In The Matter Of:

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

Bharanidharan Padmanabhan, M.D.
January 14, 2015

Jones & Fuller Reporting
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COMMONWEALTH OF MASSACHUSETTS
DIVISION OF ADMINISTRATIVE LAW APPEALS
Docket No. RM-14-363
- x
BOARD OF REGISTRATION IN MEDICINE,
Petitioner,
v.
BHARANIDHARAN PADMANABHAN, MD,
Respondent.
- x

HEARING BEFORE MAGISTRATE KENNETH BRESLER
Wednesday, January 14, 2015
10:02 a.m. to 4:02 p.m.
Civil Service Commission
One Ashburton Place, Room 503
Boston, Massachusetts

Reporter: Marianne R. Wharram, CSR/RPR

A P P E A R A N C E S

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ALSO PRESENT:

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I N D E X

WITNESS	DIRECT	CROSS	REDIRECT	RECROSS
RACHEL NARDIN, MD				
(BY MR. PAIKOS)	327		353	
(BY DR. PADMANABHAN)		340		
BARRY LEVIN, MD				
(BY MR. PAIKOS)	359			
(BY DR. PADMANABHAN)				

P R O C E E D I N G S

THE MAGISTRATE: We are on the record. Your name is?

COURT REPORTER: Marianne Wharram. My card is actually just under your gray binder there. One more.

THE MAGISTRATE: Ms. Wharram, if anybody is not clear, you'll speak up and let us know?

COURT REPORTER: Absolutely.

THE MAGISTRATE: Today is January 13th, (sic) 2015. This is appeal whose docket number is RM-14-363. The hearing -- let me back up. The petitioner is the Board of Registration in Medicine. The respondent is Bharanidharan Padmanabhan, MD. I'm the administrative magistrate, Kenneth Bresler. James Paikos, Esquire, represents the petitioner. With him is Loretta Cooke, Registered Nurse, who is a clinical care investigator for the board. References on yesterday's record to Ms. Cooke are to her. She's also a potential witness in the case. Dr. Padmanabhan represents himself. The parties' representatives are present and have filed their

Page 326

notices of appearance.
All electronic devices that make noise should be off. There will not be and should not have been any recording devices or cameras being used in the hearing today. Mr. Paikos has given us a preview of the reasons for Dr. Carter's testimony. Is that what's next?
MR. PAIKOS: Yes, Dr. Nardin.
THE MAGISTRATE: Nardin?
MR. PAIKOS: Yes.
THE MAGISTRATE: And that is background for how the Cambridge Health Alliance asked the respondent to leave, Mr. Paikos has said in his background. I note and want you to note, Dr. Padmanabhan, that the statement of allegations against you, the heart of them does not include Cambridge Health Alliance asking you to leave. This hearing is not about Cambridge Health Alliance. It is not about the Cambridge Health Alliance asking you to leave and whether the Cambridge Health Alliance was right or wrong to do so. I'm not being asked to decide who is right, you or Cambridge Health Alliance. It is possible that you established that Cambridge Health Alliance

Page 327

was wrong to discharge you and I still decide the Board of Registration in Medicine has proved its allegations against you. I'm saying this for at least two reasons; to give you perspective over the forthcoming testimony answers, explaining why I may not allow this hearing to spend excessive time on this issue. I emphasize the word excessive. We are spending time on this issue.
With that, are there any other preliminary matters?
MR. PAIKOS: No, sir.
(Dr. Padmanabhan gesturing.)
THE MAGISTRATE: Are you ready to call your witnesses?
MR. PAIKOS: Yes. We call Dr. Nardin to the stand.
RACHEL NARDIN, MD,
a witness called on behalf of the Petitioner, having first been duly sworn by the Magistrate, was examined and testified as follows:
THE MAGISTRATE: Thank you. Please be seated.
DIRECT EXAMINATION
Q. (BY MR. PAIKOS) And Dr. Nardin, could you

Page 328

state your first and last name, spelling your last name?
A. Rachel Nardin, N-A-R-D-I-N.
Q. And you're a neurologist?
A. Yes.
Q. Are you board-certified?
A. Yes.
Q. And where do you currently work?
A. At Cambridge Health Alliance.
Q. How long have you worked there?
A. Since July of 2009.
Q. And was part of -- and at a certain point, were you chief of neurology?
A. In December of 2009, I became chief.
Q. And as chief, does part of your job entail reviewing the work of other neurologists at Cambridge Health Alliance?
A. It does.
Q. Cambridge Health Alliance has several campuses?
A. Yes.
Q. What are they?
A. The Cambridge Hospital, the Whidden Hospital, and there's Somerville Hospital.

Page 329

Q. And the Whidden Hospital is in Everett, Massachusetts?
A. It is.
Q. Did Dr. Padmanabhan work for Cambridge Health Alliance?
A. Yes.
Q. And as part of your role as chief, was that to review -- I may have already asked you this -- the work of the other people in your department, other neurologists?
A. Yes.
Q. Any issues that you saw with Dr. Padmanabhan's performance?
A. Yes.
Q. And what were they?
A. Well, when I became chief, there were four areas of concern. The first was Dr. Padmanabhan had a lot of open patient records, which means that the -- there was no note or inadequate notes on the patients that he had seen, and the charts were not closed for billing, which means that the hospital cannot collect reimbursement for those visits. There was also concern about his practice of prescribing pain medications to patients in large

Page 330

quantities without adequate monitoring. There was some concern about his diagnosis of multiple sclerosis and management of those patients, and there were concerns about unprofessional behavior in his interactions both with patients and with other staff at the hospital.

Q. And at some point, was he put on probation?

A. In July -- after -- yes, in July, I think it was July of 2010.

Q. Prior to that, did you have discussions with him about the issues you talked about?

A. Yes, both -- largely because I had become chief in December 2009 and I was trying to do a lot of different things. A lot of the work to try to help Dr. Padmanabhan over those first months was done in part by Dr. Glick, my predecessor, who was helping him with documentation, and some by the department administrator, who was trying to help him work on closing his charts.

Q. And what did the probation involve? How did that come about and what did it involve?

A. Well, the probation came about because we wanted to see whether we could help Dr. Padmanabhan, you know, improve his behavior in

Page 331

these areas to a satisfactory degree, and so the four areas of concern that I outlined were explained to Dr. Padmanabhan and we tried to make clear what he needed to do to be, you know, a functioning member of the department, and it included making sure that there were notes in every patient chart and closing those charts according to department standard, which is within 48 hours. We really worked hard with him to try to get him to either discharge the pain patients or work with them to come up with a plan for management that was more consistent with what we felt was a community standard of care. And we tried to help him understand the nature of his unprofessional interactions with other people and provide some coaching. And so the probation was a period that was designed to see whether he could improve his performance in those areas.

Q. Did you -- what's a 360 review?

A. So that's something that the hospital does and I do in my division as a way of trying to assess the performance of division members, so it's you ask questions about professional behavior and clinical performance of a doctor's colleagues, and

Page 332

so doctors that refer to you, primary care doctors, and also staff who work with you, nurses in the clinic or the administrators, so we did one of those before the probation period started, and the poor performance or poor responses to that review were part of what made us -- made me feel that we needed to do the probation, and then we repeated it after the probationary period, I think in September to try to give us some sense of whether there had been improvement in the view of other doctors and staff that Dr. Padmanabhan worked with.

Q. Was there some improvement?

A. There -- I mean, there was some -- Dr. Padmanabhan had made some improvement in terms of closing charts, although there were still many charts open during the probation period. At one time, I think he still had 30 patient charts open, and there were, you know, in some areas of the 360, you know, it varied. I would say overall, there was not any significant improvement and we were most concerned by the fact that some of the comments that the physicians write in the review just suggested that Dr. Padmanabhan had lost the confidence of the physicians that referred to him

Page 333

and the physicians that he worked with.

Q. What was the -- was there a decision made on how to proceed with Dr. Padmanabhan as a member of the staff at Cambridge Health Alliance?

A. Well, at the end of the probationary period, Dr. Bor, my direct supervisor, the head of the Department of Medicine, and I reviewed the intervening evidence over the probationary period, and there were still complaints coming in from other doctors about unprofessional behavior, still difficulty closing charts, still not dramatic improvement on the 360, so we felt that reviewing that evidence that there had not been sufficient improvement that we felt comfortable that Dr. Padmanabhan was practicing to a standard -- a community standard of care and we didn't feel comfortable having him on the staff, and our plan had been to meet with him, review this, and do a more extensive review at the departmental level. We had still been sort of at the division level. So our plan had been -- and that might have included things like outside record review, so our plan had been to move forward with that process. And I think we also -- I think -- it's hard for me

Page 334

to remember exactly. I think we also met again and decided that after reviewing all that evidence that we were so concerned about the level of performance that, you know, we were going to terminate the contract, which the contracts are written that you can terminate them with 90 days notice without any cause, and we felt we had, you know, sufficient cause, and so I think our plan had been to meet with him and explain that we wanted to terminate his contract for lack of improvement, and then there was an intervening event.

Q. And were there initially -- you told us before the probation period there were issues clinically potentially that you thought were there. Did those go away after the 360 reviews and doing further review yourself?

A. They did not appear to have. You know, Dr. Padmanabhan had assured us that he was discharging his pain patients and not writing further narcotic prescriptions for most of them, and when Dr. Bor went back subsequently and did a review of that -- I think he pulled all the patient -- the records of all the patients that Dr. Padmanabhan had been prescribing narcotics

Page 335

to -- he found that that wasn't true. So you know, the patterns of behavior that caused clinical concern seemed to be continuing despite Dr. Padmanabhan's assurance to us that they weren't, so there was sort of a discrepancy.

Q. And you mentioned an intervening event, and I'm going to approach with a copy of the -- the pseudonym list, most of it covered except for Patient A. I'm going to show you what's a list of pseudonyms of names where rather than calling the patient by name, we're referring to them by Patient A, B, etc. I've just shown you Patient A. You mentioned an intervening event. What was that?

A. Well, Patient A had died. He was found I think in his car, comatose, and then died of what is presumed to be a respiratory arrest. And it was presumed by the emergency department staff that this was an opioid overdose. And I don't know myself if that was confirmed by the medical examiner or anything, but that was the presumption at the time, and this was a patient that Dr. Padmanabhan had been prescribing very large amounts of narcotics to. I was informed of this by the patient's primary care doctor, and so we felt

Page 336

that, you know, although we weren't sure, there seemed at least a possibility that Dr. Padmanabhan had provided this patient with excessive narcotics and that had led to the patient's death. And so this caused us to derail our former plan of action and Dr. Bor decided to ask the medical staff, you know, to suspend Dr. Padmanabhan's privileges at the hospital.

Q. And --

THE MAGISTRATE: What was the time frame? When did that happen? And he asked who, and was it granted, and when did he want the privileges suspended?

A. I believe that we were planning to -- Dr. Padmanabhan was away. The probationary period ended in September.

THE MAGISTRATE: Okay. Of which year?

A. Dr. Padmanabhan had a vacation of several weeks in September.

THE MAGISTRATE: September of which year?

A. Of 2010. And then I'm not sure of the exact date of the death. I believe it was late October. I think it was early November. And then

Page 337

immediately after the death, within days, Dr. Bor asked the medical executive committee to suspend privileges.

Q. And did that happen?

A. It did.

THE MAGISTRATE: Okay. I return the questioning back to Mr. Paikos.

Q. (BY MR. PAIKOS) At some point, was there a hearing after that suspension regarding Dr. Padmanabhan?

A. Yes.

Q. Do you know if there were records presented by Dr. Padmanabhan's attorney in part of their case?

A. Yes.

Q. After -- at some point, did you review records that were sent to an outside agency or outside company for review?

A. I did.

Q. And how did you determine what records those were?

A. Well, my memory is that seven of the cases were actually chosen by Dr. Padmanabhan and his counsel in the fair hearing as evidence of his

Page 338

exemplary practice and three of them were cases that I had chosen that I had concern about the quality of care.
Q. And do you know if a review was done?
A. It was.
Q. Do you remember what company it was?
A. It was Greeley.
MR. PAIKOS: I don't have any further questions.
THE MAGISTRATE: Dr. Nardin, Dr. Padmanabhan may have some questions for you.
DR. PADMANABHAN: Your Honor, as I said yesterday, I'm still immersed in Dr. Levin's testimony, so I would like to call her back an additional two days.
THE MAGISTRATE: Okay. My ruling stands from yesterday. Do you have any questions for her or not?
DR. PADMANABHAN: I am not prepared for Dr. Nardin in the middle of Dr. Levin's testimony. After the government finishes its case --
THE MAGISTRATE: Your opportunity to cross-examine Dr. Nardin is now.
DR. PADMANABHAN: This is an ambush,

Page 339

Your Honor.
THE MAGISTRATE: It's not an ambush. You know that Dr. Nardin was on the witness list and Mr. Paikos told me that he's calling Dr. Nardin this morning. He told me that -- told us that yesterday.
DR. PADMANABHAN: Forty minutes is not enough to examine Dr. Nardin, cross-examine her.
THE MAGISTRATE: We're now talking about another issue? Forty minutes?
DR. PADMANABHAN: Yes. Mr. Paikos said yesterday she is only here for an hour.
THE MAGISTRATE: Do you have questions for Dr. Nardin?
DR. PADMANABHAN: I have lots of questions for Dr. Nardin, but I need more time.
THE MAGISTRATE: Mr. Paikos, what's your understanding of Dr. Nardin's schedule?
MR. PAIKOS: My understanding was -- my estimate was an hour, but my understanding was she has cancelled patients for the day, and we've scheduled our next patient at 11:00. That was based on my testimony and what would be expected to come after.

Page 340

THE MAGISTRATE: Dr. Padmanabhan, this is your opportunity to question Dr. Nardin. Do you have questions for her?
DR. PADMANABHAN: Once again, Your Honor, if she is to leave at 11:00, there is simply not enough time.
THE MAGISTRATE: Dr. Padmanabhan, this is your opportunity to question Dr. Nardin. We'll see how far you proceed and how much you have left. If you have questions for her, I suggest that you start now.
DR. PADMANABHAN: I shall start now. I may need more time.
THE MAGISTRATE: That is my understanding.
CROSS-EXAMINATION
Q. (BY DR. PADMANABHAN) Good morning, Dr. Nardin.
A. Good morning.
Q. You said that you became chief in December of 2009. At the fair hearing, did you not present evidence that you were reviewing my work even before you became chief?
A. I believe I did.

Page 341

Q. And was it not shown that you started reviewing my work the day you joined work in July 2009, before you became chief?
A. I think I did not do a formal review until I became chief and it was my job. I had heard things about your performance that came to my notice before that.
Q. Between July 2009 and December 2009, was it your job to review my work?
A. Not formally, no.
Q. But you agree that you did?
A. I did not review you -- review your performance formally.
Q. At the fair hearing, you presented numerous documents, essentially a daily dossier that presented a daily review of my work in July 2009 and December 2009, and they were presented as testimony under oath. Do you recall?
THE MAGISTRATE: Well, that's a question rather than a statement.
Q. (BY DR. PADMANABHAN) Do you recall that they were presented at the fair hearing?
A. I don't.
Q. Do you recall that you were questioned

Page 342

under oath about the daily dossier that you collected between July 2009 and December 2009?
A. No.
MR. PAIKOS: Objection as to the clarity of the question and already asked and answered.
THE MAGISTRATE: Well, if the witness knows. The answer will stand.
Q. (BY DR. PADMANABHAN) Do you recall that you were questioned about your looking into the way I functioned between July 2009 and December 2009?
A. Not looking into, no.
Q. Dr. Nardin, what does a daily dossier mean to you?
A. There was no daily dossier, Dr. Padmanabhan.
Q. There was a 600-page dossier presented at the fair hearing, Dr. Nardin, 600 pages over ten months.
THE MAGISTRATE: Dr. Padmanabhan, could you format it as a question?
DR. PADMANABHAN: Yes.
Q. (BY DR. PADMANABHAN) So what would you call 600 pages over ten months?

Page 343

THE MAGISTRATE: That's presuming a fact that's not in evidence, so you need to establish that such a document does exist.
DR. PADMANABHAN: It was presented under oath.
THE MAGISTRATE: It's not here now.
DR. PADMANABHAN: It goes to the credibility of her answer.
THE MAGISTRATE: I'm not saying you can't ask the question --
DR. PADMANABHAN: I understand.
THE MAGISTRATE: -- but you have to establish that such a document exists.
DR. PADMANABHAN: Would I be able to introduce it at this point?
THE MAGISTRATE: No.
Q. (BY DR. PADMANABHAN) So you --
THE MAGISTRATE: But you may ask questions about it and establish that it exists.
Q. (BY DR. PADMANABHAN) Do you recall presenting a large number of documents that formed the core review of my work?
A. No.
Q. Do you recall writing notes on the margins of my dictations?
A. No.
Q. You said that you reviewed my work and my charts. How did you do that?
A. As part of the -- during the probationary period, as I did for all members of the division, I did review some of your notes according to a standardized criteria of adequacy, so if that's what you're referring to, I did review some of your notes that way.
Q. Do you recall reviewing my notes and writing on them your comments about the adequacy or inadequacy of the notes?
A. I don't recall, but I might have.
Q. Dr. Nardin, were you trained in multiple sclerosis?
A. No.
Q. Do you have any formal training in MS at all?
A. All neurologists are trained in the management of multiple sclerosis.
Q. All right. Do you have sufficient training to pass judgement over someone who has specific training in multiple sclerosis?

Page 344

Page 345

A. I believe I do, yes.
Q. We are talking about science, Dr. Nardin. We're not talking about personal belief.
MR. PAIKOS: Objection.
Q. (BY DR. PADMANABHAN) As a matter of standard --
THE MAGISTRATE: Objection is sustained. Dr. Padmanabhan, multiple sclerosis does not appear in the factual allegations.
DR. PADMANABHAN: Yes, it does, sir. Patient H. Patient H was chosen by Dr. Nardin and Dr. Nardin has already testified here under oath that she chose three of the patients sent to the Greeley Company for review.
THE MAGISTRATE: I'll give you some leeway in this line of inquiry.
DR. PADMANABHAN: Thank you.
Q. (BY DR. PADMANABHAN) So on the basis of what scientific criteria would you declare that you know more than an MS specialist?
MR. PAIKOS: Objection.
THE MAGISTRATE: I'm going to sustain the objection.
DR. PADMANABHAN: May I ask why, just

Page 346

so I can understand?
THE MAGISTRATE: It's generally not asked in courts for judges to explain their rulings on objections.
DR. PADMANABHAN: The reason I ask is to reformulate the question.
THE MAGISTRATE: This is getting far afield from the statement of allegations. Dr. Nardin has testified briefly, I believe for 20 minutes, about the background of your leaving Cambridge Health Alliance and the Greeley report.
DR. PADMANABHAN: Dr. Nardin has testified that my diagnosis of MS was one of her --
THE MAGISTRATE: Dr. Padmanabhan, we're not going to get into a big discussion about my ruling and the objection. I just gave you a reason. I hope you were listening.
DR. PADMANABHAN: I accepted the objection to that.
THE MAGISTRATE: Then proceed and ask a question.
Q. (BY DR. PADMANABHAN) You had said, Dr. Nardin, that my diagnosis of MS was one of the four concerns that you had, so my question is given

Page 347

that you didn't know anything about MS, how was that a concern for you.
MR. PAIKOS: Objection. That's not the testimony, that she didn't know anything about MS.
THE MAGISTRATE: I'm going to sustain the objection.
Q. (BY DR. PADMANABHAN) Dr. Nardin, did you send my MS diagnoses to another MS specialist during July 2009 and October 2010?
A. I'm not sure I understand the question.
Q. Did you retain a trained MS specialist to review my diagnoses of MS between July of 2009 and October 2010?
A. I don't know about that time period. I know that some of the patients that you saw regarding MS saw other MS specialists.
Q. Right, but we are talking about your response to these four concerns. So during July 2009 and December 2010, when you were my chief and you were reviewing my work as part of your job as chief, did you engage the services of a trained MS specialist to overlook or oversee or give an opinion about my diagnosis of MS?
A. No.

Page 348

Q. Would that not have been important to do?
MR. PAIKOS: Objection.
THE MAGISTRATE: I'll allow it.
A. No.
Q. (BY DR. PADMANABHAN) Dr. Nardin, you said that I was put on probation in July of 2010, that you testified to that under oath. Do you have any evidence to support that?
A. I kept minutes of our meetings and those minutes are my evidence that we met and discussed your probation.
Q. Were those minutes introduced at the fair hearing under oath?
A. I believe they were, yes.
Q. Were they or were they not, Dr. Nardin?
A. I don't remember exactly.
THE MAGISTRATE: We have the answer from the witness.
DR. PADMANABHAN: We have a belief, Your Honor.
THE MAGISTRATE: That's the witness' answer. And this hearing is not about the fair hearing that was held at the Cambridge Health Alliance.

Page 349

DR. PADMANABHAN: No, Your Honor. I'm asking her specifically about answers that she --
THE MAGISTRATE: Dr. Padmanabhan, ask your next question.
Q. (BY DR. PADMANABHAN) Dr. Nardin, you testified here today that you don't know if the patient's death was confirmed as an opiate overdose. Did you not ever look it up?
A. I don't remember at this point.
Q. You said that you were informed by the patient's primary care physician that his death was secondary to opiates prescribed by me. Do you have any evidence of that?
A. No. That was a -- that was a presumption, that it was a possibility.
Q. Between my suspension in November 2010 and the fair hearing in January of 2011, did you ever look into whether or not that was true?
THE MAGISTRATE: I'm going to rule that's irrelevant. We're going to proceed on the statement of allegations and the investigation by the Board of Registration in Medicine that presented me those allegations, but not on what was investigated by another body.

Page 350

Q. (BY DR. PADMANABHAN) Dr. Nardin, you testified that you saw the records that were presented at the fair hearing, correct?
A. Correct.
Q. So you chose the three -- three of the ten patients that were -- whose charts were sent to the Greeley Company?
A. That's my recollection.
Q. And am I to assume, and we will ask the government to confirm, that Patient H was one of those selected by you to be sent to the Greeley Company?
THE MAGISTRATE: That's not a proper question. You can ask was Patient H --
Q. (BY DR. PADMANABHAN) Was Patient H chosen by you to be sent to the Greeley Company?
A. I don't know who Patient H is.
THE MAGISTRATE: Is this important to your case?
DR. PADMANABHAN: Patient H is one of the witnesses.
THE MAGISTRATE: Will Patient H be testifying?
MR. PAIKOS: She may be testifying,

Page 351

yes.
THE MAGISTRATE: Is there any problem with showing Dr. Nardin the order and just Patient H's real name?
MR. PAIKOS: No. I can show that.
THE MAGISTRATE: Mr. Paikos is approaching the witness with the impoundment order.
A. I don't recall.
Q. (BY DR. PADMANABHAN) Okay.
THE MAGISTRATE: Okay, so Dr. Nardin, you did see the real name for Patient H?
A. Mm-hmm. Yes.
THE MAGISTRATE: And your answer is you don't recall?
A. Yes.
Q. (BY DR. PADMANABHAN) You don't recall anything about Patient H at this point?
A. I don't.
Q. Do you have any idea why you chose Patient H?
A. I don't.
Q. Do you remember the date that you and Dr. Bor approached the medical executive committee to suspend my privileges for being in immediate

Page 352

danger to public safety?
A. Not the exact date, no.
Q. If I told you it was November 9th --
THE MAGISTRATE: I'm going to stop you right there. That's not a correct form of the question, as I stated at the beginning of the hearing.
Q. (BY DR. PADMANABHAN) Do you recall informing me that my privileges had been suspended?
A. I don't.
Q. Do you recall how I was informed that my privileges had been suspended?
THE MAGISTRATE: Dr. Padmanabhan, I'm giving you some leeway in this, but this is irrelevant to the hearing, your suspension from Cambridge Health Alliance. I'm informing you that I am giving you some leeway, but this is not highly relevant and is possibly irrelevant.
A. I don't recall exactly how it happened.
Q. (BY DR. PADMANABHAN) As division chief, is it not part of your job to tell your juniors that they are being let go or fired or suspended?
A. It's the job of either the division chief or the department chief.

Page 353

Q. Do you recall if it was the department chief who delivered that news?
THE MAGISTRATE: I'm going to -- this is irrelevant. If you have objections to what happened at Cambridge Health Alliance, that is not the subject of this hearing.
DR. PADMANABHAN: No, sir. It's the credibility of the witness that's at issue.
THE MAGISTRATE: This witness has testified to your being let go and how the Greeley report came about. Her credibility is not highly at issue. It is my determination.
DR. PADMANABHAN: May I reserve the right to call her back at some point when I'm prepared for counter?
THE MAGISTRATE: My ruling last week in writing stands. I'm not going to repeat it. Do you have any further questions for her today?
DR. PADMANABHAN: No, Your Honor.
REDIRECT EXAMINATION
Q. (BY MR. PAIKOS) Just by way of brief follow-up, before you came to Cambridge Health Alliance, were you hired to become the chief?
A. No.

Page 354

Q. You're board-certified in neurology?
A. Yes.
Q. And what's the name of the board that you are certified by?
A. The American Board of Psychiatry and Neurology.
Q. And are there subspecialties in that board?
A. There are.
MR. PAIKOS: I don't have any further questions.
THE MAGISTRATE: Dr. Padmanabhan, do you have any follow-up questions to Mr. Paikos' questions?
DR. PADMANABHAN: No, sir.
THE MAGISTRATE: Okay. Dr. Padmanabhan, this is your opportunity to ask questions of Dr. Nardin. You said 40 minutes was not adequate. It sounds like you're done with your questions after 12 minutes.
DR. PADMANABHAN: Your Honor, that's because I didn't have time to prepare. I was still, as I explained yesterday, immersed in the testimony of Dr. Levin. That's page by page.
THE MAGISTRATE: Did you get the Board

Page 355

of Registration in Medicine's witness list?
DR. PADMANABHAN: Yes, sir.
THE MAGISTRATE: And you knew that Dr. Nardin would be testifying?
DR. PADMANABHAN: After Dr. Levin, yes, sir.
THE MAGISTRATE: You knew that she would be testifying at this hearing?
DR. PADMANABHAN: Absolutely, sir. I did not anticipate her being snuck in for an hour in between.
THE MAGISTRATE: She wasn't snuck in. The hearing started and the order of witnesses was not locked in. Okay, so if I rule against you, Dr. Padmanabhan, on your discovery, if I decide that discovery is complete and you do not need any more discovery to cross-examine witnesses like Dr. Nardin, you will not have another opportunity to question Dr. Nardin. I haven't ruled on your discovery request yet.
DR. PADMANABHAN: Thank you.
THE MAGISTRATE: But this may be your only opportunity to question her.
DR. PADMANABHAN: I understand, sir.

Page 356

THE MAGISTRATE: Okay. Thank you for your testimony. You may step down.
(Witness excused.)
MR. PAIKOS: Let me see if our witness from yesterday is here. We anticipated an hour, but I think we can just check the hallway.
DR. PADMANABHAN: Mr. Paikos, I am willing to stipulate that Dr. Levin is going to say the exact same things about Patient F through I as he said page by page on Patient A through E, so to move things along, I'm happy to not have him do that.
THE MAGISTRATE: Dr. Levin's testimony has been helpful to me --
DR. PADMANABHAN: All right.
THE MAGISTRATE: -- as the finder of fact.
DR. PADMANABHAN: But for two days now, he's been pretty much repeating himself.
THE MAGISTRATE: I have not found him to be repeating himself and I need him to answer questions that I have.
DR. PADMANABHAN: Very well, sir.
MR. PAIKOS: I'll see if he's here.

Page 357

DR. PADMANABHAN: I was just trying to speed things up.
(Off the record.)
THE MAGISTRATE: Ms. Wharram, I'm going to ask you to keep transcribing, including the last comment by Dr. Padmanabhan, just hoping to speed things up, whatever he said, and Mr. Paikos, I just want to make sure that you are aware of that. I don't know if you were halfway out the door when Dr. Padmanabhan said he was just trying to speed things up.
MR. PAIKOS: Yes, I was.
THE MAGISTRATE: Do you need a few minutes to get organized?
MR. PAIKOS: Yes, I do, actually. That would be great.
THE MAGISTRATE: Does five minutes make sense?
MR. PAIKOS: Yes.
THE MAGISTRATE: Okay. A five-minute break.
(Off the record.)
(Recess taken from 10:36 to 10:41.)
THE MAGISTRATE: We're back on the

Page 358

record.
MR. PAIKOS: May we have a quick moment?
THE MAGISTRATE: Before we resume testimony, I want to put these things on the record, which may or may not be necessary. Listing witnesses does not guarantee that they are called in that order. I want to point out that Dr. Levin could have ended his testimony at any time, including yesterday afternoon. I want to point out that Dr. Padmanabhan has had notice since 4 o'clock yesterday that Dr. Nardin would be testifying today. Dr. Padmanabhan proposed an Exhibit 11 that named Dr. Nardin. I get the impression that he has considered her his chief antagonist at the prehearing conference. Firstly, the hearing is not going to be about the Cambridge Health Alliance and its discharge of Dr. Padmanabhan. In other words, I anticipated that Dr. Nardin's treatment of Dr. Padmanabhan was an issue in Dr. Padmanabhan's mind and he's had plenty of time to prepare a cross-examination.
Let's proceed with substantive testimony. Mr. Paikos, are you ready to proceed?

Page 359

MR. PAIKOS: Yes.
THE MAGISTRATE: Dr. Levin, you're still under oath.
DR. LEVIN: Yes, sir.
BARRY LEVIN, MD
RESUMED DIRECT EXAMINATION
Q. (BY MR. PAIKOS) Doctor, you have in front of you the records for Patient F?
A. I do.
Q. Doctor, if you would go to Medical Record 8 for this record, Bates 190?
A. I might -- I have that right here.
Q. Okay. Is there information in this summary regarding -- actually, if we could go to Medical Record 161, rather, I apologize, which is at Bates 192? Medical Record Number 166. I'm sorry if I misspoke. It's Bates number 192. And what kind of note is this?
A. This is an ED note.
Q. And what hospital is it from?
A. I believe it's Whidden Hospital.
THE MAGISTRATE: ED being emergency department?
A. Yes, sir.

Page 360

Q. (BY MR. PAIKOS) And what does the person signing the note -- it's about Patient F. What does the patient report to her?
A. Patient states I am detoxing off heroin and alcohol.
THE MAGISTRATE: Okay, so I see that, Dr. Levin. Thank you.
Q. (BY MR. PAIKOS) Now going to Medical Record 640 -- and what was the date of that record? I'm sorry.
A. 12/11/2009.
Q. Okay. If we go to Medical Record 640, which is at Bates 195? Doctor, I apologize. If you -- if you look at Medical Records 639 and 640, 641 and 642, it looks like the encounter date for June 11th, 2010, starting at Bates 194, going to Bates 197.
A. I have reviewed this record.
Q. Okay. It's a note by Dr. Padmanabhan and a record regarding his encounter with the patient?
A. Yes.
Q. What does Dr. Padmanabhan prescribe to this patient?
A. Adderall.

Page 361

Q. Was he within the standard of care in the treatment of this patient in this matter?
A. Yes.
Q. And why is -- is there a history relative to the patient's need for this medication?
A. The history as noted in the report is that patient told doctor that she had ADD as a child and was on Adderall with good effect, then went back on this medication three to four years previously and had been on it for three years.
Q. And he went on to prescribe the patient Adderall?
A. Excuse me?
Q. And he went to prescribe the patient Adderall?
A. I'm sorry. I don't understand the question.
Q. What did he prescribe the patient?
A. He prescribed Adderall.
Q. Okay.
THE MAGISTRATE: This is Dr. Padmanabhan?
A. Yes, sir.
THE MAGISTRATE: Just to confirm, there

Page 362

is different names of providers that appear throughout medical records. I'm confirming that it was him.
Q. (BY MR. PAIKOS) Would the patient's prior history of issues of substance abuse be important in prescribing to this patient?
A. Yes.
Q. And is there any history here relative to -- in Dr. Padmanabhan's note relative to an assessment?
A. No. Excuse me. May I --
Q. Yes.
A. When you say assessment, are you saying that overall neurologic history, or are you saying an assessment in terms of drug abuse?
Q. Drug abuse.
A. I saw no indication of drug abuse in the patient history.
Q. Would it have been correct to have put that in?
A. Yes.
Q. And why?
A. It is very important history for any patient, and particularly a patient who you're

Page 363

considering prescribing abusable medication. Adderall is a medication that is oftentimes abused. It is a medication that is oftentimes prescribed. It would be important to know that this patient has a history of drug abuse, indeed quite serious drug abuse with heroin addiction.
Q. Did he follow the standard of care in prescribing this medication to the patient?
A. Yes.
DR. PADMANABHAN: Could you repeat the question?
MR. PAIKOS: Whether he followed the standard of care.
Q. (BY MR. PAIKOS) And what about relative to obtaining the history? Did he follow the standard of care relative to that?
A. The history as obtained and as listed is within the standard of care. It's difficult for me to state why such a significant history of drug abuse was not part of the history. I don't know if he didn't ask about it, if the patient just didn't tell him. That being said, the history as listed would be within the standard of care.
Q. Is the absence of the history that we saw

Page 364

in the prior note from the same hospital, is that an issue, and if so, why?
A. The absence of history would be a significant omission in the history. I don't know what records were available to the doctor. If the records were available to the doctor and he was indeed able to obtain this significant history of drug abuse by reviewing those records, then it would have been correct for him to have done so.
Q. And if we go to the next record, Doctor, if you could go to -- this is -- you've been given the records for Patient G?
A. Yes, sir.
Q. If you could go to Bates stamp -- excuse me; Medical Record 364, Bates stamp 198, do you see that record? Or let me know when you get to that record.
A. I have that record.
Q. What is that a record of? What kind of record is that?
A. This is a progress note.
Q. And is there a note by Dr. Padmanabhan?
A. Yes.
Q. What does it tell us?

Page 365

A. The note states Imitrex, six milligrams subcu now.
Q. And what is Imitrex?
A. Imitrex is a medicine that falls into a group of medicines called triptans. These are specific medications used to treat migraine headaches. They help to cause a change in the -- chemical changes in the lower portion of the brain that occurs with migraine headaches and oftentimes will help the migraine headache to resolve.
Q. The only thing in this note, it says Imitrex and the milligrams, SC now. Was Dr. Padmanabhan's care at this time within the standard of care?
A. Assuming that this is a progress note, giving information about the patient's visit, this would be below the standard of care.
Q. Why?
A. A progress note, as we've discussed previously with other patients, should include basic information, including history, examination, impression, and plan. There was no history, there was no examination, there was no impression, and the only plan that we see is the prescription of

Page 366

the medication.
THE MAGISTRATE: Mr. Paikos, if I could ask some questions?
MR. PAIKOS: Yes.
THE MAGISTRATE: Dr. Levin, what does SC mean?
A. Subcutaneous. Under the skin.
THE MAGISTRATE: And can you tell from this medical record what the relationship between Marjorie Bowen, Registered Nurse, and the doctor is? I mean, is the doctor there and Ms. Bowen is writing the note, or did the doctor turn the care over to the nurse after examining the patient? What's the relationship between --
A. In reading the note --
THE MAGISTRATE: Yes.
A. -- it appears that the doctor has ordered the medication and the nurse actually administered the medication. This was given subcutaneously, injection under the skin, and she describes that the Imitrex was given subcutaneously in the left arm. Procedure was tolerated well. Twenty minutes after the injection, headache was improved. Discharged -- I believe that's discharged in stable

Page 367

condition. So the assumption would be that he was the ordering physician; she was the administering nurse.
THE MAGISTRATE: And what do you make of the note by Elaine Torres, Registered Nurse?
A. Ms. Torres describes the patient's history of headaches.
THE MAGISTRATE: So this is in reverse chronological order?
A. Well, these appear to be three separate notes. I don't know if we can say this is in reverse chronological order --
THE MAGISTRATE: 4:09 p.m., 4:24 --
A. -- indeed, as you say. So what we see is something being administered, something being ordered and then a history. Yes, I agree that would be a reverse order.
THE MAGISTRATE: So from your reading of the note, what's the relationship between Elaine Torres, Registered Nurse, taking the history and Dr. Padmanabhan ordering Imitrex?
A. I can only conjecture, and my guess looking at the note would be that Nurse Torres was the person who greeted the patient, took a history from

Page 368

her, related this information to the doctor. The doctor made the decision on treatment and then Nurse Bowen administered the treatment.
THE MAGISTRATE: And how does that relate to the standard of care, for a registered nurse to take history and pass it on to the doctor?
A. That's the usual standard of care.
THE MAGISTRATE: Okay.
Q. (BY MR. PAIKOS) And once the doctor has the his-- has the history, someone comes in complaining of headaches, is that what the doctor relies on, or does he do -- he or she do a neurological exam, as we've discussed previously?
A. Standard of care would be to take his own history, to do his own examination, form his impressions, and formulate a plan.
Q. While also using the information from the nurse?
A. That's correct.
THE MAGISTRATE: So to ask the patient again?
A. Yes.
Q. (BY MR. PAIKOS) And do you still need to have some sort of diagnosis or suspected diagnosis?

Page 369

A. Yes.
Q. And when I say do you need it, do you need it when prescribing medication?
A. Yes.
Q. And is Imitrex a narcotic, or not?
A. No.
Q. Does it matter whether something's a narcotic or not if you need to note the reasons for it in the diagnosis or potential diagnosis for prescribing something?
A. You need to have -- the standard of care is you need to have an impression prior to prescribing medication.
THE MAGISTRATE: And an impression in this case would be what, hypothetically?
A. Migraine without aura. Excuse me. Migraine without aura would be the likely diagnosis, reading the notes briefly here.
THE MAGISTRATE: But you would expect to see an impression more than that?
A. Sorry. I'm -- would you repeat the question, please?
THE MAGISTRATE: Would you expect to see more of an impression by the doctor listed in

Page 370

the notes?
A. I would expect to see a full note. I would expect to see a history, an examination, an impression and then plan.
THE MAGISTRATE: And hypothetically, what would an impression be of a doctor examining somebody who presents with a complaint of a migraine?
A. The impression oftentimes would be migraine with aura, migraine without aura, migraine headache, and then perhaps some elaboration as well.
THE MAGISTRATE: Appears to be in pain? Is it an impression like a layperson uses it?
A. No. The impression wouldn't be appears to be in pain unless you don't have a diagnosis. If you're not sure of the problem, you might say patient presents with headache or history of headaches, or appears to be in significant discomfort, appears to be in significant pain. Diagnosis is uncertain, but most likely, this represents migraine without aura.
THE MAGISTRATE: So impression is roughly similar to diagnosis?

Page 371

A. Yes.
THE MAGISTRATE: Thank you.
Q. (BY MR. PAIKOS) If we go to Medical Record 434, Bates 199, can you tell us what this is? It says Lab and Imaging Order, but tell us what significance they have.
A. Sorry. The page number again, please?
Q. Medical Record 434.
A. I have that page.
Q. Okay. And it says Lab and Imaging Orders. Take a look at this. And it's Dr. Padmanabhan authorizing these orders?
A. Yes.
Q. And by taking a look at what is ordered, what kind of tests or labs are ordered, are you able to -- well, first, there are diagnoses listed in here on this March 24, 2010, order, correct?
A. Yes.
Q. And what are they?
A. Migraine, fibromyalgia and inflammation of the central nervous system.
Q. And what are migraines?
A. Migraine is a type of headache. How detailed a discussion would you like me to give?

