In The Matter Of:

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

Bharanidharan Padmanabhan, M.D.
January 13, 2015

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Page 125

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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 Commission
One Ashburton Place - Room 503
Boston, Massachusetts 02108
Tuesday, January 13, 2015
10:01 a.m. - 4:06 p.m.

Reporter: Carole M. Wallace, CSR

Page 126

APPEARANCES:

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ALSO PRESENT:
Loretta Cooke, Nurse Investigator

Page 127

I N D E X

NO EXHIBITS WERE MARKED ON THIS HEARING DATE

Page 128

THE MAGISTRATE: Good morning. Today is January 13, 2015. We are at the Civil Service Commission, One Ashburton Place, Boston, Massachusetts. This is a hearing before the Division of Administrative Law Appeals. This appeal has been assigned Docket No. RM-14-363. The hearing is held under the provisions of General Laws Chapter 112 Section 5 and 243 CMR 1.03. The petitioner is the Board of Registration in Medicine and the respondent is Bharanidharan Padmanabhan MD. I am Administrative Magistrate Kenneth Bresler. James Paikos, Esq. represents the petitioner. The doctor represents himself. The parties' representatives are present and have previously filed their notices of appearance.

I am going to read 801 CMR 1.01 10(d) 1 again. "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."

Page 129

There is a sentence I did not read yesterday. "Appropriate action may include refusal to allow a disruptive person to remain in the hearing room and if such a person is a party, to allow participation by representative only."

I excluded Mr. Kinan yesterday because he was being disruptive by passing notes no Dr. Padmanabhan, constantly whispering in his ear, reading a newspaper in the hearing room, and quibbling with me that what he was reading was not in fact a newspaper. I do not have a courtroom clerk to receive motions and docket them; I do not have a court officer to tell spectators to remain seated -- to be quiet and not to read newspapers. Actually, to remain seated as well.

So, Dr. Padmanabhan, anybody who shows up here at your invitation or your support, you will convey to them they are to act with proper decorum.

DR. PADMANABHAN: Yes.

THE MAGISTRATE: Is there anything else before we resume the testimony?

Page 130

DR. PADMANABHAN: Yes, you said you would look at the exhibits. I reorganized them according to the numbers.

THE MAGISTRATE: Can you give them to me?

DR. PADMANABHAN: Yes, sir. I have made multiple copies.

THE MAGISTRATE: If I remember correctly, I did not say I would look at them, I said I would find time to look at them. But you did not comply with my order, and we're not stopping to look at the exhibits now, we are going to do evidence.

DR. PADMANABHAN: I was under the impression yesterday when we left that --

THE MAGISTRATE: If you were under the impression, I will look at the documents. I am not committing to admitting them, I am committing to running a hearing and making sure that the evidence comes in.

DR. PADMANABHAN: My defense is predicated on the entrance of these exhibits, and I admitted them --

THE MAGISTRATE: Okay. Doctor, --

DR. PADMANABHAN: -- previously.

Page 131

THE MAGISTRATE: Doctor, we can't go through this forever. At the prehearing conference I told you specifically submitting the exhibits then does not count as submitting the exhibits for the hearing.

DR. PADMANABHAN: I'm --

THE MAGISTRATE: Doctor, I'm talking. I also gave you an order saying get me the exhibits by January 5. Your defense has not started yet. I will try to find time to look at your proposed exhibits. I don't know if you are disobeying my orders on purpose, I don't know if you are not capable of listening to me and obeying the orders.

DR. PADMANABHAN: May I speak?

THE MAGISTRATE: Yes.

DR. PADMANABHAN: I think it was a simple misunderstanding, sir.

THE MAGISTRATE: If it was the only misunderstanding, I wouldn't have made that comment.

DR. PADMANABHAN: Cost is also an issue. The government was able to send that whole binder by overnight express, I'm unable to

Page 132

respond in kind, so I sent in the exhibits --

THE MAGISTRATE: I don't think that cost has anything to do with you listening to me and complying with, getting me exhibits by January 5, so I'm going to take testimony now.

DR. PADMANABHAN: I also -- Sorry to interrupt. I also mentioned a motion that I wanted to produce yesterday. You said you would look at it today.

THE MAGISTRATE: I did not say I would look at it today. I asked you to get it to DALA to be docketed. I don't have a courtroom clerk, and it needs to be docketed to keep the record complete. I said I would look at it when I had time because I have to keep the evidentiary hearing going. This is not a motions hearing. Your motions are not going to delay this. I will look at the motions when appropriate. I gave you an opportunity for a motions hearing last Friday. You did not accept it.

Are we ready to proceed?

MR. PAIKOS: Yes. Dr. Levin was sworn yesterday, I believe he should still be under oath.

Page 133

THE MAGISTRATE: Dr. Levin, you are still under oath.
THE WITNESS: Yes.
THE MAGISTRATE: You may proceed.
BARRY LEVIN, MD, RESUMED
CONTINUED DIRECT EXAMINATION BY MR. PAIKOS
Q. Directing your attention to Bates 93, medical record 74, a medical record for Patient C, tab 4. After you have had a chance to look at that note, would you please assess whether it is within the standard of care.
A. I have reviewed the note, and it is not within the standard of care.
Q. And why?
A. This is a patient who has a chronic pain problem. There is limited information under the History. She feels happy but the pain has worsened. We don't know how the pain has worsened or where the pain is or really anything about the pain or his reaction to his pain medications.
The examination is listed as being stable which would be inadequate given the needs for this particular patient. The Plan is to change

Page 134

Oxycontin to 80 milligrams q.i.d., decrease oxycodone to zero. It is unclear specifically why that change was made. We don't know how much medication was prescribed or if there were refills or not.
Q. Is there anything that the standard of care would have required relative to why the patient is in pain?
A. Yes. Although there is information here about that, we do have that information. There is he is working making braces for I believe the word is scoliosis, 23 a day, so that would provide some information why his pain is worse.
Q. Do we know if it's related to the cervical radiculopathy or not, or a new injury?
A. There is no information about where the pain is, we don't know if it is a cervical radiculopathy or lumbar or where the pain is.
Q. Is there -- Doctor, directing your attention to another page in that same tab medical record 82, Bates 94.
A. I have reviewed the page.
Q. Does this raise a possible red flag and if so, why?

Page 135

A. This does raise a possible red flag. It's a call from the patient indicating that there is a problem with medication, and specifically it's a problem with opioids. There was some difficulty in getting this filled. Apparently the prescription was not given to the pharmacist prior to the 30-day regulated period. He is now requesting additional prescriptions for oxycodone and Oxycontin. Any time somebody with opioid prescriptions is doing something that is irregular, that would be a red flag or potential red flag. Generally with, I don't know if this patient had a pain contract, but pain contracts would typically be obtained in a patient like this who is on chronic opioids, and in pain contracts there is generally a provision that patients have to fill their prescriptions, nothing unusual can be done to obtain additional prescriptions.
THE MAGISTRATE: Could you tell us more about what a pain contract is in a case similar to this.
THE WITNESS: I'm not an expert in pain contracts, I'm not a pain expert. I have a

Page 136

basic knowledge of what pain contracts are. My understanding is that when a pain specialist is prescribing opioids or controlled substances, then a pain contract is formally drawn up with the patient. The pain contract indicates why the medication is being prescribed, it indicates the specifics of the medications, and lays out in great detail with the patient what circumstances they will get their medications, what circumstances they will not get their medications.
For example, I believe that extra prescriptions cannot be obtained between the routine prescriptions, that patients cannot have their prescriptions mailed to them, they have to come in to get their prescriptions. Where necessary, they have to undergo drug tests to make sure there is no abuse of the medication.
THE MAGISTRATE: Have you seen such contracts in the course of your medical practice?
THE WITNESS: I have. To clarify, those are not my contracts, though. I have seen them, but I have never drawn up one from my patients.

Page 137

THE MAGISTRATE: That was my understanding. Yes. In the past I have told Dr. Levin that I have the patient in front of me and I was asking for his interpretation. In this case, however, I'm looking at Bates 94 which I understand is page 82 in front of you, Doctor. Have you had a chance to decipher the handwriting that is significant to you?

THE WITNESS: To the best of my ability.

THE MAGISTRATE: I'm sure I could decipher it if I parsed it, but if you have already taken the time to do that, let me know what is significant and this page.

THE WITNESS: Starting on the top, June 16, 2008. Patient called to inform pharmacy will not accept prescription dated for over 30 days. He needs a new prescription for July 4. Please mail it to his home, (address given). Oxycodone 5 milligrams, number 180, Oxycontin 40 milligrams, number 90, no substitution. The patient is informed by the pharmacist that the, quote, Massachusetts state laws superseded federal law, unquote. Therefore, they cannot have -- I think the word

Page 138

is "have prescription." I'm sorry, I'm not sure what that word is. Something. -- prescription past 30 days. Please call patient when prescription is mailed out.

There is an indication June 16, voice mail; June 17, mailed, and patient -- something -- mail.

THE MAGISTRATE: Thank you.

Q. (By Mr. Paikos) Turning next to medical record number 30 which is at Bates 84. If you could review that and discuss whether it's a red flag and what part of it is important to any conclusion you reach.

A. Record dated July 30, 2007, I believe. Need new script to say no substitution for Percocet, --

Q. I think it was medical record 30, Bates 84. Your medical record of May 30.

A. This is a note dated 6-16-2009 from a Nurse Claudia O'Shea indicating there was a call from the pharmacist that the pharmacist was calling because there was a, quote, big jump, unquote, from what he, indicating the patient was taking previously with regard to the Oxycontin and wanted to verify that is correct.

Page 139

Yes, this would be a red flag.

THE MAGISTRATE: I can guess what "big jump" means, but what does it mean to you?

THE WITNESS: There is a larger, significantly larger amount of medication prescribed than previously.

THE MAGISTRATE: Thank you.

Q. (By Mr. Paikos) If we can go to medical record 48, Bates 87, medical record number 53. Those are records from a January 8, 2010 encounter. From your records it would be 48 and 53, Doctor.

A. Referring first to medical record 53 January 8, '10, this is a Progress Note from the doctor. Note indicates came in for med refills, written. There is a note from the nurse, three-month follow-up for neck pain. This note would be below the standard of care.

Q. Why is that, Doctor?

A. This is a patient who has been seen for a follow-up note. This is a Progress Note for opioid medication. This would be below the standard of care for any type of interaction with a neurologist but especially for somebody who is coming in for refills for opioid

Page 140

medication. There is no information given with regard to history, how the patient is doing, is the patient doing well, are the medications helping him, are there side effects. We have no information about the examination. There is no Impression. We don't know specifically from this note why the medicine was being prescribed, how the patient is doing, and then we have no information about specifically what is being prescribed.

The latter statement being made, we can go to page 48. On this page it does state the order of medications, so we do know specifically from this page. There is nothing in the Progress Note indicating that, but it is possible that the usual manner they would put these records together to link those two. If that is the case, we do know about the medication, and that would be within the standard of care for the medication.

Q. Do we know, Doctor, whether this medication that is bring prescribed has given relief to the patient or not?

A. We do not.

Page 141

Q. If we go to medical record number 60, 61 and 65 which are Bates 90, 91 and excuse me, 90 and 91, medical records. Excuse me, medical record 53 and -- I apologize. Medical record 60 and 61 and 65 which are Bates 89, 90 and 91. Would you review that and look up when you are done.
A. Referring to the Progress Note, 6-28-2010 from the doctor, this note is below the standard of care. There is limited information. The history provided was his neck pain has worsened recently after his son jumped on him. That is all the information that we have with regard to the history. We don't know what the patient's clinical course is other than his neck pain is worsened, but nothing else about that. We don't know the response to the medications. There is no information with regard to an examination or whether or not an examination was performed, and an examination certainly would have been indicated, particularly in a patient who has now a worsening of his neurologic status. No Impression why the patient is worse. The only plan that we have is will see Dr. Gorski at Norwood Pain Center. Patient is being referred

Page 142

to another doctor. We do not know whether he is being referred to a doctor or indeed what future follow-up will be with the doctor. There is no indication of any medications, although there is another page that indicates ordered medications Oxycontin and three Oxycontin prescriptions.
THE MAGISTRATE: Is that on page 60 of the record in front of you, Dr. Levin?
THE WITNESS: Yes, where it says ordered medication, medications in the middle of the page, there are three prescriptions for Oxycontin, each one 120 pills, start date of 6-26-2010, 7-27-2010 and 8-27-2010.
THE MAGISTRATE: What page do you have in front of you?
THE WITNESS: Page 60.
MR. PAIKOS: Bates 89.
THE MAGISTRATE: I'm looking at Bates 89. Are these the one that say "discontinued"?
THE WITNESS: It is confusing. If you come down it says "discontinued medications," says "Oxycontin," and below that it says "ordered medications." I believe those are the new medicines that are being ordered, especially

Page 143

with the start dates that are listed to the right of that.
THE MAGISTRATE: I'm looking at that. I see the start dates of June 28, July 27 and August 27, but they do say "discontinued."
THE WITNESS: It does.
THE MAGISTRATE: What does that mean to you?
THE WITNESS: It means it's very confusing to me, I don't understand it.
THE MAGISTRATE: Okay. Thank you.
Q. (By Mr. Paikos) Doctor, I would direct your attention to tab 5, the records for -- Go back to that record. On that medical record page 60, 89, it has an Approved section as well on there?
A. Yes, and that continues onto page 61, I believe. Approved section for the same medicines that we were discussing, the Oxycontin prescription for 6-28, 7-27 and 8-27-2010.
THE MAGISTRATE: Mr. Paikos, are you ready to start a new patient?
MR. PAIKOS: Yes.
THE MAGISTRATE: I want to tell the parties what I see as an issue: I may be wrong

Page 144

and decide ultimately this is not an issue, but I would like the parties to address it during the evidentiary part of the appeal and during post-hearing submissions which I assume the parties are going to do.
My questions are whether the state of medical records is part of the standard of care; if so, whether keeping medical records that are substandard is subject to discipline and whether the substandard medical records, if they are substandard, had consequences.
I know about Patient A who died, but was that related to substandard medical records. So I'm letting you know, Mr. Paikos, now so if you want to include that in the record before you conclude with Dr. Levin, you may, you can go back to previous patients if you decide to do so.
And, Dr. Padmanabhan, I'm letting you know that is a potential issue so you can prepare your case as well.
DR. PADMANABHAN: Thank you.
THE MAGISTRATE: Again, Mr. Paikos, you don't have to turn on a dime the case you are

Page 145

presenting, you can let me know if you are going to need more time or a break will be enough time to address that.

MR. PAIKOS: Thank you. We'll turn to Patient D's records, tab 5.

THE MAGISTRATE: As with yesterday, if the parties need a break, let me know. Any electronic devices that make noise should be off. There will not be and there should not have been any recording devices or cameras being used yesterday or for the rest of the hearing.

Q. (By Mr. Paikos) If you could go to medical record 3 which is at Bates number 109 and goes to medical record number 4 and Bates 110.

A. Looking at medical record pages 3 and 4, is that correct, sir?

Q. Yes. And does this give some background history regarding the patient's complaints?

A. The note does give background with regard to this patient. The doctor relates history of his treatment with epidural steroids. It's interesting that he does note he has the pleasure of seeing the patient again at the clinic. There may have been a previous note,

Page 146

but I have no record of that previous encounter. He talks mainly about his treatment, he talks about he is going for a rhizotomy, and there have been some concerns he had as well some family difficulty.

THE MAGISTRATE: Dr. Levin, a rhizotomy is what?

THE WITNESS: I believe it is a procedure where the nerve root is in some way structurally altered. I don't believe they actually physically cut it, but I think they use other instruments to actually cause a physical change within the nerve root.

THE MAGISTRATE: Thank you.

Q. (By Mr. Paikos) Why is that done, a rhizotomy?

A. For intractable pain, mainly. Would you want me to further comment on the note?

Q. In reviewing the note, does it show that the doctor followed the standard of care in the treatment of this patient?

A. The note describing the treatment for this patient is below the standard of care. The reason for that, the overall note, the history, the examination, the impression are within the

Page 147

standard of care. He describes the medication that he is giving patient, Oxycontin, giving the dosage, the number of pills per day; oxycodone dosage twice a day, p.r.n. These are within the standard of care, but we have no further information about that. We don't know the number of pills that were prescribed, we don't know if there were additional monthly prescriptions or any refills, and that would below the standard of care.

Q. Why is that important to know that?

A. It's important to know how much medication you are giving any patient. I think particularly it's important if you have a controlled substance that you know how many pills you are giving the patient. Controlled substances are always potentially abusable, and it would be important to know is the patient taking the medication that I prescribed, could the patient be doing something else, diverting the medication in some way.

Q. What is the potential harm to a patient if they are abusing medications that a doctor is prescribing?

Page 148

A. Potential harm is addiction to a medication, particularly an opioid, and there are certainly all the dangers that any individual would have from addiction as well as the dangers of overdose. Overdose can be obviously very dangerous and can even result in death.

Q. What's the reason or the rationale for documenting the record to ensure that you have the proper information regarding prescriptions?

A. I think for any medication it's important to know how many pills you are actually prescribing to the patient. This helps you to know is the patient taking the medication that you prescribed, it lets you know what you are doing. So if the patient calls me for a prescription, I go back to my notes and see what I prescribed, how many pills I prescribed, how many refills and that lets me know is it correct for me to prescribe medication for them again, should they be out or did I give them an insufficient medication. But I can go through my records and I have a good control of the medication. This is particularly important when there is a potentially abusable medication or controlled

Page 149

substance to have that control with the patient.
Q. P.r.n., what does that mean and does that impact is it appropriate for narcotics medications such as Oxycontin and oxycodone?
A. P.r.n. would indicate "as needed." In this case the order is oxycodone 30 milligrams twice a day p.r.n. So he is giving very specific instructions. He is saying the patient can take this pill twice a day as needed. The twice a day is going to be the limits on the medication. This is appropriate for this prescription.
Q. Doctor, if we go to medical records 8 and 9 which is Bates 111 and 112. Are there any issues relative to the prescribing in this case, on this note from Dr. Padmanabhan on November 19, 2007?
A. The information in this note listed under Impression is below the standard of care. Reason it's below the standard of care includes a note "I have given him a prescription for prednisone." There is no indication of the dosage of the prednisone that was given, how many pills, how the patient is supposed to take it, how long is this going to be for, are there

Page 150

to be any refills. We know no information at all. Prednisone is a medicine with potential side effects, especially with chronic usage, but acute usage as well. It is an appropriate medication under the patient's circumstances, but the information given here is below the standard of care.
He has received refills on his Oxycontin from me today. Again there is no further information in prescribing a controlled substance. Opioid, you would need to know more about it, how much is the patient allowed to take, how many pills are prescribed. There is no indication if there are other medicines being prescribed.
Previously there had been a prescription for oxycodone. That is not listed here. I don't know if any other medications have been prescribed. That would be below the standard of care.
Q. Why is it important to keep track of what you are prescribing relative to prednisone and the Oxycontin and the oxycodone?
A. It's important in terms of knowing what you are

Page 151

giving your patient, knowing what the therapeutic dosage is going to be when you follow up on the patient. Any time you see a patient like this, you should be seeing the patient in follow up to check on the result of the medication, how did the patient do, is the patient having side effects, what is the current need for medication, could be for prednisone, Oxycontin, oxycodone, and to have control of what you are giving the patient. Making certain that you are not causing the patient harm with your medication as opposed to helping the patient.
Q. Are you less able to help the patient if you are not keeping track of what you are giving the patient, and why?
A. Yes.
Q. It's harder to treat the conditions that they have?
A. It may be.
Q. If we could go to medical record 15 and 16 which are Bates 113 and 114, please. There is a note on Bates 114 medical record 16 about Valium. What is Valium?

