In The Matter Of:

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

Bharanidharan Padmanabhan, M.D.
Vol. 4
January 15, 2015

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COMMONWEALTH OF MASSACHUSETTS
DIVISION OF ADMINISTRATIVE LAW APPEALS

Civil Action No. RM-14-363

- x
BOARD OF REGISTRATION IN MEDICINE,
Petitioner,
v.
BHARANIDHARAN PADMANABHAN, MD,
Respondent.
- x

HEARING BEFORE MAGISTRATE KENNETH BRESLER
Thursday, January 15, 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

E X H I B I T S

Continued.

E X H I B I T S, continued

*Original exhibits retained by Administrative Magistrate Bresler.

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P R O C E E D I N G S
THE MAGISTRATE: Today is January 15th, 2015. This is a hearing before the Division of Administrative Law Appeals. It is being held at the Civil Service Commission, One Ashburton Place, Boston, Massachusetts. This appeal has the docket number RM-14-436 (sic). The petitioner is the Board of Registration in Medicine. The respondent is Bharanidharan Padmanabhan, MD. I am Administrative Magistrate Kenneth Bresler. James Paikos represents the petitioner. Dr. Padmanabhan represents himself. The parties' representatives are present. All electronic devices that make noise should be off.
Are we ready to resume testimony, or is there anything else?
MR. PAIKOS: Yes, we're ready. Doctor --
THE MAGISTRATE: Let me just remind Dr. Levin, you're still under oath.
THE WITNESS: Yes, sir.
RESUMED DIRECT EXAMINATION
Q. (BY MR. PAIKOS) And Doctor, if you could go to 1465, 1466, medical record number, Bates 356

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and 357?
A. I have reviewed these records.
Q. Can you assess Dr. Padmanabhan's care on that date, April 6th, 2010?
A. The care was below the standard of care.
Q. Why?
A. Reviewing the history, there's a note that the patient came in for trigger point injections of the neck, received medication with immediate relief. She is reporting that she's very sleepy and tired, less pain since the IVIg. There is no other history. This patient has multiple problems. We have no details about these problems. She is on other medications. Those are not listed. It's an incomplete history. The examination is listed as being unchanged. In a patient with her multiple neurological problems, this is below the standard of care. We would expect there to be a neurological examination, as previously discussed. Assessment is muscle spasm. There is no other information other than delayed sleep, no comment on the multiple previous problems that have been described. There have been many different problems, changing diagnoses in the progress notes.

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This is another -- I believe this is the first time we're seeing this as a single diagnosis, a single assessment, and we have no other information about her previous diagnoses. The plan -- excuse me. There's also a note, overall, a bit better. The plan is --
THE MAGISTRATE: That's vague. Am I right?
A. Yes, sir.
THE MAGISTRATE: Overall is vague and a bit better is vague?
A. That's correct. The plan, the only plan that I could see for medication is will take Somnote for a few days. Somnote, also known as chloral hydrate, is a sleeping medication. It's one that isn't used very much any more. I believe actually it was unavailable, because it wasn't on the formulary for this patient's insurance. I believe for Mass. Health, it wasn't on the insurance, because it was felt to be ineffective.
THE MAGISTRATE: Ineffective in general or for this patient?
A. Ineffective for treating sleep disturbance. It's a medicine with many side effects. Some of

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them can be quite significant. It leads to sedation. There's no other information about any of the other medicines the patient is being prescribed, yet she is being prescribed or has been prescribed a large number of different medications, including the intravenous IVIg that's being prescribed, a number of potentially very toxic medications. We have no information about what she is being prescribed, the dosages, what the plan is for the prescription. There is an interesting note from the nurse, Marianne Richard. Blood pressure, 84 over 60 sitting, 88 over 64 lying flat, so her blood pressure is low and she complains of extreme fatigue. I would be suspicious that some of her fatigue may relate to her blood pressure being low and blood pressure being low frequently is a side effect of medication. Given the multiple medications that she is on, I think it is likely that that may relate to medication effect. There would be concern that she is now being prescribed a sleeping medicine in addition to all of her other medications; could possibly lower her blood pressure even more.
Q. (BY MR. PAIKOS) Is there any indication of

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who is prescribing the sleep medication?
A. Doctor has a note here that -- I assume that's what he's saying. Will take Somnote for a few days to resync. It does not say I will prescribe. It does not say this medicine is being prescribed at this dose to be taken in such a way, this number of pills, this many refills. It only says will take Somnote, so I don't know if someone else prescribed it, if she already had it, or if he's prescribing it now.
THE MAGISTRATE: And what does resync mean to you?
A. To help her resynchronize her sleeping pattern by -- she's staying up until 2 o'clock in the morning every day. Resync to me would indicate that he's trying to help her fall asleep so that she can resume a more normal sleep cycle.
THE MAGISTRATE: Thank you, Dr. Levin. Thank you Mr. Paikos. I have more questions on this page before you leave it, but I wanted to turn the questioning back to you.
Q. (BY MR. PAIKOS) The IVIg, is that something indicated for muscle spasms?
A. No.

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Q. What is it for, if you could?
A. IVIg is a -- an immune medication. It's a very strong medicine. It's produced by pooling the immunoglobulins from different people to help treat serious immunological disorders. It isn't used for many neurological disorders. It is used for a couple of neurological disorders. It is used for a condition called Guillain-Barre, which affects nerves and the nerve roots as they comes out of the spinal cord. It causes a descending paralysis, so severe weakness. Some people develop persistent weakness that's called CIDP, chronic inflammatory demyelinating neuropathy, or polyneuropathy, and IVIg is used for that as well. It's a chronic neuropathic condition. As well, it's used for a condition called myasthenia gravis that causes severe muscle weakness. Those are the main conditions in neurology that IVIg is used for. It's used for other serious immune conditions. It's used as well with rheumatologic disorders. I believe those are the main things. I do have a handout. I could review that if you wish.
Q. Not currently. We may.
A. I'm sorry. I think you asked me about side effects as well.

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Q. Right. Side effects. Yeah.
A. It's a medicine that can lead to severe side effects. If I may, I don't recall all the side effects, so I'm referring to the handout that I gave to Mr. Paikos.
Q. Doctor, if -- the document that you have in front of you, what is the title of the document?
A. Handwritten at the top, it says IVIg Up To Date.
Q. Okay.
A. This is an article that I printed from Up To Date, the online textbook that I discussed. I had some difficulty printing it, so I printed out part of it and put the title at the top in my own writing.
THE MAGISTRATE: Let me just ask Dr. Padmanabhan, are you familiar with that source and do you have access to it?
DR. PADMANABHAN: No, but they have provided the printout.
THE MAGISTRATE: Thank you.
MR. PAIKOS: That's at Exhibit 23B.
THE MAGISTRATE: Thank you.

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A. Careful monitoring of patients newly receiving IVIg by a health care provider who is familiar with signs and symptoms of IVIg reactions is recommended. Side effects can include anaphylaxis, severe allergic reactions, headaches and neurologic side effects. It can lead to infections, including some serious infections. It can lead to thrombotic complications, stroke, heart attacks.
THE MAGISTRATE: If I could interrupt you, Dr. Levin? What's the tab number? And have I been pronouncing your name correctly?
MR. PAIKOS: 23B is the tab number.
THE MAGISTRATE: And have I been pronouncing your name correctly?
MR. PAIKOS: Yes.
THE MAGISTRATE: Paikos?
MR. PAIKOS: Paikos.
THE MAGISTRATE: Okay, so I have 23B in front of me. Dr. Levin, are there side effects that you want to particularly draw my attention to?
A. There are a couple more. There are renal complications including acute renal failure can occur. There can be severe hematologic

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complications, including severe anemia and severe hemolysis, breakdown of the blood products. So this is a medication that can really lead to quite severe complications, one that we don't prescribe lightly, and it is typically prescribed for only a very few specific conditions.
Q. (BY MR. PAIKOS) And do you -- going back to Medical Record 146, 357, is part of the standard of care when prescribing this medication or any medication to inform the patient of the side effects?
A. Yes.
Q. And to confirm that in the record?
A. Yes.
Q. And why do you tell the patient about the side effects?
A. Well, for any medication, we want the patient to know the side effects, and so if they are having problems, first of all, to be warned that these problems may occur; if they're having problems, for them to be aware of them. If the problems are not severe, they may be able to continue the medicine. You want them to be able to call you if there are severe side effects or if

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there are effects from the medication that are detrimental to them. In a medication like IVIg, you particularly want the patient to be aware of the potential for severe side effects, so if they have these side effects, they will contact you and the medication will be discontinued and you will provide them the proper treatment, if needed.
Q. And this is from a note we were looking at, April 6th, 2010. And if I could direct your attention to Medical Record Number 2100, which is at Bates 478 --
A. 2100?
Q. Yes. As I said, we are looking at an April 6th, 2010, note and this is --
THE MAGISTRATE: Actually, Mr. Paikos, if I could ask the doctor a question about the previous document? It's not noted what the IVIg is being prescribed for, right?
A. That is correct.
THE MAGISTRATE: And if the pain is better, that's a beneficial side effect, but we don't know whether it's prescribed for pain?
A. We don't.
THE MAGISTRATE: And we don't know

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where the pain is?
A. That's correct.
THE MAGISTRATE: Thank you.
Q. (BY MR. PAIKOS) Does IVIg relieve pain?
A. It's a difficult question to answer, because IVIg is used for many different conditions. Guillain-Barré would be the neurological condition that I'm familiar with that IVIg can be used for. Some patients with Guillain-Barré may have pain. If the Guillain-Barré, the neuropathic process, is improved by the IVIg, I would assume that their pain would also be improved. It is not a medication that is prescribed for pain per se. If pain is a part of the condition that's being treated, then I would assume that the pain may be improved.
Q. Okay. It's not a narcotic or a non-steroidal -- steroid medication that's used specifically for pain?
A. No.
Q. But it may result in some relief, potentially? So going back to Medical Record 2100, March 3rd, 2010, order form, approximately one month prior to the April 6th note we were looking

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at, Privigen, is that IVIg?
A. I am not familiar with the term Privigen. Above the word Privigen, in parentheses, it says IVIg, so I'm assuming that Privigen is a name of a form of IVIg.
Q. And here on this order form, it says DG CNS inflammatory disease. Is that different from muscle spasms that we see about a month later?
A. Yes.
Q. And I think you've talked about CNS inflammatory disease, but is it -- what is it?
THE MAGISTRATE: I think he has talked about it.
MR. PAIKOS: Okay, so we won't repeat.
THE MAGISTRATE: And DG stands for?
A. Diagnosis.
Q. (BY MR. PAIKOS) Now going forward again, the day after that April 6th, 2010, note at Medical Record 1471, Bates 359, you had talked about issue relative to insurance. Is this --
THE MAGISTRATE: I'm sorry, Mr. Paikos. Which Bates number?
MR. PAIKOS: 359, Medical Record 1471.
THE MAGISTRATE: Doctor, before we