Page 372

Q. Just briefly, if there's a further definition than a type of headache, but --
A. Migraine is a common type of headache. It oftentimes has a hereditary component. It relates to chemical changes in the lower portion of the brain. As a result of that, there is an enlargement of the blood vessels in the scalp over the surface the brain. This results in a severe throbbing headache over one side of the head or another, it can be both sides, frequently preceded by visual changes known as an aura, flashing lights, blind spots, jagged lines, sensitivity to light, vomiting. Oftentimes, a patient will be quite ill with a migraine headache. It's a recurrent type of headache. Some people will have them once or twice a month. Others are unlucky enough to have them more frequently. Some people have them once a year.
Q. And fibromyalgia is a diagnosis listed here on the lab and imaging orders. What is that, briefly?
A. Fibromyalgia is a condition that is sometimes difficult to diagnose and there are real questions as to the cause of it, or some people

Page 373

even question the existence of the diagnosis, but I think it probably is a real diagnosis. It results in a chronic pain syndrome, typically with pain involving different muscles, different portions of the body. There may be involvement of joints as well in terms of joint pain, but it's a non-specific diffuse pain syndrome.
Q. And there is inflammation of the central nervous system, and next to the prior two diagnoses, there is something in brackets. If you would just explain what those things in brackets are?
A. Migraine, 346.90A. I believe that's the coding for that specific diagnosis. There are specific CPT codes for -- CPT is the coding that doctors and other health professionals use to indicate what diagnosis they're making, and that's put into the computer for charges, for laboratory studies, for defining the diagnosis.
Q. And so what does --
THE MAGISTRATE: Mr. Paikos, if I could jump in, CPT stands for what?
A. I don't know.
THE MAGISTRATE: Are these codes that

Page 374

are standard for medical providers and hospitals?
A. Yes.
THE MAGISTRATE: Are they just for billing and insurance purposes, or are there also non-financial purposes to standardized codes?
A. They have many purposes. I'm not an expert on CPT codes. It's difficult for me to answer your question, but they have many different purposes in addition to just for billing.
THE MAGISTRATE: Okay.
Q. (BY MR. PAIKOS) What is inflammation of the central nervous system?
A. Inflammation of the central nervous system is a pathological description of changes in the central nervous system. Inflammation is the process that the body uses to protect itself. Protection from outside invaders, if you will. If a virus comes into the body, if bacteria comes into the body, the body will react to that by protecting itself. There's a mobilization of different cells, particularly what are called lymphocytes. There's a mobilization of different types of chemicals. This can result in antibodies. And there's a complex process where the body reacts to produce

Page 375

the process of inflammation. Inflammation is a description of a pathological process. It is not a specific diagnosis. There are many, many different conditions that involve inflammation. If you have an infection in the brain, encephalitis, meningitis, infection over the surface of the brain, that involves the process of inflammation. If you have a brain tumor, there will be inflammation around the tumor. If there is head injury with brain hemorrhage, with contusion of the brain, there will be inflammation around the area of the injury. If you have a stroke, there is inflammation around there. Multiple sclerosis is a condition that is felt to involve inflammation of the nervous system, the basic processes. It's an inflammatory process related to what's called an autoimmune disorder. The body makes a mistake, attacks normal tissue, resulting in an inflammation process. So this is a description not of a specific diagnosis, but of a pathological process within the brain.
Similarly, inflammation can occur anywhere in the body. If you cut your finger, the body will mobilize. You typically do not die if

Page 376

you cut your finger, because of the cells, the different chemicals that protect you, and there will be a redness, a swelling, a little bit of tenderness. That's the process of inflammation, and that can occur anywhere in the body. That would not be a specific diagnosis, but rather a description of a pathological process.
Q. When reviewing the records, were you able to see a note where these, you know, the diagnoses of migraine, fibromyalgia and the pathology of inflammation of the central nervous system were listed prior to this?
A. I don't remember. I'd have to go back and look through this.
Q. Did -- what are these? Do you see the tests listed? For what kind of -- what kind of tests are these?
A. There's a number of screening tests that can be used to evaluate patients for a variety of different conditions, but looking through them, in general, these are tests that would fall into a couple of different categories. These are screening tests looking for inflammation. CRP, C-reactive protein, is a test just looking for

Page 377

overall body inflammation, non-specific. If somebody has a tumor, if there's a cancer, frequently, this will be elevated. If there is some type of infection, if you have pneumonia, some other type of infection, your CRP will be elevated. If you have leukocytosis, CRP likewise we'd expect to be elevated. There are other tests looking for neurologic disorders.
Would you like me to tell you specifically a test and the diagnosis, or just overall?
Q. If you'd tell us each test and what diagnosis?
A. Rheumatoid factor would be looking for rheumatologic disorders. Ceruloplasmin, C-E-R-U-L-O-P-L-A-S-M-I-N, is a test for a disease called Wilson's disease. Methylmalonic acid is looking for B12 deficiency. Copper would also be looking for Wilson's disease. Anti-extractable nuclear antibody, also known as ANA, is looking for rheumatologic disease, as is lupus anticoagulant. That would be looking for vascular disease. Anticoagulant antibodies, A-N-T-I-C-O-A-G-U-L-A-N-T antibodies, are measures looking for vascular

Page 378

disease. Factor 5 Leiden analysis --
THE MAGISTRATE: Excuse me. I don't see Leiden.
DR. PADMANABHAN: Yes, we don't have that.
MR. PAIKOS: We have provided and we're going to rely on that first page, but Dr. Levin has the whole record in front of him.
Q. (BY MR. PAIKOS) Now, Dr. Levin, thank you. The -- we talked about rheumatological disorders. Is there a specialty in medicine called rheumatology?
A. Yes.
Q. And what does that generally deal with?
A. Rheumatologists are doctors who have the medical specialty involving disorders of the joints, muscles, oftentimes blood vessels. And this is a large variety of disorders that can involve inflammation and involve these areas of the body. It includes disorders like rheumatoid arthritis, lupus erythematosus, temporal arteritis, giant-cell arteritis, vasculitis, inflammation of the blood vessels, some of the muscle inflammatory diseases. There's a large amount of diseases that

Page 379

rheumatologists are experts in.
Q. If we go to page -- Medical Record Number page 439 at Bates 200, if we could look at that note, with an encounter date of March 24th, 2010?
A. Sorry. Was it 439 and 440 or just --
Q. 439.
A. Okay.
Q. Did you review this note?
A. I have reviewed the note.
Q. Okay. Is this a -- is Dr. Padmanabhan's treatment and the note within the standard of care at this visit?
A. This is below the standard of care.
Q. And why?
A. Looking at the history, he notes patient being upset, felt that she was treated badly by the rheumatologist. History is that she continues to have fibromyalgic pain. There is no other history in regards to the problems. We would expect there to be a more complete history. Examination, the same. There was no information at all in terms of what her exam was. I did not find a previous examination, so even with the information given exam the same, there is nothing to refer to. We

Page 380

don't know what it's the same as. Impression is CNS inflammation. That is the only diagnosis listed. CNS inflammation is a non-specific diagnosis of inflammation process. It is really not a usual and customary neurologic diagnosis. There are many diagnoses, many conditions that include CNS inflammation, but CNS inflammation by itself is a non-specific diagnosis. There is no explanation here why this impression isn't there. There is no discussion. There is nothing in the history that would suggest that there is CNS inflammation. The plan is to continue Topamax for migraines. May I go to the next page as well?
THE MAGISTRATE: Before you do, can you tell us what CNS is?
A. Sorry. Central nervous system. That would include the cerebral cortex, what we normally consider to be the brain, the lower portion of the brain known as the brain stem, the back part of the brain, the cerebellum, which is the fine control apparatus of the central nervous system, and the spinal cord. Those are all referred to as the central nervous system, as opposed to the peripheral nervous system, which is the nerves

Page 381

coming from the spinal cord out to the arms and the legs.
THE MAGISTRATE: So no indication where that diagnosis, which is not standard, came from?
A. That is correct.
THE MAGISTRATE: And no treatment plan?
A. There is a treatment plan.
THE MAGISTRATE: For CNS inflammation?
A. I don't know. There is on page 40 -- may I go to 440, because there is a medication on page 440.
MR. PAIKOS: 440 we did not provide. We provided on disk the full records of Dr. Padmanabhan earlier in the month before we provided discovery.
THE MAGISTRATE: If it's not part of your case, then I won't ask about the treatment plan for CNS inflammation.
MR. PAIKOS: I think it may be helpful for Dr. Levin to mention it, even if you don't have the record, if that's -- because it's part of his analysis and I think it completes what this note is, even though we did not include it.
A. The only thing on page 440 is will start

Page 382

Plaquenil. Tests ordered.
DR. PADMANABHAN: Objection.
THE MAGISTRATE: Basis for your objection?
DR. PADMANABHAN: Incomplete note.
THE MAGISTRATE: Is your objection that he's talking about a document not in evidence?
DR. PADMANABHAN: Yes. And I'm objecting that the government has not produced the remaining half of the note.
THE MAGISTRATE: Mr. Paikos informed me that you turned over all documents on disk.
MR. PAIKOS: Yes, the entire records on disk.
THE MAGISTRATE: And that is a subject of your motion. I understand that, Dr. Padmanabhan. I'm going to allow this testimony and we will resolve the issue of the documents that you're getting on disk, and if you deserve a follow-up question when you have the documents, we'll -- we'll give you that. I will give you that.
So I turn the questioning back to Mr. Paikos for Dr. Levin.

Page 383

Q. (BY MR. PAIKOS) What is -- we saw the plan, will continue with Topamax for migraines, and then on Medical Record 440, complete the picture that there was more to the plan. What was on that? What was part of that plan?
A. The plan is will continue Topamax for migraines. Will start Plaquenil. Tests ordered.
Q. What is Plaquenil?
A. Plaquenil is a medication that's commonly used for rheumatologic disorders.
Q. And what -- how does the Plaquenil work, briefly?
A. I don't know.
Q. Well, it's something for rheumatological disorders. Do you know what it's used for?
A. I believe it's commonly used for conditions like lupus, rheumatoid arthritis, other rheumatologic orders. It's not a medication I prescribe. It's not a medication commonly prescribed by a neurologist.
Q. Directing your attention to --
THE MAGISTRATE: Mr. Paikos, before you move on, can you get us this page?
MR. PAIKOS: I can get this. We have

Page 384

the disks here.
THE MAGISTRATE: There's a copy in front of Dr. Levin, right?
MR. PAIKOS: Yes.
THE MAGISTRATE: So we can get a copy either now or later, introduce it into evidence and get a copy to Dr. Padmanabhan, aside from the electronic record?
MR. PAIKOS: Yes. Okay.
THE MAGISTRATE: I see you're nodding. Okay.
Q. (BY MR. PAIKOS) Directing your attention to Patient G's medical record --
THE MAGISTRATE: Actually, do you want to see that now?
DR. PADMANABHAN: No, Your Honor, but I still think it's weird that they only produced one-half of the note.
THE MAGISTRATE: Okay. We'll revisit that if you want when we talk about -- well, we'll revisit it another time. It's okay. So Mr. Paikos will get you and I a copy of that page and we'll introduce it into evidence.
Q. (BY MR. PAIKOS) Bates number 201, which is

Page 385

Medical Record 444 --
A. Sir, this is a report that goes from pages 444 to 445?
Q. Yes.
A. Would you like me to look at that page as well?
Q. Yes, both pages. Thank you.
A. I do have that record.
Q. What kind of a report is it and by what kind of specialist?
A. This was dated March 30th, 2010. It is an MRI of the brain, denied contrast, and this is a report from a radiologist.
Q. And what do radiologists do?
A. Radiologists are medical doctors who specialize in a particular area of medicine that relates to imaging, and it's imaging of a portion of the body. This would include x-rays, CT scans, MRI, ultrasound, other types of scans, mammography, any test that involves an imaging of the body typically would be under the expertise of a radiologist.
Q. And it's ordered by Dr. Padmanabhan after that last note we saw and it has -- it says

Page 386

indication, fibromyalgia, migraines. What does the indication mean in that report, or what is -- on radiographic reports, what's indication on there for?

A. It's terminology used as reason for exam on this particular study. This is the information that the doctor wants to give to the radiologist to let him or her know why the test is being ordered to direct them to possible diagnoses that you are concerned about. Radiologists look at that. I think it does somewhat influence their reading, but they also will read the study just in general, looking for whatever abnormalities they find, but this would give the doctor some direction in terms of what your diagnosis is and your concerns about the patient may be.

Q. And the next page, which is Bates 202, Medical Record 445, under impressions, what are the impression sections, typically?

A. The impression section is the doctor's interpretation of the study.

Q. And what is this radiologist telling a specialist, a neurologist, about his or her impressions on this test?

Page 387

A. May I read the impression and then translate it, perhaps?

Q. Yes.

A. The impression is mild non-specific supratentorial white matter changes, most prominent along the trigones of the -- T-R-I-G-O-N-E-S, of the lateral ventricles. There is a wide differential diagnosis, but common potential etiologies include idiopathic change or mild microvascular ischemia. Description. The supratentorial means the upper portions of the brain, the cerebral cortex, as opposed to lower portions of the brain, the brain stem. White matter refers to tissue in the brain. The brain consists mainly of gray matter and white matter. Gray matter is the neurons, the nerve cells. The white matter is the nerve fibers covered by a fatty material called myelin, and it gives you a lighter color, typically. So you have white matter, the gray matter. There is a mixture between the two, but in general, these are separate.

The lateral ventricles, the ventricles are the normal fluid-filled spaces in the brain where the spinal fluid circulates. The lateral ventricles are on the sides and go posteriorly. Trigones are around the exterior portion of the lateral ventricle.

The description here is mild and non-specific supratentorial white matter changes, so the doctor is saying that within the white matter, he is seeing white matter changes that are really quite mild and they're non-specific in terms of what they mean.

Going back to the description of his findings, so typically, a doctor would give findings with detail and then an impression giving some description and conclusion. If we go back to the findings on page 444, the doctor notes there is mild non-specific poorly-defined T2 hyperintensity along the trigones of the lateral ventricles, and there is a tiny T2 hyperintense focus in the left frontal subcortical white matter. Sagittal FLAIR shows a normal corpus callosum. Again, going back, reviewing some of the anatomy, some of the jargon here, T2 refers to the process of doing the MRI. X-rays are done with x-ray procedures. The MRI is done with large magnets. The large magnets cause a depolarization of atoms. Energy is released from electrons and the machine defines that in a certain way to give very detailed pictures of a part of the body, here the brain that we're looking at. T2 refers to spin on the electron. It can be T2, T1. T2 images look a certain way. T1 images look a certain way. That's jargon that they use to describe the image. So T2, for example, there can be areas of increased signal intensity, or hyperintensity, and those show up as white, or whiter areas. What the doctor is saying here is there is a tiny T2 hyperintense focus, so we see a little tiny white dot. And he saw that on the left side in the frontal region in the subcortical white matter. So cerebral cortex, in the area below the top of the cortex, subcortical. Tiny area, little tiny white dot, left side, frontal, subcortical.

He also noted poorly defined T2 hyperintensity, white matter changes that are really quite mild along the posterior portion, the back portion of the lateral ventricle.

The sagittal FLAIR focus shows a normal corpus callosum is important in terms of the diagnosis. The corpus callosum is a large bundle of fibers that connects the two cerebral

Page 388

Page 389

Page 390

hemispheres. This particular area can be important in certain diagnoses. Sagittal refers to the image itself and the direction that we're seeing. Sagittal indicates that we are looking at it from the side, so we are looking at an image of the brain from the side, looking at it in cross-section from the side.

THE MAGISTRATE: And FLAIR means what?

A. FLAIR is another type of measurement similar to T2, T1. FLAIR, I never remember what the FLAIR stands for. Each letter stands for something, F-L-A-I-R.

THE MAGISTRATE: It's a measurement?

A. It's a measurement. And each change on the machine, the pictures will look different, so FLAIR signal, you'll have different appearances to white matter changes, to gray matter changes. Different types of pathology will look different on T1, T2 and FLAIR. FLAIR is a good imaging study to look for white matter changes, for example.

So going back again to the impression, the other information we had was mild non-specific supratentorial white matter changes, so these seem to be very mild. They're non-specific. This does

Page 391

not relate to a specific diagnosis. It's in the white matter, most prominent at the back part of the lateral ventricles, but again, really quite, quite mild. There's a wide differential diagnosis, so many possible diagnoses can give this, but most commonly, this is idiopathic change, so mild blood vessel changes, and indeed, most commonly, when you see this, these are changes that are uncertain, but typically limited clinical -- have limited clinical correlation, which basically means that you see these changes, you see little tiny white dots, but most of the time, they mean nothing. The feeling is these are probably normal changes that occur that have no pathological significance.

Q. Now, those MRI's that are referenced, did you review them yourself?

A. I did.

Q. Did you agree with the conclusions of the radiologist here?

A. Yes.

Q. And if we could go to --

DR. PADMANABHAN: Objection. How? How can he agree with the conclusions on a piece of paper?

Page 392

THE MAGISTRATE: Overruled.

Q. (BY MR. PAIKOS) If we go to Patient G's Medical Record 465, Bates 205, and it goes to Medical Record 465 to 467, Bates 205 to 207 --

A. I have reviewed the record.

Q. And this is Dr. Padmanabhan's record?

A. Yes.

Q. And what -- what does this record talk about? What is happening in this encounter of this patient?

A. The doctor notes the previous history of her being quote/unquote diagnosed with fibromyalgia. He was told that she had chronic pain. Also listed other problems, including fatigue, difficulty with attention, multitasking, migraines, that they are variable in their symptoms. There are weeks where she's much worse, can barely get out of bed, balance problems at that time, bumps into people. Some weeks she's much better in terms of fibromyalgia, and at that time, her balance is also better. Other difficulties include muscle spasms.

THE MAGISTRATE: Okay, Dr. Levin, so I see that. I have that in front of me. Thank you.

Page 393

Q. (BY MR. PAIKOS) What does Dr. Padmanabhan do? What does he discuss? Does he discuss the MRI?

A. He does.

Q. And does he reach conclusions based on the MRI?

A. I'm sorry. The previous -- you did not want to review the previous information prior to that about the blood studies?

Q. Well, there were blood studies as well?

A. Yes. Prior to that, there was a discussion that he did the comprehensive blood studies looking for neuroinflammation as well as blood markers. I believe those are the studies that we reviewed in detail. And he notes the abnormal study that she had.

Q. So there are some that are normal, which means doesn't have the condition, such as Wilson's that he is looking for?

A. Yes.

Q. What's the abnormal one?

A. The only abnormal blood marker was a strongly positive anti-RNP that's greater than eight, with a normal of 0.9 or less.

Page 394

Q. And what does he think this is?
A. I don't know. His note is, which was very suggestive given her sister has lupus.
Q. Is lupus a rheumatological type of disease?
A. Yes.
Q. And does the test, the anti-RNP test, rule out rheumatological diseases?
A. Yes.
Q. Do you know what it is?
A. It's a disease that measures a certain protein. And I had not heard of this before, but I believe I gave you a reference that I got on this, and this is a test that would be suggestive of rheumatologic disorder.
Q. Of which lupus is one?
A. Correct.
Q. And anti-SM is negative, what is that?
A. I don't know.
Q. And does he discuss going through the MRI frame by frame with the patient?
A. Yes.
THE MAGISTRATE: Mr. Paikos, if I could jump in, have you tried to find out what anti-SM is?

Page 395

A. I did not.
Q. (BY MR. PAIKOS) What are his findings here relative to what the MRI showed?
A. May I read his interpretation? I think it's probably important enough to read through this again. The sagittal FLAIR sequence, so this is a sequence looking at the brain from the side, with the FLAIR changes, shows numerous high signal lesions in all lobes, especially coming off the lateral ventricle. Perhaps if I may, I will read the note and then I will go back and interpret or explain what I think some of these things mean. Especially coming off the lateral ventricle. There is at least five clear Dawson's fingers. The pattern of distribution is very specific to multiple sclerosis. The lesions are also different ages and stages. Time parameter would be 2007. Swinton -- Swanton, excuse me, criteria. Would you like me to comment, or should I just wait for questions?
Q. What does his interpretation mean, or -- you discussed the sagittal FLAIR sequence shows high signal lesions. What does that mean?
A. His interpretation was that there were

Page 396

numerous areas of abnormality on the MRI. These involved all of the lobes of the brain. These are high signal lesions, so areas of increased T2 or increased FLAIR signal, which show up as white areas of abnormality in the brain. He describes these in all the brain, especially coming off the lateral ventricle.
Q. He talks about he sees at least five clear Dawson's fingers?
A. Dawson fingers are a descriptive abnormality we see in brain MRI. It's an area of increased signal intensity, typically T2 or FLAIR signal. It looks like a finger perpendicular to the corpus callosum. That was the area that was the middle of the brain connecting the two portions of the brain, and Dawson's finger is when you see an area perpendicular to the corpus callosum. It shows white, somewhat thick, longer than it is wide, generally much longer than it is wide. Looks almost like a small finger. These are when seen nearly pathologic for multiple sclerosis. They are not a hundred percent pathologic. We can see them in other conditions as well, but if you see somebody who has symptoms that you believe -- signs

Page 397

and symptoms that are consistent with the diagnosis of MS and you see Dawson's fingers, that is very suggestive of the diagnosis of multiple sclerosis.
Q. In reviewing this patient's record up to now, did you say -- see -- well, with your review of the -- the radiologic -- radiologist's review of the MRI, did it mention Dawson's fingers?
A. No.
Q. In your practice, have you reviewed radiographic images, or radiographic reports previously?
A. May I make a further comment?
Q. Yes.
A. If we go back to the radiologist's report --
Q. Medical Record Number 444, Bates 201 to 202.
A. Going to page 444, there is a specific remark by the radiologist at the end of that page, sagittal FLAIR shows a normal corpus callosum. So the radiologist is very specifically looking at the corpus callosum, looking for any type of abnormality, but especially Dawson's fingers. And the doctor is telling us, no, I do not see any

Page 398

abnormality. Sorry. Would you repeat the other question?
Q. So does the -- and specifically, it doesn't note that there were Dawson's fingers and this suggests that there was not?
A. It says that the corpus callosum is normal. So the fact that it is normal suggests that he does not see Dawson's fingers. The report from the radiologist is a good one, appears to be a careful reading of the MRI. Certainly, if the doctor saw Dawson's fingers, it would be expected that he would mention that.
Q. When you reviewed the MRI, did you see Dawson's fingers?
A. No.
Q. When diagnosing -- how do you -- how does a neurologist diagnose multiple sclerosis?
A. It can be a complex diagnosis and the diagnosis of multiple sclerosis, or MS, has changed over time, especially in the past 20 years or so. Just a brief discussion of multiple sclerosis?
Q. Yeah. What is it and how do you diagnose it?
A. It's a disease of the central nervous

Page 399

system, the brain spinal cord. The brain stem only includes one peripheral nerve. That's the optic nerve. Here, it involves mainly the white matter. It involves the covering of the nerve fibers, called myelin, although it can involve the nerve fibers as well themselves, and there's a disruption of the myelin. So the myelin itself is affected. Probably, this is an autoimmune process. The body makes a mistake, will attack normal tissue. This results in inflammation of the myelin, sometimes of the nerves themselves. The symptoms relate to the specific areas of the central nervous system that are involved, and there can be a large variety of different symptoms that occur with multiple sclerosis; loss of vision, double vision, incoordination, difficulty speaking, numbness of the face, numbness anywhere in the body, weakness of one arm or leg, any combination thereof, imbalance, bladder difficulties. Pain can occur, but it's typically much less of a problem in multiple sclerosis. Cognitive difficulties can occur, but they are less severe than other neurologic conditions. And you can have any combination of symptoms and signs as you see

Page 400

different patients with multiple sclerosis. So somebody can present with difficulty speaking, coordination problems and difficulty walking. They may present with weakness and numbness.
The neurological deficits, neurological symptoms typically occur in attacks and the attacks are known as exacerbations. So you'll have an attack. Something may happen. You may lose the vision in one eye. That vision will come back a few weeks later. A month later, six months later, something else happens. You have difficulty with your speech. Six months later, difficulty with coordination. So attacks, exacerbations and then remissions, an episode where something bad happens and then the patient may or may not get better, residual symptoms, and as time goes on, people tend to develop disability from the disease.
The most common type of MS is relapsing remitting disease, these attacks that I described, periods where you improve. And there's a tremendously variable course that people can have, but that's typical what you see of attacks and periods of remission.
The classical way to diagnose multiple

Page 401

sclerosis is multiple episodes, multiple attacks in space and in time, space meaning that it's in more than one portion of the central nervous system, so you may have a spinal cord lesion, a lesion referring to the area of abnormality. You may have a lesion in the brain stem, you could have a lesion in your cerebral cortex. You could have a lesion in the brain stem. So multiple areas. You don't have just one area of the nervous system involved. Again, so there's multiple lesions in space, multiple lesions over time. Something happens now, something in a month, something in six months, something in a year. And this is classical how we define the disease and diagnose the disease. The Poser criteria, Poser criteria, P-O-S-E-R criteria, is what I just described to you.
Newer criteria came about called the McDonald criteria, M-C-D-O-N-A-L-D, and I believe it was around -- I think it was in 2004, approximately. When the McDonald criteria came about, that changed things a bit, because the McDonald criteria now includes MRI data. If you have somebody who has one clinical episode, sometimes one or another, that may not be exact as

Page 402

you'd like it to be, but if they have an MRI that is consistent with the diagnosis of multiple sclerosis, then you can make a presumptive diagnosis of MS using the McDonald criteria.

So the Poser criteria had to be purely clinical. The McDonald criteria now says all right, if we have an MRI that is definitely abnormal and is abnormal consistent with the diagnosis of MS, then we can make a presumptive diagnosis. Presumptive MRI changes would include multiple areas of abnormal T2 signal, usually fairly large areas, not these little tiny nonspecific areas. We're talking about seeing multiple areas of involvement, including the cortex and the brain stem, cerebellum. Also, if you have the spinal cord, that's very helpful as well. So again, it's multiple areas, consistent MRI's, you can make the diagnosis.

If you don't have specific MRI changes, you can't make the diagnosis. So for example, if you see somebody with just a few areas that are non-specific, that is not consistent with the diagnosis, you could not use that criteria to make the diagnosis of multiple sclerosis.

Page 403

Q. You said changes in the MRI, meaning there's one MRI done or multiple MRI done, that changes between the two MRI's?

A. When I refer to changes in the MRI, I mean seeing abnormalities, seeing changes from normal. That being said, it's part of the diagnostic process and certainly part of the follow-up process for people with presumptive multiple sclerosis or a question of multiple sclerosis to do repeated MRI's and do MRI's over time to see if there is a change, are they getting more lesions, are some of the lesions improving, and then are we seeing inflammatory lesions. We also give a material called Gadolinium when doing the MRI, and the Gadolinium is a contrast material. If you see a very bright white area with the Gadolinium, that's an indication of an area of active inflammation and it tells you you have active inflammatory disease. And if you've made a diagnosis of MS, it tells you you have active MS. You need to be more specific in terms of how you assess, how you treat.

Q. Based on your review, did this person have MS?

A. No.

Page 404

Q. Why not?

A. The clinical course is not the course of MS. She does not have exacerbations. She does not have attacks. She does not have remissions. She has multiple symptoms. Let me see here. I've written down she has chronic pain that was related to previous diagnosis of fibromyalgia, a non-specific finding. She had fatigue, definitely seen in MS, is seen in many, many different conditions from overwork, depression, viral illnesses. Many, many conditions include fatigue. Troubles with attention, multitasking, non-specific. Can be seen in a variety of conditions, including Attention Deficit Disorder. Migraines, migraines are not specific to MS. Very common condition that does not relate to MS. She had no -- there are other non-specific complaints. Feelings of imbalance, especially when she just wasn't feeling well, when she was having a lot of pain. When her fibromyalgia was better, her balance got better. Muscle spasms. I don't know where those spasms were, but again, that's a non-specific symptom. She did not have clear neurologic symptoms referable to the central

Page 405

nervous system. She did not have exacerbations. She did not have remissions. The MRI, as interpreted by myself, also as interpreted officially by the radiologist, was essentially a normal MRI, some few very tiny areas of non-specific increased T2 signal.

MR. PAIKOS: Your Honor, we have the MRI. We had a projector. It just doesn't show up clearly on the projector. I would make a suggestion that we show it to Dr. Padmanabhan -- to Dr. Levin and huddle around him, for lack of a better word, and review where he sees the white spots and where the corpus callosum would be, and we can all see what he's looking at and go through it that way.

THE MAGISTRATE: Do you have any new objection? I know this is the subject of your -- one of your motions, that you did not get a paper copy.

DR. PADMANABHAN: Correct, Your Honor. And huddling around a small laptop screen I think does not meet any standards at all.

THE MAGISTRATE: Okay, so I am going to rule that we will do that, but -- and I don't know

Page 406

if you need time to set up, but in any case, I'm going to suggest a ten-minute break.
MR. PAIKOS: Yes. We're pretty much set up, but a ten-minute break would be good.
THE MAGISTRATE: Okay. Back here in ten minutes.
(Off the record.)
(Recess taken from 11:47 to 11:56.)
THE MAGISTRATE: Mr. Paikos, this is which exhibit?
MR. PAIKOS: This is 24, radiographic images for Patient G.
THE MAGISTRATE: Dr. Padmanabhan, do you want to join us and see the screen?
DR. PADMANABHAN: No, sir.
THE MAGISTRATE: All right.
Dr. Padmanabhan is declining to see the screen. He is seated in his seat.
A. I'm going to show just the sagittal image, just to orient you to the image we're looking at.
THE MAGISTRATE: We are looking at the double -- double image, there's an image on the left and the right, and Dr. Levin, as he uses a clicker, can manipulate the image.

Page 407

A. The image I'm going to explain is the one on the left. This is referred to as a sagittal image, so this is slices of the brain coming from the side, moving from side to side. Just to orient you to what we're looking at, this is of the patient's eyes right here. The nose is here. This is the top of the head, the back of the head, the spinal cord. Mouth is over here. The tongue and the area of --
THE MAGISTRATE: Dr. Levin is indicating all these places with the cursor.
A. The areas of interest are the cerebral cortex, which I'm going to outline for you right here.
THE MAGISTRATE: Towards the top of the skull.
A. In the middle portion of the brain is a structure called the corpus callosum, moving up and down.
THE MAGISTRATE: Dr. Levin showing with the cursor and manipulating the image.
A. The image is moving side to side, so in and out of this person's head, if you will.
THE MAGISTRATE: We're seeing different

Page 408

slices, in effect?
A. That is correct. So if we -- I'm starting in the left side of the brain. I'm going to move toward the right side of the brain. So this is going to the very edge of the left side of the patient's head, moving slowly toward the right side, and we're starting to see the cerebral cortex. This area here is known as the white matter, and in the center of the screen is a very tiny area of -- that's whiter than the surrounding tissue. And this would be a non-specific area of increased T2 signal, T2 hyperintensity, and that's what the radiologist I believe is describing. Behind it is perhaps another tiny area. And moving more toward the right, we begin to see this black area in the middle of the brain. This is what is called the lateral ventricle. This is the posterior portion of the lateral ventricle. The area behind it is called the trigone, and there is a small area of hyperintensity behind that as well.
THE MAGISTRATE: That white dot?
A. Yes, sir. Continuing on toward the right side, again, we see the corpus callosum and we see that the corpus callosum itself looks perfectly

Page 409

normal. It's nice and smooth. Looking at the areas of white matter above that, there is no indication of increased T2 signal. There is no increased -- there is no hyperintensity above that. There is certainly no Dawson's fingers. Dawson's fingers would be perpendicular, so they would be up and down in reference to the corpus callosum, and these would show up as intense white areas.
THE MAGISTRATE: And the corpus callosum, you're testifying, is normal from your comparison to other ones you've seen?
A. That is correct.
THE MAGISTRATE: And if there were hyperintensity, what would it show?
A. If there were hyperintensities, we would see white area, areas that are whiter than the surrounding brain.
THE MAGISTRATE: The small dots that we've seen before?
A. Correct, but they would be much larger. We would see significantly larger areas that would be perpendicular to the corpus callosum. They look about the thickness of small fingers and perhaps the length of small fingers as well. Some can be

Page 410

larger than others.
Moving toward the -- excuse me, the right side, these kind of look similar to what we just saw on the left side. There is another tiny area that I see over here, a tiny area of increased T -- increased T2 signal. That is really the -- those are the only abnormalities that I see on this study. That was really quite mild, non-specific, will likely have no clinical significance.
THE MAGISTRATE: Can you see on the left side of the screen anything that you can speculate led Dr. Padmanabhan to detect Dawson's fingers?
A. No.
MR. PAIKOS: A further request, as during the week we were able to find on the Internet a picture of a brain with Dawson's fingers, we haven't shown Dr. Padmanabhan. I don't know if that would be illustrative or not of what Dawson's fingers may or may not look like, not as an exhibit, but just as a comparison.
THE MAGISTRATE: I'll entertain it as an exhibit.
Q. (BY MR. PAIKOS) And I show you, Doctor.

Page 411

So what does this image appear to be?
A. This is likewise a -- similar to what we have just looked at, this is a sagittal MRI of the brain, so the -- in contrast to the structure I showed you before, the sinus would be here, the eye over here, the gums over here. So this would be the cerebral cortex, top, front, back. The spinal cord would be down here.
THE MAGISTRATE: Dr. Levin, if I could interrupt, what is it that we're just looking at? A new screen just came in front of me.
MR. PAIKOS: Yes. It's a new screen, but it's an image of an unidentified individual obtained simply from the Internet, and it's one slice of an MRI.
THE MAGISTRATE: That depicts Dawson's fingers?
MR. PAIKOS: That depicts Dawson's fingers. And I would ask Dr. Levin what abnormalities do you see on here.
THE MAGISTRATE: Dr. Padmanabhan, do you want to see this?
DR. PADMANABHAN: I object to exhibits just simply randomly being introduced today, Your

Page 412

Honor. Given my motion --
THE MAGISTRATE: Dr. Padmanabhan, for the bulk of exhibits, I need to see them in advance. Here and there, I will entertain exhibits, especially when this seems to be simple and relates to other exhibits. Do you want to see this?
DR. PADMANABHAN: No, Your Honor.
THE MAGISTRATE: Okay. Mr. Paikos, you may proceed.
Q. (BY MR. PAIKOS) Does this show Dawson's fingers or what Dawson's fingers would look like?
A. Yes.
Q. And where are they, if you could point to them?
A. The central portion of the image that we're looking at, this black area is the lateral ventricle. Above that would be the corpus callosum. And what we've seen in the corpus callosum are these areas of white -- whiteness. These are areas of increased T2 signal. We see numerous ones along the top of the corpus callosum. I can identify perhaps one, two, three, four, five, six, seven, eight, nine, perhaps nine or ten areas

Page 413

of increased signal intensity. The areas are perpendicular to the corpus callosum. They're very distinct. These are clearly areas of pathology. These are not -- these are not normal. And they have a thickness here, and in general, they are longer than they are wide, and this is what he described as Dawson's fingers. They look rather finger-like, if you look at them. Use your imagination. Finger by finger pointing at the corpus callosum and involving the corpus callosum. Not diagnostic without clinical information, but in the correct clinical circumstances, this MRI would be nearly diagnostic for multiple sclerosis.
THE MAGISTRATE: Mr. Paikos, can you get a printout of that before the hearing ends?
MR. PAIKOS: Yes. Yes, I can.
THE MAGISTRATE: So that's just a single shot. It's not --
MR. PAIKOS: It's not an electronic complete record that you can scroll through. It's just one page.
THE MAGISTRATE: Okay, so I'm going to make a finding that the patient's record that Dr. Levin was pointing to does not have the -- the

Page 414

features that the single photograph from the Internet has. Is there more of the patient's record?
MR. PAIKOS: There's more to go through the paper record, but not the MRI.
THE MAGISTRATE: So I've returned to my seat, and Mr. Paikos, do you have more questions on this patient?
Q. (BY MR. PAIKOS) On that day, on Medical Record 466, Bates 206, did Dr. Padmanabhan refer his patient to another doctor, a Dr. Seton?
A. Yes.
Q. And that was for the positive anti-RNP, which we discussed was a rheumatological issue?
A. Yes.
Q. So was Dr. Padmanabhan's diagnosis of MS within the standard of care?
A. No.
Q. And why is that?
A. The clinical course of this patient is not the clinical course of multiple sclerosis for the reasons previously discussed. The MRI, my reading into the official reading of the radiologist was a mild non-specific -- showed mild non-specific

Page 415

changes not consistent with the diagnosis of multiple sclerosis. His interpretation of the MRI, again, to my reading and to the reading of the interpreting radiologist, was incorrect. It was not consistent with the diagnosis of multiple sclerosis.
Q. Doctor, if we could go to Medical Record Number 4 -- 546, Bates 209 -- I'm sorry; Bates 208? Medical Record 546, Bates 208. And if you could review that note for yourself and state whether it fulfilled the -- fell within the standard of care?
A. I have reviewed this note. It is below the standard of care.
Q. And why?
A. The history is brief. It is an inadequate history. He notes that Copaxone was started. No information about explanations to the patient about Copaxone, no information that I could find in the records that he discussed Copaxone with her, discussed possible side effects, discussed how to use the medication. Describes that she has a deep ache in her right leg. Does not describe any symptoms that would relate to the diagnosis of multiple sclerosis. Does not discuss any concerns

Page 416

about multiple sclerosis or concerns about having a rheumatologic disorder. He notes that she was taking Copaxone presumably because of the diagnosis of multiple sclerosis. He notes that Plaquenil was helping, but does not say why he gave her Plaquenil, does not provide any explanation as to the particular prescription. All else as before, that is below the standard of care. We don't know what that refers to. There's history previously about a number of different difficulties. We don't know what difficulties she's having at this point, what symptoms she's having, what is better, what is worse. There is no physical examination, so we have a patient who has just been diagnosed as having multiple sclerosis who may have some other type of disorder, perhaps a rheumatologic disorder. I can't tell from the records. And there's no examination, so we don't know if she has an abnormal neurological examination that would confirm the diagnosis of MS. We don't know if she has a normal exam. We don't know if there are other problems. We don't know anything. There is no exam. The assessment is MS. Will try baclofen for the low leg stiffness/tightness. No history of

Page 417

having leg tightness. There's no physical examination to suggest that she has leg tightness. We don't know anything at all about her leg. And there is another medication, an anti-spasmodic that can have potential side effects, but we don't know why. That's the only information we have.
Q. Would it be important to know if the patient was having any -- I don't know if you call them attacks or episodes that could be MS?
A. Yes.
Q. Would it be important to note if she didn't have them?
A. Yes.
Q. Is that information here?
A. No.
Q. So is the care and treatment of this patient below the standard of care?
A. Yes.
Q. And Copaxone -- is there such a thing as drugs that are regularly used for multiple sclerosis?
A. Yes.
Q. Is Copaxone one of them?
A. Yes.