Page 152

A. Valium is a medicine that falls into the group of benzodiazepines. These are sedating tranquilizing medications and also used for muscle spasm as well.
Q. Is this the first time we are learning about the Valium?
A. I believe so.
Q. And is there any issue with the prescribing and the information about the Valium relative in the Plan section on this note in that section, relative to Valium?
A. Under History there is an indication he takes Valium for spasms as well as a touch of anxiety.
THE MAGISTRATE: Where are you for History?
THE WITNESS: Top of page 16 going down the line one, not counting the couple of words on the left. Line one, two, three beginning with "does not take." "Does not take any pills." The very top of says Medical Specialties Letter. Underneath that it says Component and Value.
MR. PAIKOS: Bates 114.
THE MAGISTRATE: Okay.

Page 153

THE WITNESS: It says "value" and says "any event pills times he," and "does not take," going to the end of that line.
THE MAGISTRATE: He takes Valium for spasms?
THE WITNESS: Yes, as well as a touch of anxiety, and it has been working out well. So there is that in the history.
A. Going to the Plan, there is no indication of a prescription for Valium. Once again this would be below the standard of care. We don't know how much Valium he is taking, we know it has been working out well, we don't know if there are side effects, and there is no indication of any prescription for Valium, so we don't know the amounts of medication or anything else about it.
THE MAGISTRATE: Where would you expect to see that sort of information about Valium along with the mention of it or elsewhere on this?
THE WITNESS: Both places. Normally you would expect he takes Valium and a listing of the amount of medication that he is taking. At

Page 154

that point frequently I know in my notes I would normally put in patient is taking X amount of Valium, giving the effect of Valium and putting a note in he is experiencing side effects and telling what the side effects are. Or he is tolerating the medicine without side effects. I would include that in the Impression. And going on to the Plan, would want to have an indication of the medicine prescribed, the specific dose of medicine and the number of pills, the number of refills for that.
THE MAGISTRATE: So you testified to what you would do. Could you relate to what you would do and do to your testimony with the standard of care.
THE WITNESS: I didn't understand your question, sir.
THE MAGISTRATE: You explained what you would do and what you do do in a similar situation noting it in the medical record, rather than your personal practice. Can you relate what you would do to the standard of care.
THE WITNESS: Yes. The standard of care

Page 155

under Plan would be to indicate a specific medication prescribed, in this case Valium. The specific dosage of the Valium, how it's to be taken, for example 5 milligrams to be taken three times a day. And then the number of pills that are being prescribed and the number of refills for that. That would be the standard of care.
THE MAGISTRATE: Thank you.
Q. (By Mr. Paikos) Why is that important to know whether or not the patient is having side effects to any of the medications he is being prescribed or she is being prescribed?
A. It's part of good medical practice. You want the patients to do well, to be improved with any medications that are prescribed for them; but if they are experiencing side effects and the side effects potentially are worse than the symptoms they are experiencing, you don't want to be prescribing those medications. Side effects may also be an indication of more serious difficulties related to a medication.
Q. Does that become more important or less important if you are prescribing Valium and

Page 156

other drugs such as Oxycontin together?
A. Yes.
Q. Why is that?
A. There frequently are added side effects from different medicines. Valium and Oxycontin frequently could have additive side effects.
Q. What are the side --
THE MAGISTRATE: If I may, what is an additive side effect?
THE WITNESS: One medication that gives you a side effect, sedation, lethargy, fatigue, depression, and you have a second medication that has a similar side effect profile; so if you take both of those medications together, then you have additive side effects so there is additional sedation from the second medication, additional potential for fatigue, depression from the second medication.
THE MAGISTRATE: The presence of side effects, does it relate to whether the patient will comply with taking the medication?
THE WITNESS: It may.
THE MAGISTRATE: Is that another reason why noting side effects is important?

Page 157

THE WITNESS: Yes.
Q. (By Mr. Paikos) What is the potential impact of the side effects?
A. Potentially would impact the daily life of a person if they are experiencing fatigue, depression, sedation. That is going to impact how they live their lives, also frequently would impact whether or not the patient is about to comply with your instructions and how you like them to take the medication. If somebody is experiencing side effects from the medicine, they may be less likely to take it or less likely to take it according to the way that you have advised them to. If somebody is having significant sedation from Valium and you prescribed it three times a day, they might take it once a day, they might cut the dose in half or take it every two or three days instead of every day, and that could be counterproductive in terms of the reason that you are prescribing the medication.
Q. Are there any safety concerns when someone had sedation or additive sedation, if that is the term?

Page 158

A. Yes.
Q. What other potential safety concerns?
A. Can affect driving, can make driving dangerous, can make it dangerous if they are working in a situation where they can potentially be injured if they are working around machinery. If there is any type of motor vehicle in addition to a car, driving a forklift; we don't want someone driving a forklift who is sedated and falling asleep. If they have to climb ladders, working outside in construction, we don't want them to fall off a high beam because they are sedated.
Q. Would that go with a potential for safety issues at home not just at work, correct?
A. That's correct.
There was an additional comment on there as well. Going to the Plan, there is a note that he has been given a new prescription for Oxycontin, and there was some question, quoting here now about certain staff at his pharmacy who apparently allegedly had given four pills less when he filled his prescription last month in the absence of owner. The pharmacy, when he fills a new prescription this time, he is going

Page 159

to have him count the pills out for him before he leaves the pharmacy just to make sure.
As previously discussed, any time there is something odd with an opioid prescription, you always have to step back and say is this a red flag. It may be that this particular patient is entirely justified and maybe someone was actually trying to take some of his medication; but whenever there is something unusual, it makes you just step back and say, okay, is there a red flag, is this something we should be paying attention to in terms of concerns about this medication.
THE MAGISTRATE: Is this odd and unusual?
THE WITNESS: It is.
THE MAGISTRATE: Thank you.
Q. (By Mr. Paikos) What steps, if any, of the standard of care are required when there is a red flag or cumulative red flags?
A. There is no hard-and-fast routine, it's more of a feeling that you get as you are caring for a patient. If you have a single possible red flag like this, it may mean absolutely nothing. If you have a patient who is on addictive,

Page 160

potentially abusable medication and you find that you are accumulating more and more red flags, that would make you more suspicious that there is a problem, that you need to be more vigilant in terms of the patient's medication and watching the patient to make sure there isn't abuse potential.
Q. If you go to medical records 20 and 21, Doctor, Bates 115 and 116. If you focus on again the second page of that note for March 28, 2008 on medical records 21, Bates 116. If you could review that and look up when you are ready.
A. Reviewing the first part of this report, reviewing the history, this is within the standard of care. He is describing patient's MRI, showing pathology and pathology of concern that could be irritating one and perhaps more than one nerve root. He does make a statement he is on Oxycontin for this for many years on this, indicating his pain, and has never been a source of problem from a prescription or diversion standpoint. Describes the amounts of medication he is taking. Wife is a nurse and monitors his pills. So he is paying attention

Page 161

to the possibilities of a red flag as we previously discussed, indicating to me that he did not feel there was a problem. This patient did not appear to have an abuse potential.

Q. Going down to the Impression, the Impression is below the standard of care?

A. The statement, I have given him refills per CFR section 1306-12 for the next three months. There is no indication as to what the refills are for, so we don't know from the Impression specifically what he is giving the patient. Previously in the history he does state the medications that that the patient is taking. He takes his Oxycontin, oxycodone, indicates what he is taking but does not state specifically what the refills are.

THE MAGISTRATE: Dr. Levin, what does that mean to you, "refills per CFR section 1306 section 12"?

THE WITNESS: Did not know what that section was and confirmed with Mr. Paikos and Ms. Cooke they informed me this relates to regulations with regard to opioids and that opioids can be prescribed for three months in a

Page 162

row from a single prescription.

THE MAGISTRATE: If a doctor other than Dr. Padmanabhan was reviewing this, what is your opinion as to whether the doctor would be able to understand that particular note?

THE WITNESS: Unless he had prior knowledge, he would not know anything about it. I did not know anything about it, either, when I read it.

MR. PAIKOS: Would this be a good time for a break?

THE MAGISTRATE: Ten minutes.

[Recess]

Q. (By Mr. Paikos) Doctor, if you could go to medical record page 173 Bates 134. That's a note from July 28, 2008?

A. What is the page number again?

Q. Medical record 173 Bates 134, handwritten note from July 28, 2008.

A. Reviewing the note of 7-28-2008, this note is below the standard of care. There is an indication in History that the patient went to a new job site that didn't work out, he was disappointed, depressed and back hurts more.

Page 163

There is no further indication or information about patient's clinical state with regard to his pain problems.

Examination is listed as being without change. This would be below the standard of care when a patient is talking about having worsening of his symptoms, he would want to do a basic examination to know why that is, is there a new problem or not. The Plan was below the standard of care.

There is an indication no change in meds. We do not know what medications are being prescribed for this patient, and it's important to know what those medications are, especially if they are controlled substances, and these are opioids.

Q. When you were discussing the part in the SOAP note, I think it doesn't give us a clinical story, why is a clinical story or clinical presentation of this patient, how he looks, important?

A. He does give us some information. I did not mean to state he gives us no information. We have information went to the job site, did not

Page 164

work out, disappointed, depressed and back hurt more, but it would be important to know more about the patient or where does the back hurt, is it both sides, is there radiation of the pain that runs to one leg or the other, are there other neurological symptoms. I don't recall again if this patient had had other specific neurologic symptoms, but it would be important to know that.

Q. Why it is important to know that?

A. Excuse me, I think it would be important to know what medication he is taking and what is his reaction to the medication, is it helping him, not helping him, does he need more pills, less pills, is he having side effects.

What was your second question?

Q. Why is it important to know the clinical presentation of a patient?

A. It's basic information in terms of helping you to figure out what is wrong with the patient, what kind of assessment you need to do, how to proceed in terms of helping the patient with medication or other types of treatment.

Q. So if he sees the patient at that time, that is

Page 165

why you need to know it at that time. Is there any reason why it should be in the record for future reference?
A. Yes. Patients come to see you for follow up, and certainly a patient like this it would be important to see the patient in follow up, and you want to know what the status of the patient was when previously seen. I can't remember all the details of a patient that I saw a year ago, nine months or six months ago, but if I have careful notes or not just myself but the standard of care would be for any physician to have careful notes to be able to go back, what was the status of the patient's back pain a year ago, what was the status of his neurologic complaints, of his neurologic examination a year ago, is it exactly the same as it is today, was it worse at that time or was it better. Again comparing him to three months ago, is there concern that he is now developing new neurologic symptoms. The neurologic symptoms are now worse, suggesting there is something going on that we need to attend to perhaps with further testing or perhaps with further evaluation,

Page 166

consulting with a neurosurgeon, for example. We don't know that.
We don't know anything about the response to the medication. Patient may be coming back and saying, gee, I really need to take a lot more Oxycontin, things are so much worse. And you go back to your notes from a year ago and find out it was exactly the same complaint at that time, asking for more medication at that time.
Q. We talked yesterday about the use of the pain scale that some practitioners use. Is that one way to flush out currently in a note that you can review back three months from now?
A. It is, and it can be very helpful. I believe most, many times people who are experts in pain or pain specialists will use that and have that documented so when the patient comes back, they will be able to go back and see three months ago the pain was 4 out of 10, six months ago it was 5 out of 10, a year ago it was 2 out of 10. So you can go back and compare from visit to visit how the patient is doing.
THE MAGISTRATE: Thank you very much for

Page 167

letting me interrupt you. I have found if I save all my questions, it takes too long to get witnesses back to where they testified, possibly the day before.
And, Dr. Padmanabhan I ask you for, I thank you in advance if I interrupt your line of questions because I may be asking your witnesses questions as well.
How often do neurologists use a pain scale in their medical records?
THE WITNESS: I can't tell you that I know for sure a hundred percent. My guess would be very frequently. I know that my usual course is to use it on a daily basis when I see a patient who had some type of pain. Looking at my colleagues' notes, I frequently see the pain scale used as well. I can't tell you the percentage of neurologists who use it.
THE MAGISTRATE: Is that the only pain scale, 1 to 10?
THE WITNESS: There are many pain scales, but that is the commonest one.
THE MAGISTRATE: Is it the standard of care to use the pain scale in the medical

Page 168

records that we have been looking at?
THE WITNESS: It would be within the standard of care to use it; it would not necessarily be below the standard of care not to use it.
THE MAGISTRATE: Thank you.
Q. (By Mr. Paikos) Would it be within the standard of care to not describe the pain level in any detail?
A. That is below the standard of care.
Q. What are other ways other than the scales that you can describe the nature of the pain and where it is?
A. By asking the patient questions about this or just listening to a patient telling you about how they feel and recording the information that you received in your history. So the patient specifically describing, yes, I'm having pain and this is how bad the pain is. It may not say 10 out of 10 or 5 out of 10, but I'm having excruciating pain or terrible pain. We'll say would you say that your headache pain is mild, moderate or severe; your neck pain, mild, moderate or severe. And they will let you know

Page 169

how they feel about their pain and tell you where the pain is. If you ask them what does the pain feel like, does it lead to a specific area, are there different types of things that will make your pain worse, different types of things that will make your pain better. These are routine questions that we ask the patient. We record them and put them in the history. We have the information, and it helps in terms of assessment when you see the patient. And when you see the patient in follow-up, you can go back and review the notes and see if the patient's information changed to know where to go in terms of helping the patient.

Q. How does the information that you get from the patient that you put in the record help you at that time to figure out a plan for the patient and in the future?

A. It's helpful with the visit that particular day because you have an indication of the level of pain, so that can help you in terms of your diagnosis and also in terms of your treatment. And also it helps you to figure out what is wrong. The level of pain oftentimes is very

Page 170

helpful in terms of knowing what the specific diagnosis is. Different types of pain may indicate different types of neurologic pathology.

If you have a nerve root that is specifically sitting -- If you have a nerve root that is actually being compressed on a disc, sitting on it, that would be excruciating pain. If the patient comes in and has just mild achiness kind of coming or going, perhaps their knee or thigh, you will know that that is not severe and will direct you perhaps to a different area in terms of diagnosis.

Q. Will it also direct you one way or the other whether you are describing and asking these questions what other tests or referrals to make as well?

A. Yes.

Q. And in the future does the note that you make on April, July 28, 2008 impact what course of treatment you take the person at that time and future notes as well?

A. Yes.

Q. How and why?

Page 171

A. The "how" would relate to neurological assessment, getting a good history, doing a good examination to try to figure out what is wrong with the patient, put the pieces together in such a way that you know or sort of try to track down the proper diagnosis and then figure out what tests should be done, what treatment, what referrals, what ancillary types of nonmedicine treatment.

The "why" is because it is good medical practice and standard medical practice. This is how every doctor works to try to put the pieces together to help these patient.

Q. On the O part it says "stable exam." Do we know what kind of exam was done?

A. We don't.

Q. Do we know -- You mentioned certain parts of a neurological exam. Do you know if all those parts were done, just some, just related to the back?

A. The only information we have is "stable exam, no change."

Q. Is it important to have a complete exam noted?

A. It's important to have some type of neurological

Page 172

examination, some type of relevant medical examination. We don't need to have a very detailed neurological examination that the neurologist would do certainly on an initial visit for every single visit. Most neurologists would not do that. You need to have some neurologic examination, at a very least a pertinent examination related to the patient's complaint and potential diagnosis.

In this case, for example, at the very least we would want to know what was the examination of his neck, his back, motor examination, reflexes, sensation, what did his gait look like; what did the patient look like in general, does he seem to be in a great deal of pain, not in much pain. All of these things would be helpful in terms of the gestalt and trying to make a diagnosis and formulating a diagnosis and helping your patient.

THE MAGISTRATE: What does "stable exam" mean to you?