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leave Bates 478 -- Doctor, are you at Medical Record 2100?
A. I can go there.
THE MAGISTRATE: Yeah, before you leave it, I want to ask a question.
A. I have that page.
THE MAGISTRATE: Okay. Do you see the cross-out at the top of the page?
A. I do.
THE MAGISTRATE: What does that indicate to you?
A. There are three medications that are crossed out. Benadryl and Tylenol are the second and third, and those are also written in the bottom, so it suggests to me that the cross-out is not for those two medicines. Privigen is listed as 600 milligrams per kilogram IV once. That is crossed out and a different dose for Privigen is written at the bottom, 36 milligrams IV ten percent solution start at 60 milliliters per hour. That appears to be a different prescription for the medication.
THE MAGISTRATE: So it appears on the same date, 35 minutes apart, the doctor changed his

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mind for some reason and just reissued it?
A. That is what appears to be.
THE MAGISTRATE: Thank you.
Q. (BY MR. PAIKOS) Now, if we go to Medical Record 1471, Bates 359, you were discussing the day earlier the doctor had prescribed a sleep medication and mentioned something about insurance. Is this where you received that information?
A. Yes.
Q. And Mass. Health has it on a list of -- as ineffective; is that correct?
A. Yes.
Q. If we go to Medical Record 2024, Bates 417, if we could look at that in conjunction with Medical Record 1494, which is at Bates 360? So again, Medical Record 2024, which is at Bates 417 and Medical Record 1494 at Bates 360. If you could look at those pages once you have them?
A. I have reviewed these records.
Q. And is Dr. Padmanabhan's care on April 21, 2010, within the standard of care?
A. Excuse me. Just to confirm, at the top of the page, it says ENC, period, date. I'm assuming that means encounter date is 5 -- excuse me;

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4/21/2010, and then I see progress notes from the doctor signed 5/3/2010. May I assume that that is the encounter from 4/21/2010?
Q. For the purposes of this, you could assume that. And is there also a note from Nurse Marianne Richard signed at 4/21 --
A. There is.
Q. -- 2010?
A. There is.
Q. If you could review those two pages in conjunction?
A. I have reviewed those two pages.
Q. And what is your opinion of the care provided?
A. Care provided was below the standard of care.
Q. And why?
A. The history given is very limited. Note is that the IVIg drip helped her systemic symptoms. We don't know what symptoms are being described. She comes in to ask for another -- I don't know what another refers to; I assume it's IVI drip, but I don't know for sure -- and decide on this as an ongoing plan. We had a full discussion of all of

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her treatment options. It's a vague statement. I don't know what treatment options were discussed. I don't know what the treatment options were for. There was no mention of any of her multiple medical diagnoses, her multiple medical problems. Just a note here, given that she is not allergic to it and has responded well, I think it is reasonable. I don't know what that refers to. I'm assuming it refers to IVIg, but again, I don't know for sure. There is no examination. This type of complex patient would require a neurological examination. There's no examination here. There really is no impression. We don't know the diagnosis that he's treating. We don't know what his impression is in terms of what's happening with the patient and where it's going to go. There is no information in regards to pain. There is no information in regards to any of the medications that he's prescribing. There is a note from the nurse, Marianne Richard, that patient complains of generalized joint pain and headaches, fatigue. Again, that is not in the doctor's note. We don't know any of the medications prescribed.
Looking at the order of 4/21/2010,

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there is an order for Percocet, for the patient to be given two pills now. I don't know why that was prescribed. Again, I don't know any of the other medicines that were prescribed.
Q. And on that order form, there's a note. Looks like 1300 hours in different handwriting?
A. There is a note stating not given, not in stock, signed by a nurse.
Q. Okay. And that is below Dr. Padmanabhan's signature?
A. It is.
Q. Would that presume that that note came after that order from the doctor?
A. Yes.
Q. Would it be important to note the reason for giving the prescription and wanting the patient to have it now?
A. Yes.
Q. And why?
A. Any time a medication is prescribed, you want to know the reason that it's prescribed. In this case, it appears to be an acute prescription of a narcotic. Any time a narcotic is prescribed, it's important to document the reason for it. Any

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time a narcotic is prescribed as an acute treatment, it would be particularly important to know why that's being prescribed, what is the indication, what is the purpose of the prescription.
THE MAGISTRATE: And the indication that it's acute, is that in effect -- it looks like it's supposed to be provided in the hospital.
A. That's what it appears to be. It appears he's prescribed two pills of Percocet to be given to the patient now.
THE MAGISTRATE: Now, right.
A. To be given now. It's a very unusual prescription. I don't know what the routine is at the center, Cambridge Health Alliance Center. I really don't know anything about Cambridge Health Alliance, so I don't know if this is an outpatient facility, if they have a hospital. This is the type of order I would normally see in the emergency room or in the hospital. I don't believe I've ever seen one for an outpatient facility.
THE MAGISTRATE: So this is an order as opposed to here's a prescription for the patient; go to the pharmacy and fill it?

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A. That's correct. Please send up -- please get two pills of Percocet and give it to the patient now.
Q. (BY MR. PAIKOS) If we go to Medical Record 1532 --
THE MAGISTRATE: Mr. Paikos, before you move on, I'd like to ask the doctor a question about Medical Record 1494, Bates 360, encounter date of April 21, 2010. Is there any indication that the doctor responded to the note by the nurse?
A. No.
THE MAGISTRATE: And then the nurse's note, what does FU today mean?
A. Follow-up today.
THE MAGISTRATE: And what does that mean to you in the context of this page?
A. That the patient is appearing for a follow-up visit.
THE MAGISTRATE: And in your experience, would the patient be meeting with the nurse before meeting with the doctor?
A. I don't know what the routine is at this particular facility. I think in most cases, that would be what would occur, that the nurse would see

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the patient, take some history, and then the doctor would see the patient afterwards, but I don't know what's done at this facility.
THE MAGISTRATE: So no apparent discussion by the doctor of -- or assessment or plan on generalized joint pain and headaches and fatigue?
A. Unless you relate that to the term systemic symptoms. Systemic symptoms takes -- is sort of a vague and non-specific term that could take into -- into account almost any symptom in the body, so you could say systemic symptoms could include generalized joint pain. It wouldn't typically be headaches.
THE MAGISTRATE: Then again, the nurse is reporting complaints of generalized joint pain, headaches and fatigue, and the doctor is saying helped her systemic symptoms, so what do you make -- what do you make of that?
A. There is no mention in the doctor's note as to her present problems.
THE MAGISTRATE: And do you have a reaction, considering the side effects that IVIg can have, to the statement, given that she's not

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allergic to it and has responded well, I think it is reasonable?
A. I think the prescription of IVIg is not reasonable. I think it's a very unusual prescription, given the patient's symptoms, given the patient's examination, given her diagnosis. I think it's an unusual prescription that is below the standard of care. It is not the type of prescription that a neurologist would normally provide. It is below the standard of care for a neurologist to order IVIg for a patient who has this clinical picture.
THE MAGISTRATE: Are there criteria other than not being allergic to it and responding well to it that should go into an assessment that it's reasonable to prescribe this?
A. The proper diagnosis. The proper diagnosis and having the proper indication for use of this medication. As I mentioned, as far as I know, there are only three different neurologic disorders that this is typically used for. There may be others that I don't know of. It is used in other specialties as well, but this is not a medication that's commonly used for neurologic conditions.

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THE MAGISTRATE: Would the potential for side effects be a criterion in deciding whether it is reasonable?
A. Yes.
Q. (BY MR. PAIKOS) Are any of the side effects fatigue?
A. I would have to go back and look at the listed side effects. I would be surprised if fatigue is not a side effect.
Q. And joint pain, what is generalized joint pain that the nurse describes?
A. It would be non-specific complaints by the patient that she is experiencing discomfort in her joints. It doesn't tell us which joints. It says that she pretty much hurts all over.
Q. And is joint pain potentially a rheumatological issue?
A. Yes.
Q. And is this the case where we had seen a rheumatologist assess whether or not the patient had rheumatological inflammation, I believe?
A. Yes.
Q. And what had that rheumatologist concluded?
A. He found no evidence of any rheumatologic disorder and he's very specifically listing the different types of rheumatologic disorders that she did not have.

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Q. And he had reviewed an MRI and concluded no inflammation?
A. I'm sorry. I would have to go back to review that. I don't recall.
Q. Okay. We may go back, but we'll go forward to something listed as an encounter date of eight May --
THE MAGISTRATE: Mr. Paikos, if I could interject, I do want to follow up on Dr. Levin saying that he didn't have the Up To Date excerpt for IVIg in front of him. So if we could turn to that, please?
A. I have it.
THE MAGISTRATE: So I am looking at Bates number 559. I don't know if you have that, Doctor, that number. It looks like page seven on the fax.
A. May I ask what the top line of the page is?
THE MAGISTRATE: Ranging from less than two to greater than 700.
A. I do have that.

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THE MAGISTRATE: Okay, so what do you see in terms of headache being a possible side effect?
A. That migraine and aseptic meningitis are side effects. Headache is a common side effect of IVIg.
THE MAGISTRATE: And do you see anything in this excerpt about fatigue being a possible side effect, or even joint pain?
A. I do not.
THE MAGISTRATE: So there is -- you see nothing in the excerpt about IVIg having a side effect of joint pain or fatigue?
A. I do not.
THE MAGISTRATE: There -- now, how common is headache to be a side effect for medications?
A. Not uncommon.
THE MAGISTRATE: Not uncommon? Given that headaches is -- headaches are a side effect of IVIg, given that headaches are not an uncommon side effect of medications in general, and then what we're seeing at Medical Record 1494, Bates 360, the nurse reporting that the patient is reporting

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headaches, how does that all coalesce in what your assessment is whether this is a reasonable medication to be giving to this patient?
A. With specific reference to headaches, it's hard for me to state whether or not she's having more headaches because of the IVIg or not. She has a history of chronic headaches, so this is a patient who has had many headaches prior to the prescription of IVIg. I cannot rule out the possibility that her headaches are worse given that headache is a common side effect of IVIg. I think the issue of headaches is a much less concerning issue than the prescription of the medication itself. I think IVIg, as far as I could tell from review of the records, there was no indication for prescription of this medication. It was given frequently. It was given in regular cycles of treatment. And the indications, as far as I could tell, were below the standard of care, that this medication should not have been prescribed for this particular patient, but once again, whether this made her headaches worse or not, I can't state. It is possible they did.
THE MAGISTRATE: So headache being a

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side effect of IVIg, the patient reporting headaches, the patient having chronic headaches, that by itself, that package of facts is not an indication that prescribing IVIg was below the standard of care?
A. That's correct.
Q. (BY MR. PAIKOS) If we could go to Medical Record 1432, Bates 365? If you could review that note and assess if it's within the standard of care?
A. Once again, and I -- perhaps to clarify this and I won't ask you the same question over again. The encounter date is listed as 5/4, as is the note from the nurse on the bottom. The note from the doctor is listed as 5/9/2010, so I'm going to assume that each of the notes that I am looking at will be the encounter date rather than the date they were signed.
Q. We'll make that presumption currently, yeah.
THE MAGISTRATE: And if the presumption is not correct, do the dates matter to your case?
MR. PAIKOS: I don't think they do. I don't think they do.

