

In The Matter Of:
Board of Registration in Medicine v.
Padmanabhan, M.D.

Bharanidharan Padmanabhan, M.D.
January 13, 2015

Jones & Fuller Reporting
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Boston, MA 02110



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1 **VOLUME: II**
 2 **PAGES: 125 - 321**
 3 **EXHIBITS: 0**
 4
 5 COMMONWEALTH OF MASSACHUSETTS
 6 DIVISION OF ADMINISTRATIVE LAW APPEALS
 7 -----X
 8 BOARD OF REGISTRATION IN MEDICINE
 9 v DOCKET NO.
 10 BHARANIDHARAN PADMANABHAN, M.D. RM-14-363
 11 -----X
 12
 13 **BEFORE:** Kenneth Bresler
 14 Administrative Magistrate
 15
 16
 17 Held at
 18 Office of the Civil Service Commission
 19 One Ashburton Place - Room 503
 20 Boston, Massachusetts 02108
 21 Tuesday, January 13, 2015
 22 10:01 a.m. - 4:06 p.m.
 23
 24 Reporter: Carole M. Wallace, CSR

1 I N D E X
 2 ness Direct Cross Redirect Recross
 3 RY LEVIN, MD 133
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 9 NO EXHIBITS WERE MARKED ON THIS HEARING DATE
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1 APPEARANCES:
 2
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 9
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 15
 16 ALSO PRESENT:
 17 Loretta Cooke, Nurse Investigator
 18
 19
 20
 21
 22
 23
 24

1 **THE MAGISTRATE:** Good morning. Today is
 2 January 13, 2015. We are at the Civil Service
 3 Commission, One Ashburton Place, Boston,
 4 Massachusetts. This is a hearing before the
 5 Division of Administrative Law Appeals. This
 6 appeal has been assigned Docket No. RM-14-363.
 7 The hearing is held under the provisions of
 8 General Laws Chapter 112 Section 5 and 243 CMR
 9 1.03. The petitioner is the Board of
 10 Registration in Medicine and the respondent is
 11 Bharanidharan Padmanabhan MD. I am
 12 Administrative Magistrate Kenneth Bresler.
 13 James Paikos, Esq. represents the petitioner.
 14 The doctor represents himself. The parties'
 15 representatives are present and have previously
 16 filed their notices of appearance.
 17 I am going to read 801 CMR 1.01 10(d) 1
 18 again. "Decorum. All parties, their authorized
 19 representatives, witnesses and other persons
 20 present at a hearing shall conduct themselves in
 21 a manner consistent with the standards of
 22 decorum commonly observed in any court. Where
 23 such decorum is not observed, the presiding
 24 officer may take appropriate action."

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1 There is a sentence I did not read
2 yesterday. "Appropriate action may include
3 refusal to allow a disruptive person to remain
4 in the hearing room and if such a person is a
5 party, to allow participation by representative
6 only."
7 I excluded Mr. Kinan yesterday because he
8 was being disruptive by passing notes no
9 Dr. Padmanabhan, constantly whispering in his
10 ear, reading a newspaper in the hearing room,
11 and quibbling with me that what he was reading
12 was not in fact a newspaper. I do not have a
13 courtroom clerk to receive motions and docket
14 them; I do not have a court officer to tell
15 spectators to remain seated -- to be quiet and
16 not to read newspapers. Actually, to remain
17 seated as well.
18 So, Dr. Padmanabhan, anybody who shows up
19 here at your invitation or your support, you
20 will convey to them they are to act with proper
21 decorum.
22 **DR. PADMANABHAN:** Yes.
23 **THE MAGISTRATE:** Is there anything else
24 before we resume the testimony?

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1 **DR. PADMANABHAN:** Yes, you said you would
2 look at the exhibits. I reorganized them
3 according to the numbers.
4 **THE MAGISTRATE:** Can you give them to me?
5 **DR. PADMANABHAN:** Yes, sir. I have made
6 multiple copies.
7 **THE MAGISTRATE:** If I remember correctly,
8 I did not say I would look at them, I said I
9 would find time to look at them. But you did
10 not comply with my order, and we're not stopping
11 to look at the exhibits now, we are going to do
12 evidence.
13 **DR. PADMANABHAN:** I was under the
14 impression yesterday when we left that --
15 **THE MAGISTRATE:** If you were under the
16 impression, I will look at the documents. I am
17 not committing to admitting them, I am
18 committing to running a hearing and making sure
19 that the evidence comes in.
20 **DR. PADMANABHAN:** My defense is
21 predicated on the entrance of these exhibits,
22 and I admitted them --
23 **THE MAGISTRATE:** Okay. Doctor, --
24 **DR. PADMANABHAN:** -- previously.

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1 **THE MAGISTRATE:** Doctor, we can't go
2 through this forever. At the prehearing
3 conference I told you specifically submitting
4 the exhibits then does not count as submitting
5 the exhibits for the hearing.
6 **DR. PADMANABHAN:** I'm --
7 **THE MAGISTRATE:** Doctor, I'm talking. I
8 also gave you an order saying get me the
9 exhibits by January 5. Your defense has not
10 started yet. I will try to find time to look at
11 your proposed exhibits. I don't know if you are
12 disobeying my orders on purpose, I don't know if
13 you are not capable of listening to me and
14 obeying the orders.
15 **DR. PADMANABHAN:** May I speak?
16 **THE MAGISTRATE:** Yes.
17 **DR. PADMANABHAN:** I think it was a simple
18 misunderstanding, sir.
19 **THE MAGISTRATE:** If it was the only
20 misunderstanding, I wouldn't have made that
21 comment.
22 **DR. PADMANABHAN:** Cost is also an issue.
23 The government was able to send that whole
24 binder by overnight express, I'm unable to

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1 respond in kind, so I sent in the exhibits --
2 **THE MAGISTRATE:** I don't think that cost
3 has anything to do with you listening to me and
4 complying with, getting me exhibits by
5 January 5, so I'm going to take testimony now.
6 **DR. PADMANABHAN:** I also -- Sorry to
7 interrupt. I also mentioned a motion that I
8 wanted to produce yesterday. You said you would
9 look at it today.
10 **THE MAGISTRATE:** I did not say I would
11 look at it today. I asked you to get it to DALA
12 to be docketed. I don't have a courtroom clerk,
13 and it needs to be docketed to keep the record
14 complete. I said I would look at it when I had
15 time because I have to keep the evidentiary
16 hearing going. This is not a motions hearing.
17 Your motions are not going to delay this. I
18 will look at the motions when appropriate. I
19 gave you an opportunity for a motions hearing
20 last Friday. You did not accept it.
21 Are we ready to proceed?
22 **MR. PAIKOS:** Yes. Dr. Levin was sworn
23 yesterday, I believe he should still be under
24 oath.

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

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

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

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1 basic knowledge of what pain contracts are. My
2 understanding is that when a pain specialist is
3 prescribing opioids or controlled substances,
4 then a pain contract is formally drawn up with
5 the patient. The pain contract indicates why
6 the medication is being prescribed, it indicates
7 the specifics of the medications, and lays out
8 in great detail with the patient what
9 circumstances they will get their medications,
10 what circumstances they will not get their
11 medications.
12 For example, I believe that extra
13 prescriptions cannot be obtained between the
14 routine prescriptions, that patients cannot have
15 their prescriptions mailed to them, they have to
16 come in to get their prescriptions. Where
17 necessary, they have to undergo drug tests to
18 make sure there is no abuse of the medication.
19 **THE MAGISTRATE:** Have you seen such
20 contracts in the course of your medical
21 practice?
22 **THE WITNESS:** I have. To clarify, those
23 are not my contracts, though. I have seen them,
24 but I have never drawn up one from my patients.

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1 **THE MAGISTRATE:** That was my
2 understanding. Yes. In the past I have told
3 Dr. Levin that I have the patient in front of me
4 and I was asking for his interpretation. In
5 this case, however, I'm looking at Bates 94
6 which I understand is page 82 in front of you,
7 Doctor. Have you had a chance to decipher the
8 handwriting that is significant to you?
9 **THE WITNESS:** To the best of my ability.
10 **THE MAGISTRATE:** I'm sure I could
11 decipher it if I parsed it, but if you have
12 already taken the time to do that, let me know
13 what is significant and this page.
14 **THE WITNESS:** Starting on the top,
15 June 16, 2008. Patient called to inform
16 pharmacy will not accept prescription dated for
17 over 30 days. He needs a new prescription for
18 July 4. Please mail it to his home, (address
19 given). Oxycodone 5 milligrams, number 180,
20 Oxycontin 40 milligrams, number 90, no
21 substitution. The patient is informed by the
22 pharmacist that the, quote, Massachusetts state
23 laws superseded federal law, unquote.
24 Therefore, they cannot have -- I think the word

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1 is "have prescription." I'm sorry, I'm not sure
2 what that word is. Something. -- prescription
3 past 30 days. Please call patient when
4 prescription is mailed out.
5 There is an indication June 16, voice
6 mail; June 17, mailed, and patient --
7 something -- mail.
8 **THE MAGISTRATE:** Thank you.
9 Q. (By Mr. Paikos) Turning next to medical record
10 number 30 which is at Bates 84. If you could
11 review that and discuss whether it's a red flag
12 and what part of it is important to any
13 conclusion you reach.
14 **A. Record dated July 30, 2007, I believe. Need new**
15 **script to say no substitution for Percocet, --**
16 Q. I think it was medical record 30, Bates 84.
17 Your medical record of May 30.
18 **A. This is a note dated 6-16-2009 from a Nurse**
19 **Claudia O'Shea indicating there was a call from**
20 **the pharmacist that the pharmacist was calling**
21 **because there was a, quote, big jump, unquote,**
22 **from what he, indicating the patient was taking**
23 **previously with regard to the Oxycontin and**
24 **wanted to verify that is correct.**

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1 **Yes, this would be a red flag.**
2 **THE MAGISTRATE:** I can guess what "big
3 jump" means, but what does it mean to you?
4 **THE WITNESS:** There is a larger,
5 significantly larger amount of medication
6 prescribed than previously.
7 **THE MAGISTRATE:** Thank you.
8 Q. (By Mr. Paikos) If we can go to medical record
9 48, Bates 87, medical record number 53. Those
10 are records from a January 8, 2010 encounter.
11 From your records it would be 48 and 53, Doctor.
12 **A. Referring first to medical record 53 January 8,**
13 **'10, this is a Progress Note from the doctor.**
14 **Note indicates came in for med refills, written.**
15 **There is a note from the nurse, three-month**
16 **follow-up for neck pain. This note would be**
17 **below the standard of care.**
18 Q. Why is that, Doctor?
19 **A. This is a patient who has been seen for a**
20 **follow-up note. This is a Progress Note for**
21 **opioid medication. This would be below the**
22 **standard of care for any type of interaction**
23 **with a neurologist but especially for somebody**
24 **who is coming in for refills for opioid**

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1 **medication. There is no information given with**
2 **regard to history, how the patient is doing, is**
3 **the patient doing well, are the medications**
4 **helping him, are there side effects. We have no**
5 **information about the examination. There is no**
6 **Impression. We don't know specifically from**
7 **this note why the medicine was being prescribed,**
8 **how the patient is doing, and then we have no**
9 **information about specifically what is being**
10 **prescribed.**
11 **The latter statement being made, we can**
12 **go to page 48. On this page it does state the**
13 **order of medications, so we do know specifically**
14 **from this page. There is nothing in the**
15 **Progress Note indicating that, but it is**
16 **possible that the usual manner they would put**
17 **these records together to link those two. If**
18 **that is the case, we do know about the**
19 **medication, and that would be within the**
20 **standard of care for the medication.**
21 Q. Do we know, Doctor, whether this medication that
22 is bring prescribed has given relief to the
23 patient or not?
24 **A. We do not.**

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

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1 **to another doctor. We do not know whether he is**
2 **being referred to a doctor or indeed what future**
3 **follow-up will be with the doctor. There is no**
4 **indication of any medications, although there is**
5 **another page that indicates ordered medications**
6 **Oxycontin and three Oxycontin prescriptions.**
7 **THE MAGISTRATE:** Is that on page 60 of
8 the record in front of you, Dr. Levin?
9 **THE WITNESS:** Yes, where it says ordered
10 medication, medications in the middle of the
11 page, there are three prescriptions for
12 Oxycontin, each one 120 pills, start date of
13 6-26-2010, 7-27-2010 and 8-27-2010.
14 **THE MAGISTRATE:** What page do you have in
15 front of you?
16 **THE WITNESS:** Page 60.
17 **MR. PAIKOS:** Bates 89.
18 **THE MAGISTRATE:** I'm looking at Bates 89.
19 Are these the one that say "discontinued"?
20 **THE WITNESS:** It is confusing. If you
21 come down it says "discontinued medications,"
22 says "Oxycontin," and below that it says
23 "ordered medications." I believe those are the
24 new medicines that are being ordered, especially

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1 with the start dates that are listed to the
2 right of that.
3 **THE MAGISTRATE:** I'm looking at that. I
4 see the start dates of June 28, July 27 and
5 August 27, but they do say "discontinued."
6 **THE WITNESS:** It does.
7 **THE MAGISTRATE:** What does that mean to
8 you?
9 **THE WITNESS:** It means it's very
10 confusing to me, I don't understand it.
11 **THE MAGISTRATE:** Okay. Thank you.
12 Q. (By Mr. Paikos) Doctor, I would direct your
13 attention to tab 5, the records for -- Go back
14 to that record. On that medical record page 60,
15 89, it has an Approved section as well on there?
16 **A. Yes, and that continues onto page 61, I believe.**
17 **Approved section for the same medicines that we**
18 **were discussing, the Oxycontin prescription for**
19 **6-28, 7-27 and 8-27-2010.**
20 **THE MAGISTRATE:** Mr. Paikos, are you
21 ready to start a new patient?
22 **MR. PAIKOS:** Yes.
23 **THE MAGISTRATE:** I want to tell the
24 parties what I see as an issue: I may be wrong

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

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1 presenting, you can let me know if you are going
2 to need more time or a break will be enough time
3 to address that.
4 **MR. PAIKOS:** Thank you. We'll turn to
5 Patient D's records, tab 5.
6 **THE MAGISTRATE:** As with yesterday, if
7 the parties need a break, let me know. Any
8 electronic devices that make noise should be
9 off. There will not be and there should not
10 have been any recording devices or cameras being
11 used yesterday or for the rest of the hearing.
12 Q. (By Mr. Paikos) If you could go to medical
13 record 3 which is at Bates number 109 and goes
14 to medical record number 4 and Bates 110.
15 **A. Looking at medical record pages 3 and 4, is that**
16 **correct, sir?**
17 Q. Yes. And does this give some background history
18 regarding the patient's complaints?
19 **A. The note does give background with regard to**
20 **this patient. The doctor relates history of his**
21 **treatment with epidural steroids. It's**
22 **interesting that he does note he has the**
23 **pleasure of seeing the patient again at the**
24 **clinic. There may have been a previous note,**

