Before you approach, Doctor, this is what I want to establish: The order was to submit all exhibits --

DR. PADMANABHAN: Yes, Your Honor.

THE MAGISTRATE: Excuse me. Remember I said that I get to talk and you stop when I talk. The order was to submit all exhibits a week before the hearing, by last week. At the prehearing conference I said the fact that you are submitting documents to me does not mean these are exhibits, so I'm looking at Exhibits 1 through 12.

DR. PADMANABHAN: The last line is --

THE MAGISTRATE: Last line of what?

DR. PADMANABHAN: The list, sir.

THE MAGISTRATE: Respondent's list of exhibits, yes.

DR. PADMANABHAN: It says that I will be including all the exhibits that I brought into the prehearing.

THE MAGISTRATE: Can you show me where it says that because I don't see that.

DR. PADMANABHAN: Respondent's Motion to Dismiss and Opposition with all attached exhibits submitted to DALA and Board of Registration in Medicine.

THE MAGISTRATE: You may be seated again. But you didn't submit it as an exhibit, it's on

the list. I specifically said at the prehearing conference I want the exhibits, not a list of exhibits. So right now I'm not taking those exhibits. If there is time, I will take a look at them, but we've been through this and I have been clear.

You can remain standing if you want or you can be seated. The parties do not have to stand when they address me. It's at their convenience. If you are used to standing, you may. If you want to stretch your legs, you may.

Doctor, can you tell me the significance of Exhibit 1, proposed Exhibit 1.

DR. PADMANABHAN: I don't have that list on me, Your Honor.

THE MAGISTRATE: Real unredacted transcript of real sworn testimony by Dr. Thomas Harter Glick.

DR. PADMANABHAN: Yes.

THE MAGISTRATE: I'm going to retract the editorializing in the --

DR. PADMANABHAN: You actually have the redacted. This is the previous list.

THE MAGISTRATE: Tell me, please, the

relevance of this, Doctor.

DR. PADMANABHAN: The Board has introduced so-called summary of interview with Dr. Glick, so in rebuttal I'm introducing the actual sworn testimony.

THE MAGISTRATE: Is the transcript, is the interview in here?

MR. PAIKOS: No, it is not. We submitted that as part of voluntary discovery. Dr. Glick was a potential witness possibly called in rebuttal. We do interviews, we take interview notes, Ms. Cooke does. There was no request for interview notes, but we provided them to Dr. Padmanabhan December 31, January 1. We are not going to admit those into evidence. If anything, we'll call Dr. Glick.

THE MAGISTRATE: I'm not inclined to admit Exhibit 1. It's a transcript. You can have live testimony if you want. I'll re-visit that if you want, but I'm not admitting respondent's Exhibit 1.

Respondent's Exhibit 2, can you tell me the relevance of that.

DR. PADMANABHAN: The issue is my

prescribing habits and my standard of care. So Dr. Carol Warfield who is probably the best expert on pain in Massachusetts, and she came, so I have the sworn testimony of Dr. Carol Warfield. Since the Board is -- I am unable to afford live witnesses to support my case, so I'm introducing sworn testimony.

THE MAGISTRATE: Any thoughts?

MR. PAIKOS: It is an expert that Dr. Padmanabhan called and testified at his fair hearing. It would be hearsay which is admissible. Dr. Padmanabhan, what he provided was the direct of the expert, not the cross. We have both and we haven't redacted it. If it's going to be admitted as a hearsay statement on his care of Patients A through E, we would ask that the entire transcript be submitted. It's a hearsay statement of an expert I believe that he hired at the time. So other than that, I have no objection as hearsay is admissible.

THE MAGISTRATE: Do you have any response to Mr. Paikos?

DR. PADMANABHAN: I agree.

THE MAGISTRATE: I'm tentatively going to

admit Exhibit 2 for the respondent. And, Mr. Paikos, I understand you are going to want to supplement that?

MR. PAIKOS: Yes. It's being redacted this morning.

THE MAGISTRATE: Respondent's Exhibit 3, I have highlighted copies. Mr. Paikos, are your copies highlighted?

MR. PAIKOS: Yes.

THE MAGISTRATE: The highlighting that you provided to me is the same highlighting that you provided to Mr. Paikos on all these exhibits?

DR. PADMANABHAN: Absolutely.

THE MAGISTRATE: Respondent's Exhibit 4, Amended Information Form for MCSR. I'm admitting that.

Respondent's Exhibit 5, FAQs from the Executive Office of Health And Human Services from their website.

Exhibit 6 I am not accepting as submitted by the doctor because it did not comply with the impoundment order on names. As a matter of fact, right now, Doctor, I'm going to hand back

an envelope with exhibits. There is an impoundment order in effect. And Ms. Wallace, as in the past I'm going to ask you if any witness or lawyer or party mistakenly identifies a patient by actual name, that you will insert "Patient A," "Patient B," "Patient C."

THE COURT REPORTER: I will do that.

THE MAGISTRATE: Doctor, do you have another Exhibit 6 for me?

DR. PADMANABHAN: That's all I have.

THE MAGISTRATE: I'm asking for a separate Exhibit 6.

DR. PADMANABHAN: The numbers are different. I assume in the administrative hearing all exhibits are admissible, and I have submitted these before both to the Board and to yourself.

THE MAGISTRATE: Doctor, if you submitted them to the Board, you did not submit them to me. My order last week was I'm not accepting your proposed Exhibits 6, get me another one, and you didn't. Now I'm giving you a chance --

DR. PADMANABHAN: I faxed it to you.

THE MAGISTRATE: Exhibit 6?

DR. PADMANABHAN: Yes.
THE MAGISTRATE: Redacted?
DR. PADMANABHAN: Yes.
THE MAGISTRATE: When did you fax it?
DR. PADMANABHAN: As soon as I got your fax.
MR. PAIKOS: I have a fax of it looks like from January 6 dated, faxed over at January 7, 7:49 a.m.
THE MAGISTRATE: Can I see a copy, Mr. Paikos.
MR. PAIKOS: (Document handed).
THE MAGISTRATE: Doctor, your proposed Exhibit 6 is two pages?
DR. PADMANABHAN: The fax contains more than Exhibit 6.
THE MAGISTRATE: Doctor, my question again, your proposed Exhibit 6 --
DR. PADMANABHAN: My proposed Exhibit 6 is different now, Your Honor, because I put it in a tabbed folder.
THE MAGISTRATE: Doctor, until you can answer my questions, I'm not admitting Exhibit 6. I have what I think are simple

questions.

DR. PADMANABHAN: Yes, that is the affidavit for the patient in redacted form.

THE MAGISTRATE: Two pages?

DR. PADMANABHAN: Yes.

THE MAGISTRATE: If you will kindly get me another copy.

DR. PADMANABHAN: I have it right here, sir.

THE MAGISTRATE: Doctor, did I just ask you for Exhibit 6?

DR. PADMANABHAN: One second, sir.

THE MAGISTRATE: No. Doctor, did I just ask you for Exhibit 6?

DR. PADMANABHAN: I'm not sure.

THE MAGISTRATE: I need you to listen to me because I'm trying to conduct a hearing. Do you have a copy of Exhibit 6 that is redacted?

DR. PADMANABHAN: Yes.

THE MAGISTRATE: Can I have it.

DR. PADMANABHAN: Except that it's not Exhibit 6 any more.

THE MAGISTRATE: I don't care about the number that you have designated. If you have

the substantive document, Doctor, --

DR. PADMANABHAN: (Document handed.)

THE MAGISTRATE: Thank you. I'm going to hand this back to you because it's not designated tab 16.

I'm accepting as respondent's Exhibit 6 an affidavit that has been redacted. And the patient's designation, not the name, Patients 1, 2 and 3 that this relates to is what?

DR. PADMANABHAN: Patient A.

THE MAGISTRATE: That is Exhibit 6.

What's the significance of your proposed Exhibit 7?

DR. PADMANABHAN: I regret I don't have the page.

THE MAGISTRATE: Doctor, we can't stop the hearing for me to explain to you what documents you have submitted to me. It looks like an immigration form, Notice of Action.

DR. PADMANABHAN: USCIS Approval Form, yes.

THE MAGISTRATE: What is the relevance of it?

DR. PADMANABHAN: It shows that my

termination from Cambridge Health Alliance was fraudulent and the report to the Board was fraudulent.

THE MAGISTRATE: I don't see that. I don't think that is relevant. I'm not admitting that as an exhibit.

DR. PADMANABHAN: May I object, Your Honor?

THE MAGISTRATE: I gave you a chance to explain, and your objection is on the record because there is a stenographer here.

Exhibit 8 from the respondent I'm admitting.

Exhibit 9 I assume has to do with a particular patient's care?

DR. PADMANABHAN: Yes.

THE MAGISTRATE: Are you guessing or are you familiar with Exhibit 9?

DR. PADMANABHAN: Yes. I am very familiar with it.

THE MAGISTRATE: Exhibit 10 I admit.

The relevance of Exhibit 11?

DR. PADMANABHAN: Exhibit 11 deals with the conduct of this investigation by the Board

of Registration in Medicine.

THE MAGISTRATE: This hearing is about the allegations against you, not the investigation underlying it in general as I amplified at the prehearing conference.

I'm returning to you your proposed Exhibits 1, 7 and 11.

DR. PADMANABHAN: I didn't realize, Your Honor, that I submitted them that you would toss them.

THE MAGISTRATE: I'm not tossing them. I considered them for relevance. As the presiding officer I have a responsibility to make sure this hearing is not diluted by irrelevant issues and sidetracking issues. I have to sort the wheat from the chaff, and I determined by viewing them in my office and asking you questions about them that they are not the wheat of this investigation.

I might ask questions of both sides. My asking questions does not mean that I'm taking sides or that I have decided the case already. We will be doing a balancing act. We will get the benefit of the informality of an

administrative law hearing and we will not discard all rules of procedure and evidence. We have seen an example of the informality of the administrative hearing which I have accepted the transcript which is under the rules of evidence hearsay.

If you need a break, let me know. We will be stopping today at noon. All electronic devices that make noise should be off. There will be no nodding of heads, shaking of heads by anyone in the hearing room in reaction to testimony or anything said by the parties.

I remind the parties again not to fax and send by US mail the same submission. Put a docket number, the DALA docket number and send it to the other side.

The parties will not attempt to refresh memories of witnesses by showing witnesses a document that they have never seen before, and I will not allow the parties to impeach a witness by showing them a document that another person prepared recording that witness' words. I will not allow the parties to ask one witness why another person may have said something. I will

not allow the parties to ask a witness to comment on another witness' testimony.

If you start a question with "would it surprise you," I'm going to stop you. "Would it fresh your memory if I told you," I'm going to stop you. "If I suggest to you," I'm going to stop that question as well.