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A. I have reviewed the record and this is below the standard of care.
Q. (BY MR. PAIKOS) And why?
A. Looking at the history, we have a very brief limited history, that she's here to discuss the plan going forward, has benefited from IVIg treatments. There is no information about the symptoms. There's no information about any of her multiple diagnoses that she's been given. We don't know what her clinical symptoms are at this point. There's a statement that she's benefited from the IVIg treatments, but we don't know how. We don't know what symptoms this has helped to improve. It's a vague statement that doesn't give us any information at all. After a long discussion, we have elected to continue the IVIg every six to eight weeks. Again, this is a very powerful treatment, and as far as I can see, there is no explanation for why this is being given or any concerns about the possible toxicity of the medication. There is no other history. There is no neurological examination. Once again, this is a patient whose clinical assessment required a neurological examination as previously described.

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There is no impression. We have no impression about the patient at all. The plan is -- is part of the history, to continue the IVIg every six to eight weeks. There's also a note that she received trigger point injections during this visit. There is no indication of why the trigger point injections were given. We don't know the diagnosis for the trigger point injections and there's no other information about plan, including no other medications, and this is a patient who in further review appears to have been receiving multiple different medications. There's no indication here of anything that she has been -- is receiving, no prescription information at all.
Q. And what does the nursing note indicate?
A. Follow-up for generalized pain, quote, autoimmune, unquote, disorder. She is not sure if she needs medication refill.
Q. What is autoimmune, quote/unquote, disorder?
A. Autoimmune, the term autoimmune refers to the immune process we discussed previously where the body protects itself from outside invaders. The body protects itself from attack from the

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outside. Sometimes the body makes a mistake and will attack normal tissue. When that happens, it's referred to as an autoimmune process, or if it's a condition or a disease, an autoimmune disorder. Typically, we will not say autoimmune disorder as a general term. Typically, there's an autoimmune disorder that we're concerned about. There are many autoimmune disorders. Rheumatoid arthritis, lupus erythematosus, these are autoimmune disorders. She then wrote, she is not sure if she needs medication refill. There's no indication what that refers to. She had been prescribed multiple medicines. I don't know what medicines those -- she's requesting a refill on.

Q. And are autoimmune rheumatological or neurological, potentially, or does that not fit into that category?

A. There are many autoimmune disorders that affect the nervous system. MS is very likely an autoimmune disorder. There are more common conditions like Bell's palsy, which is an autoimmune disorder, Guillain-Barré that I mentioned before, chronic inflammatory demyelinating polyneuropathy, myasthenia. These

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are all autoimmune disorders. There are many, many neurological autoimmune disorders.

Q. The consult from the rheumatologist, do you remember if he discussed rheumatological disorders or autoimmune disorders?

A. He did.

Q. And if we could go to Medical Record 384, Bates 301, the second part of that May 18th, 2008, note by Dr. Romain?

A. I do have page 384.

Q. Okay. And under impressions, did Dr. Romain rule out autoimmune issues?

A. The impression from Dr. Romain is I do not find evidence of articular disease specifically, or any systemic autoimmune or inflammatory rheumatologic disorder.

Q. If your -- if the diagnosis of doctor -- of another physician is different than yours, would it be important to note why you've diagnosed someone with something that wasn't there before?

A. Yes.

Q. Are there any studies, different studies, that show autoimmune that you've seen in the record up until that day?

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A. I'm sorry. Any studies that indicate an autoimmune disorder?

Q. Yes, up until the time of that nursing note on May 4th, 2010, if you remember.

A. No.

Q. So turning to two pages, the first one is at Medical Record 2099 and Bates 477, and if you could --

A. I have page 2099.

Q. 2099, which is Bates 477, and if you could also go to Medical Record 1565, which is at Bates 366?

A. I have reviewed these records.

Q. And if you could also look at -- and I apologize for not knowing it earlier -- Medical Record 1570, Bates 367, which is after the computer note, the EMR note?

A. This is dated 5/26/2010?

Q. Yes.

A. I do have that as well.

Q. Okay, so -- and that page has a prescription approved by Dr. Padmanabhan for Percocet. If you could review these pages and state whether or not the care or -- provided or the

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advice given was within the standard of care?

A. The first note that I have is a report from -- a progress note from a Nurse Ruth Krause, K-R-A-U-S-E, RN, and she describes this as being the patient's third IVIg infusion that she feels has helped her. Vital signs are stable. Discussed the possibility of increasing the rate of infusion. This is not a note from the doctor. This is a note from the nurse. Do you wish me to comment on the nurse's note?

Q. And there's a comment relative to Dr. Padmanabhan coming in briefly to talk with the patient?

A. She states that the doctor came in to the treatment room to briefly talk with patient.

Q. And at Medical Record 2099 from that day, Dr. Padmanabhan provided an order for IVIg?

A. Yes.

Q. And how -- what's the frequency of the IVIg at the bottom of that note or that order?

A. Repeat monthly for one year. Start date, 3/18/2010.

Q. And was the care or advice provided that day within the standard of care?

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A. There is no indication from the records that I have that any advice was provided other than the nurse stating that the doctor briefly spoke with the patient. The care advice -- excuse me. The care that was provided was below the standard of care. The care that was provided was prescription of IVIg, which for reasons previously discussed is below the standard of care for this patient. The diagnosis listed is CNS inflammatory disease. This is a vague diagnosis that relates more to the pathological process than to a neurological disease. As previously discussed, that would be below the standard of care in terms of making a diagnosis by a neurologist and using that diagnosis as the rationale for treatment with IVIg. In addition, there is a prescription for Percocet with no clinical information in any of the records that I could find around this date. That would be below the standard of care.

Q. And just to make it a little easier logistically, we'll come back to Medical Record 2099 for the Solumedrol part of it from July 15, 2010.

THE MAGISTRATE: And where is the

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Percocet on Medical Record 2099?

MR. PAIKOS: It's not on 2099. It's on Medical Record 1570, Bates 357, with an encounter date of May 26th, 2010.

THE MAGISTRATE: Okay. I see it. Thank you.

DR. PADMANABHAN: Objection.

THE MAGISTRATE: Basis?

DR. PADMANABHAN: Different dates. The date on 1570 is June 6th, and we are talking about an encounter from May 26. I don't see the relevance. I don't see why the government has put these two together.

THE MAGISTRATE: Well, I see, because the encounter date is the same, but you can raise it during your case or -- either on cross-examination or by testifying about it.

DR. PADMANABHAN: Did you say the encounter date is the same, Your Honor?

THE MAGISTRATE: I'm looking at Medical Records 1565 and 1570, Bates 366 and 367, and the encounter date is the same. You can bring it up during your case.

DR. PADMANABHAN: Thank you.

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Q. (BY MR. PAIKOS) Now, if we go to Medical Record --

THE MAGISTRATE: Mr. Paikos, if I could interject? Dr. Levin, a question about 1565, Bates 366.

A. 1565?

THE MAGISTRATE: 1565. So the nurse is talking about tolerating the medication. What does that mean to you?

A. That the medication -- she notes that the -- she is not experiencing significant side effects from the medication.

THE MAGISTRATE: So this is an indication that side effects are being monitored?

A. Yes.

Q. (BY MR. PAIKOS) If you could go to Medical Record 1608, which has an encounter date of 6/17/10 and a note by Dr. Padmanabhan on 6/17/10?

DR. PADMANABHAN: Which page, please?

MR. PAIKOS: Medical Record 1608, 6/17/10, please.

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

Q. (BY MR. PAIKOS) And why?

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A. There's a note that the patient came in for Botox in her neck with cervical dystonia, but there's no previous indication that I can recall of a diagnosis of cervical dystonia. There is a note that she tolerated it well. There is no other history. There's no history of previous problems with cervical dystonia. There's no history of her other multiple problems, no history of pain problems, no history of her headaches, no mention of her receiving IVIg or Solumedrol or any other medications. There's no other history at all. There's no examination, so we don't know, did she have evidence of cervical dystonia on her exam, did she have some other neurological abnormality. The impression was that she tolerated it well, usually feels better in a couple of days. And there's no plan, so we don't know what his plan for the -- for the patient is. Typically, when a prescription or a treatment of Botox is given, there would be a note, patient to call if she has side effects, side effects were discussed with the patient. There's no information about that here as well.

Q. Doctor, you talked about cervical dystonia I think yesterday, but that's a condition where

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your head comes down to your shoulder, in a sense?
A. Correct. The head and the neck will go to one side and involuntarily be held to that side.
Q. And is Botox something used typically for cervical dystonia?
A. Yes.
Q. And we talked a little bit about side effects and the nurse discussing her reaction. Can there be side effects in between the various injections of IVIg?
A. Yes.
THE MAGISTRATE: Dr. Levin, on the same document, how important is it to note where the injections are?
A. It's the standard of care.
THE MAGISTRATE: To note where they are?
A. Correct.
THE MAGISTRATE: And how does this report com-- comport with the standard of care?
A. It states six spots, three on -- three each side. It doesn't tell us specifically where the injections were. It just --
THE MAGISTRATE: Does that comply with

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or not comply with the standard of care?
A. It does not comply with the standard of care.
THE MAGISTRATE: In a previous record we saw about two injections -- four injections, two on each side of the neck, how does that comply or not comply with the standard of care?
A. I believe the previous note was a diagram and the diagram put X's where the injections were given. It gives us a basic idea, but it really didn't give us the specifics in terms of where the injections were given. The pictures were hard to interpret. There were, I believe, injections in the neck as well as in the back. It was hard to know specifically where the injections were. That would be below the standard of care.
THE MAGISTRATE: Mr. Paikos, I assume you have your notes and you can direct us back to the previous record that we were looking at?
MR. PAIKOS: Relative to the diagrams?
THE MAGISTRATE: Injections. No, not diagrams. The injections. It may have been the previous set of documents that we were looking at.
MR. PAIKOS: Relative to the nursing

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note? If we go to Medical Record 1565, 366 --
THE MAGISTRATE: Mr. Paikos, do you remember a medical record, four shots, two on each side of the neck? Is it this one or the one before this?
MR. PAIKOS: Are you talking about the --
THE MAGISTRATE: Oh, you know what? It's Medical Record 1608, Bates 370. Six spots, three each side.
A. 1608?
THE MAGISTRATE: Right.
Q. (BY MR. PAIKOS) Dr. Levin, do you have that in front of you?
A. Yes, sir. I believe that's the present encounter that we've been discussing, page 16, right?
THE MAGISTRATE: Was there one before that?
MR. PAIKOS: There was a diagram before that.
THE MAGISTRATE: One without a diagram. If I'm remembering correctly, two sides -- I'm sorry. Four shots, two on each side.