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1 **but I have no record of that previous encounter.**
2 **He talks mainly about his treatment, he talks**
3 **about he is going for a rhizotomy, and there**
4 **have been some concerns he had as well some**
5 **family difficulty.**
6 **THE MAGISTRATE:** Dr. Levin, a rhizotomy
7 is what?
8 **THE WITNESS:** I believe it is a procedure
9 where the nerve root is in some way structurally
10 altered. I don't believe they actually
11 physically cut it, but I think they use other
12 instruments to actually cause a physical change
13 within the nerve root.
14 **THE MAGISTRATE:** Thank you.
15 Q. (By Mr. Paikos) Why is that done, a rhizotomy?
16 **A. For intractable pain, mainly. Would you want me**
17 **to further comment on the note?**
18 Q. In reviewing the note, does it show that the
19 doctor followed the standard of care in the
20 treatment of this patient?
21 **A. The note describing the treatment for this**
22 **patient is below the standard of care. The**
23 **reason for that, the overall note, the history,**
24 **the examination, the impression are within the**

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1 **standard of care. He describes the medication**
2 **that he is giving patient, Oxycontin, giving the**
3 **dosage, the number of pills per day; oxycodone**
4 **dosage twice a day, p.r.n. These are within the**
5 **standard of care, but we have no further**
6 **information about that. We don't know the**
7 **number of pills that were prescribed, we don't**
8 **know if there were additional monthly**
9 **prescriptions or any refills, and that would**
10 **below the standard of care.**
11 Q. Why is that important to know that?
12 **A. It's important to know how much medication you**
13 **are giving any patient. I think particularly**
14 **it's important if you have a controlled**
15 **substance that you know how many pills you are**
16 **giving the patient. Controlled substances are**
17 **always potentially abusable, and it would be**
18 **important to know is the patient taking the**
19 **medication that I prescribed, could the patient**
20 **be doing something else, diverting the**
21 **medication in some way.**
22 Q. What is the potential harm to a patient if they
23 are abusing medications that a doctor is
24 prescribing?

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1 **A. Potential harm is addiction to a medication,**
2 **particularly an opioid, and there are certainly**
3 **all the dangers that any individual would have**
4 **from addiction as well as the dangers of**
5 **overdose. Overdose can be obviously very**
6 **dangerous and can even result in death.**
7 Q. What's the reason or the rationale for
8 documenting the record to ensure that you have
9 the proper information regarding prescriptions?
10 **A. I think for any medication it's important to**
11 **know how many pills you are actually prescribing**
12 **to the patient. This helps you to know is the**
13 **patient taking the medication that you**
14 **prescribed, it lets you know what you are doing.**
15 **So if the patient calls me for a prescription, I**
16 **go back to my notes and see what I prescribed,**
17 **how many pills I prescribed, how many refills**
18 **and that lets me know is it correct for me to**
19 **prescribe medication for them again, should they**
20 **be out or did I give them an insufficient**
21 **medication. But I can go through my records and**
22 **I have a good control of the medication. This**
23 **is particularly important when there is a**
24 **potentially abusable medication or controlled**

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

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

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

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

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1 **THE WITNESS:** It says "value" and says
2 "any event pills times he," and "does not take,"
3 going to the end of that line.
4 **THE MAGISTRATE:** He takes Valium for
5 spasms?
6 **THE WITNESS:** Yes, as well as a touch of
7 anxiety, and it has been working out well. So
8 there is that in the history.
9 **A. Going to the Plan, there is no indication of a**
10 **prescription for Valium. Once again this would**
11 **be below the standard of care. We don't know**
12 **how much Valium he is taking, we know it has**
13 **been working out well, we don't know if there**
14 **are side effects, and there is no indication of**
15 **any prescription for Valium, so we don't know**
16 **the amounts of medication or anything else about**
17 **it.**
18 **THE MAGISTRATE:** Where would you expect
19 to see that sort of information about Valium
20 along with the mention of it or elsewhere on
21 this?
22 **THE WITNESS:** Both places. Normally you
23 would expect he takes Valium and a listing of
24 the amount of medication that he is taking. At

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1 that point frequently I know in my notes I would
2 normally put in patient is taking X amount of
3 Valium, giving the effect of Valium and putting
4 a note in he is experiencing side effects and
5 telling what the side effects are. Or he is
6 tolerating the medicine without side effects. I
7 would include that in the Impression. And going
8 on to the Plan, would want to have an indication
9 of the medicine prescribed, the specific dose of
10 medicine and the number of pills, the number of
11 refills for that.
12 **THE MAGISTRATE:** So you testified to what
13 you would do. Could you relate to what you
14 would do and do to your testimony with the
15 standard of care.
16 **THE WITNESS:** I didn't understand your
17 question, sir.
18 **THE MAGISTRATE:** You explained what you
19 would do and what you do do in a similar
20 situation noting it in the medical record,
21 rather than your personal practice. Can you
22 relate what you would do to the standard of
23 care.
24 **THE WITNESS:** Yes. The standard of care

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

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1 other drugs such as Oxycontin together?
2 **A. Yes.**
3 **Q. Why is that?**
4 **A. There frequently are added side effects from**
5 **different medicines. Valium and Oxycontin**
6 **frequently could have additive side effects.**
7 **Q. What are the side --**
8 **THE MAGISTRATE:** If I may, what is an
9 additive side effect?
10 **THE WITNESS:** One medication that gives
11 you a side effect, sedation, lethargy, fatigue,
12 depression, and you have a second medication
13 that has a similar side effect profile; so if
14 you take both of those medications together,
15 then you have additive side effects so there is
16 additional sedation from the second medication,
17 additional potential for fatigue, depression
18 from the second medication.
19 **THE MAGISTRATE:** The presence of side
20 effects, does it relate to whether the patient
21 will comply with taking the medication?
22 **THE WITNESS:** It may.
23 **THE MAGISTRATE:** Is that another reason
24 why noting side effects is important?

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

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

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

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

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1 to the possibilities of a red flag as we
2 previously discussed, indicating to me that he
3 did not feel there was a problem. This patient
4 did not appear to have an abuse potential.
5 Q. Going down to the Impression, the Impression is
6 below the standard of care?
7 A. The statement, I have given him refills per CFR
8 section 1306-12 for the next three months.
9 There is no indication as to what the refills
10 are for, so we don't know from the Impression
11 specifically what he is giving the patient.
12 Previously in the history he does state the
13 medications that that the patient is taking. He
14 takes his Oxycontin, oxycodone, indicates what
15 he is taking but does not state specifically
16 what the refills are.
17 THE MAGISTRATE: Dr. Levin, what does
18 that mean to you, "refills per CFR section 1306
19 section 12"?
20 THE WITNESS: Did not know what that
21 section was and confirmed with Mr. Paikos and
22 Ms. Cooke they informed me this relates to
23 regulations with regard to opioids and that
24 opioids can be prescribed for three months in a

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1 row from a single prescription.
2 THE MAGISTRATE: If a doctor other than
3 Dr. Padmanabhan was reviewing this, what is your
4 opinion as to whether the doctor would be able
5 to understand that particular note?
6 THE WITNESS: Unless he had prior
7 knowledge, he would not know anything about it.
8 I did not know anything about it, either, when I
9 read it.
10 MR. PAIKOS: Would this be a good time
11 for a break?
12 THE MAGISTRATE: Ten minutes.
13 [Recess]
14 Q. (By Mr. Paikos) Doctor, if you could go to
15 medical record page 173 Bates 134. That's a
16 note from July 28, 2008?
17 A. What is the page number again?
18 Q. Medical record 173 Bates 134, handwritten note
19 from July 28, 2008.
20 A. Reviewing the note of 7-28-2008, this note is
21 below the standard of care. There is an
22 indication in History that the patient went to a
23 new job site that didn't work out, he was
24 disappointed, depressed and back hurts more.

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1 There is no further indication or information
2 about patient's clinical state with regard to
3 his pain problems.
4 Examination is listed as being without
5 change. This would be below the standard of
6 care when a patient is talking about having
7 worsening of his symptoms, he would want to do a
8 basic examination to know why that is, is there
9 a new problem or not. The Plan was below the
10 standard of care.
11 There is an indication no change in meds.
12 We do not know what medications are being
13 prescribed for this patient, and it's important
14 to know what those medications are, especially
15 if they are controlled substances, and these are
16 opioids.
17 Q. When you were discussing the part in the SOAP
18 note, I think it doesn't give us a clinical
19 story, why is a clinical story or clinical
20 presentation of this patient, how he looks,
21 important?
22 A. He does give us some information. I did not
23 mean to state he gives us no information. We
24 have information went to the job site, did not

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1 work out, disappointed, depressed and back hurt
2 more, but it would be important to know more
3 about the patient or where does the back hurt,
4 is it both sides, is there radiation of the pain
5 that runs to one leg or the other, are there
6 other neurological symptoms. I don't recall
7 again if this patient had had other specific
8 neurologic symptoms, but it would be important
9 to know that.
10 Q. Why it is important to know that?
11 A. Excuse me, I think it would be important to know
12 what medication he is taking and what is his
13 reaction to the medication, is it helping him,
14 not helping him, does he need more pills, less
15 pills, is he having side effects.
16 What was your second question?
17 Q. Why is it important to know the clinical
18 presentation of a patient?
19 A. It's basic information in terms of helping you
20 to figure out what is wrong with the patient,
21 what kind of assessment you need to do, how to
22 proceed in terms of helping the patient with
23 medication or other types of treatment.
24 Q. So if he sees the patient at that time, that is

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

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1 consulting with a neurosurgeon, for example. We
2 don't know that.
3 We don't know anything about the response
4 to the medication. Patient may be coming back
5 and saying, gee, I really need to take a lot
6 more Oxycontin, things are so much worse. And
7 you go back to your notes from a year ago and
8 find out it was exactly the same complaint at
9 that time, asking for more medication at that
10 time.
11 Q. We talked yesterday about the use of the pain
12 scale that some practitioners use. Is that one
13 way to flush out currently in a note that you
14 can review back three months from now?
15 **A. It is, and it can be very helpful. I believe**
16 **most, many times people who are experts in pain**
17 **or pain specialists will use that and have that**
18 **documented so when the patient comes back, they**
19 **will be able to go back and see three months ago**
20 **the pain was 4 out of 10, six months ago it was**
21 **5 out of 10, a year ago it was 2 out of 10. So**
22 **you can go back and compare from visit to visit**
23 **how the patient is doing.**
24 **THE MAGISTRATE:** Thank you very much for

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

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1 records that we have been looking at?
2 **THE WITNESS:** It would be within the
3 standard of care to use it; it would not
4 necessarily be below the standard of care not to
5 use it.
6 **THE MAGISTRATE:** Thank you.
7 Q. (By Mr. Paikos) Would it be within the standard
8 of care to not describe the pain level in any
9 detail?
10 **A. That is below the standard of care.**
11 Q. What are other ways other than the scales that
12 you can describe the nature of the pain and
13 where it is?
14 **A. By asking the patient questions about this or**
15 **just listening to a patient telling you about**
16 **how they feel and recording the information that**
17 **you received in your history. So the patient**
18 **specifically describing, yes, I'm having pain**
19 **and this is how bad the pain is. It may not say**
20 **10 out of 10 or 5 out of 10, but I'm having**
21 **excruciating pain or terrible pain. We'll say**
22 **would you say that your headache pain is mild,**
23 **moderate or severe; your neck pain, mild,**
24 **moderate or severe. And they will let you know**

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1 how they feel about their pain and tell you
2 where the pain is. If you ask them what does
3 the pain feel like, does it lead to a specific
4 area, are there different types of things that
5 will make your pain worse, different types of
6 things that will make your pain better. These
7 are routine questions that we ask the patient.
8 We record them and put them in the history. We
9 have the information, and it helps in terms of
10 assessment when you see the patient. And when
11 you see the patient in follow-up, you can go
12 back and review the notes and see if the
13 patient's information changed to know where to
14 go in terms of helping the patient.
15 Q. How does the information that you get from the
16 patient that you put in the record help you at
17 that time to figure out a plan for the patient
18 and in the future?
19 A. It's helpful with the visit that particular day
20 because you have an indication of the level of
21 pain, so that can help you in terms of your
22 diagnosis and also in terms of your treatment.
23 And also it helps you to figure out what is
24 wrong. The level of pain oftentimes is very

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1 helpful in terms of knowing what the specific
2 diagnosis is. Different types of pain may
3 indicate different types of neurologic
4 pathology.
5 If you have a nerve root that is
6 specifically sitting -- If you have a nerve root
7 that is actually being compressed on a disc,
8 sitting on it, that would be excruciating pain.
9 If the patient comes in and has just mild
10 achiness kind of coming or going, perhaps their
11 knee or thigh, you will know that that is not
12 severe and will direct you perhaps to a
13 different area in terms of diagnosis.
14 Q. Will it also direct you one way or the other
15 whether you are describing and asking these
16 questions what other tests or referrals to make
17 as well?
18 A. Yes.
19 Q. And in the future does the note that you make on
20 April, July 28, 2008 impact what course of
21 treatment you take the person at that time and
22 future notes as well?
23 A. Yes.
24 Q. How and why?