THE WITNESS: I'm not sure. It can mean many different things. It may mean that the exam is the same as when he was previously seen,

Page 173

it may mean it is the same as when he was seen multiple times in the past or perhaps a long time ago. There is no way of knowing because there is no information.
THE MAGISTRATE: What does "no change" mean --
THE WITNESS: That the exam --
THE MAGISTRATE: -- to you?
THE WITNESS: To me means the exam was the same as previously noted.
THE MAGISTRATE: Thank you.
Q. (By Mr. Paikos) At the bottom it says RTC and 3MO. Does that mean --
A. Return to clinic.
Q. In three months. If you go to medical records 174 Bates 135, if you would read that note by Dr. Padmanabhan.
A. I have a note here dated October 14, 2008. This note would be below the standard of care.
Q. Why is that?
A. History, hoping for epidural shots, no change. We have no information with regard to the patient, we don't know what the patient's clinical status is. We know he would like to

Page 174

get epidural shots, but we don't know anything more about the patient. Is he in pain, is the pain better, worse, does he have neurological symptoms. Taking medicines, having relief, side effects, not getting relief. The examination is listed as being stable, no change. Gives me no information about what the patient's clinical status is.
The Plan is to continue regime, RX given. I don't know what medications are prescribed, the number of medicines. I don't know anything at all about the medicine.
THE MAGISTRATE: What about "continue regimen," what does that mean to you?
THE WITNESS: That what is being done for the patient is the same as what was previously done. I don't know, "regimen" can refer to medication, it can refer to other types of treatment as well.
THE MAGISTRATE: Is this clear or unclear?
THE WITNESS: Unclear.
Q. (By Mr. Paikos) Is the clarity of this note important to the taking care of the patient,

Page 175

providing the care that they need?
A. Yes.
Q. So this is enough to be able to provide the proper care to this particular patient in this note?
A. I would view this as being below the standard of care.
Q. Would, from time to time would other neurologists, physicians have access to your notes, any physician's notes?
A. Yes.
Q. In what circumstances?
A. If a patient is referred to another clinician, typically you would send notes. If I send a patient to a neurosurgeon, I would send copies of the notes. Notes are shared with the primary care doctor typically. If there are other clinicians who are working with a patient, the physical therapist might want to see your notes for thoughts about your patients. If you are being covered by other doctors if you are not on call and your colleagues get a call from a patient who has a medical problem, neck pain, back pain, they may be calling to have a refill

Page 176

on your prescription, I think it is important to have information in your notes so when that occurs, the covering physician can go on and say now I understand what is going on with this patient, I can understand the medicines he is getting, and I can see specifically what was prescribed. If you are talking about a controlled medication especially what dosage the patient gets, how many pills, have there been refills, what was the patient's clinical course.
Someone calls and said I'm having terrible, terrible pain, not had it before, you review the records and there is documentation of the exact same problem occurring many times previously, there may be an indication that the patient is drug seeking. You can see that in the note. And it would be important to have all the information in the medical record.
Q. You say when someone is covering, you are talking about another neurologist covering your case on a call for emergency situations?
A. Yes.
Q. Looking at this note, would a subsequent --
Well, let me ask you this: If the patient

Page 177

leaves the practice, new neurologist, is it standard practice for them to request prior medical records and prior neurological notes?
A. Yes.
Q. Would this note give enough information to a subsequent provider, someone on call or referring physician to determine how to properly treat this patient?
A. No.
Q. Someone, subsequent provider or other provider receiving, giving a consultation or on call for this physician, would they know what prescriptions to prescribe if the patient was out?
A. No.
Q. If they prescribe them prescriptions without -- Is it important to have information of what the patient is getting for medication and narcotics to prescribe them additional narcotics?
A. Yes.
Q. What can be the impact of an error of prescribing too much medication to a patient?
A. Can result in severe side effects. Quite detrimental to a patient. Can result in injury,

Page 178

in the most extreme situation death. If the patient is prescribed medication on top of other medication it could be, for example for opioids, someone could be given more medication than is proper and the patient could have an overdose. You could be prescribing a medication that has side effects that interact with the first prescription, and that could be detrimental to a patient as well.
Q. Going back to the Subjective of this note, it says something. Are you able to read the handwriting?
A. I believe so.
Q. What do you think it says?
A. Hoping --
DR. PADMANABHAN: Objection.
THE MAGISTRATE: Basis?
DR. PADMANABHAN: It says "going in for epidural shots."
THE MAGISTRATE: This is your handwriting?
Any objection to accepting this?
MR. PAIKOS: I can presume for the next question it says "going in for epidural shots."

Page 179

DR. PADMANABHAN: The first letter is capital G in cursive.
THE MAGISTRATE: Do you have any objection to this coming in?
MR. PAIKOS: No.
THE MAGISTRATE: Do we have a stipulation it says "going in for epidural shots"? Do you have any reason to doubt that?
MR. PAIKOS: No.
Q. (By Mr. Paikos) This note saying "going in for epidural shots," that is under Subjective. What does that mean to you?
A. The patient is going to be having a particular treatment. The name of the treatment is an epidural injection. Typically this is an injection of a steroid material placed into the area around a nerve root, can be done for lumbar or cervical problems. And there would indicate to me the patient is going in for the epidural shots. Most of the time this is done for a pain problem, but it can be done for other neurological problems as well.
Q. Do we know if this is for a pain problem or neurological problem?

Page 180

A. No.
Q. Would it be important to know that for the care of the patient?
A. Yes.
Q. Do we know what part of the body the epidural shots are going to be?
A. Not from the Subjective, although looking at the Assessment is lumbar radiculopathy so the presumption would be this is in the lumbar region, but it is not specifically stated under Subjective.
Q. On the note medical record 173, the prior note July 28, 2008, there is note under Subjective, "back hurts more." And we have under Subjective on the October 14, 2008 note, "no change." Do you know if that "no change" refers to the increased pain, the pain before that July 28 visit? Do we know what the "no change" means?
A. No.
DR. PADMANABHAN: What page?
MR. PAIKOS: 173 and 174 of the medical record.
Q. (By Mr. Paikos) What is lumbar radiculopathy?
A. The nerve roots as they come out of the spinal

Page 181

cord begin in the cervical region, the neck and through the thorax, mid portion the back and lower portion of the back. The lumbar region there are nerve roots that come out at each level, and they are referred to as radicals. "Opathy" means a problem with. So a radiculopathy is a problem with a nerve root. In this case would be a nerve root related to the lumbar region, the lower back.

Q. Do we know clearly from this note if epidural shots are being given in the lumbar or for some other back pain?

A. We do not.

Q. Would it be important to know those things?

A. Yes.

THE MAGISTRATE: Before you move on, let me ask Dr. Levin, should medical records like the Progress Notes that we're looking at for October 14, 2008, should it be a standalone record, or is it acceptable practice and standard practice to have a Progress Note reference implicitly or explicitly previous medical records?

THE WITNESS: It would be within the

Page 182

standard of care to reference previous notes.

THE MAGISTRATE: So each Progress Note does not need to be a standalone, complete with pain levels, medications taken as long as someone flipping through the medical record could find the previous references?

THE WITNESS: That's correct.

THE MAGISTRATE: Thank you.

Q. (By Mr. Paikos) Is referencing the level of pain or describing the level of pain more important or less important when there are narcotics prescribed?

A. More important.

Q. Why is that?

A. It's important to have good control of your medication with any abusable medication especially narcotics, and I think it's important to know what the patient's status is in terms of how they are doing, are they better, worse, what is their level of pain, is their level of pain such that they require narcotic medication, is the pain that they are experiencing being improved by the medication so should a dosage of the medication be increased, decreased, stopped,

Page 183

additional medications added. All this information would be helped by more information about the patient's pain level.

Q. Is that the same for the patient's examination and results of the examination?

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

Q. Would it also be important in assessing pain in a patient who is being prescribed narcotics to have a, is it more important when there is a patient being prescribed narcotics to have a more complete exam?

A. I think it's important when there is a patient being prescribed narcotics that there be a neurological examination. You may not have a complete neurological examination. Frequently you do not, especially if there has been a complete neurological examination recently in the records. But it would be important to have at least a pertinent neurological examination focusing on the area of the patient's complaints.

Q. The note that we saw for July 28, 2008, is that a pertinent note or pertinent examination done?

A. No.

Page 184

THE MAGISTRATE: What was the previous one?

MR. PAIKOS: Bates 134, medical record 173.

THE MAGISTRATE: Which has two notes on it.

MR. PAIKOS: Yes, July 28, 2008.

Q. (By Mr. Paikos) And you said that is not a pertinent note?

A. That would not be an adequate note.

Q. What about at Bates 135 medical record 174?

A. Looking at the note dated 10-14-2008, the examination is listed as being stable, without change. That would not be an adequate note. That would be below the standard of care.

Q. Was there even an exam done on that day?

A. The assumption is there was an examination since Subjective is listed as being stable. Objective typically refers to an examination.

Q. If we go to medical record number 175, Bates 136.

A. I reviewed the records.

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

Page 185

A. It is below the standard of care.
Q. Why?
A. Looking at the history and I tried to read this as best as I can, the history, Subjective. Changed his old recliner for a new one (same model) but is causing problems so now he has been sleeping in a different chair. Not happy. Patient -- I believe the word is "seen," I'm not a hundred percent sure, with Dr. Rettig.
This history, the history is below the standard of care. He gives us very little information about the patient. We know that, something about where he is sleeping, but we have no idea what his clinical status is. We know nothing about his pain, we know nothing about his neurological status other than he is not happy. We also know, I believe there is an encounter with Dr. Rettig. I don't know who Dr. Rettig is or what his place is in the patient's care. There is no information there that tells us about what the patient's clinical status is. That is below the standard of care.
Under Objective the examination is stable for reasons previously described. It would be

Page 186

important to have a follow-up examination. There is no examination.
The Assessment and Plan is severe back pain, chronic, and then information about worker's compensation denying patient's medication. Refills are given. We do not know what refills were given. We don't know what prescriptions the patient is taking, we don't know the doses, the number of pills given, we don't know if that has been adjusted.
Looking back at this we have no idea if the medicine is helping the patient, harming him, is he having side effects. It is below the standard of care.
Q. We've seen a few notes where the exam has been listed, or under Objective as "stable." At a certain point is there a diminishing return in having such, well, just writing "stable" in a note when there hasn't been a notation of a complete exam previously? If you understand my question.
A. I believe so. The longer time goes on where there is an indication of "stable," the less helpful that information is. If a patient is

Page 187

being seen a week after a visit and the examination is exactly the same you might say detailed neurological examination was performed and it is the same as on a previous note or was stable. If you have "stable" in another note three months, six months, a year later, the longer you go, there is less information, and you really don't know what exam was performed. If it is stated neurological examination was performed, back was normal, motor examination, sensation reflexes, strength and gait were all normal then, or they were all stable, then that would be certainly helpful. But just having the word "stable" is not helpful and the longer you have follow-up notes that give you that same exact information or lack of information, the more difficulty you have.
Q. And more difficulty in treating the patient?
A. Yes.
Q. And if you are having difficulty treating the patient, can you provide them the medical care that they need?
A. It becomes difficult.
Q. And here it says on this note, April 14, 2009

Page 188

"severe back pain, chronic." Is that a change in his prior pain?
A. I don't know.
Q. You don't know, but would the practitioner looking at these notes know?
A. I don't believe so.
Q. So is that a proper justification for refills being given as noted at the bottom?
A. The information that is listed here is below the standard of care for prescribing refills and medication. Whether it's a justification for the refills that were given, I don't know because there is no indication about what refills were given. I don't know what medications were prescribed, so to comment on the appropriateness of the evaluation to those medications, we don't know what medications were prescribed.
Q. We're looking at the April 14, 2009 note. If we go to medical record 184 and 185, Bates 587 and 588.
THE MAGISTRATE: Before you do, if I could ask Dr. Levin, worker's compensation decided he does not need pain medication any

Page 189

more. Is that a red flag?
THE WITNESS: A red flag in terms of the concern that he is abusing his medication?
THE MAGISTRATE: A red flag along those lines or any other sort of red flag.
THE WITNESS: No. Worker's compensation has its own rules and oftentimes will make its own decisions for reasons that are difficult to understand, so I can't say that having a decision by worker's compensation would definitely be a red flag for a concern by the patient.
THE MAGISTRATE: Thank you.
Q. (By Mr. Paikos) Just to reference those pages again, medical record 184 and 185 at Bates 587 and 588.
A. I do have those records.
Q. Are the prescriptions written for the note April 14, 2009?
A. Yes.
Q. And one of those prescriptions is for Valium with five refills?
A. That's correct.
Q. Is there anywhere in the recent note why Valium

Page 190

is being prescribed to this patient?
A. There is no information that I can see that indicates that.
Q. Is the prescription for Valium within the standard of care?
THE MAGISTRATE: Excuse me, Mr. Paikos, I'm looking at 587.
MR. PAIKOS: And 588.
THE MAGISTRATE: Thank you.
A. The dose of Valium is a high one, 10 milligrams three times a day. It is not necessarily beyond the standard of care. Certainly that is a dose that we use, particularly in people who have severe muscle spasm. There would be some concern because the dose being relatively high is approaching the doses that have abuse potential, it's approaching the doses where patients may go through withdrawal if they suddenly stopped it, their medication. It is below that, but it is approaching those doses.
We have a one month's supply. Interestingly, the one month's supply would give the patient less than three pills a day. A one-month supply is 75 pills where it is

Page 191

prescribed as t.i d. which is three pills a day. So there is apparently some caution with regard to the number of medicines that are being prescribed to him. It's being refilled for five refills, so this is a six-month supply of this medication. Under the usual course if you are prescribing this medication in this dosage, they would not be for a routine follow-up for six months.
THE MAGISTRATE: Dr. Levin, can you walk us through the language on this Valium prescription and what each means to a practitioner and a pharmacist.
THE WITNESS: The first line is the patient's name. To the right is the date, 4-14-2009. The prescription for Valium 10 milligrams, the dose of milligrams. PO means by mouth. T.id. is three times a day. P.r.n., as needed. Number 75, refills.
THE MAGISTRATE: That means 75 pills?
THE WITNESS: Correct, 75 pills. Refills five is circled, so that would indicate five refills. This is a one-month supply, 75 pills, and that can be refilled each month for a total

Page 192

of five refills. And for the entire prescription it would be a six-month supply of the medication. The VND numbers is listed doctor's signature is listed, and says "no substitutions" which means the patient is to get the name brand of Valium as opposed to the generic form the medication.
THE MAGISTRATE: What do you make of the fact that three pills a day for a month is more than 75?
THE WITNESS: I don't know. Although it does say "as needed," suggesting perhaps that the patient would not need three pills a day every day. Some days he might need two, some days one, but a total over a period one month would be 75 pills as opposed to 90 which would be three pills a day.
THE MAGISTRATE: Thank you.
Q. (By Mr. Paikos) Would it be important to have noted in the April 19 note what the reason for the Valium prescription was?
A. Yes.
Q. Why is that?
A. It's a medication that can be helpful to a

Page 193

patient or a medicine that can be harmful to a patient. It also had an abuse potential. This is a medicine that is an abused medicine. It can lead to significant side effects. Again if he is taking more medicine than is prescribed, it's at a sufficient level that he could go through drug withdrawal if he suddenly stopped taking the medication. This is a medicine that you should have some control over in terms of side effects and in terms of helping your patient versus harming your patient.

Q. When prescribing any medication including Valium are there, do you discuss and note whether you had a conversation about side effects with the patient?

A. Yes.

Q. Why is that?

A. It's important medically/legally to protect yourself. If the patient has severe side effects from a medication, it is important to document that. It's important in terms of patient care that you let the patient know what the effect of the medication is going to be and what the potential side effects are. If you are

Page 194

prescribing a medication that can have significant side effects, you want to know that and you want the patient to know about potential interactions with other drugs, with current medications and how it may affect their daily life including potential dangers that you may put them at, driving a car, using equipment or at work.

You also want to know if your patient is having side effects. It is important to let your patient know if you are having side effects, they should contact you so you would know potentially if the medication is harmful.

Q. Is the note that a physician writes about, a prescription about anything, is that a note to themselves that assists in their thought process?

A. It is a note to themselves that can assist in their thought process, but more importantly this is a medical record, a medical/legal record that will document what the patient has told you, what you are observing, what your thought processes are and your conclusion as well as your plans for the patient. All of these things

Page 195

are important in terms of patient care and recording this for patient care both for yourself and others who may be involved in the patient's care.

Q. Is it important for continuum of care?

A. Yes.

Q. What can be the impact of taking Valium and alcohol?

A. Can have a severe side effects. There are, as we discussed previously, additive side effects. You can have a multiplication of side effects from Valium. People who drink alcohol and take Valium become sedated much more easily, become intoxicated much more easily, with all the consequences involved with those activities.

Q. Is it important to tell your patient that and that you note it in the record?

A. Yes.

THE MAGISTRATE: If a patient has side effects, it's also important so that the doctor can mitigate those side effects for the patient's health and comfort, is that right?

THE WITNESS: That is right. You might not say specifically what side effects you

Page 196

discussed, but I think that at least typically you would put in the prescribing medication, in this case Valium, possible side effects were discussed.

Q. (By Mr. Paikos) Is that part of the reason that you take a social history from a patient when you see them?

A. Yes.

Q. Is the standard of care to take an initial social history, update it or which one or both?

A. Standard of care would be to take an initial social history. Wouldn't necessarily update a social history unless the patient comes to you and had something pertinent in their social history that they want to share with you, but I would not go through a routine social history on every follow-up visit.

Q. Directing your attention to medical record 44, Bates 118. Actually on medical record 45 is the same visit, July 10, 2009, Bates 118 and 119.

A. This note from July 10, 2009 from the doctor is below the standard of care. The History is listed as no change in back pain symptoms. Has been swimming two mornings a week. Right knee

Page 197

need replacing. Inadequate history with the patient's medical problems. We don't know very much at all about the back pain except there has been no change. We have no other information about other neurological problems. We do know his right knee needs replacing. We are not sure quite why that is. Assumption would be there is pain, mobility problems, gait problems. We don't know any information about the medications he has been taking, how are the medicines helping him, does he have side effects.

The exam is listed as "exam stable." As previously discussed, follow up with the patient. Assessment and Plan is a cervical and lumbar radiculopathy. There is an indication that there is a problem in both the neck and the back with nerve root compression. Again there is no specific information about this, no mention of his neck under the History, no mention of other neurological problems. And the only Plan that is listed, I believe it is a plan although I'm not a hundred percent sure, says "1000 K cal. diet!" I don't know if that is a history from the patient or recommendation from

Page 198

the doctor. There is no recommendation with regard to medications, no information with regard to pain treatment for him.

THE MAGISTRATE: Aside from the context of a thousand K cal. diet, what does that mean to you?

THE WITNESS: I don't know what it means.

THE MAGISTRATE: A thousand calorie diet or you don't know?

THE WITNESS: I know that a thousand calorie diet is a low-calorie diet, but I don't know, is this something that the patient is doing, is this something that is recommended to him. If it's being recommended, I have no idea why it is recommended. Is he obese? It's a low-cal. diet, so it's quite low. I have no information.

THE MAGISTRATE: Is K cal. standard shorthand for calorie?

THE WITNESS: Not that I know of.

THE MAGISTRATE: Thank you.

Q. (By Mr. Paikos) Is there a new diagnosis, cervical radiculopathy?

A. I would have to go back and look at previous

Page 199

notes. I don't recall seeing that diagnosis before, but I would have to go back and look at previous notes.

Q. And the records will obviously speak for themselves, but when there is a new diagnosis for a patient, what should be done, if anything?

A. Well, the new diagnosis would presumably be related to prior information in the record. It would be related to the history so we would know that the patient is coming in with a history, with complaints that relate to the new diagnosis. There should be an examination that is at least, at the very least targeting the symptoms that the patient is complaining about.

For example, complaints of a cervical problem, there would want to be an examination of the neck, you would want an examination of the arms, hands, the strength, sensation, reflexes, probably an examination of the legs as well since you can get changes in the legs related to neck problems, cervical problems. What the gait shows. You would want to know is the pain extending, is it going down the back, and certainly in this case he has a lumbar

Page 200

problem as well.

We would want a good examination related to the patient's complaints and the patient's history, and I would want to have a discussion why the diagnosis is being made and a plan for further evaluation. Does the patient require radiologic procedures, an MRI, are medications being prescribed. Is he being referred to physical therapy, other types of adjutant treatment, is a chiropractor being seen for his back, all sorts of different types of options for it.

Q. If we go sort of keep at two different pages at the same time for two different dates, we have this one with a respondent's July 10, 2009 note, medical record 44, 118; and we have medical record 175 which is an exam of approximately three months earlier on April 14, 2009 at medical record 175, Bates 136.

The exam three months before, was cervical radiculopathy noted in the AP or anywhere?