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A. Oh, I believe page 1465 discusses trigger point injections.
THE MAGISTRATE: Okay. Medical Record 1465, Bates 356. Came in for trigger point injections in her neck. Dr. Levin, is where the patient received trigger point injections important?
A. Yes. Yes.
THE MAGISTRATE: Should it be noted here?
A. Yes.
THE MAGISTRATE: Is there a standard number of trigger point injections, or --
A. No.
THE MAGISTRATE: -- should the number be noted?
A. There is not a standard number. The number of the injections and the specific location of the injections, it is standard of care to indicate that specific information about the injections.
THE MAGISTRATE: Number and location --
A. Yes, sir.
THE MAGISTRATE: -- and dosage?
A. Correct.

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THE MAGISTRATE: Thank you.
A. That would also include the dosage for each injection.
Q. (BY MR. PAIKOS) So on that, we were talking previously about the 6/17/2010 encounter, the Botox for the cervical dystonia at Medical Record 1608, Bates 370. And if you could go to Medical Record 2112 at Bates 482?
THE MAGISTRATE: If it's getting warm in here and if anybody wants to take a jacket off, that's okay.
A. I have that record.
Q. (BY MR. PAIKOS) And that's also from June 17, 2010?
A. Yes, sir.
Q. And that has -- does that have all the information needed for -- for the Botox injections to be within the standard of care?
A. No.
Q. What is not there and what is there that should be there?
A. The 6/17/2010 report that I see on page 2112 is an order for Botox. It states Botox-A, 100 international units per vial. Please

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send two vials. So this is actually an order from the doctor to get the medication. The standard of care would not be for him to have listed other clinical information on this. This meets the standard of care for ordering a Botox vial.
Q. Does it give us more information that would change your opinion relative to the care that he provided when he ordered the Botox and didn't specify whether -- where it would be?
A. This does not change my opinion in regards to this progress note.
Q. Okay.
A. The progress note remains below the standard of care. His order of the Botox is within the standard of care.
Q. In other order forms, we may have seen a diagram. There's no diagram here.
A. I don't recall seeing a diagram on an order form. I do recall seeing diagrams in progress sheets.
Q. Okay.
A. But I may be mistaken.
Q. Well, there is no diagram here on this particular page?

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A. No.
Q. Okay. And if we go to Medical Record 1665, 1665, at Bates 371, if you could review that record?
A. I have reviewed this report of 6/29/2010 and this is below the standard of care.
Q. Why?
A. History is limited. Indicates that the patient is to get IVIg today and that she has a good decrease in symptoms from IVIg and Solumedrol, but she still has pain. There's no indication as to what the specific symptoms are that are being addressed. We don't know what symptoms were improved. We don't know what the diagnosis was. There's no clinical information as to specifically why these medications are being prescribed. We don't know how often the Solumedrol is being given. We don't know the dosage of the Solumedrol. History indicates subjective at the neck, is very tight again. She feels like it's broken. Again, there's no other clinical information as to her clinical symptoms. Given her multiple neurologic symptoms, a more complete history would be standard of care. The examination, there is no neurological

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examination. As previously described, a neurological examination in a patient of this complexity would be the standard of care. There is no examination. Assessment is cervical dystonia and inflammation. Once again, there is no examination to indicate that she actually had cervical dystonia. I don't believe I saw any records in the entire chart indicating that the patient actually had documentation on examination of cervical dystonia. Other diagnosis is inflammation. It's a non-specific diagnosis. We don't know where the inflammation is. We don't know is he discussing CNS inflammation, general inflammation, inflammation in her neck related to the cervical dystonia. It's a vague statement. It's below the standard of care. The plan is will give Botox today, and there is no other specific information about the Botox. I don't know if there is another note about giving the Botox. If Botox was administered, then the standard of care would be to have a complete note for Botox. Any time Botox is administered, there should be a complete note giving the history as to why the Botox is being given, exactly where the Botox is given, the

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amount that's given, specifying the exact area of the body that it's given in detail, and then discussing whether or not the patient has tolerated the treatment, has side effects, instructions to the patient. There is nothing here. Other plan is patient will continue on the drips for now. I have no idea what drips means. Presumably, that relates to other medications, possibly IVIg, possibly Solumedrol, one or the other. There's no indication specifically what that is particularly for the prescription of potentially very toxic medications. This is below the standard of care. There is no indication of prescription for other indications. When reviewing the records, the patient apparently did receive other medications, including narcotics, and there is no indication in this report.

Q. Going to Medical Record Number 1694 and Bates 372, if you could assess that note and inform us if that's within the standard of care?

A. Excuse me. Did you direct me to page 1695 as well?

Q. 1695, the note continues there, the nursing note, if you could read those two together.

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A. I have reviewed this report and the report from the doctor is below the standard of care.

Q. And why?

A. There is a brief note, comes in prior to her Solumedrol drip, had a long discussion in response to the anti-inflammatory therapies. There's no indication specifically which therapies he's referring to. The assumption would be IVIg and Solumedrol, but there were other medications prescribed. He isn't saying what the discussion included. He's not saying why she is being treated. We don't know her diagnosis. We don't know her reaction to the medication. There is a note that the Botox apparently reduces the dystonia, but revs up the joint pain, and there is no further history. A history would be required of a patient of this complexity. There is no neurological examination. The neurological examination is the standard of care for a patient with these multiple neurologic symptoms, as previously described. There is no impression. So no diagnosis, no impression, we don't know his thoughts at all about the patient, how the patient is doing in general. And then under plan, there is

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nothing listed as plan, but there is a note, she will continue on both IVIg and MP, which I'm assuming is Solumedrol, for now. There is a further note from Nurse Marianne Richard. Complains of unsteady gait, swaying left to right, neck and spine pain, eight slash ten, very lethargic, energy, poor. There is no note in the doctor's progress note of any of these complaints. Once again, these complaints would -- the standard of care would be for the patient to have a history of these problems, to have a careful neurological examination. We don't know if the symptoms, unsteady gait, swaying left to right, very lethargic, energy poor, are these symptoms of her neurological problem, does she have a neurological diagnosis that is causing these, or are these side effects from her multiple medications? It's not unlikely that it could be side effects, but we have no idea. We have no information. It's below the standard of care.

Q. Is there anything in there about Percocet?

A. No.

Q. If you could go to that page, I would ask you to put aside Medical Record 2099, Bates 477,

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and that's a July 15th -- it's an order form that includes an order from July 15th, 2010, the date of this encounter.

A. I have that record.

Q. And what was ordered by Dr. Padmanabhan on that day?

A. Solumedrol, one gram, 1,000 milligrams, Protonix, and Percocet.

(Reporter clarification.)

A. Solumedrol, one gram, 1,000 milligrams, Protonix and Percocet.

Q. Does this order form change your assessment of the standard of care?

A. No.

Q. Should there be information relative that's here that would also need to be in the actual progress note?

A. Yes.

Q. And what is that?

A. The dose of Solumedrol should be listed in the progress note. There is no indication that the Solumedrol was actually given, although there is a statement that she comes in prior to her Solumedrol drip. He does not indicate in his plan that he's

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prescribing it. Patient was given two tablets of Percocet. There's no indication why she was given that. There's no prescription for the Percocet. He also prescribed Protonix. We don't know why that is. The presumption would be that he is protecting his patient's stomach from the Solumedrol, because Solumedrol, among its multiple significant side effects, it can cause stomach irritation and ulcer disease. That would be the presumption. There is no indication of that in the progress notes.

Q. If you could go to --

THE MAGISTRATE: Mr. Paikos, I'd like to interject.

MR. PAIKOS: Yes.

THE MAGISTRATE: Dr. Levin, before you put away Medical Record 2099, Bates 477, if a doctor is ordering medication for a patient during a visit, does the doctor need to prescribe it? I'm looking at the Percocet. If the doctor is saying to the in-house pharmacy, give me two Percocet tablets now; I want to give them to the patient, does the doctor actually write out a prescription as well?

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A. I don't know what the routine would be at this medical facility. This is not something that is typically done in a private office. When I see notes like this, generally, this is the emergency room or an in-patient in the hospital. If I wrote an order for a patient to receive two Percocet, I would have to write a prescription, give it to the patient. The patient would have to bring it to the pharmacist to get the medication. This appears to be something different from their facility and I don't know what their routine is at the facility.

Q. So let me ask you about a hypothetical doctor and a hypothetical patient in the hospital. If the doctor wanted to get two tablets of Percocet to that patient, would the doctor need to write a prescription?

A. The doctor would need to write an order.

THE MAGISTRATE: Something like that we're looking at right now?

A. Correct. So this would be the type of order that I or any other doctor would write in the hospital, assuming that we're still writing orders. Most of the time, we're doing them in electronic medical records, but assuming we're writing an

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order, this would be the type of order you would write. It would also be important for the order itself, the reason for the order, to be documented in the medical record in the progress note.

THE MAGISTRATE: Let me ask you about the progress note, Medical Record 1694, 372, Bates 372. There's the note about MP, IVIg and MP.

A. I believe MP refers to Solumedrol, methyl prednisolone.

THE MAGISTRATE: Thank you.

Q. (BY MR. PAIKOS) If we could go briefly, Doctor, to Medical Record 1700 at Bates 374?

A. I do have that record.

Q. Okay. And that just shows an MRI, a brain MRI, that Dr. Padmanabhan is ordering on that day?

A. Correct.

Q. Now, if we could go to Medical Record 2098, an August 17th -- an August 2010 order form?

A. 2098?

Q. Yes, at Bates 476.

A. I have that record.

Q. And this is an order form on August 17th. The patient is getting Solumedrol, Protonix, and on August 23rd, 2010, she's getting Imitrex and

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Percocet?