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1 A. The "how" would relate to neurological
2 assessment, getting a good history, doing a good
3 examination to try to figure out what is wrong
4 with the patient, put the pieces together in
5 such a way that you know or sort of try to track
6 down the proper diagnosis and then figure out
7 what tests should be done, what treatment, what
8 referrals, what ancillary types of nonmedicine
9 treatment.
10 The "why" is because it is good medical
11 practice and standard medical practice. This is
12 how every doctor works to try to put the pieces
13 together to help these patient.
14 Q. On the O part it says "stable exam." Do we know
15 what kind of exam was done?
16 A. We don't.
17 Q. Do we know -- You mentioned certain parts of a
18 neurological exam. Do you know if all those
19 parts were done, just some, just related to the
20 back?
21 A. The only information we have is "stable exam, no
22 change."
23 Q. Is it important to have a complete exam noted?
24 A. It's important to have some type of neurological

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1 examination, some type of relevant medical
2 examination. We don't need to have a very
3 detailed neurological examination that the
4 neurologist would do certainly on an initial
5 visit for every single visit. Most neurologists
6 would not do that. You need to have some
7 neurologic examination, at a very least a
8 pertinent examination related to the patient's
9 complaint and potential diagnosis.
10 In this case, for example, at the very
11 least we would want to know what was the
12 examination of his neck, his back, motor
13 examination, reflexes, sensation, what did his
14 gait look like; what did the patient look like
15 in general, does he seem to be in a great deal
16 of pain, not in much pain. All of these things
17 would be helpful in terms of the gestalt and
18 trying to make a diagnosis and formulating a
19 diagnosis and helping your patient.
20 THE MAGISTRATE: What does "stable exam"
21 mean to you?
22 THE WITNESS: I'm not sure. It can mean
23 many different things. It may mean that the
24 exam is the same as when he was previously seen,

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1 it may mean it is the same as when he was seen
2 multiple times in the past or perhaps a long
3 time ago. There is no way of knowing because
4 there is no information.
5 **THE MAGISTRATE:** What does "no change"
6 mean --
7 **THE WITNESS:** That the exam --
8 **THE MAGISTRATE:** -- to you?
9 **THE WITNESS:** To me means the exam was
10 the same as previously noted.
11 **THE MAGISTRATE:** Thank you.
12 Q. (By Mr. Paikos) At the bottom it says RTC and
13 3MO. Does that mean --
14 **A. Return to clinic.**
15 Q. In three months. If you go to medical records
16 174 Bates 135, if you would read that note by
17 Dr. Padmanabhan.
18 **A. I have a note here dated October 14, 2008. This**
19 **note would be below the standard of care.**
20 Q. Why is that?
21 **A. History, hoping for epidural shots, no change.**
22 **We have no information with regard to the**
23 **patient, we don't know what the patient's**
24 **clinical status is. We know he would like to**

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

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1 providing the care that they need?
2 **A. Yes.**
3 Q. So this is enough to be able to provide the
4 proper care to this particular patient in this
5 note?
6 **A. I would view this as being below the standard of**
7 **care.**
8 Q. Would, from time to time would other
9 neurologists, physicians have access to your
10 notes, any physician's notes?
11 **A. Yes.**
12 Q. In what circumstances?
13 **A. If a patient is referred to another clinician,**
14 **typically you would send notes. If I send a**
15 **patient to a neurosurgeon, I would send copies**
16 **of the notes. Notes are shared with the primary**
17 **care doctor typically. If there are other**
18 **clinicians who are working with a patient, the**
19 **physical therapist might want to see your notes**
20 **for thoughts about your patients. If you are**
21 **being covered by other doctors if you are not on**
22 **call and your colleagues get a call from a**
23 **patient who has a medical problem, neck pain,**
24 **back pain, they may be calling to have a refill**

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

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1 leaves the practice, new neurologist, is it
2 standard practice for them to request prior
3 medical records and prior neurological notes?
4 **A. Yes.**
5 Q. Would this note give enough information to a
6 subsequent provider, someone on call or
7 referring physician to determine how to properly
8 treat this patient?
9 **A. No.**
10 Q. Someone, subsequent provider or other provider
11 receiving, giving a consultation or on call for
12 this physician, would they know what
13 prescriptions to prescribe if the patient was
14 out?
15 **A. No.**
16 Q. If they prescribe them prescriptions without --
17 Is it important to have information of what the
18 patient is getting for medication and narcotics
19 to prescribe them additional narcotics?
20 **A. Yes.**
21 Q. What can be the impact of an error of
22 prescribing too much medication to a patient?
23 **A. Can result in severe side effects. Quite**
24 **detrimental to a patient. Can result in injury,**

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1 **in the most extreme situation death. If the**
2 **patient is prescribed medication on top of other**
3 **medication it could be, for example for opioids,**
4 **someone could be given more medication than is**
5 **proper and the patient could have an overdose.**
6 **You could be prescribing a medication that has**
7 **side effects that interact with the first**
8 **prescription, and that could be detrimental to a**
9 **patient as well.**
10 Q. Going back to the Subjective of this note, it
11 says something. Are you able to read the
12 handwriting?
13 **A. I believe so.**
14 Q. What do you think it says?
15 **A. Hoping --**
16 **DR. PADMANABHAN:** Objection.
17 **THE MAGISTRATE:** Basis?
18 **DR. PADMANABHAN:** It says "going in for
19 epidural shots."
20 **THE MAGISTRATE:** This is your
21 handwriting?
22 Any objection to accepting this?
23 **MR. PAIKOS:** I can presume for the next
24 question it says "going in for epidural shots."

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1 **DR. PADMANABHAN:** The first letter is
2 capital G in cursive.
3 **THE MAGISTRATE:** Do you have any
4 objection to this coming in?
5 **MR. PAIKOS:** No.
6 **THE MAGISTRATE:** Do we have a stipulation
7 it says "going in for epidural shots"? Do you
8 have any reason to doubt that?
9 **MR. PAIKOS:** No.
10 Q. (By Mr. Paikos) This note saying "going in for
11 epidural shots," that is under Subjective. What
12 does that mean to you?
13 **A. The patient is going to be having a particular**
14 **treatment. The name of the treatment is an**
15 **epidural injection. Typically this is an**
16 **injection of a steroid material placed into the**
17 **area around a nerve root, can be done for lumbar**
18 **or cervical problems. And there would indicate**
19 **to me the patient is going in for the epidural**
20 **shots. Most of the time this is done for a pain**
21 **problem, but it can be done for other**
22 **neurological problems as well.**
23 Q. Do we know if this is for a pain problem or
24 neurological problem?

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

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1 cord begin in the cervical region, the neck and
2 through the thorax, mid portion the back and
3 lower portion of the back. The lumbar region
4 there are nerve roots that come out at each
5 level, and they are referred to as radicals.
6 "Opathy" means a problem with. So a
7 radiculopathy is a problem with a nerve root.
8 In this case would be a nerve root related to
9 the lumbar region, the lower back.
10 Q. Do we know clearly from this note if epidural
11 shots are being given in the lumbar or for some
12 other back pain?
13 A. We do not.
14 Q. Would it be important to know those things?
15 A. Yes.
16 THE MAGISTRATE: Before you move on, let
17 me ask Dr. Levin, should medical records like
18 the Progress Notes that we're looking at for
19 October 14, 2008, should it be a standalone
20 record, or is it acceptable practice and
21 standard practice to have a Progress Note
22 reference implicitly or explicitly previous
23 medical records?
24 THE WITNESS: It would be within the

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1 standard of care to reference previous notes.
2 THE MAGISTRATE: So each Progress Note
3 does not need to be a standalone, complete with
4 pain levels, medications taken as long as
5 someone flipping through the medical record
6 could find the previous references?
7 THE WITNESS: That's correct.
8 THE MAGISTRATE: Thank you.
9 Q. (By Mr. Paikos) Is referencing the level of pain
10 or describing the level of pain more important
11 or less important when there are narcotics
12 prescribed?
13 A. More important.
14 Q. Why is that?
15 A. It's important to have good control of your
16 medication with any abusable medication
17 especially narcotics, and I think it's important
18 to know what the patient's status is in terms of
19 how they are doing, are they better, worse, what
20 is their level of pain, is their level of pain
21 such that they require narcotic medication, is
22 the pain that they are experiencing being
23 improved by the medication so should a dosage of
24 the medication be increased, decreased, stopped,

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1 additional medications added. All this
2 information would be helped by more information
3 about the patient's pain level.
4 Q. Is that the same for the patient's examination
5 and results of the examination?
6 A. I'm sorry, I don't understand your question.
7 Q. Would it also be important in assessing pain in
8 a patient who is being prescribed narcotics to
9 have a, is it more important when there is a
10 patient being prescribed narcotics to have a
11 more complete exam?
12 A. I think it's important when there is a patient
13 being prescribed narcotics that there be a
14 neurological examination. You may not have a
15 complete neurological examination. Frequently
16 you do not, especially if there has been a
17 complete neurological examination recently in
18 the records. But it would be important to have
19 at least a pertinent neurological examination
20 focusing on the area of the patient's
21 complaints.
22 Q. The note that we saw for July 28, 2008, is that
23 a pertinent note or pertinent examination done?
24 A. No.

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1 THE MAGISTRATE: What was the previous
2 one?
3 MR. PAIKOS: Bates 134, medical record
4 173.
5 THE MAGISTRATE: Which has two notes on
6 it.
7 MR. PAIKOS: Yes, July 28, 2008.
8 Q. (By Mr. Paikos) And you said that is not a
9 pertinent note?
10 A. That would not be an adequate note.
11 Q. What about at Bates 135 medical record 174?
12 A. Looking at the note dated 10-14-2008, the
13 examination is listed as being stable, without
14 change. That would not be an adequate note.
15 That would be below the standard of care.
16 Q. Was there even an exam done on that day?
17 A. The assumption is there was an examination since
18 Subjective is listed as being stable. Objective
19 typically refers to an examination.
20 Q. If we go to medical record number 175, Bates
21 136.
22 A. I reviewed the records.
23 Q. Is Dr. Padmanabhan's care on this day within the
24 standard of care?

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

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

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

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1 "severe back pain, chronic." Is that a change
2 in his prior pain?
3 **A. I don't know.**
4 **Q. You don't know, but would the practitioner**
5 **looking at these notes know?**
6 **A. I don't believe so.**
7 **Q. So is that a proper justification for refills**
8 **being given as noted at the bottom?**
9 **A. The information that is listed here is below the**
10 **standard of care for prescribing refills and**
11 **medication. Whether it's a justification for**
12 **the refills that were given, I don't know**
13 **because there is no indication about what**
14 **refills were given. I don't know what**
15 **medications were prescribed, so to comment on**
16 **the appropriateness of the evaluation to those**
17 **medications, we don't know what medications were**
18 **prescribed.**
19 **Q. We're looking at the April 14, 2009 note. If we**
20 **go to medical record 184 and 185, Bates 587 and**
21 **588.**
22 **THE MAGISTRATE:** Before you do, if I
23 could ask Dr. Levin, worker's compensation
24 decided he does not need pain medication any

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

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

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1 **prescribed as t.i.d. which is three pills a day.**
2 **So there is apparently some caution with regard**
3 **to the number of medicines that are being**
4 **prescribed to him. It's being refilled for five**
5 **refills, so this is a six-month supply of this**
6 **medication. Under the usual course if you are**
7 **prescribing this medication in this dosage, they**
8 **would not be for a routine follow-up for six**
9 **months.**
10 **THE MAGISTRATE:** Dr. Levin, can you walk
11 us through the language on this Valium
12 prescription and what each means to a
13 practitioner and a pharmacist.
14 **THE WITNESS:** The first line is the
15 patient's name. To the right is the date,
16 4-14-2009. The prescription for Valium
17 10 milligrams, the dose of milligrams. PO means
18 by mouth. T.id. is three times a day. P.r.n.,
19 as needed. Number 75, refills.
20 **THE MAGISTRATE:** That means 75 pills?
21 **THE WITNESS:** Correct, 75 pills. Refills
22 five is circled, so that would indicate five
23 refills. This is a one-month supply, 75 pills,
24 and that can be refilled each month for a total

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

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1 patient or a medicine that can be harmful to a
2 patient. It also had an abuse potential. This
3 is a medicine that is an abused medicine. It
4 can lead to significant side effects. Again if
5 he is taking more medicine than is prescribed,
6 it's at a sufficient level that he could go
7 through drug withdrawal if he suddenly stopped
8 taking the medication. This is a medicine that
9 you should have some control over in terms of
10 side effects and in terms of helping your
11 patient versus harming your patient.
12 Q. When prescribing any medication including Valium
13 are there, do you discuss and note whether you
14 had a conversation about side effects with the
15 patient?
16 A. Yes.
17 Q. Why is that?
18 A. It's important medically/legally to protect
19 yourself. If the patient has severe side
20 effects from a medication, it is important to
21 document that. It's important in terms of
22 patient care that you let the patient know what
23 the effect of the medication is going to be and
24 what the potential side effects are. If you are

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1 prescribing a medication that can have
2 significant side effects, you want to know that
3 and you want the patient to know about potential
4 interactions with other drugs, with current
5 medications and how it may affect their daily
6 life including potential dangers that you may
7 put them at, driving a car, using equipment or
8 at work.
9 You also want to know if your patient is
10 having side effects. It is important to let
11 your patient know if you are having side
12 effects, they should contact you so you would
13 know potentially if the medication is harmful.
14 Q. Is the note that a physician writes about, a
15 prescription about anything, is that a note to
16 themselves that assists in their thought
17 process?
18 A. It is a note to themselves that can assist in
19 their thought process, but more importantly this
20 is a medical record, a medical/legal record that
21 will document what the patient has told you,
22 what you are observing, what your thought
23 processes are and your conclusion as well as
24 your plans for the patient. All of these things

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1 are important in terms of patient care and
2 recording this for patient care both for
3 yourself and others who may be involved in the
4 patient's care.
5 Q. Is it important for continuum of care?
6 A. Yes.
7 Q. What can be the impact of taking Valium and
8 alcohol?
9 A. Can have a severe side effects. There are, as
10 we discussed previously, additive side effects.
11 You can have a multiplication of side effects
12 from Valium. People who drink alcohol and take
13 Valium become sedated much more easily, become
14 intoxicated much more easily, with all the
15 consequences involved with those activities.
16 Q. Is it important to tell your patient that and
17 that you note it in the record?
18 A. Yes.
19 THE MAGISTRATE: If a patient has side
20 effects, it's also important so that the doctor
21 can mitigate those side effects for the
22 patient's health and comfort, is that right?
23 THE WITNESS: That is right. You might
24 not say specifically what side effects you

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1 discussed, but I think that at least typically
2 you would put in the prescribing medication, in
3 this case Valium, possible side effects were
4 discussed.
5 Q. (By Mr. Paikos) Is that part of the reason that
6 you take a social history from a patient when
7 you see them?
8 A. Yes.
9 Q. Is the standard of care to take an initial
10 social history, update it or which one or both?
11 A. Standard of care would be to take an initial
12 social history. Wouldn't necessarily update a
13 social history unless the patient comes to you
14 and had something pertinent in their social
15 history that they want to share with you, but I
16 would not go through a routine social history on
17 every follow-up visit.
18 Q. Directing your attention to medical record 44,
19 Bates 118. Actually on medical record 45 is the
20 same visit, July 10, 2009, Bates 118 and 119.
21 A. This note from July 10, 2009 from the doctor is
22 below the standard of care. The History is
23 listed as no change in back pain symptoms. Has
24 been swimming two mornings a week. Right knee

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1 need replacing. Inadequate history with the
 2 patient's medical problems. We don't know very
 3 much at all about the back pain except there has
 4 been no change. We have no other information
 5 about other neurological problems. We do know
 6 his right knee needs replacing. We are not sure
 7 quite why that is. Assumption would be there is
 8 pain, mobility problems, gait problems. We
 9 don't know any information about the medications
 10 he has been taking, how are the medicines
 11 helping him, does he have side effects.
 12 The exam is listed as "exam stable." As
 13 previously discussed, follow up with the
 14 patient. Assessment and Plan is a cervical and
 15 lumbar radiculopathy. There is an indication
 16 that there is a problem in both the neck and the
 17 back with nerve root compression. Again there
 18 is no specific information about this, no
 19 mention of his neck under the History, no
 20 mention of other neurological problems. And the
 21 only Plan that is listed, I believe it is a plan
 22 although I'm not a hundred percent sure, says
 23 "1000 K cal. diet!" I don't know if that is a
 24 history from the patient or recommendation from