A. Looking at page 175, that is the 4-14-2009, is that correct?

Page 201

Q. Yes.
A. There is no indication of a cervical problem on that date. Then on July 10, 2009 there is an indication of cervical and lumbar radiculopathy.
Q. And the exam on 4-14 is stable, and the exam on July 10, 2009 was stable?
A. That is how it is indicated.
Q. We don't know from April 14, 2009 whether the neck is even examined?
A. That's correct.
Q. Do we know what was examined on July 10, 2009?
A. No.
Q. Would it be important to note that?
A. Yes.
Q. Why?
A. To give the patient proper care. In order to give the patient proper care, you would need to have an examination to assess the new acute problems and the problems that were changing as well as older problems to see if there is a change in the patient's examination, and formulate a plan in terms of how you can help that patient.
Q. If the exam is stable between April and July and

Page 202

there is a new diagnosis of cervical radiculopathy, does that make sense?
A. It's difficult to comment on the examination because no information is given other than it's stable. Perhaps an additional comment as well if his right knee needs replacement, that would suggest there is a knee problem, and we have no examination describing the knee problem or whether it is a new problem or old problem.
Q. "Exam stable," is that something that might be used to say there was no change in the exam?
A. Yes.
Q. Could it mean something else?
A. It's difficult to state what it means because we have no information.
Q. Do we know if there was a knee exam done?
A. No.
Q. Would a neurologist, if you believe a patient needed a new knee, what would be the course to take?
A. A neurologist may or may not be expert in examining knees, but certainly at the very least a neurologist would be able to do a basic assessment of problems related to that leg. He

Page 203

could certainly watch the patient walk, check strength, reflexes, check sensation and perhaps do very basic mobility problems, not the type of sophistication that an orthopedist would do, but you can do a basic examination and have an idea how much pain is your patient having, does that seem to be relating to the back problem.
Q. Would there be any referrals that the standard of care would require?
A. The standard of care would require a discussion of the problem. The note here "right knee needs replacing" may be the doctor's own impression or it may be a history that the patient is coming in himself saying I have a bad knee, I have been told I need to have a knee replacement or, gee, my knee is really bad for a long time and I think I need a knee replacement. But we don't know that. All we have is "right knee needs replacing."
Q. If you are seeing a patient who you believe needs a knee replacement, what would the standard of care require?
A. I would discuss that with the person, give him my advice saying I think you have a knee

Page 204

problem. I typically would not make the decision that the patient needs a replacement as a neurologist. Typical neurologist would not have the expertise to make the decision whether or not a patient needs to have a knee replacement. The correct course of action after discussing it with the patient would be to offer a referral to an expert, typically an orthopedist.
Q. What would be a course for a neurologist to take, if any, if there is a new diagnosis of cervical radiculopathy?
A. To document specifically what the patient's history is, to document what the patient's complaints are that would relate to this diagnosis that can lead you to make the diagnosis, do a careful neurological examination with reference to the areas of involvement. As previously noted, an examination of the neck, possibly the back, the arms, the legs, the gait, do a neurologic examination looking for evidence of dysfunction to the cervical region, particularly the nerve roots.
Q. Any referrals or diagnostic tests?

Page 205

A. Depending on the clinical indication. Frequently when you have somebody that you think has a cervical radiculopathy, you will refer them for physical therapy. You may and frequently will obtain a cervical MRI.
Q. Are any of those things in Dr. Padmanabhan's plan?
A. No.
Q. Is there a medication change to deal with the new problem?
A. There is no indication of any medication prescribed on the progress sheet.
Q. Doctor, if we could go to medical record page 56 which is at Bates 120.
THE MAGISTRATE: Before you ask the question, Mr. Paikos, I neglected to say at the beginning because we did not go past twelve, today I expect to go to one o'clock and take a lunch break roughly around one, and I expect to take a break soon for about five minutes. So whenever it makes sense for you, Mr. Paikos, to take it now or ask a few more questions, a few more documents.
MR. PAIKOS: I think we can take a break

Page 206

now.
THE MAGISTRATE: Five minutes.
[Recess]
THE MAGISTRATE: Let's resume.
Q. (By Mr. Paikos) Dr. Levin, if we go to Patient D's medical record 56 which is at Bates 120.
A. I have viewed this note.
Q. And was Dr. Padmanabhan's care within the standard of care?
A. It is not. This note is below the standard of care. And I also have some concerns about the statements related to this patient in terms of the standard of care. The history from the note of 9-21-2009 indicates patient complained of tingling in the front of his right foot along with a weakness in his left thigh for the past six weeks every morning when getting out of bed which gets better as the day goes on and the knee holds his weight.
This is an insufficient history. There is a lot more information that should be indicated in order to properly assess this patient and that would be expected from the care

Page 207

of a neurologist from the history from a neurologist.
The examination shows no power loss. That is --
THE MAGISTRATE: Dr. Levin, could you go back. Such as? What would you expect to see? What do you consider missing?
THE WITNESS: I would like to know is he having pain, does the patient have neck pain, back pain, is this different from what he has been experiencing previously. The indication is that he has been having the symptoms for the past six weeks. There is no indication whether or not he has ever experienced anything like this before.
We know what is happening with his strength and his left thigh. We don't know anything about the sensation of the left lower extremity or anything about the weakness in his right lower extremity or if there is any pain in either lower extremity, if he has neck or back pain. No indication of whether or not there are problems in his arms or hands, is he having difficulty with his walking. Is there anything

Page 208

in particular that will make this worse, is there anything specifically that makes it better. He indicates that he gets better as the day goes on, but is it better with moving his leg, is it better with walking. We just don't know that much about it. We know some portion but not enough information about this.
The examination is below the standard of care. This is a patient who is presenting with an acute problem, a problem that potentially could be a serious problem. The localization from the history is difficult to put together. There are a number of different possibilities in terms of localizing it to a portion of the nervous system.
Typically with the examination you would have more information to help you with that. The examination gives us no information except for there is no power loss. The patient is complaining of weakness in the left thigh. The doctor did not find any weakness, but there is nothing else that is explained to us or given to us. We don't know if he has neck or back pain, spasm in the back. We don't know if indeed

Page 209

there are changes in his reflexes in his sensation, we don't know what his gait looked like, so we don't know very much about this.
The assessment is myelopathy. "Myelo" refers to the spinal cord, "opathy" means a problem with. So he is diagnosing a patient who has a spinal cord problem, presumably acute to subacute spinal cord problem that he did not have previously.
That is a potentially very serious neurological problem. We don't know specifically again what is going on. It says intermittent symptoms, perhaps positional, related to mattress pad. Refers to the L-4 level. That is difficult to understand.
The spinal cord ends at L1-2. It ends between the first and second lumbar levels. So if you have an L-4 nerve root and each of those has a disc between them, the spinal cord ends between the L-1 and 2 level, so the L-4 level would be below where the spinal cord ends. The diagnosis is myelopathy which is difficult to understand and the basis of an L-4 nerve root. It's difficult to understand how the myelopathy

Page 210

would be related to a mattress pad.
The Plan --
THE MAGISTRATE: Because it's a more severe condition?
THE WITNESS: Potentially a more severe condition. If the patient had a myelopathy, that's a condition that can lead to paralysis, bowel and bladder dysfunction, assuming this is the lower portion of the spine. Can lead to loss of sensation, gait impairment. This is potentially quite serious if the assumption is that the patient may have a myelopathy.
THE MAGISTRATE: And too serious to be related to a mattress pad or caused by inadequate mattress pad?
THE WITNESS: Yes. I think the positional changes related to a mattress pad would give a myelopathy. The Plan is to change the pad, go to aqua therapy and traction. This is below the standard of care. If you think your patient had a myelopathy, that patient needs to have an MRI, and the MRI needs to be done as soon as possible, oftentimes on an emergent basis if you really suspect the patient

Page 211

had a myelopathy.
I don't know that this patient needs to have this emergently because the symptoms were there for six weeks and no indication whether this is getting better or worse. We don't know that for sure. If the indication was he was getting worse, he should have an emergent MRI to make sure it is not spinal cord compression.
All told this is a note that is below the standard of care. We don't know what other plans there are. We don't know if any medication was prescribed. There is no medication listed here. So we don't know if the medicine has been prescribed acutely, if any of the previous medicines were prescribed or not. There is no information.
Q. (By Mr. Paikos) The L-4 is not part of the spinal cord, just to be clear?
A. The spine -- Stepping back for just a moment, the spine has three, four basic levels. Cervical is the neck, thoracic is mid back, lumbar and sacral together are the lower back, and that is the delineation, the description of the levels on the back.

Page 212

So you can look at any of those sections of the back and refer to the bone, to the nerve roots, to the back itself. You can say this is the L-4 nerve root, you can say this is the L-4 vertebral level. So it can refer to a number of different areas. Or you can refer to the L-4 segments or the L-4 level of the spinal cord.
You may also refer to the L-4 innervation. The supply from the L-4 level that begins in the spinal cord comes out to the nerve roots and comes down to the leg, and we know specifically where L-4 would be approximately.
Q. Does the L-4, where it refers to the L-4 level, does that help understand anything having to do with the myelopathy?
A. Reading just the note, the note would indicate there is a concern about an L-4 spinal cord abnormality, so the myelopathy refers to the L-4 level.
Q. The exam says "no power loss." Where is the no power loss?
A. I don't know. All we know it says "no power loss." We don't know what part of the body was examined.

Page 213

Q. Would it be important to know which part of the body had the power loss?
A. Yes.
Q. Would that impact the potential emergent nature of getting an MRI?
A. Yes.
Q. So a subsequent provider or even Dr. Padmanabhan coming back and looking at the note would not know where the issue was relative to the power loss?
A. Correct.
Q. And would the subsequent provider or Dr. Padmanabhan if Dr. Padmanabhan didn't remember after three months, would they be able to provide adequate care to this patient?
A. No.
Q. If we go to Patient D's medical record 63, Bates 121, and it goes to Bates 122, medical record 64. If you can review that note.
A. I have reviewed the note, and this note is below the standard of care.
Q. Why?
A. Looking at the History, date is 11-3-2009 and the previous date was 9-29-2009, approximately

Page 214

six weeks or so following the last visit. There is no indication of how the patient is doing now compared to his previous evaluation, and there was concern about the myelopathy. We don't know if he is better, worse. He describes this as a routine follow-up visit. The patient comes in to see a neurologist and the diagnosis is a myelopathy, possible spinal cord damage or spinal cord compression, that is not a routine problem. And the next visit would not be a routine follow-up visit if there has been no visits between those two appointments.
He notes ongoing back pain. Also reports a hardness behind his right knee. This is a new problem going on. He continues to have sharp pain radiating down his legs from his back, and his right foot is numb on the dorsal surface. Previous note did not indicate sharp pains, did not indicate pains radiating down his legs from his back.
THE MAGISTRATE: So there is a disconnect between "he continues"?
THE WITNESS: Correct.
THE MAGISTRATE: And that possibly should

Page 215

have been noted before?
THE WITNESS: Correct. If it's continuing, then the presumption would be this is a continuation of something that should have been previously described.
A. The right foot numbness had been described previously. Previously had been described again in the front of the right foot, and here he is saying the dorsal surface. So that would be the same.
On examination, continues to have antalgic gait. We don't know if it was present before, although he states it was continuing. We don't know what his gait was previously since there was no information. I did find his right calf to be a touch firmer than his left calf. He has a positive straight leg raise test.
This is an inadequate examination.
In terms of the myelopathy, I don't know if there is evidence of myelopathy, or I don't know what his reflexes showed, what his strength, his sensation. He is describing a new problem with regard to the calf. And the assessment and plan is chronic back pain due to

Page 216

work-related severe injury years ago.
THE MAGISTRATE: Before you go on, is it significant to you about right calf being a touch firmer than the left calf?
THE WITNESS: Yes.
THE MAGISTRATE: What is the significance?
THE WITNESS: I don't know, but it would be a concern there my be something, a new medical problem related to his calf. I would be concerned about deep-vein thrombosis. Other things can cause it. He could have an infection in the area, but certainly something that you need to have further medical care.
THE MAGISTRATE: What is a straight-leg raise test and what is a positive straight-leg raise test?
THE WITNESS: Could be done two ways: Either with the patient lying down, supine, or with the patient sitting up. And while the patient is lying down, you actually raise the leg up with the knee extended without the knee being bent and observe if the patient has pain in that position; if so, what degree of

Page 217

elevation will produce pain.
It can occur with many different conditions. Most commonly you will see if there is a back problem, but it can also be seen with other conditions. You can see if there is a problem in the leg itself, you can see it with the knee problem. Many different conditions can give you a positive straight-leg raising test.
THE MAGISTRATE: "Positive" means causing pain or discomfort?
THE WITNESS: When you raise the patient's leg up, the patient typically complains of pain typically at less than 90 degrees of elevation. The smaller the degree of elevation, the greater the concern. If you raise it up and the patient complains of pain at five degrees, you are more concerned than if they complain at 90 degrees. Typically this is combined with other lower extremity tests.
There are two tests that are commonly done at the same time, Cardic maneuver and Patrick maneuver are commonly done. The Cardic maneuver --
THE MAGISTRATE: Is the absence of those

Page 218

two maneuvers significant.
THE WITNESS: It gives us less information and makes the positive straight-leg raising test less helpful.
THE MAGISTRATE: How does it relates to the standard of care, the absence of notations about the other two maneuvers?
THE WITNESS: They would not definitely be required.
THE MAGISTRATE: Is examination or assessment of the calves standard?
THE WITNESS: Would that be a standard part of the neurological examination?
THE MAGISTRATE: Yes.
THE WITNESS: No. It would be a standard of care when the patient complains of hardness behind the right knee. This patient complained of hardness behind the right knee, so it was within the standard of care for the doctor to examine his calves.
THE MAGISTRATE: Thank you.
A. Looking at Assessment, he had chronic back pain due to severe injury many years ago. There is no indication of the previous concern about

Page 219

myelopathy. There is no discussion of the sharp pain going down the leg or of the foot being numb. We don't know if that is a new problem, did it appear to be a new problem from his previous visit. Is this a chronic problem he had had for many years that we haven't heard about before, and there was no discussion about the calf.
He does note that he strongly urged patient to seek urgent medical attention for his calves. He states he will see a hospital closer to his home. If there is no local medical care available, then that would be within the standard of care. When you have a patient with an acute problem and there is a concern for example for deep-vein thrombosis, typically you would want that patient to be seen more urgently. I think most doctors if they are within a medical facility, have a hospital, have access to a primary care doctor, to an internist. They would have to have that patient seen urgently. The fact that the patient says he will see someone close to home and the doctor did indicate to the patient that he was

Page 220

concerned, that he needed to seek urgent medical attention, that is within the standard of care.
Ongoing with that or continuing with that patient, he describes the patient having a bona fide medical need for Oxycontin, oxycodone, periodic facet injections that he has been prescribed for many years, had absolutely no trouble with him filling the prescriptions written. That would again seem to indicate that he finds the patient to be trustworthy and does not think it is a red flag that he requires these medications.
Unfortunately, we do not see any indication of what medications will be prescribed. We don't know if he was prescribed oxycodone, Oxycontin, Valium or any other medications. There is no information here at all. Perhaps of further interest, the note from the nurse, Marianne Richard, on the same date indicates 8/10 low back pain now radiating down both legs, right foot is numb, he continued to ambulate with a cane. This is giving additional information that he had not previously had. Previously we did not know that his pain

Page 221

radiates down both legs or he was using a cane. There is no examination to corroborate this to give us additional information. We don't know if this person is very ill or if he has routine chronic problems.

THE MAGISTRATE: Do we know from this medical record which August 10 it is?

THE WITNESS: 8/10 indicates the pain level was 8 out of 10 on the pain scale.

THE MAGISTRATE: This is being reported by a nurse. Presumably on the same day?

THE WITNESS: Correct. I believe at the bottom we see Marianne E. Richard, RN, registered nurse, 11-3-2009 and notes continues 8/10 low back pain.

THE MAGISTRATE: Would you expect to see under Assessment and Plan something to do with the cane?

THE WITNESS: Yes. I would expect that to be in the doctor's notes as well.

THE MAGISTRATE: How does it relate to the standard of care that is not there?

THE WITNESS: Sorry, I misspoke. I would expect to see it under Subjective rather than

Page 222

Assessment and Plan, although frequently you would see that in Assessment and Plan as well. It is below the standard of care but there is no indication of his requiring a cane to ambulate.

Q. (By Mr. Paikos) Says "continues." Do we know how long he has had a cane?

A. We do not.

Q. Would that be important to know to assess the patient and treat the patient?

A. Yes.

THE MAGISTRATE: If I could ask another question and interrupt you with your indulgence. Dr. Levin, in addition to your opinion that these medical records are generally substandard, is there a problem looking at Bates 121, medical record 63 that it doesn't relate to the previous medical record?

A. Yes.

THE MAGISTRATE: It's not following up on even the inadequate information in the previous medical record?

THE WITNESS: That is correct.

THE MAGISTRATE: That is your opinion?

THE WITNESS: That's correct.

Page 223

THE MAGISTRATE: Thank you.

Q. (By Mr. Paikos) If we can go to 79, Bates 123. That is a 12-1 note of sometime later, less than three months after the September 21, 2009 note?

A. Correct.

Q. What is your assessment of this care provided that day?

A. This is below the standard of care.

Q. Why?

A. Looking at this as itself, I think it's important to look at this note by itself and then looking at this note as it relates to the patient's continuing medical care and as it relates to the previous notes of November 3 and September 21, 2009. This particular note he discusses the insurance company denying coverage, but they stopped payment for injections and prescriptions. And then all else remains the same; there is no other information. We have no information with regard to myelopathy of this diagnosis of September of 2009, we have no information with regard to the hardness of his calf problem behind his knee, whether he indeed had an evaluation at an emergency room or

Page 224

urgent care center. Was there a severe problem or not.

We have no information in terms of what the patient's present clinical status is. We don't know if he is having back pain, pain in his legs, is he having numbness in his foot. Is he having difficulty walking, does he use a cane. Is he having a neck problem. He previously described it as cervical radiculopathy as well. No information at all. All we know is all else remains the same.

The examination is listed as exam unchanged, so there is no information that we have in terms of examination. The assumption would be exam unchanged, so it would be just the same as when he saw the patient before, indicating that he still has this problem with the hardness in his left and right calf and cervical radiculopathy. We can take that at his word as being unchanged.

That would mean straight-leg raising is positive and there is still concern about what is happening with the right calf, is there a problem there. We have no information again.