A. Correct.

Q. Now, August 23rd, 2010, Imitrex order, what is Imitrex typically prescribed for?

A. Migraine headaches. To my knowledge, it is not used for anything except for migraine headaches.

Q. And Doctor, if you could keep that note in front of you, that order, and go to Medical Record 1759 at Bates 378?

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

Q. Why?

A. There is an indication that the patient is coming in for a discussion of the current regime of staggering IVIg and Solumedrol every two weeks. That's the first indication that I've seen in the records of this pattern of prescription. It's an unusual pattern of chronic prescription, one that would need to have some explanation. There's no indication of what the explanation is for this treatment in regards to a specific diagnosis. It states that the treatment is helping her. It says the pain and fatigue, getting things done is

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better, that she strongly feels the regime is helping her. Symptoms are down 75 percent. IVIg is helping joint stiffness and pain; Solumedrol, fatigue and shooting pain. She still has some issues with muscle spasm, but is better than before. This is an incomplete history, particularly with this type of treatment regime. This is a very unusual regimen of medications. These are both medicines that have significant side effects. Solumedrol also has many serious side effects, particularly when given with regular IV infusions. The examination is listed as unchanged. This is below the standard of care for a neurologist, especially with a patient with multiple neurologic problems, as previously described.

The impression is CNS and systemic inflammation. Again, these are vague diagnoses, neither of which relates to a specific neurological or general diagnosis. Especially with the treatment this patient is receiving, this is under the standard of care. There is no other information in terms of the impressions. The plan is will continue regime and reevaluate

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periodically. There is no -- also will get Botox periodically for paroxysmal dystonia. There is no mention of paroxysmal dystonia in the history. There is no mention of the examination showing dystonia. The specifics of the regime are not listed. We don't know any other medicines that she's getting. We know that she had received other medicines before, including opioids. There is no indication of that. The patient was given Imitrex subcutaneously, Percocet at the time -- at the time I believe of her infusion. There is no mention of that, no mention of why she received it.

Q. Paroxysmal dystonia, what is that and is it different from cervical?

A. Paroxysmal dystonia would be another term for cervical dystonia.

Q. Is there a mention of migraines in this note?

A. No.

Q. And previously, we had seen some issues regarding joint pain. Anything about that here?

A. Only the mention of pain.

Q. And in the -- I believe the subjective says her symptoms are down by 75 percent. Is it clear

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what symptoms, or 75 percent of what or when?

A. No.

Q. Would it be important to know that?

A. Yes.

Q. And why?

A. To know specifically how the medicine is affecting the symptoms, which symptoms are improved 75 percent would be an important thing to know. There is a statement about symptoms being improved by IVIg, by Solumedrol, but it's vague and it's really difficult to figure out what's going on with the patient.

Q. If we could go to Medical Record 18-- 1843 --

THE MAGISTRATE: Mr. Paikos, if I could interject?

MR. PAIKOS: Yes.

THE MAGISTRATE: I'd like to Dr. Levin some questions, after which I'm going to propose a break.

MR. PAIKOS: Yes.

THE MAGISTRATE: So still on Medical Record 759, Bates 378, can you comment on the lack of an explanation about why the IVIg and the

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Solumedrol treatments are being staggered?

A. No.

THE MAGISTRATE: Should they be explained?

A. Yes.

THE MAGISTRATE: The staggering should be explained, besides other details about the treatments?

A. Yes.

THE MAGISTRATE: I want to ask you about the last sentence in that paragraph. She still has some issues with muscle spasm, but better than before. How does -- does that comply with the standard of care or not?

A. No.

THE MAGISTRATE: Why not?

A. We don't know where the muscle spasm is.

THE MAGISTRATE: How about some issues? Is that a concern? Is that vague or is that sufficient information?

A. Could you repeat the question, please?

THE MAGISTRATE: I'm looking at the phrase some issues.

A. Oh.

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THE MAGISTRATE: Is that sufficient or is that too vague?
A. That's too vague.
THE MAGISTRATE: And better than before, is that sufficient information or is that too vague?
A. Better than before would be reasonable.
THE MAGISTRATE: Let me ask you about Medical Record 2098, same date, Bates 476. It seems like this patient is coming in and the doctor is ordering Percocet on a per-visit basis. What do you make of that?
A. It is an unusual practice to prescribe Percocet at the time of an infusion. I don't know if it's because the infusion itself is causing pain and he's treating the pain. The nurse's note that we have on page 1759 indicates that the patient was having significant pain at the time she came in for her visit and her infusion. It is unclear to me if he prescribed that for the pain that she had been experiencing when she came in or if the treatment itself caused the pain.
THE MAGISTRATE: So let's say that patient was experiencing pain in general. Should

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the doctor have been prescribing Percocet so that she could manage her pain when she wasn't in the office?
A. The indication for the prescription of Percocet is something that it would be important to document in terms of the history to know what type of pain the patient is describing, along with the usual characteristics that you would obtain in the history of the patient's pain. Along with that, it would be important to have an examination to corroborate the pain to see what neurological abnormalities are observed and then to formulate an impression as to what the cause of the pain is, and then after you formulate the impression, to formulate a plan as to the proper treatment, possibly including Percocet.
THE MAGISTRATE: So if the patient had pain between visits unrelated to the injections, the standard of care would call for her to be evaluated and to see whether the Percocet would be appropriate as prescribed?
A. Correct.
THE MAGISTRATE: And if she was experiencing pain between visits to be treated when

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she came in, however many weeks apart, would be below the standard of care?
A. It would be an unusual way to prescribe Percocet.
THE MAGISTRATE: Okay. Anything else about these?
MR. PAIKOS: No.
THE MAGISTRATE: With that, I'm going to propose a ten-minute break.
(Off the record.)
(Recess taken from 11:30 to 11:40.)
Q. (BY MR. PAIKOS) If you could go to Bates 382? Doctor, if you could review that note?
A. Excuse me. What page is that?
Q. 1843, Bates 382. And if you could review the note and state whether or not it is within the standard of care? And it goes, actually, from Medical Record 1843 to 1844, Bates 382-383.
A. I have reviewed the report of October 6th, 2010. This was below the standard of care.
Q. And why?
A. There is a discussion from the patient. She came in to discuss what to do long-term to stop the inflammation in her body, how to get her life

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back. He notes that she drags in.
THE WITNESS: May I quote this information?
THE MAGISTRATE: You may quote it and move very quickly to commenting on it.
THE WITNESS: Sure.
A. A discussion that her brain is no longer sharp. She was an A student. Has a spacey look. People are questioning whether she's on drugs, illegal drugs, because of her spacey look. And he notes that he has also seen this change. Doesn't appear as sharp or as quick as before. There is no other history. This is a patient with multiple problems, multiple neurologic problems. He's describing her as having inflammation in her body, but there is no discussion as to the symptoms related to the inflammation in her body as he describes. There is no comment on other diagnoses that she's been given in the past. The cervical dystonia, different types of pains, many different neurologic symptoms, there's no comment on the specific medications that she is receiving, no comment on the response to IVIg or Solumedrol or indeed naming those or other medications in the

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history that she's getting. No mention about opioids; no mention of Imitrex, either orally or subcutaneously. This would be below the standard of care.

The examination, it's noted that her mental status remains normal per the usual office tests. She has a late left pronator drift with bilateral palm cupping. There is no other neurological examination listed. This is below the standard of care for a neurologist for the reasons previously described.

Q. (BY MR. PAIKOS) I'm sorry. Were you done with your answer?

A. The assessment is CNS inflammation. This is a non-specific vague diagnosis, as previously described, and would not merit the medications that the patient is receiving, would not merit medications with such potential side effects as regular doses of IVIg and Solumedrol. He notes that he remains convinced that her brain is being suppressed by inflammation, describes that he is giving the Solumedrol and IVIg in a staggered fashion, every two weeks, alternating. This is a very high dose of both medications. It is below

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the standard of care for the given diagnosis. And he further in discussion with the patient made a decision to give her cyclophosphamide for a one-week oral treatment. This is below the standard of care. The cyclophosphamide is a medication with many potential serious side effects. This is an anti-cancer drug that is typically not prescribed for neurological disorders. It is sometimes prescribed for multiple sclerosis. It is not prescribed as a first line drug. It would be typically a second line drug or further line. Potential for many serious side effects, serious infections, serious bladder problems, cancers occurring in the long term with the treatment, and he's adding this on top of Solumedrol and IVIg. There would be no indication for adding a third toxic medication given the diagnosis of CNS inflammation. He also gave her trigger point injections on the same visit on the left side of her neck, along the shoulder and four tough spots, and the patient had relief quickly after the injections. It is below the standard of care not to give us specific information as to why the injections were given, where were they given

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specifically, how much medication was in each injection, did she have any side effects from the injection. He also wrote a prescription for Zofran. There is no indication why Zofran was prescribed. Zofran is an anti-nausea medication. There is no indication that the patient has nausea, I don't know if that's for nausea that she has now or if it's for medications that he's prescribing, that she could be having side effects.

Q. And Doctor, it does show he sent her for a 3T scan and waiting for the CD's from Mass. General?

A. Yes.

THE MAGISTRATE: Is that the lab tests in the last line, also wrote for lab tests?

A. I don't know what the lab tests are. It just says lab tests. I don't know what those are. There's no indication. The standard of care, if you order lab tests, would be to specify which lab tests you are ordering.

THE MAGISTRATE: And her mental status remains normal per the usual office tests. Do you know what the usual office tests are?

A. It's not a term that would commonly be

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used. I don't know what the term usual office tests means. I know what the usual neurologic mental status testing is in the office, so I know what a neurologist would do in the usual course of events as a mental status test in his or her office. I'm not familiar with the term usual office tests.

Q. Could the she drags in, as noted early on in the note, could that be the result of some of the medications she's taking?

A. Yes.

Q. And there's no discussion of any impact, if any, of any narcotic she's on on that October 5th, 2010, note. Could you go to Medical Record 1814, Bates 380?

A. 1814?

Q. 1814, Bates 380.

A. I have that ready.

Q. And does that appear that there were medications ordered on that date, Oxycodone and Adderall?

A. Yes.

Q. And who is shown as the provider or the orderer?

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A. Excuse me. I'm a little confused as to the dates. I see an encounter date of 9/27 for the medications that were ordered. The encounter date for the progress note appears to be October 5th.
Q. And my question is is there any indication of, in the progress note that followed this, these orders, of how she's doing on these medications.
A. There's no indication of any information at all about the medication, no indication that they were prescribed, if they were helping her, harming her, if there were any side effects. There was no mention of the medications.
Q. If we go to Medical Record 1848, Bates 384 to 385, does this discuss a car accident?
THE MAGISTRATE: Are you leaving --
MR. PAIKOS: Yes.
THE MAGISTRATE: -- 1814, Mr. Paikos?
MR. PAIKOS: Yes.
THE MAGISTRATE: Okay. If I could ask Dr. Levin a question about that before you move on? Dr. Levin, Medical Record 1814, Bates 380, a side effect of Oxycodone can be tiredness, lack of attention. Is that right?
A. Yes.