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1 the doctor. There is no recommendation with
 2 regard to medications, no information with
 3 regard to pain treatment for him.
 4 THE MAGISTRATE: Aside from the context
 5 of a thousand K cal. diet, what does that mean
 6 to you?
 7 THE WITNESS: I don't know what it means.
 8 THE MAGISTRATE: A thousand calorie diet
 9 or you don't know?
 10 THE WITNESS: I know that a thousand
 11 calorie diet is a low-calorie diet, but I don't
 12 know, is this something that the patient is
 13 doing, is this something that is recommended to
 14 him. If it's being recommended, I have no idea
 15 why it is recommended. Is he obese? It's a
 16 low-cal. diet, so it's quite low. I have no
 17 information.
 18 THE MAGISTRATE: Is K cal. standard
 19 shorthand for calorie?
 20 THE WITNESS: Not that I know of.
 21 THE MAGISTRATE: Thank you.
 22 Q. (By Mr. Paikos) Is there a new diagnosis,
 23 cervical radiculopathy?
 24 A. I would have to go back and look at previous

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1 notes. I don't recall seeing that diagnosis
 2 before, but I would have to go back and look at
 3 previous notes.
 4 Q. And the records will obviously speak for
 5 themselves, but when there is a new diagnosis
 6 for a patient, what should be done, if anything?
 7 A. Well, the new diagnosis would presumably be
 8 related to prior information in the record. It
 9 would be related to the history so we would know
 10 that the patient is coming in with a history,
 11 with complaints that relate to the new
 12 diagnosis. There should be an examination that
 13 is at least, at the very least targeting the
 14 symptoms that the patient is complaining about.
 15 For example, complaints of a cervical
 16 problem, there would want to be an examination
 17 of the neck, you would want an examination of
 18 the arms, hands, the strength, sensation,
 19 reflexes, probably an examination of the legs as
 20 well since you can get changes in the legs
 21 related to neck problems, cervical problems.
 22 What the gait shows. You would want to know is
 23 the pain extending, is it going down the back,
 24 and certainly in this case he has a lumbar

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1 problem as well.
 2 We would want a good examination related
 3 to the patient's complaints and the patient's
 4 history, and I would want to have a discussion
 5 why the diagnosis is being made and a plan for
 6 further evaluation. Does the patient require
 7 radiologic procedures, an MRI, are medications
 8 being prescribed. Is he being referred to
 9 physical therapy, other types of adjunct
 10 treatment, is a chiropractor being seen for his
 11 back, all sorts of different types of options
 12 for it.
 13 Q. If we go sort of keep at two different pages at
 14 the same time for two different dates, we have
 15 this one with a respondent's July 10, 2009 note,
 16 medical record 44, 118; and we have medical
 17 record 175 which is an exam of approximately
 18 three months earlier on April 14, 2009 at
 19 medical record 175, Bates 136.
 20 The exam three months before, was
 21 cervical radiculopathy noted in the AP or
 22 anywhere?
 23 A. Looking at page 175, that is the 4-14-2009, is
 24 that correct?

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

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

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

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1 **problem. I typically would not make the**
2 **decision that the patient needs a replacement as**
3 **a neurologist. Typical neurologist would not**
4 **have the expertise to make the decision whether**
5 **or not a patient needs to have a knee**
6 **replacement. The correct course of action after**
7 **discussing it with the patient would be to offer**
8 **a referral to an expert, typically an**
9 **orthopedist.**
10 Q. What would be a course for a neurologist to
11 take, if any, if there is a new diagnosis of
12 cervical radiculopathy?
13 **A. To document specifically what the patient's**
14 **history is, to document what the patient's**
15 **complaints are that would relate to this**
16 **diagnosis that can lead you to make the**
17 **diagnosis, do a careful neurological examination**
18 **with reference to the areas of involvement. As**
19 **previously noted, an examination of the neck,**
20 **possibly the back, the arms, the legs, the gait,**
21 **do a neurologic examination looking for evidence**
22 **of dysfunction to the cervical region,**
23 **particularly the nerve roots.**
24 Q. Any referrals or diagnostic tests?

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

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1 now.
2 **THE MAGISTRATE:** Five minutes.
3 [Recess]
4 **THE MAGISTRATE:** Let's resume.
5 Q. (By Mr. Paikos) Dr. Levin, if we go to
6 Patient D's medical record 56 which is at Bates
7 120.
8 **A. I have viewed this note.**
9 Q. And was Dr. Padmanabhan's care within the
10 standard of care?
11 **A. It is not. This note is below the standard of**
12 **care. And I also have some concerns about the**
13 **statements related to this patient in terms of**
14 **the standard of care. The history from the note**
15 **of 9-21-2009 indicates patient complained of**
16 **tingling in the front of his right foot along**
17 **with a weakness in his left thigh for the past**
18 **six weeks every morning when getting out of bed**
19 **which gets better as the day goes on and the**
20 **knee holds his weight.**
21 **This is an insufficient history. There**
22 **is a lot more information that should be**
23 **indicated in order to properly assess this**
24 **patient and that would be expected from the care**

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

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

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

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1 would be related to a mattress pad.
2 The Plan --
3 **THE MAGISTRATE:** Because it's a more
4 severe condition?
5 **THE WITNESS:** Potentially a more severe
6 condition. If the patient had a myelopathy,
7 that's a condition that can lead to paralysis,
8 bowel and bladder dysfunction, assuming this is
9 the lower portion of the spine. Can lead to
10 loss of sensation, gait impairment. This is
11 potentially quite serious if the assumption is
12 that the patient may have a myelopathy.
13 **THE MAGISTRATE:** And too serious to be
14 related to a mattress pad or caused by
15 inadequate mattress pad?
16 **THE WITNESS:** Yes. I think the
17 positional changes related to a mattress pad
18 would give a myelopathy. The Plan is to change
19 the pad, go to aqua therapy and traction. This
20 is below the standard of care. If you think
21 your patient had a myelopathy, that patient
22 needs to have an MRI, and the MRI needs to be
23 done as soon as possible, oftentimes on an
24 emergent basis if you really suspect the patient

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

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

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1 Q. Would it be important to know which part of the
2 body had the power loss?
3 **A. Yes.**
4 Q. Would that impact the potential emergent nature
5 of getting an MRI?
6 **A. Yes.**
7 Q. So a subsequent provider or even Dr. Padmanabhan
8 coming back and looking at the note would not
9 know where the issue was relative to the power
10 loss?
11 **A. Correct.**
12 Q. And would the subsequent provider or
13 Dr. Padmanabhan if Dr. Padmanabhan didn't
14 remember after three months, would they be able
15 to provide adequate care to this patient?
16 **A. No.**
17 Q. If we go to Patient D's medical record 63, Bates
18 121, and it goes to Bates 122, medical record
19 64. If you can review that note.
20 **A. I have reviewed the note, and this note is below
21 the standard of care.**
22 Q. Why?
23 **A. Looking at the History, date is 11-3-2009 and
24 the previous date was 9-29-2009, approximately**

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

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

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1 **work-related severe injury years ago.**
2 **THE MAGISTRATE:** Before you go on, is it
3 significant to you about right calf being a
4 touch firmer than the left calf?
5 **THE WITNESS:** Yes.
6 **THE MAGISTRATE:** What is the
7 significance?
8 **THE WITNESS:** I don't know, but it would
9 be a concern there may be something, a new
10 medical problem related to his calf. I would be
11 concerned about deep-vein thrombosis. Other
12 things can cause it. He could have an infection
13 in the area, but certainly something that you
14 need to have further medical care.
15 **THE MAGISTRATE:** What is a straight-leg
16 raise test and what is a positive straight-leg
17 raise test?
18 **THE WITNESS:** Could be done two ways:
19 Either with the patient lying down, supine, or
20 with the patient sitting up. And while the
21 patient is lying down, you actually raise the
22 leg up with the knee extended without the knee
23 being bent and observe if the patient has pain
24 in that position; if so, what degree of

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1 elevation will produce pain.
2 It can occur with many different
3 conditions. Most commonly you will see if there
4 is a back problem, but it can also be seen with
5 other conditions. You can see if there is a
6 problem in the leg itself, you can see it with
7 the knee problem. Many different conditions can
8 give you a positive straight-leg raising test.
9 **THE MAGISTRATE:** "Positive" means causing
10 pain or discomfort?
11 **THE WITNESS:** When you raise the
12 patient's leg up, the patient typically
13 complains of pain typically at less than 90
14 degrees of elevation. The smaller the degree of
15 elevation, the greater the concern. If you
16 raise it up and the patient complains of pain at
17 five degrees, you are more concerned than if
18 they complain at 90 degrees. Typically this is
19 combined with other lower extremity tests.
20 There are two tests that are commonly
21 done at the same time, Cardic maneuver and
22 Patrick maneuver are commonly done. The Cardic
23 maneuver --
24 **THE MAGISTRATE:** Is the absence of those

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1 two maneuvers significant.
2 **THE WITNESS:** It gives us less
3 information and makes the positive straight-leg
4 raising test less helpful.
5 **THE MAGISTRATE:** How does it relates to
6 the standard of care, the absence of notations
7 about the other two maneuvers?
8 **THE WITNESS:** They would not definitely
9 be required.
10 **THE MAGISTRATE:** Is examination or
11 assessment of the calves standard?
12 **THE WITNESS:** Would that be a standard
13 part of the neurological examination?
14 **THE MAGISTRATE:** Yes.
15 **THE WITNESS:** No. It would be a standard
16 of care when the patient complains of hardness
17 behind the right knee. This patient complained
18 of hardness behind the right knee, so it was
19 within the standard of care for the doctor to
20 examine his calves.
21 **THE MAGISTRATE:** Thank you.
22 **A. Looking at Assessment, he had chronic back pain**
23 **due to severe injury many years ago. There is**
24 **no indication of the previous concern about**

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

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

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

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

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

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

12 THE WITNESS: Correct. I believe at the
13 bottom we see Marianne E. Richard, RN,
14 registered nurse, 11-3-2009 and notes continues
15 8/10 low back pain.

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

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

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

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

1 THE MAGISTRATE: Thank you.

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

5 A. Correct.

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

8 A. This is below the standard of care.

9 Q. Why?

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

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

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

7 A. We do not.

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

10 A. Yes.

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

18 A. Yes.

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

22 THE WITNESS: That is correct.

23 THE MAGISTRATE: That is your opinion?

24 THE WITNESS: That's correct.

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

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

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

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

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

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

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1 **concerns about a myelopathy and now does not**
2 **show, then you would indicate that as well.**
3 **If you have an MRI and the MRI is normal,**
4 **then you could say, okay, the patient is now**
5 **feeling better and less concerned about this. I**
6 **do not find evidence of a myelopathy on my**
7 **examination, the MRI did not show evidence of**
8 **myelopathy at this time, I do not believe that**
9 **the patient had a myelopathy. You discuss what**
10 **you thought was going on. You might say I**
11 **believe the pain relates to another problem,**
12 **lumbar radiculopathy. Chronic pain, you may say**
13 **previously noted concerns may have related to**
14 **lumbar radiculopathy but I do not find evidence**
15 **at this time of a myelopathy. It's important to**
16 **do a history, the exams and the test and**
17 **document what you did.**
18 **Q.** You do something similar when assessing or
19 eliminating a cervical radiculopathy?
20 **A. Yes.**
21 **Q.** Doing certain tests, examinations and noting
22 that the person does not have it?
23 **A. Yes. Or report that the patient is improved or**
24 **worsened.**

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

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1 particular person or not, I don't know.
2 **THE MAGISTRATE:** What does it mean in
3 this context, "counseling"?
4 **THE WITNESS:** That you spent face-to-face
5 time talking to the patient for more than
6 50 percent of your visit.
7 **THE MAGISTRATE:** Does that have anything
8 to do with something with this patient who is
9 presenting so many problems, reported so many
10 problems in previous visits to spend 50 percent
11 of the time face-to-face time counseling the
12 patient as opposed to doing a physical exam, and
13 tests like the straight-leg test, does that
14 relate to standard of care?
15 **THE WITNESS:** You would assume that
16 "counseling" means you are counseling the
17 patient, offering advice. The term "counseling"
18 typically refers to just face-to-face
19 discussion, so it has to do with your history
20 and your discussion with the patient explaining
21 what you think is wrong are them, talking to
22 them about their problems, telling what your
23 plan is to be doing. It isn't necessarily
24 counseling in terms of a psychological,

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

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

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1 **previous notes including the note I believe of**
2 **9-21 where he indicated that the patient had**
3 **complained of a hardness behind the right knee.**
4 **Excuse me. I believe it was November 30, page**
5 **63. The patient complained of hardness behind**
6 **the right knee and never got follow-up care on**
7 **that. We don't know if what we are seeing today**
8 **relates to the previously described problem from**
9 **November 3 or this is a new problem.**
10 Q. If we go to medical record 104 Bates 125. If
11 you could review that note.
12 A. **This is a note dated January 12, 2010, and**
13 **comments on this would have to be similar to the**
14 **previous note. This is not a note that would be**
15 **for a standard of care of a neurologist assuming**
16 **there was no care for this patient within the**
17 **neurologic point of view.**
18 **The concern is here that there is**
19 **swelling in his legs, one plus pitting edema**
20 **today. The rash has subsided a lot. Tested**
21 **negative for DVT, deep-vein thrombosis,**
22 **congestive heart failure, blood results. I**
23 **asked Dr. Mattie to take a look which he kindly**
24 **did. We don't know what Dr. Matti's conclusions**

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1 were. We decided to do a pelvis CT to rule out
2 lymphatic outflow obstruction and plan for rest
3 as before.
4 Again this is not a note that we would
5 hold to the standard of care of a neurologist.
6 The doctor has chosen at this point to see the
7 patient for a medical problem. Looking at this
8 just in terms of a medical problem, again we
9 have no examination, there is no objective
10 information here about his examination. We do
11 not know what Dr. Matti said, we didn't know who
12 Dr. Matti is or what type of doctor he is, so we
13 don't know if he is a dermatologist, vascular
14 surgeon. There is no information here.
15 In addition to that, I think we have to
16 look at this perhaps as related to previous
17 notes in his care of the patient as a
18 neurologist. I don't know if there had been
19 medications prescribed. We don't have any
20 information about any care as related to the
21 patient's previous visits. I don't know if this
22 is a standalone visit because of his rash,
23 edema, the leg problems, or is this a
24 representative of his follow-up note for the