Remember that there is no jury. You do not have to make the same point multiple times. I remind the parties that the purpose of redirect examination is not to make your best point a second time. The purpose of recross examination is not to make your best point a second time.

I might allow one side to explore a subissue and decide it's not relevant and then not let the other side explore it. There is no prejudice to the parties. Remember, there is no jury.

The door to the hearing room is open. There is an occasional sound coming through. If it becomes too distracting or too noisy, please let me know.

Doctor, you are here without a lawyer.

That is not necessarily a disadvantage.

This is how the hearing will proceed: I will hear opening statements first from the Board of Registration in Medicine and then from you, if you wish. You have three options: You can waive your opening statement; you can give me an opening statement right after Mr. Paikos does; or when Mr. Paikos is done presenting the case on behalf of the Board of Registration in Medicine, you can give an opening statement.

The purpose of an opening statement is not to argue to me or editorialize, it is to preview for me what you think your witnesses will say and the documents will show.

Then Mr. Paikos will call a witness. After Mr. Paikos is done asking questions of any witness, you get a chance to ask questions of the witness. That is your chance to bring out information that favors you or show you that the witness is not believable, and it is not time to argue with the witness. It is not a time to tell me directly or indirectly why I should rule in your favor.

When Mr. Paikos is done calling witnesses

and you are done asking questions, you will get a chance to testify or call witnesses in whichever order you want. Mr. Paikos will get a chance to ask you questions and questions of your witnesses.

I know that there are some motions pending. Doctor, as I said last week, I will rule on your motions when we have a chance to give you an opportunity to follow up, if follow-up is necessary.

Quickly from the Board I have two motions, a Motion to Use Electronic Records at the hearing. Mr. Paikos what is the software to view the disks?

MR. PAIKOS: It's embedded in the program itself, and we were going to hopefully be able to project it on the wall, that is our plan, so the expert can talk about certain images.

THE MAGISTRATE: Mr. Paikos, you are taking care of the technology, the software and the images?

MR. PAIKOS: Yes. Sometimes viewing can be glitchy depending on the computer, but we know it works with ours.

DR. PADMANABHAN: I object, Your Honor.
THE MAGISTRATE: What basis?
DR. PADMANABHAN: I have never agreed to an electronic submission or media throughout this case. I have put an objection of mine on record in paper three or four times.
THE MAGISTRATE: I understand from Mr. Paikos that this is the only way to display these records.
DR. PADMANABHAN: We have display radiographic images in courtrooms before.
THE MAGISTRATE: Is there prejudice to you by showing it electronically?
DR. PADMANABHAN: I have not used any of the images because I have not had any electronic images in my computer. I am not aware of any images, and I have not seen any images because I do not trust electronic submissions. I made that clear to the Board and I only file objections on paper.
THE MAGISTRATE: I'm letting Exhibits 24 and 25 come in. I will see them electronically. If you have any objection, we'll revisit it. I'm not saying I will rule in your favor, but I

am granting that Motion to Use Electronic Records at the Hearing.

Mr. Paikos, your Motion to Impound Additional Records. If patient names are impounded, why is that necessary?

MR. PAIKOS: They are redacted. I think it's extra-precautionary. They are already redacted, so it may be duplicative. These are the CVS records.

THE MAGISTRATE: It's possibly redundant, possibly not?

MR. PAIKOS: I think it is redundant. Since they are in evidence, there has been no issue. I withdraw the motion.

THE MAGISTRATE: Is there anything else before we start? Doctor?

DR. PADMANABHAN: I have here a Motion to Compel Discovery from the Government and to Seek Sanctions for Fraud --

THE MAGISTRATE: Excuse me, Doctor. As soon as I start talking, you stop talking. Is this a motion that you already submitted?

DR. PADMANABHAN: Yes. There are three of them, but you have not ruled on any of them

yet.

THE MAGISTRATE: Did you get my ruling on these motions tentatively and why I was not ruling on them right away?

DR. PADMANABHAN: This is fundamental to the case, Your Honor. If you look at the exhibit list that the government has submitted, there is an unknown --

THE MAGISTRATE: Doctor, I have ruled on this and I preserved your rights. This is not a new motion, so we are going to start the substantive part of the hearing.

DR. PADMANABHAN: It's a new motion, Your Honor.

THE MAGISTRATE: Doctor, I asked you whether it was a new motion or whether I already have it. Which is it?

DR. PADMANABHAN: It's a new motion. I wrote it last night.

THE MAGISTRATE: This is not a motions hearing, this is a hearing to take evidence.

DR. PADMANABHAN: It's about the relevance and the credibility of the evidence.

THE MAGISTRATE: Have you given

Mr. Paikos a copy of that?

DR. PADMANABHAN: Here.

THE MAGISTRATE: I'm not going to accept it, and here's why: I need you to mail it or drop it off at my office so it gets docketed. We have a docket going. And I'm not ruling on it right now anyway because I'm not ruling on discovery motions right now as I said last week.

DR. PADMANABHAN: May I ask how we can proceed with the hearing without discovery?

THE MAGISTRATE: I wrote it in my ruling. I answered that question.

Mr. Paikos, are you ready for an opening statement?

MR. PAIKOS: May I address a few issues relating to the exhibits?

THE MAGISTRATE: Yes.

MR. PAIKOS: The copy that was initially sent to us regarding Dr. Warfield's testimony was not redacted. I received by fax Dr. Padmanabhan's redactions. However, someone at my office is redacting the entire transcript currently, so I would just alert you that you may have something that is not redacted, but we

are going to present it to you in complete form.

THE MAGISTRATE: Exhibit 2 as that stands now, response to Exhibit 2?

MR. PAIKOS: Yes.

THE MAGISTRATE: Doctor, do you have a response to that?

DR. PADMANABHAN: I fully support the government introducing exhibits after January 5.

THE MAGISTRATE: We are talking about your Exhibit 2 and Mr. Paikos notifying me that is not in compliance with the impoundment order.

DR. PADMANABHAN: Actually it is in compliance, Your Honor. I redacted it myself. Here is the government's version.

THE MAGISTRATE: Doctor, one issue at a time.

DR. PADMANABHAN: It's the same issue, sir. This is the full transcript of Dr. Warfield's testimony.

THE MAGISTRATE: Doctor, listen to me, please. You are talking about proposed Exhibit 2 that you handed me, we're not talking about the whole transcript. Is this in compliance with the impoundment order?

DR. PADMANABHAN: Indeed, sir. Mr. Paikos proposes to substitute it with his --

THE MAGISTRATE: Doctor, one issue at a time.

Mr. Paikos, can you bring to my attention where it is not in compliance.

MR. PAIKOS: I believe 179 is one place where it is not in compliance.

DR. PADMANABHAN: That must be the previous fax. I did send a redacted copy out to everybody.

THE MAGISTRATE: The issue is whether this respondent's Exhibit 2 that I'm holding in my hand is in compliance with the impoundment order or not, and it is not. Doctor, I'm giving this back to you.

DR. PADMANABHAN: I did send a redacted copy, sir, that was in compliance by fax to you.

THE MAGISTRATE: I'm taking a look at Exhibits 1 through 11 that you sent and there was what I listed as my exhibits. I did not get a replacement. So the respondent's exhibit numbers that you marked will remain. Even though there are missing gaps, I'm not changing

the respondent's proposed numbers.

Anything else, Mr. Paikos?

MR. PAIKOS: On January 5 which was the date of discovery, I believe we sent by courier to your office additional prescriptions for Patient D that we wanted to include in the hearing. So we did not talk about those, and I haven't confirmed recently and it wasn't in the federal binder. It came afterwards as a separate.

THE MAGISTRATE: It would be in Exhibit 5?

MR. PAIKOS: Part of Exhibit 5. I called it Exhibit 26 and provided a supplemental exhibit list.

THE MAGISTRATE: I do have that. I'm sorry, I did go through tab 23. After the fact I admit as Exhibit 26 records related to Patient D and as Exhibit 27 Greeley report, G R E E L E Y report.

DR. PADMANABHAN: I have the copy of redacted Exhibit 2.

THE MAGISTRATE: Can you show Mr. Paikos.

DR. PADMANABHAN: He has a copy as well.

THE MAGISTRATE: There are different copies floating around, and I'm asking you to show him that copy.

MR. PAIKOS: This appears to be what we have, again it's without the cross examination of Dr. Warfield.

THE MAGISTRATE: But it is redacted?

MR. PAIKOS: It is redacted.

THE MAGISTRATE: I'm accepting a copy and marking it as Exhibit 2. It is partial transcript, but it has been redacted.

MR. PAIKOS: I have one question: When we present later in the week before our case is over the complete transcript of Dr. Warfield redacted, it has on it the page numbers from the transcript as part of the entire hearing. I don't know if you want separate Bates stamps or the numbers from the hearing transcript.

THE MAGISTRATE: If it has page numbers, that is fine. And if the parties can agree there are parts that are not relevant, that would help me, too.

MR. PAIKOS: Yes.

THE MAGISTRATE: With that are you ready

for an opening statement?

MR. PAIKOS: Yes. This case deals with Dr. Padmanabhan's care of nine patients, A through I, our argument that he provided substandard care to these patients. You will hear from Dr. Levin who will testify as to that. Additionally, report from Dr. Horowitz also indicates the substandard care of those nine patients. There is also an issue over a period of time Dr. Padmanabhan did not have his Massachusetts Controlled Substance Registration which is something required for him to prescribe medication, Schedule II through VI, I believe. That is the evidence that we expect to have at hearing.

THE MAGISTRATE: Doctor, what do you expect the evidence to show?

DR. PADMANABHAN: I expect the evidence to show that my standard of care was appropriate, my level of expertise is unmatched by the expert quote unquote that the Board is providing live. And I once again strenuously object to the author of the Statement of Allegations not being present to testify under

oath.

THE MAGISTRATE: I'm standing up, and is that where the witness usually testifies?

MR. PAIKOS: That is what we were told, yes.

THE MAGISTRATE: If you are ready, you may call your first witness.

MR. PAIKOS: He may feel more comfortable using the end of our table for papers if that is acceptable.

THE MAGISTRATE: That is acceptable to me.

DR. PADMANABHAN: May I speak, Your Honor?

THE MAGISTRATE: Yes.

DR. PADMANABHAN: You have completely gutted my exhibit list, sir.

THE MAGISTRATE: We are proceeding with the hearing.

BARRY LEVIN, MD, SWORN

DIRECT EXAMINATION BY MR. PAIKOS

Q Good morning.

A Good morning.

Q Could you please state your name for the record.