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THE MAGISTRATE: And Adderall is to increase focus and attention?
A. Yes.
THE MAGISTRATE: What's -- what's the possibility of going on by prescribing both of these? Is there a possible connection?
A. I don't know. There was no -- there is no record, there's no information given in the record as to why either medication is being prescribed or indeed that either medicine is being prescribed.
THE MAGISTRATE: Have you seen Adderall prescribed to counter the effects of Oxycodone?
A. No.
THE MAGISTRATE: Thank you.
Q. (BY MR. PAIKOS) Actually, if we go to Medical Record 1921, Bates 389?
DR. PADMANABHAN: What's the Bates?
MR. PAIKOS: It's Bates 389.
A. I do have page 1921.
Q. (BY MR. PAIKOS) And it has a date of November 3rd, 2010?
A. Yes, sir.
Q. And what does it show for medications ordered on that day?

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A. Oxycodone, five milligrams, one pill four times a day as needed, 60 pills total with no refills.
Q. If we go to page Medical Record 1931, Bates 390, also November 3rd, 2010 --
A. I have that page.
Q. And does it appear that Cymbalta is being ordered by Dr. Padmanabhan?
A. Yes.
Q. What is Cymbalta?
A. Cymbalta I believe falls into the category of antidepressants. It's used for a variety of conditions, including depression. It can be used for pain problems on occasion.
Q. Any indication that you've seen up to that -- this point for the -- for Cymbalta in the record?
A. There's no indication that this medicine was considered or prescribed.
Q. And if we could go to Medical Record 1958 to 59, which is at Bates 392 and 393, if you can review those pages?
A. Sorry. 1958?
Q. 1958 and 1959.

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A. I have reviewed these notes and the note of 1959 is below the standard of care.
Q. And why?
A. The doctor notes that the patient was there with whole body and joint pain and fatigue that responds to Solumedrol and IVIg. Does not state what dosage she's getting, what the treatment regime is for the IVIg. Does not state any of her other medical problems. Does not state any of her other medications that she's receiving. He notes that she is there to go over her MRI, that he did review the MRI with her frame by frame, and yet the brain MRI is entirely normal. There is no neurological examination. The assessment is fibromyalgia versus undifferentiated connective tissue disease, and the statement noted I am unable to find a CNS lesion to account for any inflammation etiology. He further notes that he is returning patient to the care of her PCP -- I believe Dr. Stout is her PCP -- for pain management and to Rheumatology for tissue disease and that he will continue to follow with the migraine and dystonia. It's unclear to me how he came to the impression that he did. He is now making a radical

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change in his assessment of the patient. He previously had been diagnosing her with CNS inflammation and systemic inflammation, prescribing several toxic medications for this in frequent dosages, and now on the basis of an MRI, he's stating that she does not have these conditions. He's diagnosing her with a new diagnosis now, fibromyalgia versus undifferentiated connective tissue disease. This is a bit difficult to understand the reasoning behind this and indeed there is no reasoning except that I am unable to find a CNS lesion to account for any inflammation etiology. She had previously had an MRI. She previously had an MRI on April 4th, 2008, which was also a normal MRI. So the fact that she has a normal MRI is not new information. Her previous MRI again had been normal, prior to the diagnoses that had been made. He is sending her back to her PCP and is referring her to a rheumatologist, referring her for pain management. There is no indication of what medications are being prescribed. There is no indication as to what is going to be happening with the previous treatment. She had been on IVIg, Solumedrol. I don't know if

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she continued on cyclophosphamide or not. She was getting regular doses. So we don't know what's going to be happening with those treatments. Are they going to be suddenly stopped? Is another doctor taking over? We don't know. He had prescribed a number of different medications. There's no indication as to what is going to happen, except that presumably, he would not be prescribing opioids, that he's giving her pain management to her PCP, referring her to Rheumatology to follow up for tissue disease. That seems a bit an odd referral, given that the rheumatologist stated the patient had no rheumatologic disease. He is following her for her migraine and dystonia. Again, we have very little information about either of those diagnoses and we do not know what medications he's going to prescribe.

Q. So over the course of the treatment we've seen in these records, do you know approximately how many different diagnoses?

A. I did go through the records to try to summarize and to put pieces together and I wrote down every diagnosis that I could find as I went through it. I'm sure I'm missing some, but I found at least ten different diagnoses.

Q. And how many different medications?

A. Once again, I copied down all the ones that I could find going back and forth, and I'm certain that I've missed a couple. Eighteen medicines.

Q. And for any of those diagnoses, no information on why the diagnosis was being made?

A. Limited information, very limited information. We have two complete neurological examinations. Let me get you the dates on those. December 8th, 2009, and February 10th, 2010, there were complete neurological evaluations. On both of those dates, the neurological examination was normal. The remainder of the progress notes give minimal or no clinical information in regards to the patient's examination. The majority of the records do not list the prescriptions, why they're being given, how they're being given, the amounts that they're given, so -- of the medications that I noted, including several quite toxic medications. There is minimal information.

MR. PAIKOS: I have no further questions.

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THE MAGISTRATE: Dr. Padmanabhan, I assume you have questions for Dr. Levin.

DR. PADMANABHAN: I have many questions for Dr. Levin, but perhaps we could break for lunch first.

THE MAGISTRATE: Any objection?

MR. PAIKOS: I have no objection.

DR. PADMANABHAN: I also need a ruling from you about my exhibits.

THE MAGISTRATE: Do you plan on using them for cross-examination?

DR. PADMANABHAN: Yes.

THE MAGISTRATE: Let's turn to the exhibits now.

MR. PAIKOS: Your Honor, if there's a break, should we have Dr. Levin step out, stay here, or does it matter?

THE MAGISTRATE: It's up to him. Right now, it doesn't matter. Right now, we're doing something procedural, so if you want to release him or let him --

MR. PAIKOS: Whatever his preference.

THE WITNESS: Whatever you would like me to do.

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MR. PAIKOS: If you stay here, that would be fine.
THE MAGISTRATE: Okay, so I'm looking at Respondent's Proposed Exhibits. Dr. Padmanabhan, you've handed me a notebook with Exhibits 1 through 20, but Respondent's Exhibits 1 through 11 are already in evidence, so to avoid duplication, to avoid the actual bulk of documents and to avoid any possible confusion, I'm going to hand these back to you.
Proposed Respondent's Exhibit 12, Mr. Paikos, do you have any objection to that?
MR. PAIKOS: The prior -- the initial letter and -- with attachments?
THE MAGISTRATE: I'm looking at just a letter of December 22 to Nancy Lian, director of medical staff services, from you, and I'm looking at a letter dated November 9th, 2011, also to Ms. Lian, also from you. Do you have any objection to those?
MR. PAIKOS: I -- I currently don't. I might argue about the weight, but --
THE MAGISTRATE: Okay, so those are admitted.

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(Respondent's Exhibit 12 admitted into evidence.)
THE MAGISTRATE: Respondent's Proposed Exhibit 13 is a letter dated January 29th, 2013, from Dr. Padmanabhan to the Board of Registration in Medicine, the complaints committee. Do you have any objection to that?
MR. PAIKOS: No.
THE MAGISTRATE: And there are attachments also in that exhibit. There's a cover letter, cover report from the -- from Greeley, the table of contents from Greeley and a February 20th, 2013, letter to Dr. Padmanabhan from the Board of Registration in Medicine. That's all part of the same exhibit, so that's admitted.
(Respondent's Exhibit 13 admitted into evidence.)
Respondent's Exhibit 14 is a cover letter dated July 11, 2014, from the Board of Registration in Medicine to Dr. Padmanabhan and a two-page attachment. Any objection to that, Mr. Paikos?
MR. PAIKOS: I have -- just want to make sure I'm in the right -- if I could just ask

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what the attachments were?
THE MAGISTRATE: It's one page with the respondent's name and the investigator's name, your name, complaint committee. It says -- it's marked page seven of nine. And the next page, sir, it's marked page three of three. I don't have an actual transcript. The respondent's list of exhibits calls it the transcript of complaints committee meetings, but that's not what I have in front of me.
MR. PAIKOS: I think those are meeting minutes of the complaint committee. I currently have no objection. I may argue the weight --
THE MAGISTRATE: Certainly.
MR. PAIKOS: -- and the relevance at the time they come in.
THE MAGISTRATE: Okay, so Dr. Padmanabhan, your exhibit list calls them transcripts, but these are actually minutes. Is that correct? I'm not looking at a transcript.
DR. PADMANABHAN: That's fine.
THE MAGISTRATE: So we're talking about one letter and those two --
DR. PADMANABHAN: Yes.

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THE MAGISTRATE: -- short excerpts?
(Respondent's Exhibit 14 admitted into evidence.)
THE MAGISTRATE: Respondent's Exhibit 15 is a termination letter from the Cambridge Health Alliance. Mr. Paikos, any objection?
MR. PAIKOS: No.
THE MAGISTRATE: Okay. That's admitted.
(Respondent's Exhibit 15 admitted into evidence.)
THE MAGISTRATE: Exhibit 16 is on letterhead of Sloan & Walsh. It's to Eve Slattery, a lawyer at Dwyer & Collora, signed by Brian Sullivan dated September 9th, 2010. Any objection to that?
MR. PAIKOS: I'm not sure I have it or am able to locate it. Thank you.
DR. PADMANABHAN: Tab 16.
MR. PAIKOS: I don't see the relevance relative to the background of what -- you know, the statement of allegations and what happened after Dr. Padmanabhan's initial summary suspension, and

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this deals with requests by Cambridge Health for him not to in part go to their facilities.
THE MAGISTRATE: Do I hear a specific objection?
MR. PAIKOS: I think relevance.
THE MAGISTRATE: Okay. I'm going to admit it.
(Respondent's Exhibit 16 admitted into evidence.)
THE MAGISTRATE: Exhibit 17, the respondent's CV, I assume you have no objection?
MR. PAIKOS: No.
THE MAGISTRATE: That's admitted.
(Respondent's Exhibit 17 admitted into evidence.)
THE MAGISTRATE: Exhibit 18, it's listed in the respondent's list of exhibits as example of respondent's MRI expertise and standard of care. Mr. Paikos, any objection?
MR. PAIKOS: No. Is this Exhibit 18?
DR. PADMANABHAN: Yes.
MR. PAIKOS: No objection.
THE MAGISTRATE: Does this have to do with a patient, Dr. Padmanabhan, who is in the