Page 418

Q. And when prescribing any medication, do you tell the patient -- we may have discussed this before -- the side effects and potential issues?
A. Yes.
Q. Would it be important to note what you talked about or that you did in fact mention it to the patient?
A. Yes.
Q. If we could go to Medical Record 679, Bates 209, and that note continues onto the next page. Did Dr. Padmanabhan -- how was Dr. Padmanabhan's care on that day?
A. I have reviewed this record dated 7/8/2010, and this is below the standard of care.
Q. Why?
A. The history describes that the patient is feeling better, describes problems with her abusive ex-husband, with increasing anxiety, some confusion, putting milk in the closet instead of the refrigerator, losing weight, and has more pep with her shots. Doesn't tell us what her shots are. Doesn't tell us what medications she's receiving; does she have side effects; if the shots are indeed Copaxone, is she tolerating it; does she

Page 419

have side effects from the Copaxone; what other medications is she getting. We don't know anything about her neurologic status. We don't know what her symptoms are. We don't know if she's had attacks. There's no description, no information about her previous complaints. We don't know how her migraine headaches are doing, how is her pain doing, has she had new neurologic symptoms, has she had attacks. There's no information. The examination is listed as being unchanged, but for the fact she appears lighter and brighter. I'm not sure what that means. Otherwise, we have no information about a neurological examination. The standard of care, especially in a patient you've diagnosed with multiple sclerosis, you've begun on a new medication, that has a number of different problems, the standard of care would be to perform a neurological examination and a follow-up note. The assessment is MS plus anxiety. There is no other information. There is no information about why she's getting Plaquenil. Does she have a rheumatologic disorder? There's no information about her migraine headaches, no information about her other possible diagnoses, and there's no

Page 420

information about what other medications he is prescribing. Is she continuing to get Copaxone? Continuing to get Plaquenil? Has she gotten other medications? If so, what are the doses she's getting; doses, pills, how many is she getting, how many refills is she getting? There's nothing, no information.
Q. It says MS plus anxiety. With a diagnosis of MS, is that unusual?
A. Is it unusual if you have anxiety when you have MS?
Q. Yes.
A. No, it is not.
Q. If we go to page Medical Record 772, which is at Bates 212, if you could review that note and state whether or not that Dr. Padmanabhan's treatment was within the standard of care?
A. I have reviewed this note. It is below the standard of care.
Q. Why -- why?
A. The history as listed is incomplete and a sparse history. She feels generally okay. Good and bad weeks, describing her drop in pain. Some weeks where she trips. Aches and pains are better

Page 421

on Copaxone. So he tells us she's taking Copaxone. We don't know what other medications she's taking. Is she taking Plaquenil? Does she have side effects from the Copaxone? Aches and pains are better on Copaxone.
THE MAGISTRATE: Is this the first mention of Copaxone?
A. No, sir, this is not. Copaxone is not a medication for pain.
Q. (BY MR. PAIKOS) What does it do?
A. Copaxone is an immune modulator medication used to specifically treat the pathology causing multiple sclerosis. We have no information about other neurologic symptoms, nothing to indicate she's had exacerbations, has not had exacerbations. Usually, we like to know the functional status of somebody if we think they have multiple sclerosis. There is no other information about the possible rheumatologic disorder. She had been referred to get a second rheumatological opinion, presumably an opinion of a rheumatologist. No information about that. So there's quite limited information. About the examination, there is no examination. Examination is unchanged, so we have no information

Page 422

about the examination concerns. As previously discussed, the follow-up neurological examination is the standard of care, especially with somebody who you've diagnosed with multiple sclerosis.
Q. And there's a nursing note on that date, follow for headaches. She is pain free, as long -- quoting the patient, as long as I take the medication. Is there any assessment by Dr. Padmanabhan of the headaches?
A. No.
Q. Is that important, given that there was some mention or some concerns about migraines previously?
A. Yes. And in addition, he previously was prescribing Topamax for headaches. I don't know if he continued the prescription or not. There was no indication of that. Indeed, looking at the plan, there is no information with regards to any medication, so we don't know is she still taking Copaxone, has that stopped; is she taking Plaquenil; is she taking Seronil, is she taking Topamax, is she taking other medications. No information at all.
THE MAGISTRATE: Mr. Paikos, if I could

Page 423

jump in? Dr. Levin, remind me, R-O-S dash V?
A. Review of systems. Review of systems would be asking about other types of medical problems, difficulties with chest pain, shortness of breath, GI problems, joint pain, a multitude of different types of medical problems that you can have.
THE MAGISTRATE: And V-E otherwise?
A. I believe that's negative. I believe that's a dash, indicating negative.
THE MAGISTRATE: Thank you.
Q. (BY MR. PAIKOS) Now, if we go to -- excuse me -- Medical Record 857 to 859, which is at Bates 214, 215 and 216 --
A. Excuse me. I do have that.
Q. Okay. And what's the date of this encounter?
A. January 28th, 2011.
Q. And who is this a note from?
A. Davender Khera. D-A-V-E-N-D-E-R; last name is K-H-E-R-A, MD. And I believe beneath her name, it states neurology, so presumably, this is a neurology consultation.
Q. And at the bottom of Medical Record 857, 214, does it discuss follow-up by Dr. Dejager?

Page 424

A. Yes.
Q. And it says, patient was seen at MS center January 24th, 2011. Seen by Dr. Dejager. She was told that her MRI on 3/30/2010 showed no evidence of multiple sclerosis. Do you see where that is?
A. Yes.
Q. Is that the same one you reviewed?
A. Yes.
Q. And what does the -- what does Dr. Khera do in this note and conclude herself?
A. Dr. Khera performs a detailed neurological examination. As previously described, she does a quite excellent note where she goes through the history, neurological examination. She then formulates an assessment and plan.
Q. Okay. What's her assessment?
A. She notes that the patient came with a questionable -- or question mark history of -- excuse me -- history of question mark multiple sclerosis. Came to review her neuro-imaging and treatment plan. She reviewed the patient's MRI performed on 3/30/2011, and if I can quote her, there is an insignificant amount of white matter disease.

Page 425

THE MAGISTRATE: Okay, Dr. Levin. I see that. Thank you.
Q. (BY MR. PAIKOS) Did she find Dawson's fingers?
A. No.
Q. How was her clinical presentation, this patient, according to Dr. Khera?
A. Examination was nearly normal. She found a couple of changes in her examination. Did not make sense in terms of organic disease. So she found changes that were suggestive more of functional illness as opposed to organic disease. Her impression was that she did not believe the patient had multiple sclerosis and that the patient was told the same thing earlier this week at the Partners MS center.
THE MAGISTRATE: What's the difference between functional and organic?
A. Organic would relate to a specific physical problem. A functional problem is a symptom that typically will relate to emotional difficulties.
THE MAGISTRATE: So is this doctor saying it related to emotional difficulties?
A. Well, in her specific description of her --

Page 426

may I go back to her examination?
THE MAGISTRATE: Yes.
A. She describes the patient as having giveaway weakness. So patients can have giveaway weakness, which is when you go to examine them and they sort of give away their arm. That is not true weakness. If someone is truly weak, you examine the arm, examine the leg, and you'll find muscle weakness. You'll find problems in your examination. Someone who has giveaway weakness, you're pushing on their arm and they suddenly will give away, oftentimes in very dramatic fashion. That is not related to specific organic weakness, specific physical weakness, but rather, it's due to emotional changes which will cause that person to give away.
DR. PADMANABHAN: Objection.
THE MAGISTRATE: Basis?
DR. PADMANABHAN: Neither organic nor functional appears in that note.
THE MAGISTRATE: Dr. Levin, that's your interpretation of the note; in effect, the concepts of organic versus functional?
A. This is my interpretation of the doctor's

Page 427

examination.
THE MAGISTRATE: Overruled.
A. Should I continue?
THE MAGISTRATE: Yes, please.
A. The doctor also notes some sensory loss on the right side of her body that doesn't make anatomic sense.
THE MAGISTRATE: And which page is this?
A. Sorry. This is continuing the assessment and plan, page 859 --
MR. PAIKOS: Bates 260.
THE MAGISTRATE: Thank you.
A. -- of Dr. Khera. If you go to the first paragraph, the last line of the first paragraph, under assessment and plan, some sensory loss in the right side of her body that doesn't make anatomic sense. The sensory examination is performed to look for any changes in sensation, any abnormality of sensation, and this relates to a number of different types of sensation. I have to go back and look at which types of sensation she examined.
THE MAGISTRATE: Yes.
A. And you look for changes that are

Page 428

consistent with abnormalities within the nervous system, either the central nervous system and/or the peripheral nervous system, depending specifically on what different patterns of sensory loss, depending on where the abnormality is in the nervous system. So for example, if somebody has peripheral neuropathy, neuropathy, nerve damage in their legs, you'll see decreased sensation occurring peripherally, in the distal portion of the legs and the feet. If someone has had a stroke and it's on the right side of the brain, you may see a loss of sensation over the left side of the body. So these types of anatomical changes, observed sensory changes, can relate to anatomical abnormalities within the nervous system.
Her particular examination did not make anatomical sense. When we see somebody where we can't put the pieces together, there are several explanations. One is that we're just not able to do it. There are people who we're not able to understand with a single visit to make a proper diagnosis, but if you see someone like this patient who has some types of difficulty and then does have a sensory change, this is a sensory change that

Page 429

commonly will occur in functional illness. So interpreting -- and I can only conjecture as to Dr. Khera's opinion. Interpreting her examination, this would seem to suggest functional illness as opposed to organic or anatomical changes.
THE MAGISTRATE: A layperson would say this person is not really sick. Would that be a fair characterization from a layman's standpoint?
A. Sick is a very non-specific term and can relate to a large number of many -- of different medical problems. Sickness also involves -- sickness can involve organic disease. Sickness can involve emotional disease. I believe people with psychiatric illnesses would certainly be considered sick.
THE MAGISTRATE: So this doctor may be saying that this patient does not have organic disease?
A. That is correct. She's saying -- may I go back to her note? She's saying specifically, I do not think she has multiple sclerosis. And she goes on further, I told her that I do not think the problem is in the central nervous system based on the history I took and based on the normal MRI.

Page 430

Q. (BY MR. PAIKOS) So we have a diagnosis of not multiple sclerosis, and we don't have a diagnosis of what it is?
A. We do not -- if we go on further to the plan, there is a note. I urged the patient to speak with her PCP and psychiatrist about the next step and treatment of her full body weakness, pain, anxiety and depression. Again, the implication would be this is something going on that is not a neurological problem. She did not know specifically what it was. Certainly, psychiatric disease would be in the differential diagnosis for her symptoms, or at least some of her symptoms, but no, she did not find evidence of neurologic disease.
THE MAGISTRATE: So this doctor is ruling out neurologic disease and not making a diagnosis, but suggesting a possible diagnosis through a referral to a PCP and a psychiatrist?
A. She is suggesting further evaluation to see if a diagnosis can be made.
Q. (BY MR. PAIKOS) And does she continue with the Copaxone?
A. The recommendation was I do not feel the

Page 431

patient should continue on Copaxone.
Q. You mentioned that the medication has side effects. What are the side effects of this medication?
A. Many possible side effects. Common side effects include flushing reaction, where you get a feeling from your abdomen coming up over your entire body, redness, sometimes sweating and very intense flushing feeling. It doesn't last for a long time; typically ten, 15 minutes, sometimes longer. You can have injection site reaction. It's not uncommon. The medication is given through -- at this time, it was given by daily injections, given subcutaneously. Can cause local inflammation, areas of redness, soreness, sometimes can lead to atrophy. There can be areas below where the injection is where you lose fat tissue, you lose subcutaneous tissue. Those are the main side effects, the main -- allergic reactions are always possible. I have seen other more unusual side effects. I have one patient who is on Copaxone right now who I'm following because of liver dysfunction, and she's actually having worsening of her liver enzymes and liver function.

Page 432

I am concerned it could be the Copaxone that is causing that. It's uncommon, but a reportable side effect from Copaxone. There are many possible side effects, but those are some of the common ones.
Q. And if you will turn to the next patient, Patient H --
THE MAGISTRATE: Before you do that, if I could ask Dr. Levin, is there a problem with a patient receiving Copaxone who does not have multiple sclerosis besides the side effects?
A. Probably. I think in general, we don't wish to have our patients take medications that are not indicated. Copaxone specifically, we're talking about somebody taking a very expensive medication. I believe it's upwards of $1,200 a month to take this medication. The medication is given by daily injections, so there is some discomfort in the local. Side effects, you would have discomfort in the area of injection, again, the redness, the inflammation, and the potential for side effects. Those would be the main concerns. I think in general, we don't want our patients taking medications they don't need, certainly medicines that can cause them discomfort

Page 433

or potential harm.
THE MAGISTRATE: And do you have any thoughts on any anxiety that the patient might undergo who has a diagnosis of multiple sclerosis and then -- and doesn't actually have it?
A. Yes. That is a very significant problem. MS is a difficult disease to be diagnosed with. As discussed, it's an unpredictable disease. It typically is seen in patients ages 20 to 40, less common under 20, less common over the age of 40 at initial onset, so we're talking for the most part people who are young, people who are active, who are very vital. This type of person is then told they have a disease of the central nervous system that is unpredictable. It can produce a large variety of neurologic symptoms and you don't know when you wake up in the morning if you're going to have an attack. You could have been fine when you woke up, the middle of the day, and then by the end of the day, you're beginning to have paralysis and coordination difficulty, loss of speaking, loss of vision, so by itself, it is a diagnosis that will make people very anxious and very upset and concerned about what's going to happen. It's also

Page 434

a disease that can result in significant disability. People with multiple sclerosis can end up with severe neurologic problems, end up in a wheelchair. It can result in early death. Some people do quite well. But certainly, in answer to your question, it's a disease that makes people very anxious.

THE MAGISTRATE: Do patients administer Copaxone themselves?

A. Yes, usually themselves. Some people can't give themselves an injection, so a partner or close individual will do that for them.

THE MAGISTRATE: Are you aware of how much time it takes a patient who does have multiple sclerosis or has been diagnosed with it, how much it takes to manage that illness or that diagnosis on a daily basis?

A. It depends on the level of the disease. If somebody has no symptoms or has minimal symptoms and doesn't have any significant neurologic impairment, then the pain management of the disease would be the medication, so for example, with Copaxone, it would be the amount of time taken each day to prepare the medication, to give the

Page 435

injection.

THE MAGISTRATE: Do you know how long that takes?

A. To physically do it? I don't know specifically. My guesstimate would be half an hour or less to actually physically give the injection.

THE MAGISTRATE: I mean, the medicine, does it come in daily doses? Does it have to be mixed by the patient?

A. I would have to go back to -- well, no, 2011, this was a prefilled injector. They were prefilled injectors. Not everybody uses them. It's mixed. You take the syringe, inject yourself and it's done.

THE MAGISTRATE: Does it have to be refrigerated?

A. I don't believe so. I believe Copaxone can go 30 days without refrigeration, but you still have to be careful not to have extremes of temperature. But going back to your original question, many people, indeed most people with MS do have neurologic deficits, so depending on the deficits you have, obviously, if you have bladder incontinence, that's going to affect your day. If

Page 436

you have to walk with a cane, that's certainly going to affect you. If you have to use a wheelchair, that's going to affect your life.

THE MAGISTRATE: Well, I'm thinking about management for Patient G, who did not have multiple sclerosis, who is treating herself as if she did and how much time it took out of her day. Less than 30 minutes is your guesstimate?

A. Yes.

THE MAGISTRATE: Going as low as what? I mean, five minutes for an injection?

A. I suppose it's possible. I don't know. It depends how quickly they can prepare the syringe, give the injection.

THE MAGISTRATE: Thank you.

Q. (BY MR. PAIKOS) Doctor, you mentioned age ranges for multiple sclerosis when it's typically diagnosed. What were those age ranges?

A. Most common age is 20 to 40.

Q. Okay. Twenty to 40, you said?

A. Forty.

Q. The -- we have the medical record which has the patient's date of birth. On April 13th, 2010, what was her age, or thereabouts?

Page 437

A. Sorry. What year was this again?

Q. 2010. April.

A. I believe she was 44.

Q. So she was outside of the range?

A. No. Twenty to 40 is the most common, but certainly, 44 would not be what we'd call unusual.

Q. And directing your attention to the next record, which would be of Patient H -- Doctor, directing your attention to Medical Record 185, Bates stamped 217 at this Tab 9, and this is a note from October 26th, 2007. Under suggestive, it tells the age of the patient?

A. Yes.

Q. She's 64?

A. Correct.

Q. And what is her conditions and history, overall conditions and any neurological issues that she may have had in the past?

A. The patient is presenting as a new patient, establish care. History of metabolic syndrome, hypertension, hyperlipidemia, and a stroke 15 plus years ago with residual left lower extremity weakness.

Q. And after that, she denies any specific

Page 438

concerns today?
A. Excuse me. In addition, she has diabetes -- diabetes. Excuse me.
Q. And this is from the, if you look at the top, the RE Health Center in Revere?
A. Yes.
Q. And that's Cambridge Health Alliance letterhead, as we've seen in some of the other records as well?
A. Yes.
Q. And if we go to Medical Record 208, page 218, that's a December 17th, 2007, note. That's again the RE Health Center in Revere?
A. Yes.
Q. And what are her -- she has numerous diagnoses. Any that relate to potential neuropathic or immunological issues?
A. There's a note that she continues to have leg pain, mostly in the evenings, at night, described as achy in character. And the impression or the assessment was leg pain, peripheral neuropathy versus myalgias. Rule out restless leg syndrome.
Q. And neuropathy versus myalgias, what are

Page 439

those two things?
A. Peripheral neuropathy, neuro means nerve, opathy means a problem with, so neuropathy is a problem with a nerve. It doesn't tell us anything more about where the nerve is, the pathology, just that there's a problem with the nerve. Peripheral typically refers to problems in the legs. It may refer to the arms as well. So possible diagnosis is a problem with the nerves, presumably, in this patient in the legs and the feet, a peripheral neuropathy.
Q. So Doctor, if we go to Medical Records 286, 87 and 288, which are Bates stamped 220, 221 and 222, is that another MRI report? I'm sorry. What is that?
A. Excuse me. What page?
Q. It was Medical Record 286 to 288. Is that a note of Dr. Padmanabhan's?
A. Yes. This is a note from Dr. P.
Q. Okay. And does it relate some more history at the bottom of 286 to 287 about her stroke?
A. I do see the history is related.
Q. And what was the history and what other -- what did he put down in his note?

Page 440

A. He notes in his history that she had a significant stroke when in South Carolina. Has had further episodes of weakness of her left arm and leg, also heaviness and pain in her legs after walking certain distances and has numbness in her feet that comes and goes.
Q. What are his impressions?
A. His impression was an old stroke, possibly lacunar, in the right hemisphere with occasional symptomatic re-emergence that is possibly flow-related.
Q. Is that a reasonable potential diagnosis?
A. Yes.
Q. And why?
A. Given the history that she related, her symptoms -- give me a moment just to look at the examination. Looking at the history that he obtained, looking at his neurological examination, this would be a reasonable impression putting that information together.
Q. Okay. And was there an MRI ordered --
A. Yes.
Q. -- following this?
A. Yes.

Page 441

Q. If we could go to Medical Record 300 to 301? I'm sorry. Make sure I'm in the right record. Actually, 300 to -- Medical Record 300 to 303, Bates 223 to 226. What is that record, Doctor?
A. This is a report dated March 7th, 2008, of an MRI of the brain, non-contrast. Reason for exam, TIA back pain, neurogenic claudication. This continues as an MRA of the brain and an MRA of the neck.
Q. What's an MRA?
A. A stands for angiogram. So this is an MR study done with the MR image technique looking at blood vessels, so MRA of the brain would be looking at blood vessels of the brain; MRA of the neck would be looking at the blood vessels of the neck. MRA, angiogram. May I go back to the description?
Q. Yes.
A. The description is -- I'm going to read it and then perhaps interpret it. A moderate amount of subcentimeter T2 hyperintense foci are scattered in the periventricular and subcortical white matter, mostly in the frontal and parietal lobes. So he's saying subcentimeters, so these are very

Page 442

small areas of T2 hyperintensity, as we have previously discussed, in the periventricular region, around the fluid-filled spaces, subcortical, areas below the deeper portions of the cerebral hemispheres, mostly in the frontal lobe and parietal lobe. Frontal is front of the brain; parietal is further back in the brain. The pattern is non-specific. No lesions demonstrate Dawson's fingers. There is some involvement of the white matter along the callosal septal interface, so the area between the corpus callosum and going from that towards the white matter, there is some involvement there. There are no lesions within the corpus callosum or in the posterior fossa, so in the lower portion of the brain, there are no lesions in those areas.

His impression was moderate amounts of non-specific supratentorial white matter changes, so these moderate white matter changes. These are non-specific. They are involving the upper portions of the brain, not the brain stem, not the cerebellum. Common etiologies include microvascular ischemia, idiopathic changes, changes in blood vessels or non-specific changes that are

Page 443

not clinically significant. Potential etiologies include demyelinating disease, including multiple sclerosis.

The MRA study does not appear to show significant changes. There were some technical issues questioned of some narrowing of the internal arteries, internal carotid artery, both sides.

Q. Based on the MR report you have and the clinical picture of the patient, would this patient have MS?

A. No.

Q. And why not?

A. The clinical history is that something happened to her greater than 15 years ago. She was told that she had a stroke. She had weakness of her left leg and she's persistently had weakness of the left arm and the left leg. There's nothing to suggest that she's had exacerbations or remissions.

Looking at her neurological examination, the doctor found some fairly subtle changes involving the left side of the body consistent with the previous cerebral infarction. His diagnosis was indeed she had a lacunar cerebral infarction, which was a reasonable diagnosis. So

Page 444

there is no history to suggest multiple sclerosis. The MRI changes that I've described are non-specific and do not suggest multiple sclerosis.

Q. You mentioned the lacunar infraction. Does that relate back to the stroke 15 years ago?

A. Cerebral infarction.

Q. Infarction. Okay.

A. Cerebral infarction. May I go back and explain that a little bit?

Q. Yeah.

A. Cerebral infarct means that there's an area of decreased circulation to a portion of the brain. If that area's circulation is decreased for a long enough period of time, that part of the brain will die. When that happens, it's referred to as a stroke or an infarct. Cerebral refers to the portions of the brain. If the brain flow is restored, then that's referred to as an area of ischemia. If it comes and goes, it's referred to as a transient ischemic attack, so you can have a threatened stroke or you can actually have a stroke or an infarction. The lacunar relates to the size of the particular stroke. By definition of a lacunar infarct, it's ten millimeters or less, and

Page 445

pathologically, they're different from other types of strokes as well.

Q. So is what the MRI shows consistent with the stroke that occurred 15 years ago?

A. No.

Q. Okay. And you mentioned the change -- the weakness in one side of the leg and then the same side of the body. Is that significant relative to her stroke?

A. Yes.

Q. Why?

A. If she did have a right cerebral infarction, which was the clinical diagnosis from the doctor, that would be expected to give you weakness on the left side involving the arm and the leg. It can be one or the other. Sometimes we just see it in one extremity, but typically, it would be the extremities on the side contralateral to the area of the stroke.

Q. So is that -- is her symptoms consistent with the diagnosis of a stroke she had 15 years ago?

A. Yes.

Q. If you go to Bates 230, which is Medical

Page 446

Record 334, Medical Record 334 to 35 and Bates 230 to 231, is that a note from Dr. Padmanabhan?
A. What is the page number again, please?
Q. Medical record is 344 to 345.
A. I have reviewed the record.
Q. Okay. And on the first page, Medical Record 344 and Bates 230, it talks about the sagittal FLAIR sequence is extremely suggestive of multiple sclerosis, but it could be, paraphrasing, other symptoms. Is that a correct assessment based on the records you reviewed?
A. No.
Q. Why not?
A. I have not reviewed the images myself, but looking at the previous described report from the radiologist who officially read the study, the description is not of a study suggestive of multiple sclerosis. It shows a study which has non-specific changes, and that multiple sclerosis was within the differential diagnosis, but was unlikely.
THE MAGISTRATE: And the differential diagnosis again means what?
A. When you see somebody who has a medical

Page 447

problem, in formulating your impression, you go through the different possibilities for the diagnosis. So you say all right. I can see the problems that this person has and this would be consistent with having Diagnoses A, B and C. If someone presents with a cough, you could say all right. This person has a cough. Depending on the clinical circumstances, I might be concerned about the flu, I might be concerned about tuberculosis, I might be concerned about a lung tumor. The lateral diagnoses would be in the differential diagnosis of a cough.
THE MAGISTRATE: Is it fair to say a layperson would call it a possible diagnosis?
A. Yes.
Q. (BY MR. PAIKOS) Then on the next page, Bates 231, Medical Record 345, what were Dr. Padmanabhan's conclusions?
A. That she may have actually had an MS attack 15 years or so before, when she was in South Carolina, rather than a lacunar stroke.
Q. What information is there in the record up to this point that there -- that that is potentially correct?

Page 448

A. Nothing that I could find.
Q. Okay. And there's a mention about Dawson's fingers?
A. Yes.
Q. Is that mentioned in the radiologist's report?
A. Sorry. Do you have the date again, the page number for the radiologist's report? Excuse me.
Q. 300.
A. Page 300? It is mentioned in the radiologist's report. There was a note here, no lesions demonstrate the Dawson's finger morphology slash pattern of multiple sclerosis.
DR. PADMANABHAN: Objection.
A. He specifically mentioned that he does not see Dawson's fingers.
THE MAGISTRATE: Basis?
DR. PADMANABHAN: You asked, or Mr. Paikos asked Dr. Levin what he saw in my note, and I don't see a mention of lacunar stroke anywhere in my notes.
THE MAGISTRATE: It's not strictly an objection, but let's locate it for Dr. Padmanabhan,

Page 449

because I think I've seen it.
MR. PAIKOS: It is in the notes in the Bates 217 in a prior provider's record, so it may not specifically be -- and I can point it out. I'm not sure if Dr. Padmanabhan noted the years or not.
THE MAGISTRATE: Mr. Paikos, are you aware of it in Bates 230 or 231? Yes. It's on page 231. It is possible, given her history and her exam, that she has had MS and that the South Carolina episode was actually an MS attack rather than lacunar stroke. Dr. Padmanabhan?
DR. PADMANABHAN: There is nothing to suggest that this attack is the one that was referred to in the original document 15 years ago.
THE MAGISTRATE: So I'm going to accept Dr. Levin's testimony and overrule your objection.
Q. (BY MR. PAIKOS) So the MRI showed no Dawson's fingers?
A. That is correct.
Q. And part of the plan is to repeat the MRI in three months?
A. Yes.
THE MAGISTRATE: Mr. Paikos, I see you flipping through pages. It's getting close to

Page 450

one o'clock.
MR. PAIKOS: Yes.
THE MAGISTRATE: Is this a good time to break within this record?
MR. PAIKOS: Yes.
THE MAGISTRATE: All right. Let's take a one-hour break.
(Off the record.)
(Lunch recess taken from 1:00 to 2:03.)
THE MAGISTRATE: We are back on the record and Dr. Levin is still under oath.
RESUMED DIRECT EXAMINATION
Q. (BY MR. PAIKOS) Dr. Levin, do you remember being asked about an abbreviation, NKDA, yesterday?
A. Yes.
Q. Do you remember what it is now?
A. I did confer with our nurse, who tells me that it relates to no drug allergies.
Q. Okay. Going to Patient's Medical Record 435 to 436, which is at Bates 262 to 263 --
THE MAGISTRATE: I'm sorry. The Bates numbers again?
MR. PAIKOS: 262 to 263.
Q. (BY MR. PAIKOS) What is that? What is

Page 451

this?
A. This is an MRI report dated 7/2/2008. It's an MRI of the brain, non-contrast.
Q. Okay. And on 263, which is Medical Record 436, Bates 263, there's a line that says clinical indication. What is that?
A. That would be the information typically given to the radiology department by the ordering physician.
Q. And does it say on the prior page or this page who that ordering physician is?
A. Yes. Dr. P.
Q. And why -- why is that given?
A. It gives the interpreting radiologist an idea of the concerns of the ordering physician; tells him or her what potential diagnoses may be and at least some of their thinking in terms of why you are ordering the study. You would like the radiologist to look at the study in at least some reference to your clinical concerns about the patient.
Q. And in technique, what's the technique?
A. The technique describes the particular protocol that was used in doing the study. In this

Page 452

case, there is a standard MS, multiple sclerosis, department protocol. When MRI's are done, they use a variety of different techniques. Different settings are done on the machine so that you end up with a -- anywhere between I guess six to 12 different sets of images. Some of those are standard, done on every patient. Some would be different depending on whether you're looking for a stroke, whether you're looking for multiple sclerosis, what the particular concern you have is. And this is a description here of what was specifically done. There is a notation it was done using standard MS department protocol imaging.
Q. And under finding, what does this radiologist say the findings were?
A. Excuse me. If I may further comment on the technique, no IV contrast was given, patient refused. So with a typical MS protocol study, you like to see contrast, see if there is contrast enhancement looking for active lesions. This patient said that she did not wish to have contrast material.
THE MAGISTRATE: So how is contrast done and what is it the patient refused?

Page 453

A. An intravenous injection.
THE MAGISTRATE: And what does the intravenous injection do?
A. In brain MRI, which is, of course, what we're looking at here, if there are active areas of inflammation or if there is a breakdown in the blood-brain barrier -- normally, blood vessels come into the brain, they leave the brain, and there is no connection between the blood vessels and the brain as far as you can see on your imaging study. If there is a breakdown in the blood-brain barrier, then there will be a change in what you see on the imaging study, so for example, if someone has had a stroke, you may see changes in the blood-brain barrier, where if you give a contrast, you may see changes in the contrast in the brain. If someone has active multiple sclerosis, active areas of inflammation from MS, then you may see areas of what's called contrast enhancement, so you'll see white areas that will show up that did not show up or showed up much more poorly prior to giving them the contrast material.
THE MAGISTRATE: So this is an agent that is administered intravenously to a patient and

Page 454

that agent creates the contrast that shows up on an MRI?
A. Correct.
THE MAGISTRATE: And this patient refused to do it?
A. That's correct.
Q. (BY MR. PAIKOS) Doctor, if you -- it says under technique, compared with the prior exam from 3/7/08. Is that the note -- the exam we looked at earlier, the radiographic image note?
A. Yes.
Q. And is that something commonly done, important to do?
A. It is commonly done and it's important to do.
Q. Why is it important to do?
A. It's important to be able to contrast your present study with previous study to see if there's been any change. Has the patient gotten better, is the patient worse. Sometimes the pattern of change can be very helpful in terms of making a diagnosis. For example, patients with MS commonly will have a change in their MRI study. That's the reason we repeat studies oftentimes. In patients with MS,

Page 455

you do an initial study. It may be equivocal. You see some mild changes. You do a repeat study and you see different areas that are new. This will help you in making a diagnosis. Or someone may present with a new problem, someone has worsening headaches that they didn't have previously. You did the study a year ago, two years ago. It was normal. You do a study now. You see an area of distinct abnormality that indicates things have changed now. You're dealing with a brain tumor, or they've had a stroke, they have MS.
Q. If there are changes on it, would that be potentially indicative of an MS attack or that they're -- something happened in the brain that supports a diagnosis of MS?
A. Changes certainly occur when someone has an MS attack. In people who have MS, the correlation between their clinical course and the MRI findings oftentimes is poor. Most of the time, we'll see many more lesions, many more areas of abnormality on the MRI than we would appreciate given the patient's clinical course, and there is not a good correlation. In other words, someone who shows up with weakness in their left arm will not

Page 456

necessarily have an abnormality on the right side of the brain. If we're lucky, they will have it and we can say okay, that's what's going on there, but it's not like somebody who has a stroke, where we see the stroke on the right side of the brain and someone is showing left-sided weakness. With MS, frequently, we'll see many more abnormalities on the MRI than we'll see from what the patient reports to you clinically.
Q. Now, do you see the areas of findings and summary? If you could review those?
A. Perhaps I'll -- would you like me to read them and then interpret them?
Q. Yes.
THE MAGISTRATE: Actually, if I could interject, just interpret them. If you need to review them, I understand.
A. The description from the interpreting radiologist is that there are punctate white meta changes, so very tiny areas of increased signal in the white matter consistent with multiple sclerosis, with MS. The periventricular white matter on both cerebral hemispheres. I have some problems reading through it now. The description,

Page 457

the detail given to us by the radiologist is less than I would expect to have. It's less than we have on the previous radiologist's interpretation. This is not the exact type of detailed interpretation that you would expect.
THE MAGISTRATE: When you say previous, previous for this patient, or --
A. Yes. So we compare this to the previous MRI report. This one is much less detailed. It's much less exact, and the doctor -- typically, you make findings, you describe what you see and then you go to a summary or impression. What this doctor is doing is making a diagnosis while reading the study, while giving us the findings. Punctate white meta changes are noted consistent with multiple sclerosis. That's not typically what you do with a findings report. You would say this is what I see. These are where the areas are. This is what they look like. This is the localization, this is the distribution, and then give us a good description, and then in the impression or the summary, say this is what I've seen and this is consistent with the diagnosis of multiple sclerosis. So this -- it does bother me that the

Page 458

doctor does not give us a better description. The doctor does note that the findings are stable, stable in size, number and distribution, meaning that they're just the same as they were before. Can't tell if any of the lesions are active, because there's no contrast. There is no mention of the corpus callosum. There is a mention that the posterior fossa is normal, the brain stem area is normal. And then the summary is white demyelination, which is a very peculiar term. I don't believe I've seen that term before. Demyelination means that there is abnormalities involving the myelin. Typically, this would be white matter. So when you see white matter lesions, you typically say white matter demyelination. No change from prior MRI. So this doctor is look at this saying okay, this looks exactly the same as it looked before, and this is consistent with multiple sclerosis.

If we go back and we look at the interpretation of the previous doctor I cited that looks exactly the same according to this doctor, that doctor said these are non-specific changes, idiopathic, meaning of no clinical significance,

Page 459

and possibly, but unlikely -- I believe the term was unlikely multiple sclerosis.

Q. Now, Doctor, going to Medical Record 440, Bates 264 --

A. I have one additional comment, if I may.

Q. Yes.

A. I think the clinical indication was important. If we look at the clinical indication for this study and we look at the clinical indication for the last study, it's very different. May we go back and look at the previous clinical indication?

Q. Was it an indication for multiple sclerosis?

A. It was not.

THE MAGISTRATE: What Bates number, please, Mr. Paikos?

MR. PAIKOS: 252, Medical Record 425.

THE MAGISTRATE: And the Bates number is?

MR. PAIKOS: 252.

A. I'm sorry. The medical record?

Q. (BY MR. PAIKOS) 425, I believe. Oh, that might be -- no, that's the current one. I

Page 460

apologize.

A. Is it 280 -- or I'm sorry. Page 300? Is that correct?

Q. Medical Record 300, Bates 223.

A. So if we look at page 300, at the top of the page, reason for exam is TIA back pain, neurogenic claudication. The indication for this study, and again, the interpreting doctor stated moderate amounts of non-specific white matter change; less likely potential etiologies include demyelinating disease. In this particular study, the study on page 436, the clinical indication was multiple sclerosis. So this doctor is being told this patient has multiple sclerosis. He's now looking at the study and saying okay, you told me this patient has multiple sclerosis.

THE MAGISTRATE: Being told, or being told tentatively?

A. Clinical indication is multiple sclerosis.

THE MAGISTRATE: He's being told, and that's why it is not standard protocol?

A. It does not say rule out MS. It says MS. It doesn't say possible MS. It says MS.

THE MAGISTRATE: Is there a difference

Page 461

between clinical indication on your Medical Record 435, Bates 263, and reason for exam, your Medical Record 300, Bates 223?

A. I'm sorry. What was the second page, the last page?

THE MAGISTRATE: Reason for exam.

A. And that was page 300?

THE MAGISTRATE: 300. Is there a difference between clinical indication and reason for exam?

A. That's interesting. You've just drawn my attention to something I didn't notice. If we go to the bottom of page 435, normally, I would expect to see either reason for exam or clinical indication. If we go to the bottom of page 435, it states reason for exam.

THE MAGISTRATE: MS?

A. MS.

THE MAGISTRATE: And clinical indication, MS?

A. And clinical indication, MS. If we go to 300, reason for exam, TIA, back pain, neurogenic claudication; indication, transient ischemic attack.

Page 462

THE MAGISTRATE: And what's TIA stand for?
A. Transient ischemic attack.
THE MAGISTRATE: Oh, I see it right underneath.
A. So this doctor is told definitely this is a patient who has MS.
THE MAGISTRATE: Medical record 300, Bates 223 is from one doctor and Medical Record 435, Bates 262, that's from Dr. Padmanabhan. So it's from two different referring doctors.
A. I'm sorry. I'm not following you, sir.
THE MAGISTRATE: Medical Record 300, Bates 223 is from Steven Auerbach, MD.
A. He's the interpreting radiologist.
THE MAGISTRATE: He's the interpreting.
A. Interpreting radiologist, yes.
THE MAGISTRATE: But both ordering physician is Dr. Padmanabhan both times?
A. Correct.
THE MAGISTRATE: I see. So do we have an indication as to why the reason for exam in the indication is different?
A. I do not know that, no.

Page 463

THE MAGISTRATE: But the techniques are different, too, for the two MRI's. One is standard protocol for MS.
A. Yes.
THE MAGISTRATE: Would those lead to MRI's that would be comparable; you could compare and say there's no change?
A. Looking at the first study on page 300, that's dated 3/7/2008, you are correct. The study was performed using the sagittal T1; ah, but then sagittal FLAIR was added to the routine. So the patient did have a sagittal FLAIR as well. We do not know the specific technique used for the MS department protocol. Standard MS imaging would include sagittal FLAIR and would include an axial FLAIR study as well as contrast material, but in this case, of course, no contrast material was given.
Looking at the initial study, I would view that as being an adequate MS study.
THE MAGISTRATE: Allowing for a comparison between the two MRI's?
A. Correct.
THE MAGISTRATE: And allowing a

Page 464

conclusion that no change from prior MRI, Medical Record 436, Bates 263?
A. That is correct.
THE MAGISTRATE: Thank you. Mr. Paikos?
Q. (BY MR. PAIKOS) And prior to the MRI, had Dr. Padmanabhan begun to consider MS as a possible diagnosis, prior to this second MRI where there's an indication, clinical indication -- let me rephrase it. On the July 2nd, 2008, MRI, where there's a reason for exam, MS, and clinical indication of MS, prior to that, we had seen notes showing that Dr. Padmanabhan was considering MS?
A. May we go back to his previous note?
Q. Yes, and that's I believe at 344 to 345, Medical Record; Bates 230 to 231.
A. On this date, 4/7/2008, the doctor does discuss his reading of the MRI, and his reading of the brain MRI was different than the radiologist's reading of the MRI in that clinically, he does note his suspicion that she actually has MS.
Q. So this note from -- just to be clear -- from April 7th, 2008, is after the first MRI, which showed no Dawson's fingers, and this note is

Page 465

afterwards, but Dr. Padmanabhan says there is Dawson's fingers on the first?
A. That's correct.
Q. So this note of April 4th, April 7th, 2008, was before the second MRI of July 2nd, 2008, at Bates 262, Medical Record 435, where the ordering physician -- well, where it says reason for exam, MS; clinical indication, MS?
A. Correct.
Q. Was there a clinical indication for MS at the time of the second exam?
A. In my opinion or in the doctor's opinion?
Q. In your opinion.
A. In my opinion, there was not.
Q. And why not?
A. The patient's clinical history was not read as remissions and exacerbations. The clinical symptoms the patient had are not suggestive of MS. She had an episode that had occurred previously, I think we had discussed, in South Carolina many years ago that was stated to have been a stroke. Had originally felt that that was -- the original diagnosis was a lacunar infarction. I agreed with that assessment. I believe that was a correct

Page 466

assessment of the history that was obtained, as well as his examination of the patient, so there was no clinical history to suggest multiple sclerosis. And the report from the interpreting radiologist was of a study showing non-specific changes. That appeared to be a study consistent with multiple sclerosis.

Q. Directing your attention to Medical Record 440 --

THE MAGISTRATE: Mr. Paikos, if I could interject, before we move on, Dr. Levin, is there a connection or possible connection in your assessment between a clinical indication for MS and then the findings that are consistent with MS?

A. Is there a possible connection between the two?

THE MAGISTRATE: Yes.

A. Yes.

THE MAGISTRATE: What is that connection or possible connection?

A. The doctor who -- the clinical information for the study was multiple sclerosis. That was the clinical diagnosis. The PE's diagnosis was multiple sclerosis. And the doctor who read the

Page 467

study, the interpreting radiologist, also stated this study is consistent with multiple sclerosis.

THE MAGISTRATE: Is there a relationship between those two doctors, the first clinical indication by one doctor and the findings by a second doctor?

A. I don't understand the question.

THE MAGISTRATE: Did the clinical indication influence the findings, as best you can determine?