A Barry Levin, MD.
Q Dr. Levin, where do you work?
A Concord, Massachusetts.
Q Doing what?
A I'm a neurologist.
Q How long have you been a neurologist?
A 37 years.
Q And are you Board certified?
A Yes.
Q What does that entail?
A Entails taking, going through training in college, medical school, internship, residency, then taking a level of different examinations to prove your competency in your specialty.
Q What is the Board that certifies neurologists?
A American Academy of Neurology and Psychiatry.
Q Why is it Neurology and Psychiatry?
A Historically neurology and psychiatry were together, so up to around the fifties if you were a neurologist, you were also a psychiatrist and vice versa. Around the fifties there was a division, so someone specializing in either neurology or psychiatry, but historically the Board stayed together, so now it's through the

Board of Neurology and Psychiatry with a specialization of neurology or psychiatry.

Q Doctor, where did you go to medical school?

A Northwestern.

Q And did you do an internship?

A I did.

Q I just want to show you what is marked as Exhibit 12. I have it here. What is that Exhibit 12?

A (Indicating).

Q If you can tell us what it is if you recognize it.

A (Indicating).

Q I'm sorry, Exhibit 11.

A That is my CV.

Q And after medical school did you do a residency?

A Yes.

Q What is a residency?

A It's a period of training typically at a hospital where you specialize in a specialized area of medicine.

Q And what did you do your residency in?

A Neurology.

Q Have you worked in private practice?

A Yes.
Q In neurology since about when?
A 1977.
Q And at any point did you have any clinical or teaching appointments?
A Yes.
Q Did you at some point belong to the National MS Society?
A Yes.
Q Have you always practiced in Massachusetts?
A No.
Q Where did you initially practice?
A Rhode Island.
Q Where was your clinical and teaching appointment?
A Brown University.
Q Do you recall how long you were a teacher there?
A When I first went into practice in 1977, I was hired as a part-time teaching neurologist at Pawtucket Memorial Hospital, and I was there for five years working part time in private practice, part time as a teaching neurologist while being on the staff, Brown University. After five years I was then on clinical staff of

Brown University.
Q What does it mean to be on the clinical staff of any university?
A Basically I was available to do teaching and I did teaching of medical students, interns, residents, provide community lectures. I did different seminars for the medical students, I did sessions teaching medical students how to do neurological examinations.
Q Does your CV show your involvement in the National MS Society?
A Yes.
Q Throughout your career have you treated MS?
A Yes.
Q And is that multiple sclerosis?
A Yes.
Q I can take that back from you. What is neurology, the specialty of neurology?
A Neurology is a specialty of medicine that relates to the nervous system which would be the brain, the lower portion of brain, the brain stem, spinal cord, nerves, muscles, relates to disease that can affect any of these areas of the body. Many common diseases including

headaches, dizziness, multiple sclerosis, Parkinson's disease; pain problems relating to the neck, the back, nerve problems, muscle problems, a large variety of problems that can affect the nervous system.

Q What does a neurological exam entail?

A A detailed examination typically will include a general examination, general examination involving the head, the neck, the carotid arteries, the pulses, involves the heart, oftentimes checking the vital signs.

The neurological examination specifically involves a number of different areas. First is a mental status examination, checking the cognitive status, any cognitive difficulties. Motor examination, examining the muscles, the strength, reflexes.

Sensory examination, different sensations to pin, light, touch, vibration, position, senses in the body, coordination like cerebellar functioning, gait or ability to walk, station, balance, and what are known as the cranial nerves. There are 12 cranial nerves that provide the special senses, different functions

related to the head, to the neck and we go through numbers 1 through 12 from smell down to the functioning of the tongue.

Q When conducting a plan, you note or do you note neurological symptoms, if there is such a thing?

A Yes.

Q What are neurological symptoms?

A Neurological symptoms are what the patients report to you, what somebody is hearing, maybe their description of a headache, a change in sensation, change in vision and speech, change in their balance. It's what the patient is experiencing.

Q After you have conducted the exam, do you record these things in records?

A Yes.

Q After you conduct an exam, is there a plan that you follow?

A Yes.

Q What is involved in a plan?

A In formulating the plan for a particular patient you take the information that the patient has given you typically for a neurologist. A very long and detailed history. We do a long

examination, try to put the pieces together from what the patient has told you, from the patient's signs, what you actually observed in seeing the patient and formulating an impression about what you think is going on with the patient. You come up with a specific diagnosis.

After you formulate your impressions, you try to decide what is the best way to evaluate the patient, and you need to have studies at that point. Oftentimes follow up is required and what treatment is required including medications. You may include such things as physical therapy, may include referral to another professional as well. The last would be formulating a plan for when you are going to see that patient again, if you need to see the patient again; if so, when would you like to see the patient.

Q Doctor, at some point were you retained by the Board to review records?

A Yes.

Q Did you receive a few boxes of medical records?

A Yes.

Q I'm going to show you the pseudonym list, if you

would take a look another that, please.
A (The witness complies).
Q Are those the records that you reviewed for Patients A through I?
A Yes.
Q I want to show you some records. Do you recognize those records?
A I do.
Q Who are they for? There is a pseudonym order if, and if you could use the pseudonym which I can keep close to you for reference.
A Patient A.
Q Pursuant to a request from enforcement staff, did you provide a list of records that you thought were or might be relevant?
A Yes.
Q So you reviewed the entire record but submitted a list of records that might be important?
A Yes.
Q If I could ask you to turn to what is marked as medical record number 5 in your record and Bates stamp 8 for the record.
THE MAGISTRATE: What exhibit are we in?
MR. PAIKOS: Tab 2, Exhibit 2.

THE MAGISTRATE: Did you hand the witness the entire Exhibit 2 or the original medical record?

MR. PAIKOS: The original medical record that he had.

Q (By Mr. Paikos) Doctor, if you could go to the medical record number 5 which is Bates stamped 8 that the Magistrate has and Dr. Padmanabhan has.

A I'm sorry, I'm not sure about the page that you are talking about.

Q Number 5. Have you found the page?

A Yes.

Q What is this record -- The next two pages are a September 5, 2007 exam by Dr. Padmanabhan?

A I believe this is October 8, 2007.

Q Yes, October 8, 2007.

DR. PADMANABHAN: What page?

MR. PAIKOS: Bates stamp 8, medical record page 5 tab 2.

Q (By Mr. Paikos) Did you review this record?

A Yes.

Q And what is this record?

A This appears to be a neurological evaluation of Patient A performed by the doctor.

Q If you could provide some of the history of this patient based on the note.

A He notes that he saw the patient at a neurology clinic, that he had seen him before when he was practicing in southern Massachusetts. Patient has elected to follow me for his care. He has also had difficulty getting his pain medicines refilled by a neurologist he left behind in the old practice, hence his visit today.

Lower back pain, right lumbar radiculopathy since 2003. Also since 2004, excuse me, trouble with his right wrist. No real changes in symptoms since we last met. No indication of when he had previously met the patient. Then there was a physical examination of the patient giving vital signs.

There is a neurological examination, looking at the pertinent findings under the neurological examination. The finger intrinsics on the left and right side were about 5 minus, so it was a very mild weakness. There was vibration loss to the feet on both sides. Positive straight-leg raising test on the right side but no real weakness. Gait was somewhat

antalgic.

Impression was a right lumbar radiculopathy with ongoing chronic pain.

THE MAGISTRATE: "Antalgic" meaning what?

THE WITNESS: "Antalgic" meaning there was some sense of imbalance.

Q (By Mr. Paikos) Doctor, were there any medications prescribed?

A I don't know.

Q Is it listed in the record?

A Excuse me, I misspoke. There is a note giving him a refill on his pain medicines today.

Q Does it note exactly what the pain medicines are, the dosage or the milligrams?

A There is no additional information other than giving him a refill on his pain medicines.

Q Doctor, taking a look at, based on your experience as a neurologist, did, how would you assess Dr. Padmanabhan's examination and impression?

A The examination is good, it's a good neurological examination. Impression is within the standard of care.

Q What about relative to the prescribing?

A There is no information as to what medication was prescribed, what the medicine was, the dosage, how it was supposed to be given, how many pills were given or whether there were refills or not. This would be below the standard of care.

Q Directing your attention to medical record 17 which is Bates stamp 10, the next two pages show an examination on October 31, 2007.

A Excuse me, this is Bates stamp 17?

Q 17 for your medical record 17. What date is that note from?

A October 31, 2007.

Q Does it go to the next page as well?

A Yes.

Q And is there any mention of a patient going to a pain clinic?

A There is a statement, he tells me he does not wish to follow up with the pain clinic in Duxbury and would actually be moving to West Duxbury fairly soon, making the trip less onerous.

Q If you go to the next page, page 18 of the medical records and the Magistrate's Bates

number is 11. Is there any information about prescribing at this page at the same visit of October 31, 2007?

A There is a statement, I have given him a refill on his pain medicine today. He will most likely come back every month for a refill.

Q Is this note within the standard of care?

A Which note?

Q This note, October 31 in the medical record, 17 and 18 for Patient A.

A The history is limited. There is a mention of his severe lumbar radiculopathy with chronic pain, limited history but within the standard of care. The neurological examination is within the standard of care. The impression is right lumbar radiculopathy with ongoing chronic pain, and that is within the standard of care.

The information with regard to refill on his pain medication, he does not state what the medicine is that he is prescribing, if there is one medicine or more than one medicine. We don't know the dosage, we don't know how many pills were prescribed or whether or not there were refills. That is below the standard of

care.
Q Doctor, relative to prescribing, is there something referred to as potential red flags?
A Yes.
Q What is that?
A It would be a nonspecific term that could relate to many, many different areas. It's a feeling that you get as you review a record, as you talk to patients, as you see patients in your daily practice that something may be wrong, if a patient does something that you get concerned.

For example, if I have a patient who cancels a lot of appointments and then is calling for medications between those appointments, that would be a red flag, a problem.

If I have a patient who is saying to me that they lost their medication and does this frequently, I would be concerned. If for some reason I am concerned there may not be full cooperation with the patient and this may raise some concerns, a red flag, if you will.
Q What about, indicated something about the patient not following directions or not doing

the plan. Does that include going to referrals?
A Yes.
Q I want to direct you to the next note which is in your medical record 27 and 28, a visit of December 24, 2007, and at the hearing Magistrate's Bates 12 and 13. Who conducted that note or wrote that note?
A The doctor.
THE MAGISTRATE: Who did?
THE WITNESS: Dr. Padmanabhan.
Q (By Mr. Paikos) How would you assess this relative to the standard of care?
A This note is within the standard of care.
Q Is there a notation about how much, what the medication is and whether there is a change and how often the patient is to take them?
A Under Medications there is category of medications. States unchanged including Oxycontin 80 milligrams two pills twice a day. He takes 90 milligrams of Neurontin a day all told.
Under Impression, I have given him a prescription today for Oxycontin 80-milligram pills, two pills twice a day. He will come back

in two months' time for a refill.
Q Directing your attention to the medical record for Patient A, 34 to 35 a visit of February 22, 2008, if you could look at that note.
A I have reviewed the note.
Q Is the prescription within the standard of care here?
A No.
Q Why not? Is that on page 35 of the medical record number?
A Yes.
Q Why not?
A Under Impression the statement, I have increased his Oxycontin dose to two 80-milligram pills four times a day. He will take as many as he needs during the course of the day. He may need six or seven pills some days. I have asked him not to go on short-term oxycodone breakthrough pills. I have given him a prescription for Oxycontin for this month, next month and the month after.
Q Why is that not within the standard of care, with that explanation?
A The instructions are vague, the instructions

that he can take as many as he needs during the course of the day. The usual practice would be to specify how many pills a patient may take. If a patient can take more than the usual amount you are prescribing, then that would be specified as well. For example, you might say two pills four times a day, may take as much as two pills six times a day, eight times a day, but you would not leave it open-ended for as many as he can take during the course of a day. You wouldn't do that particularly for an abusable medication.