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1 patient for his back problems, his possible
2 myelopathy, his numbness. I don't know that
3 because there is no information here about his
4 neurologic problems. If this is a follow-up
5 note, that also includes his neurological
6 problems. If there is medication prescribed for
7 his neurologic problems at the time of this
8 visit, that would be below the standard of care.
9 Q. Why would it be important to know the things
10 that you mentioned that aren't included in the
11 exam?
12 A. We didn't know what kind of visit this is. This
13 appears to be a visit for concerns about
14 swelling in the legs, rash and edema.
15 THE MAGISTRATE: Dr. Levin, can you
16 interpret the first substantive line on this
17 Progress Note, the "one plus pitting."
18 THE WITNESS: Pitting edema, "edema"
19 means "swelling." When you examine someone,
20 this would refer to swelling in the legs.
21 Swelling in the legs with one plus pitting
22 edema, you go to the ankle, go to the foot,
23 gently press your thumb in and if you can leave
24 an imprint when you take your thumb away, that

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1 is referred to as pitting edema. In terms of
2 one plus or greater, I would have to say at this
3 point in my career that is beyond my expertise.
4 THE MAGISTRATE: Thank you.
5 Q. (By Mr. Paikos) Medical record 122, Bates 126,
6 would you turn to that, please. Have you
7 reviewed that note, Doctor?
8 A. I have.
9 Q. Was Dr. Padmanabhan's care within the standard
10 of care on this date?
11 A. It was below the standard of care.
12 Q. Why?
13 A. The history that we are being given. First of
14 all there is limited information with regard to
15 previous concerns about the legs. The only
16 information we have about that is the purpura
17 returned when he took a Dilaudid pill. I'll
18 come back to that in just a moment. He is
19 almost at his baseline. He has had his shots
20 placed, prednisone taper, health is well.
21 Purpura returned when he took a Dilaudid pill
22 without noticing the name of the manufacturer.
23 All else is the same.
24 We have no history, we don't know if

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1 anything is happening neurologically, no
2 information with regard to his pain with his
3 legs, his numbness, the concern about him having
4 a myelopathy. We have no information with
5 regard to his neck, his arms. There is no
6 history here at all.
7 We have very little information in terms
8 of what happened with his legs in terms of the
9 follow-up. He was going to be having a pelvic
10 ultrasound. No information about that or no
11 information about follow up with other doctors.
12 And then we have information about his
13 shots. We don't know what type of shots he has,
14 if this is an epidural injection, if they are
15 facet blocks. We have no information about
16 that, what medication he received or his
17 reaction to the medicines except we are told
18 that prednisone taper helped as well.
19 Unfortunately there is no previous information
20 about a prednisone taper. This is the first
21 time we have seen information that he received
22 prednisone.
23 THE MAGISTRATE: And that it tapered.
24 THE WITNESS: And that it tapered,

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1 correct.

2 **THE MAGISTRATE:** And how it helped. And

3 there is no indication of how it helped?

4 **THE WITNESS:** That's correct.

5 **A.** The purpura returned when he took a Dilaudid

6 pill, and there is a note that we'll get the

7 name of, the generic name of the manufacturer

8 and record it as an allergy. This the first

9 indication that he was prescribed Dilaudid.

10 Dilaudid is another narcotic, another opioid.

11 So looking at the note, previously he had been

12 on Oxycontin, oxycodone, and now it appears he

13 is also receiving a prescription for Dilaudid.

14 This is the first time that I have seen Dilaudid

15 in the progress notes. We don't know how long

16 he has been getting it, why he is getting it,

17 how much was prescribed, did it help him or did

18 he have side effects from it. All we know is

19 all else is the same.

20 There is no Examination listed, there is

21 no Impression, no information here at all. Says

22 all else the same. I don't know if that refers

23 to History, no Examination. We don't know

24 anything else.

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1 Q. What is a prednisone taper?

2 **A.** It is a, typically you give somebody a course of

3 prednisone. Prednisone is an anti-inflammatory

4 medication taken by mouth. And frequently you

5 will give them a tapering course and start them

6 perhaps at 40 milligrams a day, 60 milligrams a

7 day for one or two days, and the next day go to

8 40 milligrams or 50 milligrams for two days,

9 20 milligrams for one or two days and bring them

10 down for a period of a week to ten days. And it

11 is referred to as a steroid taper or a

12 prednisone taper.

13 The Assessment and Plan is chronic

14 radiculopathy. We don't know if that refers to

15 the neck or back or both, we don't know anything

16 about his symptoms or what's happening with him

17 clinically. Is he better, worse, does he have a

18 myelopathy, has that been ruled out, does he

19 have symptoms from that. The concern about the

20 deep vein thrombosis, it looks like that was

21 ruled out. He had a pelvic lymphatic problem.

22 We didn't know anything about that.

23 We don't know what meds were refilled or

24 prescriptions. We don't know the names of the

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1 **medicines or what he has been given, the**

2 **dosages, the refills. There is no information.**

3 Q. Prednisone you said is a steroid?

4 **A. Yes.**

5 Q. Are shots, there is a reference to shots, and we

6 don't know what they are from this note. Are

7 there sometimes steroid shots given?

8 **A. Yes.**

9 Q. Do steroids have potential negative

10 consequences?

11 **A. Are you referring to the oral and the shots or**

12 **both?**

13 Q. Just in general.

14 **A. In general steroids are medicines that need to**

15 **be respected. They have a potential for many**

16 **serious side effects, particularly with chronic**

17 **usage, must less so with acute usage. You can**

18 **give a short-term course or injections as well.**

19 **With chronic usage there are many serious side**

20 **effects, breakdown of bone, accumulation of fat**

21 **in the face, in the upper back, can lead to**

22 **liver disease, lead to weakness, breakdown of**

23 **muscles, weakness in the lower extremities, lead**

24 **to ulcers, so many possible significant side**

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1 **effects from chronic usage. Much less so with**

2 **prednisone taper. Short course most of the time**

3 **is very well tolerated. But again even with a**

4 **short course there are other possible serious**

5 **side effects. For example, can cause a joint**

6 **necrosis, a breakdown of the joint, typically**

7 **the hip or shoulder. A rare side effect but one**

8 **that we with will generally warn our patients**

9 **about, should they develop sudden pain in the**

10 **joint. Again side effects from epidural**

11 **injections, much less so, typically very few**

12 **systemic side effects, although you may have**

13 **local side effects from the injections.**

14 Q. Would it be important to know what kind of

15 injections for a subsequent provider?

16 **A. Yes.**

17 Q. Why?

18 **A. We don't know what type of shots were placed, if**

19 **it was an epidural, they could have been facet**

20 **blocks, trigger-point injections. There are**

21 **many possible shots. Generically he could have**

22 **gotten a flu shot. I don't think so. He was**

23 **referring to a shot for his pain, but I don't**

24 **know that.**

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1 Q. Going to medical record 139 Bates 127 --
2 **THE MAGISTRATE:** Before you move on, if I
3 could ask Dr. Levin, how would the first
4 substantive line, what does that mean to you,
5 Patient D is almost at baseline again?
6 **THE WITNESS:** It means nothing. I have
7 no information. I don't know what his baseline
8 is.
9 **THE MAGISTRATE:** We don't know what
10 "almost" means.
11 **THE WITNESS:** (No response).
12 **THE MAGISTRATE:** Even if we knew
13 baseline.
14 **THE WITNESS:** If we knew baseline, I
15 guess we would know what "almost" is.
16 **THE MAGISTRATE:** So if we knew baseline,
17 we still wouldn't know how great the magnitude
18 of deviation from the baseline is.
19 **THE WITNESS:** Correct. We have no idea
20 what this refers to, if it refers to his neck,
21 his back, to his numbness, to his pain in his
22 legs. Does it refer to the knee problem, does
23 it refer to the firmness of his calf, does it
24 refer to his purpura. We have no idea what that

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

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1 Q. (By Mr. Paikos) On this note March 18, 2008 now,
2 is there anything regarding pain down the back
3 of the patient's leg? March 18, 2010 the one
4 the Magistrate was just asking you about on your
5 medical record 122, not moving away from that.
6 **A. It does say encounter, top says encounter date**
7 **March 18, and I see from the doctor March 21**
8 **says signed. So the assumption would be that he**
9 **signed it, especially since the registered**
10 **nurse's note is March 18. So we are talking**
11 **about the note of March 18?**
12 Q. Yes, encounter date and the signed date from
13 Dr. Padmanabhan is March 21. Is there any
14 notation about pain down the back of the leg,
15 left or right?
16 **A. No.**
17 Q. If we go to medical record 139 of Bates 127,
18 June 15, 2010 examination. That goes to the
19 next Bates stamp and medical record number page.
20 **A. What is the page number?**
21 Q. Medical record 139 and Bates 127 and 128.
22 **THE MAGISTRATE:** Are you moving on from
23 126, or are you relating it to 126?
24 **MR. PAIKOS:** We'll relate it to 126.

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

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1 was going to try to get the name of the generic
2 manufacturer and the doctor was going to record
3 this as an allergy. Whether this was going to
4 be reported to the manufacturer or some other
5 agency, I don't know.
6 **THE MAGISTRATE:** Do you interpret
7 "recorded as an allergy" to mean in the
8 patient's records?
9 **THE WITNESS:** Yes.
10 **THE MAGISTRATE:** And the patient's
11 records do not have an indication of him being
12 prescribed Dilaudid?
13 **THE WITNESS:** Not that I saw.
14 **THE MAGISTRATE:** If he was prescribed
15 that and he threw them out, would that be a
16 concern?
17 **THE WITNESS:** Potentially could be a red
18 flag that the patient threw out an opioid.
19 **THE MAGISTRATE:** And it also means he is
20 not complying with the prescription?
21 **THE WITNESS:** No, that wouldn't be true.
22 If a patient is having what he believes to be an
23 adverse reaction and chooses not to take the
24 medication because he thinks he is having a side

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1 effect and adverse reaction, that would not be
2 correct. That would be something that would be
3 quite sensible on the part of the person. The
4 purpura was better, he took a Dilaudid and he
5 noticed that his purpura returned. And I think
6 it would be sensible on the part of the patient
7 to say this pill seems to be giving side
8 effects, I'm not going to take them any more. I
9 think it would be reasonable on the patient's
10 part not to take the pill.
11 **THE MAGISTRATE:** Would it be the standard
12 of care for the follow-through that this medical
13 record indicates on the patient noticing the
14 return of his purpura and discarding the
15 medication?
16 **THE WITNESS:** Repeat the question?
17 **THE MAGISTRATE:** Seeing as the patient
18 noticed the return of his purpura and discarding
19 the medication, is the doctor's response as
20 recorded in the medical record within the
21 standard of care, doctor's response to that
22 report an action by the patient?
23 **THE WITNESS:** It's within the standard of
24 care.

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

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

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1 of care. Discussing the note, there is a note
2 that the patient has not had as good a response
3 to the set of epidural steroid injections as
4 before. The prednisone course still had pain
5 down the back of the left leg greater than the
6 right leg. Still struggles with his weight.
7 There is no other information with regard
8 to his pain problems. There is no information
9 with regard to the previously mentioned
10 myelopathy, no further discussion of the
11 previous problem as related to his rash, either
12 the purpura or the other rash related to or
13 possibly to the Dilaudid. No information with
14 regard to the prescribed oral medications with
15 the exception of prednisone. There is a
16 discussion of that.
17 The examination lists detailed vital
18 signs. The only other information about the
19 examination is exam not changed at all. This
20 would be below the standard of care. There is
21 no information in terms of his neck problem, his
22 back problem, his leg problems. We have no
23 information at all.
24 Assessment, his back pain and

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1 radiculopathy. I don't know where the
2 radiculopathy was. We don't know if it relates
3 to the lumbar region, cervical region. We don't
4 have any real detailed information.
5 Meds were refilled. We don't know what
6 medications were refilled, we don't know doses
7 of medicines, what they have been used for, the
8 amount prescribed. We have no information at
9 all about the medications that are being
10 prescribed.
11 There is a Plan to change his diet and
12 timings, presumably by the time the meals are
13 taken. There is a note below the doctor's note
14 from the nurse indicating that continues to have
15 pain 9/10; with pain med, down to 6/10. States
16 cortisone injections have helped. Uses cane
17 when ambulating, careful when doing stairs.
18 This seems in conflict with the doctor's note,
19 and the nurse is indicating her history is that
20 the cortisone injections have helped. His note
21 indicates he has not had as good a response from
22 the latest set of steroidal injections.
23 Would you like me to relate it to a
24 previous note?

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1 Q. Yes. If I could, is there a mention in the
2 March 18, 2010 note of pain down the back of
3 left leg greater than right leg?
4 A. No.
5 Q. But still has pain down the back of his left leg
6 greater than right leg on June 15, 2010?
7 A. Correct.
8 Q. Is there an issue with that discrepancy?
9 A. The issue would be that there is a discrepancy.
10 June 15, 2010 he still has the pain, but in the
11 previous note there is a no indication that he
12 had the pain. The previous note indicated that
13 he was almost at his baseline, but there was no
14 clinical information with the exception of his
15 purpura returning.
16 Q. Would it be important to know where the
17 radiculopathy is on June 15, 2010, cervical
18 versus lumbar, and if so, why?
19 A. Yes. It would be important because this is a,
20 the basic information in terms of proper care of
21 the patient. We would want to know if he is
22 having pain in his neck, his arms or his legs
23 and his back. Are they separate problems, are
24 they occurring together, how are they affecting

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1 him. What medications is he getting for these,
2 are the medications helping him, specifically in
3 terms of prescribed oral medications in addition
4 to the prednisone and the epidural injection.
5 Q. If we go to September 1, 2010, medical records
6 154.
7 A. Reviewing the Progress Note of 9-1-2010, this
8 note is below the standard of care. History is
9 patient is here for his refills. He needs to
10 have his epidural shots done again. All else as
11 before. That's, everything that is written is
12 the entire note.
13 There is no information, no history. We
14 don't know anything about his pain, we don't
15 know where the pain is, what his response is,
16 what his response to medicines is with the
17 exception of he needs to have the epidural
18 shots. But we don't know if he has had further
19 ones, ones since his last visit helped him or
20 not. We have no information with regard to any
21 examination, no neurological examination and no
22 impression. So we don't know how the patient is
23 doing, what the medical progress is. Does he
24 still have concerns of a myelopathy, are there

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

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

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

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1 prescriptions one month at a time for a total of
2 three months.
3 **THE MAGISTRATE:** I see it, thank you.
4 Q. Turning next to the next patient --
5 **THE MAGISTRATE:** We are done with the
6 documents for Patient D?
7 **MR. PAIKOS:** Yes.
8 Q. This is at tab 6 Patient E's medical record 3,
9 Bates 137 to 139, medical records page 3, 4 and
10 5.
11 A. Shall I continue through 4 and 5?
12 Q. Patient E, what are the problems he presents
13 with?
14 A. He had a fall. He has sharp severe pain
15 radiating down the right leg, occasionally
16 numbness in the posterior thigh. Severe back
17 pain. And it says "occasional pinch." Doesn't
18 state specifically where the pinch is.
19 Q. And there is some information regarding his
20 wanting to finish a criminal justice degree
21 going to the US Special Forces and the New
22 Hampshire Police as well on the medical record
23 3, Bates 137?
24 A. Yes.