A. I was not the doctor. I was not the interpreting doctor. I can certainly conjecture as to what I think might have occurred.

THE MAGISTRATE: Yes, please.

A. I think that it's not unlikely that the radiologist who read the second study looked and saw the clinical diagnosis was multiple sclerosis and was therefore swayed in his reading to look at the images and give a diagnosis of multiple sclerosis. I think had the doctor not had that diagnosis, he may have been objective, and I suspect that he was not objective in his interpretation of the study. I think he was being more subjective. I think he was swayed. Seeing

Page 468

that he immediately makes the diagnosis in his findings, which is unusual, you wouldn't normally say I see punctate findings and this is consistent with MS. You would say I see punctate findings, here they are, tell us what's positive, tell us what's negative, think about it for a while and then come together with the impression. And he may at that point still say I see these clinical changes that I believe are consistent with multiple sclerosis, but the fact that he made such a quick diagnosis and also that he doesn't tell us why he feels differently than the other doctor -- he says no change from prior MRI. Sometimes certain doctors disagree with each other all the time, but if you are disagreeing, oftentimes, a doctor will say previous study was interpreted as being normal or as being non-specific; looking at the study today, I believe this is more consistent with a diagnosis of multiple sclerosis, or he might say given the clinical diagnosis of multiple sclerosis, then I find these MRI changes consistent with that diagnosis.

THE MAGISTRATE: And yet there are no changes?

Page 469

A. That is correct.

THE MAGISTRATE: So if the interpreting doctor was swayed by the clinical indication, an erroneous clinical indication led to erroneous findings?

A. That is correct.

THE MAGISTRATE: Thank you.

A. Not erroneous findings. Erroneous interpretation.

THE MAGISTRATE: Erroneous interpretation that appears under findings?

A. Right.

Q. (BY MR. PAIKOS) Have you seen that sort of scenario in your own practice?

A. I have. There have been instances where the radiologist has given me a diagnosis that I believe is incorrect, and it may be because he was given a clinical diagnosis, and then my goal -- I said listen, I think this clinical diagnosis was wrong. I don't think the patient has that. I think the patient has another disease. He may look and say well, you know, you're right. If the patient doesn't have that disease, then this is not consistent with the disease. And likewise, the

Page 470

opposite can happen. You tell them to go back. A study may have been read as non-specific and I go back and say we didn't tell you what was going on with this patient, but this patient has MS, and he'll look at the study and say oh, well, if the patient has MS, then what I thought was non-specific before really is more consistent. Now that I have more patient data, yeah, there is a little involvement of the corpus callosum that I really didn't appreciate, I should have looked more closely, and I think it is consistent with MS. That's the beauty of being able to look at these and other tests and discuss with colleagues.

Q. Now, directing your attention to Medical Record 440 to 442, which is at Bates 264 to 266, and if you could review that note, the note by Dr. Padmanabhan, let me know when you're done.

A. I have reviewed this report.

Q. And is Dr. Padmanabhan's care within the standard of care?

A. This report is below the standard of care.

Q. Why?

A. In reviewing the impression, excuse me, reviewing the history, he notes that she had been

Page 471

diagnosed with a stroke in South Carolina and I had doubted that diagnosis when I first saw her back in March of 2008. I believe in his note of March 2008, he had diagnosed her with a stroke, possibly a lacunar stroke. He had agreed that indeed he did not doubt the diagnosis, according to his notes. He notes that she has significant -- continues to have significant spasticity, while there was no previous report to indicate that she had spasticity. He describes her having some difficulty, left-right dragging getting up in the morning, knee doesn't bend, lots more charleyhorses, lots more cramps, more in the left leg than in the right. Otherwise, pretty much the same. Fatigue is an issue. And he describes her diet, her being diabetic, monitoring her blood sugar. There's no history here or there's little history to assess her for whether or not she has multiple sclerosis, any history suggesting present or past remissions or exacerbations, no real hard neurological findings except findings that relate to what had previously been called stroke. So she had difficulty with her left leg. She's had difficulties with her left leg for 15 plus years

Page 472

from what was said to be a stroke in the past. No evidence that this has gotten worse. No evidence of spasticity. So really nothing in the history to suggest multiple sclerosis.

Looking at his examination, and the examination is within the standard of care, he notes that the tone is normal in her legs and is normal in her arms. There's no evidence of spasticity. So he does not describe her as having increased tone. He states it very specifically. Tone is normal. She does not have spasticity, according to his examination. He finds that maybe there is slight increase in tone in the left leg, but is really minimal. Bulk is slightly reduced all over. Power is five slash five, so normal strength. Coordination is off on the left side still. So there are some mild left-sided value findings consistent with a previous right-sided cerebral abnormality. She is not ataxic, doesn't show any significant changes, no spasticity, no new findings, nothing that's really different from what he saw before when he diagnosed her with a probable old right cerebral infarction. So we have the MRI changes, which again, alone are not sufficient to

Page 473

make a diagnosis of multiple sclerosis, but we do not have any real clinical changes. She's also at this point 64, I believe, 65. He's postulating that perhaps this happened 15 plus years ago, which would have put her in her early 50's. A little old for onset of MS, certainly possible, but as far as we know, she's had no other intervening problems over the years. So one episode 15 plus years ago, left leg weakness, and no new neurologic symptoms over 15 years. That's not a diagnosis of multiple sclerosis.

Q. Spasticity, is that different than spasms?

A. Spasms are something that a patient describes where there can be a tightening of muscles. Spasms typically would imply that it's coming and going, or you can have muscle spasm that will be a more continuous spasm; muscle spasm in the back, for example, from irritation. If you have a disk problem, if you strained your back from lifting with muscle strain, you can have muscle spasm, a tightening of the muscles themselves. That's different than spasticity.

THE MAGISTRATE: Which I have in front of me. Thank you.

Page 474

A. Right. Which is as we described yesterday.
Q. (BY MR. PAIKOS) What was the plan for medication?
A. Plan was to begin her on CellCept.
Q. What is CellCept?
A. CellCept is a form of chemotherapy most commonly used for cancer patients.
Q. Is it something commonly used for MS patients?
A. No.
Q. Have you seen it used for MS patients?
A. I have never seen it used. I did look it up. I looked up the Brigham & Women's MS clinic site to see if they were using it, since they have a number of experimental protocols that they use, and they do list CellCept as one of the medications that they do occasionally use. I think it's very unlikely that they use this frequently. I think it's probably used very infrequently. This would be a third or fourth line drug. It's a very toxic medication. It has the potential for many serious side effects, including late onset cancers. Typically --
THE MAGISTRATE: It can create cancers?

Page 475

A. Correct, as a side effect. Places like the Brigham MS clinic have experimental protocols, so they have drugs that may be useful that they're using on an experimental basis. They also would tend to more commonly see patients who are very seriously ill, who have serious problems with their disease, with MS, and aren't responding to more standard therapies, so they would potentially be more likely to use types of chemotherapy, other potentially very serious medications in terms of being detrimental to the patients.
THE MAGISTRATE: Third line or fourth line means what?
A. That you would typically try one or two other medications before you would try this. It may even be further down the line. I've never in my career seen CellCept used. I've been doing this for a long time and I've seen a number of other experimental therapies over the years, but not CellCept, but again, it is in the Brigham & Women's website, so obviously, they do use it on occasion.
Q. (BY MR. PAIKOS) If we can go to tab -- which I will get for you, Dr. Levin, Tab 23C and 23D will be the next two. Please identify those

Page 476

two exhibits.
A. This is the reference that I got from the Partners Multiple Sclerosis Center on CellCept.
Q. And how do they -- how is it administered by them?
A. It's given orally, and they describe the forms that they use.
Q. And why is a protocol necessary with something like CellCept?
A. Because of potential serious side effects.
Q. And if you go to the next tab, this is a computer printout, and have you written something at the top?
A. I did.
Q. What did you write?
A. This is part of the handout on CellCept, and this is from -- I believe this is -- oh, this is from Up To Date. This is from the -- it's really a computer textbook called Up To Date. And I couldn't print the whole thing, so I printed some of it.
Q. Okay. And does that discuss some of the reasons for the medication and its impact, side effects?

Page 477

A. It does.
Q. And are there warnings that come with the medication? I can take that back from you.
A. Yes, it has a boxed warning, what's referred to as a boxed warning.
THE MAGISTRATE: Mycophenolate is CellCept?
A. That's correct. The boxed warning states, experienced physician, only health care providers experienced in immunosuppressive therapy --
THE MAGISTRATE: Okay. I can see that. Thank you.
Q. (BY MR. PAIKOS) And there is also mention in the medical record we were looking at of another prescription for baclofen. What is -- I think we talked about baclofen yesterday. What is that for?
A. Baclofen is an anti-spasticity medication.
Q. Is there a clinical reason in this note for the baclofen?
A. The clinical reason given is that she has -- excuse me. Backing up, under impression, it states multiple sclerosis. There's no clinical discussion of spasticity. He does mention in the history, she continues to have significant

Page 478

spasticity, but then in his examination notes that he did not find evidence of spasticity. And impression is multiple sclerosis with no mention of spasticity.
Q. Under the description of the examination, would baclofen be the correct medicine to prescribe?
A. Looking at the examination as listed --
THE MAGISTRATE: Mr. Paikos, which Bates or page number, please?
MR. PAIKOS: The examination is at 265.
A. Looking at the examination as listed in this progress note, there is no indication for that.
Q. (BY MR. PAIKOS) And what are the negative side effects? What are the side effects of baclofen?
A. The main side effect is fatigue and weakness. Sometimes patients who take baclofen can develop significant weakness, if, for example, they're having some weakness related to the process causing spasticity and they can no longer get out of a chair, they can no longer walk because of the weakness, and it can also cause significant

Page 479

fatigue.
Q. If you go to Medical Record Number 454, Bates 257 --
THE MAGISTRATE: Is the weakness as a side effect reversible?
A. Yes.
Q. (BY MR. PAIKOS) And that discusses some of the financial and stresses she has associated with the medication and with the multiple sclerosis?
A. Yes.
Q. Multiple sclerosis diagnosis, I should say.
A. Yes.
Q. Now, if we go to Medical Record 549, Bates 275 --
THE MAGISTRATE: Before you do, Mr. Paikos, so Dr. Levin, I'm looking at Medical Record 454, Bates 267, and the progress note by a social worker. And the patient is experiencing anxiety or stress of being newly diagnosed and financial stress. As far as you know, how expensive is managing MS?
A. It can be quite expensive, depending on the medication. The MS medications, standard medications, are upwards of a thousand dollars a

Page 480

month. I don't know how expensive CellCept is and I don't know what medication she actually got from looking at this, this sheet, but the -- these medicines are very expensive.
THE MAGISTRATE: So Mr. Paikos, is this part of your case, that an incorrect diagnosis led to this stress and the financial stress?
MR. PAIKOS: I think it -- yes, potentially.
THE MAGISTRATE: If that's your case, if you could give me information, please, about the cost of medications that this patient was prescribed or misprescribed --
MR. PAIKOS: Okay.
Q. (BY MR. PAIKOS) If we go to --
THE MAGISTRATE: -- and in a relative sense, anything else we know about this patient's finances and insurance.
Q. (BY MR. PAIKOS) If we go to Medical Record 549, Bates 275?
THE MAGISTRATE: Bates 265?
Q. (BY MR. PAIKOS) Bates 275, excuse me. The medical record for 549. This is a telephone consult with the initials BP at the end. It

Page 481

discusses Avonex. What is Avonex?
A. Avonex is one of the standard immune modulating medications for MS.
Q. Did you see any notation of when it was prescribed by Dr. Padmanabhan?
A. No.
Q. Other than this?
A. No.
DR. PADMANABHAN: What page are you?
MR. PAIKOS: Medical Record 549, Bates 275.
Q. (BY MR. PAIKOS) Would it be in the standard of care to fail to know that you're prescribing Avonex to a patient?
A. The standard of care is to indicate in great detail that you are prescribing this medication, including a discussion of why you're prescribing it, how it's being given and the potential side effects for the medication.
Q. If we could move to the next record? Now, Doctor, you reviewed approximately 2,000 pages for Patient I?
A. Yes, sir.
Q. And as with the other records, did you as

Page 482

part of the preparation provide certain records or numbers or page numbers that were -- more or less provided background or were relevant to this specific hearing?
A. Yes.
Q. Would it be safe to say the first 900 or a thousand pages in the record, if you can say it, provided background from other providers and other information?
A. Yes. Some of those were really quite important background in terms of understanding the patient and understanding what occurred later with the patient.
Q. If we could go to Medical Record 71, Bates 277? And that number provides some -- and it's a 9/25/06 emergency note. It provides some past medical history.
A. Yes.
Q. And what is -- it lists chronic migraines, thyroidectomy, tonsillectomy and ovarian cysts from Medical Record 71?
A. Yes.
Q. And the migraines is the -- is a neurological condition?

Page 483

A. Yes.
Q. If we could go to Medical Record 310, Bates 288? And is this a brain MRI ordered by Dr. Padmanabhan?
A. Yes.
Q. Is this -- if you could go to the findings -- well, actually, if you could just go to the impressions first? Does this person -- or let me strike that. If you could review the report yourself and provide us an assessment if there is multiple sclerosis or neurological issues with this patient?
A. This is a radiologic report. This is an MRI report. The diagnosis of multiple sclerosis would not have been made on the basis just of an MRI report. An MRI report can be suggestive and quite helpful in terms of making the diagnosis either positively or negatively. That being stated, the study that you're discussing right now of 2/29/2008 brain MRI non-contrast showed mild and non-specific changes. There were several scattered gray white matter areas of high signal intensity. The doctor notes they may be related to migraine headaches. These are non-specific findings that

Page 484

frequently can be seen with migraine headaches. Demyelinating process is in the differential diagnosis, but is less likely. If we look at the findings that the doctor describes, she's describing scattered areas of very small increased signal intensity, high FLAIR -- typically, high FLAIR, high T2 signal measuring 1.5 to two millimeters. So these are very small areas, likely representing non-specific findings.
Q. So does this person have MS?
A. Once again, the diagnosis of MS would be made clinically. This MRI report does not support, or to my reading suggest MS.
Q. Does it support any kind of inflammation?
A. No.
Q. Inflammation of the central nervous system?
A. No. This is essentially a mildly abnormal to normal study.
Q. If we could go to Medical Record 2047, Bates 440?
A. Two thousand?
Q. 2047.
DR. PADMANABHAN: 2047?
MR. PAIKOS: 2047, yes, at Bates 440.

Page 485

THE MAGISTRATE: If anybody needs a break in the last hour, let me know.
MR. PAIKOS: It may make sense to break just to kind of figure out at least how to sort the records, given that there are a large amount. It would be great for a break in general.
DR. LEVIN: I have the record if you wish.
MR. PAIKOS: I think a break may be good for me as well.
THE MAGISTRATE: A five-minute break?
MR. PAIKOS: Yes.
THE MAGISTRATE: Five minutes.
(Off the record.)
(Recess taken from 2:57 to 3:03.)
Q. (BY MR. PAIKOS) Doctor, I'm going to redirect you again to Medical Record 86 to 87, Bates --
A. 2047, you didn't want that?
Q. No, not yet.
A. Excuse me. What page again, please?
Q. Medical Records 86 to 88, Bates 279, 280 and 81.
A. I'm sorry. Once again. The pages that I

Page 486

have, I don't have Bates.
Q. Medical Record 86.
A. I do have those pages.
Q. Okay. And this is a CT, head without contrast, from October 2006?
THE MAGISTRATE: The Bates number again, Mr. Paikos?
MR. PAIKOS: Bates 279, 280 and 81.
A. CT scan of the head without contrast dated 10/10/2006. This was a normal study.
Q. (BY MR. PAIKOS) A normal study? So would this be able to note inflammation, a CT study?
A. Possibly.
Q. And going to Medical Records 245 to 246 -- excuse me. If you could go to Medical Record Number 2064 at Bates 457?
A. Sorry. Page number?
Q. Medical Record 2064 at 457.
A. And that's Medical Record 2064?
Q. Yes. What is that?
A. This is a note dated 2/28/2008, and it is a -- appears to be a prescription for Depo-Medrol, one vial, and Xylocaine, one vial, both now, please.

Page 487

Q. What are these medications typically prescribed for?
A. Oftentimes for trigger point injections.
Q. Is there anything in the notes up to this point that would justify the -- these medications?
A. I don't believe we've gotten to any -- sorry. The answer is no.
Q. Okay. We'll go to Medical Record 2048, Bates 441. And at the bottom, what is there?
A. I see a progress note dated 4/11/2008 from the doctor.
Q. Okay. If you could review the note and state whether or not it's within the standard of care?
A. This is below the standard of care.
Q. And why?
A. The -- there is a history of different symptoms that the patient is experiencing. There's worsening of pins and needles, heaviness in the legs. I believe this is soles all a-tingle. Balance is decreased. Denies bladder trouble. Rest as before. So there is new symptoms that the patient is experiencing, a number of new symptoms, suggestive that there may be a new neurological

Page 488

problem. The examination states no change from last evaluation. I don't know what the last evaluation showed. In a patient who presents with multiple new neurologic symptoms, the standard of care is to perform a neurological examination, as we have previously discussed. The assessment and plan, I see question mark inflammation, bulging disk. There's no other information given in terms of impression. And then plan, for MRI, cervical, thoracic and lumbosacral spine and returning to clinic after the MRI, that is within the standard of care.
Q. Okay. And if we go to Bates number three -- I'm sorry; Medical Record Number 343-347, Bates 292 to 296. So that's Medical Record 343, starting there, and Bates 292. Let me know when you're at Medical Record 343, Doctor.
A. I have record number 343.
Q. Okay. And that shows an MRI at lumbar spine, non-contrast, ordered by Dr. Padmanabhan?
A. That's correct.
Q. And if we go to the next page, what's the impression?
A. Minimal degenerative changes, facet joints,

Page 489

L5. Otherwise unremarkable. Basically, a normal study.
Q. Does it show inflammation of the central nervous system?
A. No.
Q. Is the spine part of the central nervous system?
A. The spine is part of the central nervous system.
Q. If we go to the next page, Medical Record 343, Bates 294?
A. Excuse me. The next page, 343 or 345?
Q. Medical Record 345, Bates 294, is that another MRI order from Dr. Padmanabhan?
A. Yes.
Q. And what is it? What part of the body?
A. The thoracic spine.
Q. If we go to the next page, Medical Record 346, Bates 295, what's the impression?
A. Unremarkable MRI of the thoracic spine.
Q. And lower down in that page is another MRI ordered, for the MRI of -- it says cerv spine without and with contrast. What does that mean?
A. This is an MRI of the cervical spine

Page 490

without and with contrast.
Q. And what are the impressions on the next page?
A. Unremarkable cervical MRI.
Q. And these were done about 4/11/08?
A. Yes.
Q. If we go to another part of the record, Medical Record 2047, which is Bates 440, and if you could review that note and state whether or not it's within the standard of care?
A. This is below the standard of care.
Q. Why?
A. The history as related is that she continues to have cervical spasm and other inflammatory complaints. To see Dr. Romain, the rheumatologist. Tests done. Does not give us any information except for cervical spasm. I don't know what the inflammatory complaints were. It's a non-specific term. Can include many, many different types of concerns. We have no other information in terms of the patient's history. That is below the standard of care. To see Dr. Romain, generally, that would be in the plan as opposed to the history unless it had been

Page 491

previously noted. The examination is stable. So we don't know anything at all about her neurological examination. Again, that's below the standard of care. A patient who is having active complaints, we would expect to see at least a focused neurological examination. MRI was reviewed with the patient. It does not state which MRI was reviewed. We don't know if this is the brain or one of the spinal MRI's. This is a note that there were a few white spots. And he mentions no MS diagnosis, I don't know what that next word is. It says diagnosis something -- oh, diagnosis for now. Excuse me. I'm looking at this. I think this is continued on two lines. No MS diagnosis for now. Will watch. That's under objective. That's under information about the exam. The assessment and plan, autoimmune inflammation. I don't know what that means. That's a non-specific term. It doesn't tell us the part of the body it refers to. It doesn't give us a definite diagnosis. Coordinate closely with Dr. Romain, and then a prescription, Plaquenil and Percocet prescription given, that is below the standard of care. There's no dose, no number of pills, no number of refills

Page 492

and we don't know why it's being prescribed. No information about the medications.
Q. And Plaquenil, is that a medication we talked about yesterday or the day before? What is Plaquenil?
A. It's a medication used for rheumatologic -- typically, for rheumatologic disorders.
Q. And prior to this, there were the MRI's of the brain and parts of the spine. Did those show inflammation?
A. She had MRI of actually the entire spine, cervical through the lumbar, and those did not show evidence of inflammation.
Q. Do you know what were the diagnosis -- where the diagnosis or the assessment of inflammation comes from?
A. I don't.
Q. If we go to Medical Record 359, Bates 297, Medical Record 359, Bates 297, is this is an orthopedic note? I'm sorry. Rheumatological ops note ordered by the orthopedic department at Medical Record 359?
A. This is a note that states reviewed and electronically signed by Paul Romain, MD. A

Page 493

different doctor actually dictated it.
DR. PADMANABHAN: I have one page.
Q. (BY MR. PAIKOS) Doctor, referring you to the history of present illness, does it give the patient's history there?
A. It does. This is a very detailed history of present illness.
Q. Okay. And what does it include on page 359?
A. The doctor notes a long, complex history of a multitude of complaints, including recurrent migraines for which she is under the care of Dr. P., limited blurred vision, low back pain for many years, sacroiliitis on the right with bursitis.
Q. And Doctor, if I can direct your attention to another note, to Medical Record 2045?
A. Perhaps one further comment in terms of neurological symptoms. She described paraesthesias and numbness on her right more than her left lower extremity.
DR. PADMANABHAN: Where?
Q. (BY MR. PAIKOS) Are you at page 359, Doctor?

Page 494

A. Sorry. I'm at page 360.
Q. Okay. We'll stay with 359 and stop the review there.
A. Excuse me.
Q. If we go to page Medical Record 2045, which is Bates 438 --
A. Sorry. Which medical record number again, please?
Q. Medical Record 2045.
A. 2045?
Q. Yes.
A. All right. I have that report.
Q. Okay. And what is this? Is it from May 9th, 2008?
A. It is. What I see is listed under progress notes. [Patient I] came in for trigger point injections and --
THE MAGISTRATE: Is that the patient?
MR. PAIKOS: Yes.
THE MAGISTRATE: Okay. I'm going to block that out in my copy and ask Ms. Wharram to use Patient I.
A. Excuse me. Patient came in for trigger point injections, and there's a description of the

Page 495

medication used. There is a diagram showing where the injections were given.
Q. And what -- what are those medications?
A. DepoMedrol and Xylocaine.
Q. And does it say what the injections are for? What are they treating?
A. It does not.
Q. What are those medications typically prescribed for?
A. Trigger point injections.
Q. Okay. What condition?
A. Patients with fibromyalgia may have trigger point injections in areas of pain or painful muscle contraction. Can be used for non-specific types of muscle pain on occasion.
THE MAGISTRATE: If I could ask a question, Dr. Levin? We've seen a couple of these diagrams indicating where the injections are going in the torso. Is the absence of such a diagram when a doctor gives injections below the standard of care?
A. No.
THE MAGISTRATE: They're kind of optional?

Page 496

A. Yes. If there's no diagram, then the standard of care would be to state where the injections were given.
THE MAGISTRATE: Does this diagram indicate -- well, does it have to be the back? Is it clear which side is the right and which side is left?
A. It is not. Just looking at this particular note, I would say this is below the standard of care, because I don't understand where the injections were given either. The usual course, the standard of care would be to state how many injections were given, what medication was used, the amount of medication that was given, where the injections specifically were given and how much of the medication was injected at each spot.
THE MAGISTRATE: Can trigger point injections go on the front or the back of the torso?
A. My guess would be the answer is yes. I'm trying to recall if I've ever seen or heard of a trigger point injection -- yes. Excuse me. The answer to your question is yes.
THE MAGISTRATE: It can be front or

Page 497

back?
A. Yes.
THE MAGISTRATE: So it's not clear -- there's no right or left on this diagram?
A. That's correct.
THE MAGISTRATE: Thank you.
Q. (BY MR. PAIKOS) Doctor, getting to Medical Record 2094 at Bates 475 --
DR. PADMANABHAN: Which page, again?
MR. PAIKOS: Medical Record 2094, Bates 475.
Q. (BY MR. PAIKOS) Doctor, what's the date of this note?
A. 5/15/2008.
Q. And is this from Dr. Padmanabhan?
A. Yes.
Q. And it's an attending physician's statement and gives us idiopathic CNS inflammation. If you could assess whether this diagnosis is -- is within the standard of care, the diagnosis that Dr. Padmanabhan makes in this document?
A. The diagnosis is below the standard of care.
Q. And why?

Page 498

A. Stated diagnoses are idiopathic CNS inflammation with associated systemic inflammation, parentheses, mixed connective tissue disease, end parentheses. I don't know what idiopathic CNS inflammation refers to. That is not a standard diagnosis. The statement that it's associated with systemic inflammation again is quite vague and non-specific. Mixed connective tissue disease is a specific diagnosis, and that by itself would be within the standard of care, but when put in together with the other diagnoses, it's quite confusing. I don't understand what the diagnosis is.

Q. And under that same, you know, section one, what's her -- the last line about her prognosis is she'll need lifelong care and treatment?

A. Yes.

Q. And he discusses in section two the disability from work. Does that -- based on what we've seen in the record, is that a correct conclusion as to this patient or something that can be discerned regarding this patient?

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

Page 499

Q. Were there clinical indications in the record that you saw previously that support this conclusion, that she has spasticity and connective tissue pain all day long?

A. I do not recall seeing other information in the medical records or in his notes that would support this information.

THE MAGISTRATE: Mr. Paikos, do we know the source of this, other than the medical records, what it was used for?

MR. PAIKOS: No, I don't believe we do.

THE MAGISTRATE: I mean, it's not something that another doctor would look at.

MR. PAIKOS: I'm not sure, but it appears to be something related to disability.

THE MAGISTRATE: Well, let me ask Dr. Levin. Is this the kind of thing that if a doctor found in a medical file that a doctor would look at this or discount as not being in a typical format?

A. I would look at this. I definitely -- I think a doctor typically, if there is a statement of disability, that would be an important part of the medical record that you pay attention to.

Page 500

Q. (BY MR. PAIKOS) If we go -- that's a May 15th form filled out by Dr. Padmanabhan. If we could go to Medical Record 382, 383 and 384, which is at Bates 299, 300 and 301; again, that's Medical Record 382, where it begins, and Bates 299.

A. Excuse me. That was 382, 383 and 384?

Q. Yes.

A. This is a report from the rheumatologist, from Dr. Paul Romain.

Q. And does it say under history of present illness why she's there?

A. Yes.

Q. And why is she there?

A. For question of lupus.

Q. And that's a rheumatological disease?

A. Yes.

Q. Now, at page 384, Bates 301, under impression at page 384, this doctor, Dr. Romain, gives an impression?

A. He does.

Q. And did he make conclusions relative to what the patient had or didn't have?

A. Yes.

Q. What did he state that she did not have?

Page 501

A. He found no evidence of articular disease specifically or any systemic autoimmune or inflammatory rheumatologic disorder.

Q. Does he talk about the medication being prescribed by Dr. Padmanabhan?

A. Yes.

Q. And what is he -- what's the name of that?

A. Hydroxychloroquine. That's also known as Plaquenil.

Q. And what is his assessment of whether he sees a reason for it?

A. He saw no indication for use of this medication.

Q. And does he indicate why, or the -- his lack of findings?

A. He states that she has no evidence of a rheumatologic disorder and that he saw no indication for the use of this medication.

Q. Now, if we go to Bates -- excuse me; Medical Record 2061 at Bates 454, that was a May 15th note that we just saw. And that's 2061 for the medical record, Bates 454.

A. I have that record.

Q. And is this order form for medication by

Page 502

Dr. Padmanabhan?
A. There are two notes on this page dated 5/20/2008 and seven -- I believe 7/30/2008. The 5/20/2008 is an order for Xylocaine, one vial now, and DepoMedrol, one vial. Send stat, please. Below that is an order for Botox, 100 international units, one vial.
Q. Were these appropriate medications to prescribe?
A. I don't know why they were prescribed.
Q. Okay. And is that within the -- given the lack of inflammation that we saw on the MRI's -- well, what are these medications typically prescribed for?
A. Xylocaine and DepoMedrol --
THE MAGISTRATE: We have this on the record, right, for all three meds?
MR. PAIKOS: Yes, we do, actually.
THE MAGISTRATE: Okay. Thank you.
A. Those are, as previously described, for trigger point injections. Botox can be used for a variety of neurological conditions, chronic migraine, dystonias, particularly cervical dystonia. Can be used for significant problems

Page 503

with spasticity; for example, spasticity related to a stroke or to cerebral palsy. I believe we discussed these in some detail yesterday. There is no indication on these notes nor in any other progress notes that I saw as to why these were being prescribed.
Q. (BY MR. PAIKOS) Doctor, I'll ask you to go back to the electronic medical record, 424 for the medical record number, Bates 302.
A. I have that record.
Q. And what is this record, from whom?
Medical record 424 to 425, 302 to 303 for the Bates numbers.
A. The signature is Anatoly Shalnov, A-N-A-T-O-L-Y, Shalnov, S-H-A-L-N-O-V, MD. And Dr. Shalnov is in the orthopedic department, although I believe that that is not his specialty.
Q. Do you remember seeing his name in prior records?
A. Yes.
Q. And do you remember there being potential referrals or suggested referrals to him?
A. Yes.
Q. Do you remember what they were for?

Page 504

A. For specialized pain medicine.
Q. Okay. And on the page Medical Record 424, Bates 303, does he also discuss the MRI's and the past medical history, or in the past medical history?
A. There is a discussion of the past medical history. I do not see a discussion of past MRI's.
Q. In the -- on page 425, under past medical history, the patient underwent, prior to the section that has medication list?
A. Thank you. I do see that.
Q. Okay. And does he comment on those MRI's and other, I believe, x-rays as well?
A. The patient underwent extensive radiological evaluation, including MRI of the cervical spine, lumbar spine, brain, multiple x-rays. All of them are not remarkable.
Q. And what does that mean?
A. That the studies were essentially normal.
Q. And under his impression, does he give a recommendation as to whether there should be opioids?
A. Yes.
Q. And what is that?

Page 505

A. Opioid medications are definitely not indicated.
Q. If we could go to the Medical Record Number 2058, Bates 451?
A. 451?
Q. Yes.
A. I'm sorry. 058 --
Q. 2058 --
A. So my number is 2058.
Q. 2058.
A. I have that page.
Q. And that's a prescription for Solumedrol by Dr. Padmanabhan?
A. Yes.
Q. What is that?
A. Solumedrol is an intravenous steroid.
Q. And what is that typically prescribed for?
A. For inflammatory conditions. It can be used for patients who are having exacerbations, attacks of multiple sclerosis. It can be used for serious inflammatory conditions like sepsis. It can be used with serious inflammation due to lung problems. Solumedrol is also used for treating cancer patients. There's a significant history, so

Page 506

this is a significant -- it's a large dose of steroid intravenously.
Q. And if you could go to another medical record number, 2079 at Bates 472? The last prescription was July 11th, 2008, and I asked you to look at the 2079 medical record number at Bates 472.
A. I have that page.
Q. And what else did Dr. Padmanabhan prescribe on those dates?
A. Prilosec, Toradol, Percocet and Klonopin.
Q. And Klonopin is what?
A. Klonopin is a benzodiazapine. It's an antianxiety sedating medication.
Q. And Percocet is what?
A. That is a narcotic. It's an opioid.
Q. Anything you've seen in the record that explains why the patient is on these particular medications?
A. No.
Q. Now, if you could go to -- that was a July 11th, 2008, note. If you could go to Medical Record 562 for the patient, Bates 309, does this indicate the patient is on some sort of methadone

Page 507

program?
A. Yes.
DR. PADMANABHAN: Objection.
THE MAGISTRATE: Basis?
DR. PADMANABHAN: Attention needs to be paid to the date of the note. I was not working at that clinic and the patient was not my patient on that date.
THE MAGISTRATE: Okay, so you can bring that out in your case.
Q. (BY MR. PAIKOS) If we could go to Medical Record 2080, Bates 473, Doctor? Again, that's Medical Record 2080, Bates 473.
A. I have that record.
Q. Is this something showing that the patient was on Solumedrol at this time?
A. Yes.
Q. And the longer a patient is on this drug, the likelihood that there will be a negative side effects increases?
A. Yes.
DR. PADMANABHAN: Bates 480, you said?
MR. PAIKOS: Medical Record 2080, Bates 473.

Page 508

A. Sorry. Did you want me to comment on this note?
Q. (BY MR. PAIKOS) Yes. I'm sorry.
A. All right. This is a note of November 11, 2008. It indicates the provider assessment. The signature is from a nurse. Doctor -- the doctor is listed as the provider.
DR. PADMANABHAN: Which page are you?
A. And provider assessment is please set up for Solumedrol IV for three -- times three days starting on 11/12.
THE MAGISTRATE: Bates 473.
Q. (BY MR. PAIKOS) Doctor, if you could go to Medical Record 2031, Bates 424? And if you could review that note and state whether or not it's within the standard of care?
A. This note is below the standard of care.
Q. And why is it?
A. The history, fall on the ice this morning, felt a sharp pain in right buttock going down the leg. Also has had -- I believe it says CL -- I'm not sure if that means chronic -- migraine now for 30 days, photophobic. Examination states negative straight leg raising test, no loss of reflexes.

Page 509

Rest as before. That is an inadequate examination for a neurologist. That is below the standard of care. The patient has fallen. There is concern of an acute injury. We don't know what the back examination showed. We don't know what her sensation was, her strength, her gait. In addition, she has had headache, migraine for 30 days, suggesting the need for further neurologic examination to ensure that there is no serious brain problem that's causing that. There is no examination to tell us whether or not there was a problem. The assessment is migraine with aura. The history does not indicate an aura. History notes that she is very photophobic. That is not the same as an aura. The aura are changes that occur with the migraine. Loss of vision, blind spots, flashing lights, jagged lines is the typical aura that people will have. There is no history to suggest that she had an aura. Continue prophylaxis plus Imitrex, with no indication of what the prophylaxis is. I don't know what medication she is getting for the prophylaxis. We don't know the dosage of Imitrex. There are different dosages you can prescribe. We don't know how many pills, how

Page 510

often she's getting them, how many refills. We don't know anything about it. We don't know anything about other medication she's getting. Is she getting other medication, is she getting injections? Again, no indication. There's also no indication of any plan for follow-up.

Q. If we could go to a note at Medical Record 2032, Bates 425, April 29th, 2009? And that's Medical Record Number 2032, Bates 425. And if you could review it and let me know when you have reviewed it?

A. I have reviewed this record. It is below the standard of care.

Q. And why?

A. Portions of this record are difficult to read. I will do my best to interpret it. There is a note that the ganglion is still present and hurts. There is no indication of where the ganglion is. I did not see a previous note indicating that there was a ganglion. We know nothing about that. The -- I believe this reads the whole body ache is -- I believe the word is gone, but I'm not sure. Joints, too, I don't know what that means. Hands and feet burn. Migraines

Page 511

more frequent as well. This is insufficient information about the multiple problems that this patient has. I believe the note that we saw previously was the one that was prior to this where she indicated that she's having migraines for 30 days in a row, and then this is an indication that her migraines are more frequent. That's a little difficult to understand.

THE MAGISTRATE: So migraines plus might indicate more frequent?

A. It just says migraines more frequent as well, and previously, the note was she's had a migraine for 30 days.

THE MAGISTRATE: Oh, I see.

A. Okay, so we have multiple problems, problems that are new problems. Some of them are new. They're described poorly. We have very little information about the different complaints that the patient has, and the examination is listed as being stable, so there is no information. This is below the standard of care for a neurologist for reasons that we previously reviewed.

Diagnosis is migraines plus question mark MCTD. I believe that is mixed connective

Page 512

tissue disorder. So it's uncertain what the diagnosis is. The plan includes a Prednisone trial, Cymbalta for the burning, and labs. There's no indication that labs were ordered. There is no indication of the dose of the Cymbalta, no indication of how many pills were prescribed. The Prednisone trial is five milligrams a day. We don't know how long that's going to be given for. No indication about the number of pills, number of refills, no information about other treatments that the patient may be receiving at this time.

Q. If we could go to Bates -- Medical Record 2010, Bates 478, a March 3rd, 2010, note?

THE MAGISTRATE: 478?

MR. PAIKOS: 478, yes.

A. I do have that report.

Q. (BY MR. PAIKOS) And what day is that report?

A. It's quite difficult to read. It's very small.

Q. Okay.

A. I believe it's July --

DR. PADMANABHAN: You said 2010, Mr. Paikos? Page 478 is 2100.

Page 513

A. 2100. I have page 2010. You said page 2100?

Q. (BY MR. PAIKOS) I may have. Why don't we instead go to a date around that time of March 22, 2010.

A. Page number?

Q. Medical Record Number 1428 to 1429 at Bates 353 to 354.

A. You did say 1028?

Q. 1428.

A. 1428.

Q. And that's at Bates 353?

A. And mine is 1428?

Q. Yes. If you could review that note?

A. I do have that report.

Q. Okay. And how would you assess the doctor's treatment on that day, March 22, 2010?

A. This note is below the standard of care.

Q. And why?

A. The history indicates that she had her first IVIG dose last week. This is dated 3/22/2010. She's getting better. Fatigue is there to an extent. The migraines continue. All else the same. She has been prescribed a very serious

Page 514

medication, IVIG, that we can discuss in more detail, with little indication as to why she is getting it. There is very little information in terms of the clinical status. Migraines continue. We don't know how often. We don't know how bad they are. And then all else the same. If we went back to the previous note, that would indicate that there was multiple different problems that had been described previously that are not being described now. This is a very complex patient. The statement all else the same is an inadequate statement given the complexity of her clinical situation. The exam is listed as unchanged. That is below the standard of care for a neurologist, especially taking care of a patient this complex. The assessment is CNS inflammation with some improvement subjectively on IVIG. She looks less weighed down today as well when she moves. Will follow to see how long the effect lasts.

CNS inflammation is a non-specific diagnosis. I don't know what it refers to. This is not a standard neurological diagnosis. It describes a pathological process that can be seen with many, many different diagnoses.

Page 515

There is no information in terms of plan. We don't know if the plan is to give her more IVIG, what other medications she is being given. I believe she is being given multiple medications. There are no details. IVIG is a potentially serious medication in terms of side effects. It's not one that is given often for neurological disorders. When given, it's given for very specific indications and under controlled circumstances. I don't understand why it's being prescribed under these circumstances.

Q. If we go to Medical Record 1465 --

THE MAGISTRATE: Mr. Paikos, you know we're shortly before 4 o'clock.

MR. PAIKOS: We are. I probably won't take more than three minutes to discuss the next note, or any note, so this would be a good point to stop.

THE MAGISTRATE: Okay, so we will resume tomorrow at 10 o'clock.

DR. PADMANABHAN: Your Honor, it would be great if you could just give me some timetable, because -- to bring my witnesses in, because --

THE MAGISTRATE: Let's ask Mr. Paikos.

Page 516

Scheduling witnesses is an inexact science, but let's see what his best guess is.

MR. PAIKOS: I think we would probably finish with Dr. Levin tomorrow in the morning, and we -- then we would have the cross. I'm not sure how long the cross would take, but we would have -- given the information that's been brought in, we would have potentially one or two additional witnesses who would take probably a little less than -- a little more than half a day between the two of them, I think, with direct and cross.

THE MAGISTRATE: Dr. Padmanabhan, do you have a sense of how long your cross-examination of Dr. Levin will take?

DR. PADMANABHAN: I think it will take the rest of tomorrow for my cross with Dr. Levin.