Q There is an abbreviation prn, as needed?

A Yes.

Q How is that different than the statement in this medical record?

A It is not.

Q It's similar to that but not the usual wording?

A Correct.

THE MAGISTRATE: Is this an abusive medication?

THE WITNESS: Yes.

THE MAGISTRATE: Let me ask the doctor a question: The phrase "I asked him to not go on

short-term oxycodone breakthrough pills," what does that mean to you?

THE WITNESS: That he has asked him not to take an additional narcotic in addition to the Oxycontin that he is already prescribed.

THE MAGISTRATE: Is there any indication why the patient might be taking oxycodone in addition to the Oxycontin?

THE WITNESS: Not that I could understand.

THE MAGISTRATE: Thank you.

Q (By Mr. Paikos) Doctor, directing your attention to the December 5, 2008 note at medical record number 233 which is Bates page 46. Your record, Doctor, would be at medical record under 233. If you would review that note and please say if it's, whether or not it's within the standard of care.

A I have reviewed the note. It is not within the standard of care.

Q Why is this from December 5, 2008 not within the standard of care?

A The history. When medical notes are put together, oftentimes there is a system used

called the subjective, objective, assessment and plan. That would be the note. This particular note is within that system, abbreviated SOAP. It refers to subjective, that is what the patient is telling you, the history from the patient. O refers to objective information what the doctor observes, what you are seeing. A and P refer to assessment and plan, how you are putting the information together and what the plan is for the future, medications.

Here the history is everything is going okay. Review of systems, ROS, negative for any changes. Objective, O, is stable. Assessment and plan, lumbar radiculopathy. Prescription given for three months, Oxycontin 80 milligrams 180 pills per month.

The history is not typically what one would expect from a neurologist, is not the kind of history that you would get, particularly from a patient who is in chronic pain on narcotics.

The examination, we really need to know what the doctor is seeing, how is the patient doing, are there changes in the exam. What are we seeing? There is no information what has

been seen at all.

THE MAGISTRATE: Where should it be in your opinion on this page?

THE WITNESS: Under O you would have a detailed neurological examination.

A The plan for Oxycontin 80 milligrams, there is no information about how much the patient is supposed to be taking. There is no specific directions about the Oxycontin. Is he supposed to be taking one a day or twenty a day? We don't have any information.

Q We've seen some of the complete neurological exams in Dr. Padmanabhan's notes that we saw earlier that you said were within the standard of care.

A Yes.

Q Why does that have to continue onward if nothing is changed? Why do you have to repeat that kind of exam?

THE WITNESS: In general it's important to know how the patient is doing from visit to visit. So you would do, you may not do an entire neurological examination but you would certainly do at least an abbreviated

neurological examination and record that examination as opposed to just putting down "stable."

I have to go back and see when the last recorded neurological examination was to know what "stable" even referred to. But you want to examine the patient. You have a patient with chronic pain, has lumbar radiculopathy, I'd like to know number one, does he have any abnormalities on this examination, has the examination changed, has he gotten better, worse to know where we are going in terms of trying to help him and in terms of prescriptions of his medication.

Q Doctor, if we could go next to the medical record 235 which is at Bates 47. That is a May 15, 2008. Again that is at medical record number 235 and Bates stamp number 47.

THE MAGISTRATE: I'm going to ask the newspaper to stop rattling, please.

Q (By Mr. Paikos) If you could review that note and describe whether or not it is in the standard of care.

A This May 15, 2008 is the correct date?

Q Yes.
A I reviewed the note.
Q Is it within the standard of care?
A No.
Q Why not?
A Once began reviewing each portion of the particular note under Subjective, feeling no pain but has insomnia due to mind racing, quote unquote. We would hope to have more information about the patient. This is a patient with chronic pain who is taking chronic narcotics. There should be more history in terms of how the patient is doing. Is he doing well other than just feeling no pain; is he tolerating the medicines well; has he increased the dosage, decreased the dosage.

Vital signs are as above. That is within the standard of care. They are listed above the note. Neuro exam unchanged would be below the standard of care. I would like to see specifics in terms of what he is observing with the patient.

Back pain no change is the Impression, and that is within the standard of care.

Prescription given, no information about what prescription was given, whether it was a narcotic, was it another type of medication, were there multiple medicines, how much medicine was prescribed, how often refills. There is no explanation.

There is a note that a pain agreement was signed. There is a second Impression of insomnia plus anxiety, given Xanax 1 milligram, asked him to take a half pill if that is enough. That is below the standard of care. There is no information about how much medication was prescribed, the number of pills, the number of refills. That would be expected to be in the note.

THE MAGISTRATE: Mr. Paikos, I'm going to ask you to pause. Someone asked me to see if I want the door closed. Let me go out and see if someone wanted the door closed.

[Pause]

THE MAGISTRATE: I did not see that person who poked her head in the room, so I assume we are not disturbing anyone.

Before we begin testimony, Doctor, you

are allowed to have friends, relatives with you, but at a certain point if you are receiving advice consistently, I'm going to need you to make an appearance and have the person with you make an appearance. So you can either identify who is with you feeding you notes and whispering to you. I'm just putting that on the record. There is nothing nefarious to you, but I need to know who is in the hearing room assisting you.

DR. PADMANABHAN: He is a personal friend. He is asking me about my practice at Cambridge Hospital.

THE MAGISTRATE: I'll ask you to identify yourself because the doctor won't.

UNIDENTIFIED PERSON: I'm an observer. Let me delineate. First of all, let me address this is not a newspaper rattling. I'm not reading a newspaper. This is an article written by the doctor, and in there, in that article I was trying to reference a point that you made. So it's not a newspaper per se.

THE MAGISTRATE: The typical decorum in a court, and I have been appearing in courts for decades, is that people don't read newspapers.

UNIDENTIFIED PERSON: I wasn't reading a newspaper. I just explained what it is.

THE MAGISTRATE: I'm presiding over the hearing and I'm not going to quibble with anybody, especially a person who is refusing to identify himself.

UNIDENTIFIED PERSON: I'm a, I'm a free-lance journalist. I'm a witness in this hearing.

THE MAGISTRATE: Can you identify yourself.

UNIDENTIFIED PERSON: I don't have to.

THE MAGISTRATE: I'm going to exclude you from the hearing room.

UNIDENTIFIED PERSON: You are going to throw me out? On what basis?

THE MAGISTRATE: I'm excluding you from the hearing room, and I don't have to explain to you.

UNIDENTIFIED PERSON: What basis? It's a public hearing.

THE MAGISTRATE: I am allowed to maintain decorum in a hearing.

UNIDENTIFIED PERSON: Well, Judge, you

are doing a poor job. It's so biased, it's pathetic.

THE MAGISTRATE: I'm suspending the hearing for a moment while I report this. I do need decorum in the hearing room.

[The Magistrate and the unidentified person leave the room]

[Pause]

THE MAGISTRATE: I went out to the reception area to ask the Civil Service Commission receptionist to make sure that person is leaving the office and leaving the building. He has reported that he is leaving the building, and I hope that is the case.

Mr. Paikos.

Q (By Mr. Paikos) We were talking about a note relative to page 15 on medical record number 235, Bates 47 where it says "no pain, RX given." If you could direct your attention to medical record 241, Bates 51.

THE MAGISTRATE: Actually, Doctor, before you answer, I need to put this on the record. The person who was just excluded who refused to identify himself was muttering to me and called

me "a pathetic" out in the reception area. I don't take that personally; however, I do see it as a disruption. If you plan to call him as a witness, I'm going to exclude him.

You are shaking your head no. You are not planning to call him as a witness?

DR. PADMANABHAN: I never plan to call him as a witness.

THE MAGISTRATE: He said he was a witness.

DR. PADMANABHAN: He wanted to be.

THE MAGISTRATE: Are you in contact with him?

DR. PADMANABHAN: I have seen him once before, sir.

THE MAGISTRATE: That is not what I asked. I asked are you in contact with him.

DR. PADMANABHAN: He is a social friend. He is not involved in this case. It is the first time he has come to any of these hearings.

THE MAGISTRATE: He is not on your witness list?

DR. PADMANABHAN: No.

THE MAGISTRATE: Mr. Paikos, resume.

Q (By Mr. Paikos) There is no information in the note about prescriptions what is at medical record 241?
A Medical record 241 is photocopies of three different prescriptions.
Q For what day is that?
A May 15, 2008.
Q And we see from here that what medications were prescribed?
A Xanax, Oxycontin and Neurontin.
Q And what kind of drug is Neurontin?
A Neurontin is category is actually an anticonvulsive, antiseizure medication used for a lot of different purposes in medicine and specifically in neurology. One of the main helpful conditions for Neurontin is for different types of pain. It's commonly prescribed as a pain medication.
Q That Neurontin and the Oxycontin are not in Dr. Padmanabhan's note, are they, from May 15 at medical record number 235, Bates 47?
A There is no specific mention of either medication.
Q If we go to a note, handwritten note

February 27, 2009 at the medical record number 232 Bates stamp for this Exhibit 45. That is 232, Bates 45, medical record 232, Doctor. Would you review this note and provide an opinion whether or not it is within the standard of care and why.

A The note is dated February 27, 2009. Subjective, no change. Meds okay. O, Objective, stable. Assessment and Plan, back pain, continue regime. RX given. This was below the standard of care.

Q Why?

A Under Subjective the history from the patient, the standard of care would be to know how the patient is doing, what is his clinical course, are the medications helping him or not, are there further problems.

Under Objective, O, has there been a change in the examination, what specifically does the examination show, are there any abnormalities on the exam.

Under the Plan, continue regime. Prescription given. The standard of care would be to specifically state which medications are

being given, are there other plans besides medication. In terms of medication, how many milligrams are being prescribed, are there refills, how is the medication to be taken.

Q If you go to medical record 61 for Patient A which is Bates 18. That is an encounter date of August 26, 2009?

A I'm sorry, I'm a little confused on numbers.

Q Page 61.

A My page 61?

Q Yes.

A Encounter date, August 26, 2009.

Q Is this within the standard of care?

A No.