Page 225

Is the man becoming a paraplegic from his myelopathy.
THE MAGISTRATE: And that is a danger?
THE WITNESS: Most certainly.
A. Has he lost reflexes of sensation, what is his bowel and bladder function. We don't know what is happening with him neurologically.
Assessment and Plan is lumbar radiculopathy, chronic pain, again indicating just chronic problems, no other information about the concerns that were expressed previously.
Prescription was written. We don't know what prescriptions were written, we don't know is this the opioids, is this Valium, are there other medications, has he written a prescription for facet injections, for epidural injections. And a note from the nurse indicating chronic pain follow up, so again there is no information from her, either.
Q. (By Mr. Paikos) If there is a diagnosis made by a physician, neurologist in particular, and you remove that from the diagnosis from the medical record, what would be required to get to that

Page 226

point? If you determine that the patient has myelopathy, you realize he or she doesn't, what do you need to do with the patient and what do you need to know?
A. You would need to do a careful evaluation of the possible medical condition. So in this case we're talking about a myelopathy. You certainly want to have an initial, careful neurological examination, you want to have repeat neurological examinations to see if the patient's course has changed, and certainly want to get a history from the patient that can tell you did something change, is he now having bowel and bladder dysfunction, more trouble walking.
If you are diagnosing a myelopathy, almost certainly you want to have an MRI, you want to have the information from the MRI and to have further treatment to know what happened with the patient. All of that would need to be documented. If indeed the patient says, no, I'm feeling better, the symptoms I had before really aren't there any more. Or you do the examination and your examination previously did not show evidence of myelopathy or showed

Page 227

concerns about a myelopathy and now does not show, then you would indicate that as well.
If you have an MRI and the MRI is normal, then you could say, okay, the patient is now feeling better and less concerned about this. I do not find evidence of a myelopathy on my examination, the MRI did not show evidence of myelopathy at this time, I do not believe that the patient had a myelopathy. You discuss what you thought was going on. You might say I believe the pain relates to another problem, lumbar radiculopathy. Chronic pain, you may say previously noted concerns may have related to lumbar radiculopathy but I do not find evidence at this time of a myelopathy. It's important to do a history, the exams and the test and document what you did.
Q. You do something similar when assessing or eliminating a cervical radiculopathy?
A. Yes.
Q. Doing certain tests, examinations and noting that the person does not have it?
A. Yes. Or report that the patient is improved or worsened.

Page 228

Q. We don't see any of that in these records?
A. No.
THE MAGISTRATE: Before you move on, Mr. Paikos, Dr. Levin, there is a notation on this record "more than 50 percent counseling." What does that mean to you?
THE WITNESS: That more than 50 percent of the time of the visit was spent in counseling. I can postulate why that note is there.
THE MAGISTRATE: Yes.
THE WITNESS: We are all now dealing with reimbursements and depending what the code is for the type of patient interaction, counseling may or may not be an important part of that code. There is a particular follow-up code that I commonly use that most specialists would use, and if you want to charge for that level of care, you either have to have a certain amount of time, you have to have certain criteria in your notes in terms of complexity of your history and the examination. This type of thing and counseling is part of the charge.
Whether or not that relates to this

Page 229

particular person or not, I don't know.
THE MAGISTRATE: What does it mean in this context, "counseling"?
THE WITNESS: That you spent face-to-face time talking to the patient for more than 50 percent of your visit.
THE MAGISTRATE: Does that have anything to do with something with this patient who is presenting so many problems, reported so many problems in previous visits to spend 50 percent of the time face-to-face time counseling the patient as opposed to doing a physical exam, and tests like the straight-leg test, does that relate to standard of care?
THE WITNESS: You would assume that "counseling" means you are counseling the patient, offering advice. The term "counseling" typically refers to just face-to-face discussion, so it has to do with your history and your discussion with the patient explaining what you think is wrong are them, talking to them about their problems, telling what your plan is to be doing. It isn't necessarily counseling in terms of a psychological,

Page 230

emotional sense, it's more 50 percent of the time is spent in face-to-face discussion, and this would meet the standard of care.
THE MAGISTRATE: Thank you.
Q. (By Mr. Paikos) Medical record 94 Bates 124, that is a note from December 22, 2009 by Dr. Padmanabhan.
A. This note is below the standard of care.
Q. Why is that?
A. This is an urgent visit and this would not typically be a visit for a neurologist. This is a medical problem that would not typically be cared for by a neurologist. He came in with a new rash on his calves, right much worse than the left and looks purpuric, P U R P U R I C. Purpura, I assume there were multiple small abuses seen on the skin, and that can indicate a hematologic disorder. Admitted to South Shore Hospital overnight on the Saturday. Told to see dermatology. Reports increased pain in the left calf more than the right.
Assessment is purpura with Plan, sent for lab work and Dopplers of the calves.
THE MAGISTRATE: Dopplers being?

Page 231

THE WITNESS: Doppler is an ultrasound study looking in this case at the blood vessels of the calves of the legs to see if there is evidence presumably of a deep-vein thrombosis or some other blood vessel abnormality.
A. The examination is not listed. The only thing noted here it looks purpuric to me. There is no other information. This is now becoming a non-neurological visit, so I don't know that the standard of care here should relate to a neurologist. The standard of care here should relate to a general physician. This is not the type of evaluation that a neurologist would normally do.
Normally if you see a patient with this type of problem, you refer the patient to see a, some type of generalist or an emergency room. Be that as it may, the doctor chose to evaluate the problem on his own. The Dopplers of the calves, the blood work is appropriate. That is within the standard of care. What is not within the standard of care is the lack of the examination.
This has to also be related back to the

Page 232

previous notes including the note I believe of 9-21 where he indicated that the patient had complained of a hardness behind the right knee. Excuse me. I believe it was November 30, page 63. The patient complained of hardness behind the right knee and never got follow-up care on that. We don't know if what we are seeing today relates to the previously described problem from November 3 or this is a new problem.
Q. If we go to medical record 104 Bates 125. If you could review that note.
A. This is a note dated January 12, 2010, and comments on this would have to be similar to the previous note. This is not a note that would be for a standard of care of a neurologist assuming there was no care for this patient within the neurologic point of view.
The concern is here that there is swelling in his legs, one plus pitting edema today. The rash has subsided a lot. Tested negative for DVT, deep-vein thrombosis, congestive heart failure, blood results. I asked Dr. Mattie to take a look which he kindly did. We don't know what Dr. Matti's conclusions

Page 233

were. We decided to do a pelvis CT to rule out lymphatic outflow obstruction and plan for rest as before.

Again this is not a note that we would hold to the standard of care of a neurologist. The doctor has chosen at this point to see the patient for a medical problem. Looking at this just in terms of a medical problem, again we have no examination, there is no objective information here about his examination. We do not know what Dr. Matti said, we didn't know who Dr. Matti is or what type of doctor he is, so we don't know if he is a dermatologist, vascular surgeon. There is no information here.

In addition to that, I think we have to look at this perhaps as related to previous notes in his care of the patient as a neurologist. I don't know if there had been medications prescribed. We don't have any information about any care as related to the patient's previous visits. I don't know if this is a standalone visit because of his rash, edema, the leg problems, or is this a representative of his follow-up note for the

Page 234

patient for his back problems, his possible myelopathy, his numbness. I don't know that because there is no information here about his neurologic problems. If this is a follow-up note, that also includes his neurological problems. If there is medication prescribed for his neurologic problems at the time of this visit, that would be below the standard of care.

Q. Why would it be important to know the things that you mentioned that aren't included in the exam?

A. We didn't know what kind of visit this is. This appears to be a visit for concerns about swelling in the legs, rash and edema.

THE MAGISTRATE: Dr. Levin, can you interpret the first substantive line on this Progress Note, the "one plus pitting."

THE WITNESS: Pitting edema, "edema" means "swelling." When you examine someone, this would refer to swelling in the legs. Swelling in the legs with one plus pitting edema, you go to the ankle, go to the foot, gently press your thumb in and if you can leave an imprint when you take your thumb away, that

Page 235

is referred to as pitting edema. In terms of one plus or greater, I would have to say at this point in my career that is beyond my expertise.

THE MAGISTRATE: Thank you.

Q. (By Mr. Paikos) Medical record 122, Bates 126, would you turn to that, please. Have you reviewed that note, Doctor?

A. I have.

Q. Was Dr. Padmanabhan's care within the standard of care on this date?

A. It was below the standard of care.

Q. Why?

A. The history that we are being given. First of all there is limited information with regard to previous concerns about the legs. The only information we have about that is the purpura returned when he took a Dilaudid pill. I'll come back to that in just a moment. He is almost at his baseline. He has had his shots placed, prednisone taper, health is well. Purpura returned when he took a Dilaudid pill without noticing the name of the manufacturer. All else is the same.

We have no history, we don't know if

Page 236

anything is happening neurologically, no information with regard to his pain with his legs, his numbness, the concern about him having a myelopathy. We have no information with regard to his neck, his arms. There is no history here at all.

We have very little information in terms of what happened with his legs in terms of the follow-up. He was going to be having a pelvic ultrasound. No information about that or no information about follow up with other doctors.

And then we have information about his shots. We don't know what type of shots he has, if this is an epidural injection, if they are facet blocks. We have no information about that, what medication he received or his reaction to the medicines except we are told that prednisone taper helped as well. Unfortunately there is no previous information about a prednisone taper. This is the first time we have seen information that he received prednisone.

THE MAGISTRATE: And that it tapered.

THE WITNESS: And that it tapered,

Page 237

correct.
THE MAGISTRATE: And how it helped. And there is no indication of how it helped?
THE WITNESS: That's correct.
A. The purpura returned when he took a Dilaudid pill, and there is a note that we'll get the name of, the generic name of the manufacturer and record it as an allergy. This the first indication that he was prescribed Dilaudid. Dilaudid is another narcotic, another opioid. So looking at the note, previously he had been on Oxycontin, oxycodone, and now it appears he is also receiving a prescription for Dilaudid. This is the first time that I have seen Dilaudid in the progress notes. We don't know how long he has been getting it, why he is getting it, how much was prescribed, did it help him or did he have side effects from it. All we know is all else is the same.
There is no Examination listed, there is no Impression, no information here at all. Says all else the same. I don't know if that refers to History, no Examination. We don't know anything else.

Page 238

Q. What is a prednisone taper?
A. It is a, typically you give somebody a course of prednisone. Prednisone is an anti-inflammatory medication taken by mouth. And frequently you will give them a tapering course and start them perhaps at 40 milligrams a day, 60 milligrams a day for one or two days, and the next day go to 40 milligrams or 50 milligrams for two days, 20 milligrams for one or two days and bring them down for a period of a week to ten days. And it is referred to as a steroid taper or a prednisone taper.
The Assessment and Plan is chronic radiculopathy. We don't know if that refers to the neck or back or both, we don't know anything about his symptoms or what's happening with him clinically. Is he better, worse, does he have a myelopathy, has that been ruled out, does he have symptoms from that. The concern about the deep vein thrombosis, it looks like that was ruled out. He had a pelvic lymphatic problem. We didn't know anything about that.
We don't know what meds were refilled or prescriptions. We don't know the names of the

Page 239

medicines or what he has been given, the dosages, the refills. There is no information.
Q. Prednisone you said is a steroid?
A. Yes.
Q. Are shots, there is a reference to shots, and we don't know what they are from this note. Are there sometimes steroid shots given?
A. Yes.
Q. Do steroids have potential negative consequences?
A. Are you referring to the oral and the shots or both?
Q. Just in general.
A. In general steroids are medicines that need to be respected. They have a potential for many serious side effects, particularly with chronic usage, must less so with acute usage. You can give a short-term course or injections as well. With chronic usage there are many serious side effects, breakdown of bone, accumulation of fat in the face, in the upper back, can lead to liver disease, lead to weakness, breakdown of muscles, weakness in the lower extremities, lead to ulcers, so many possible significant side

Page 240

effects from chronic usage. Much less so with prednisone taper. Short course most of the time is very well tolerated. But again even with a short course there are other possible serious side effects. For example, can cause a joint necrosis, a breakdown of the joint, typically the hip or shoulder. A rare side effect but one that we with will generally warn our patients about, should they develop sudden pain in the joint. Again side effects from epidural injections, much less so, typically very few systemic side effects, although you may have local side effects from the injections.
Q. Would it be important to know what kind of injections for a subsequent provider?
A. Yes.
Q. Why?
A. We don't know what type of shots were placed, if it was an epidural, they could have been facet blocks, trigger-point injections. There are many possible shots. Generically he could have gotten a flu shot. I don't think so. He was referring to a shot for his pain, but I don't know that.

Page 241

Q. Going to medical record 139 Bates 127 --
THE MAGISTRATE: Before you move on, if I could ask Dr. Levin, how would the first substantive line, what does that mean to you, Patient D is almost at baseline again?
THE WITNESS: It means nothing. I have no information. I don't know what his baseline is.
THE MAGISTRATE: We don't know what "almost" means.
THE WITNESS: (No response).
THE MAGISTRATE: Even if we knew baseline.
THE WITNESS: If we knew baseline, I guess we would know what "almost" is.
THE MAGISTRATE: So if we knew baseline, we still wouldn't know how great the magnitude of deviation from the baseline is.
THE WITNESS: Correct. We have no idea what this refers to, if it refers to his neck, his back, to his numbness, to his pain in his legs. Does it refer to the knee problem, does it refer to the firmness of his calf, does it refer to his purpura. We have no idea what that

Page 242

means.
THE MAGISTRATE: I can guess, but, Dr. Levin, I want to hear from you. He threw them out without noticing the name of the manufacturer. He will get the name of the generic manufacturer. What is the significance of that?
THE WITNESS: The concern is the patient had an allergy to Dilaudid. He did not have an allergy to other opioids, and I would have to look it up. I don't know what the cross-reactivity is. If you are allergic to Dilaudid, does that mean that you would be allergic to Oxycontin or oxycodone as well? That would seem not to be the cause because he had been on that with no trouble. If there is a cross-reactivity, and I don't know this, then the patient was having a problem with the medication, he would worry about it being not the specific medicine but rather perhaps the generic formulation. The generic formulation may have other impurities or substances in the medication that could have resulted in the allergy.

Page 243

Q. (By Mr. Paikos) On this note March 18, 2008 now, is there anything regarding pain down the back of the patient's leg? March 18, 2010 the one the Magistrate was just asking you about on your medical record 122, not moving away from that.
A. It does say encounter, top says encounter date March 18, and I see from the doctor March 21 says signed. So the assumption would be that he signed it, especially since the registered nurse's note is March 18. So we are talking about the note of March 18?
Q. Yes, encounter date and the signed date from Dr. Padmanabhan is March 21. Is there any notation about pain down the back of the leg, left or right?
A. No.
Q. If we go to medical record 139 of Bates 127, June 15, 2010 examination. That goes to the next Bates stamp and medical record number page.
A. What is the page number?
Q. Medical record 139 and Bates 127 and 128.
THE MAGISTRATE: Are you moving on from 126, or are you relating it to 126?
MR. PAIKOS: We'll relate it to 126.

Page 244

Q. Is there a notation about leg pain on this note?
A. There is.
Q. What does it say?
A. Still has pain down the back of his left leg greater than his right leg.
Q. So reading the rest of the note on the two pages, could you assess the standard of care?
THE MAGISTRATE: You are asking Dr. Levin to go beyond 126 at this point?
MR. PAIKOS: Yes, to 127 and 128.
THE MAGISTRATE: If I could follow up on some questions on 126 before you do that. The encounter date of March 18, 2010, does this relate to concerns and reporting to the manufacturer about side effects? He threw them out without noticing the name of the manufacturer.
THE WITNESS: I don't know. The presumption that I would make from looking at this, the doctor was concerned why the patient had a drug allergy, what appeared to be a drug allergy. He was concerned about possibly the generic form as causing the drug allergy. Although the patient said he threw them out, he

Page 245

was going to try to get the name of the generic manufacturer and the doctor was going to record this as an allergy. Whether this was going to be reported to the manufacturer or some other agency, I don't know.
THE MAGISTRATE: Do you interpret "recorded as an allergy" to mean in the patient's records?
THE WITNESS: Yes.
THE MAGISTRATE: And the patient's records do not have an indication of him being prescribed Dilaudid?
THE WITNESS: Not that I saw.
THE MAGISTRATE: If he was prescribed that and he threw them out, would that be a concern?
THE WITNESS: Potentially could be a red flag that the patient threw out an opioid.
THE MAGISTRATE: And it also means he is not complying with the prescription?
THE WITNESS: No, that wouldn't be true. If a patient is having what he believes to be an adverse reaction and chooses not to take the medication because he thinks he is having a side

Page 246

effect and adverse reaction, that would not be correct. That would be something that would be quite sensible on the part of the person. The purpura was better, he took a Dilaudid and he noticed that his purpura returned. And I think it would be sensible on the part of the patient to say this pill seems to be giving side effects, I'm not going to take them any more. I think it would be reasonable on the patient's part not to take the pill.
THE MAGISTRATE: Would it be the standard of care for the follow-through that this medical record indicates on the patient noticing the return of his purpura and discarding the medication?
THE WITNESS: Repeat the question?
THE MAGISTRATE: Seeing as the patient noticed the return of his purpura and discarding the medication, is the doctor's response as recorded in the medical record within the standard of care, doctor's response to that report an action by the patient?
THE WITNESS: It's within the standard of care.

Page 247

THE MAGISTRATE: Thank you.
Q. (By Mr. Paikos) Going now to Patient D's medical record 139, Bates 127.
THE MAGISTRATE: Mr. Paikos, you can start on that. We're a couple of minutes away from one o'clock.
MR. PAIKOS: We could take the break now, that is fine.
THE MAGISTRATE: Let's break for an hour.
[Pause]
THE MAGISTRATE: Back on the record. Dr. Padmanabhan, you had a motion for me and I said file it at DALA. I happen to be walking back to DALA, so I will take it. I don't know when it's going to be docketed.
DR. PADMANABHAN: (Document handed.)
THE MAGISTRATE: I can't commit to when I will be able to look at it substantively.
DR. PADMANABHAN: This is a different date.
THE MAGISTRATE: This is dated today. Is this the one that you were referring to yesterday?
DR. PADMANABHAN: Yes.

Page 248

THE MAGISTRATE: Same motion but with a different date?
DR. PADMANABHAN: Yes, because I certified that I handed it, so it is today's date.
THE MAGISTRATE: I see. Thank you.
With that we will take a one-hour break.
[Lunch Recess]
THE MAGISTRATE: Dr. Levin, you are still under oath.
THE WITNESS: Yes.
Q. (By Mr. Paikos) I think on medical 122 Bates 126 we saw AP chronic radiculopathy, meds refilled. If you could now go to the 6-15-2010 note, medical record 139 Bates 127. Look at this note and assess the care provided.
A. I have reviewed the page.
Q. How would you assess the June 15, 2010 note in of itself relating to the prior note of March 18, 2010?
A. Would you like me to discuss the note by itself first or discuss them together?
Q. Discuss it for itself.
A. This note dated 6-15-2010 was below the standard

Page 249

of care. Discussing the note, there is a note that the patient has not had as good a response to the set of epidural steroid injections as before. The prednisone course still had pain down the back of the left leg greater than the right leg. Still struggles with his weight.