THE MAGISTRATE: Okay, so let's -- let's assume that's true. Then Mr. Paikos, a half day for two other witnesses?

MR. PAIKOS: At the most. At the most.

THE MAGISTRATE: At the most on Friday?

MR. PAIKOS: Yes.

THE MAGISTRATE: And you expect that to be your case?

Page 517

MR. PAIKOS: I think so, yes. And that's checking -- I just would want to confirm availability with them as well.

THE MAGISTRATE: Certainly.

Dr. Padmanabhan, what do you expect -- how long do you expect your case to last?

DR. PADMANABHAN: I need at least three days, and so I have a patient who cannot come on Friday, but can come on Monday, so we will need to extend it to Monday to get this patient. He was ready to go yesterday and today, but since, you know, this went on much longer than I thought, he is not able to come Thursday. Friday.

THE MAGISTRATE: Okay. Well, if I may speak, Monday can't be done. It's a state holiday. The building won't be open. I don't have my calendar in front of me. Right now, we're scheduled to go through Friday. I don't have my calendar in front of me in terms of my availability, and in terms of -- I would have to consult with the Civil Service Commission in terms of the availability of this hearing room.

DR. PADMANABHAN: I will need at least three days.

Page 518

THE MAGISTRATE: So one of the things we will do probably after Dr. Levin finishes testifying is figure out when we resume after this week.

MR. PAIKOS: The one issue is I don't recall getting a witness list. I remember getting the exhibit list, but I'm not sure I've seen a witness list.

THE MAGISTRATE: Did you send a witness list to Mr. Paikos?

DR. PADMANABHAN: Always. I received everything you have received. I sent it once, if I may say, with the names and I sent it once again with the names redacted, so twice.

THE MAGISTRATE: Okay. Well, I returned to you the witness list that had unredacted names.

DR. PADMANABHAN: The names.

THE MAGISTRATE: I don't believe I received a copy of that. I know you said you faxed it. I haven't received it.

DR. PADMANABHAN: I'm happy to give it to you here. They have also received everything.

THE MAGISTRATE: Well, Mr. Paikos is

Page 519

saying, my understanding, he doesn't have it.

MR. PAIKOS: We've seen no actual witness list separate from that. And I got the several exhibits and the reference to 12. And I don't know if I -- it was in the back or I didn't see it or --

DR. PADMANABHAN: I sent it twice, once with the full names and once with the names redacted.

THE MAGISTRATE: So as long as you're getting me a copy and getting Mr. Paikos a copy, too?

DR. PADMANABHAN: I can fax everybody. Yes.

THE MAGISTRATE: Okay. If you fax it today, it will get docketed tomorrow. I won't necessarily have it in the hearing room.

DR. PADMANABHAN: I can bring it here.

THE MAGISTRATE: If you could fax it in, then it will get docketed. I'm just saying I may not have it. It may not be docketed by tomorrow by the time I come here.

DR. PADMANABHAN: Okay.

THE MAGISTRATE: Anything else?

Page 520

MR. PAIKOS: I would just request that you bring in a copy tomorrow, because I may not be at the office tomorrow to get the fax.

DR. PADMANABHAN: Okay.

THE MAGISTRATE: Thank you.

(Off the record.)

(Whereupon the proceedings were suspended for the day at 4:02 p.m.)

Page 521

C E R T I F I C A T E

I, Marianne R. Wharram, Certified Shorthand Reporter, Registered Professional Reporter, and Notary Public, do hereby certify that the foregoing transcript, Volume III, Pages 322-520, is a true and accurate transcription of my stenographic notes taken on Wednesday, January 14, 2015, in Boston, Massachusetts.

Dated this 23rd day of January, 2015.

Marianne R. Wharram
Certified Shorthand Reporter
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$1,200 (1)
432:15

[

[Patient (1)
494:16

A

abbreviation (1)
450:14
abdomen (1)
431:7
able (11)
343:14;364:7;371:16;376:8;410:16;428:19,20;454:17;470:12;486:12;517:13
abnormal (8)
393:15,21,22;402:8,8,11;416:19;484:17
abnormalities (8)
386:13;403:5;410:7;411:20;428:1,15;456:7;458:12
abnormality (12)
396:1,5,11;397:23;398:1;401:5;427:19;428:5;455:9,20;456:1;472:19
above (3)
409:2,4;412:18
absence (3)
363:24;364:3;495:19
Absolutely (2)
325:10;355:9
abusable (1)
363:1
abuse (8)
362:5,15,16,17;363:5,6,20;364:8
abused (1)
363:2
abusive (1)
418:17
accept (1)
449:15
accepted (1)
346:18
according (6)
331:7;344:7;425:7;458:22;471:6;472:12
ache (2)
415:22;510:22
Aches (2)
420:24;421:4
achy (1)
438:20
acid (1)
377:17
action (1)
336:5
active (10)
403:17,18,20;433:12;452:20;453:5,17,17;458:5;491:4
actual (1)
519:2
actually (20)
325:5;337:23;357:15;359:14;366:18;384:14;431:23;433:5;435:6;441:3;444:21;447:19;449:10;456:15;464:21;480:2;483:7;492:11;493:1;502:18
acute (1)
509:4
ADD (1)
361:7
added (1)
463:11
Adderall (6)
360:24;361:8,12,15,19;363:2
addiction (1)
363:6
addition (4)
374:9;422:14;438:2;509:7
additional (3)
338:15;459:5;516:8
adequacy (2)
344:8,12
adequate (3)
330:1;354:18;463:20
administer (1)
434:8
administered (5)
366:18;367:15;368:3;453:24;476:4
administering (1)
367:2
administrative (1)
325:16
administrator (1)
330:18
administrators (1)
332:3
advance (1)
412:4
affect (3)
435:24;436:2,3
affected (1)
399:7
afield (1)
346:8
afternoon (1)
358:10
afterwards (1)
465:1
again (37)
334:1;340:4;368:21;371:7;388:19;390:21;391:3;395:6;401:10;402:17;404:22;408:23;415:3;430:8;432:19;437:1;438:13;446:3,23;448:7;450:22;460:8;472:24;475:20;484:11;485:17,21,24;486:7;491:3;494:7;497:9;498:7;500:4;507:12;510:5;518:13
against (3)
326:16;327:3;355:14
age (6)
433:10;436:16,18,19,24;437:12
agency (1)
337:17
agent (2)
453:23;454:1
ages (2)
395:17;433:9
ago (11)
437:22;443:14;444:5;445:4,22;449:14;455:7,7;465:21;473:4,8
agree (4)
341:11;367:16;391:18,23
agreed (2)
465:23;471:5
ah (1)
463:10
alcohol (1)
360:5
allegations (6)
326:15;327:3;345:9;346:8;349:21,23
allergic (1)
431:19
allergies (1)
450:18
Alliance (19)
326:12,17,19,20,21,23,24;328:9,17,19;329:5;333:4;346:11;348:24;352:16;353:5,23;358:17;438:7
allow (3)
327:6;348:3;382:17
Allowing (2)
463:21,24
almost (1)
396:20
alone (1)
472:24
along (6)
356:11;387:6;388:16;389:19;412:22;442:10
although (4)
332:15;336:1;399:5;503:17
always (2)
431:20;518:11
ambush (2)
338:24;339:2
American (1)
354:5
amount (6)
378:24;424:23;434:23;441:20;485:5;496:14
amounts (3)
335:23;442:17;460:9
ANA (1)
377:20
analysis (2)
378:1;381:22
Anatoly (1)
503:14
A-N-A-T-O-L-Y (1)
503:15
anatomic (2)
427:7,17
anatomical (4)
428:13,14,17;429:5
anatomy (1)
388:20
and/or (1)
428:2
angiogram (2)
441:12,17
answered (1)
342:6
antagonist (1)
358:15
antianxiety (1)
506:14
antibodies (3)
374:23;377:23,24
antibody (1)
377:20
anticipate (1)
355:10
anticipated (2)
356:5;358:19
anticoagulant (2)
377:21,23
A-N-T-I-C-O-A-G-U-L-A-N-T (1)
377:23
Anti-extractable (1)
377:19
anti-RNP (3)
393:23;394:6;414:13
anti-SM (2)
394:17,23
anti-spasmodic (1)
417:4
anti-spasticity (1)
477:17
anxiety (7)
418:18;419:19;420:8,10;430:8;433:3;479:19
anxious (2)
433:23;434:7
apologize (3)
359:15;360:13;460:1
apparatus (1)
380:21
appeal (1)
325:12
appear (6)
334:17;345:9;362:1;

367:10;411:1;443:4
appearance (1)
326:1
appearances (1)
390:16
appeared (1)
466:6
appears (11)
366:17;370:13,15,19,20;
398:9;419:11;426:20;
469:11;486:22;499:15
appreciate (2)
455:21;470:10
approach (1)
335:7
approached (1)
351:23
approaching (1)
351:7
appropriate (1)
502:8
approximately (2)
401:20;481:21
April (6)
436:23;437:2;464:23;
465:4,4;510:8
area (31)
375:11;385:16;389:14,15;
390:1;396:11,14,17;401:5,9;
403:16,17;407:9;408:8,10,
11,14,16,19,20;409:16;
410:5,5;412:17;432:19;
442:11;444:11,18;445:19;
455:8;458:8
areas (48)
329:17;331:1,2,18;
332:18;378:19;389:8,10;
396:1,3,5;399:12;401:8;
402:11,12,13,14,17,21;
405:5;407:12;409:2,8,16,21;
412:20,21,24;413:1,3;
431:15,16;442:1,4,16;453:5,
17,18,20;455:3,20;456:10,
20;457:18;483:22;484:5,8;
495:13
area's (1)
444:13
arm (9)
366:22;399:18;426:6,8,
11;440:3;443:17;445:15;
455:24
arms (3)
381:1;439:8;472:8
around (9)
375:9,11,13;388:2;
401:19;405:11,21;442:3;
513:4
arrest (1)
335:16
arteries (1)
443:7
arteritis (2)
378:21,22
artery (1)
443:7
arthritis (2)
378:21;383:17
articular (1)
501:1
aside (1)
384:7
assess (5)
331:22;403:21;471:18;
497:19;513:16
assessment (24)
362:10,13,15;416:23;
419:19;422:8;424:15,16;
427:10,16;438:21;446:10;
465:24;466:1,13;483:10;
488:6;491:16;492:15;
501:10;508:5,9;509:12;
514:16
associated (3)
479:8;498:2,6
assume (2)
350:9;516:18
Assuming (1)
365:15
assumption (1)
367:1
assurance (1)
335:4
assured (1)
334:18
ataxic (1)
472:19
a-tingle (1)
487:20
atoms (1)
388:24
atrophy (1)
431:16
attack (11)
399:9;400:8;433:18;
444:20;447:19;449:10,13;
455:13,17;461:24;462:3
attacks (12)
375:18;400:6,6,13,19,22;
401:1;404:4;417:9;419:5,9;
505:20
attending (1)
497:17
attention (13)
383:21;384:12;392:15;
404:12,14;437:7,9;461:12;
466:8;470:14;493:16;
499:24;507:5
attorney (1)
337:13
Auerbach (1)
462:14
aura (12)
369:16,17;370:10,10,22;
372:11;509:12,13,15,15,18,
19
authorizing (1)
371:12
autoimmune (4)
375:17;399:8;491:17;
501:2
availability (3)
517:3,20,22
available (2)
364:5,6
Avonex (4)
481:1,1,2,14
aware (3)
357:8;434:13;449:7
away (5)
334:15;336:15;426:6,12,
16
axial (1)
463:15

B

B12 (1)
377:18
back (52)
325:13;334:21;337:7;
338:14;353:14;357:24;
361:8;376:13;380:19;
382:23;388:10,13,19;
389:20;390:21;391:2;
395:11;397:14;400:9;406:5;
407:7;411:7;426:1;427:21;
429:20;435:10,20;441:8,17;
442:7;444:5,8;450:10;
458:20;459:11;460:6;
461:22;464:14;470:1,3;
471:2;473:18,19;477:3;
493:13;496:5,18;497:1;
503:8;509:4;514:7;519:5
background (6)
326:11,14;346:10;482:3,
8,11
Backing (1)
477:21
baclofen (8)
416:23;477:15,16,17,19;
478:6,17,19
bacteria (1)
374:18
bad (3)
400:14;420:23;514:5
badly (1)
379:16
balance (4)
392:18,21;404:21;487:21
barely (1)
392:18
barrier (3)
453:7,11,15
BARRY (1)
359:5
based (8)
339:23;393:5;403:22;
429:23,24;443:8;446:10;
498:19
basic (2)
365:21;375:15
basically (2)
391:10;489:1
basis (8)
345:18;382:3;426:18;
434:17;448:18;475:4;
483:15;507:4
Bates (104)
359:11,16,17;360:13,16,
17;364:14,15;371:4;379:3;
384:24;386:17;392:3,4;
397:16;414:10;415:8,8,9;
418:10;420:15;423:13;
427:12;437:10;439:13;
441:4;445:24;446:1,7;
447:17;449:3,7;450:20,21;
451:5;459:4,16,19;460:4;
461:2,3;462:9,10,14;464:2,
16;465:6;470:15;478:10;
479:3,14,17;480:20,21,22;
481:11;482:15;483:3;
484:20,24;485:18,22;486:1,
6,8,16;487:9;488:13,15,16;
489:11,13,19;490:8;492:18,
19;494:6;497:8,11;500:4,5,
17;501:19,20,22;503:9,12;
504:3;505:4;506:4,7,23;
507:12,13,22,24;508:12,14;
510:8,9;512:12,13;513:8,12
beauty (1)
470:12
became (6)
328:14;329:16;340:20,23;
341:3,5
become (2)
330:12;353:23
bed (1)
392:18
begin (2)
408:15;474:4
beginning (2)
352:6;433:20
begins (1)
500:5
begun (2)
419:15;464:7
behalf (1)
327:18
behavior (5)
330:4,24;331:23;333:10;
335:2
Behind (3)
408:14,19,20
belief (2)
345:3;348:19
below (26)
365:17;379:13;389:14;
415:12;416:8;417:17;
418:14;420:18;431:16;
442:4;470:21;487:15;
490:11,22;491:3,23;495:20;
496:9;497:22;502:6;508:17;

509:2;510:12;511:21;
513:18;514:14
bend (1)
471:12
beneath (1)
423:20
benzodiazapine (1)
506:13
besides (1)
432:10
best (3)
467:9;510:16;516:2
better (13)
392:20,21;400:15;404:20,
21;405:12;416:12;418:17;
420:24;421:5;454:19;458:1;
513:22
Bharanidharan (1)
325:15
big (1)
346:15
billing (3)
329:21;374:4,9
binder (1)
325:5
birth (1)
436:23
bit (3)
376:3;401:21;444:9
black (2)
408:15;412:17
bladder (3)
399:19;435:23;487:21
blind (2)
372:12;509:16
block (1)
494:21
blood (16)
372:7;378:17,23;391:6;
393:9,10,12,13,22;441:14,
15,16;442:24;453:7,9;
471:16
blood-brain (3)
453:7,11,14
blurred (1)
493:13
Board (8)
325:14,20;327:2;349:22;
354:3,5,7,24
board-certified (2)
328:6;354:1
body (28)
349:24;373:5;374:16,18,
19,19,24;375:17,23,24;
376:5;377:1;378:20;385:18,
20;389:3;399:8,17;427:6,
17;428:13;430:7;431:8;
443:21;445:8;489:16;
491:19;510:22
Bor (5)
333:6;334:21;336:6;
337:1;351:23
both (9)
330:5,12;372:10;385:7;
443:7;456:23;462:18,19;
486:23
bother (1)
457:24
Botox (2)
502:6,21
bottom (5)
423:23;439:21;461:13,15;
487:9
Bowen (3)
366:10,11;368:3
boxed (3)
477:4,5,8
BP (1)
480:24
brackets (2)
373:10,11
brain (74)
365:8;372:6,8;375:5,7,8,
10,11,21;380:18,19,19,20;
385:12;387:12,13,13,14,14,
23;389:3;390:6;395:7;
396:2,5,6,11,15,16;399:1,1;
401:6,8;402:15;407:3,17;
408:3,4,16;409:17;410:17;
411:4;428:11;441:7,9,14,15;
442:6,7,15,21,21;444:12,14,
17,17;451:3;453:4,8,8,10,
16;455:10,14;456:2,5;
458:8;464:19;483:3,20;
491:8;492:9;504:16;509:10
break (10)
357:21;406:2,4;450:4,7;
485:2,3,6,9,11
breakdown (2)
453:6,11
breath (1)
423:4
Bresler (1)
325:17
brief (3)
353:21;398:21;415:15
briefly (5)
346:9;369:18;372:1,21;
383:12
Brigham (3)
474:13;475:2,20
bright (1)
403:16
brighter (1)
419:11
bring (4)
507:9;515:23;519:18;
520:2
brought (1)
516:7
building (1)
517:16
bulging (1)
488:7
bulk (2)
412:3;472:14
bumps (1)
392:19
bundle (1)
389:23
burn (1)
510:24
burning (1)
512:3
bursitis (1)
493:15
buttock (1)
508:20

C

calendar (2)
517:17,19
call (8)
327:13,15;338:14;342:24;
353:14;417:8;437:6;447:14
called (17)
327:18;358:7;365:5;
374:21;375:16;377:17;
378:11;387:18;399:5;
401:17;403:14;407:18;
408:17,19;453:19;471:22;
476:19
calling (2)
335:10;339:4
callosal (1)
442:10
callosum (25)
388:19;389:22,23;396:14,
17;397:20,22;398:6;405:13;
407:18;408:23,24;409:7,10,
22;412:19,20,22;413:2,10,
10;442:11,14;458:7;470:9
Cambridge (20)
326:12,17,18,19,21,23,24;
328:9,17,19,23;329:4;333:4;
346:11;348:23;352:16;
353:5,22;358:17;438:7
came (12)
330:22;341:6;353:11,22;
381:4;401:17,20;411:11;
424:17,20;494:16,23
cameras (1)
326:4
campuses (1)
328:20
can (112)
334:6;346:1;350:14;
351:5;356:6;366:8;367:11,
22;371:4;372:10;374:23;
375:22;376:5,19;378:18;
380:14;383:23,24;384:5;
389:4,7;390:1;391:5,23;
392:18;396:22;398:18;
399:5,13,19,21,23;400:2,21;
402:3,9,18;404:13;405:14;
406:24;409:24;410:10,11;
412:23;413:14,16,20;417:5;
423:6;424:22;426:4;428:14;
429:2,9,12,12;430:21;
431:11,14,16,16;432:24;
433:15;434:1,2,4;435:17;
436:13;444:20,21;445:16;
447:3;449:4;453:10;454:21;
456:3;467:9,12;470:1;
473:14,16,20;474:24;
475:22;477:3,11;478:19,22,
23,24;479:22;482:7;483:16;
484:1;490:19;493:16;
495:14;496:17,24;498:21;
502:21,24;505:18,20,22;
507:9;509:24;514:1,23;
517:9;519:13,18
cancelled (1)
339:21
cancer (3)
377:2;474:7;505:24
cancers (2)
474:22,24
cane (1)
436:1
car (1)
335:15
card (1)
325:5
care (70)
325:20;331:13;332:1;
333:16;335:24;338:3;
349:11;361:1;363:7,13,16,
18,23;365:13,14,17;366:12;
368:5,7,14;369:11;379:11,
13;414:17;415:11,13;416:8;
417:16,17;418:12,14;
419:14,17;420:17,19;422:3;
437:20;470:19,20,21;472:6;
477:9;481:13,15;487:14,15;
488:5,12;490:10,11,22;
491:4,23;493:12;495:21;
496:2,10,12;497:20,23;
498:10,16;508:16,17;509:3;
510:13;511:21;513:18;
514:14,15
career (1)
475:17
careful (2)
398:9;435:19
Carolina (5)
440:2;447:21;449:10;
465:20;471:1
carotid (1)
443:7
Carter's (1)
326:6
case (14)
325:22;337:14;338:21;
350:19;369:15;381:17;
406:1;452:1;463:17;480:6,
10;507:10;516:24;517:6
cases (2)
337:22;338:1
categories (1)
376:22

cause (9)
334:7,8;365:7;372:24;
388:23;426:15;431:14;
432:24;478:24
caused (2)
335:2;336:5
causing (4)
421:12;432:2;478:22;
509:10
CellCept (11)
474:4,5,6,16;475:17,20;
476:3,9,16;477:7;480:1
cells (3)
374:20;376:1;387:16
center (6)
408:9;424:2;425:16;
438:5,13;476:3
central (21)
371:21;373:8;374:12,13,
15;376:11;380:16,21,23;
398:24;399:12;401:3;
404:24;412:16;428:2;
429:23;433:14;484:16;
489:3,6,8
cerebellum (3)
380:20;402:15;442:22
cerebral (20)
380:17;387:12;389:14,24;
401:7;407:12;408:7;411:7;
442:5;443:22,23;444:6,8,11,
16;445:12;456:23;472:19,
23;503:2
certain (9)
328:12;389:1,5,6;390:2;
394:10;440:5;468:13;482:1
Certainly (13)
398:10;403:7;409:5;
429:14;430:11;432:24;
434:5;436:1;437:6;455:16;
467:12;473:6;517:4
certified (1)
354:4
Ceruloplasmin (1)
377:15
C-E-R-U-L-O-P-L-A-S-M-I-N (1)
377:16
cerv (1)
489:22
cervical (8)
488:9;489:24;490:4,14,
17;492:12;502:23;504:16
chair (1)
478:23
change (18)
365:7;387:9;390:14;
391:6;403:10;428:24,24;
445:6;453:12;454:19,20,23;
458:16;460:10;463:7;464:1;
468:13;488:1
changed (3)
398:19;401:21;455:10
changes (59)
365:8;372:5,11;374:14;
387:5;388:5,7;389:18;
390:17,17,20,23;391:7,8,11,
13;395:8;402:10,19;403:1,3,
4,5;415:1;425:9,11;426:15;
427:19,24;428:13,14;429:5;
442:18,19,23,23,24;443:5,
21;444:2;446:19;453:14,16;
455:2,12,16;456:20;457:15;
458:23;466:6;468:9,21,24;
472:20,24;473:2;483:21;
488:24;509:15
character (1)
438:20
characterization (1)
429:8
charges (1)
373:18
charleyhorses (1)
471:13
chart (1)
331:7
charts (9)
329:20;330:19;331:7;
332:15,16,17;333:11;344:4;
350:6
check (1)
356:6
checking (1)
517:2
chemical (2)
365:8;372:5
chemicals (2)
374:22;376:2
chemotherapy (2)
474:6;475:9
chest (1)
423:4
chief (18)
328:13,14,15;329:7,16;
330:13;340:20,23;341:3,5;
347:19,21;352:20,23,24;
353:2,23;358:15
child (1)
361:7
chose (3)
345:13;350:5;351:19
chosen (4)
337:23;338:2;345:11;
350:15
chronic (6)
373:3;392:13;404:6;
482:19;502:22;508:22
chronological (2)
367:9,12
circulates (1)
387:24
circulation (2)
444:12,13
circumstances (4)
413:12;447:8;515:10,11
cited (1)
458:21
Civil (1)
517:21
CL (1)
508:21
clarity (1)
342:5
classical (2)
400:24;401:13
claudication (3)
441:8;460:7;461:23
clear (8)
325:8;331:4;395:14;
396:8;404:23;464:22;496:6;
497:3
clearly (2)
405:9;413:3
clicker (1)
406:24
clinic (5)
332:3;474:13;475:2;
488:11;507:7
clinical (60)
325:19;331:24;335:2;
391:9,9;401:23;402:6;
404:2;410:9;413:11,12;
414:20,21;425:6;443:9,13;
445:13;447:8;451:6,20;
455:18,22;458:24;459:7,8,9,
11;460:12,19;461:1,9,14,19,
21;464:9,11;465:8,10,16,17;
466:3,13,21,23;467:5,8,17;
468:8,20;469:3,4,18,19;
473:2;477:18,20,22;499:1;
514:4,12
clinically (5)
334:14;443:1;456:9;
464:20;484:12
close (2)
434:11;449:24
closed (1)
329:21
closely (2)
470:11;491:21
closet (1)
418:19
closing (4)
330:19;331:7;332:15;
333:11
CNS (13)
380:2,3,7,7,11,15;381:8,
18;497:18;498:1,4;514:16,
20
coaching (1)
331:16
codes (4)
373:15,24;374:5,7
coding (2)
373:14,15
Cognitive (1)
399:21
colleagues (2)
331:24;470:13
collect (1)
329:22
collected (1)
342:2
color (1)
387:19
comatose (1)
335:15
combination (2)
399:18,24
comfortable (2)
333:14,17
coming (8)
333:9;381:1;395:9,13;
396:6;407:3;431:7;473:16
comment (8)
357:6;395:19;397:12;
452:16;459:5;493:18;
504:12;508:1
comments (2)
332:22;344:12
Commission (1)
517:21
committee (2)
337:2;351:23
common (11)
372:3;387:8;400:18;
404:16;431:5;432:4;433:10,
10;436:19;437:5;442:22
commonly (12)
383:9,16,19;391:6,7;
429:1;454:12,14,22;474:7,8;
475:5
community (2)
331:12;333:16
company (6)
337:18;338:6;345:14;
350:7,12,16
comparable (1)
463:6
compare (2)
457:8;463:6
compared (1)
454:8
comparison (3)
409:11;410:21;463:22
complaining (1)
368:11
complaint (1)
370:7
complaints (8)
333:9;404:17;419:6;
490:15,18;491:5;493:11;
511:18
complete (4)
355:16;379:20;383:3;
413:20
completes (1)
381:22
complex (5)
374:24;398:18;493:10;
514:10,15
complexity (1)
514:12
component (1)

372:4
comprehensive (1)
393:12
computer (3)
373:18;476:12,19
concepts (1)
426:22
concern (9)
329:17,23;330:2;331:2;335:3;338:2;347:2;452:10;509:3
concerned (8)
332:21;334:3;386:10;432:1;433:24;447:8,9,10
concerns (13)
330:4;346:24;347:18;386:15;415:24;416:1;422:1,12;432:22;438:1;451:15,20;490:20
conclude (1)
424:10
conclusion (4)
388:13;464:1;498:21;499:3
conclusions (5)
391:18,23;393:5;447:18;500:21
condition (7)
367:1;372:22;375:14;393:18;404:16;482:24;495:11
conditions (14)
375:4;376:20;380:6;383:16;396:23;399:23;404:10,11,14;437:16,17;502:22;505:18,21
confer (1)
450:17
conference (1)
358:16
confidence (1)
332:24
confirm (4)
350:10;361:24;416:20;517:2
confirmed (2)
335:19;349:7
confirming (1)
362:2
confusing (1)
498:12
confusion (1)
418:19
conjecture (3)
367:22;429:2;467:12
connecting (1)
396:15
connection (6)
453:9;466:12,12,15,20,20
connective (4)
498:3,8;499:3;511:24
connects (1)
389:24
consider (2)
380:18;464:7
considered (2)
358:15;429:14
considering (2)
363:1;464:13
consistent (28)
331:12;397:1;402:2,8,17,22;415:1,5;428:1;443:22;445:3,20;447:5;456:21;457:15,23;458:19;466:6,14;467:2;468:3,9,18,21;469:24;470:7,11;472:18
consists (1)
387:15
consult (2)
480:24;517:21
consultation (1)
423:22
continue (9)
380:12;383:2,6;427:3;430:22;431:1;509:19;513:23;514:4
continued (2)
422:16;491:14
continues (7)
379:17;418:10;438:18;441:9;471:8;477:24;490:14
continuing (5)
335:3;408:22;420:2,3;427:10
continuous (1)
473:17
contract (2)
334:5,10
contraction (1)
495:14
contracts (1)
334:5
contralateral (1)
445:18
contrast (21)
385:12;403:15;411:4;452:17,19,19,21,23;453:15,16,19,22;454:1,17;458:6;463:16,17;486:5,9;489:23;490:1
control (1)
380:20
controlled (1)
515:9
contusion (1)
375:10
Cooke (2)
325:19,21
Coordinate (1)
491:21
coordination (4)
400:3,13;433:21;472:16
Copaxone (27)
415:16,18,19;416:3;417:19,23;418:24;419:1;420:2;421:1,1,4,5,7,8,11;422:20;430:23;431:1,22;432:1,3,9,13;434:9,23;435:17
Copper (1)
377:18
copy (11)
335:7;384:2,5,7,22;405:19;494:21;518:20;519:11,11;520:2
cord (7)
380:22;381:1;399:1;401:4;402:16;407:8;411:8
core (1)
343:22
corpus (25)
388:19;389:22,23;396:14,17;397:20,22;398:6;405:13;407:18;408:23,24;409:7,9,22;412:18,19,22;413:2,10,10;442:11,14;458:7;470:9
correlation (3)
391:10;455:17,23
cortex (9)
380:17;387:12;389:14,15;401:7;402:14;407:13;408:8;411:7
cost (1)
480:12
cough (3)
447:6,7,12
counsel (1)
337:24
counter (1)
353:15
couple (3)
376:22;425:9;495:17
course (10)
400:21;404:2,2;414:20,21;453:4;455:18,22;463:17;496:11
COURT (2)
325:4,10
courts (1)
346:3
covered (2)
335:8;387:17
covering (1)
399:4
CPT (4)
373:15,15,22;374:7
cramps (1)
471:13
C-reactive (1)
376:24
create (1)
474:24
creates (1)
454:1
credibility (3)
343:8;353:8,11
criteria (14)
344:8;345:19;395:18;401:15,15,15,17,18,20,22;402:4,5,6,23
cross (4)
516:5,6,11,16
CROSS-EXAMINATION (3)
340:16;358:22;516:13
cross-examine (3)
338:23;339:8;355:17
cross-section (1)
390:6
CRP (3)
376:23;377:5,6
CT (4)
385:18;486:4,9,12
current (1)
459:24
currently (1)
328:8
cursor (2)
407:11,21
customary (1)
380:5
cut (2)
375:23;376:1
Cymbalta (2)
512:3,5
cysts (1)
482:20

D

daily (9)
341:15,16;342:1,13,15;431:13;432:17;434:17;435:8
damage (1)
428:7
danger (1)
352:1
dash (2)
423:1,9
data (2)
401:22;470:8
date (17)
336:23;351:22;352:2;360:9,15;379:4;422:5;423:15;436:23;448:7;464:17;476:18,19;497:12;507:6,8;513:4
dated (10)
385:11;418:13;441:6;451:2;463:9;486:9,21;487:10;502:2;513:21
dates (1)
506:10
Davender (1)
423:19
D-A-V-E-N-D-E-R (1)
423:19
Dawson (1)
396:10
Dawson's (28)
395:14;396:9,16;397:2,7,23;398:4,8,11,14;409:5,5;

410:12,17,20;411:16,18; 412:11,12;413:7;425:3; 442:8;448:2,13,17;449:18; 464:24;465:2
day (17)
339:21;341:2;414:9; 418:12;433:19,20;434:24; 435:24;436:7;492:4;499:4; 512:7,17;513:17;516:10,19; 520:8
days (12)
334:6;337:1;338:15; 356:18;435:18;508:10,23; 509:8;511:6,13;517:8,24
deal (1)
378:14
dealing (1)
455:10
death (6)
336:4,23;337:1;349:7,11; 434:4
December (9)
328:14;330:13;340:20; 341:8,17;342:2,11;347:19; 438:12
decide (3)
326:22;327:1;355:15
decided (2)
334:2;336:6
decision (2)
333:2;368:2
declare (1)
345:19
declining (1)
406:17
decreased (4)
428:8;444:12,13;487:21
deep (1)
415:21
deeper (1)
442:4
deficiency (1)
377:18
Deficit (1)
404:14
deficits (3)
400:5;435:22,23
define (1)
401:14
defined (1)
389:17
defines (1)
389:1
defining (1)
373:19
definite (1)
491:20
definitely (5)
402:7;404:8;462:6; 499:21;505:1
definition (2)
372:2;444:23
degenerative (1)
488:24
degree (1)
331:1
Dejager (2)
423:24;424:3
delivered (1)
353:2
demonstrate (2)
442:8;448:13
demyelinating (3)
443:2;460:11;484:2
demyelination (3)
458:10,12,16
denied (1)
385:12
denies (2)
437:24;487:21
department (15)
329:9;330:18;331:5,8; 333:7;335:17;352:24;353:1; 359:23;451:8;452:2,13; 463:14;492:21;503:16
departmental (1)
333:19
depending (6)
428:3,5;435:22;447:7; 452:8;479:22
depends (2)
434:18;436:13
depicts (2)
411:16,18
depolarization (1)
388:24
DepoMedrol (3)
495:4;502:5,15
Depo-Medrol (1)
486:22
depression (2)
404:10;430:8
derail (1)
336:5
describe (5)
389:7;415:22;457:11; 472:9;476:6
described (13)
400:19;401:16;413:7; 424:12;438:20;444:2; 446:15;474:1;493:19; 502:20;511:17;514:9,9
describes (13)
366:20;367:6;396:5; 415:21;418:16,17;426:3; 451:23;471:10,15;473:14; 484:4;514:23
describing (3)
408:13;420:23;484:5
description (20)
374:14;375:2,19;376:7; 387:10;388:4,10,13;419:5; 425:24;441:17,19;446:17; 452:11;456:18,24;457:21; 458:1;478:5;494:24
descriptive (1)
396:10
deserve (1)
382:19
designed (1)
331:17
despite (1)
335:3
detail (6)
388:12;393:15;457:1; 481:16;503:3;514:2
detailed (6)
371:24;389:2;424:11; 457:4,9;493:6
details (1)
515:5
detect (1)
410:12
determination (1)
353:12
determine (2)
337:20;467:10
detoxing (1)
360:4
detrimental (1)
475:11
develop (2)
400:17;478:20
devices (2)
326:2,4
diabetes (2)
438:2,3
diabetic (1)
471:16
diagnose (5)
372:23;398:17,22;400:24; 401:14
diagnosed (11)
392:12;416:14;419:15; 422:4;433:7;434:15;436:18; 471:1,4;472:22;479:19
diagnoses (17)
347:8,12;371:16;373:10; 376:9;380:6;386:9;390:2; 391:5;419:24;438:16;447:5, 11;451:16;498:1,11;514:24
diagnosing (1)
398:16
diagnosis (122)
330:2;346:13,23;347:23; 368:24,24;369:9,9,18; 370:16,21,24;372:19;373:1, 2,14,17,19;375:3,20;376:6; 377:10,13;380:2,4,5,8; 381:4;386:15;387:8;389:23; 391:1,4;397:1,3;398:18,19; 402:2,4,9,10,18,20,23,24; 403:19;404:7;414:16;415:1, 5,23;416:3,20;420:8; 428:22;430:1,3,12,18,18,21; 433:4,22;434:16;439:8; 440:12;443:23,24;445:13, 21;446:20,23;447:3,11,14; 454:21;455:4,15;457:13,23; 464:8;465:23;466:23,23; 467:17,19,21;468:1,11,19, 20,22;469:16,18,19;471:2,6; 473:1,10;479:11;480:6; 483:14,17;484:3,11;491:11, 12,12,14,20;492:14,15; 497:19,20,22;498:6,9,12; 511:23;512:2;514:21,22
diagnostic (3)
403:6;413:11,13
diagram (5)
495:1,19;496:1,4;497:4
diagrams (1)
495:18
dictated (1)
493:1
dictations (1)
344:1
die (2)
375:24;444:15
died (2)
335:14,15
diet (1)
471:16
difference (3)
425:17;460:24;461:9
different (48)
330:14;362:1;373:4,4; 374:8,20,22;375:3;376:2,20, 22;390:15,16,17,18;395:16; 399:14;400:1;404:9;407:24; 416:10;419:16;423:5; 427:21;428:4;429:10;445:1; 447:2;452:3,3,6,8;455:3; 459:10;462:11,23;463:2; 464:19;472:21;473:12,22; 487:17;490:20;493:1; 509:23;511:18;514:8,24
differential (7)
387:8;391:4;430:12; 446:20,22;447:11;484:2
differently (1)
468:12
difficult (7)
363:18;372:23;374:7; 433:7;510:15;511:8;512:19
difficulties (9)
392:21;399:19,21;416:10, 11;423:4;425:21,23;471:24
difficulty (11)
333:11;392:15;399:16; 400:2,3,11,12;428:23; 433:21;471:11,23
diffuse (1)
373:7
DIRECT (7)
327:23;333:6;359:6; 386:9;450:12;493:16; 516:11
Directing (6)
383:21;384:12;437:7,9; 466:8;470:14
direction (2)

386:14;390:3
disability (5)
400:17;434:2;498:19;
499:15,23
disagree (1)
468:14
disagreeing (1)
468:15
discerned (1)
498:22
discharge (3)
327:1;331:10;358:18
Discharged (2)
366:24,24
discharging (1)
334:19
discomfort (4)
370:20;432:18,19,24
discount (1)
499:19
discovery (5)
355:15,16,17,20;381:15
discrepancy (1)
335:5
discuss (11)
393:2,2;394:19;415:24;
423:24;464:18;470:13;
476:22;504:3;514:1;515:16
discussed (16)
348:10;365:19;368:13;
395:22;414:14,22;415:19,
20,20;418:2;422:2;433:8;
442:2;465:20;488:6;503:3
discusses (3)
479:7;481:1;498:18
discussing (1)
483:19
discussion (9)
346:15;371:24;380:10;
393:11;398:21;477:23;
481:17;504:6,7
discussions (1)
330:10
disease (40)
377:16,17,19,21,22;378:1;
394:4,10;398:24;400:17,19;
401:14,14;403:18;424:24;
425:10,12;429:12,13,18;
430:12,15,17;433:7,8,14;
434:1,6,18,21;443:2;460:11;
469:21,23,24;475:7;498:3,8;
500:15;501:1
diseases (3)
378:24,24;394:7
disk (6)
381:13;382:12,14,19;
473:19;488:8
disks (1)
384:1
disorder (11)
375:17;394:14;404:14;
416:2,16,16;419:22;421:19;
501:3,17;512:1
disorders (10)
377:8,15;378:10,16,18,20;
383:10,15;492:7;515:8
disruption (1)
399:6
distal (1)
428:9
distances (1)
440:5
distinct (2)
413:3;455:9
distribution (3)
395:15;457:20;458:3
division (6)
331:21,22;333:20;344:6;
352:20,23
docket (1)
325:12
docketed (3)
519:16,20,21
doctor (90)
335:24;359:7,10;360:13;
361:7;364:5,6,10;366:10,11,
12,17;368:1,2,6,9,11;
369:24;370:6;386:7,14;
388:6,11,14;389:10;392:11;
397:24;398:10;410:24;
414:11;415:7;425:22;427:5;
429:16;430:16;436:16;
437:8;439:12;441:5;443:20;
445:14;454:7;457:10,13;
458:1,2,17,21,22,23;459:3;
460:8,13;462:6,9;464:17;
466:21,24;467:5,6,11,12,20;
468:12,15;469:3;481:21;
483:23;484:4;485:16;
487:11;488:17;493:1,3,10,
16,24;495:20;497:7,12;
499:13,18,18,22;500:18;
503:7;507:12;508:6,6,13
doctors (10)
332:1,1,10;333:10;
373:16;378:15;385:15;
462:11;467:4;468:14
doctor's (5)
331:24;386:20;426:24;
465:12;513:17
document (5)
343:3,13;382:7;449:14;
497:21
documentation (1)
330:17
documents (5)
341:15;343:21;382:12,18,
20
dollars (1)
479:24
done (22)
330:16;338:4;354:18;
364:9;388:22,23;403:2,2;
435:14;441:13;452:2,4,7,12,
12,24;454:12,14;470:17;
490:5,16;517:15
door (1)
357:9
dosage (1)
509:23
dosages (1)
509:23
dose (4)
491:24;506:1;512:5;
513:21
doses (3)
420:4,5;435:8
dossier (5)
341:15;342:1,13,15,17
dot (3)
389:12,16;408:21
dots (2)
391:11;409:18
double (3)
399:15;406:22,22
doubt (1)
471:6
doubted (1)
471:2
down (10)
356:2;404:6;407:19;
409:7;411:8;439:24;475:16;
489:21;508:20;514:18
Dr (295)
325:23;326:6,8,15;
327:12,15,24;329:4,13,17;
330:15,16,24;331:3;332:11,
14,23;333:3,6,15;334:18,21,
24;335:4,22;336:2,6,7,15,
18;337:1,10,13,23;338:10,
11,12,13,19,20,20,23,24;
339:3,4,7,8,11,14,15,16,18;
340:1,2,4,7,8,12,17,18;
341:21;342:9,13,16,18,20,
22,23;343:4,7,11,14,17,20;
344:15;345:2,5,8,10,11,12,
17,18,24;346:5,9,12,12,14,
18,22,23;347:7,7;348:5,5,
15,19;349:1,3,5,5;350:1,1,
15,20;351:3,9,10,16,23;
352:8,13,20;353:7,13,19;
354:11,14,16,17,20,23;
355:2,4,5,5,9,15,18,19,21,
24;356:7,8,13,15,18,23;
357:1,6,10;358:8,11,12,13,
14,18,19,20,20;359:2,4;
360:7,19,22;361:22;362:9;
363:10;364:22;365:13;
366:5;367:21;371:11;378:4,
7,9;379:10;381:14,20;382:2,
5,8,17,24;384:3,7,16;
385:23;391:22;392:6,23;
393:1;405:10,11,20;406:13,
15,17,23;407:10,20;410:12,
18;411:9,19,21,23;412:2,8;
413:24;414:10,11,16;
418:11,12;420:16;422:9;
423:1,24;424:3,9,11;425:1,
7;426:17,19,21;427:14;
429:3;432:8;439:18,19;
446:2;447:18;448:15,19,20,
24;449:5,11,12,16;450:11,
13;451:12;462:10,19;464:7,
13;465:1;466:11;470:17,19;
475:23;479:16;481:5,9;
483:4;484:23;485:7;488:20;
489:14;490:15,23;491:21;
493:2,13,22;495:17;497:9,
15,21;499:17;500:2,9,18;
501:5;502:1;503:16;505:13;
506:9;507:3,5,22;508:8;
512:23;515:21;516:4,12,14,
15,16;517:5,7,23;518:2,11,
18,22;519:7,13,18,23;520:4
dragging (1)
471:11
dramatic (2)
333:11;426:12
drawn (1)
461:11
drop (1)
420:23
drug (10)
362:15,16,17;363:5,5,19;
364:8;450:18;474:20;
507:18
drugs (2)
417:20;475:3
due (2)
426:14;505:22
duly (1)
327:19
during (5)
332:16;344:5;347:9,18;
410:16
dysfunction (1)
431:23
dystonia (1)
502:24
dystonias (1)
502:23