Q Why not?

A This does not list SOAP although it does say AP. It does not say S or O, but there are specific categories on the time note. This is a typed note. I'm assuming those relate to again Subjective and Objective.

Under Subjective it states no change, working hard, feeling well. Under Objective, exam stable.

A and P, lumbar radiculopathy, refills

written.

For Subjective I would like to know the usual information that a neurologist would get, what specifically is the history from the patient rather than just "no change." Is he experiencing pain, is he better, is he worse, to know more information. Under the examination it would be expected that there would be a neurological examination giving the specifics about how the patient is doing currently, are there any abnormalities.

Under the Plan, refills written. There is no information about what medications are prescribed, the dose, how often they are to be taken, the refills. We don't know anything about that.

Q Doctor, what is a pain scale?

A Pain scale would be a scale where the patient would tell you how bad their pain is. There are many different pain scales. One that is commonly used would be asking the patient to tell you how is your pain on a 1 to 10 scale, 1 being almost nothing, 10 being the worst possible, going up over 10. 10 over 10 would be

the worst pain possible.
Q Are you able to tell what the patient's pain level is here at this note?
A No.
Q Going to the medical record number 70 which is at Bates 19, if you could review that note.
A I reviewed the note.
Q What is it?
A This is a typewritten note from Cambridge Health Alliances, EB Medical Specialties about Patient A. Top information states "approved," and it lists three medications. It lists Oxycontin, 80 milligrams. There are three separate listings for that, two tablets every four to six hours oral. Dispense 240 tablets. Start date is October 23, 2009. That is all three of the prescriptions. Each of those is for 240 tablets.

On the bottom it says Progress Notes. There is a note from Tina Williams, again October 29, 2009 is the date. It was signed, refill request form for Gabapentin. 800 milligrams has been faxed to Professional Pharmacy in Norwell by Bunny.

Then there is a note from Elaine Torres, RN, registered nurse from 10-23-2009, the date it was signed. "Please read the note. States he lost his script and he is on his way to pick up another one."

Q And we discussed red flags. Is this a potential red flag?

A Yes.

THE MAGISTRATE: If I could ask a question: Why three prescriptions for what appear to be the same medication at the same dosage?

THE WITNESS: I don't know.

THE MAGISTRATE: Thank you.

Q (By Mr. Paikos) Doctor, directing your attention to medical record 79 to 80, Bates stamp 21 to 22, doctor's note on medical record 80 which is Bates 22.

A Yes.

Q What does that note say?

A "Came in for routine refills. Done."

Q Is that within the standard of care?

A No.

Q Why not?

A Once again I would expect to see a note indicating his neurological evaluation, what was the history from the patient and what did the examination show, what are the impressions. Is the patient doing well, is the patient doing poorly. What is the plan for the patient, the medications that are being prescribed. We need to know specifically what medications are being prescribed, what is the dosage, how is the medicine to be prescribed and how is it to be taken and how many refills.

THE MAGISTRATE: What page are we on, Mr. Paikos?

MR. PAIKOS: That was Bates 21 and 22.

THE MAGISTRATE: Doctor, doesn't that page indicate the dosage and how often it is supposed to be taken?

THE WITNESS: There is no indication on the doctor's notes. The page before that there is a note, medications that start with "encounter."

THE MAGISTRATE: I see. There is no correlation between 73 that you have and page 79?

THE WITNESS: Sorry?

THE MAGISTRATE: Are you saying there is no correlation between page 73 that you have, Bates 20, and page 79 that you have which is 21?

THE WITNESS: I was looking at pages 79 and 80. Do you want me to go back to page 73?

THE MAGISTRATE: What is it that page 79 does not have a correlation to?

THE WITNESS: Page 80 there is a note from the doctor indicating he "came in for routine refills. Done." I don't know what medications were prescribed, what the refills refer to. On the previous page, 79, it indicates medications at the start of the encounter. It may very well be that all of those medications were refilled, but I have no information to indicate that it was or was not.

THE MAGISTRATE: Thank you.

Q (By Mr. Paikos) If you could go to the medical record number 86 and 90 which is at Bates 23 and 24. What does that medical record 86 show for prescriptions?

A Oxycontin 80 milligrams, two tablets every four to six hours oral. Dispensed 240 tablets, no

refills. Start date of 4-12-2010, end date 7-7-2010. Below that are two additional prescriptions, the same prescriptions for Oxycontin. Start date of 5-11-2010 and 6-10-2010.

Q The next page, that is page 90, is the note from that same day which is at Bates 24?

A Both are dated 4-12-2010.

Q Is that note within the standard of care?

A No.

Q Why not?

A The history is (Patient A's name), excuse me, Patient A returns for a routine refill. I informed him that I shall be transferring his chronic pain management to pain specialists. I discussed his case with Dr. Shalnov, S H A L N O V, who has agreed to see him. He will see Dr. Shalnov at TCH as he has just moved to Cambridge. He may well benefit from shots in his back, etc. He agrees.

THE MAGISTRATE: TCH being what, do you know?

THE WITNESS: I don't.

A Once again under the History we would expect to

have a history of how the patient is doing. We don't know if the patient is doing well or doing poorly. There is no examination listed. There was no Impression in terms of what his impressions are about the patient at this point in time. We have a Plan in terms of transferring his chronic pain management, and that is within the standard of care as is the statement that he may well benefit from shots in his back, etc. There is no information in terms of medication that was prescribed.

We do have on the same date approved medications, approved prescriptions for Oxycontin, and the assumption would be that these are medications that were prescribed, but there is no specific indication of that.

I don't know from the notes whether there were other medications that were prescribed.

THE MAGISTRATE: Where do we see the prescriptions? Previous page, Bates stamp 23?

MR. PAIKOS: Medical record 86, I believe.

THE MAGISTRATE: Bates 23.

Q (By Mr. Paikos) Doctor, directing your attention

to medical record number 112, 113, 115 which is Bates 26, 27 and 28, if you can go there and tell us what this is a note of.

A How many pages are you directing me to?

Q 112 and 113 and 115. Under 112, where was this patient seen?

A Patient was seen at the emergency room. At the top of the page it says Whidden Hospital in Everett, Massachusetts. The History, patient is a 37-year-old male, presents to the ER complaining of constant moderate sharp pain in the head and the neck. Started acutely after he was in a motor vehicle accident. The patient was a restrained passenger and his car hit a guardrail. There is a detailed examination listed.

Q What about the patient's social history?

A Social history is history of drug abuse in the past. Denies any drug abuse at present.

Q The patient denies any current drug abuse, but is that significant for assessing the patient for risk of diversion or abuse of drugs?

A The history of drug abuse in the past would be a concern. That would be once again a red flag,

at least making me think about this, whether or not he needed to be concerned about a prescription for narcotic medication potentially for his medication that there would be a drug abuse as a possibility.

Q Now, Doctor, going to the medical record 15 which is Bates 2008, what is this part of?

A This is part of the emergency room record from Whidden Hospital from the same date as the previous notes that we were discussing.

Q Doctor, is this part of some sort of radiographic exam?

A It is a report of a CT of spine, CAT scan of the spine without contrast. There is also noted a CT of the head without contrast.

THE MAGISTRATE: The page again?

MR. PAIKOS: Bates 28.

Q Under Conclusions is where you are looking?

A Actually I was going back to the previous page that you had directed me to. That gives the note that this is a radiographic procedure, gives the date of 6-10-2010, but it's a CT of the C spine without contrast and the CT of the head without contrast.

THE MAGISTRATE: What kind of procedure did you say, Doctor?

THE WITNESS: CT scan, CAT scan.

THE MAGISTRATE: Before, you put an adjective and then a procedure.

THE WITNESS: Did I say "without contrast"?

THE MAGISTRATE: Between that.

THE WITNESS: CT scan of the cervical spine and CT of the head without contrast.

THE MAGISTRATE: I'll wait for the transcript. Thank you.

Q (By Mr. Paikos) Medical record 15 which is Bates 28 is there a conclusion of finding of that image?

A There is.

Q What is the finding?

A Vertebral bodies are at normal height. On the sagittal reformatted images linear lucency is seen at the junction of the lamina with the spinous process of C-5 on the left side. A corresponding abnormality is not evident on the axial images. If point tenderness cannot be elicited in this region, a spinous process

fracture cannot be definitely excluded. No prevertebral soft tissue swelling is seen. Images of the upper lungs are not diagnostic. Shall I continue with the Conclusion?

Q Yes, the Conclusion as well.

A Conclusion is linear lucency involving the spinous process of C-5 on the left as described. This could be artifactual. However, clinical correlation is suggested to exclude a lineal fracture.

Q What, if you can explain in more lay terms what is seen on this CT scan or suspected?

A This is a CT scan of the cervical spine, so it's a particular radiologic procedure of the upper portion of the spine. CT scan shows us images where there are slices through the spine itself. It shows us information about the anatomy of the spine. The spine is made up of a number of different anatomical portions. The vertebral body is the large body of the spine itself, and coming off the back of the spine is an area of bone called spinous process. There is a connection between the spinous process and the bone. If there could be for example, if there

is for example a fracture, you may see an area of abnormality between the spinous process and the vertebral body, and that can show up as a shadow or area of less than usual density and it would be referred to as an area of lucency. So lucency would be referred to as an area less dense than the surrounding bone, and that is frequently what a fracture shows.

Q So there is information there to suggest a possible fracture?

A Yes.

Q And there is nothing on the other side of the person's spine corresponding to that. Is that significant?

A (No response.)

MR. PAIKOS: I'll retract the question. I'm not sure I understand it myself.

Q (By Mr. Paikos) Let me go to the medical record number 134. That is at page Bates 29. Is there more information here about that would be important in assessing addiction risk or abuse of medication risk?

A Yes.

Q What is that?

A The middle of the page under Patient History, this is dated 6-15-2010. Under Medical it states past medical history, depression, IV drugs user.

THE MAGISTRATE: Where is that, IV drug user? I see it at the top. I do see that.

Q (By Mr. Paikos) Doctor, if you go to medical record 143 to 144, 30 and 31 of the Bates numbers, starting with 143 what does that show for the medication for Oxycontin?

A The date of the page is 7-1-2010. The middle of the page it states under approved Oxycontin 80 milligrams two tablets every four to six hours oral, dispense 240 tablets, zero refills, start date is 7-7-2010. And there are two additional prescriptions for the same medication, same amounts for August 6, 2010 and September 5, 2010.

THE MAGISTRATE: Do you remember my question to you about a previous prescription in which it appeared to be three prescriptions for Oxycontin all on the same date, all for the same dosage and same frequency, and I asked you and you said you did not know. Is there a reason

that you could speculate why that might be prescribed? Is there a legitimate reason?