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

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

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1 last answer, Dr. Levin, this appears to be an
2 initial visit?
3 **THE WITNESS:** Yes.
4 **THE MAGISTRATE:** Are such medical records
5 supposed to be more detailed than follow-up?
6 **THE WITNESS:** In general, yes.
7 **THE MAGISTRATE:** Do we have anything to
8 compare this medical record for Patient E with
9 the initial visit to the previous patients we've
10 seen?
11 **THE WITNESS:** I would have to go back to
12 those previous charts to answer your question
13 correctly.
14 **THE MAGISTRATE:** But is it a fair
15 comparison to compare an initial visit report
16 with follow-up visit reports?
17 **THE WITNESS:** Yes.
18 **THE MAGISTRATE:** And in general is this
19 the kind of detail the standard of care calls
20 for in follow-up visit reports?
21 **THE WITNESS:** No, that would not be
22 correct. This is the type of detail one would
23 expect in an initial visit. Follow-up visits
24 also demand detail but they don't demand as much

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1 detail in general as an initial visit.
2 Depending on the patient's needs, depending on
3 the acuteness of the situation and depending on
4 the patients's clinical course, your follow-up
5 note may or may not be this detailed, but in
6 general this is a routine neurological
7 evaluation, the initial visit.
8 For follow-up visits the History
9 oftentimes is more focused, not as detailed as
10 this, but there should still be a detailed
11 history. The neurological examination would not
12 in general have to be as complete as this, but
13 many elements of the neurologic examination
14 still need to be present. Frequently an entire,
15 brief neurological examination is listed for a
16 follow-up visit.
17 When I see patients for a follow-up
18 visit, I include every element of the
19 neurological examination in my follow-up visit
20 in my note. I do not include some portions of
21 the exam that I do on my initial visit. For
22 example, when I first see a patient I examine
23 smell, I examine visual fields, sensation on the
24 face. Unless there is a reason to do so on

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1 follow-up visits, I don't examine those on
2 follow-up visits, so that would not be included
3 in my note, but I still would examine mental
4 status, motor examination, etc.
5 **THE MAGISTRATE:** Looking at the medical
6 record that starts on page 3, Bates 137, what in
7 this initial visit report would you expect to
8 find in a follow-up visit report that you have
9 seen lacking so far?
10 **THE WITNESS:** You expect to have a
11 history, so you expect there to be a follow-up
12 history detailing the patient's present course,
13 his present clinical symptoms, what has changed
14 since the last visit. If this is a pain
15 problem, has the pain gotten better or worse,
16 where is the pain, what are the circumstances of
17 it, is it extending to other portions of the
18 body, is the pain going from the back to the
19 legs, for example.
20 **THE MAGISTRATE:** Can you point out where
21 that kind of thing appears in this actual
22 record?
23 **THE WITNESS:** In this note?
24 **THE MAGISTRATE:** Yes, that you would

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1 expect to see roughly comparably in follow-up
2 visit notes. I'm looking for a comparison.
3 **THE WITNESS:** Well, again it could be a
4 follow-up visit, so typically you would say
5 "since his last appointment," or I would
6 oftentimes put in "since his last appointment on
7 9-19-2007 patient is" and you would say the
8 patient is better, worse, the patient is the
9 same. "Patient continues to have," and you
10 would describe symptoms that you described
11 before. There is a description of severe back
12 pain, so I might say the usual course would be
13 "patient continues to have severe back pain" and
14 that the patient's back pain has improved or
15 changed in some way. He notes that there is a
16 severe sharp pain radiating down the right leg,
17 so there would be a note, "right leg pain is
18 improved" or "right leg pain continues to be
19 severe with radiation down the leg, continues to
20 start at the hip and goes all the way down,
21 continues to have numbness occasionally in the
22 posterior thigh" or "numbness in the thigh is
23 gone" or "numbness has become worse and now
24 involves the left leg extremity," comments on

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1 what is happening.
2 Describing what has been the effect of
3 treatment, "patient has gone for aqua therapy
4 and found this to be helpful;" "patient went to
5 aqua therapy and it didn't help him, is now
6 taking Percocet at one tablet three times a day
7 with good improvement, pain improving from 9/10
8 to 2/10."
9 **THE MAGISTRATE:** These are hypothetical
10 examples?
11 **THE WITNESS:** I'm using this as a
12 template. You were asking me what I would do,
13 what he could possibly do as a template. These
14 are the types of things. For each area of the
15 examination, for Objective, for the Physical
16 Examination you would like to see a pertinent
17 examination relating to his problem; the
18 examination of the neck and the back, what is
19 the examination of at the very least, the lower
20 extremities, motor reflexes, coordination, what
21 does his gait look like. And these should be
22 parts of the follow-up exam. You wouldn't have
23 to have every single detail of the initial exam.
24 **THE MAGISTRATE:** Thank you.

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1 Q. (By Mr. Paikos) On October 31, 2007 there is a
2 visit that the patient had to the ER beginning
3 at medical record number 12 going to 13 and 14
4 and Bates 142, 143 and 144. What would be
5 significant in this note for further treating
6 the patient?
7 **A. This is an evaluation I believe at an emergency**
8 **center, SH Emergency Center, appears to be an**
9 **emergency center. Emergency department report**
10 **on page 12. This is from --**
11 **THE MAGISTRATE:** I assume that is
12 Somerville Hospital.
13 **THE WITNESS:** I would assume so.
14 May I state the name of the physician?
15 **MR. PAIKOS:** Yes.
16 **A. The name of the physician is Patti, P A T T I,**
17 **Purpura, P U R P U R A, MD. Dr. Purpura gives a**
18 **very detailed evaluation of the patient, medical**
19 **history and evaluation and has some significant**
20 **concerns that she raises.**
21 **She reviewed, took a full medical history**
22 **from the patient and reviewed the other records.**
23 **She notes that on reviewing his old records, it**
24 **appears he has been seen several times by a**

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1 neurologist at Whidden Hospital. She read the
2 consult into the computer with the assumption
3 that this is Dr. Padmanabhan's consult and notes
4 there was some conflict in the history that the
5 patient told the patient versus what he had told
6 her. Specifically he had told the neurologist
7 that he had an abnormal MRI, and in addition he
8 told her that he had an initial injury six
9 months ago and was reagravated today.
10 He told her he was given a prescription
11 for Percocet that he had filled at the beginning
12 of October and he ran out of medication two
13 weeks ago. She called a number of different
14 pharmacies and found discrepancies in the
15 information that had been given to her by the
16 patient. After calling Brooks as well as
17 Walgreens Pharmacy, it was clear that the
18 patient has been seeing multiple different
19 physicians to get narcotic medication. I am
20 concerned that the patient is exhibiting signs
21 of addiction, is not being truthful about the
22 medication he is using and uses multiple
23 different physicians to obtain medication. I
24 explained that I am concerned --

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1 **THE MAGISTRATE:** I can see that on the
2 third page of the record.
3 **A.** She basically says she is not going to give him
4 a narcotic, advised him to discuss this
5 medication with his physicians and gave him a
6 limited number of Motrin for his pain.
7 **Q.** Is Motrin a narcotic?
8 **A.** It is not. It is a nonsteroidal
9 anti-inflammatory medication.
10 **Q.** And did she also raise concerns about addiction?
11 **A.** She did.
12 **Q.** And one of the diagnoses is back pain and the
13 other one is narcotic-seeking behavior?
14 **A.** Correct.
15 **Q.** And he was discharged in good condition on
16 October 31, 2007?
17 **A.** Correct.
18 **Q.** If we go to medical record number 198 which is
19 Bates 162, medical record 198 Bates 162.
20 **THE MAGISTRATE:** Before you do that, if I
21 could ask Dr. Levin, the fact that Dr. Purpura
22 examined medical records of Dr. Padmanabhan,
23 indicates the importance of any doctor's records
24 being complete so that another doctor can

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1 examine them and understand them?
2 **THE WITNESS:** That's correct.
3 **Q.** (By Mr. Paikos) The other page was medical
4 record 198, Bates 162.
5 **A.** Reviewing the records from November 2, 2007 this
6 note is below the standard of care.
7 **Q.** Why?
8 **A.** History indicates continuing back pain, working
9 with UPS not helping. I don't know what "not
10 helping" refers to. I don't know if that refers
11 to his UPS or refers to medication or his aqua
12 therapy. I don't know what that refers to. We
13 have no information other than "continuing to
14 have back pain," no information about pains in
15 his legs, numbness, weakness, no information
16 about any medication that he has been taking, if
17 he is taking Percocet or not taking Percocet.
18 No information that he is going to the emergency
19 room. We don't know anything at all. There is
20 no history there other than "he continues to
21 have back pain."
22 **Objective** is positive muscle spasm,
23 positive guarded movements. We don't know where
24 the muscle spasms are, there is no indication of

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1 any specific part of the body, we don't know
2 what the guarded movements are or what part of
3 the body is guarded. There is no other
4 neurological examination or other physical
5 examination, so there is no guidance in terms of
6 how the patient is doing objectively.
7 **Assessment and Plan,** there is no
8 **Assessment.** We have no diagnosis, we don't know
9 what the impressions are in terms of what is
10 wrong with the patient, is this a neck problem,
11 a back problem, a neck problem. There is no
12 information. We don't know how he is doing in
13 items of the medication, we don't know what
14 medications were prescribed previously and his
15 response, we don't know how he did with the aqua
16 therapy. There is no information.
17 **The Plan** is aqua therapy. Avoid reinjury
18 and pain control. I don't know what "pain
19 control" refers to. The assumption would be
20 that this would be some type of medication, but
21 I don't know if this refers to medication, what
22 was prescribed, if there were injections or not.
23 **There is no information.**
24 **Again** going back to your previous

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1 question, were the emergency room physician to
2 look at this or some other physician to look at
3 this, they would have no information about the
4 patient, if the patient is a drug-seeking
5 patient, if he has a narcotics problem. There
6 would be no way to know that from this record.
7 Q. And you said there was no diagnosis. Is it
8 important to have a diagnosis when seeing a
9 patient?
10 A. Yes.
11 Q. Why?
12 A. It guides you in terms of your assessment for
13 the patient and what you are doing to help the
14 patient, at least to have a basic diagnosis if
15 not a definitive diagnosis to know what you are
16 dealing with in a general sense. Guides you
17 knowing what the patient is complaining of and
18 guides you in terms of your overall assessment
19 of the patient. If you are fortunate enough to
20 have a definitive diagnosis, that is very
21 helpful in terms of guiding you for treatment;
22 if you don't have a definitive diagnosis, to
23 know what type of problem you are dealing with
24 so you can focus on it each time you see the

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1 patient to try to help the patient.
2 Q. Doctor, if we can go to medical records 27 and
3 28 which is Bates 145 and 146. Does that talk
4 about the patient's career plans or path in
5 medical record 27?
6 A. Would you like me to discuss the note first or
7 answer your question?
8 Q. If you could discuss the note initially and any
9 issues that are there.
10 A. The history of the examination is certainly much
11 more detailed than the previous follow-up notes.
12 It would be within the standard of care. He
13 notes the visit to the emergency room and
14 concerns about patient visiting multiple
15 physicians to get narcotic medicines. Also
16 notes that he had seen Dr. Shalnov who is a pain
17 specialist to receive a set of epidural
18 steroidal injections which helped him. He
19 described how the patient is doing. His
20 examination I think is a good example of the
21 type of exam that you were asking me about
22 before. This is a good follow-up neurological
23 examination. The only thing that I can see in
24 the exam that should be here that is not here is

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1 an examination of his back. There is no
2 examination of back or neck. That would be
3 below the standard of care. The remainder of
4 the exam is within the standard of care.
5 His Impression is within the standard of
6 care. His prescription, he does detail that he
7 has given him Percocet three pills, three times
8 a day, and previously had been or currently is
9 at a dose of 15 milligrams three times a day is
10 sufficient. I'm a little confused that I don't
11 know if the 15 milligrams three times a day
12 refers to Percocet or refers to a different
13 medication. He does not state how many pills of
14 Percocets he is giving, he doesn't state if
15 there are any refills.
16 Given the concern about his patient
17 having drug-seeking behavior, I would think that
18 would be quite important to know how many pills
19 he is prescribing, either refills. If the
20 15 milligrams three time a day refers to
21 Percocet, and again I don't know that as a
22 designation for Percocet so I'm not sure what
23 that refers to, if that is referring to another
24 medication, the specifics, missing specifics

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1 about the medications would be below the
2 standard of care, especially in a patient who
3 may have a problem with narcotic abuse.
4 Q. Does this note show any kind of Assessment --
5 Well, there is no mention about -- There is
6 mention that Dr. Padmanabhan had access to
7 Dr. Purpura's note, correct?
8 A. Correct.
9 Q. Is there mention of anything about the patient's
10 potential addiction that the ER physician
11 thought that he left in good condition or that
12 he showed narcotic seeking behavior?
13 A. He discusses Dr. Purpura's notes and the concern
14 about seeing multiple different physicians to
15 get narcotic medications, filling them at
16 multiple pharmacies, so Dr. Purpura does not use
17 the term "narcotic-seeking behavior" or
18 Dr. Purpura's assessment. He does in effect
19 describe that behavior. In his Impression he
20 does not mention it.
21 Q. Does he mention any assessment he did to
22 determine whether or not this person was at risk
23 of misusing or abusing this medication --
24 A. No.