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statement of allegations?
DR. PADMANABHAN: No, but it's about my ability to read MRI, which is in the statement of allegations.
THE MAGISTRATE: I will admit it and I will allow you to demonstrate its relevance and argue how much weight I should give it.
DR. PADMANABHAN: Great. It's also about how I wrote the notes.
(Respondent's Exhibit 18 admitted into evidence.)
THE MAGISTRATE: Respondent's Exhibit 19, Dr. Padmanabhan, does this have to do with patients who are listed in the statement of allegations?
DR. PADMANABHAN: This is about the previous exhibit. They're related.
THE MAGISTRATE: It relates to Patient I, or relates to your previous exhibit?
DR. PADMANABHAN: Yes, the one in 18.
THE MAGISTRATE: Just your expertise and ability to read MRI?
DR. PADMANABHAN: Correct.
THE MAGISTRATE: Mr. Paikos, any

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objection to that?
MR. PAIKOS: No.
THE MAGISTRATE: Okay, so I will admit it and I will allow you to argue that it's relevant when I accord it weight. Doctor, what's the relevance of Exhibit 19?
DR. PADMANABHAN: No, Exhibit 19 was the one that we just talked about.
THE MAGISTRATE: I'm sorry. And you've explained that it's connected to --
DR. PADMANABHAN: Eighteen and 19 go together.
THE MAGISTRATE: Respondent's 19.
(Respondent's Exhibit 19 admitted into evidence.)
THE MAGISTRATE: And Dr. Padmanabhan, why is your proposed Exhibit 20 relevant?
DR. PADMANABHAN: He will be testifying about that, Patient J.
THE MAGISTRATE: Okay. And Patient J is not in the statement of allegations?
DR. PADMANABHAN: No, but he's one of my witnesses and it goes to my ability to diagnose multiple sclerosis and manage complex cases.

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THE MAGISTRATE: Mr. Paikos?
MR. PAIKOS: I have no objection currently. I may reraise relevance at the time or argue relevance or the weight.
THE MAGISTRATE: Yeah, Doctor, I may revisit relevance, too. I'm not convinced of the relevance of Patient J testifying. I'm not convinced of the relevance of a patient who is not in the statement of allegations testifying.
DR. PADMANABHAN: He was brought in to rebut Dr. Nardin's testimony yesterday.
THE MAGISTRATE: And as indicated yesterday, Dr. Nardin's testimony is of limited relevance. Dr. Nardin does not appear in the statement of allegations. Cambridge Health Alliance does not appear in the statement of allegations. If you prove that you gave superior care to Patient J and you prove it beyond a reasonable doubt, you still may lose this appeal.
DR. PADMANABHAN: I understand.
THE MAGISTRATE: And I'm not going to -- I will allow you some leeway into exploring your care of Patient J. I am not committing myself to allow you to explore it as much as you want,

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because I doubt the relevance.
DR. PADMANABHAN: Thank you.
(Respondent's Exhibit 20 admitted into evidence.)
THE MAGISTRATE: With that, the --
DR. PADMANABHAN: There's two more.
THE MAGISTRATE: Thank you. I'm going to strike the editorializing from the list of exhibits. This is -- you're proposing to introduce e-mail string between you and a Thomas Glick in 2008. First of all, what's the relevance of this?
DR. PADMANABHAN: It's about the ongoing troubles I had with Stephan Auerbach, and both of those people have been introduced in Dr. Levin's testimony yesterday in terms of their reading of the MRI's and how my diagnosis of MS is incorrect because Dr. Auerbach did not find any Dawson's fingers, so that's highly relevant to the testimony.
THE MAGISTRATE: And who is Thomas Glick?
DR. PADMANABHAN: Dr. Glick was my chief of neurology before Dr. Nardin came in, and he's on the witness list.

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THE MAGISTRATE: Mr. Paikos? You know what? I still don't have a witness list.
DR. PADMANABHAN: No, no. He's on the board's witness list. Your Honor, I faxed you a witness list and you shouted at me because it had the patient's names and you gave it back to me.
THE MAGISTRATE: Yes, of course I gave it back to you, because you violated the impoundment order.
DR. PADMANABHAN: I re-faxed it back to you. I have it here.
THE MAGISTRATE: Okay. I'm looking at the petitioner's witness list. I see Thomas Glick only as a potential re-- a potential witness, but Doctor, I'm still allowed to ask you the relevance, who he is and what the relevance is to your case.
DR. PADMANABHAN: It's about diagnosing MRI and looking at the credibility of Dr. Auberbach's MRI reports. Yesterday, we had a very lengthy discussion on credibility of MRI reports and compared with Dr. Auerbach. It's in the testimony from yesterday.
THE MAGISTRATE: Mr. Paikos, any comment on Respondent's Proposed Exhibit 21?

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MR. PAIKOS: I think from our perspective, it's not relative. I understand a bit of Dr. Padmanabhan's theory of his case. I don't think it's relevant to the statement of allegations. I don't think it necessarily will come to the con-- you know, I would reserve, you know, to argue that it's relative to its weight. I think there is, you know, e-mail discussions between Dr. Glick and Dr. Padmanabhan regarding certain issues, but you know, I think it matters as to what the weight of it is and what the context of it is to some degree, so I reserve to argue the weight of it. I think I don't currently have an objection as to it. I'm not sure as to its relevance.
THE MAGISTRATE: So I'm going to admit Respondent's Exhibit 21. Dr. Padmanabhan, I will tell you that I prefer live testimony, testimony that can be subject to cross-examination and that I can ask questions of. Hearsay is allowed in these proceedings, so I'm going to admit it, but I may not give it a whole lot of weight, because I'm not -- unless Dr. Glick actually testifies. So I see you're nodding your head. So you understand?

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DR. PADMANABHAN: Yes, sir.
(Respondent's Exhibit 21 admitted into evidence.)
THE MAGISTRATE: Respondent's Exhibit 22. Any objection, Mr. Paikos?
MR. PAIKOS: No.
THE MAGISTRATE: Okay, so I'll admit that.
(Respondent's Exhibit 22 admitted into evidence.)
THE MAGISTRATE: Okay. Now, Dr. Padmanabhan, I'm looking at respondent's list of witnesses. It's the first time I've seen this, a list that is in compliance with the impoundment order and does not have people's actual names. One of the reasons I asked for a witness list by January 5th is that so I could evaluate who you're planning on calling.
DR. PADMANABHAN: Your Honor, I faxed it to your office three times. In fact, I have my journal from the fax machine here. I can show it to you.
THE MAGISTRATE: Okay. If you want to make a copy for me, you can, but I'm not going to

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parse this piece of paper that you just handed to me.
DR. PADMANABHAN: I was just proving that I actually faxed it to you.
THE MAGISTRATE: I'm not going to parse it while I'm looking here now to decide whether or not you did fax it. As I've said before, the question is not whether you faxed it. The question is whether I received it. So let me proceed.
This is the first time I'm looking at your list of witnesses, which I wanted on January 5th. One of the reasons I want a list of witnesses is so I can evaluate where the hearing is going and how long it's going to last. I see that you're calling three patients who are in the statement of allegations, Patients C, D and I, but I also see Patient J, K, L, M, N, O, P. First of all, does the impoundment order cover them, Mr. Paikos?
MR. PAIKOS: No, it does not, the additional patients.
THE MAGISTRATE: If you're planning on calling patients to demonstrate that you in fact did give superior care, or care within the

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standard, it's not going to prove the -- disprove the statement of allegations, and I'm not sure I'm going to allow it. Can you tell me more about Patients K through P?
DR. PADMANABHAN: They are patients who were contemporaneous with the patients listed in the statement of allegations in the list chosen by Dr. Nardin and they are here to testify about --
THE MAGISTRATE: Okay. I'm not accepting that Dr. Nardin chose the patients in the statement of allegations, so aside from that, tell me.
DR. PADMANABHAN: The patients will come and testify about the care they received at the same time. Dr. Nardin referred to the community standard of care in her testimony yesterday, that I did not meet the standard of care, so I think it's important to examine the community standard of care and what care the other patients received at the same time on the same dates.
THE MAGISTRATE: Do you propose them as expert witnesses?
DR. PADMANABHAN: They're here to

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present their experience of my care.
THE MAGISTRATE: Are they doctors in addition to being patients?
DR. PADMANABHAN: No, sir. They are the recipients of my care.
THE MAGISTRATE: So I'm ruling -- I'm not going to allow their testimony. It's not relevant to this hearing. It will prolong the hearing unnecessarily and take too many resources. If you want to submit to the Board of Registration in Medicine, in case I recommend discipline, if you want to submit to the Board of Registration in Medicine mitigation of any discipline, this information from the patients that you provided excellent care to them or standard care, I will allow that. I will pass it on to the board, but it's not going to enter into my decision on whether you provided substandard care to the patients listed in the statement of allegations as detailed and alleged in the statement of allegations.
Anything else before we break for lunch?
MR. PAIKOS: May I ask one clarification relative to the patients listed here

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in Dr. Padmanabhan's witness list? Are you saying they are able to testify relative to -- potentially relative to mitigating factors?
THE MAGISTRATE: I'm sorry. I will clarify that. You can submit that in writing and I will pass it on to the Board of Registration in Medicine in the event that I recommend discipline. I will pass it on to mitigate. You can argue to the Board of Registration in Medicine that any discipline should be mitigated, but I'm not going to allow live testimony of Patients J, K, L, M, N, O, P to demonstrate that the statement of allegations are -- are not true. I'm not going to allow the live testimony. You can submit it to me in writing, and I'm not going to take that into consideration in deciding whether the statement of allegations are true.
DR. PADMANABHAN: The other issue is you said you were going to give us a timetable or a schedule for where, when I shall present my case.
THE MAGISTRATE: We're going to -- we're going to wait to see until the Board of Registration in Medicine completes its case. At a certain point -- I don't want to delay testimony.

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We'll wait until Dr. Levin is done testifying and then we will go over -- or the board is done with its witnesses, and then we will review calendars.
MR. PAIKOS: Nothing further.
THE MAGISTRATE: Okay, so we'll resume in an hour.
(Off the record.)
(Lunch recess taken from 12:22 to 1:27.)
THE MAGISTRATE: So we're back on the record. I apologize for being a few minutes late. I'm running back and forth between my office. All electronic devices that make noise should be off. There are no recording devices or cameras allowed in the hearing room.
Dr. Padmanabhan, are you ready to begin cross-examination?
DR. PADMANABHAN: Yes.
THE MAGISTRATE: Please proceed.
CROSS-EXAMINATION
Q. (BY DR. PADMANABHAN) Good afternoon.
A. Good afternoon.
Q. Dr. Levin, when were you retained by the government to testify at this disciplinary hearing?
A. Approximately October of 2014.