THE WITNESS: On this particular prescription there are three months. On the previous prescription you asked me about, there was the same medication and it listed a start date as being the same start date for all three medications for all three prescriptions. It didn't make any sense to me. I don't know if it was a typo. It would seem quite unlikely that the same medication would have been prescribed to start three different prescriptions of the same medication to start on the same date, but I did not understand the information on the sheet.

THE MAGISTRATE: No possible explanation comes to mind, except the possibility of an error that you mentioned?

THE WITNESS: I guess the possibility has to be considered there were three different prescriptions for Oxycontin given to start on the same date.

THE MAGISTRATE: Why wouldn't they just be one prescription with multiple pills, increase the number of pills for that one

prescription?

THE WITNESS: That would be the usual course of events.

THE MAGISTRATE: Okay, thank you.

Q (By Mr. Paikos) On that same day, medical record 44, Bates 31, there is a note from Elaine Torres. What is this, what is the notice about?

A States he is not able to see another doctor and is running out of medication. His last visit was 4-12-2010. He was a no-show for Dr. Shalnov on 6-15-2010.

Further down near the bottom of the page, second paragraph from the bottom, calls today. Patient called today stated that he is not going to be able to see another doctor; therefore, he wants to talk to Dr. Bharani about that as soon as possible. Patient needs to know if he should come in because he is running out of the medication.

Q Go to medical record 148, 150 and 151. Are those from a July 7 encounter, 2010, at Bates 32, 33 and 34?

A 148 through 151?

Q 148, 150 and 151.

A I have the pages, and the dates are 7-7-2010.
Q And the History on 168 has the depression and IV drug user on that day?
A Yes.
Q If you go to page 151, I ask you review that note.
A This is a note from doctor dated 7-7-2010.
Q Is this within the standard of care?
A No.
Q Why not?
A History is listed. Patient A states he was in friend Steve's car after Steve had his teeth pulled at MGH, and Steve was driving and looking at papers at same time and eventually totaled the car on guardrail. Patient A was seen in our ER and there may be a faint spinous process fracture, but he was deemed to be stable and allowed home without a collar. His neck is of course killing him now in addition to his back. No radiculopathy or myelopathy on exam of his arms. At his last visit I hold him I would no longer be filling any medicines for back pain. He still has not seen a pain specialist and claims he has an appointment with Dr. Ronald

Boney, B O N E Y, on October 21. He agrees that today's prescriptions are my last.

The History is within the standard of care. He relates the history of his accident, history of him having additional pain in his neck and his back. The examination states no radiculopathy or myelopathy on exam in his arms. That is below the standard of care. I don't know what the rest of the exam showed. I don't know what his neck showed, what his back showed. I understand what he is talking about when he said no radiculopathy or myelopathy, but I don't know how he showed that that was not the case. I don't know what the neurological examination showed. I would need to know the details, and the usual practice would be to list the details telling you about what the patient did or did not have on examination.

The Impression, there is really no Impression at all. We don't know what his impressions are about the spinous, possible spinous process fracture. The patient may have a fracture or it may not be anything significant, but we don't know that. And here

we have a patient telling us he is having very bad pain in his neck, has a possible fracture in his neck, but there is no information about any impression, no impression about any plan for further evaluation, nothing a simple repeat CT scan or X ray, no follow-up studies. There is no information. There is no information about any further follow-up for him in terms of his neck problem, in terms of a possible fracture.

He does state he is going to give him prescriptions only for that date and no further prescriptions, and we don't know what the prescriptions are. There is no specific information given. He does not talk about concerns about abuse. A patient who did not keep his referral to a pain center, we have very little information. It is below the standard of care.

Q What could be wrong with the patient relative to his neck?

A He may have a fracture.

Q What could that result in?

A Potentially it could result in an instability in his neck. It could lead to a more serious

fracture if there is further instability in the neck. Could be anything from worsening of his pain, compression of the nerve root or even spinal cord compression.

Q Is the fact that the ER, according to this, let him leave with a collar, is that significant in Dr. Padmanabhan's assessment? Does that change the way he should have acted?

A He was deemed to be stable and allowed home without a collar. That indicates that the doctor in the emergency room did not prescribe a collar. We know nothing else except that.

Q There was the mention we talked about pain clinic, I'm not sure -- Pain specialist. What are those, clinics and specialist?

A Pain specialist would be a doctor who has a particular specialty in taking care of patients who have acute pain and more likely and more commonly with chronic pain. These would be doctors who have specialized training, oftentimes Board certified in taking care of patients with chronic pain. It is an extremely complex and difficult area, and these are doctors who with their backgrounds have learned

about taking care of patients with chronic pain, knowing how to evaluate and what types of people they need to work with, include the types of health professionals and who know a great deal about prescribing medications for pain including narcotics.

Q There is a note from August 11, medical record number 154 Bates 35, from Tina Williams. Do you see that, Doctor?

A Yes.

Q Dr. Bharani states no more Oxycontin for this patient from him. Is that within the standard of care?

A Yes.

Q Why?

A He had previously stated that there was, he was giving the patient his last prescription which was July 10 -- Excuse me, July 7. And he is now reiterating this was his last prescription, that he will not prescribe additional Oxycontin for this patient, and that is within the standard of care.

Q If you go to medical record 160, Bates 37, what does that appear to show on October 1?

A Again date is October 1, 2010. It lists medications at the start of encounter. Oxycontin 80 milligrams, two tablets every four to six hours, dispense 240 tablets, no refills and states start 10-1-2010. Underneath that, the same Oxycontin prescription. Start date is 10-31-2010. Underneath that, another prescription for Oxycontin, same prescription as previously noted, start date of November 30, 2010.

Below that in addition is a prescription for Adderall, Gabapentin, clonidine, Seroquel, Xanax and Baclofen.

Q If you go to medical record 161, Bates 38, that is another note from October 1, 2010 from Tina Williams. Called Dr. Jorgensen's office --

THE MAGISTRATE: Mr. Paikos, ask your question about the page.

Q (By Mr. Paikos) If you could read those in conjunction with the next note at 171, Bates 39, also October 1.

A This is a note from October 1, 2010 from, signed by Tina Williams. Called Dr. Jorgensen, J O R G E N S E N, office to set up appointment.

THE MAGISTRATE: I see what it says. Could you interpret it as it relates to other pages as well.

A I don't know anything more than what is written here. Just states he called Dr. Jorgensen's office to set up an appointment. Doesn't tell me who he is, what his specialty is.

Q Go to the next medical record, 171, Bates 39. Is there a note from Dr. Padmanabhan?

A Yes.

Q What is that note about?

A Patient A comes in for his Oxycontin refill. He has had a severe back pain since fall off a roof years ago and has been stable on this dose for many years. I have asked him to see Dr. Andrew Jorgensen at Everett Family Health Center as CHA Neurology is not supposed to manage chronic pain any more. Meds written for three months to tide over the transition. All discussed fully. Patient is in agreement.

Below that is a note from Marianne Richard, RN, from the same date. Complains of pain 8/10, cervical and lower back pain.

Q Doctor, is that within the standard of care?

A No.
Q Why not?
A Under the Subjective we have no information about his present state of pain other than he has had severe back pain since falling off the roof years ago and he is on a stable dose of Oxycontin for many years. There is no reference to any specific symptoms. There is no information about the back pain, about his neck pain, no reference to his previous severe neck pain that the patient had previously, no reference to the question of there being a cervical fracture.

No information about how he is doing with his medication. Don't know anything about the Oxycontin, don't know if he is having side effects from other medications. The previous page that we looked at indicated that the patient may be taking many different medications, although we don't know that. There is no record about that.

Under Objective under Examination there was no examination, so we don't know how the patient is doing. Is the examination normal, is

there an indication of a severe neck problem, is he doing better, is he doing worse, does he have any abnormalities on the exam.

In terms of Impression, the only impression is that there really is no Impression at all, which is below the standard of care.

In terms of Plan, he does give a reasonable plan in terms of referring him to Dr. Jorgensen and indicates meds were written for three months to tide over the transition, a bit of a surprise given the previous notes that we saw concerning prescribing medication.

THE MAGISTRATE: What is the surprise?

THE WITNESS: The previous note indicated he is not going to prescribe any further narcotics, and here we have an indication that meds were written for three months. He does not state which meds were written. The presumption would be that it is Oxycontin, although certainly could have been many other medications that were prescribed on that date given the list of medications that we have. But there is nothing listed here and we don't know what medications were prescribed and probably the

pills, how many pills and refills.
Q Go to the medical record 182 to 184. On 182 which is Bates 41 is this an ER record?
A Yes.
Q Why is the patient being brought in at this time?
A The record indicates that as of the date of the visit, 11-2-2010, all history is obtained from EMS, family members, others as the patient is unable to give a history due to unconsciousness. The patient, states here that the patient reports sustained sudden loss of consciousness an hour prior to arrival. History obtained from the police officers and medics states that the --
THE MAGISTRATE: I'm going to interrupt you. I have it in front of me, I see it substantively. I'm more interested in your commentary and interpretation of it as it relates to other documents. You can highlight what is there for me, but I do have it in front of me.
MR. PAIKOS: If I could change the question.

Q (By Mr. Paikos) What happened to this patient according to the emergency room?
A He was driving with friends, they pulled into a driveway and they could not arouse him. He was in the back seat. Rescue appears to have been called. He was anoxic, not breathing at the time.
THE MAGISTRATE: "Anoxic" means what?
THE WITNESS: There was lack of oxygen to the brain. Presumably that refers to his not breathing. When the paramedics came, perhaps I could translate this, he did not have a heart beat, was not breathing, he was intubated. Brought to the hospital to the emergency room. He had no pulse, he was not breathing, they attempted CPR, CPR failed, and the patient was pronounced dead at 8:19 p.m.
Q Is there a reason, presumed reason for the death?
A Yes.
Q Is that on 184, Diagnoses?
A Yes.
Q What are those?
A Number 1, cardiac arrest; 2 acidosis; 3 likely

opiate overdose.

Q We'll move to the next patient, Patient B.

THE MAGISTRATE: Before you do that, I want to do some housekeeping matters if I could.

Doctor, for tomorrow you will have your own copy of the exhibits that I have admitted. Mr. Paikos had been kind enough to let you look at his, but you have your own copy. You will be using the numbers as you submitted them. You submitted them and I accepted those exhibits, and they are marked for a reason.

If you have other exhibits for me, I can't commit to admitting them, but I will look at them. You have to submit them to Mr. Paikos, you have to submit them to me. They will use the respondent's exhibit numbers that I have already used, so they will start with respondent's Exhibit 13. You have respondent's Exhibit 11 which I did not accept, but -- I'm sorry, we'll start with respondent's Exhibit 13 because you put on your list of exhibits Respondent's Motions to Dismiss.

Let me ask you, Doctor, is that what you want, Exhibit 12, the motion to dismiss?