E

earlier (3)
381:14;425:15;454:10
early (3)
336:24;434:4;473:5
ED (2)
359:19,22
edge (1)
408:5
effect (8)
361:8;408:1;426:22;
432:3;475:1;478:18;479:5;
514:19
effects (24)
415:20;417:5;418:3,23;
419:1;421:4;431:3,3,5,6,19,
21;432:4,10,18,21;474:22;
476:10,24;478:16,16;
481:19;507:20;515:7

eight (2)
393:24;412:24
either (7)
331:10;352:23;384:6;
428:2;461:14;483:18;
496:11
elaboration (1)
370:11
Elaine (2)
367:5,19
electron (1)
389:4
electronic (4)
326:2;384:8;413:19;503:8
electronically (1)
492:24
electrons (1)
389:1
elevated (3)
377:3,5,7
else (8)
400:11;416:7;480:17;
506:9;513:23;514:6,11;
519:24
emergency (3)
335:17;359:22;482:16
emotional (4)
425:21,23;426:15;429:13
emphasize (1)
327:7
encephalitis (1)
375:5
encounter (5)
360:15,20;379:4;392:9;
423:16
end (8)
333:5;397:19;433:19;
434:2,3;452:4;480:24;498:3
ended (2)
336:16;358:9
ends (1)
413:15
Energy (1)
388:24
engage (1)
347:21
enhancement (2)
452:20;453:19
enlargement (1)
372:7
enough (5)
339:8;340:6;372:17;
395:5;444:14
ensure (1)
509:9
entail (1)
328:15
entertain (2)
410:22;412:4
entire (3)
382:13;431:8;492:11
enzymes (1)
431:24
episode (5)
400:14;401:23;449:10;
465:19;473:8
episodes (3)
401:1;417:9;440:3
equivocal (1)
455:1
erroneous (5)
469:4,4,8,8,10
erythematosus (1)
378:21
especially (10)
395:9,13;396:6;397:23;
398:20;404:18;412:5;
419:14;422:3;514:15
Esquire (1)
325:18
essentially (4)
341:15;405:4;484:17;
504:19
establish (4)
343:3,13,19;437:20
established (1)
326:24
estimate (1)
339:20
etc (1)
335:12
etiologies (4)
387:9;442:22;443:1;
460:10
evaluate (1)
376:19
evaluation (4)
430:20;488:2,3;504:15
even (6)
340:22;373:1;379:23;
381:20,23;475:16
evenings (1)
438:19
event (3)
334:11;335:6,13
Everett (1)
329:1
everybody (2)
435:12;519:13
evidence (21)
333:8,13;334:2;337:24;
340:22;343:2;348:8,10;
349:13;382:7;384:6,23;
424:4;430:14;472:2,2,8;
478:2;492:13;501:1,16
exacerbations (10)
400:7,13;404:3;405:1;
421:15,15;443:18;465:17;
471:20;505:19
exact (6)
336:23;352:2;356:9;
401:24;457:4,10
exactly (5)
334:1;348:16;352:19;
458:18,22
exam (23)
368:13;379:22,24;386:5;
416:21,23;441:8;449:9;
454:8,9;460:6;461:2,6,10,
14,16,22;462:22;464:11;
465:7,11;491:16;514:13
EXAMINATION (55)
327:23;353:20;359:6;
365:21,23;368:15;370:3;
379:20,23;416:13,18,19;
417:2;419:10,13,18;421:23,
23,24;422:1,2;424:12,14;
425:8,9;426:1,10;427:1,18;
428:16;429:3;440:17,18;
443:20;450:12;466:2;472:5,
6,12;478:1,5,8,11,12;488:1,
5;491:1,3,6;508:23;509:1,5,
9,11;511:19
examine (4)
339:8;426:5,7,8
examined (2)
327:20;427:22
examiner (1)
335:20
examining (2)
366:13;370:6
example (10)
389:7;390:20;402:20;
428:6;434:22;453:13;
454:22;473:18;478:20;
503:1
excellent (1)
424:13
except (3)
335:8;471:21;490:17
excessive (3)
327:6,7;336:3
Excuse (27)
361:13;362:11;364:14;
369:16;378:2;395:18;410:2;
423:11,14;424:19;438:2,3;
439:16;448:8;452:16;
470:23;477:21;480:22;
485:21;486:15;489:12;
491:13;494:4,23;496:22;
500:6;501:19
excused (1)
356:3
executive (2)
337:2;351:23
exemplary (1)
338:1
Exhibit (5)
358:13;406:10;410:21,23;
518:7
exhibits (6)
411:23;412:3,5,6;476:1;
519:4
ex-husband (1)
418:18
exist (1)
343:3
existence (1)
373:1
exists (2)
343:13,19
expect (13)
369:19,23;370:2,3;377:6;
379:19;457:2,5;461:13;
491:5;516:23;517:5,6
expected (3)
339:23;398:11;445:14
expensive (5)
432:14;479:21,22;480:1,4
experienced (2)
477:9,10
experiencing (3)
479:18;487:18,23
experimental (4)
474:15;475:2,4,19
expert (1)
374:6
expertise (1)
385:21
experts (1)
379:1
explain (6)
334:9;346:3;373:11;
395:12;407:1;444:9
explained (2)
331:3;354:22
explaining (1)
327:5
explains (1)
506:18
explanation (2)
380:9;416:6
explanations (2)
415:17;428:19
extend (1)
517:10
extensive (2)
333:19;504:14
extent (1)
513:23
exterior (1)
388:2
extremely (1)
446:8
extremes (1)
435:19
extremities (1)
445:18
extremity (3)
437:22;445:17;493:21
eye (2)
400:9;411:5
eyes (1)
407:6

F

face (1)
399:17
facet (1)
488:24
fact (7)

332:21;343:2;356:17;
398:7;418:6;419:11;468:10
factor (2)
377:14;378:1
factual (1)
345:9
fail (1)
481:13
fair (11)
337:24;340:21;341:14,22;
342:18;348:12,22;349:17;
350:3;429:8;447:13
fairly (2)
402:12;443:20
fall (2)
376:21;508:19
fallen (1)
509:3
falls (1)
365:4
far (5)
340:9;346:7;453:10;
473:6;479:20
fashion (1)
426:12
fat (1)
431:17
fatigue (7)
392:15;404:8,11;471:15;
478:18;479:1;513:22
fatty (1)
387:17
fax (4)
519:13,15,19;520:3
faxed (1)
518:20
features (1)
414:1
feel (3)
332:6;333:16;430:24
feeling (5)
391:12;404:19;418:17;
431:7,9
Feelings (1)
404:18
feels (2)
420:22;468:12
feet (4)
428:10;439:10;440:6;
510:24
fell (1)
415:11
felt (9)
331:12;333:12,14;334:7;
335:24;375:14;379:16;
465:22;508:20
few (5)
357:13;400:10;402:21;
405:5;491:10
fibers (4)
387:17;389:24;399:4,6
fibromyalgia (10)
371:20;372:19,22;376:10;
386:1;392:13,20;404:7,20;
495:12
fibromyalgic (1)
379:18
figure (2)
485:4;518:3
file (1)
499:18
filed (1)
325:24
filled (1)
500:2
finances (1)
480:18
financial (3)
479:8,20;480:7
find (12)
379:22;386:13;394:23;
410:16;415:18;425:3;426:8,
9;430:14;448:1;468:21;
478:2
finder (1)
356:16
finding (3)
404:8;413:23;452:14
findings (29)
388:11,12,14;395:2;
452:15;455:18;456:10;
457:11,14,17;458:2;466:14;
467:5,9;468:2,3,4;469:5,8,
11;471:21,21;472:18,21;
483:6,24;484:4,9;501:15
finds (1)
472:12
fine (2)
380:20;433:18
finger (8)
375:23;376:1;396:13,16,
20;413:9,9;448:13
finger-like (1)
413:8
fingers (29)
395:14;396:9,10;397:2,7,
23;398:4,8,11,14;409:5,6,
23,24;410:13,18,20;411:17,
19;412:12,12;413:7;425:4;
442:9;448:3,17;449:18;
464:24;465:2
finish (1)
516:4
finishes (2)
338:21;518:2
fired (1)
352:22
first (18)
327:19;328:1;329:17;
330:15;371:16;378:7;421:6;
427:14,15;446:6;463:8;
464:23;465:2;467:4;471:2;
482:6;483:8;513:21
Firstly (1)
358:16
five (9)
357:17;395:14;396:8;
412:23;436:11;472:15,15;
485:13;512:7
five-minute (2)
357:20;485:11
FLAIR (22)
388:18;389:21;390:8,9,
10,11,15,19,19;395:6,8,22;
396:4,12;397:20;446:8;
463:11,12,15,16;484:6,7
F-L-A-I-R (1)
390:12
flashing (2)
372:11;509:17
flipping (1)
449:24
flow (1)
444:17
flow-related (1)
440:11
flu (1)
447:9
fluid (1)
387:24
fluid-filled (2)
387:23;442:3
flushing (2)
431:6,9
foci (1)
441:21
focus (3)
388:17;389:11,21
focused (1)
491:6
follow (4)
363:7,15;422:6;514:19
followed (1)
363:12
following (3)
431:22;440:23;462:12
follows (1)
327:20
follow-up (8)
353:22;354:12;382:20;
403:7;419:18;422:2;423:24;
510:6
form (5)
352:5;368:15;474:6;
500:2;501:24
formal (2)
341:4;344:18
formally (2)
341:10,13
format (2)
342:21;499:20
formed (1)
343:21
former (1)
336:5
forms (1)
476:7
formulate (1)
368:16
formulates (1)
424:15
formulating (1)
447:1
forthcoming (1)
327:5
Forty (3)
339:7,10;436:21
forward (1)
333:23
fossa (2)
442:14;458:8
found (8)
335:1,14;356:20;425:8,
10;443:20;499:18;501:1
four (6)
329:16;331:2;346:24;
347:18;361:9;412:23
fourth (2)
474:20;475:12
frame (3)
336:11;394:20,20
free (1)
422:6
frequent (4)
511:1,7,10,11
frequently (6)
372:10,17;377:3;456:7;
474:18;484:1
Friday (4)
516:21;517:9,13,18
front (12)
359:7;378:8;384:3;
392:24;411:7,11;442:6;
473:23;496:18,24;517:17,19
frontal (6)
388:18;389:13,16;441:23;
442:5,6
fulfilled (1)
415:11
full (4)
370:2;381:13;430:7;519:8
function (1)
431:24
functional (8)
421:16;425:11,18,20;
426:20,23;429:1,4
functioned (1)
342:11
functioning (1)
331:5
further (17)
334:16,20;338:8;353:18;
354:9;372:1;397:12;410:15;
429:22;430:4,20;440:3;
442:7;452:16;475:16;
493:18;509:8

G

Gadolinium (3)
403:14,15,16
gait (1)

509:6
ganglion (3)
510:17,19,20
gave (3)
346:16;394:12;416:5
general (7)
376:21;386:12;387:21;
413:5;432:11,22;485:6
generally (5)
346:2;378:14;396:19;
420:22;490:23
gesturing (1)
327:12
GI (1)
423:5
giant-cell (1)
378:22
giveaway (3)
426:4,4,10
given (45)
326:5;346:24;364:11;
366:19,21;379:23;394:3;
412:1;422:11;431:12,13,14;
432:17;440:15;449:8;451:8,
13;452:17;455:21;457:1;
463:18;468:20;469:16,18;
476:6;477:20;481:18;485:5;
488:8;491:23;495:2;496:3,
11,13,14,15;502:11;512:8;
514:12;515:4,4,7,8,8;516:7
gives (5)
387:18;451:14;495:20;
497:18;500:19
giving (6)
352:14,17;365:16;388:12;
453:21;457:14
Glick (1)
330:16
goal (1)
469:18
goes (8)
343:7;385:2;392:3;
400:16;424:13;429:21;
440:6;444:19
Good (12)
340:17,19;361:8;390:19;
398:9;406:4;420:22;450:3;
455:22;457:20;485:10;
515:17
government (3)
338:21;350:10;382:9
granted (1)
336:12
gray (6)
325:5;387:15,16,20;
390:17;483:22
great (4)
357:16;481:16;485:6;
515:22
greater (2)
393:23;443:14
Greeley (7)
338:7;345:14;346:11;
350:7,11,16;353:10
greeted (1)
367:24
group (1)
365:5
G's (2)
384:13;392:2
guarantee (1)
358:7
guess (4)
367:22;452:5;496:20;
516:2
guesstimate (2)
435:5;436:8
gums (1)
411:6

H

half (4)
382:10;435:5;516:10,18
halfway (1)
357:9
hallway (1)
356:6
handout (1)
476:16
Hands (1)
510:24
happen (5)
336:11;337:4;400:8;
433:24;470:1
happened (5)
352:19;353:5;443:14;
455:14;473:4
happening (1)
392:9
happens (4)
400:11,14;401:11;444:15
happy (2)
356:11;518:22
hard (3)
331:9;333:24;471:20
harm (1)
433:1
head (9)
333:6;372:9;375:9;407:7,
7,23;408:6;486:4,9
headache (11)
365:10;366:23;370:11,18;
371:23;372:2,3,9,14,15;
509:7
headaches (13)
365:7,9;367:7;368:11;
370:19;419:7,23;422:6,9,15;
455:6;483:24;484:1
Health (23)
326:12,17,18,19,21,23,24;
328:9,17,19;329:5;333:4;
346:11;348:23;352:16;
353:5,22;358:17;373:16;
438:5,7,13;477:9
heard (3)
341:5;394:11;496:21
hearing (25)
325:13;326:5,18;327:6;
337:9,24;340:21;341:14,22;
342:18;348:13,22,23;
349:17;350:3;352:7,15;
353:6;355:8,13;358:16;
413:15;482:4;517:22;
519:17
heart (1)
326:16
heaviness (2)
440:4;487:19
held (1)
348:23
help (7)
330:15,18,23;331:13;
365:7,10;455:4
helpful (5)
356:14;381:19;402:16;
454:21;483:17
helping (2)
330:17;416:5
hemisphere (1)
440:9
hemispheres (3)
390:1;442:5;456:23
hemorrhage (1)
375:10
hereditary (1)
372:4
heroin (2)
360:4;363:6
herself (2)
424:10;436:6
high (7)
395:8,23;396:3;483:22;
484:6,6,7
highly (2)
352:17;353:11
himself (3)
325:23;356:19,21
hired (1)
353:23
his- (1)
368:10
history (85)
361:4,6;362:5,8,14,18,23;
363:5,15,17,19,20,22,24;
364:3,4,7;365:21,22;367:6,
16,20,24;368:6,10,15;370:3,
18;379:15,17,18,20;380:11;
392:11;415:15,16;416:9,24;
418:16;420:21,22;424:14,
18,19;429:24;437:16,20;
439:20,22,23;440:1,15,17;
443:13;444:1;449:8;465:16;
466:1,3;470:24;471:17,18,
19;472:3;477:24;482:17;
487:17;490:13,21,24;493:4,
5,6,10;500:10;504:4,5,7,9;
505:24;508:19;509:13,13,
18;513:20
holiday (1)
517:15
Honor (13)
338:12;339:1;340:5;
348:20;349:1;353:19;
354:20;384:16;405:7,20;
412:1,8;515:21
hope (1)
346:17
hoping (1)
357:6
Hospital (11)
328:23,24,24;329:1,21;
330:6;331:20;336:8;359:20,
21;364:1
hospitals (1)
374:1
hour (6)
339:12,20;355:10;356:5;
435:5;485:2
hours (1)
331:8
H's (1)
351:4
huddle (1)
405:11
huddling (1)
405:21
hundred (1)
396:22
hurts (1)
510:18
Hydroxychloroquine (1)
501:8
hyperintense (3)
388:17;389:11;441:21
hyperintensities (1)
409:15
hyperintensity (8)
388:15;389:9,18;408:12,
20;409:4,14;442:1
hyperlipidemia (1)
437:21
hypertension (1)
437:21
hypothetically (2)
369:15;370:5

I

I] (1)
494:16
ice (1)
508:19
idea (2)
351:19;451:15
identify (2)
412:23;475:24
idiopathic (7)
387:9;391:6;442:23;
458:24;497:18;498:1,4
ill (2)
372:14;475:6

illness (7)
425:12;429:1,4;434:16;
493:4,7;500:11
illnesses (2)
404:11;429:14
illustrative (1)
410:19
image (17)
389:7;390:2,5;406:19,20,
22,22,24;407:1,3,21,22;
411:1,13;412:16;441:13;
454:10
images (7)
389:5,5;397:10;406:12;
446:14;452:6;467:19
imagination (1)
413:9
Imaging (11)
371:5,10;372:20;385:17,
17,20;390:19;452:13;
453:10,13;463:14
imbalance (2)
399:19;404:18
Imitrex (9)
365:1,3,4,12;366:21;
367:21;369:5;509:20,23
immediate (1)
351:24
immediately (2)
337:1;468:1
immersed (2)
338:13;354:22
immune (2)
421:11;481:2
immunological (1)
438:17
immunosuppressive (1)
477:10
impact (1)
476:23
impairment (1)
434:21
implication (1)
430:8
imply (1)
473:15
important (19)
348:1;350:18;362:5,23;
363:4;389:22;390:1;395:5;
417:7,11;418:5;422:11;
454:13,14,16,17;459:8;
482:11;499:23
impoundment (1)
351:7
impression (39)
358:14;365:22,23;369:12,
14,20,24;370:4,6,9,14,15,23;
380:1,9;386:19,20;387:1,4;
388:12;390:21;425:13;
438:20;440:8,19;442:17;
447:1;457:12,21;468:7;
470:23;477:21;478:3;488:9,
23;489:19;500:18,19;
504:20
impressions (6)
368:16;386:18,24;440:7;
483:8;490:2
improve (3)
330:24;331:17;400:20
improved (1)
366:23
improvement (8)
332:10,12,14,20;333:12,
14;334:10;514:17
improving (1)
403:12
inadequacy (1)
344:13
inadequate (4)
329:19;415:15;509:1;
514:11
include (18)
326:16;365:20;380:7,17;
381:23;385:18;387:9;
392:22;402:10;404:11;
431:6;442:22;443:2;460:10;
463:15,15;490:19;493:8
included (2)
331:6;333:22
includes (4)
378:20;399:2;401:22;
512:2
including (11)
357:5;358:10;365:21;
392:14;402:14;404:14;
443:2;474:22;481:17;
493:11;504:15
Incomplete (2)
382:5;420:21
incontinence (1)
435:24
incoordination (1)
399:16
incorrect (3)
415:4;469:17;480:6
increase (1)
472:13
increased (15)
389:8;396:3,4,12;405:6;
408:12;409:3,4;410:5,6;
412:21;413:1;456:20;
472:10;484:5
increases (1)
507:20
increasing (1)
418:18
indeed (9)
363:5;364:7;367:14;
391:7;418:24;422:17;
435:21;443:23;471:6
indicate (10)
373:17;421:14;471:9;
481:15;496:5;501:14;
506:24;509:13;511:10;
514:7
indicated (3)
432:13;505:2;511:5
indicates (4)
390:4;455:9;508:5;513:20
indicating (4)
407:11;423:9;495:18;
510:20
indication (49)
362:17;381:3;386:1,2,3;
403:17;409:3;422:17;451:6;
459:7,8,10,12,13;460:7,12,
19;461:1,9,15,20,21,23;
462:22,23;464:9,9,12;465:8,
10;466:13;467:5,9;469:3,4;
478:13;501:12,18;503:4;
509:20;510:5,6,18;511:6;
512:4,5,6,9;514:2
indications (2)
499:1;515:9
indicative (1)
455:13
individual (2)
411:13;434:12
inexact (1)
516:1
infarct (3)
444:11,16,24
infarction (9)
443:22,24;444:6,7,8,22;
445:13;465:23;472:23
infection (4)
375:5,6;377:4,5
inflammation (53)
371:20;373:8;374:11,13,
15;375:1,1,4,7,9,11,13,14,
18,22;376:4,11,23;377:1;
378:19,22;380:2,3,4,7,7,12;
381:8,18;399:10;403:17;
431:15;432:20;453:6,18;
484:14,16;486:12;488:7;
489:3;491:17;492:10,13,16;
497:18;498:2,2,5,7;502:12;
505:22;514:16,20
inflammatory (9)
375:16;378:23;403:13,18;
490:15,18;501:3;505:18,21
influence (2)
386:11;467:9
information (51)
359:13;365:16,21;368:1,
17;379:21,23;386:6;390:22;
393:8;413:11;415:17,18;
417:6,14;419:5,9,13,20,20,
22,23;420:1,7;421:13,18,21,
22,24;422:18,23;440:20;
447:22;451:7;466:21;
480:11;482:9;488:8;490:17,
21;491:16;492:2;499:5,7;
511:2,18,20;512:10;514:3;
515:1;516:7
informed (4)
335:23;349:10;352:11;
382:11
informing (2)
352:9,16
infraction (1)
444:4
infrequently (1)
474:19
initial (3)
433:11;455:1;463:19
initially (1)
334:12
initials (1)
480:24
inject (1)
435:13
injected (1)
496:16
injection (13)
366:20,23;431:11,17;
432:19;434:11;435:1,6;
436:11,14;453:1,3;496:22
injections (18)
431:13;432:17;487:3;
494:17,24;495:2,5,10,13,18,
20;496:3,11,13,15,18;
502:21;510:5
injector (1)
435:11
injectors (1)
435:12
injury (3)
375:10,12;509:4
inquiry (1)
345:16
insignificant (1)
424:23
instances (1)
469:15
instead (2)
418:19;513:4
insufficient (1)
511:1
insurance (2)
374:4;480:18
intense (2)
409:8;431:9
intensity (5)
389:8;396:12;413:1;
483:22;484:6
interactions (2)
330:5;331:15
interest (1)
407:12
interesting (1)
461:11
interface (1)
442:10
interject (2)
456:16;466:11
internal (2)
443:6,7
international (1)
502:6
Internet (3)
410:17;411:14;414:2

interpret (5)
395:11;441:20;456:13,16;510:16
interpretation (13)
386:21;395:4,21,24;415:2;426:22,24;457:3,5;458:21;467:23;469:9,11
interpreted (3)
405:3,3;468:16
interpreting (13)
415:4;429:2,3;451:14;456:18;460:8;462:15,16,17;466:4;467:1,12;469:2
interrupt (1)
411:10
intervening (5)
333:8;334:11;335:6,13;473:7
into (14)
342:10,12;346:15;349:18;365:4;373:18;374:18,18;376:21;384:6,23;392:19;414:23;453:8
intravenous (3)
453:1,3;505:16
intravenously (2)
453:24;506:2
introduce (3)
343:15;384:6,23
introduced (2)
348:12;411:24
invaders (1)
374:17
investigated (1)
349:24
investigation (1)
349:21
investigator (1)
325:20
involve (9)
330:20,21;375:4,14;378:19,19;399:5;429:12,13
involved (3)
396:2;399:13;401:9
involvement (5)
373:5;402:14;442:9,13;470:9
involves (5)
375:7;385:20;399:3,4;429:11
involving (7)
373:4;378:16;413:10;442:20;443:21;445:15;458:13
irrelevant (4)
349:20;352:15,18;353:4
irritation (1)
473:18
ischemia (3)
387:10;442:23;444:19
ischemic (3)
444:20;461:23;462:3
issue (11)
327:7,8;339:10;353:8,12;358:20;364:2;382:18;414:14;471:15;518:5
issues (9)
329:12;330:11;334:13;362:5;418:3;437:17;438:17;443:6;483:11
IV (2)
452:17;508:10
IVIG (5)
513:21;514:1,17;515:3,5

J

jagged (2)
372:12;509:17
James (1)
325:17
January (4)
325:11;349:17;423:17;424:3
jargon (2)
388:20;389:6
job (6)
328:15;341:5,9;347:20;352:21,23
join (1)
406:14
joined (1)
341:2
joint (2)
373:6;423:5
joints (4)
373:5;378:17;488:24;510:23
judgement (1)
344:23
judges (1)
346:3
July (18)
328:11;330:8,8,9;341:3,8,16;342:2,11;347:9,12,19;348:6;464:10;465:5;506:5,22;512:22
jump (3)
373:22;394:23;423:1
June (1)
360:16
juniors (1)
352:21
justify (1)
487:5

K

keep (1)
357:5
Kenneth (1)
325:17
kept (1)
348:9
Khera (5)
423:19;424:9,11;425:7;427:14
K-H-E-R-A (1)
423:20
Khera's (1)
429:3
kind (12)
359:18;364:19;371:15;376:16,16;385:9,10;410:3;484:14;485:4;495:23;499:17
Klonopin (3)
506:11,12,13
knee (1)
471:12
knew (2)
355:3,7
known (6)
372:11;377:20;380:19;400:7;408:8;501:8
knows (1)
342:8

L

L5 (1)
489:1
Lab (3)
371:5,10;372:20
laboratory (1)
373:18
labs (3)
371:15;512:3,4
lack (4)
334:10;405:11;501:15;502:12
lacunar (10)
440:9;443:23;444:4,22,24;447:21;448:21;449:11;465:23;471:5
laptop (1)
405:21
large (14)
329:24;335:22;343:21;378:18,24;388:23,23;389:23;399:13;402:12;429:10;433:15;485:5;506:1
largely (1)
330:12
larger (3)
409:20,21;410:1
last (17)
328:1,1;353:16;357:5;385:24;423:19;427:15;431:9;459:10;461:5;485:2;488:2,2;498:15;506:4;513:21;517:6
lasts (1)
514:19
late (2)
336:23;474:22
later (6)
384:6;400:10,10,10,12;482:12
lateral (14)
387:7,22,24;388:3,16;389:20;391:3;395:10,13;396:7;408:17,18;412:17;447:10
layman's (1)
429:8
layperson (3)
370:14;429:6;447:14
lead (2)
431:16;463:5
least (11)
327:4;336:2;395:14;396:8;430:13;451:17,19;485:4;491:5;517:7,23
leave (5)
326:13,17,20;340:5;453:8
leaving (1)
346:10
led (4)
336:4;410:12;469:4;480:6
leeway (3)
345:16;352:14,17
left (29)
340:9;366:21;388:17;389:12,16;406:23;407:2;408:3,5;410:4,11;428:12;437:22;440:3;443:16,17,17,21;445:15;455:24;471:13,23,24;472:13,16;473:9;493:20;496:7;497:4
left-right (1)
471:11
left-sided (2)
456:6;472:17
leg (22)
399:18;415:22;416:24;417:1,2,3;426:8;438:19,21,22;440:4;443:16,17;445:7,16;471:14,23,24;472:13;473:9;508:21,24
legs (8)
381:2;428:8,10;439:7,10;440:4;472:7;487:20
Leiden (2)
378:1,3
length (1)
409:24
lesion (5)
401:4,4,6,6,7
lesions (17)
395:9,16,23;396:3;401:10,11;403:11,12,13;442:8,13,16;448:13;452:20;455:20;458:5,15
less (17)
393:24;399:20,22;433:9,10;435:6;436:8;444:24;457:1,2,9,10;460:10;482:2;484:3;514:17;516:9
letter (1)
390:11
letterhead (1)

438:8
leukocytosis (1)
377:6
level (4)
333:19,20;334:3;434:18
Levin (39)
354:23;355:5;356:8;
358:8;359:2,4,5;360:7;
366:5;378:7,9;381:20;
382:24;384:3;392:23;
405:11;406:23;407:10,20;
411:9,19;413:24;423:1;
425:1;426:21;432:8;448:20;
450:11,13;466:11;475:23;
479:16;485:7;495:17;
499:17;516:4,14,16;518:2
Levin's (4)
338:13,20;356:13;449:16
life (1)
436:3
lifelong (1)
498:16
lifting (1)
473:20
light (1)
372:13
lighter (2)
387:18;419:11
lights (2)
372:12;509:17
likelihood (1)
507:19
likely (7)
369:17;370:21;410:9;
460:10;475:9;484:3,8
likewise (3)
377:6;411:2;469:24
limited (4)
391:9,9;421:22;493:13
line (8)
345:16;427:15;451:5;
474:20;475:12,13,16;498:15
lines (3)
372:12;491:14;509:17
list (12)
335:8,9;339:3;355:1;
474:16;504:10;518:6,7,8,10,
16;519:3
listed (17)
363:17,22;369:24;371:16;
372:19;376:12,16;380:3;
392:14;419:10;420:21;
478:8,12;494:15;508:7;
511:19;514:13
listen (1)
469:19
listening (1)
346:17
Listing (1)
358:6
lists (1)
482:19
little (15)
376:3;389:12,15;391:11;
402:12;444:9;470:9;471:17;
473:5;511:8,18;514:2,3;
516:9,10
liver (3)
431:23,24,24
lobe (2)
442:5,6
lobes (3)
395:9;396:2;441:23
local (2)
431:14;432:18
localization (1)
457:19
locate (1)
448:24
locked (1)
355:14
long (15)
328:10;422:6,7;431:10;
435:2;444:13;475:18;
493:10;499:4;512:8;514:19;
516:6,13;517:6;519:10
longer (8)
396:18,19;413:6;431:11;
478:22,23;507:18;517:12
look (43)
349:8,18;360:14;371:11,
14;376:14;379:3;385:5;
386:10;389:5,5;390:15,18,
19;409:22;410:3,20;412:12;
413:7,8;427:19,22,24;438:4;
440:16;451:19;457:19;
458:17,20;459:8,9,11;460:5;
467:18;469:21;470:5,12;
474:12;484:3;499:13,19,21;
506:6
looked (6)
411:3;454:9;458:18;
467:16;470:10;474:13
looking (55)
342:10,12;367:22;376:20,
23,24;377:7,14,18,19,20,22,
24;379:15;386:13;389:3;
390:4,5,6;393:12,19;395:7;
397:21,22;405:14;406:20,
21;407:5;409:1;411:10;
412:17;422:17;440:17,18;
441:13,14,16;443:19;
446:15;452:8,9,20;453:5;
460:15;463:8,19;468:17;
472:5;477:14;478:8,12;
479:16;480:3;491:13;496:8
looks (7)
360:15;396:13,19;408:24;
458:17,22;514:17
Loretta (1)
325:19
lose (3)
400:8;431:17,18
losing (1)
418:20
loss (9)
399:15;427:5,16;428:5,
12;433:21,21;508:24;
509:16
lost (1)
332:23
lot (4)
329:18;330:13,14;404:19
lots (3)
339:15;471:12,13
low (3)
416:24;436:10;493:13
lower (8)
365:8;372:5;380:18;
387:12;437:22;442:15;
489:21;493:20
lucky (1)
456:2
lumbar (3)
488:19;492:12;504:16
lumbosacral (1)
488:10
Lunch (1)
450:9
lung (2)
447:10;505:22
lupus (7)
377:21;378:21;383:17;
394:3,4,15;500:14
lymphocytes (1)
374:21

M

machine (3)
389:1;390:15;452:4
MAGISTRATE (279)
325:2,7,11,17;326:9,11;
327:13,19,21;336:10,17,20;
337:6;338:10,16,22;339:2,9,
13,17;340:1,7,14;341:19;
342:7,20;343:1,6,9,12,16,
18;345:7,15,22;346:2,7,14,
20;347:5;348:3,17,21;349:3,
19;350:13,18,22;351:2,6,10,
13;352:4,13;353:3,9,16;
354:11,15,24;355:3,7,12,22;
356:1,13,16,20;357:4,13,17,
20,24;358:4;359:2,22;
360:6;361:21,24;366:2,5,8,
16;367:4,8,13,18;368:4,8,
20;369:14,19,23;370:5,13,
23;371:2;373:21,24;374:3,
10;378:2;380:14;381:3,6,8,
16;382:3,6,11,15;383:22;
384:2,5,10,14,19;390:8,13;
392:1,23;394:22;405:16,23;
406:5,9,13,16,21;407:10,15,
20,24;408:21;409:9,13,18;
410:10,22;411:9,16,21;
412:2,9;413:14,17,22;414:6;
421:6;422:24;423:7,10;
425:1,17,22;426:2,18,21;
427:2,4,8,13,23;429:6,16;
430:16;432:7;433:2;434:8,
13;435:2,7,15;436:4,10,15;
446:22;447:13;448:18,23;
449:6,15,23;450:3,6,10,21;
452:23;453:2,23;454:4;
456:15;457:6;459:16,19;
460:17,20,24;461:6,8,17,19;
462:1,4,8,13,16,18,21;463:1,
5,21,24;464:4;466:10,17,19;
467:3,8,14;468:23;469:2,7,
10;473:23;474:24;475:12;
477:6,11;478:9;479:4,15;
480:5,10,16,21;485:1,11,13;
486:6;494:18,20;495:16,23;
496:4,17,24;497:3,6;499:8,
12,16;502:16,19;507:4,9;
508:12;511:9,14;512:14;
515:13,19,24;516:12,17,21,
23;517:4,14;518:1,9,15,19,
24;519:10,15,19,24;520:5
magnets (2)
388:23,23
main (4)
431:18,19;432:21;478:18
mainly (2)
387:15;399:3
makes (5)
375:17;399:9;434:6;
468:1;497:21
making (7)
331:6;373:17;430:17;
454:21;455:4;457:13;
483:17
mammography (1)
385:19
manage (1)
434:16
management (5)
330:3;331:11;344:21;
434:21;436:5
managing (1)
479:21
manipulate (1)
406:24
manipulating (1)
407:21
many (32)
332:15;374:6,8;375:3,3;
380:6,6;391:5;404:9,9,11,
11;420:5,6;429:10;431:5;
432:3;435:21;455:20,20;
456:7;465:20;474:21;
490:19,19;493:14;496:12;
509:24;510:1;512:6;514:24,
24
March (9)
371:17;379:4;385:11;
441:6;471:3,4;512:13;
513:4,17
margins (1)
343:24
Marianne (1)
325:4