There is no other information with regard to his pain problems. There is no information with regard to the previously mentioned myelopathy, no further discussion of the previous problem as related to his rash, either the purpura or the other rash related to or possibly to the Dilaudid. No information with regard to the prescribed oral medications with the exception of prednisone. There is a discussion of that.

The examination lists detailed vital signs. The only other information about the examination is exam not changed at all. This would be below the standard of care. There is no information in terms of his neck problem, his back problem, his leg problems. We have no information at all.

Assessment, his back pain and

Page 250

radiculopathy. I don't know where the radiculopathy was. We don't know if it relates to the lumbar region, cervical region. We don't have any real detailed information.

Meds were refilled. We don't know what medications were refilled, we don't know doses of medicines, what they have been used for, the amount prescribed. We have no information at all about the medications that are being prescribed.

There is a Plan to change his diet and timings, presumably by the time the meals are taken. There is a note below the doctor's note from the nurse indicating that continues to have pain 9/10; with pain med, down to 6/10. States cortisone injections have helped. Uses cane when ambulating, careful when doing stairs. This seems in conflict with the doctor's note, and the nurse is indicating her history is that the cortisone injections have helped. His note indicates he has not had as good a response from the latest set of steroidal injections.

Would you like me to relate it to a previous note?

Page 251

Q. Yes. If I could, is there a mention in the March 18, 2010 note of pain down the back of left leg greater than right leg?

A. No.

Q. But still has pain down the back of his left leg greater than right leg on June 15, 2010?

A. Correct.

Q. Is there an issue with that discrepancy?

A. The issue would be that there is a discrepancy. June 15, 2010 he still has the pain, but in the previous note there is a no indication that he had the pain. The previous note indicated that he was almost at his baseline, but there was no clinical information with the exception of his purpura returning.

Q. Would it be important to know where the radiculopathy is on June 15, 2010, cervical versus lumbar, and if so, why?

A. Yes. It would be important because this is a, the basic information in terms of proper care of the patient. We would want to know if he is having pain in his neck, his arms or his legs and his back. Are they separate problems, are they occurring together, how are they affecting

Page 252

him. What medications is he getting for these, are the medications helping him, specifically in terms of prescribed oral medications in addition to the prednisone and the epidural injection.

Q. If we go to September 1, 2010, medical records 154.

A. Reviewing the Progress Note of 9-1-2010, this note is below the standard of care. History is patient is here for his refills. He needs to have his epidural shots done again. All else as before. That's, everything that is written is the entire note.

There is no information, no history. We don't know anything about his pain, we don't know where the pain is, what his response is, what his response to medicines is with the exception of he needs to have the epidural shots. But we don't know if he has had further ones, ones since his last visit helped him or not. We have no information with regard to any examination, no neurological examination and no impression. So we don't know how the patient is doing, what the medical progress is. Does he still have concerns of a myelopathy, are there

Page 253

concerns about a lumbar and/or cervical radiculopathy, is he doing well, poorly. We don't know, there is no information, and no information with regard to any plan or any medicines that have been prescribed. There is no information at all.
Q. Did Dr. Padmanabhan provide adequate care to this patient on this day?
A. No.
Q. We don't know if "all else before" refers to the prior visits or the other visits which had the variety of recurring problems?
A. That's correct.
THE MAGISTRATE: Before you move on, Dr. Levin, is there a way to reconcile "all else as before" and "he needs to have his epidural shots done again"?" Doesn't that indicate that "all else" is not "as before"?
THE WITNESS: I don't know what "all else as before" refers to. It's a vague statement, and I don't know what it means.
THE MAGISTRATE: If in fact this patient does need to have epidural shots done again, does that indicate that all else is not as

Page 254

before?
THE WITNESS: Not necessarily. It may be that what was happening before was that he needed to have epidural shots, so he continues to have that need. But I'm only guessing; I don't know.
THE MAGISTRATE: Is there a way to reconcile the nurse's note that "the pain is increasing" with the doctor's note that "all else as before"?
THE WITNESS: I cannot.
THE MAGISTRATE: Is it in conflict?
THE WITNESS: Again I don't know what "all else as before" is referring to, so it's difficult for me to say whether or not it's in conflict since I have no information with regard to the patient's pain. There is inadequate information to compare the two notes.
Q. (By Mr. Paikos) Doctor, if you could go to medical record 160 to 162, Bates 130 to 133. Who is this from? Is this a note from Dr. Padmanabhan?
A. It is not, it is a note from-- Do you want me to state the name on the record?

Page 255

Q. For the physician, yes.
A. The name of the person writing this note is Lee C R A M B E R G, M D. States "Neurologist" under his name.
Q. Is this a neurological exam that would be typical of what a neurologist would write?
A. This is a detailed neurological evaluation and it is an evaluation that would be typical of what a neurologist would write.
Q. And under, on page 162 for the medical record, Bates 132 there is a section that, part of that starts "to tide the patient over until." What was Dr. Cramberg's plan relative to the prescribing of further Oxycontin, oxycodone and Diazepam -- Which is Valium?
A. Yes. If I may read it, it states, to tide the patient over until he is able to find a physician who will assume responsibility for his analgesic prescriptions. I have acceded to the patient's request for renewal of his pain medications today, his Oxycontin, oxycodone and Diazepam, each for a one-month supply with no refills. I will see him in follow-up in one month. I am willing to renew his analgesic

Page 256

prescriptions one month at a time for a total of three months.
THE MAGISTRATE: I see it, thank you.
Q. Turning next to the next patient --
THE MAGISTRATE: We are done with the documents for Patient D?
MR. PAIKOS: Yes.
Q. This is at tab 6 Patient E's medical record 3, Bates 137 to 139, medical records page 3, 4 and 5.
A. Shall I continue through 4 and 5?
Q. Patient E, what are the problems he presents with?
A. He had a fall. He has sharp severe pain radiating down the right leg, occasionally numbness in the posterior thigh. Severe back pain. And it says "occasional pinch." Doesn't state specifically where the pinch is.
Q. And there is some information regarding his wanting to finish a criminal justice degree going to the US Special Forces and the New Hampshire Police as well on the medical record 3, Bates 137?
A. Yes.

Page 257

Q. At the bottom of that page there is a history about what he had been prescribed previously?
A. Yes.
Q. What had he been given by other physicians?
A. Percocet.
Q. On the next page is there an Impression?
A. Yes.
Q. How is Dr. Padmanabhan's neurological note here?
A. It's within the standard of care.
Q. What is his Impressions and Plan?
A. Impression is lumbar disc disease with a pinched nerve root, that the MRI showed a disc protrusion at L5-S1, L4-5 levels. Plan was for aqua therapy, epidural steroids, Percocet, and to have a follow-up appointment in three weeks.
Q. Is that Plan, Impression within the standard of care given what you have in front of you?
A. Yes.
Q. If we go to medical record for Patient E --
A. The only concern I have with him within the note, there is no indication of the amount of Percocet that is being prescribed.
Q. Why is that important?
A. That any time a medication is prescribed,

Page 258

particularly an abusable medication, it's important to know the number of pills that are bring prescribed, are there going to be refills.
DR. PADMANABHAN: May I object, Your Honor.
THE MAGISTRATE: And the basis?
DR. PADMANABHAN: It's right there (indicating).
THE MAGISTRATE: Well, you can bring it to Dr. Levin's attention on cross examination, or you can confer with Mr. Paikos if you want.
THE WITNESS: May I make a further comment?
MR. PAIKOS: Yes.
A. Looking once again, I believe I have misspoken. There was a note here that 90 pills were prescribed, so my previous statement about the problem with the Percocet prescription is incorrect. It was within the standard of care.
Q. This is, essentially this is the way that neurological notes should be written to be within the standard of care?
A. Correct.
THE MAGISTRATE: Following up or your

Page 259

last answer, Dr. Levin, this appears to be an initial visit?
THE WITNESS: Yes.
THE MAGISTRATE: Are such medical records supposed to be more detailed than follow-up?
THE WITNESS: In general, yes.
THE MAGISTRATE: Do we have anything to compare this medical record for Patient E with the initial visit to the previous patients we've seen?
THE WITNESS: I would have to go back to those previous charts to answer your question correctly.
THE MAGISTRATE: But is it a fair comparison to compare an initial visit report with follow-up visit reports?
THE WITNESS: Yes.
THE MAGISTRATE: And in general is this the kind of detail the standard of care calls for in follow-up visit reports?
THE WITNESS: No, that would not be correct. This is the type of detail one would expect in an initial visit. Follow-up visits also demand detail but they don't demand as much

Page 260

detail in general as an initial visit. Depending on the patient's needs, depending on the acuteness of the situation and depending on the patients's clinical course, your follow-up note may or may not be this detailed, but in general this is a routine neurological evaluation, the initial visit.
For follow-up visits the History oftentimes is more focused, not as detailed as this, but there should still be a detailed history. The neurological examination would not in general have to be as complete as this, but many elements of the neurologic examination still need to be present. Frequently an entire, brief neurological examination is listed for a follow-up visit.
When I see patients for a follow-up visit, I include every element of the neurological examination in my follow-up visit in my note. I do not include some portions of the exam that I do on my initial visit. For example, when I first see a patient I examine smell, I examine visual fields, sensation on the face. Unless there is a reason to do so on

Page 261

follow-up visits, I don't examine those on follow-up visits, so that would not be included in my note, but I still would examine mental status, motor examination, etc.

THE MAGISTRATE: Looking at the medical record that starts on page 3, Bates 137, what in this initial visit report would you expect to find in a follow-up visit report that you have seen lacking so far?

THE WITNESS: You expect to have a history, so you expect there to be a follow-up history detailing the patient's present course, his present clinical symptoms, what has changed since the last visit. If this is a pain problem, has the pain gotten better or worse, where is the pain, what are the circumstances of it, is it extending to other portions of the body, is the pain going from the back to the legs, for example.

THE MAGISTRATE: Can you point out where that kind of thing appears in this actual record?

THE WITNESS: In this note?

THE MAGISTRATE: Yes, that you would

Page 262

expect to see roughly comparably in follow-up visit notes. I'm looking for a comparison.

THE WITNESS: Well, again it could be a follow-up visit, so typically you would say "since his last appointment," or I would oftentimes put in "since his last appointment on 9-19-2007 patient is" and you would say the patient is better, worse, the patient is the same. "Patient continues to have," and you would describe symptoms that you described before. There is a description of severe back pain, so I might say the usual course would be "patient continues to have severe back pain" and that the patient's back pain has improved or changed in some way. He notes that there is a severe sharp pain radiating down the right leg, so there would be a note, "right leg pain is improved" or "right leg pain continues to be severe with radiation down the leg, continues to start at the hip and goes all the way down, continues to have numbness occasionally in the posterior thigh" or "numbness in the thigh is gone" or "numbness has become worse and now involves the left leg extremity," comments on

Page 263

what is happening.

Describing what has been the effect of treatment, "patient has gone for aqua therapy and found this to be helpful;" "patient went to aqua therapy and it didn't help him, is now taking Percocet at one tablet three times a day with good improvement, pain improving from 9/10 to 2/10."

THE MAGISTRATE: These are hypothetical examples?

THE WITNESS: I'm using this as a template. You were asking me what I would do, what he could possibly do as a template. These are the types of things. For each area of the examination, for Objective, for the Physical Examination you would like to see a pertinent examination relating to his problem; the examination of the neck and the back, what is the examination of at the very least, the lower extremities, motor reflexes, coordination, what does his gait look like. And these should be parts of the follow-up exam. You wouldn't have to have every single detail of the initial exam.

THE MAGISTRATE: Thank you.

Page 264

Q. (By Mr. Paikos) On October 31, 2007 there is a visit that the patient had to the ER beginning at medical record number 12 going to 13 and 14 and Bates 142, 143 and 144. What would be significant in this note for further treating the patient?

A. This is an evaluation I believe at an emergency center, SH Emergency Center, appears to be an emergency center. Emergency department report on page 12. This is from --

THE MAGISTRATE: I assume that is Somerville Hospital.

THE WITNESS: I would assume so.

May I state the name of the physician?

MR. PAIKOS: Yes.

A. The name of the physician is Patti, P A T T I, Purpura, P U R P U R A, MD. Dr. Purpura gives a very detailed evaluation of the patient, medical history and evaluation and has some significant concerns that she raises.

She reviewed, took a full medical history from the patient and reviewed the other records. She notes that on reviewing his old records, it appears he has been seen several times by a

Page 265

neurologist at Whidden Hospital. She read the consult into the computer with the assumption that this is Dr. Padmanabhan's consult and notes there was some conflict in the history that the patient told the patient versus what he had told her. Specifically he had told the neurologist that he had an abnormal MRI, and in addition he told her that he had an initial injury six months ago and was reaggravated today.

He told her he was given a prescription for Percocet that he had filled at the beginning of October and he ran out of medication two weeks ago. She called a number of different pharmacies and found discrepancies in the information that had been given to her by the patient. After calling Brooks as well as Walgreens Pharmacy, it was clear that the patient has been seeing multiple different physicians to get narcotic medication. I am concerned that the patient is exhibiting signs of addiction, is not being truthful about the medication he is using and uses multiple different physicians to obtain medication. I explained that I am concerned --

Page 266

THE MAGISTRATE: I can see that on the third page of the record.

A. She basically says she is not going to give him a narcotic, advised him to discuss this medication with his physicians and gave him a limited number of Motrin for his pain.

Q. Is Motrin a narcotic?

A. It is not. It is a nonsteroidal anti-inflammatory medication.

Q. And did she also raise concerns about addiction?

A. She did.

Q. And one of the diagnoses is back pain and the other one is narcotic-seeking behavior?

A. Correct.

Q. And he was discharged in good condition on October 31, 2007?

A. Correct.

Q. If we go to medical record number 198 which is Bates 162, medical record 198 Bates 162.

THE MAGISTRATE: Before you do that, if I could ask Dr. Levin, the fact that Dr. Purpura examined medical records of Dr. Padmanabhan, indicates the importance of any doctor's records being complete so that another doctor can

Page 267

examine them and understand them?

THE WITNESS: That's correct.

Q. (By Mr. Paikos) The other page was medical record 198, Bates 162.

A. Reviewing the records from November 2, 2007 this note is below the standard of care.

Q. Why?

A. History indicates continuing back pain, working with UPS not helping. I don't know what "not helping" refers to. I don't know if that refers to his UPS or refers to medication or his aqua therapy. I don't know what that refers to. We have no information other than "continuing to have back pain," no information about pains in his legs, numbness, weakness, no information about any medication that he has been taking, if he is taking Percocet or not taking Percocet. No information that he is going to the emergency room. We don't know anything at all. There is no history there other than "he continues to have back pain."

Objective is positive muscle spasm, positive guarded movements. We don't know where the muscle spasms are, there is no indication of

Page 268

any specific part of the body, we don't know what the guarded movements are or what part of the body is guarded. There is no other neurological examination or other physical examination, so there is no guidance in terms of how the patient is doing objectively.

Assessment and Plan, there is no Assessment. We have no diagnosis, we don't know what the impressions are in terms of what is wrong with the patient, is this a neck problem, a back problem, a neck problem. There is no information. We don't know how he is doing in items of the medication, we don't know what medications were prescribed previously and his response, we don't know how he did with the aqua therapy. There is no information.

The Plan is aqua therapy. Avoid reinjury and pain control. I don't know what "pain control" refers to. The assumption would be that this would be some type of medication, but I don't know if this refers to medication, what was prescribed, if there were injections or not. There is no information.

Again going back to your previous

Page 269

question, were the emergency room physician to look at this or some other physician to look at this, they would have no information about the patient, if the patient is a drug-seeking patient, if he has a narcotics problem. There would be no way to know that from this record.

Q. And you said there was no diagnosis. Is it important to have a diagnosis when seeing a patient?

A. Yes.

Q. Why?

A. It guides you in terms of your assessment for the patient and what you are doing to help the patient, at least to have a basic diagnosis if not a definitive diagnosis to know what you are dealing with in a general sense. Guides you knowing what the patient is complaining of and guides you in terms of your overall assessment of the patient. If you are fortunate enough to have a definitive diagnosis, that is very helpful in terms of guiding you for treatment; if you don't have a definitive diagnosis, to know what type of problem you are dealing with so you can focus on it each time you see the

Page 270

patient to try to help the patient.

Q. Doctor, if we can go to medical records 27 and 28 which is Bates 145 and 146. Does that talk about the patient's career plans or path in medical record 27?

A. Would you like me to discuss the note first or answer your question?

Q. If you could discuss the note initially and any issues that are there.

A. The history of the examination is certainly much more detailed than the previous follow-up notes. It would be within the standard of care. He notes the visit to the emergency room and concerns about patient visiting multiple physicians to get narcotic medicines. Also notes that he had seen Dr. Shalnov who is a pain specialist to receive a set of epidural steroidal injections which helped him. He described how the patient is doing. His examination I think is a good example of the type of exam that you were asking me about before. This is a good follow-up neurological examination. The only thing that I can see in the exam that should be here that is not here is

Page 271

an examination of his back. There is no examination of back or neck. That would be below the standard of care. The remainder of the exam is within the standard of care.

His Impression is within the standard of care. His prescription, he does detail that he has given him Percocet three pills, three times a day, and previously had been or currently is at a dose of 15 milligrams three times a day is sufficient. I'm a little confused that I don't know if the 15 milligrams three times a day refers to Percocet or refers to a different medication. He does not state how many pills of Percocets he is giving, he doesn't state if there are any refills.

Given the concern about his patient having drug-seeking behavior, I would think that would be quite important to know how many pills he is prescribing, either refills. If the 15 milligrams three time a day refers to Percocet, and again I don't know that as a designation for Percocet so I'm not sure what that refers to, if that is referring to another medication, the specifics, missing specifics

Page 272

about the medications would be below the standard of care, especially in a patient who may have a problem with narcotic abuse.

Q. Does this note show any kind of Assessment -- Well, there is no mention about -- There is mention that Dr. Padmanabhan had access to Dr. Purpura's note, correct?

A. Correct.

Q. Is there mention of anything about the patient's potential addiction that the ER physician thought that he left in good condition or that he showed narcotic seeking behavior?

A. He discusses Dr. Purpura's notes and the concern about seeing multiple different physicians to get narcotic medications, filling them at multiple pharmacies, so Dr. Purpura does not use the term "narcotic-seeking behavior" or Dr. Purpura's assessment. He does in effect describe that behavior. In his Impression he does not mention it.