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

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

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

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

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

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1 **the type of examination that would be expected**
2 **for a neurologist for a follow-up.**
3 **The Impression in general is within the**
4 **standard of care, there is muscle spasm,**
5 **significant muscle spasms more on the right than**
6 **left. He gives him treatment for this and he**
7 **describes treatment he gave him for this.**
8 **Then he prescribes Percocet and he**
9 **increased the dose from five 325 to ten 325 and**
10 **increased it I believe from one pill now up to**
11 **two pills three times a day. He is unclear --**
12 **Excuse me, I misread it. Previous dose was five**
13 **325, three pills three times a day. He is now**
14 **prescribing ten 325, two pills, three times a**
15 **day. There is no indication of the number of**
16 **pills that were prescribed, whether or not there**
17 **is a refill, additional prescriptions or just a**
18 **single month or are there any other medications**
19 **being prescribed. There is no mention here of**
20 **the possibility of narcotic abuse, concerns over**
21 **narcotic inconsistencies. That would be below**
22 **the standard of care.**
23 **Q. Was there a reason noted specifically for the**
24 **change in the medication in the Percocet?**

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

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1 has a sudden onset of pain in his back.
2 **THE WITNESS:** Yes.
3 **THE MAGISTRATE:** I want you to compare
4 these two pages of medical record 34, Bates 147,
5 he threw his back out while loading a truck.
6 **THE WITNESS:** Correct.
7 **THE MAGISTRATE:** Is this a red flag?
8 **THE WITNESS:** It is when we add in the
9 knowledge that he has pain-seeking behavior, and
10 there are a number of incidents in the history
11 as obtained by Dr. Purpura in the emergency room
12 compared to the history obtained from
13 Dr. Padmanabhan on 9-19-2007. So the answer to
14 your question is yes.
15 **THE MAGISTRATE:** Is it a red flag that
16 somebody who fell down the stairs in September
17 of 2007 is loading trucks in December of 2007?
18 **THE WITNESS:** Yes.
19 **THE MAGISTRATE:** Back to medical record
20 12 Bates 142, is there a red flag that the
21 patient is reporting he injured his back
22 approximately six months ago and comparing that
23 to medical record 3, Bates 137 that he reported
24 tripping down the stairs which was only one

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1 month before?
2 **THE WITNESS:** I'm sorry, was the question
3 is this a red flag?
4 **THE MAGISTRATE:** Is this a red flag?
5 **THE WITNESS:** Yes.
6 **THE MAGISTRATE:** Thank you, Mr. Paikos.
7 Q. (By Mr. Paikos) Doctor, if we go to medical
8 record pages 50 and 51.
9 **A. I have reviewed this report, and it is below the**
10 **standard of care.**
11 Q. Why?
12 **A. Looking for Impression as to how the patient is**
13 **doing since his last appointment, I do not see**
14 **an Impression. I see a History, I see the**
15 **Physical Examination including the Neurological**
16 **Examination, I see a Plan but I see no**
17 **Impression.**
18 Q. If there is a Plan, why is an Impression still
19 important?
20 **A. The Impression tells you what the doctor thinks**
21 **is going on with the patient, his report, his**
22 **interpretation of the patient's history, how**
23 **well the patient has been doing since the last**
24 **visit combined with his impressions related to**

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

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1 **A. Yes. The specific medications are not**
2 **mentioned. He comes in for trigger point**
3 **injections as they currently, helped immensely**
4 **the last time and held him for at least two**
5 **weeks. And there is a note under Plan, I have**
6 **gone ahead and given him trigger point**
7 **injections, paraspinally. He does not state**
8 **which medications are given.**
9 Q. If we go to medical record 65 and 66 --
10 **THE MAGISTRATE:** Before you do that, if I
11 may, Mr. Paikos. So, Dr. Levin, the records for
12 lidocaine and the other medication indicates
13 what was given?
14 **THE WITNESS:** It indicates what was
15 ordered.
16 **THE MAGISTRATE:** And how is it different?
17 I mean would this, he would put in an order
18 during the office visit so it gets delivered to
19 the procedure room and he can administer it.
20 How does it relate?
21 **THE WITNESS:** I don't know. I see an
22 order for the lidocaine, sent two 2-milliliter
23 vials stat, please, and Depo-Medrol
24 40 milligrams, sent two 1-milliliter vials.

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1 This was in the hospital. Then this would be a
2 typical way to write an order in the hospital
3 and get this from the pharmacy and the patient
4 would get the medication.
5 I don't know what the routine is at
6 Cambridge Health Alliance or how they handle
7 this type of medication. The assumption would
8 be as you have suggested that the doctor did
9 indeed write this order and the medications were
10 brought to him and these were the medications
11 that were injected; however, on his note there
12 is no indication what was injected.
13 **THE MAGISTRATE:** But it is part of the
14 paper trail, presumably?
15 **THE WITNESS:** Correct.
16 **THE MAGISTRATE:** What does "stat" mean?
17 **THE WITNESS:** Immediately, as quickly as
18 possible.
19 **THE MAGISTRATE:** Thank you. Mr. Paikos.
20 Q. If we go to the medical record 65 and 66, Bates
21 153 and 152.
22 **A. I have reviewed this note. It is below the**
23 **standard of care.**
24 Q. Why?

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1 **A. Looking at the physical examination, this is a**
2 **reasonable neurological follow-up examination.**
3 **There is no examination of the back. The**
4 **patient is coming in for a back problem, and**
5 **there is no back examination. The Impression is**
6 **he has lumbar radiculopathy. I don't recall**
7 **whether we had seen that specific diagnosis**
8 **before. I don't believe so. He does mention,**
9 **by the way, under his History that he is on**
10 **oxycodone 15 milligrams two pills three times a**
11 **day. I don't believe there was a previous**
12 **indication that the patient was on oxycodone.**
13 **Previously he had been on Percocet.**
14 **So now he is describing a young man who**
15 **had trauma to his back who has improved. He has**
16 **been approved for disability. He limited his**
17 **activities and definitely looks better, quote**
18 **unquote, that the epidural shots seemed to have**
19 **helped. He is prescribing the oxycodone. I**
20 **don't know what oxycodone, excuse me, the**
21 **specifics of the oxycodone, I don't know how**
22 **many pills he is taking, I don't know how many**
23 **months he has prescribed. He previously was on**
24 **Percocet. I don't know if he is still on**

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1 **Percocet or if there are other medications that**
2 **he is taking.**
3 **Q. If there were prescriptions in the record**
4 **showing the dose, would that in some way satisfy**
5 **part of the issues relative to the prescribing?**
6 **A. It may.**
7 **Q. Additionally this patient has gone from being**
8 **able to run a long period of time to being**
9 **considered for disability. That with the fact**
10 **of the ER record regarding drug-seeking**
11 **behavior, does that raise a concern or did you**
12 **learn why he has gone from being able to run to**
13 **the issue of potential disability?**
14 **A. It is not explained well. There is an**
15 **indication that he is limiting his activities.**
16 **He is not running up and down hills, lifting**
17 **weights. He is on disability so presumably he**
18 **is not lifting weights into a UPS truck as well.**
19 **It seems you can assume from the notes that he**
20 **is better coinciding with the decrease in his**
21 **physical activities. Overall he does seem to be**
22 **improved, so it's not clear why he medication**
23 **has not changed. He is continued on the same**
24 **medication.**

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1 **THE MAGISTRATE:** Doctor, if a patient
2 presented to you with pain like this patient but
3 also reported he is running two miles in nine
4 minutes, would you start doubting the patient?
5 **THE WITNESS:** Yes.
6 **THE MAGISTRATE:** One of the things
7 doesn't match?
8 **THE WITNESS:** Correct.
9 **THE MAGISTRATE:** And that is a red flag?
10 **THE WITNESS:** Yes.
11 **THE MAGISTRATE:** Thank you.
12 **Q. (By Mr. Paikos) If you go to medical record 196**
13 **Bates 160. Review the notes of June 13, 2008.**
14 **A. I reviewed the note of 6-13-2008, and this is**
15 **below the standard of care.**
16 **Q. Why?**
17 **A. The history is limited. Feeling better overall,**
18 **and he has been home. Gives a little bit of**
19 **information about his activities. No other**
20 **information with regard to his neurologic status**
21 **since his last appointment. We don't know where**
22 **he pain is, is he experiencing pain. Does he**
23 **have other neurologic symptoms, problem with his**
24 **legs, pain, numbness, weakness. What**

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1 **medications is he taking, are the medications**
2 **helping him. Is he still on disability, what**
3 **activity is he able to tolerate. The neurologic**
4 **examination is positive knots and spasms. There**
5 **is no other information listed for the**
6 **neurologic examination. We don't know where the**
7 **knots and spasms were.**
8 **Q. Would that be important to know?**
9 **A. Yes.**
10 **Q. Why?**
11 **A. Are is no description of where it is. Is it in**
12 **his back, legs, neck, arms, his chest. We have**
13 **no information at all. We don't know anything**
14 **more about his neurologic examination. We've**
15 **seen from previous follow-up notes a good**
16 **example of a proper note and examination for**
17 **follow-up note. Basically none of that**
18 **information is here, so we don't know what is**
19 **happening with the patient neurologically. It**
20 **is very difficult to know what his progress has**
21 **been.**
22 **And then the Assessment is lumbar**
23 **radiculopathy and trigger points. That is a new**
24 **diagnosis. He is having trigger points now in**

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1 addition to having lumbar radiculopathy. He has
2 a second diagnosis or additional diagnosis.
3 He will come in Tuesday for injections.
4 We don't know what type of injections or what he
5 is coming in for, or we don't know any other
6 medications that he is prescribed. We know
7 previously he was on oxycodone and Percocet. We
8 don't know if he is still getting those. There
9 is no other information about medications that
10 he is getting. Is he going to be having further
11 epidural injections, has he had further epidural
12 injections, has he gotten prednisone, will he be
13 getting prednisone. There is no information
14 about this at all.
15 **THE MAGISTRATE:** What was the second
16 diagnosis that appears on this?
17 **THE WITNESS:** Trigger points.
18 **THE MAGISTRATE:** What is that?
19 **THE WITNESS:** Trigger points are areas of
20 pain, typically muscle pain. You can see them
21 in the neck, in the back, sometimes basically
22 see them anywhere in the body, but they are
23 areas of pain that relate to muscle tightness
24 and sometimes to muscle spasm.

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

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

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

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1 **damage along the neuro axis from the brain to**
 2 **the brain stem to the spinal cord, that can**
 3 **result in a problem with the arm or the leg**
 4 **resulting in a problem with movement, typically**
 5 **with weakness.**
 6 **Along with the weakness there is a**
 7 **significant decrease in the tone in the arm or**
 8 **the leg, and that is referred to as spasticity.**
 9 **People who have spasticity will sometimes have**
 10 **spasms as well. The arm may voluntarily**
 11 **contract or the leg may involuntarily contract**
 12 **as well, the foot may be held in a fixed**
 13 **contracted position as may the arm and different**
 14 **portions in the arm, the shoulder, the elbow.**
 15 **With injections of Botox, that can help**
 16 **to release some of the spasticity or improve**
 17 **some of the spasticity, and the person can use**
 18 **their arm better than they could prior to the**
 19 **injections. This would not be medication that**
 20 **you would give just for simple muscle spasm for**
 21 **a neck problem, back problem unless there was**
 22 **some other type of neurologic diagnosis.**
 23 Q. So far we haven't seen in this patient?
 24 A. No.

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1 Q. Medical record 199 Bates 163. Medical record
 2 199 Bates 163 --
 3 **THE MAGISTRATE:** Mr. Paikos, if I could
 4 ask a follow-up on Bates 168. In this record of
 5 Botox, is this similar to vials that are being
 6 ordered, vials being ordered presumably for use
 7 of the doctor in his office?
 8 **THE WITNESS:** That would be the
 9 assumption.
 10 **THE MAGISTRATE:** And the paper trail
 11 doesn't continue into progress reports,
 12 follow-up reports?
 13 **THE WITNESS:** I think there is a note
 14 that Mr. Paikos is drawing my attention to that
 15 does give some further information.
 16 **THE MAGISTRATE:** Okay. And one last
 17 question on medical record 204 Bates 168. NKDA,
 18 is that of significance, that notation at the
 19 top?
 20 **THE WITNESS:** Yes, I know it is, but I am
 21 blocking it out. I don't remember at this
 22 moment.
 23 **THE MAGISTRATE:** Okay.
 24 Q. (By Mr. Paikos) If you go to 199, medical record

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1 199 Bates 163.
 2 **A. I have that note.**
 3 Q. Can you tell what date it is?
 4 **A. I do not see a date on that note. I do see a**
 5 **date on the previous page. It appears to be a**
 6 **continuation from one page to the other. Bottom**
 7 **of page 198 the note dated 8-27-08 from a nurse,**
 8 **I believe, and there is an arrow extending below**
 9 **198 that appears to go to the next page**
 10 **suggesting to me that the note that you see from**
 11 **the doctor is the same date.**
 12 Q. Again about Botox?
 13 **A. Correct. States, given Botox A and gives the**
 14 **number of units given, that the injections were**
 15 **given to five spots. There is a diagram. The**
 16 **diagram shows a single injection into the**
 17 **cervical, posterior cervical region and four**
 18 **injections into what appears to be the lumbar**
 19 **region although I'm not sure if it is extending**
 20 **sacrally or extending to the thorax region, but**
 21 **injections definitely into the lower and perhaps**
 22 **one in the middle back as well.**
 23 Q. What does it say this is for?
 24 **A. There is no indication as to why the injection**

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1 **was given. There is a note that patient noted**
 2 **improvement before leaving the clinic, positive,**
 3 **severe muscle spasm.**
 4 Q. We don't know if it's given for the muscle spasm
 5 and what reason?
 6 **A. Correct.**
 7 Q. Muscle spasm wouldn't be a common indication
 8 based on your training and experience for giving
 9 Botox?
 10 **A. Not as far as I know.**
 11 Q. Medical record 195, Bates 159, the medical
 12 record 195 Bates 159. There is a 10-16-2008
 13 note from Dr. Padmanabhan.
 14 **A. I do have that note.**
 15 Q. If you could review that and assess whether the
 16 doctor followed standard of care.
 17 **A. This note is below the standard of care for a**
 18 **Progress Note. The History is that patient is**
 19 **overjoyed that he had improvement in spasms**
 20 **following his second Botox injection. He is**
 21 **feeling much better. Came in very happy.**
 22 **Objective has limited information. There**
 23 **is no other information with regard to his back**
 24 **problems. He has lumbar radiculopathy. Other**

1 medications. We don't know what his physical
 2 activities are at this point, we don't know what
 3 his overall pain is at that point, we don't know
 4 anything else at all.
 5 Objective, still has muscle spasms but
 6 less severely. Rest as before. So again we
 7 have a very limited examination. This is an
 8 inadequate and below-the-standard-of-care note
 9 in terms of a follow-up neurological examination
 10 for this patient for the reasons that we have
 11 previously discussed.
 12 Assessment is, Plan is muscle spasm and
 13 there is no other information. We don't know
 14 which muscle spasm he is referring to, we don't
 15 have any other information about how he is doing
 16 with his pain problem, neck problem, back
 17 problem, leg problems. We don't know how he is
 18 doing with his medications, what medications are
 19 being given. It just says RX given - pain! I
 20 don't know what that means. There was no
 21 indication of which medications were prescribed.
 22 This is a patient who had been prescribed
 23 oxycodone, Percocet, prednisone, epidural
 24 injections. We do not know if one or all of