Marjorie (1)
366:10
mark (4)
424:18,19;488:7;511:24
marker (1)
393:22
markers (1)
393:13
Massachusetts (1)
329:2
material (7)
387:18;403:13,15;452:22;
453:22;463:16,17
matter (38)
345:5;361:2;369:7;387:5,
14,15,15,16,17,19,20;388:5,
7,7,18;389:14,18;390:17,17,
20,23;391:2;399:3;408:9;
409:2;424:23;441:23;
442:10,12,18,19;456:21,23;
458:14,14,15;460:9;483:22
matters (1)
327:10
may (78)
327:5;329:8;338:11;
340:13;343:18;345:24;
350:24;353:13;355:22;
356:2;358:2,6,6;362:11;
373:5;380:13;381:9,19;
386:16;387:1;395:4,10;
397:12;400:4,8,8,15,15;
401:4,5,24;410:20,20;
412:10;416:15;418:2;426:1;
428:11;429:16,19;437:18;
439:7;441:17;444:8;447:19;
449:3;451:16;452:16;
453:14,15,18;455:1,4;459:5,
11;464:14;467:21;468:7;
469:17,21;470:2;475:3,16;
483:23;485:3,9;487:24;
494:14;495:12;500:2;
501:21;512:11;513:3;
517:14;518:13;519:21,21;
520:2
maybe (1)
472:12
McDonald (5)
401:18,20,22;402:4,6
M-C-D-O-N-A-L-D (1)
401:18
MCTD (1)
511:24
MD (7)
325:16;327:17;359:5;
423:20;462:14;492:24;
503:15
mean (16)
332:13;342:13;366:6,11;
386:2;388:9;391:12;395:12,
21,23;403:4;435:7;436:11;
489:23;499:12;504:18
meaning (4)
401:2;403:1;458:3,24
means (16)
329:18,21;387:11;390:8;
391:10;393:18;419:12;
439:2,3;444:11;446:23;
458:12;475:13;491:18;
508:22;510:24
measurement (3)
390:9,13,14
measures (2)
377:24;394:10
measuring (1)
484:7
medical (130)
335:19;336:6;337:2;
351:23;359:10,14,16;360:8,
12,14;362:2;364:15;366:9;
371:3,8;374:1;378:16;
379:2;383:3;384:13;385:1,
15;386:18;392:3,4;397:16;
414:9;415:7,9;418:9;
420:14;423:3,6,12,23;
429:11;436:22;437:9;
438:11;439:12,17;441:1,3;
445:24;446:1,4,6,24;447:17;
450:19;451:4;459:3,18,22;
460:4;461:1,3;462:8,9,13;
464:1,16;465:6;466:8;
470:14;477:14;479:2,13,16;
480:19,23;481:10;482:14,
17,21;483:2;484:19;485:17,
22;486:2,14,15,18,19;487:8;
488:14,15,17;489:10,13,18;
490:8;492:18,19,22;493:17;
494:5,7,9;497:7,10;499:6,9,
18,24;500:3,4;501:20,22;
503:8,9,12;504:2,4,4,6,8;
505:3;506:3,6,22;507:11,13,
23;508:14;510:7,9;512:12;
513:7;515:12
medication (58)
361:5,9;363:1,2,3,8;366:1,
18,19;369:3,13;381:10;
383:9,18,19;415:21;417:4;
418:1;419:16;421:9,11;
422:8,19;431:2,4,12;432:15,
16,16;434:22,24;474:3,21;
476:23;477:3,17;479:9,23;
480:2;481:17,19;492:3,6;
495:1;496:13,14,16;501:4,
13,18,24;504:10;506:14;
509:21;510:3,4;514:1;515:6
medications (28)
329:24;365:6;418:22;
419:2;420:1,4;421:2;
422:22;432:12,23;474:16;
475:10,15;479:23,24;
480:12;481:3;487:1,5;
492:2;495:3,8;502:8,13;
505:1;506:19;515:3,5
Medicine (10)
325:15;327:2;333:7;
349:22;365:4;378:11;
385:16;435:7;478:6;504:1
medicines (3)
365:5;432:24;480:4
Medicine's (1)
355:1
meds (1)
502:17
meet (3)
333:18;334:8;405:22
meetings (1)
348:9
member (2)
331:5;333:3
members (2)
331:22;344:6
memory (1)
337:22
meningitis (1)
375:6
mention (13)
381:20;397:7;398:12;
418:6;421:7;422:12;448:2,
21;458:6,7;477:13,23;478:3
mentioned (9)
335:6,13;431:2;436:16;
444:4;445:6;448:5,11,16
mentions (1)
491:10
met (2)
334:1;348:10
meta (2)
456:19;457:15
metabolic (1)
437:20
methadone (1)
506:24
Methylmalonic (1)
377:17
microvascular (2)
387:10;442:23
middle (5)
338:20;396:15;407:17;
408:16;433:19
might (12)
333:21;344:14;359:12;
370:17;433:3;447:8,9,10;
459:24;467:13;468:19;
511:10
migraine (26)
365:6,9,10;369:16,17;
370:8,9,10,10,22;371:20,23;
372:3,14;373:13;376:10;
419:7,23;483:23;484:1;
502:23;508:22;509:7,12,16;
511:13
migraines (20)
371:22;380:13;383:2,7;
386:1;392:16;404:15,15;
422:12;482:19,23;493:12;
510:24;511:5,7,9,11,23;
513:23;514:4
mild (16)
387:4,9;388:4,8,15;
389:19;390:22,24;391:4,6;
410:8;414:24,24;455:2;
472:17;483:20
mildly (1)
484:17
milk (1)
418:19
milligrams (3)
365:1,12;512:7
millimeters (2)
444:24;484:8
mind (1)
358:21
mine (1)
513:13
minimal (3)
434:19;472:14;488:24
minutes (17)
339:7,10;346:10;348:9,
10,12;354:17,19;357:14,17;
366:22;406:6;431:10;436:8,
11;485:13;515:16
misprescribed (1)
480:13
misspoke (1)
359:17
mistake (2)
375:17;399:9
mixed (5)
435:9,13;498:3,8;511:24
mixture (1)
387:20
Mm-hmm (1)
351:12
mobilization (2)
374:20,22
mobilize (1)
375:24
moderate (4)
441:20;442:17,19;460:9
modulating (1)
481:3
modulator (1)
421:11
moment (2)
358:3;440:16
Monday (3)
517:9,10,15
monitoring (2)
330:1;471:16
month (6)
372:16;381:14;400:10;
401:12;432:16;480:1
months (7)
330:15;342:19,24;400:10,
12;401:12;449:21
more (50)
325:6;331:12;333:19;
339:16;340:13;345:20;
355:17;369:20,24;372:17;
379:20;383:4;401:2;403:11,
20;408:15;414:2,4,7;
418:20;425:11;431:20;
439:5,20;453:21;455:20,20;

456:7;467:24;468:18;470:7,8,10;471:12,13,13;473:17;475:5,7,9;482:2;493:20;511:1,7,10,11;514:1;515:3,16;516:10
morning (7)
339:5;340:17,19;433:17;471:12;508:19;516:4
morphology (1)
448:13
most (19)
332:21;334:20;335:8;370:21;387:5;391:2,5,7,12;400:18;433:11;435:21;436:19;437:5;455:19;474:6;516:20,20,21
mostly (3)
438:19;441:23;442:5
motion (2)
382:16;412:1
motions (1)
405:18
Mouth (1)
407:8
move (6)
333:23;356:11;383:23;408:3;466:11;481:20
moves (1)
514:18
moving (6)
407:4,18,22;408:6,14;410:2
MRA (7)
441:9,9,11,14,15,17;443:4
MRI (83)
385:12,19;388:21,22;393:3,6;394:19;395:3;396:1,11;397:7;398:10,13;401:22;402:1,7,10,19;403:1,2,2,4,14;405:2,5,8;411:3,15;413:12;414:5,22;415:2;424:4,21;429:24;439:14;440:21;441:7;444:2;445:3;449:17,20;451:2,3;453:4;454:2,23;455:18,21;456:8;457:9;458:16;464:1,6,8,10,18,19,20,23;465:5;468:13,21;472:23;483:3,14,16,16,20;484:12;488:9,11,19;489:14,20,21,22,24;490:4;491:6,7;492:11;504:15
MRI's (15)
391:15;402:17;403:3,9,10;452:2;463:2,6,22;491:9;492:8;502:12;504:3,7,12
much (17)
340:9;356:19;392:17,19;396:19;399:20;406:3;409:20;434:14,15;436:7;453:21;457:9,10;471:14;496:15;517:12
multiple (102)
330:2;344:15,21,24;345:8;375:13;395:16;396:21;397:3;398:17,19,21;399:14,21;400:1,24;401:1,1,8,10,11;402:2,11,14,17,24;403:2,8,9;404:5;413:13;414:21;415:2,5,24;416:1,4,15;417:20;419:15;421:13,17;422:4;424:5,19;425:14;429:21;430:2;432:10;433:4;434:2,14;436:6,17;443:2;444:1,3;446:9,18,19;448:14;452:1,9;453:17;456:21;457:16,23;458:19;459:2,13;460:13,14,16,19;466:3,7,22,24;467:2,17,19;468:9,19,20;471:19;472:4;473:1,10;476:3;477:22;478:3;479:9,11;483:11,14;488:4;504:16;505:20;511:2,15;514:8;515:4
multitasking (2)
392:15;404:12
multitude (2)
423:5;493:11
muscle (10)
378:23;392:22;404:21;426:8;473:16,17,20,20;495:13,15
muscles (4)
373:4;378:17;473:15,21
myalgias (2)
438:22,24
Mycophenolate (1)
477:6
myelin (6)
387:18;399:5,7,7,10;458:13
myself (3)
335:19;405:3;446:14

N

name (11)
325:3;328:1,2;335:11;351:4,11;354:3;423:19,20;501:7;503:18
named (1)
358:14
names (8)
335:10;362:1;518:13,14,17,18;519:8,8
narcotic (4)
334:20;369:5,8;506:16
narcotics (3)
334:24;335:23;336:3
Nardin (39)
326:8,9;327:15,17,24;328:3;338:10,20,23;339:3,4,8,14,16;340:2,8,18;342:13,18;344:15;345:2,11,12;346:9,12,23;347:7;348:5,15;349:5;350:1;351:3,10;354:17;355:4,18,19;358:12,14
N-A-R-D-I-N (1)
328:3
Nardin's (2)
339:18;358:19
narrowing (1)
443:6
nature (1)
331:14
nearly (3)
396:21;413:13;425:8
necessarily (2)
456:1;519:17
necessary (2)
358:6;476:8
neck (3)
441:10,15,16
need (23)
339:16;340:13;343:2;355:16;356:21;357:13;361:5;368:23;369:2,2,8,11,12;403:20;406:1;412:3;432:23;456:16;498:16;509:8;517:7,9,23
needed (2)
331:4;332:7
needles (1)
487:19
needs (2)
485:1;507:5
negative (7)
394:17;423:8,9;468:6;478:15;507:19;508:23
negatively (1)
483:18
Neither (1)
426:19
nerve (11)
387:16,17;399:2,3,4,5;428:7;439:2,4,5,6
nerves (3)
380:24;399:11;439:9
nervous (27)
371:21;373:9;374:12,13,15;375:15;376:11;380:16,21,23,24;398:24;399:12;401:3,9;405:1;428:1,2,3,6,15;429:23;433:14;484:16;489:4,6,8
neuro (1)
439:2
neurogenic (3)
441:8;460:7;461:22
neuro-imaging (1)
424:20
neuroinflammation (1)
393:13
neurologic (17)
362:14;377:8;380:5;399:23;404:24;419:3,8;421:14;430:14,17;433:16;434:3,20;435:22;473:9;488:4;509:8
neurological (24)
368:13;400:5,5;416:19;419:13,18;422:2;424:11,14;430:10;437:17;440:18;443:19;471:21;482:24;483:11;487:24;488:5;491:3,6;493:19;502:22;514:22;515:8
neurologist (7)
328:4;383:20;386:23;398:17;509:2;511:21;514:14
neurologists (3)
328:16;329:10;344:20
neurology (5)
328:13;354:1,6;423:21,22
neurons (1)
387:16
neuropathic (1)
438:17
neuropathy (7)
428:7,7;438:22,24;439:2,3,11
new (16)
405:16;411:11,12;419:8,16;437:19;455:3,5;472:20;473:9;487:22,23,24;488:4;511:16,17
Newer (1)
401:17
newly (1)
479:19
news (1)
353:2
next (22)
326:7;339:22;349:4;364:10;373:9;380:13;386:17;418:10;430:6;432:5;437:7;447:16;475:24;476:11;481:20;488:22;489:10,12,18;490:2;491:11;515:16
nice (1)
409:1
night (1)
438:19
nine (2)
412:24,24
NKDA (1)
450:14
nodding (1)
384:10
noise (1)
326:2
non-contrast (4)
441:7;451:3;483:20;488:20
non-financial (1)
374:5
nonspecific (1)
402:13
non-specific (41)
373:7;377:1;380:3,8;

387:4;388:5,8,15;390:22,24;
402:22;404:8,13,17,23;
405:6;408:11;410:8;414:24,
24;429:9;442:8,18,20,24;
444:3;446:19;458:23;460:9;
466:5;468:17;470:2,7;
483:21,24;484:9;490:19;
491:18;495:14;498:8;
514:20
nor (2)
426:19;503:4
normal (32)
375:18;387:23;388:19;
389:21;391:13;393:17,24;
397:20;398:6,7;399:9;
403:5;405:5;409:1,10;
413:4;416:21;425:8;429:24;
455:8;458:8,9;468:16;
472:7,8,11,15;484:18;
486:10,11;489:1;504:19
normally (4)
380:17;453:7;461:13;
468:2
nose (1)
407:6
notation (2)
452:12;481:4
note (105)
326:14,14;329:19;359:18,
19;360:2,19;362:9;364:1,21,
22;365:1,11,15,19;366:12,
15;367:5,19,23;369:8;
370:2;376:9;379:4,8,9,11;
381:22;382:5,10;384:18;
385:24;394:2;395:11;398:4;
415:10,12;417:11;418:5,10;
419:18;420:15,18;422:5;
423:18;424:10,13;426:20,
22;429:20;430:5;437:10;
438:12,18;439:18,19,24;
446:2;448:12,20;454:9,10;
458:2;464:14,20,22,24;
465:4;470:16,16;471:3;
477:18;478:13;479:17;
482:16;486:12,21;487:10,
12;490:9;491:9;492:20,21,
23;493:17;496:9;497:13;
501:21;506:22;507:6;508:2,
4,15,17;510:7,17,19;511:3,
12;512:13;513:14,18;514:7;
515:17,17
noted (5)
361:6;389:17;449:5;
457:15;491:1
notes (37)
329:19;331:6;343:24;
344:7,10,11,13;367:11;
369:18;370:1;379:15;
388:14;392:11;393:15;
415:16;416:2,4;424:17;
427:5;440:1;448:22;449:2;
464:12;470:24;471:7,7;
472:7;478:1;483:23;487:4;
493:10;494:16;499:6;502:2;
503:4,5;509:14
notice (4)
334:6;341:7;358:11;
461:12
notices (1)
326:1
November (4)
336:24;349:16;352:3;
508:4
nuclear (1)
377:20
number (44)
325:12;343:21;359:16,17;
371:7;376:18;379:2;384:24;
397:16;415:8;416:10;
419:16;427:20;429:10;
446:3;448:8;458:3;459:16,
19;474:15;475:18;478:10;
479:2;482:15;486:6,16,17;
487:23;488:13,14,18;
491:24,24;494:7;503:9;
505:4,9;506:4,6;510:9;
512:9,9;513:6,7
numbers (4)
450:22;482:2,2;503:13
numbness (5)
399:16,17;400:4;440:5;
493:20
numerous (5)
341:14;395:8;396:1;
412:22;438:15
Nurse (13)
325:19;366:10,13,18;
367:3,5,20,23;368:3,6,18;
450:17;508:6
nurses (1)
332:2
nursing (1)
422:5

O

oath (8)
341:18;342:1;343:5;
345:12;348:7,13;359:3;
450:11
object (1)
411:23
objecting (1)
382:9
Objection (20)
342:4;345:4,7,21,23;
346:16,19;347:3,6;348:2;
382:2,4,6;391:22;405:17;
426:17;448:15,24;449:16;
507:3
objections (2)
346:4;353:4
objective (3)
467:21,22;491:15
observed (1)
428:14
obtain (1)
364:7
obtained (4)
363:17;411:14;440:18;
466:1
obtaining (1)
363:15
obviously (2)
435:23;475:21
occasion (2)
475:21;495:15
occasional (1)
440:9
occasionally (1)
474:17
occur (10)
375:22;376:5;391:13;
399:14,19,22;400:6;429:1;
455:16;509:16
occurred (4)
445:4;465:19;467:13;
482:12
occurring (1)
428:9
occurs (1)
365:9
o'clock (4)
358:11;450:1;515:14,20
October (5)
336:24;347:9,13;437:11;
486:5
off (12)
326:3;357:3,22;360:4;
395:9,13;396:6;406:7;
450:8;472:16;485:14;520:6
office (1)
520:3
official (1)
414:23
officially (2)
405:4;446:16
often (3)
510:1;514:5;515:7
oftentimes (12)
363:2,3;365:9;370:9;
372:4,13;378:17;426:12;
454:24;455:19;468:15;
487:3
old (3)
440:8;472:23;473:5
omission (1)
364:4
Once (10)
340:4;368:9;372:16,18;
484:11;485:24;518:12,13;
519:7,8
One (57)
325:6;332:3,16;346:13,
23;350:10,20;372:9;393:21;
394:15;398:9;399:2,18;
400:9;401:3,9,23,24;403:2;
405:18;407:1;411:14;
412:23;413:21;417:23;
424:7;428:19;431:21;445:7,
16,17;449:13;450:1;457:9;
459:5,24;462:9;463:2;
467:5;473:8;474:16;475:14;
481:2;486:23,23;491:9;
493:2,18;498:14;502:4,5,7;
511:4;515:7;516:8;518:1,5
one-half (1)
384:18
one-hour (1)
450:7
ones (3)
409:11;412:22;432:4
only (14)
339:12;355:23;365:11,24;
367:22;380:2;381:24;
384:17;393:22;399:1;410:7;
417:6;429:2;477:9
onset (3)
433:11;473:6;474:22
onto (1)
418:10
opathy (1)
439:3
open (4)
329:18;332:16,17;517:16
opiate (1)
349:7
opiates (1)
349:12
opinion (8)
347:23;421:20,21;429:3;
465:12,12,13,14
opioid (3)
335:18;505:1;506:16
opioids (1)
504:22
opportunity (6)
338:22;340:2,8;354:16;
355:18,23
opposed (5)
380:23;387:12;425:12;
429:5;490:24
opposite (1)
470:1
ops (1)
492:20
optic (1)
399:2
optional (1)
495:24
orally (1)
476:6
order (13)
351:3,7;355:13;358:8;
367:9,12,17;371:5,17;
489:14;501:24;502:4,6
ordered (14)
366:17;367:16;371:14,15;
382:1;383:7;385:23;386:8;
440:21;483:3;488:20;
489:22;492:21;512:4
ordering (8)

367:2,21;451:8,11,15,18;
462:18;465:6
Orders (4)
371:10,12;372:20;383:18
organic (10)
425:10,12,18,19;426:13,
19,23;429:5,12,17
organized (1)
357:14
orient (2)
406:20;407:4
original (3)
435:20;449:14;465:22
originally (1)
465:22
orthopedic (3)
492:20,21;503:16
Others (2)
372:16;410:1
Otherwise (4)
419:12;423:7;471:14;
489:1
out (19)
357:9;358:8,10;381:1;
392:18;394:7,23;407:23;
430:17;436:7;438:22;449:4;
460:22;478:22;485:4;
494:21;500:2;507:10;518:3
outline (1)
407:13
outlined (1)
331:2
outside (5)
333:22;337:17,18;374:17;
437:4
ovarian (1)
482:20
over (25)
327:4;330:15;333:8;
342:18,24;344:23;366:13;
372:7,9;375:6;382:12;
398:20;401:11;403:10;
407:8;410:5;411:6,6;
428:12;431:7;433:10;
472:15;473:8,10;475:19
overall (5)
332:19;362:14;377:1,11;
437:17
overdose (2)
335:18;349:8
overlook (1)
347:22
overrule (1)
449:16
Overruled (2)
392:1;427:2
oversee (1)
347:22
overwork (1)
404:10
own (3)
368:14,15;469:14

P

Padmanabhan (177)
325:16,23;326:15;327:12;
329:4,17;330:15,24;331:3;
332:11,14,23;333:3,15;
334:18,24;335:22;336:2,15,
18;337:10,23;338:11,12,19,
24;339:7,11,15;340:1,4,7,
12,17;341:21;342:9,16,20,
22,23;343:4,7,11,14,17,20;
345:5,8,10,17,18,24;346:5,
12,14,18,22;347:7;348:5,19;
349:1,3,5;350:1,15,20;
351:9,16;352:8,13,20;353:7,
13,19;354:11,14,16,20;
355:2,5,9,15,21,24;356:7,15,
18,23;357:1,6,10;358:11,13,
18,20;360:19,22;361:22;
363:10;364:22;367:21;
371:11;378:4;381:14;382:2,
5,8,17;384:7,16;385:23;
391:22;393:1;405:10,20;
406:13,15,17;410:12,18;
411:21,23;412:2,8;414:10;
418:11;422:9;426:17,19;
446:2;448:15,19,24;449:5,
11,12;462:10,19;464:7,13;
465:1;470:17;481:5,9;
483:4;484:23;488:20;
489:14;493:2,22;497:9,15,
21;500:2;501:5;502:1;
505:13;506:9;507:3,5,22;
508:8;512:23;515:21;
516:12,15;517:5,7,23;
518:11,18,22;519:7,13,18,
23;520:4
Padmanabhan's (15)
329:13;335:4;336:7;
337:13;358:20;362:9;
365:13;379:10;392:6;
414:16;418:12;420:16;
439:18;447:18;470:19
page (74)
354:23,23;356:10,10;
371:7,9;378:7;379:2,3;
380:13;381:9,10,24;383:23;
384:22;385:5;386:17;
388:14;397:18,19;413:21;
418:11;420:14;427:8,11;
438:12;439:16;446:3,6;
447:16;448:8,11;449:8;
451:10,11;460:2,5,6,12;
461:4,5,7,13,15;463:8;
478:10;481:9;482:2;485:21;
486:17;488:22;489:10,12,
18,21;490:3;493:2,9,23;
494:1,5;497:9;500:17,18;
502:2;504:2,8;505:11;
506:8;508:8;512:24;513:1,
1,6
pages (9)
342:18,24;385:3,7;
449:24;481:21;482:7;
485:24;486:3
paid (1)
507:6
Paikos (169)
325:17;326:5,8,10,13;
327:11,15,24;337:7,8;338:8;
339:4,11,17,19;342:4;345:4,
21;347:3;348:2;350:24;
351:5,6;353:21;354:9;
356:4,7,24;357:7,12,15,19;
358:2,24;359:1,7;360:1,8;
362:4;363:12,14;366:2,4;
368:9,23;371:3;373:21;
374:11;378:6,9;381:12,19;
382:11,13,24;383:1,22,24;
384:4,9,12,21,24;392:2;
393:1;394:22;395:2;405:7;
406:3,9,11;410:15,24;
411:12,18;412:9,11;413:14,
16,19;414:4,7,9;421:10;
422:24;423:11;425:3;
427:12;430:1,22;436:16;
447:16;448:20;449:2,6,17,
23;450:2,5,13,23,24;454:7;
459:17,18,21,23;464:5,6;
466:10;469:13;474:2;
475:22;477:13;478:9,11,15;
479:7,16;480:5,8,14,15,19,
22;481:10,12;484:24;485:3,
9,12,16;486:7,8,11;493:3,
23;494:19;497:7,10,12;
499:8,11,14;500:1;502:18;
503:7;507:11,23;508:3,13;
512:15,17,24;513:3;515:13,
15,24;516:3,18,20,22;517:1;
518:5,10,24;519:2,11;520:1
Paikos' (1)
354:12
pain (35)
329:24;331:10;334:19;
370:13,16,20;373:3,3,6,7;
379:18;392:14;399:19;
404:6,20;419:7;420:23;
421:9;422:6;423:4,5;430:7;
434:21;438:19,21;440:4;
441:8;460:6;461:22;493:13;
495:13,15;499:4;504:1;
508:20
painful (1)
495:13
pains (2)
420:24;421:4
palsy (1)
503:2
paper (3)
391:24;405:18;414:5
paraesthesias (1)
493:19
paragraph (2)
427:15,15
paralysis (1)
433:20
parameter (1)
395:17
paraphrasing (1)
446:9
parentheses (2)
498:3,4
parietal (3)
441:23;442:6,7
part (30)
328:12,15;329:7;330:16;
332:6;337:13;344:5;347:20;
352:21;363:20;380:19;
381:16,21;383:5;389:2;
391:2;403:6,7;433:11;
444:14;449:20;476:16;
480:6;482:1;489:6,8,16;
490:7;491:19;499:23
particular (11)
385:16;386:6;390:1;
416:7;428:16;444:23;
451:23;452:10;460:11;
496:8;506:18
particularly (3)
362:24;374:21;502:23
parties' (1)
325:23
partner (1)
434:11
Partners (2)
425:16;476:3
parts (1)
492:9
pass (2)
344:23;368:6
past (10)
398:20;437:18;471:20;
472:1;482:17;504:4,4,6,7,8
pathologic (2)
396:21,22
pathological (6)
374:14;375:2,20;376:7;
391:14;514:23
pathologically (1)
445:1
pathology (5)
376:10;390:18;413:3;
421:12;439:5
patient (155)
329:18;331:7;332:17;
334:22;335:9,11,12,12,14,
21;336:3;339:22;345:11,11;
350:10,14,15,17,20,22;
351:4,11,17,20;356:9,10;
359:8;360:2,3,4,20,23;
361:2,7,11,14,18;362:6,18,
24,24;363:4,8,21;364:12;
366:13;367:24;368:20;
370:18;372:13;379:15;
384:13;386:16;392:2,10;
394:20;400:15;406:12;
414:8,11,20;415:17;416:14;
417:8,17;418:2,7,16;419:14;

422:7;424:2,17;425:7,13,14; 426:3;428:22;429:17;430:5; 431:1,21;432:5,6,9;433:3; 434:14;435:9;436:5;437:8, 12,19,19;439:10;443:9,9; 451:21;452:7,17,21,24; 453:24;454:4,19,20;456:8; 457:7;460:14,16;462:7; 463:12;465:18;466:2; 469:20,21,23;470:4,4,6,8; 473:13;479:18;480:12; 481:14,22;482:12,13; 483:12;487:18,23;488:3; 491:4,7;494:18,22,23; 498:21,22;500:22;504:9,14; 506:18,23,24;507:7,7,15,18; 509:3;511:3,19;512:11; 514:10,15;517:8,10
patients (30)
329:20,24;330:3,5; 331:10;334:19,23;339:21; 345:13;347:15;350:6; 365:20;376:19;400:1;426:4; 432:12,23;433:9;434:8; 454:22,24;474:7,9,11;475:5, 11;478:19;495:12;505:19, 24
patient's (21)
335:24;336:4;349:7,11; 361:5;362:4;365:16;367:6; 397:4;407:6;408:6;413:23; 414:2;424:21;436:23; 450:19;455:22;465:16; 480:17;490:21;493:5
pattern (4)
395:15;442:7;448:14; 454:20
patterns (2)
335:2;428:4
Paul (2)
492:24;500:9
pay (1)
499:24
PCP (2)
430:6,19
peculiar (1)
458:10
people (22)
329:9;331:15;372:15,17, 24;392:19;400:16,21;403:8; 428:20;429:13;433:12,12, 23;434:2,5,6,10;435:21,21; 455:17;509:18
pep (1)
418:20
percent (1)
396:22
Percocet (3)
491:22;506:11,15
perfectly (1)
408:24
perform (2)
419:17;488:5
performance (8)
329:13;331:18,22,24; 332:5;334:3;341:6,13
performed (3)
424:22;427:18;463:10
performs (1)
424:11
perhaps (12)
370:11;387:2;395:10; 408:14;409:23;412:23,24; 416:16;441:20;456:12; 473:4;493:18
period (11)
331:16;332:4,8,16;333:6, 8;334:13;336:15;344:6; 347:14;444:14
periods (2)
400:20,23
peripheral (8)
380:24;399:2;428:3,7; 438:21;439:2,6,10
peripherally (1)
428:9
periventricular (3)
441:22;442:2;456:22
perpendicular (5)
396:13,17;409:6,22;413:2
persistently (1)
443:16
person (10)
360:1;367:24;403:22; 426:15;429:7;433:13;447:4, 7;483:8;484:10
personal (1)
345:3
person's (1)
407:23
perspective (1)
327:4
PE's (1)
466:23
petitioner (3)
325:14,18;327:18
photograph (1)
414:1
photophobic (2)
508:23;509:14
physical (4)
416:13;417:1;425:19; 426:14
physically (2)
435:4,6
physician (8)
349:11;367:2;451:9,11, 15;462:19;465:7;477:9
physicians (3)
332:22,24;333:1
physician's (1)
497:17
picture (3)
383:3;410:17;443:9
pictures (2)
389:2;390:15
piece (1)
391:23
pieces (1)
428:18
pills (5)
420:5;491:24;509:24; 512:6,9
pins (1)
487:19
places (2)
407:11;475:1
plan (35)
331:11;333:17,21,23; 334:8;336:5;365:22,24; 368:16;370:4;380:12;381:6, 7,18;383:2,4,5,6;422:17; 424:15,21;427:11,16;430:5; 449:20;474:2,4;488:7,9; 490:23;491:17;510:6;512:2; 515:2,2
planning (1)
336:14
Plaquenil (15)
382:1;383:7,8,9,11;416:4, 6;419:21;420:3;421:3; 422:21;491:22;492:3,5; 501:9
Please (15)
327:21;369:22;371:7; 427:4;446:3;459:17;467:14; 475:24;478:10;480:11; 485:21;486:24;494:8;502:5; 508:9
plenty (1)
358:21
plus (9)
419:19;420:8;437:21; 471:24;473:4,8;509:20; 511:9,23
pm (2)
367:13;520:8
pneumonia (1)
377:4
point (26)
328:12;330:7;337:8,16; 343:15;349:9;351:17; 353:14;358:8,10;412:14; 416:11;447:23;449:4;468:8; 473:3;487:3,5;494:16,24; 495:10,13;496:17,22; 502:21;515:17
pointing (2)
413:9,24
poor (3)
332:5,5;455:19
poorly (3)
389:17;453:21;511:17
poorly-defined (1)
388:15
portion (14)
365:8;372:5;380:18; 385:17;388:2;389:19,20; 401:3;407:17;408:18; 412:16;428:9;442:15; 444:12
portions (8)
373:4;387:11,13;396:15; 442:4,21;444:17;510:15
Poser (3)
401:15,15;402:5
P-O-S-E-R (1)
401:15
positive (3)
393:23;414:13;468:5
positively (1)
483:18
possibilities (1)
447:2
possibility (2)
336:2;349:15
possible (20)
326:23;386:9;391:5; 415:20;419:24;421:18; 430:18;431:5,20;432:3; 436:12;439:8;447:14;449:8; 460:23;464:7;466:12,15,20; 473:6
possibly (6)
352:18;440:8,10;459:1; 471:5;486:13
posterior (4)
389:19;408:18;442:14; 458:8
posteriorly (1)
388:1
postulating (1)
473:3
potential (16)
325:22;369:9;387:8; 417:5;418:3;432:20;433:1; 438:16;440:12;443:1; 451:16;460:10;474:21; 476:10;481:19;503:21
potentially (8)
334:14;447:24;455:13; 475:8,10;480:9;515:6;516:8
Power (1)
472:15
practice (4)
329:23;338:1;397:9; 469:14
practicing (1)
333:15
preceded (1)
372:10
predecessor (1)
330:16
Prednisone (2)
512:2,7
prefilled (2)
435:11,12
prehearing (1)
358:16
preliminary (1)
327:10
preparation (1)

482:1
prepare (4)
354:21;358:21;434:24;436:13
prepared (2)
338:19;353:15
prescribe (9)
360:22;361:11,14,18;383:19;478:7;502:9;506:9;509:24
prescribed (17)
349:12;361:19;363:3;383:20;480:13;481:5;487:2;492:1;495:9;501:5;502:10,14;503:6;505:17;512:6;513:24;515:11
prescribing (15)
329:24;334:24;335:22;362:6;363:1,8;369:3,10,12;418:1;420:2;422:15;481:14,16,18
prescription (9)
365:24;416:7;422:16;477:15;486:22;491:22,22;505:12;506:5
prescriptions (1)
334:20
present (11)
325:24;340:21;400:2,4;454:18;455:5;471:19;493:4,7;500:10;510:17
presentation (1)
425:6
presented (9)
337:12;341:14,16,17,22;342:17;343:4;349:23;350:3
presenting (2)
343:21;437:19
presents (4)
370:7,18;447:6;488:3
presumably (4)
416:3;421:20;423:21;439:9
presumed (2)
335:16,17
presuming (1)
343:1
presumption (2)
335:20;349:14
presumptive (4)
402:3,9,10;403:8
pretty (3)
356:19;406:3;471:14
preview (1)
326:6
previous (21)
379:22;392:11;393:7,8;404:7;419:6;443:22;446:15;454:18;457:3,6,7,8;458:21;459:11;464:14;468:16;471:9;472:18;510:19;514:7
previously (22)
361:9;365:20;368:13;397:11;414:22;416:9;422:1,13,14;424:12;442:2;455:6;465:19;471:22;488:6;491:1;499:2;502:20;511:4,12,22;514:9
Prilosec (1)
506:11
primary (3)
332:1;335:24;349:11
print (1)
476:20
printed (1)
476:20
printout (2)
413:15;476:12
Prior (22)
330:10;362:4;364:1;369:12;373:9;376:12;393:8,11;449:3;451:10;453:21;454:8;458:16;464:1,6,8,12;468:13;492:8;503:18;504:9;511:4
privileges (6)
336:7,13;337:3;351:24;352:9,12
probable (1)
472:22
probably (10)
373:2;391:13;395:5;399:8;432:11;474:19;515:15;516:3,9;518:2
probation (10)
330:7,20,22;331:16;332:4,7,16;334:13;348:6,11
probationary (5)
332:8;333:5,8;336:15;344:5
problem (19)
351:2;370:17;399:20;425:20,20;429:23;430:10;432:8;433:6;439:3,4,6,9;447:1;455:5;473:19;488:1;509:10,12
problems (25)
379:19;392:14,18;400:3;416:22;418:17;419:17;423:3,5,6;426:9;429:11;434:3;439:7;447:4;456:24;473:7;475:6;502:24;505:23;511:2,15,16,16;514:8
Procedure (1)
366:22
procedures (1)
388:22
proceed (7)
333:3;340:9;346:20;349:20;358:23,24;412:10
proceedings (1)
520:7
process (19)
333:23;374:16,24;375:1,2,7,16,19,20;376:4,7;380:4;388:21;399:8;403:7,7;478:21;484:2;514:23
processes (1)
375:15
produce (2)
374:24;433:15
produced (2)
382:9;384:17
professional (1)
331:23
professionals (1)
373:16
prognosis (1)
498:15
program (1)
507:1
progress (8)
364:21;365:15,19;478:13;479:17;487:10;494:15;503:5
projector (2)
405:8,9
prominent (2)
387:5;391:2
proper (2)
350:13;428:21
prophylaxis (3)
509:19,21,22
proposed (1)
358:13
protect (2)
374:16;376:2
protecting (1)
374:19
Protection (1)
374:17
protein (2)
376:24;394:11
protocol (8)
451:24;452:2,13,18;460:21;463:3,14;476:8
protocols (2)
474:15;475:2
proved (1)
327:2
provide (5)
331:15;381:12;416:6;482:1;483:10
provided (6)
336:3;378:6;381:13,15;482:3,8
provider (3)
508:5,7,9
providers (4)
362:1;374:1;477:9;482:8
provider's (1)
449:3
provides (2)
482:15,16
pseudonym (1)
335:8
pseudonyms (1)
335:10
psychiatric (2)
429:14;430:11
psychiatrist (2)
430:6,19
Psychiatry (1)
354:5
public (1)
352:1
pulled (1)
334:22
punctate (4)
456:19;457:14;468:3,4
purely (1)
402:5
purposes (4)
374:4,5,6,8
pushing (1)
426:11
put (9)
330:7;348:6;358:5;362:19;373:18;428:18;439:24;473:5;498:10
putting (2)
418:19;440:19

Q

quality (1)
338:3
quantities (1)
330:1
questionable (1)
424:18
quick (2)
358:2;468:10
quickly (1)
436:13
quite (16)
363:5;372:14;388:8;389:19;391:3,4;410:8;421:22;424:13;434:5;479:22;482:10;483:17;498:7,11;512:19
quote (1)
424:22
quote/unquote (1)
392:12
quoting (1)
422:7

R

RACHEL (2)
327:17;328:3
radiographic (5)
386:3;397:10,10;406:11;454:10
radiologic (2)
397:6;483:13
radiological (1)
504:15
radiologist (24)
385:13,22;386:7,22;391:19;397:19,21;398:9;

405:4;408:13;414:23;415:4;
446:16;451:14,19;452:15;
456:19;457:1;462:15,17;
466:5;467:1,16;469:16
radiologists (3)
385:14,15;386:10
radiologist's (7)
397:6,14;448:5,8,12;
457:3;464:19
radiology (1)
451:8
raising (1)
508:24
randomly (1)
411:24
range (1)
437:4
ranges (2)
436:17,18
rather (8)
335:10;341:20;359:15;
376:6;413:7;426:14;447:21;
449:11
RE (2)
438:5,13
reach (1)
393:5
react (1)
374:19
reaction (2)
431:6,11
reactions (1)
431:19
reacts (1)
374:24
read (14)
386:12;387:1;395:4,5,10;
441:19;446:16;456:12;
465:16;466:24;467:16;
470:2;510:16;512:19
reading (16)
366:15;367:18;369:18;
386:11;398:10;414:22,23;
415:3,3;456:24;457:13;
464:18,18,20;467:18;484:13
reads (1)
510:21
ready (3)
327:13;358:24;517:11
real (6)
351:4,11;372:23;373:2;
471:20;473:2
really (15)
331:9;380:4;388:8;
389:19;391:3;410:6,8;
429:7;470:7,10;472:3,14,21;
476:19;482:10
reason (18)
346:5,17;386:5;441:7;
454:23;460:6;461:2,6,9,14,
16,22;462:22;464:11;465:7;
477:18,20;501:11
reasonable (3)
440:12,19;443:24
reasons (6)
326:6;327:4;369:8;
414:22;476:23;511:22
recall (18)
341:18,21,24;342:9;
343:20,24;344:11,14;351:8,
14,16;352:8,11,19;353:1;
496:21;499:5;518:6
received (5)
518:11,12,20,21,23
receiving (3)
418:23;432:9;512:11
Recess (4)
357:23;406:8;450:9;
485:15
recollection (1)
350:8
recommendation (2)
430:24;504:21
record (163)
325:2,21;333:22;357:3,
22;358:1,6;359:10,11,15,16;
360:9,9,12,18,20;364:10,15,
16,17,18,19,20;366:9;371:4,
8;378:8;379:2;381:21;
383:3;384:8,13;385:1,8;
386:18;392:3,4,5,6,8;397:4,
16;406:7;413:20,23;414:3,5,
10;415:7,9;418:9,13;
420:14;423:12,23;436:22;
437:8,9;438:11;439:17;
441:1,3,3,4;446:1,1,4,5,7;
447:17,22;449:3;450:4,8,11,
20;451:5;459:3,18,22;
460:4;461:2,3;462:8,10,13;
464:2,16;465:6;466:9;
470:15;477:14;479:2,13,17;
480:20,23;481:10,20;482:7,
14,21;483:2;484:19;485:7,
14,17;486:2,15,18,19;487:8;
488:14,15,17,18;489:11,13,
19;490:7,8;492:18,19,22;
493:17;494:5,7,9;497:8,10;
498:20;499:2,24;500:3,5;
501:20,22,23;502:17;503:8,
9,10,11,12;504:2;505:3;
506:4,6,17,23;507:12,13,14,
23;508:14;510:8,9,12,15;
512:13;513:7;515:12;520:6
recording (1)
326:4
records (29)
329:18;334:23;337:12,17,
20;350:2;359:8;360:14;
362:2;364:5,6,8,12;376:8;
381:13;382:13;415:19;
416:17;438:9;439:12;
446:11;481:24;482:1;485:5,
22;486:14;499:6,9;503:19
recurrent (2)
372:15;493:11
redacted (2)
518:14;519:9
REDIRECT (2)
353:20;485:17
redness (4)
376:3;431:8,15;432:20
reduced (1)
472:14
re-emergence (1)
440:10
refer (5)
332:1;379:24;403:4;
414:10;439:8
referable (1)
404:24
reference (5)
394:12;409:7;451:20;
476:2;519:4
referenced (1)
391:15
References (1)
325:20
referral (1)
430:19
referrals (2)
503:22,22
referred (9)
332:24;380:22;407:2;
421:19;444:15,18,19;
449:14;477:5
referring (5)
335:11;344:9;401:5;
462:11;493:3
refers (10)
387:14;388:21;389:4;
390:2;416:9;439:7;444:16;
491:19;498:5;514:21
refills (4)
420:6;491:24;510:1;
512:10
reflexes (1)
508:24
reformulate (1)
346:6
refrigerated (1)
435:16
refrigeration (1)
435:18
refrigerator (1)
418:20
refused (3)
452:18,24;454:5
regarding (5)
337:9;347:16;359:14;
360:20;498:22
regards (2)
379:19;422:18
region (2)
389:13;442:3
Registered (5)
325:19;366:10;367:5,20;
368:5
Registration (4)
325:14;327:2;349:22;
355:1
regularly (1)
417:20
reimbursement (1)
329:22
relapsing (1)
400:18
relate (13)
368:5;391:1;399:11;
404:16;415:23;425:19,21;
428:14;429:10;438:16;
439:20;444:5;471:21
related (12)
368:1;375:16;404:6;
425:23;426:13;439:22;
440:15;478:21;483:23;
490:13;499:15;503:1
relates (6)
372:4;385:17;412:6;
427:20;444:22;450:18
relationship (4)
366:9,14;367:19;467:4
relative (9)
361:4;362:8,9;363:14,16;
395:3;445:8;480:16;500:21
released (1)
388:24
relevant (2)
352:18;482:3
relies (1)
368:12
rely (1)
378:7
remaining (1)
382:10
remark (1)
397:19
remarkable (1)
504:17
remember (13)
334:1;338:6;348:16;
349:9;351:22;376:13;
390:10;450:13,16;503:18,
21,24;518:6
remind (1)
423:1
remission (1)
400:23
remissions (6)
400:14;404:4;405:2;
443:18;465:17;471:20
remitting (1)
400:19
repeat (7)
353:17;363:10;369:21;
398:1;449:20;454:24;455:2
repeated (2)
332:7;403:9
repeating (2)
356:19,21
rephrase (1)
464:10
report (35)