Q. Does he mention any assessment he did to determine whether or not this person was at risk of misusing or abusing this medication --

A. No.

Page 273

Q. -- given the ER note?
A. Yes.
Q. Would that be below the standard of care?
A. Yes.
Q. There is a conversation that he had with the patient about it as you could see from this note?
A. He mentions we had a very long discussion about his future, but he does not mention any discussion of concerns about narcotic-seeking behavior or prescription of the narcotic medication, too, other than the specifics of what he is giving him as his prescription.
Q. It says we had a very long discussion on his future, and he has promised to have a more helpful attitude.
I'll leave the record to speak for itself and not ask you a question about it.
THE MAGISTRATE: Mr. Paikos, if I could ask some follow-up questions. Just to confirm, Dr. Levin, we know from the top of medical record 28, Bates 146 --
THE WITNESS: What page?
THE MAGISTRATE: Page 28, Bates 146. We

Page 274

know that Dr. Padmanabhan is familiar with Dr. Purpura's report. Do we have any indication that he acted on it?
THE WITNESS: No.
THE MAGISTRATE: Is that below the standard of care?
THE WITNESS: Yes.
THE MAGISTRATE: I'm looking on the same page at vital signs which do not appear in a lot of the records we've seen before in the follow-up visits. Should vital signs be in the follow-up visit reports?
THE WITNESS: Typically vital signs are in the follow-up visits. It's not essential. It is still within the standard of care for a neurologist not to have the vital signs. Sometimes you include some of them. For my routine I include heart rate for my follow-up visits and typically blood pressure as well.
THE MAGISTRATE: But to have vital signs absent from follow-up visit reports is not below the standard of care?
THE WITNESS: Correct.
Q. (By Mr. Paikos) Go to medical record 34 and 35,

Page 275

Bates 147 and 148. If you could review that note.
A. Before I review that, you asked me a question on the previous one that I don't believe I answered. You asked a question about the type of work he was doing, and in the pertinent, on page 27 the bottom of the page he has been in a training program to become a career police officer. He has recently accepted an offer to join the Drug Enforcement Administration and has recently returned from a training trip down to Florida. That was of some concern. We have a patient who appears to have narcotic-seeking behavior that it would not appear to be appropriate for that person to be a Drug Enforcement Administration officer.
Q. Did it explain some of the things he was able to do physically as part of his training?
A. Yes, he was able to physically do significant activities without a problem.
Q. Does that raise a further concern relative to the prescribing of narcotics, that there is this information about his ability to run two miles in under nine minutes?

Page 276

A. It does. He is somebody saying he has significant pain and needs to have pain medication to help him with his pain, and yet he is able to run two miles in under nine minutes. That seems to be some conflict there.
Q. That is part the reason, is that part of the reason that Dr. Padmanabhan's prescribing of the narcotics was below the standard of care in addition to what you have already mentioned?
A. I think there is a disconnect between the history of his ability to run two miles under nine minutes, his training to join the Drug Enforcement Administration and his need to have Percocet, his need to have a narcotic. At the very least that would be something that would be worth mentioning, something that is worth discussing under the impression.
Q. And there is no acting upon these inconsistencies or suspicions based on the ER note and what is in Dr. Padmanabhan's note?
A. Correct.
Q. If we go to medical record 34 and 35, the March 24, 2007 visit which is Bates 147 and 148 as well as medical record 34 and 35, if you

Page 277

could review that note.
A. I have reviewed the note. The history is within the standard of care. There are some points in the history that are perhaps worth noting, that he is working at UPS delivering parcels and he again has thrown his back out. He is going to graduate from the police academy. Again this would cause me concern having somebody who potentially may have a narcotic addiction problem who is going to be a police officer.
There is a little bit of a mixture here of the history and physical examination. He complains of increase of muscle spasms in the lower back, and indeed they are very easily palatable, much worse on the right than the left.
Jumping from the history to the exam, the neurological examination is within the standard of care. And again we go back to your question about proper follow-up neurologic examination, and this is really quite a good neurological examination for a follow-up note. He goes through pertinent examination. Neurologically there is an examination of the back, and this is

Page 278

the type of examination that would be expected for a neurologist for a follow-up.
The Impression in general is within the standard of care, there is muscle spasm, significant muscle spasms more on the right than left. He gives him treatment for this and he describes treatment he gave him for this.
Then he prescribes Percocet and he increased the dose from five 325 to ten 325 and increased it I believe from one pill now up to two pills three times a day. He is unclear -- Excuse me, I misread it. Previous dose was five 325, three pills three times a day. He is now prescribing ten 325, two pills, three times a day. There is no indication of the number of pills that were prescribed, whether or not there is a refill, additional prescriptions or just a single month or are there any other medications being prescribed. There is no mention here of the possibility of narcotic abuse, concerns over narcotic inconsistencies. That would be below the standard of care.
Q. Was there a reason noted specifically for the change in the medication in the Percocet?

Page 279

A. Indirectly. He states significant muscle spasm more on the right than the left, and he is treating him and increasing the dose. He does not state I'm going to increase his dose, but he does state that hopefully by the time he returns next week, he will improve in terms of his severe muscle spasm and back pain and relates to his trigger point injections.
Q. You said it changed from five 325 Percocet to 10 325 Percocet. What do those numbers mean?
A. I don't know. I'm assuming that the first number refers to the narcotic and the second I believe is acetaminophen but I'm not a hundred per sure. It is not a medicine that I commonly prescribe.
THE MAGISTRATE: Mr. Paikos, can I jump in. I want to ask you about the very first document for Patient E, medical record 3 and Bates 137. This indicates that the patient fell down the stairs and injured himself. Do you see that?
THE WITNESS: Yes.
THE MAGISTRATE: I want you to turn now to medical record 12, Bates 142. This says he

Page 280

has a sudden onset of pain in his back.
THE WITNESS: Yes.
THE MAGISTRATE: I want you to compare these two pages of medical record 34, Bates 147, he threw his back out while loading a truck.
THE WITNESS: Correct.
THE MAGISTRATE: Is this a red flag?
THE WITNESS: It is when we add in the knowledge that he has pain-seeking behavior, and there are a number of incidents in the history as obtained by Dr. Purpura in the emergency room compared to the history obtained from Dr. Padmanabhan on 9-19-2007. So the answer to your question is yes.
THE MAGISTRATE: Is it a red flag that somebody who fell down the stairs in September of 2007 is loading trucks in December of 2007?
THE WITNESS: Yes.
THE MAGISTRATE: Back to medical record 12 Bates 142, is there a red flag that the patient is reporting he injured his back approximately six months ago and comparing that to medical record 3, Bates 137 that he reported tripping down the stairs which was only one

Page 281

month before?
THE WITNESS: I'm sorry, was the question is this a red flag?
THE MAGISTRATE: Is this a red flag?
THE WITNESS: Yes.
THE MAGISTRATE: Thank you, Mr. Paikos.
Q. (By Mr. Paikos) Doctor, if we go to medical record pages 50 and 51.
A. I have reviewed this report, and it is below the standard of care.
Q. Why?
A. Looking for Impression as to how the patient is doing since his last appointment, I do not see an Impression. I see a History, I see the Physical Examination including the Neurological Examination, I see a Plan but I see no Impression.
Q. If there is a Plan, why is an Impression still important?
A. The Impression tells you what the doctor thinks is going on with the patient, his report, his interpretation of the patient's history, how well the patient has been doing since the last visit combined with his impressions related to

Page 282

his neurological examination.
Q. Does he again prescribe this patient Percocet?
A. Yes.
Q. What is Depo-Medrol?
A. Depo-Medrol is a type of steroid.
Q. And is the patient going to Dr. Shalnov?
A. Yes.
Q. For what?
A. For epidural steroids.
Q. And just to complete this date, on Bates 167, medical record 203.
A. Perhaps before leaving that, there is a prescription for Percocet. Getting the specific dosage, no notation of how many pills were prescribed, whether or not there is a refill for the month prescriptions, whether or not there are other medications that he is prescribing, other oral medications that he is prescribing. Excuse me, what page?
Q. Medical record 203 and Bates 167.
A. A note dated 1-22-2008. Appears to be an order that was written for lidocaine and Depo-Medrol ordering two vials of each medication.
Q. Is that mentioned in his note of that day?

Page 283

A. Yes. The specific medications are not mentioned. He comes in for trigger point injections as they currently, helped immensely the last time and held him for at least two weeks. And there is a note under Plan, I have gone ahead and given him trigger point injections, paraspinally. He does not state which medications are given.
Q. If we go to medical record 65 and 66 --
THE MAGISTRATE: Before you do that, if I may, Mr. Paikos. So, Dr. Levin, the records for lidocaine and the other medication indicates what was given?
THE WITNESS: It indicates what was ordered.
THE MAGISTRATE: And how is it different? I mean would this, he would put in an order during the office visit so it gets delivered to the procedure room and he can administer it. How does it relate?
THE WITNESS: I don't know. I see an order for the lidocaine, sent two 2-milliliter vials stat, please, and Depo-Medrol 40 milligrams, sent two 1-milliliter vials.

Page 284

This was in the hospital. Then this would be a typical way to write an order in the hospital and get this from the pharmacy and the patient would get the medication.
I don't know what the routine is at Cambridge Health Alliance or how they handle this type of medication. The assumption would be as you have suggested that the doctor did indeed write this order and the medications were brought to him and these were the medications that were injected; however, on his note there is no indication what was injected.
THE MAGISTRATE: But it is part of the paper trail, presumably?
THE WITNESS: Correct.
THE MAGISTRATE: What does "stat" mean?
THE WITNESS: Immediately, as quickly as possible.
THE MAGISTRATE: Thank you. Mr. Paikos.
Q. If we go to the medical record 65 and 66, Bates 153 and 152.
A. I have reviewed this note. It is below the standard of care.
Q. Why?

Page 285

A. Looking at the physical examination, this is a reasonable neurological follow-up examination. There is no examination of the back. The patient is coming in for a back problem, and there is no back examination. The Impression is he has lumbar radiculopathy. I don't recall whether we had seen that specific diagnosis before. I don't believe so. He does mention, by the way, under his History that he is on oxycodone 15 milligrams two pills three times a day. I don't believe there was a previous indication that the patient was on oxycodone. Previously he had been on Percocet.

So now he is describing a young man who had trauma to his back who has improved. He has been approved for disability. He limited his activities and definitely looks better, quote unquote, that the epidural shots seemed to have helped. He is prescribing the oxycodone. I don't know what oxycodone, excuse me, the specifics of the oxycodone, I don't know how many pills he is taking, I don't know how many months he has prescribed. He previously was on Percocet. I don't know if he is still on

Page 286

Percocet or if there are other medications that he is taking.

Q. If there were prescriptions in the record showing the dose, would that in some way satisfy part of the issues relative to the prescribing?

A. It may.

Q. Additionally this patient has gone from being able to run a long period of time to being considered for disability. That with the fact of the ER record regarding drug-seeking behavior, does that raise a concern or did you learn why he has gone from being able to run to the issue of potential disability?

A. It is not explained well. There is an indication that he is limiting his activities. He is not running up and down hills, lifting weights. He is on disability so presumably he is not lifting weights into a UPS truck as well. It seems you can assume from the notes that he is better coinciding with the decrease in his physical activities. Overall he does seem to be improved, so it's not clear why he medication has not changed. He is continued on the same medication.

Page 287

THE MAGISTRATE: Doctor, if a patient presented to you with pain like this patient but also reported he is running two miles in nine minutes, would you start doubting the patient?

THE WITNESS: Yes.

THE MAGISTRATE: One of the things doesn't match?

THE WITNESS: Correct.

THE MAGISTRATE: And that is a red flag?

THE WITNESS: Yes.

THE MAGISTRATE: Thank you.

Q. (By Mr. Paikos) If you go to medical record 196 Bates 160. Review the notes of June 13, 2008.

A. I reviewed the note of 6-13-2008, and this is below the standard of care.

Q. Why?

A. The history is limited. Feeling better overall, and he has been home. Gives a little bit of information about his activities. No other information with regard to his neurologic status since his last appointment. We don't know where he pain is, is he experiencing pain. Does he have other neurologic symptoms, problem with his legs, pain, numbness, weakness. What

Page 288

medications is he taking, are the medications helping him. Is he still on disability, what activity is he able to tolerate. The neurologic examination is positive knots and spasms. There is no other information listed for the neurologic examination. We don't know where the knots and spasms were.

Q. Would that be important to know?

A. Yes.

Q. Why?

A. Are is no description of where it is. Is it in his back, legs, neck, arms, his chest. We have no information at all. We don't know anything more about his neurologic examination. We've seen from previous follow-up notes a good example of a proper note and examination for follow-up note. Basically none of that information is here, so we don't know what is happening with the patient neurologically. It is very difficult to know what his progress has been.

And then the Assessment is lumbar radiculopathy and trigger points. That is a new diagnosis. He is having trigger points now in

Page 289

addition to having lumbar radiculopathy. He has a second diagnosis or additional diagnosis.
He will come in Tuesday for injections. We don't know what type of injections or what he is coming in for, or we don't know any other medications that he is prescribed. We know previously he was on oxycodone and Percocet. We don't know if he is still getting those. There is no other information about medications that he is getting. Is he going to be having further epidural injections, has he had further epidural injections, has he gotten prednisone, will he be getting prednisone. There is no information about this at all.
THE MAGISTRATE: What was the second diagnosis that appears on this?
THE WITNESS: Trigger points.
THE MAGISTRATE: What is that?
THE WITNESS: Trigger points are areas of pain, typically muscle pain. You can see them in the neck, in the back, sometimes basically see them anywhere in the body, but they are areas of pain that relate to muscle tightness and sometimes to muscle spasm.

Page 290

THE MAGISTRATE: I myself don't need a break, but let me ask other people if we need a break before we continue.
[Recess]
THE MAGISTRATE: Let's resume.
Q. (By Mr. Paikos) Doctor, if you would go to medical record 204, Bates 168. Are those physician orders?
A. Yes.
Q. And for August 28, '08 and September 29, '08?
A. Yes.
Q. What are those? What is the order for?
A. Those are both orders for Botox.
Q. What is Botox used for neurologically?
A. It is used for a number of different conditions neurologically. It is used for chronic headaches, chronic migraines, used for different types of dystonias, conditions that can affect different parts of the body and resulting movement disorder. The most common type of dystonia is cervical dystonia known as torticollis, involuntary movement of the head and neck to one side and is difficult for the patient to move beyond that. You can have

Page 291

dystonias in the hand where it is difficult to use the hand.
Botox is used for conditions that have significant spasticity. For example, if someone has had a stroke and there is marked increase in the tone of the arm or the leg, one of my patients with cerebral palsy who is getting Botox injections who had significant spasticity in her legs, these are usual uses of Botox in neurologic disease.
In general the use of Botox is quite regulated. You have to meet certain criteria before you can actually use Botox in terms of medical indications and in terms of insurance reimbursement.
Q. (By Mr. Paikos) Was there any indication that you saw this patient, anything in Dr. Padmanabhan's notes about prescribing this patient Botox?
A. Not that I saw.
Q. Would that need to be in the record whether you were prescribing this or ordering this medication?
A. Yes.

Page 292

Q. What kind or would it be -- There was a muscle spasm as well that I believe that Dr. Padmanabhan mentioned in another place, or spasms I should say. Would that be something that might be indicated for it?
A. Muscle spasm is not an indication by itself for treatment of Botox as far as I know. I have never heard of Botox as being indicated for pure muscle spasm.
Q. Would it be indicated for radiculopathy?
A. No.
Q. What conditions, are you able to name the conditions where it could be indicated if there were spasms?
A. Post stroke. Spasticity, not spasms. You may have spasms with spasticity. Would you like me to explain?
Q. Sure.
A. Normally the muscle tone is regulated by nerve fibers. The fibers begin in the brain, the cerebral cortex and come down to the lower portion of the brain and come into the spinal cord. And there is a modulation of tone in the extremities, in the arm or leg. If there is

Page 293

damage along the neuro axis from the brain to the brain stem to the spinal cord, that can result in a problem with the arm or the leg resulting in a problem with movement, typically with weakness.

Along with the weakness there is a significant decrease in the tone in the arm or the leg, and that is referred to as spasticity. People who have spasticity will sometimes have spasms as well. The arm may voluntarily contract or the leg may involuntarily contract as well, the foot may be held in a fixed contracted position as may the arm and different portions in the arm, the shoulder, the elbow.

With injections of Botox, that can help to release some of the spasticity or improve some of the spasticity, and the person can use their arm better than they could prior to the injections. This would not be medication that you would give just for simple muscle spasm for a neck problem, back problem unless there was some other type of neurologic diagnosis.

Q. So far we haven't seen in this patient?

A. No.

Page 294

Q. Medical record 199 Bates 163. Medical record 199 Bates 163 --

THE MAGISTRATE: Mr. Paikos, if I could ask a follow-up on Bates 168. In this record of Botox, is this similar to vials that are being ordered, vials being ordered presumably for use of the doctor in his office?

THE WITNESS: That would be the assumption.

THE MAGISTRATE: And the paper trail doesn't continue into progress reports, follow-up reports?

THE WITNESS: I think there is a note that Mr. Paikos is drawing my attention to that does give some further information.

THE MAGISTRATE: Okay. And one last question on medical record 204 Bates 168. NKDA, is that of significance, that notation at the top?

THE WITNESS: Yes, I know it is, but I am blocking it out. I don't remember at this moment.

THE MAGISTRATE: Okay.

Q. (By Mr. Paikos) If you go to 199, medical record 199 Bates 163.

A. I have that note.

Q. Can you tell what date it is?

A. I do not see a date on that note. I do see a date on the previous page. It appears to be a continuation from one page to the other. Bottom of page 198 the note dated 8-27-08 from a nurse, I believe, and there is an arrow extending below 198 that appears to go to the next page suggesting to me that the note that you see from the doctor is the same date.

Q. Again about Botox?

A. Correct. States, given Botox A and gives the number of units given, that the injections were given to five spots. There is a diagram. The diagram shows a single injection into the cervical, posterior cervical region and four injections into what appears to be the lumbar region although I'm not sure if it is extending sacrally or extending to the thorax region, but injections definitely into the lower and perhaps one in the middle back as well.

Q. What does it say this is for?

A. There is no indication as to why the injection was given. There is a note that patient noted improvement before leaving the clinic, positive, severe muscle spasm.

Page 296

Q. We don't know if it's given for the muscle spasm and what reason?

A. Correct.

Q. Muscle spasm wouldn't be a common indication based on your training and experience for giving Botox?

A. Not as far as I know.

Q. Medical record 195, Bates 159, the medical record 195 Bates 159. There is a 10-16-2008 note from Dr. Padmanabhan.

A. I do have that note.

Q. If you could review that and assess whether the doctor followed standard of care.

A. This note is below the standard of care for a Progress Note. The History is that patient is overjoyed that he had improvement in spasms following his second Botox injection. He is feeling much better. Came in very happy.

Objective has limited information. There is no other information with regard to his back problems. He has lumbar radiculopathy. Other

Page 297

medications. We don't know what his physical activities are at this point, we don't know what his overall pain is at that point, we don't know anything else at all.