1 taking or the effect. We don't know the side
 2 effects. There is no other information about
 3 his clinical course, how he has done since his
 4 last appointment other than improvement with
 5 Botox.
 6 Objective, examination is listed as
 7 stable exam without change. Once again this is
 8 an inadequate, below-the-standard-of-care
 9 follow-up neurologic examination for the reasons
 10 we previously described.
 11 Assessment and Plan, Assessment is lumbar
 12 radiculopathy. Describes the discussion that he
 13 had with him about accepting, acceptance in
 14 plans, and then he was given a prescription for
 15 Dilaudid to avoid ER visits. This is a
 16 below-the-standard-of-care note. We don't know
 17 what the dose of the Dilaudid is, how many pills
 18 he is prescribing, how many refills he is given.
 19 Is he prescribing other medication, is he
 20 continuing to prescribe other narcotics another
 21 nonnarcotic medications. There is no
 22 information.
 23 THE MAGISTRATE: Before we move on,
 24 Dr. Levin, the last two written lines on 194

1 those medications have been prescribed at this
 2 point. We have no information. This is below
 3 the standard of care.
 4 Q. Medical record 194 which is at Bates 158. If
 5 you could review that note.
 6 A. I have reviewed this note. This note is below
 7 the standard of care.
 8 Q. Why?
 9 A. Notes continued improvement with Botox. We
 10 don't know what is improved, what problem the
 11 Botox is being prescribed for. Has five really
 12 bad days a month. We don't know what that
 13 refers to. Bad days because he is in pain?
 14 Where is the pain, does he have other neurologic
 15 symptoms, are they bad days because he is
 16 depressed, because something happened to him.
 17 There is nothing about that.
 18 There is a note for which he takes
 19 Dilaudid. First indication of a prescription
 20 for Dilaudid, a narcotic, so this would appear
 21 to be a third opioid that is being prescribed.
 22 I don't know if Dilaudid is in addition to
 23 oxycodone and Percocet, replacing them. There
 24 is no information. We don't know how much he is

1 medical record and Bates 158, I see "Dilaudid to
 2 avoid ER visit." What does it say before that?
 3 THE WITNESS: "Given RX for Dilaudid."
 4 THE MAGISTRATE: And what's your
 5 assessment of prescribing Dilaudid to avoid ER
 6 visits?
 7 THE WITNESS: Standing by itself it is
 8 difficult to understand that. Given that the
 9 patient had already been prescribed two other
 10 narcotics and I don't know if he is taking them
 11 or not, I think the idea of giving him a
 12 narcotic to avoid an ER visit is not an
 13 unreasonable thing to do. If we have a patient
 14 who is going to the ER frequently, a patient who
 15 is suffering with acute pains, there is no
 16 indication that he is going to the emergency
 17 room frequently, there is no indication that he
 18 is suffering from acute pain. We have no
 19 description about his pain, all we know he is
 20 having no improvement, five bad days a month but
 21 we don't know what that means. We can't assess
 22 whether the Dilaudid is reasonable. It would
 23 appear not to be reasonable to give another
 24 opioid with the history that we have.

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1 **THE MAGISTRATE:** Reasonable without a
2 history of going to the ER?
3 **THE WITNESS:** Correct. In addition, I
4 believe this was the gentleman there was a
5 concern about narcotic-seeking behavior, that he
6 indeed may have a problem with narcotic abuse.
7 **MR. PAIKOS:** May I approach Dr. Levin?
8 **THE MAGISTRATE:** You may.
9 Q. (By Mr. Paikos) Doctor, there is a medical
10 record where the medical record is blocked out
11 because of a copying issue. I show you Bates
12 180. It would be difficult for you to find
13 because I can't give you a page number. I will
14 show you this copy here.
15 **A. Yes.**
16 Q. What are those?
17 **A. Two prescriptions written on November 6, 2008,**
18 **the same date as the Progress Note that we've**
19 **been discussing, one of them for Dilaudid,**
20 **4 milligrams PO b.i.d. p.r.n. 45 with no**
21 **refills. The other for oxycodone 30 milligrams**
22 **three pills PO, t.i d., 270 pills prescribed.**
23 Q. Doctor, do you remember seeing Dilaudid being
24 prescribed in Dr. Padmanabhan's medical progress

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1 notes prior to that day?
2 **A. Not to the best of my memory.**
3 Q. If you can go to medical record 219 Bates 183.
4 **A. I have that page.**
5 Q. What are those? What is on that page?
6 **A. This is a medication list, appears to be**
7 **medications that have been prescribed. It's a**
8 **little difficult for me to understand. I'm not**
9 **used to seeing this type of form for an**
10 **outpatient.**
11 Q. Doctor, actually it's medical record 219.
12 **A. I'm looking at 183.**
13 Q. Medical record 219, Bates 183. Previously we
14 were talking about the note on November 6, 2008.
15 **A. I do have that note.**
16 Q. These are two prescriptions, one for Dilaudid
17 and one for Duragesic?
18 **A. Correct.**
19 Q. Do you recall seeing medical records
20 corresponding to this?
21 **A. I do not.**
22 Q. What is Duragesic?
23 **A. It is a type of pain medication, a nonnarcotic**
24 **pain medication, I believe it's nonnarcotic,**

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

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

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1 the standard of care for a neurologic follow-up
2 note. We have no information with regard to how
3 the patient its doing. Does the exam show neck
4 problems, back problems, other neurologic
5 problems. There is no way of knowing.
6 Assessment is radiculopathy. We don't
7 know what part of the body that refers to, if he
8 is having neck problems, back problems, arms,
9 legs. No information at all. We do not know
10 what medications were prescribed or what dose,
11 how many were given. No information at all.
12 Q. In the note I would direct your attention,
13 Doctor, to medical records 209, 210, I believe,
14 which is Bates 173 and 174.
15 A. These appear to be the same days as the Progress
16 Note. These are prescriptions on 3-3-2009.
17 First is for oxycodone, 15 milligrams four pills
18 q.i.d, 480 pills prescribed.
19 THE MAGISTRATE: What is q.i.d?
20 THE WITNESS: Four times a day.
21 A. This medication is being prescribed four pills
22 four times a day and the patient is given 480
23 pills. This is a very large prescription. This
24 is a larger prescription than we've seen before.

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1 The dose is larger and the number of pills given
2 to the patient is significantly larger, and we
3 don't know why.
4 The next prescription for methadone,
5 10 milligrams, two pills PO b.i.d., twice a day,
6 120 pills of methadone are prescribed. This is
7 the first indication that we've seen for a
8 prescription for methadone. There is no
9 indication why it is being prescribed. There is
10 no report that I saw or any mention in my
11 Progress Note as to the prescription of
12 methadone. My understanding is that when
13 methadone is prescribed, it needs to be listed
14 as being for pain. There is no indication that
15 this is being prescribed for pain.
16 Q. Why does it have to be listed as prescribed for
17 pain?
18 A. My understanding is that is the regulation for a
19 neurologist who prescribes the medication
20 outside of a methadone center.
21 Q. And if we go to medical record 211 which is
22 Bates 175, medical record 212 which is at 176.
23 Those are two prescriptions for January 8, 2009?
24 A. There are two prescriptions for January 8, 2009.

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1 The first is for oxycodone, 30 milligrams, three
2 pills, three times a day. 270 pills are
3 prescribed. The second is for Oxycontin
4 80 milligrams b.i.d. 60 milligrams are
5 prescribed.
6 Q. What is Oxycontin?
7 A. Oxycontin is another narcotic.
8 Q. Did you see in the record --
9 A. It's an opioid.
10 Q. Did you see in the record why there was a change
11 for the oxycodone from 270 to 480 between the
12 January prescription to the March prescription?
13 A. No.
14 Q. Did you see anywhere in the record why the
15 Oxycontin was prescribed?
16 A. No.
17 Q. Would it be the standard of care to note these
18 kinds of things?
19 A. Yes.
20 Q. Why?
21 A. In order to have good control of the medication
22 and prescribing for the patient. I think in
23 this case there are beginning to be more
24 concerns this is a patient who had drug abuse

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1 problems, who had opioid abuse problems, and the
2 prescription for the methadone could be quite
3 suggestive of that. And you want to have good
4 control, you want to know what the patient needs
5 to have his pain controlled, if he is having
6 side effects, and overall patient care it is
7 important to have good control.
8 THE MAGISTRATE: Is there a reason to
9 prescribe a patient both oxycodone and
10 Oxycontin?
11 THE WITNESS: I'm not a pain specialist,
12 but one is short acting and one is longer acting
13 so patients sometimes may require both.
14 Q. (By Mr. Paikos) Medical record 192 Bates 156 as
15 well as medical record 207 Bates 171. That's
16 medical record 192 Bates 156 for the note, and
17 medical record 207 Bates 171 for the
18 prescriptions.
19 A. Looking at the note page 192 dated 4-4-2009,
20 this note is below the standard of care. The
21 history Subjective is pain. No other
22 information. We don't know where the pain is,
23 we don't know anything else about the patient,
24 we have no information about his history, what

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

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

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

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1 screen and waiting for the results before
2 sending the patient off with a prescription for
3 methadone and oxycodone?
4 THE WITNESS: I'm not a pain specialist,
5 but I believe the correct thing to do would be
6 to get the tox screen prior to prescribing
7 medications. It should be noted this would be
8 an unusual action for a neurologist. I have
9 never ordered a tox screen under these
10 circumstances. The only time I have ever
11 ordered a tox screen is when someone presents
12 with an acute medical problem and I'm concerned
13 about an acute medical problem and possibly an
14 abuse problem or medications or drugs taken that
15 I have not prescribed. So this note is a
16 circumstance where I would normally order a tox
17 screen. I don't prescribe methadone, I don't
18 prescribe oxycodone. So again that being said,
19 this strikes me as being an unusual set of
20 circumstances. I think the correct thing would
21 be to get the tox screen prior to giving the
22 patient a prescription for two narcotics.
23 Q. (By Mr. Paikos) If we can go to medical record
24 231 Bates 189.

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

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1 such a letter before. That being said, this
2 would appear to be appropriate in terms of
3 notifying the patient that he is discharging him
4 from his care. According to the letter, he is
5 obligated to give the patient a 30-day supply of
6 medicine. He doesn't say what medicine he is
7 obliged to give him nor does it say what
8 medicine he is giving him.
9 I would expect under the circumstances it
10 would be within the standard of care for him to
11 list specifically what medicines he is giving
12 him, how much he is giving him along with the
13 notice to the patient that he will no longer be
14 prescribing medicine for him.
15 Q. Doctor, quickly turn to medical record pages 209
16 and 205, Bates 170 and 169.
17 A. Page 209 is a prescription dated 3-3-2001.
18 Q. I'm sorry, 206.
19 A. 206 is dated 5-14-2009, a prescription for
20 methadone, 10 milligrams four pills b.i.d.
21 number 240. The same date oxycodone
22 15 milligrams number 360 on May 22, eight days
23 later. There was a prescription for methadone
24 10 milligrams four pills b.i.d., 240 pills.

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

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1 Again the date of the letter was May 13. We
2 have a prescription for oxycodone 360 tablets
3 for 5-22-2009 and a prescription written on 5-14
4 to be filled on 5-23. Appears there are
5 prescriptions for oxycodone for 360 tablets to
6 be filled on May 22 and May 23.
7 Q. Bates 170, the May 14, prescription for four
8 pills b.i.d., that is at medical record 206.
9 A. That is the methadone four pills b.i.d.
10 Q. Four pills two times a day?
11 A. Correct.
12 Q. That is eight pills?
13 A. Yes.
14 Q. And the quantity is 240?
15 A. Correct.
16 Q. Would that be a 30-day supply?
17 A. Yes.
18 Q. And oxycodone on that day is three pills q.i.d.
19 Is that four, three pills four times a day?
20 A. Yes, 360.
21 Q. That is 360 pills. Does that look like a 30-day
22 supply?
23 A. Yes.
24 Q. Do the two scripts, May 22 methadone and

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1 oxycodone, do those also look like they are
2 30-day prescriptions?
3 **A. They do.**
4 Q. Was it within the standard of care from
5 Dr. Padmanabhan to prescribe these narcotics to
6 this patient?
7 **A. (No response).**
8 **MR. PAIKOS:** Let me ask a question.
9 Well, I have already asked the question. I
10 don't think I have any further questions on this
11 particular set of prescriptions or facts.
12 **THE MAGISTRATE:** Time to wrap up?
13 **MR. PAIKOS:** Yes.
14 **THE MAGISTRATE:** We are ending for the
15 day and resume tomorrow at ten o'clock.
16 **MR. PAIKOS:** May I bring up one thing.
17 We have another witness scheduled for tomorrow.
18 May we suspend Dr. Levin and put her on and
19 start with Dr. Levin again?
20 **THE MAGISTRATE:** How long is your other
21 witness?
22 **MR. PAIKOS:** I'm saying an hour.
23 **THE MAGISTRATE:** Any objection?
24 **DR. PADMANABHAN:** Who is the witness?

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1 **MR. PAIKOS:** Dr. Nardin.
2 **DR. PADMANABHAN:** I would prefer wrapping
3 one witness first instead of jumping.
4 **THE MAGISTRATE:** How much more with
5 Dr. Levin?
6 **MR. PAIKOS:** We have several more
7 patients.
8 **THE MAGISTRATE:** What is your best
9 estimate of how many hours with Dr. Levin?
10 **MR. PAIKOS:** I would say another day and
11 a half.
12 **THE MAGISTRATE:** And the reason to bring
13 in the other witness for an hour?
14 **MR. PAIKOS:** She would provide some of
15 the information relative to Dr. Padmanabhan's
16 ending at Cambridge Health Alliance.
17 **THE MAGISTRATE:** Is she not available on
18 another day?
19 **MR. PAIKOS:** No, she is not. She is a
20 physician and has cleared her schedule for
21 tomorrow.
22 **THE MAGISTRATE:** Your preference is to
23 hear one witness, but I'm going to accommodate
24 the witness' schedule, so the other witness can

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

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1 her direct examination tomorrow. We're going to
2 get in as much cross examination as you have a
3 basis for, the understanding is we may
4 inconvenience her on another week to come back
5 for what may be a large or small amount of cross
6 examination.
7 **MR. PAIKOS:** Certainly.
8 **THE MAGISTRATE:** So there is no
9 prejudice. I know you have a preference, but
10 we're going to accommodate the witness' schedule
11 because scheduling witnesses is an inexact
12 science and we are trying to keep this hearing
13 moving.
14 Anything else for today?
15 We'll resume tomorrow at ten o'clock.
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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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