346:11;353:11;360:3; 361:6;385:2,9,13;386:2; 397:15;398:8;439:14;441:6; 443:8;446:15;448:6,8,12; 451:2;457:9,17;466:4; 470:18,21;471:9;483:9,13, 14,16,16;484:12;494:12; 500:8;512:16,18;513:15
reportable (1)
432:2
REPORTER (2)
325:4,10
reports (3)
386:3;397:10;456:9
representatives (1)
325:24
representing (1)
484:9
represents (3)
325:18,23;370:22
request (3)
355:20;410:15;520:1
reserve (1)
353:13
residual (2)
400:16;437:22
resolve (2)
365:10;382:18
respiratory (1)
335:16
respondent (2)
325:15;326:13
responding (1)
475:7
response (1)
347:18
responses (1)
332:5
Rest (3)
487:22;509:1;516:16
restless (1)
438:22
restored (1)
444:18
result (4)
372:6;374:23;434:1,4
resulting (1)
375:18
results (3)
372:8;373:2;399:10
resume (3)
358:4;515:20;518:3
RESUMED (2)
359:6;450:12
retain (1)
347:11
return (1)
337:6
returned (2)
414:6;518:16
returning (1)
488:10
Revere (2)
438:5,13
reverse (3)
367:8,12,17
reversible (1)
479:5
review (44)
329:8;331:19;332:5,22; 333:18,19,22;334:16,22; 337:16,18;338:4;341:4,9,12, 12,16;343:22;344:7,9; 345:14;347:12;379:8; 391:16;393:8;397:5,6; 403:22;405:12;415:10; 420:15;423:2,2;424:20; 456:11,17;470:16;483:9; 487:12;490:9;494:3;508:15; 510:10;513:14
reviewed (24)
333:7;344:3;360:18; 379:9;392:5;393:14;397:9; 398:13;415:12;418:13; 420:18;424:7,21;446:5,11, 14;470:18;481:21;491:6,8; 492:23;510:11,12;511:22
reviewing (13)
328:16;333:12;334:2; 340:22;341:2;344:11; 347:20;364:8;376:8;388:20; 397:4;470:23,24
reviews (1)
334:15
revisit (2)
384:19,21
Rheumatoid (3)
377:14;378:20;383:17
rheumatologic (13)
377:15,21;383:10,18; 394:14;416:2,16;419:22; 421:19;492:6,7;501:3,17
rheumatological (8)
378:10;383:14;394:4,7; 414:14;421:20;492:20; 500:15
rheumatologist (4)
379:17;421:21;490:16; 500:8
Rheumatologists (2)
378:15;379:1
rheumatology (1)
378:12
right (48)
326:21,22;344:22;347:17; 352:5;353:14;356:15; 359:12;384:3;402:7;406:16, 23;407:6,13;408:4,6,15,22; 410:3;415:22;427:6,17; 428:11;431:22;440:9;441:2; 445:12;447:3,7;450:6; 456:1,5;462:4;469:12,22; 471:14;472:23;474:1; 483:19;493:14,20;494:12; 496:6;497:4;502:17;508:4, 20;517:17
right-sided (1)
472:18
RM-14-363 (1)
325:13
role (1)
329:7
Romain (6)
490:15,23;491:21;492:24; 500:9,18
room (2)
517:22;519:17
R-O-S (1)
423:1
roughly (1)
370:24
routine (1)
463:11
row (1)
511:6
rule (6)
349:19;355:14;394:6; 405:24;438:22;460:22
ruled (1)
355:19
ruling (4)
338:16;346:16;353:16; 430:17
rulings (1)
346:3

S

sacroiliitis (1)
493:14
safe (1)
482:6
safety (1)
352:1
Sagittal (15)
388:18;389:21;390:2,4; 395:6,22;397:20;406:19; 407:2;411:3;446:8;463:10, 11,12,15
same (17)
356:9;364:1;379:21,24; 380:1;424:7;425:15;445:7; 458:4,18,22;471:15;498:14; 509:15;513:24;514:6,11
satisfactory (1)
331:1
saw (22)
329:12;347:15,16;350:2; 362:17;363:24;383:1; 385:24;389:12;398:10; 410:4;448:20;467:17;471:2; 472:22;499:2;501:12,17,21; 502:12;503:5;511:3
saying (15)
327:3;343:9;362:13,14; 388:6;389:10;425:23; 429:17,19,20;441:24; 458:17;460:15;519:1,20
SC (2)
365:12;366:6
scalp (1)
372:7
scan (1)
486:9
scans (2)
385:18,19
scattered (3)
441:21;483:21;484:5
scenario (1)
469:14
schedule (1)
339:18
scheduled (2)
339:22;517:18
Scheduling (1)
516:1
science (2)
345:2;516:1
scientific (1)
345:19
sclerosis (86)
330:3;344:16,21,24; 345:8;375:13;395:16; 396:21;397:3;398:17,19,21; 399:15,21;400:1;401:1; 402:3,24;403:8,9;413:13; 414:21;415:2,6,24;416:1,4, 15;417:21;419:15;421:13, 17;422:4;424:5,20;425:14; 429:21;430:2;432:10;433:4; 434:2,15;436:6,17;443:3; 444:1,3;446:9,18,19;448:14; 452:1,10;453:17;456:22; 457:16,24;458:19;459:2,14; 460:13,14,16,19;466:4,7,22, 24;467:2,17,20;468:10,19, 20;471:19;472:4;473:1,11; 476:3;477:22;478:3;479:9, 11;483:11,14;505:20
screen (7)
405:21;406:14,17;408:9; 410:11;411:11,12
screening (2)
376:18,23
scroll (1)
413:20
seat (2)
406:18;414:7
seated (2)
327:22;406:18
second (7)
421:20;461:4;464:8; 465:5,11;467:6,16
secondary (1)
349:12
section (4)
386:20;498:14,18;504:10
sections (1)
386:19
sedating (1)
506:14
seeing (10)

388:7;390:3;402:13;
403:5,5,12;407:24;467:24;
499:5;503:18
seem (2)
390:23;429:4
seemed (2)
335:3;336:2
seems (1)
412:5
sees (3)
396:8;405:12;501:11
selected (1)
350:11
send (3)
347:8;502:5;518:9
sensation (7)
427:19,20,21,22;428:8,12;
509:6
sense (9)
332:9;357:18;425:10;
427:7,18;428:17;480:17;
485:3;516:13
sensitivity (1)
372:12
sensory (7)
427:5,16,18;428:4,14,24,
24
sent (8)
337:17;345:13;350:6,11,
16;518:12,13;519:7
separate (3)
367:10;387:21;519:3
sepsis (1)
505:21
septal (1)
442:10
September (4)
332:8;336:16,19,20
sequence (4)
395:6,7,22;446:8
serious (10)
363:5;474:21;475:6,10;
476:10;505:21,22;509:9;
513:24;515:6
seriously (1)
475:6
Seronil (1)
422:21
Service (1)
517:21
services (1)
347:21
set (3)
406:1,4;508:9
Seton (1)
414:11
sets (1)
452:6
settings (1)
452:4
seven (3)
337:22;412:24;502:3
several (5)
328:19;336:18;428:18;
483:21;519:4
severe (3)
372:8;399:22;434:3
shall (1)
340:12
Shalnov (3)
503:14,15,16
S-H-A-L-N-O-V (1)
503:15
sharp (1)
508:20
sheet (1)
480:3
shortly (1)
515:14
shortness (1)
423:4
shot (1)
413:18
shots (3)
418:21,21,23
show (18)
335:9;351:5;389:9;396:4;
405:8,10;406:19;409:8,14;
410:24;412:11;443:4;
453:20,20;472:20;489:3;
492:9,12
showed (10)
395:3;411:5;414:24;
424:4;449:17;453:21;
464:24;483:20;488:3;509:5
showing (7)
351:3;407:20;456:6;
464:13;466:5;495:1;507:15
shown (3)
335:12;341:1;410:18
shows (11)
388:19;389:21;395:8,22;
396:18;397:20;445:3;
446:18;454:1;455:23;
488:19
sic (1)
325:12
sick (3)
429:7,9,15
Sickness (3)
429:11,12,12
side (62)
372:9;389:13,16;390:5,6,
7;395:7;407:4,4,4,22,22;
408:3,4,5,7,23;410:3,4,11;
415:20;417:5;418:3,23;
419:1;421:3;427:6,17;
428:11,12;431:2,3,5,5,19,
21;432:2,3,10,18,21;443:21;
445:7,8,15,18;456:1,5;
472:16;474:22;475:1;
476:10,23;478:16,16,18;
479:5;481:19;496:6,6;
507:19;515:6
sides (3)
372:10;388:1;443:7
signal (19)
389:8;390:16;395:8,23;
396:3,4,12,13;402:11;405:6;
408:12;409:3;410:6;412:21;
413:1;456:20;483:22;484:6,
7
signature (2)
503:14;508:6
signed (1)
492:24
significance (4)
371:6;391:14;410:9;
458:24
significant (22)
332:20;363:19;364:4,7;
370:19,20;433:6;434:1,20;
440:2;443:1,5;445:8;471:7,
8;472:20;477:24;478:20,24;
502:24;505:24;506:1
significantly (1)
409:21
signing (1)
360:2
signs (2)
396:24;399:24
similar (4)
370:24;390:10;410:3;
411:2
Similarly (1)
375:22
simple (1)
412:5
simply (3)
340:5;411:14,24
single (3)
413:18;414:1;428:21
sinus (1)
411:5
sister (1)
394:3
site (2)
431:11;474:14
situation (1)
514:13
six (6)
365:1;400:10,12;401:12;
412:24;452:5
size (2)
444:22;458:3
skin (2)
366:7,20
skull (1)
407:16
slash (2)
448:14;472:15
slice (1)
411:15
slices (2)
407:3;408:1
slight (1)
472:13
slightly (1)
472:14
slowly (1)
408:6
small (10)
396:20;405:21;408:20;
409:18,23,24;442:1;484:5,8;
512:20
smooth (1)
409:1
snuck (2)
355:10,12
social (1)
479:18
soles (1)
487:20
Solumedrol (5)
505:12,16,23;507:16;
508:10
somebody (14)
370:7;377:2;396:24;
400:2;401:23;402:21;
421:17;422:3;428:6,17;
432:14;434:19;446:24;
456:4
someone (14)
344:23;368:10;426:7,10;
428:10,22;447:6;453:13,16;
455:4,5,16,23;456:6
Somerville (1)
328:24
something's (1)
369:7
sometimes (10)
372:23;399:10;401:24;
431:8,10,15;445:16;454:20;
468:13;478:19
somewhat (2)
386:11;396:18
soreness (1)
431:15
sorry (31)
359:16;360:10;361:16;
369:21;371:7;379:5;380:16;
393:7;398:1;415:8;427:10;
437:1;439:14;441:2;448:7;
450:21;459:22;460:2;461:4;
462:12;485:24;486:17;
487:7;488:14;492:20;494:1,
7;498:23;505:7;508:1,3
sort (7)
333:20;335:5;368:24;
426:6;469:13;485:4;506:24
sounds (1)
354:18
source (1)
499:9
South (5)
440:2;447:21;449:10;
465:20;471:1
space (3)
401:2,2,10
spaces (2)
387:23;442:3
sparse (1)

420:22
spasm (6)
473:16,17,17,21;490:14, 17
spasms (6)
392:22;404:21,22;473:12, 13,15
spasticity (16)
471:8,10;472:3,9,11,20; 473:12,22;477:23;478:1,2,4, 22;499:3;503:1,1
speak (3)
325:8;430:6;517:15
speaking (3)
399:16;400:2;433:21
specialist (6)
345:20;347:8,11,22; 385:10;386:23
specialists (1)
347:16
specialize (1)
385:16
specialized (1)
504:1
specialty (3)
378:11,16;503:17
specific (23)
344:23;365:6;373:14,15; 375:3,20;376:6;391:1; 395:15;397:18;399:12; 402:19;403:20;404:15; 425:19,24;426:13,14; 437:24;463:13;482:4;498:9; 515:9
specifically (16)
349:2;377:10;397:21; 398:3;421:12;428:4;429:20; 430:11;432:13;435:5; 448:16;449:4;452:12; 472:10;496:15;501:2
speculate (1)
410:12
speech (1)
400:12
speed (3)
357:2,6,10
spelling (1)
328:1
spend (1)
327:6
spending (1)
327:8
spin (1)
389:4
spinal (9)
380:22;381:1;387:24; 399:1;401:4;402:16;407:8; 411:7;491:9
spine (12)
488:10,20;489:6,8,17,20, 22,24;492:9,11;504:16,16
spot (1)
496:16
spots (4)
372:12;405:13;491:10; 509:17
stable (5)
366:24;458:2,3;491:1; 511:20
staff (7)
330:6;332:2,11;333:4,17; 335:17;336:6
stages (1)
395:17
stamp (2)
364:14,15
stamped (2)
437:10;439:13
stand (3)
327:16;342:8;462:1
standard (71)
331:8,13;333:15,16; 345:6;361:1;363:7,13,15,18, 23;365:14,17;368:5,7,14; 369:11;374:1;379:11,13; 381:4;414:17;415:11,13; 416:8;417:17;418:14; 419:14,17;420:17,19;422:3; 452:1,7,13;460:21;463:2,14; 470:20,21;472:6;475:8; 479:23;481:2,13,15;487:13, 15;488:4,11;490:10,11,22; 491:4,23;495:20;496:2,9,12; 497:20,22;498:5,10;508:16, 17;509:2;510:13;511:21; 513:18;514:14,22
standardized (2)
344:8;374:5
standards (1)
405:22
standpoint (1)
429:8
stands (6)
338:17;353:17;373:22; 390:11,11;441:12
start (4)
340:11,12;381:24;383:7
started (4)
332:4;341:1;355:13; 415:16
starting (5)
360:16;408:2,7;488:16; 508:11
stat (1)
502:5
state (12)
328:1;363:19;415:10; 420:16;487:13;490:9;491:7; 496:2,12;500:24;508:15; 517:15
stated (6)
352:6;460:8;465:21; 467:1;483:19;498:1
statement (9)
326:15;341:20;346:8; 349:21;497:17;498:6; 499:22;514:11,12
states (11)
360:4;365:1;423:21; 461:16;472:10;477:8,22; 488:1;492:23;501:16; 508:23
status (3)
419:3;421:16;514:4
stay (1)
494:2
stem (8)
380:19;387:13;399:1; 401:6,8;402:15;442:21; 458:8
step (2)
356:2;430:7
steroid (2)
505:16;506:2
Steven (1)
462:14
stiffness/tightness (1)
416:24
still (18)
327:1;332:15,17;333:9, 10,11,20;338:13;354:22; 359:3;368:23;384:17; 422:19;435:18;450:11; 468:8;472:17;510:17
stipulate (1)
356:8
stop (3)
352:4;494:2;515:18
stopped (1)
422:20
straight (1)
508:24
strain (1)
473:20
strained (1)
473:19
strength (2)
472:16;509:6
stress (4)
479:19,20;480:7,7
stresses (1)
479:8
strictly (1)
448:23
strike (1)
483:9
stroke (31)
375:12;428:10;437:21; 439:21;440:2,8;443:15; 444:5,16,21,21,23;445:4,9, 19,21;447:21;448:21; 449:11;452:9;453:14; 455:11;456:4,5;465:21; 471:1,4,5,22;472:1;503:2
strokes (1)
445:2
strongly (1)
393:23
structure (2)
407:18;411:4
studies (7)
373:19;393:9,10,12,14; 454:24;504:19
study (53)
386:6,12,21;390:19; 393:15;410:8;441:13;443:4; 446:16,17,18;451:18,19,24; 452:18;453:10,13;454:18, 18,23;455:1,2,7,8;457:14; 459:9,10;460:8,11,12,15; 463:8,9,16,19,20;466:5,6, 22;467:1,2,16,23;468:16,17; 470:2,5;483:19;484:18; 486:10,11,12;489:2
subcentimeter (1)
441:21
subcentimeters (1)
441:24
subcortical (6)
388:18;389:13,15,16; 441:22;442:4
subcu (1)
365:2
Subcutaneous (2)
366:7;431:18
subcutaneously (3)
366:19,21;431:14
subject (3)
353:6;382:15;405:17
subjective (1)
467:24
subjectively (1)
514:17
subsequently (1)
334:21
subspecialties (1)
354:7
substance (1)
362:5
substantive (1)
358:23
subtle (1)
443:20
suddenly (1)
426:11
sufficient (4)
333:13;334:7;344:22; 472:24
sugar (1)
471:17
suggest (13)
340:10;380:11;406:2; 417:2;429:4;443:18;444:1, 3;449:13;466:3;472:4; 484:13;509:19
suggested (2)
332:23;503:22
suggesting (4)
430:18,20;471:19;509:8
suggestion (1)
405:10
suggestive (10)

394:3,13;397:3;425:11; 437:11;446:8,17;465:18; 483:16;487:24
suggests (2)
398:5,7
summary (5)
359:13;456:11;457:12,22; 458:9
supervisor (1)
333:6
support (5)
348:8;484:12,14;499:2,7
supports (1)
455:15
suppose (1)
436:12
supratentorial (5)
387:5,11;388:5;390:23; 442:18
sure (14)
331:6;336:1,22;347:10; 357:8;370:17;419:12;441:2; 449:5;499:14;508:22; 510:23;516:5;518:7
surface (2)
372:8;375:6
surrounding (2)
408:10;409:17
suspect (1)
467:22
suspected (1)
368:24
suspend (3)
336:7;337:2;351:24
suspended (5)
336:13;352:9,12,22;520:8
suspension (3)
337:9;349:16;352:15
suspicion (1)
464:21
sustain (2)
345:22;347:5
sustained (1)
345:8
Swanton (1)
395:18
swayed (3)
467:18,24;469:3
sweating (1)
431:8
swelling (1)
376:3
Swinton (1)
395:18
sworn (1)
327:19
symptom (2)
404:23;425:20
symptomatic (1)
440:10
symptoms (30)
392:17;396:24;397:1; 399:11,14,24;400:6,16; 404:5,24;415:23;416:12; 419:4,8;421:14;430:13,13; 433:16;434:19,19;440:16; 445:20;446:10;465:18; 473:9;487:18,22,23;488:4; 493:19
syndrome (4)
373:3,7;437:20;438:23
syringe (2)
435:13;436:13
system (27)
371:21;373:9;374:12,13, 15;375:15;376:11;380:16, 21,23,24;399:1,12;401:3,9; 405:1;428:2,2,3,6,15; 429:23;433:14;484:16; 489:4,7,9
systemic (3)
498:2,7;501:2
systems (2)
423:2,2

T

T1 (5)
389:4,5;390:10,18;463:10
T2 (23)
388:15,17,21;389:3,4,5,7, 11,17;390:10,18;396:3,12; 402:11;405:6;408:12,12; 409:3;410:6;412:21;441:21; 442:1;484:7
Tab (4)
437:10;475:22,23;476:11
talk (3)
384:20;392:8;501:4
talked (5)
330:11;378:10;418:6; 477:16;492:4
talking (8)
339:9;345:2,3;347:17; 382:7;402:13;432:14; 433:11
talks (2)
396:8;446:7
technical (1)
443:5
technique (7)
441:13;451:22,22,23; 452:17;454:8;463:13
techniques (2)
452:3;463:1
telephone (1)
480:23
telling (2)
386:22;397:24
tells (6)
403:18,19;421:1;437:12; 450:17;451:16
temperature (1)
435:20
temporal (1)
378:21
ten (7)
342:18,24;350:5;406:6; 412:24;431:10;444:24
tend (2)
400:16;475:5
tenderness (1)
376:4
ten-minute (2)
406:2,4
tentatively (1)
460:18
term (6)
429:9;458:10,11;459:1; 490:19;491:18
terminate (3)
334:4,6,9
terminology (1)
386:5
terms (24)
332:14;362:15;373:6; 379:21;386:14;388:8; 389:22;392:20;403:21; 425:10;451:17;454:21; 475:10;482:11;483:17; 488:8;490:21;493:18;514:4; 515:1,6;517:19,20,21
test (11)
376:24;377:10,12,16; 385:20;386:8,24;394:6,6,13; 508:24
testified (8)
327:20;345:12;346:9,13; 348:7;349:6;350:2;353:10
testifying (7)
350:23,24;355:4,8; 358:12;409:10;518:3
testimony (15)
326:7;327:5;338:14,20; 339:23;341:18;347:4; 354:23;356:2,13;358:5,9,24; 382:17;449:16
tests (11)
371:15;376:16,17,18,21, 23;377:7;382:1;383:7; 470:13;490:16
textbook (1)
476:19
therapies (2)
475:8,19
therapy (1)
477:10
thereabouts (1)
436:24
therefore (1)
467:18
thereof (1)
399:18
thick (1)
396:18
thickness (2)
409:23;413:5
thinking (2)
436:4;451:17
third (2)
474:20;475:12
thoracic (3)
488:10;489:17,20
though (1)
381:23
thought (3)
334:14;470:6;517:12
thoughts (1)
433:3
thousand (3)
479:24;482:7;484:21
threatened (1)
444:21
three (16)
338:1;345:13;350:5,5; 361:9,10;367:10;412:23; 449:21;488:13;502:17; 508:10,10;515:16;517:7,24
throbbing (1)
372:9
throughout (1)
362:2
Thursday (1)
517:13
thyroidectomy (1)
482:20
TIA (4)
441:8;460:6;461:22;462:1
tightening (2)
473:14,21
tightness (2)
417:1,2
times (2)
462:19;508:10
timetable (1)
515:22
tiny (13)
388:17;389:11,12,15,16; 391:11;402:12;405:5; 408:10,14;410:4,5;456:20
tissue (10)
375:18;387:14;399:9; 408:11;431:17,18;498:3,8; 499:4;512:1
Today (11)
325:11;326:5;349:6; 353:18;358:13;411:24; 438:1;468:18;514:18; 517:11;519:16
together (4)
428:18;440:20;468:7; 498:11
told (18)
334:12;339:4,5,5;352:3; 361:7;392:13;424:4;425:15; 429:22;433:13;443:15; 460:13,15,17,18,20;462:6
tolerated (1)
366:22
tolerating (1)
418:24
tomorrow (7)

515:20;516:4,16;519:16, 22;520:2,3
tone (4)
472:7,10,11,13
tongue (1)
407:8
tonsillectomy (1)
482:20
took (3)
367:24;429:24;436:7
top (8)
389:15;407:7,15;411:7; 412:22;438:5;460:5;476:13
Topamax (5)
380:12;383:2,6;422:15,22
Toradol (1)
506:11
Torres (4)
367:5,6,20,23
torso (2)
495:19;496:19
toward (5)
408:4,6,15,22;410:2
Towards (2)
407:15;442:12
toxic (1)
474:20
trained (4)
344:15,20;347:11,21
training (3)
344:18,22,24
transcribing (1)
357:5
transient (3)
444:20;461:23;462:3
translate (1)
387:2
treat (3)
365:6;403:21;421:12
treated (1)
379:16
treating (3)
436:6;495:6;505:23
treatment (14)
358:19;361:2;368:2,3; 379:11;381:6,7,17;417:16; 420:17;424:21;430:7; 498:16;513:17
treatments (1)
512:10
tremendously (1)
400:21
trial (2)
512:3,7
tried (3)
331:3,13;394:23
trigger (8)
487:3;494:16,23;495:10, 12;496:17,22;502:21
trigone (1)
408:19
trigones (3)
387:6;388:2,16
T-R-I-G-O-N-E-S (1)
387:6
trips (1)
420:24
triptans (1)
365:5
trouble (1)
487:21
Troubles (1)
404:12
true (4)
335:1;349:18;426:6; 516:18
truly (1)
426:7
try (6)
330:14;331:9;332:9; 416:23;475:14,15
trying (6)
330:13,18;331:21;357:1, 10;496:21
tuberculosis (1)
447:9
tumor (5)
375:8,9;377:2;447:10; 455:10
turn (3)
366:12;382:23;432:5
turned (1)
382:12
Twenty (3)
366:22;436:20;437:5
twice (3)
372:16;518:14;519:7
two (27)
327:4;338:15;356:18; 373:9;387:20;389:24; 396:15;403:3;412:23;439:1; 455:7;462:11;463:2,22; 466:16;467:4;475:14,24; 476:1;484:7,21;491:14; 498:18;502:2;516:8,11,19
type (13)
371:23;372:2,3,15;377:4, 5;390:9;394:4;397:22; 400:18;416:16;433:13; 457:4
types (13)
374:22;385:19;390:18; 423:3,6;427:21,22;428:13, 23;445:1;475:9;490:20; 495:14
typical (4)
400:22;452:18;499:19; 509:17
typically (31)
373:3;375:24;385:21; 386:19;387:19;388:11; 391:9;396:12;399:20;400:6; 425:21;431:10;433:9; 436:17;439:7;445:17;451:7; 457:10,16;458:13,15; 473:15;474:23;475:14; 484:6;487:1;492:7;495:8; 499:22;502:13;505:17

U

ultrasound (1)
385:19
uncertain (3)
370:21;391:8;512:1
unchanged (3)
419:10;421:24;514:13
uncommon (2)
431:12;432:2
under (32)
325:5;341:18;342:1; 343:5;345:12;348:7,13; 359:3;366:7,20;385:21; 386:18;427:16;433:10; 437:11;450:11;452:14; 454:8;469:11;477:21;478:5; 491:15,15;493:12;494:15; 498:14;500:10,17;504:8,20; 515:9,11
undergo (1)
433:4
underneath (1)
462:5
underwent (2)
504:9,14
unidentified (1)
411:13
units (1)
502:7
unless (2)
370:16;490:24
unlikely (5)
446:21;459:1,2;467:15; 474:18
unlucky (1)
372:16
unpredictable (2)
433:8,15
unprofessional (3)
330:4;331:14;333:10
unredacted (1)
518:17
unremarkable (3)
489:1,20;490:4
unusual (5)
420:9,10;431:20;437:6; 468:2
up (36)
325:8,13;331:11;349:8; 357:2,7,11;389:9;396:4; 397:4;405:8;406:1,4; 407:18;409:6,8;431:7; 433:17,19;434:3,3;447:22; 452:4;453:20,20,21;454:1; 455:23;471:11;474:13,13; 476:18,19;477:21;487:4; 508:9
upper (2)
387:11;442:20
upset (2)
379:16;433:23
upwards (2)
432:15;479:24
urged (1)
430:5
use (16)
373:16;389:6;402:23; 413:8;415:21;436:2;452:2; 474:15,17,18;475:9,21; 476:7;494:22;501:12,18
used (28)
326:5;365:6;376:19; 383:10,15,16;386:5;417:20; 421:12;451:24;463:13; 474:7,8,11,12,19;475:17; 492:6;495:1,14;496:13; 499:10;502:21,24;505:19, 20,22,23
useful (1)
475:3
uses (4)
370:14;374:16;406:23; 435:12
using (6)
368:17;402:4;452:13; 463:10;474:14;475:4
usual (3)
368:7;380:5;496:11
usually (3)
402:11;421:16;434:10

V

vacation (1)
336:18
vague (1)
498:7
value (1)
472:17
variable (2)
392:16;400:21
varied (1)
332:19
variety (7)
376:19;378:18;399:13; 404:13;433:16;452:3; 502:22
vascular (2)
377:22,24
vasculitis (1)
378:22
V-E (1)
423:7
ventricle (8)
388:3;389:20;395:10,13; 396:7;408:17,18;412:18
ventricles (6)
387:7,22,22;388:1,16; 391:3
versus (3)
426:23;438:22,24
vessel (1)

391:7
vessels (9)
372:7;378:17,23;441:14,15,16;442:24;453:7,9
vial (5)
486:23,23;502:4,5,7
view (2)
332:10;463:20
viral (1)
404:10
virus (1)
374:18
vision (7)
399:15,15;400:9,9;433:22;493:13;509:16
visit (3)
365:16;379:12;428:21
visits (1)
329:22
visual (1)
372:11
vital (1)
433:13
vomiting (1)
372:13

W

wait (1)
395:19
wake (1)
433:17
walk (2)
436:1;478:23
walking (2)
400:3;440:5
wants (1)
386:7
warning (3)
477:4,5,8
warnings (1)
477:2
watch (1)
491:15
way (9)
331:21;342:10;344:10;353:21;389:2,5,6;400:24;405:15
weak (1)
426:7
weakness (24)
399:17;400:4;426:4,5,7,9,10,13,14;430:7;437:23;440:3;443:15,16;445:7,15;455:24;456:6;473:9;478:19,20,21,24;479:4
website (1)
475:21
week (5)
353:16;410:16;425:15;513:21;518:4
weeks (6)
336:19;392:17,19;400:10;420:23,24
weighed (1)
514:18
weight (1)
418:20
weird (1)
384:17
weren't (2)
335:5;336:1
Wharram (4)
325:4,7;357:4;494:21
what's (27)
326:7;331:19;335:9;339:17;354:3;366:14;367:19;375:16;386:3;393:21;423:15;424:16;425:17;433:24;441:11;451:22;453:19;456:3;462:1;468:5,6;477:4;488:22;489:19;497:12;498:15;501:7
wheelchair (2)
434:4;436:3
Whereupon (1)
520:7
Whidden (3)
328:23;329:1;359:21
white (48)
387:5,13,15,17,19;388:5,6,7,18;389:9,12,13,16,18;390:16,20,23;391:2,11;396:4,18;399:3;403:16;405:12;408:8,21;409:2,8,16;412:20;424:23;441:22;442:9,12,18,19;453:20;456:19,21,22;457:15;458:9,14,14,15;460:9;483:22;491:10
whiteness (1)
412:20
whiter (3)
389:10;408:10;409:16
whole (3)
378:8;476:20;510:22
whose (2)
325:12;350:6
wide (5)
387:7;391:4;396:19,19;413:6
willing (1)
356:8
Wilson's (3)
377:17,19;393:18
wish (3)
432:12;452:21;485:8
within (26)
331:8;337:1;361:1;363:18,23;365:13;375:21;379:11;388:6;414:17;415:11;420:17;428:1,15;442:13;446:20;450:4;470:19;472:6;487:13;488:11;490:10;497:19;498:10;502:11;508:16
without (12)
330:1;334:6;369:16,17;370:10,22;413:11;435:18;486:4,9;489:23;490:1
witness (16)
325:22;327:18;339:3;342:7;348:18;351:7;353:8,9;355:1;356:3,4;518:6,8,9,16;519:3
witness' (1)
348:21
witnesses (9)
327:14;350:21;355:13,17;358:7;515:23;516:1,9,19
woke (1)
433:19
Women's (2)
474:13;475:20
word (4)
327:7;405:12;491:11;510:22
words (2)
358:18;455:23
work (18)
328:8,16;329:4,9;330:14,19;331:10;332:2;340:22;341:2,2,9,16;343:22;344:3;347:20;383:11;498:19
worked (4)
328:10;331:9;332:11;333:1
worker (1)
479:18
working (1)
507:6
worse (4)
392:17;416:13;454:20;472:2
worsening (3)
431:24;455:5;487:19
write (2)
332:22;476:15
writing (5)
334:19;343:24;344:12;353:17;366:12
written (3)
334:5;404:6;476:12
wrong (3)
326:21;327:1;469:20

X

x-ray (1)
388:22
x-rays (4)
385:18;388:22;504:13,17
Xylocaine (4)
486:23;495:4;502:4,15

Y

year (6)
336:17,21;372:18;401:13;437:1;455:7
years (20)
361:9,10;398:20;437:22;443:14;444:5;445:4,21;447:20;449:5,14;455:7;465:21;471:24;473:4,8,8,10;475:19;493:14
yesterday (14)
338:13,17;339:6,12;354:22;356:5;358:10,12;450:14;474:1;477:16;492:4;503:3;517:11
yesterday's (1)
325:21
young (1)
433:12

0

0.9 (1)
393:24
058 (1)
505:7

1

1.5 (1)
484:7
1:00 (1)
450:9
10 (1)
515:20
10/10/2006 (1)
486:10
10:36 (1)
357:23
10:41 (1)
357:23
100 (1)
502:6
1028 (1)
513:9
11 (2)
358:13;508:4
11/12 (1)
508:11
11:00 (2)
339:22;340:5
11:47 (1)
406:8
11:56 (1)
406:8
11th (3)
360:16;506:5,22
12 (3)
354:19;452:6;519:4
12/11/2009 (1)
360:11
13th (2)
325:11;436:23
1428 (4)
513:7,10,11,13

1429 (1)
513:7
1465 (1)
515:12
15 (12)
431:10;437:21;443:14;
444:5;445:4,21;447:20;
449:14;471:24;473:4,8,10
15th (2)
500:2;501:21
161 (1)
359:15
166 (1)
359:16
17th (1)
438:12
185 (1)
437:9
190 (1)
359:11
192 (2)
359:16,17
194 (1)
360:16
195 (1)
360:13
197 (1)
360:17
198 (1)
364:15
199 (1)
371:4

2

2,000 (1)
481:21
2/28/2008 (1)
486:21
2/29/2008 (1)
483:20
2:03 (1)
450:9
2:57 (1)
485:15
20 (5)
346:10;398:20;433:9,10;
436:19
200 (1)
379:3
2004 (1)
401:19
2006 (1)
486:5
2007 (3)
395:17;437:11;438:12
2008 (11)
441:6;464:10,23;465:4,5;
471:3,4;494:14;506:5,22;
508:5
2009 (17)
328:11,14;330:13;340:21;
341:3,8,8,16,17;342:2,2,11,
11;347:9,12,19;510:8
201 (2)
384:24;397:16
2010 (19)
330:9;336:22;347:9,13,
19;348:6;349:16;360:16;
371:17;379:4;385:11;
436:23;437:2;512:13,13,23;
513:1,5,17
2011 (4)
349:17;423:17;424:3;
435:11
2015 (1)
325:12
202 (2)
386:17;397:17
2031 (1)
508:14
2032 (2)
510:8,9
2045 (4)
493:17;494:5,9,10
2047 (6)
484:19,22,23,24;485:19;
490:8
2048 (1)
487:8
205 (2)
392:3,4
2058 (4)
505:4,8,9,10
206 (1)
414:10
2061 (2)
501:20,21
2064 (3)
486:16,18,19
207 (1)
392:4
2079 (2)
506:4,6
208 (3)
415:8,9;438:11
2080 (3)
507:12,13,23
209 (2)
415:8;418:10
2094 (2)
497:8,10
2100 (3)
512:24;513:1,2
212 (1)
420:15
214 (2)
423:13,24
215 (1)
423:13
216 (1)
423:13
217 (2)
437:10;449:3
218 (1)
438:12
22 (2)
513:4,17
220 (1)
439:13
221 (1)
439:13
222 (1)
439:14
223 (5)
441:4;460:4;461:3;462:9,
14
226 (1)
441:4
230 (5)
445:24;446:1,7;449:7;
464:16
231 (5)
446:2;447:17;449:7,8;
464:16
23C (1)
475:23
23D (1)
475:24
24 (2)
371:17;406:11
245 (1)
486:14
246 (1)
486:14
24th (2)
379:4;424:3
252 (2)
459:18,21
257 (1)
479:3
260 (1)
427:12
262 (4)
450:20,23;462:10;465:6
263 (6)
450:20,23;451:4,5;461:2;
464:2
264 (2)
459:4;470:15
265 (2)
478:11;480:21
266 (1)
470:15
267 (1)
479:17
26th (1)
437:11
275 (4)
479:14;480:20,22;481:11
277 (1)
482:15
279 (2)
485:22;486:8
280 (3)
460:2;485:22;486:8
286 (3)
439:12,17,21
287 (1)
439:21
288 (3)
439:13,17;483:3
28th (1)
423:17
292 (2)
488:15,16
294 (2)
489:11,13
295 (1)
489:19
296 (1)
488:15
297 (2)
492:18,19
299 (2)
500:4,5
29th (1)
510:8
2nd (2)
464:10;465:5

3

3/22/2010 (1)
513:22
3/30/2010 (1)
424:4
3/30/2011 (1)
424:22
3/7/08 (1)
454:9
3/7/2008 (1)
463:9
3:03 (1)
485:15
30 (7)
332:17;435:18;436:8;
508:23;509:8;511:6,13
300 (16)
441:1,3,3;448:10,11;
460:2,4,5;461:3,7,8,22;
462:8,13;463:8;500:4
301 (3)
441:2;500:4,17
302 (2)
503:9,12
303 (3)
441:4;503:12;504:3
309 (1)
506:23
30th (1)
385:11
310 (1)
483:2
334 (2)
446:1,1
343 (5)
488:15,17,18;489:11,12
343-347 (1)
488:14
344 (3)
446:4,7;464:15

345 (5)
446:4;447:17;464:15;
489:12,13
346 (1)
489:19
346.90A (1)
373:13
35 (1)
446:1
353 (2)
513:8,12
354 (1)
513:8
359 (6)
492:18,19,22;493:9,23;
494:2
360 (5)
331:19;332:18;333:12;
334:15;494:1
364 (1)
364:15
382 (3)
500:3,5,6
383 (2)
500:3,6
384 (4)
500:3,6,17,18
3rd (1)
512:13

4

4 (3)
358:11;415:8;515:14
4/11/08 (1)
490:5
4/11/2008 (1)
487:10
4/7/2008 (1)
464:17
4:02 (1)
520:8
4:09 (1)
367:13
4:24 (1)
367:13
40 (7)
354:17;381:9;433:9,10;
436:19,20;437:5
424 (4)
503:8,12;504:2;508:14
425 (6)
459:18,23;503:12;504:8;
510:8,9
434 (2)
371:4,8
435 (6)
450:20;461:2,13,15;
462:10;465:6
436 (4)
450:20;451:5;460:12;
464:2
438 (1)
494:6
439 (3)
379:3,5,6
44 (2)
437:3,6
440 (12)
379:5;381:10,11,12,24;
383:3;459:3;466:9;470:15;
484:20,24;490:8
441 (1)
487:9
442 (1)
470:15
444 (5)
385:1,3;388:14;397:16,18
445 (2)
385:3;386:18
451 (2)
505:4,5
454 (4)
479:2,17;501:20,22
457 (2)
486:16,18
465 (2)
392:3,4
466 (1)
414:10
467 (1)
392:4
472 (2)
506:4,7
473 (4)
507:12,13,24;508:12
475 (2)
497:8,11
478 (4)
512:13,14,15,24
48 (1)
331:8
480 (1)
507:22
4th (1)
465:4

5

5 (1)
378:1
5/15/2008 (1)
497:14
5/20/2008 (2)
502:3,4
50's (1)
473:5
546 (2)
415:8,9
549 (4)
479:13;480:20,23;481:10
562 (1)
506:23

6

600 (2)
342:18,24
600-page (1)
342:17
639 (1)
360:14
64 (2)
437:14;473:3
640 (3)
360:9,12,14
641 (1)
360:15
642 (1)
360:15
65 (1)
473:3
679 (1)
418:9

7

7/2/2008 (1)
451:2
7/30/2008 (1)
502:3
7/8/2010 (1)
418:13
71 (2)
482:14,21
772 (1)
420:14
7th (3)
441:6;464:23;465:4

8

8 (1)
359:10
81 (2)
485:23;486:8
857 (2)
423:12,23
859 (2)
423:12;427:11
86 (3)
485:17,22;486:2
87 (2)
439:13;485:17
88 (1)
485:22

9

9 (1)
437:10
9/25/06 (1)
482:16
90 (1)
334:6
900 (1)
482:6
9th (2)
352:3;494:14