DR. PADMANABHAN: I think I misunderstood what you said at the prehearing conference about bringing them in which is why I organized that list that way because I went by what I remembered what you said. I would have been more than happy to produce this binder before January 5. I had everything ready already, but because of what you said, I think I was misled by myself. I'm not blaming you.

Following Exhibit 13, in Exhibit 13 according to that list I would be happy to bring in all the exhibits that I already presented at the prehearing.

THE MAGISTRATE: Now that I am looking at your exhibit list dated January 2, 2015, I think I understand, so let me ask. You are proposing as Exhibit 12 your motion to dismiss?

DR. PADMANABHAN: And related exhibits.

THE MAGISTRATE: How many exhibits does it have attached to it? Because I don't have that in front of me.

DR. PADMANABHAN: Seven. The original motion to dismiss had 26 exhibits attached to it, but I will not be introducing all of them.

THE MAGISTRATE: That answers one of my questions. So instead of introducing as Exhibit 12 and all attached exhibits, why don't you get a copy to me tomorrow, and Mr. Paikos, of all additional exhibits that were originally attached to your motion to dismiss that you proposed as exhibits. We will start with respondent's Exhibit 13. I can't guarantee that I will rule on it tomorrow, and I can't guarantee is that I'm going to admit them.

My larger goal in this hearing, and that is the ground for a lot of my rulings, is to keep this hearing going, to take evidence, we have witnesses here and witnesses lined up, rather than going through procedural matters and motions.

Two other procedural matters before we resume testimony: For the record, Mr. Paikos, please identify who is with you from the Board of Registration in Medicine.

MR. PAIKOS: Loretta Cooke.

THE MAGISTRATE: Doctor, I need to know the name of your social friend who was with you.

DR. PADMANABHAN: Doug Kinan.

THE MAGISTRATE: Could you spell his name.

DR. PADMANABHAN: D O U G K I N A N.

THE MAGISTRATE: K I N A N?

DR. PADMANABHAN: K I N A N.

THE MAGISTRATE: Thank you. With that we will take a break. Let's all take, will five minutes be enough?

MR. PAIKOS: I think so.

[Recess]

THE MAGISTRATE: We're back on the record. Dr. Levin is still under oath.

Q (By Mr. Paikos) Doctor, you have in front of you the record for Patient B?

A Yes.

Q And did you review those records?

A Yes.

Q If you go to medical record number 9 and 10 which is Bates 53 for Patient B, would you review those two pages.

A (The witness complies)

Q Page 10 shows the history how the patient received his injury at work?

A Yes.

Q What is the doctor's Impressions for this patient?
A I don't know. Excuse me. There is no specific Impression listed. At the bottom of the page there is a note as a primarily encounter diagnosis of radiculopathy, so perhaps that is an Impression. Underneath that it states comment, unchanged.
Q What is the Plan?
A Refill written.
Q Directing your attention to the December 16 note, medical record pages 16, 20 and 21 which is Bates 55, 56 and 57, if you would just review those pages.
A What were the pages?
Q We'll do it one page at a time. Page 16 with an encounters date of December 16, 2009. What does that show for medications at the start of the encounter?
A Medications at the start of the encounter, Oxycontin with specifics listed, oxycodone with specifics listed, and Xanax with specifics listed.
Q And the medical record on page 20, is that a

note by Dr. Padmanabhan which is Bates 56?
A Yes.
Q What does that note indicate?
A This is dated 12-19-2009. Did not go to the ER after hurting his face. Neck and back still visibly hurting. In for refills. Review of systems. No fevers or weight loss, no headache, no dyspnea or chest pain, no abdominal pain, no sadness or anxiety that interferes with daily activities. Exam unchanged.
Q Medical record page 21 Bates 57 is a note from a nurse with some information from that same day?
A Yes, there is additional information from the doctor above that as well.
Q What is that additional information from Dr. Padmanabhan?
A AP, Assessment Plan, is radiculopathy. It states under that, counsel 30 minutes, and there is a note from Linda R E P P U C C I, RN, from the same date, 12-16-2009. Tripped and fell.
THE MAGISTRATE: I see that. Thank you.
Q (By Mr. Paikos) Is Dr. Padmanabhan's note within the standard of care?
A No.

Q Why not?
A There is very limited history, no details in terms of what is happening with the patient. We don't know anything about his medication, his response to the medications. The only note for the examination is exam unchanged. That is an inadequate examination. The Assessment and Plan are radiculopathy, so there was no information in terms of how the patient is doing, was he doing better, worse, are the medications helping him. And there is no information about what prescriptions were given to this patient.
Q Page 16 of the medical record numbers Bates -- Well, let me ask you this: From the prior note how long had passed which is at medical record 9 and 10?
A Previous note was 12-8-2009; this note was 12-16-2009.
Q And the medications prescribed, did it say for what period of time?
A I'm sorry, I didn't understand the question.
Q On page medical record 9 does it say how much was prescribed at that time on 12-8?
A The indications are a bit confusing. States

medications at start of encounter, and it does list start for different medications. Would you repeat the question?

Q That was essentially it. And there had been eight days between that exam and the next one on the 16th of December, correct?

A Yes.

THE MAGISTRATE: Medications at start of encounter means the medications that the patient reports being on when the appointment starts?

THE WITNESS: I would assume so. I don't know for sure, but I would assume that would be the case.

THE MAGISTRATE: When you say something is confusing, what is it that is confusing?

THE WITNESS: They seem to be combining both the medications that the patient was taking when he arrived for the encounter and the medications that are being prescribed for the patient, but there is a mixture there. If you look for example on page 9, it states this is an encounter date of 12-8 and they list medication at the start of the encounter, there are a number of medications listed, and the start date

for different medications. There is one date on the top, excuse me, one medicine at the top, oxycodone start date is 12-8. The assumption would be that that was given on that date. Oxycontin again number 90, no refills. Start date is 12-8, so the assumption for me would be that the medications were also prescribed on that date. The other medicines, Xanax, lisinopril and the other prescriptions for oxycodone are different dates, near dates that are predating that particular encounter date, suggesting to me those had previously been prescribed.

THE MAGISTRATE: Thank you.

Q (By Mr. Paikos) Directing your attention to medical record 27, Bates 59, that is a December 31, 2009 encounter date. Are you at that page 27 of the medical record?

A Yes.

Q Is that note within the standard of care?

A No.

Q Why not?

A Note dated 12-31-2009. That's the date it was signed. Meds refilled. All stable. That is

listed as being a Progress Note.
Q Why is that not within the standard of care as a Progress Note?
A We would expect as previously discussed there to be a History; Subjective, to be an examination; for there to be an Impression. There is none of that information. Under Plan all we have is meds refilled, all stable. So perhaps relating to an Impression. But that would be an inadequate Impression according to the standard of care. Meds refilled, there was no information about what medications were refilled or any details about those medicines.
Q Doctor, if you could go to medical record 32 and 37 and read those together at Bates 61 and 62.
A I have reviewed them.
Q Is the note at medical record 37 Bates 62 within the standard of care?
A No.
Q Why not?
A The history as related is an inadequate history. There are some details, but it does not tell us very much about how the patient is doing. The examination is listed as being unchanged

neurologically. He moves very slowly now, and this is an inadequate neurological examination given the patient's continued problems as well as his acute problems relating to his fall and breaking his teeth.

The Assessment is radiculopathy. There is no mention in the Assessment which is also the same as the Impression about his falling and breaking his teeth. He is miserable, but we don't know why he is miserable. I have no idea what his medical problem was related to breaking his teeth. I don't know if it was related to an additional injury, did he have an additional injury, are we talking about something specifically to his teeth. There is inadequate information here.

In terms of the Plan, I have given him prescription for Plaquenil. I don't know why Plaquenil was prescribed. There is no indication why it was bring prescribed, how much is being prescribed, how is it taken, how many refills if any. Oxycodone, likewise.

THE MAGISTRATE: What would you expect Plaquenil to be prescribed for?

THE WITNESS: In this particular patient or in general?

THE MAGISTRATE: In general.

THE WITNESS: It is prescribed for rheumatological disorders, rheumatoid arthritis and related disorders.

THE MAGISTRATE: Any reason why this patient, from the record?

THE WITNESS: Not that I could see.

Q (By Mr. Paikos) Doctor, we were talking about that date, and there was a note for medical record 32, page 61. Is Xanax listed on there?

A Xanax is listed at the top of the page.

Q Under medications at start of the encounters?

A Yes, medications at the start of the encounter, and the start date of the medication is listed as 12-16-2009.

Q Doctor, if we go to medical record number 39, 40 and 41 which is Bates 63, 64 and 65. That is a note from an encounter date of 12-8-2010?

A Yes.

Q If you start at the, go to the medical record 40, Bates 64, is there a note at the bottom regarding seeking refills for Xanax from Elaine

Torres?
A There is no indication that I can see in the note regarding seeking refills.
Q At medical record 40 at the bottom of the page?
A Yes.
Q Does it say Xanax and number 20 with refills?
A Xanax 2 milligrams one tab four times a day if needed, 120 with four refills per Dr. Padmanabhan.
Q What does that mean, "with four refills," on a prescription?
A There is a one-month supply of the medication, 120 pills, and it can be filled four more times for a total of five months' supply.
Q If you go to the next page, page 41 of the medical records, Bates 65, is there a note by Dr. Padmanabhan there?
A Not that I can see.
Q Is there a note about issues that the patient had with the pharmacy at the bottom by Ms. Torres?
A There is a note, patient states he was given a different prescription for his visit today. When he got home, he realized he had no more

refills on his Xanax and would like a refill on that.

Q Does it appear that the prescription was actually written on that day?

A I don't know. Looking at the, again medications at start of encounter on page 39, that's, the date is February 8, 2010, Xanax is listed as one of the medications at the start of the encounter and the date is 12-16-2009. What is confusing to me is at the bottom it lists the ordered medications, and that is not one of the ordered medications in that particular page. That being said, on the next page, page 40, Nurse Elaine Torres indicates what the specific prescription is and that Dr. Bharani called this into the pharmacy.

Q Was it within the standard of care, was there any issues with Dr. Padmanabhan's prescribing to the patient at this point?

A I think there are a number of issues, perhaps. One is that we don't know why the medication was being prescribed. We're talking specifically about Xanax?

Q Yes.

A We don't know why the medication is bring prescribed and there is no indication on this why it is being given. This is really quite a large dose of Xanax. He is given 8 milligrams a day which is quite a significant dose, not certainly a dose that would be unheard of, but a dose that would cause you to pay attention certainly on a chronic basis. And this was being prescribed as a five-month refill, again with no clinical information to indicate why the medication was being prescribed.

Q Is the lack of clinical information a violation of the standard of care?

A It's below the standard of care.

Q Any issues relative to the patient and the having issues with the pharmacy?

A (No response.)

Q We talked earlier about red flags. Is this a potential red flag?

A Yes.

Q Why?