Objective, still has muscle spasms but less severely. Rest as before. So again we have a very limited examination. This is an inadequate and below-the-standard-of-care note in terms of a follow-up neurological examination for this patient for the reasons that we have previously discussed.

Assessment is, Plan is muscle spasm and there is no other information. We don't know which muscle spasm he is referring to, we don't have any other information about how he is doing with his pain problem, neck problem, back problem, leg problems. We don't know how he is doing with his medications, what medications are being given. It just says RX given - pain! I don't know what that means. There was no indication of which medications were prescribed.

This is a patient who had been prescribed oxycodone, Percocet, prednisone, epidural injections. We do not know if one or all of

Page 298

those medications have been prescribed at this point. We have no information. This is below the standard of care.

Q. Medical record 194 which is at Bates 158. If you could review that note.

A. I have reviewed this note. This note is below the standard of care.

Q. Why?

A. Notes continued improvement with Botox. We don't know what is improved, what problem the Botox is being prescribed for. Has five really bad days a month. We don't know what that refers to. Bad days because he is in pain? Where is the pain, does he have other neurologic symptoms, are they bad days because he is depressed, because something happened to him. There is nothing about that.

There is a note for which he takes Dilaudid. First indication of a prescription for Dilaudid, a narcotic, so this would appear to be a third opioid that is being prescribed. I don't know if Dilaudid is in addition to oxycodone and Percocet, replacing them. There is no information. We don't know how much he is

Page 299

taking or the effect. We don't know the side effects. There is no other information about his clinical course, how he has done since his last appointment other than improvement with Botox.

Objective, examination is listed as stable exam without change. Once again this is an inadequate, below-the-standard-of-care follow-up neurologic examination for the reasons we previously described.

Assessment and Plan, Assessment is lumbar radiculopathy. Describes the discussion that he had with him about accepting, acceptance in plans, and then he was given a prescription for Dilaudid to avoid ER visits. This is a below-the-standard-of-care note. We don't know what the dose of the Dilaudid is, how many pills he is prescribing, how many refills he is given. Is he prescribing other medication, is he continuing to prescribe other narcotics another nonnarcotic medications. There is no information.

THE MAGISTRATE: Before we move on, Dr. Levin, the last two written lines on 194

Page 300

medical record and Bates 158, I see "Dilaudid to avoid ER visit." What does it say before that?

THE WITNESS: "Given RX for Dilaudid."

THE MAGISTRATE: And what's your assessment of prescribing Dilaudid to avoid ER visits?

THE WITNESS: Standing by itself it is difficult to understand that. Given that the patient had already been prescribed two other narcotics and I don't know if he is taking them or not, I think the idea of giving him a narcotic to avoid an ER visit is not an unreasonable thing to do. If we have a patient who is going to the ER frequently, a patient who is suffering with acute pains, there is no indication that he is going to the emergency room frequently, there is no indication that he is suffering from acute pain. We have no description about his pain, all we know he is having no improvement, five bad days a month but we don't know what that means. We can't assess whether the Dilaudid is reasonable. It would appear not to be reasonable to give another opioid with the history that we have.

Page 301

THE MAGISTRATE: Reasonable without a history of going to the ER?
THE WITNESS: Correct. In addition, I believe this was the gentleman there was a concern about narcotic-seeking behavior, that he indeed may have a problem with narcotic abuse.
MR. PAIKOS: May I approach Dr. Levin?
THE MAGISTRATE: You may.
Q. (By Mr. Paikos) Doctor, there is a medical record where the medical record is blocked out because of a copying issue. I show you Bates 180. It would be difficult for you to find because I can't give you a page number. I will show you this copy here.
A. Yes.
Q. What are those?
A. Two prescriptions written on November 6, 2008, the same date as the Progress Note that we've been discussing, one of them for Dilaudid, 4 milligrams PO b.i.d. p.r.n. 45 with no refills. The other for oxycodone 30 milligrams three pills PO, t.i d., 270 pills prescribed.
Q. Doctor, do you remember seeing Dilaudid being prescribed in Dr. Padmanabhan's medical progress

Page 302

notes prior to that day?
A. Not to the best of my memory.
Q. If you can go to medical record 219 Bates 183.
A. I have that page.
Q. What are those? What is on that page?
A. This is a medication list, appears to be medications that have been prescribed. It's a little difficult for me to understand. I'm not used to seeing this type of form for an outpatient.
Q. Doctor, actually it's medical record 219.
A. I'm looking at 183.
Q. Medical record 219, Bates 183. Previously we were talking about the note on November 6, 2008.
A. I do have that note.
Q. These are two prescriptions, one for Dilaudid and one for Duragesic?
A. Correct.
Q. Do you recall seeing medical records corresponding to this?
A. I do not.
Q. What is Duragesic?
A. It is a type of pain medication, a nonnarcotic pain medication, I believe it's nonnarcotic,

Page 303

given as a patch to the patient. You put a patch and keep that on for a variable period of time. This appears to be one every three days.
Q. Would it be important to note why you are adding or changing a medication, whether it's, especially if it's a narcotic like Dilaudid?
A. Yes.
Q. Why?
A. As basic care you want to know or it's important to document what you are prescribing for a patient to try to help the patient. You want to know what other medications the patient is getting to look for potential side effects for potential interactions, additive side effects from medications to be able to follow that to know if the patient is being helped or if the patient is being harmed.
I note on page 219 there is another prescription for 8-13-2008 also for Dilaudid on that day.
Q. The two prescriptions on, you didn't find in the medical record note.
A. Correct, not to the best of my memory.
Q. Doctor, if you go to medical record 193 which is

Page 304

at Bates 157.
A. I do have that in front of me, a Progress Note from 3-3 I believe 2009. It's hard for me to read the last number. This note is below the standard of care. Would you like me to discuss that?
Q. Yes, please.
A. The Subjective, the History is an indication no change. There is a zero with a line through it indicating no change. Objective is stable. Assessment and Plan is radiculopathy. Prescription given. So there is no history and no changes. We don't know what the "no change" refers to. Is the patient continuing to do badly, is the patient continuing to do well. Is he having pain, if so where is the pain. Is he having neurologic symptoms, if so where are they. What medicines is he receiving, what other treatments is he receiving. We don't know any of that. Suffering side effects from the his medicines, abusing his medicines, is he compliant. No information at all.
Objective, again the examination is stable. As previously discussed this is below

Page 305

the standard of care for a neurologic follow-up note. We have no information with regard to how the patient its doing. Does the exam show neck problems, back problems, other neurologic problems. There is no way of knowing.

Assessment is radiculopathy. We don't know what part of the body that refers to, if he is having neck problems, back problems, arms, legs. No information at all. We do not know what medications were prescribed or what dose, how many were given. No information at all.

Q. In the note I would direct your attention, Doctor, to medical records 209, 210, I believe, which is Bates 173 and 174.

A. These appear to be the same days as the Progress Note. These are prescriptions on 3-3-2009. First is for oxycodone, 15 milligrams four pills q.i.d, 480 pills prescribed.

THE MAGISTRATE: What is q.i.d?

THE WITNESS: Four times a day.

A. This medication is being prescribed four pills four times a day and the patient is given 480 pills. This is a very large prescription. This is a larger prescription than we've seen before.

Page 306

The dose is larger and the number of pills given to the patient is significantly larger, and we don't know why.

The next prescription for methadone, 10 milligrams, two pills PO b.i.d., twice a day, 120 pills of methadone are prescribed. This is the first indication that we've seen for a prescription for methadone. There is no indication why it is being prescribed. There is no report that I saw or any mention in my Progress Note as to the prescription of methadone. My understanding is that when methadone is prescribed, it needs to be listed as being for pain. There is no indication that this is being prescribed for pain.

Q. Why does it have to be listed as prescribed for pain?

A. My understanding is that is the regulation for a neurologist who prescribes the medication outside of a methadone center.

Q. And if we go to medical record 211 which is Bates 175, medical record 212 which is at 176. Those are two prescriptions for January 8, 2009?

A. There are two prescriptions for January 8, 2009.

Page 307

The first is for oxycodone, 30 milligrams, three pills, three times a day. 270 pills are prescribed. The second is for Oxycontin 80 milligrams b.i.d. 60 milligrams are prescribed.

Q. What is Oxycontin?

A. Oxycontin is another narcotic.

Q. Did you see in the record --

A. It's an opioid.

Q. Did you see in the record why there was a change for the oxycodone from 270 to 480 between the January prescription to the March prescription?

A. No.

Q. Did you see anywhere in the record why the Oxycontin was prescribed?

A. No.

Q. Would it be the standard of care to note these kinds of things?

A. Yes.

Q. Why?

A. In order to have good control of the medication and prescribing for the patient. I think in this case there are beginning to be more concerns this is a patient who had drug abuse

Page 308

problems, who had opioid abuse problems, and the prescription for the methadone could be quite suggestive of that. And you want to have good control, you want to know what the patient needs to have his pain controlled, if he is having side effects, and overall patient care it is important to have good control.

THE MAGISTRATE: Is there a reason to prescribe a patient both oxycodone and Oxycontin?

THE WITNESS: I'm not a pain specialist, but one is short acting and one is longer acting so patients sometimes may require both.

Q. (By Mr. Paikos) Medical record 192 Bates 156 as well as medical record 207 Bates 171. That's medical record 192 Bates 156 for the note, and medical record 207 Bates 171 for the prescriptions.

A. Looking at the note page 192 dated 4-4-2009, this note is below the standard of care. The history Subjective is pain. No other information. We don't know where the pain is, we don't know anything else about the patient, we have no information about his history, what

Page 309

happened since his last visit and his reaction to medications.
The examination is listed as stable.
This is below the standard of care for a neurologic follow-up note for the reasons previously described.
Assessment and Plan, patient was sent for random urine tox screen. Prescription given for now with lengthy talk. After he left the tox screen, tests positive for cocaine. He had denied drug use. I shall discharge him from my care.
Looking at the medications that were prescribed that date, April 24, 2009, there is a prescription for oxycodone, 15 milligrams, three pills q.i.d., four times a day, 360 pills; and a prescription for methadone, 10 milligrams, four pills b.i.d. twice a day with 240 pills prescribed.
Q. What can be the impact of a patient who is taking methadone, oxycodone and cocaine?
A. I think he has a high risk for drug abuse.
Q. Is there a reason in the note why the tox screen was given, any information?

Page 310

A. Repeat the question?
Q. Is there any information in the note as to why Dr. Padmanabhan at this stage after seeing the patient is recommending or has tested the patient for illicit drugs?
A. No.
Q. Does the standard of care dictate there should be?
A. Yes. Let me back up. There is no reason that any doctor can't test any patient at any time, so it would certainly be within the standard of care to test any of his patients with a tox screen, certainly any of his patients that he is prescribing opioid for, it would be within the standard of care to do that. This is the first time he has done that. There is no indication why he did that, so the standard of care would suggest that he should indicate is he suspicious of a drug problem, is he suspicious of his patient having an abuse problem. Standard of care would indicate that he should have that information on his notes and proceed with the drug screen.
Q. And that is the April 24, 2009 note. If you

Page 311

could go to --
THE MAGISTRATE: Mr. Paikos, before you do, if I could ask Dr. Levin some follow-up questions. There is no indication what the lengthy talk is about?
THE WITNESS: There is not.
THE MAGISTRATE: Could you comment on the standard of care of ordering a patient to receive a urine screen and giving methadone and oxycodone at the same time.
THE WITNESS: I'm not a pain specialist. It strikes me as being a bizarre series of events.
THE MAGISTRATE: And does this medical record of April 29, 2009 indicate that the tox screen was run and results were received on the same day?
THE WITNESS: Since there is no other date indicated, the assumption would be that after he left, the tox screen came back that same day positive for cocaine as indicated as such.
THE MAGISTRATE: Do you have any opinion as to the standard of care of ordering a tox

Page 312

screen and waiting for the results before sending the patient off with a prescription for methadone and oxycodone?
THE WITNESS: I'm not a pain specialist, but I believe the correct thing to do would be to get the tox screen prior to prescribing medications. It should be noted this would be an unusual action for a neurologist. I have never ordered a tox screen under these circumstances. The only time I have ever ordered a tox screen is when someone presents with an acute medical problem and I'm concerned about an acute medical problem and possibly an abuse problem or medications or drugs taken that I have not prescribed. So this note is a circumstance where I would normally order a tox screen. I don't prescribe methadone, I don't prescribe oxycodone. So again that being said, this strikes me as being an unusual set of circumstances. I think the correct thing would be to get the tox screen prior to giving the patient a prescription for two narcotics.
Q. (By Mr. Paikos) If we can go to medical record 231 Bates 189.

Page 313

THE MAGISTRATE: Mr. Paikos, we'll go for five more minutes.
MR. PAIKOS: Yes.
A. This is a letter page 231 from the patient, to the patient from Dr. Padmanabhan. He notes that he is enclosing the last prescriptions. He is writing for chronic pain, he is giving prescriptions mandated as a 30-day supply of medicine. Does not state what the mandated supply comes from. He is discharging the patient from his care, giving him a month to find a new physician. He notes, given your claimed financial status, it is not hard to conclude that pain pills prescribed to you in good faith are diverted to help fund your cocaine habit. As per the pain contract you signed, you were obligated to abstain from illegal activities including purchasing or selling drugs on the street. Best wishes for your health. Yours truly.
This would appear to be within the standard of care. Again I'm not a pain physician, have never been in the position of having to write such a letter, I have never seen

Page 314

such a letter before. That being said, this would appear to be appropriate in terms of notifying the patient that he is discharging him from his care. According to the letter, he is obligated to give the patient a 30-day supply of medicine. He doesn't say what medicine he is obliged to give him nor does it say what medicine he is giving him.
I would expect under the circumstances it would be within the standard of care for him to list specifically what medicines he is giving him, how much he is giving him along with the notice to the patient that he will no longer be prescribing medicine for him.
Q. Doctor, quickly turn to medical record pages 209 and 205, Bates 170 and 169.
A. Page 209 is a prescription dated 3-3-2001.
Q. I'm sorry, 206.
A. 206 is dated 5-14-2009, a prescription for methadone, 10 milligrams four pills b.i.d. number 240. The same date oxycodone 15 milligrams number 360 on May 22, eight days later. There was a prescription for methadone 10 milligrams four pills b.i.d., 240 pills.

Page 315

This prescription does state for pain. And the same date, again eight days later from the previous prescription, oxycodone 15 milligrams, three pills q.i.d. number 360.
Q. And the four prescriptions are dated after he sent the letter of May 13, 2009?
A. Refresh my memory.
Q. Medical record 231, Bates 189.
A. The letter states that he is going to give a mandated 30-day supply of medication. I don't know specifically that would be for these medications, how many would be a 30-day supply. He gives two prescriptions for methadone on May 22 and May 23. Excuse me. I'm a little confused.
May 14. This is quite confusing. There is a prescription here for May 14 for methadone. It says fill on May 23. And there is a second prescription for methadone dated 5-22-2009. So this appears to be a prescription for methadone to be filled on the 22nd and a second prescription for methadone to be filled on the 23rd of May.
We have prescriptions for oxycodone.

Page 316

Again the date of the letter was May 13. We have a prescription for oxycodone 360 tablets for 5-22-2009 and a prescription written on 5-14 to be filled on 5-23. Appears there are prescriptions for oxycodone for 360 tablets to be filled on May 22 and May 23.
Q. Bates 170, the May 14, prescription for four pills b.i.d., that is at medical record 206.
A. That is the methadone four pills b.i.d.
Q. Four pills two times a day?
A. Correct.
Q. That is eight pills?
A. Yes.
Q. And the quantity is 240?
A. Correct.
Q. Would that be a 30-day supply?
A. Yes.
Q. And oxycodone on that day is three pills q.i.d. Is that four, three pills four times a day?
A. Yes, 360.
Q. That is 360 pills. Does that look like a 30-day supply?
A. Yes.
Q. Do the two scripts, May 22 methadone and

Page 317

oxycodone, do those also look like they are 30-day prescriptions?
A. They do.
Q. Was it within the standard of care from Dr. Padmanabhan to prescribe these narcotics to this patient?
A. (No response).
MR. PAIKOS: Let me ask a question. Well, I have already asked the question. I don't think I have any further questions on this particular set of prescriptions or facts.
THE MAGISTRATE: Time to wrap up?
MR. PAIKOS: Yes.
THE MAGISTRATE: We are ending for the day and resume tomorrow at ten o'clock.
MR. PAIKOS: May I bring up one thing. We have another witness scheduled for tomorrow. May we suspend Dr. Levin and put her on and start with Dr. Levin again?
THE MAGISTRATE: How long is your other witness?
MR. PAIKOS: I'm saying an hour.
THE MAGISTRATE: Any objection?
DR. PADMANABHAN: Who is the witness?

Page 318

MR. PAIKOS: Dr. Nardin.
DR. PADMANABHAN: I would prefer wrapping one witness first instead of jumping.
THE MAGISTRATE: How much more with Dr. Levin?
MR. PAIKOS: We have several more patients.
THE MAGISTRATE: What is your best estimate of how many hours with Dr. Levin?
MR. PAIKOS: I would say another day and a half.
THE MAGISTRATE: And the reason to bring in the other witness for an hour?
MR. PAIKOS: She would provide some of the information relative to Dr. Padmanabhan's ending at Cambridge Health Alliance.
THE MAGISTRATE: Is she not available on another day?
MR. PAIKOS: No, she is not. She is a physician and has cleared her schedule for tomorrow.
THE MAGISTRATE: Your preference is to hear one witness, but I'm going to accommodate the witness' schedule, so the other witness can

Page 319

come in and --
DR. PADMANABHAN: The government has known from the beginning how many charts they are producing and how long their witness is going to take to go through each and every paper page by page.
THE MAGISTRATE: We don't have information about the other witness' availability.
DR. PADMANABHAN: It was wrong I would think to arrange with Dr. Nardin that she should be accommodated tomorrow because that really does go against my interest. I'm not prepared to rebut because I'm still completely involved in Dr. Levin's testimony.
THE MAGISTRATE: If you need information to cross examine the witness tomorrow, we'll bring her back.
Any objection to bringing her back, not necessarily this week?
MR. PAIKOS: Certainly, yes. I don't have an objection, I want to accommodate obviously her schedule.
THE MAGISTRATE: We are going to get in

Page 320

her direct examination tomorrow. We're going to get in as much cross examination as you have a basis for, the understanding is we may inconvenience her on another week to come back for what may be a large or small amount of cross examination.
MR. PAIKOS: Certainly.
THE MAGISTRATE: So there is no prejudice. I know you have a preference, but we're going to accommodate the witness' schedule because scheduling witnesses is an inexact science and we are trying to keep this hearing moving.
Anything else for today?
We'll resume tomorrow 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 13, 2015.

Carole M. Wallace, CSR

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