A That's confusing. Any time there is a confusing note between, from a patient regarding medication, regarding a pharmacy, especially

when it is an abusable medication, that would be for, I should say an abusable medication, that would be a red flag making you at least pay attention. Is there a concern about this patient abusing the medicine, could he be doing something else with it besides taking it as prescribed.

Q Doctor, what is Xanax?

A Xanax is an antianxiety medication.

Q Does it fall, is it a benzodiazepine, an opioid?

A It is a benzodiazepine. I have one further comment previously. To the best of my knowledge generally Xanax cannot be called in as a prescription because it's a controlled substance. You have to give the patient a written prescription for that. I may be wrong, I may be wrong on that. But it is a benzodiazepine.

THE MAGISTRATE: What do you know about Xanax's potential abuse by patients?

THE WITNESS: It has a significant abuse potential.

THE MAGISTRATE: What are its effects? Why would a patient abuse it?

THE WITNESS: I can't speak to why a patient would take a medicine to abuse it. It is an antianxiety medication, has a sedation effect. In terms of its use as an abusable medication, I couldn't comment on that.

THE MAGISTRATE: Thank you.

Q (By Mr. Paikos) Going to April 7, 2010, medical record number 67, Bates 68?

A 67?

Q 67. -- there was a note by Ms. Torres about the patient not having an MRI done and it's not the first time. And there was a script for lorazepam --

THE MAGISTRATE: Mr. Paikos, if you could ask questions about the document.

Q Is this a potential red flag?

A Yes.

Q Why?

A An MRI was ordered. He, Elaine Torres, the nurse, indicates that Shield, S H I E L D, MRI called to inform us that he would not have the MRI done. This is not the first time he has been a no-show according to them. He gave him a prescription for lorazepam 1 milligram two

tablets to have the testing, not a very large dose of medication. It is potentially abusable medication, although certainly this is a very small dose and it would be a red flag.

Q Going to --

THE MAGISTRATE: Why a red flag?

THE WITNESS: When a patient doesn't show up for a test, that would make you concerned. Especially somebody who is having chronic pain you would expect would be quite concerned about what is going on. We don't know what type of MRI, a neck or back MRI; but assuming he had symptoms relating to those areas, you would expect that the patient would very much want to know what was going on and want to work with the doctor to try to get better.

In addition a prescription was given, very small amount of medication but a potentially abusable medication as well. Lorazepam is the same as Xanax, I believe.

THE MAGISTRATE: Is the concern that the patient may not have pain, or is the concern that the patient is not amendable to compliance with the doctor's orders?

THE WITNESS: The latter.

THE MAGISTRATE: Thank you.

Q (By Mr. Paikos) Medical record 76 and 81 which is Bates 70 and 71, April 21 encounter, if you could review the medications on 76, medical record 76 and Dr. Padmanabhan's note on 81.

A Just for clarification of the dates, the doctor's note is listed as 4-22-2010, but it does state it was signed on that date. I'm going to assume, if I may, it was a note from 4-21-2010?

Q Let me ask you, is there an encounter date of 4-21-2010 at the top of the page?

A There is.

Q Do you know if electronic medical records get signed and can be signed on a different time than it is actually entered, if you know?

A I'm sorry, I don't understand the question.

Q Okay. Let me focus on the record itself, Dr. Padmanabhan's note signed April 21, 2010 on medical record 81, Bates 71. Is that within the standard of care?

A No.

Q Why not?

A The history has been yet another car accident, poor sleep past few days, neck pain increased very slow. For the first time got lost on his way to the clinic. Informed Patient B I am transferring his care.

THE MAGISTRATE: I see that. If you could provide commentary on it in relation to other documents, that would be helpful.

A The history that is related is inadequate, less than the standard of care, below the standard of care. I would expect more information. There is no examination listed, there is no neurological examination.

In terms of the Impression, there basically is no impression. Plan is that he is being transferred to another doctor for chronic pain management, given two months' supply to tide him over. We don't know why the patient is transferred to another doctor or what the patient's clinical diagnoses are. We don't know what the concerns are. Has he had problems related to the car accident. Again there is no examination. Is he doing just fine or is he doing badly. We don't know what medications

were prescribed.

THE MAGISTRATE: If I can jump in with another question, two months' supply to tide him over, is that reasonable or within the standard of care?

THE WITNESS: I don't know what the medicine was. It would depend which medicines we are talking about. If we are talking about Oxycontin or oxycodone, about narcotics, I would not consider that to be within the standard of care. That being said, I am not a pain specialist.

THE MAGISTRATE: Thank you.

Q (By Mr. Paikos) Medical record 86, Bates 72, there is an issue with the patient not wanting to speak with -- Well, if you could look at 86 in conjunction with medical record 93 which are Bates 72 and 73.

A I reviewed those.

Q Is Dr. Padmanabhan's care on that day within the standard of care?

A No.

Q Why not?

A The history does provide us information. It

doesn't tell me as much as I would like to know, as I think we need to know in terms of assessing what the patient's present status is. We know no information about how this relates to his previous problems.

Patient is presenting now with an acute problem. He has a new symptom, he has a pain problem at the base of neck going into the scapula curving around to the axilla to the right chest, leaves him breathless at times. There is no examination.

The prescription possibly could relate to an acute or possibly severe medical problem, either a neurologic problem or some other type of medical problem, but we don't know that. We don't know whether he is fine or very ill. We don't know anything because there is no examination.

There was no Impression about this. We don't know what his thoughts were about this in any way at all. And there is no plan for further evaluation, there is no plan for chest X ray, no plan for follow-up on this. We don't have any information at all. There is no

information about whether or not medications were prescribed.

Q Medical record 112 at Bates 74, if you could read the note there regarding that visit regarding Dr. Padmanabhan.

A Note indicates that the patient is supposed to be seen at the Norwood Pain Center, but he canceled because there was no PCP referral and he has not seen a PCP for three years. The patient came in to get assurance --

THE MAGISTRATE: Dr. Levin, give us your interpretation of that in relation to other documents.

A Patient was quite concerned that his pain medication would not be stopped until he got a PCP and referral, and the doctor agreed this would be done as soon as possible.

The concern I would have again is in terms of the red flag. This is a patient who is referred to a pain center who I would assume would know something about the referral. Or perhaps the patient does not know that, perhaps it was something innocent on his part. I would have expected there would have been at least

something done on the part of the referral office to know if such a referral is required or the PCP referral is required. There are a lot of things here that I don't know. But again just seems odd when there is something odd with the patient, particularly a patient who is taking chronic narcotics. That would be another red flag.

THE MAGISTRATE: What else don't you know by looking at page 112 in front of you, Bates 74?

THE WITNESS: I don't know anything about the patient. I have no idea how he is doing, I don't know if his chronic problems are worse, better, I don't know what his chronic problems are, what has happened in terms of the problem that I described with radiating of the pain to the scapula, to his axilla. I have no information whether this is a serious medical problem or one that has resolved. I don't know what his examination was or what his pain medications are or other medicines. I have no idea what is bring prescribed, I have no idea what the doses are, nothing.

THE MAGISTRATE: How does this document encounter date of May 19, 2010 relate to the standard of care?

THE WITNESS: This would be below the standard of care.

THE MAGISTRATE: Thank you.

Q (By Mr. Paikos) Medical record 137 which is Bates 79. Medical record 137, Bates 79. Is this a note about a canceled appointment?

A Yes.

Q Is that a potential red flag?

A Yes.

Q Was that to the pain clinic?

A Yes.

Q If we go to page 142 --

A May I further comment on it because I think it is perhaps a concern?

Q Yes.

A Looking at the note, there wasn't just a question of a canceled appointment, he went for his appointment and the nurse saw him, took his vital signs, got information from him and he walked out, he just didn't wait to see them. He wanted to see a different doctor. He booked him

to see a different doctor in Fall River and they called and said he was canceling it, he was having a heart attack, and he was told to go to Norwood Hospital. This is a very strange note and would certainly be a great concern of something going on, perhaps drug use.

Q And this was a June 29, 2010 note. If we go to July 9, 2010, does it appear that Dr. Padmanabhan continues to prescribe for this patient?

A Yes.

Q If we could turn to Patient C. If you go to medical record 3, Bates 81. How do you assess Dr. Padmanabhan's note from that medical record number 3, 4 and 5 which is Bates 81, 82 and 83?

A This note is within the standard of care.

Q And back on medical record 3, Bates 81, this shows that he was a previous patient of Dr. Padmanabhan's?

A Yes.

Q What kind of injury did he have?

A A root stretch injury.

Q What is that?

A "Root" refers to a nerve root. The nerve roots

are the anatomical area in the body that come out of the spinal cord. So there are nerve roots that come to the arms, nerve roots that come to the legs. Does not indicate this related to the arms or the legs. I don't know if this is a cervical injury or a lumbar injury.

Q Doctor, if you can go to the medical record 89, Bates 96. We saw the first note that you just read was from June 16, 2009 and this is one from November 14, 2007.

A I believe the previous note was July 19, 2007.

Q You are probably correct. Yes.

A Which page?

Q That was a 2007 note, I apologize, that we were just discussing at Bates 81, 82 and 83, July 19, 2007. And if you go to medical record 89, Bates 96, November 14, 2007 note, what kind of note is that? Says it's a telephone consultation form.

A Yes.

Q And does that have any -- It shows the client complaint, do you see that, and prescriptions. Is there clinical information for these prescriptions being prescribed?

A The only clinical information I see is which

medications are being requested, Oxycontin and Percocet, and that patient is going away.

THE MAGISTRATE: Five minutes, if you can plan accordingly.

Q Is that within the standard of care?

A Assuming this is a Progress Note relating to a patient encounter, it is not.

THE MAGISTRATE: Why not?

THE WITNESS: There is no history to tell us anything about the patient, what his pain problem is, indeed any of his problems. There is no examination, no neurological examination, no assessment, no impression to tell us anything about the patient and putting why medicines are being prescribed. There is information about what the patient is concerned about, but we don't know what was actually prescribed. So we have no details about the medicines that were prescribed including amounts or refills.

THE MAGISTRATE: This your page 40, Bates 86, is that what we are talking about?

MR. PAIKOS: Medical record 89 Bates 96.

Q And that was the note that you were discussing on November 14, 2007, correct?

A Yes.

MR. PAIKOS: This might be a good time to stop. I would be moving to another note within this.

THE MAGISTRATE: Okay. Anything procedural in the last couple of minutes?

(No response)

THE MAGISTRATE: With that we'll end for today, and I thank the parties and the witness Ms. Cooke and we'll resume tomorrow morning at ten o'clock.

* * * *

C E R T I F I C A T E

I, Carole M. Wallace, Certified Shorthand Reporter, do hereby certify that the foregoing transcript is a true and accurate record of my stenographic notes taken to the best of my skill and ability on January 12, 2015.

Carole M. Wallace, CSR