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Q. When did you receive all the charts to review?
A. Sometime between October and November of 2014.
Q. In looking through your CV, I see that you haven't done any fellowships, no subspecialty training.
A. That's correct.
(Comments off the record.)
Q. (BY DR. PADMANABHAN) Have you published any articles in peer-reviewed scientific journals?
A. No.
Q. According to the CV, you were chairman of the Rhode Island branch of the National MS Society?
A. Correct.
Q. You have listed that under medical boards. Does that count as a medical board?
A. Actually, I -- I have to look at my CV to see how it is listed. I was actually on the board as well.
Q. It's Tab 12.
A. I was on the board as well of the Rhode Island MS Society.
Q. But is it a board, the MS Society?

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A. A medical board?
Q. Yes. It's listed under medical boards.
A. It's a board of directors of the MS Society of the State of Rhode Island. Again, I was also similarly on the --
Q. I understand that, but the heading is membership in medical boards. Medical boards usually has a specific --
THE MAGISTRATE: Well, if you can pose it as a question?
Q. (BY DR. PADMANABHAN) Did you ever serve on medical boards?
A. I am not sure I understand your question.
Q. Dr. Levin, why did the National MS Society select you to serve within the Rhode Island chapter? Do you have a large MS patient population that you follow?
A. I think officially, I was chosen because of a colleague who was working on the board thought I would be a good fit to be on the board, asked me if I would join it, and I did.
Q. How many MS patients do you care for?
A. At the present time, or previously?
Q. Right now.

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A. I don't know. Approximately ten to 15.
Q. How many of your patients have a diagnosis of fibromyalgia?
A. As the primary diagnosis?
Q. Carry a diagnosis of fibromyalgia --
A. I don't know.
Q. -- that you know this person has fibromyalgia.
A. I don't know.
Q. How many of your patients have -- carry a diagnosis of chronic fatigue syndrome?
A. I don't know.
Q. How many patients with chronic pain do you provide care for, manage their pain?
A. I do not manage chronic pain per se. Many of my patients have chronic pain, but if the main diagnosis that they have is chronic pain unrelated to other neurologic issues, then I would not treat them, not by myself.
Q. How many of your ten to 15 MS patients also suffer from chronic pain?
A. None.
Q. In how many of your patients over the years did you think OxyContin was appropriate?

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A. Very few.
Q. How many patients do you write OxyContin prescriptions for every month?
A. Zero.
Q. Have you ever written OxyContin prescriptions for patients?
A. No.
Q. According to the board website, your license was renewed in 2013; is that correct?
A. Yes.
Q. Have you completed all CME requirements of continued licensure in this Commonwealth?
A. Yes.
Q. Are you aware of the requirements for maintaining licensure in Massachusetts?
A. Yes.
Q. Are you aware that four hours must be spent on reviewing and learning about government regulations?
A. I'm sorry. I didn't understand your question.
Q. Are you aware that four hours must be spent on reviewing and learning about government regulations; specifically, board regulations?

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A. Yes.
Q. Have you met that requirement?
A. Yes.
Q. Are you aware of any new government requirements that came into force in 2012 before your license was renewed in 2013?
A. I know there were many different government regulations. I can't --
Q. Massachusetts state regulations specifically?
A. I can't speak to one regulation that stands out.
Q. Did you complete the required CME courses to satisfy the opioid prescribing requirement?
A. Yes.
Q. You testified under oath this week that you had never heard of Title 21, Chapter 2, Section 1306.12?
A. Yes.
Q. And you stated that no neurologist would know what that means. And on the basis of what knowledge did you give Magistrate Bresler that statement, that no neurologist would know what CFR Chapter 2, Section 1306.12 means?

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A. It was not something that I was familiar with, and I believe that the average neurologist would not recognize that particular series of numbers and letters.
THE MAGISTRATE: Dr. Padmanabhan, before you ask your next question, I'll tell you that I generally disfavor questions reminding the witness that he testified under oath, because all of the testimony is under oath.
Q. (BY DR. PADMANABHAN) Yesterday, you mentioned that I had referenced 1306.12, and you said it again just now, in a patient note, that it would certainly have confused any neurologist reading the note, and so it fell below the standard of care. On the basis of what knowledge did you give Magistrate Bresler that statement?
A. I don't understand your question.
Q. That seeing 1306, or CFR 1306.12 in a note automatically confuses the average neurologist, how did you arrive at that conclusion?
A. I believe I was responding to a question as to whether or not seeing that note would be confusing to the average neurologist, and my answer was to the best of my knowledge, I didn't know

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anything about it and I suspect that the average neurologist would not know about those particular numbers and letters as well.
Q. Are you aware, Dr. Levin, that the CME's of the state-mandated opioid CME course are specifically taught about Section 1306.12?
A. I did not remember that.
Q. Please turn to Patient D, MR 20-21, Bates 115.
THE MAGISTRATE: I'm sorry. Bates number?
DR. PADMANABHAN: 115 to 116.
A. Could you repeat the page number, please?
Q. (BY DR. PADMANABHAN) MR 20 to 21 for Patient D. Please tell us, what is the encounter date for this visit?
A. December 16, 2009.
Q. Given that the state mandate came into force in 2012, what conclusion do you draw from my currently correctly referencing that regulation back in 2009?
A. I don't understand the question.
Q. I shall repeat. Given that the state mandate, which explicitly teaches all licensed

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physicians in Massachusetts about CFR Section 1306 --

THE MAGISTRATE: Okay. That's not in evidence, so I'm not going to allow you to ask that question.

DR. PADMANABHAN: It's a legal requirement, Your Honor, for licensure.

THE MAGISTRATE: It's not in evidence. It hasn't been testified to or it's not an exhibit.

DR. PADMANABHAN: May I introduce it?

THE MAGISTRATE: You can. Mr. Paikos, any objection?

MR. PAIKOS: I'm not sure -- is he introducing the regulation or the -- I'm not sure what he's seeking to introduce. Can I get a copy?

THE MAGISTRATE: Well, let's take a look and then you can see if you have an objection.

MR. PAIKOS: If I can ask what Bates number we're on again?

DR. PADMANABHAN: It's 115.

MR. PAIKOS: 115. Thank you.

THE MAGISTRATE: And the encounter date, Dr. Padmanabhan?

DR. PADMANABHAN: The encounter date is

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March 15, '8. 2008.

A. I'm sorry. I misunderstood your directions. If you could give me not the Bates numbers, but --

Q. (BY DR. PADMANABHAN) Twenty. Patient D, page 20. So my question is in 2008, I have referenced CFR 1306.12 in the note. What conclusion do you draw from that?

THE WITNESS: Your Honor, I believe I have a different record than I'm being directed to.

THE MAGISTRATE: Okay, so Dr. Padmanabhan, I understand that Dr. Levin has records that do not have the Bates number on them.

DR. PADMANABHAN: It's MR 20, sir. Patient D, MR 20. So that's Tab 6.

A. Right, the date for page 20 that I have --

THE MAGISTRATE: I'm sorry. I don't have this as Tab 6. And we're talking Patient D as in David?

DR. PADMANABHAN: Tab 5.

A. I'm sorry. I thought you said B as in boy.

Q. (BY DR. PADMANABHAN) Okay. The question is what conclusion do you draw from the fact that I referenced CFR 1306.12 back in 2008 itself.

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A. I have no conclusions.

Q. Dr. Levin, why did you not know anything about Title 21, Chapter 2, Section 1306.12?

A. I am not familiar with the specific title that you're giving me, sir.

Q. It's the Code of Federal Regulations that involves how DEA --

THE MAGISTRATE: Okay. You need to pose questions, Dr. Padmanabhan.

Q. (BY DR. PADMANABHAN) Are you aware of the Code of Federal Regulations that the DEA uses to control how prescriptions are written and how prescriptions must be written?

A. I am not familiar with a specific regulation. I'm familiar with the use of DEA with the requirement that every physician has to use his DEA number to write prescriptions.

Q. After the government sent you the medical records in October or November of 2014 for your review, did you notice this reference in this chart for Section 1306.12?

A. Yes.

Q. Dr. Levin, you knew you were coming to testify in a hearing that would decide whether or

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not a doctor will continue to practice medicine, so did you look up this regulation?

A. No.

Q. May I ask why not?

A. I didn't look it up.

THE MAGISTRATE: Dr. Padmanabhan, in general, I'm going to ask you to ask one question at a time.

DR. PADMANABHAN: It was a follow-on question after he said no.

THE MAGISTRATE: In general, I'm going to ask you to ask one question at a time. It hasn't been a problem yet, but some of the questions you're asking have two questions in them.

Q. (BY DR. PADMANABHAN) I'm now going to turn to Patient A as in apple, Medical Record Number 43.

THE MAGISTRATE: And the Bates number? Doctor, do you have the Bates number?

DR. PADMANABHAN: No.

THE MAGISTRATE: Dr. Padmanabhan, I'm sorry. I didn't hear you.

DR. PADMANABHAN: I may be mistaken about the 43 part. One second.

THE MAGISTRATE: Your exhibits do have

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Bates numbers; is that correct?
DR. PADMANABHAN: Yes, they do. It's 143. My apologies.
THE MAGISTRATE: Bates 30?
DR. PADMANABHAN: One second, sir. Yes, Bates 30.
Q. (BY DR. PADMANABHAN) You had testified that you did not know why three separate prescriptions were written to start at the same date.
THE MAGISTRATE: Wait for an answer. Dr. Levin, do you have an answer for the question?
A. I'm sorry. I did not hear a question.
DR. PADMANABHAN: Right. There is no question yet. He testified that he did not know why --
THE MAGISTRATE: You have to pose questions.
DR. PADMANABHAN: Right. I was going to.
THE MAGISTRATE: I'm waiting for an acknowledgement that Dr. Levin actually testified to that. That's what I'm -- that's the question that I'm waiting for an answer from him.

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A. I believe at one point during the testimony, I did note and testify that there were three prescriptions for OxyContin that had the same start date.
Q. (BY DR. PADMANABHAN) Have you ever written three prescriptions in a row for a patient for a controlled substance?
A. No.
Q. Given that you have never written follow-on prescriptions per CFR 1306.12, on what basis did you --
THE MAGISTRATE: Well, that's not in evidence, so you can rephrase the question.
DR. PADMANABHAN: He just --
THE MAGISTRATE: CFR is not in evidence. You can ask a similar question, but you're going to need to reformat it.
Q. (BY DR. PADMANABHAN) Dr. Levin, given that you've never written three prescriptions in a row, that is, an original prescription and two follow-on prescriptions for a controlled substance, how can you be qualified to render an opinion on the practice of writing said scripts, specifically referring to page 143?

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A. My opinion was based on my observation of the records and has no basis related to my personal experience in treating patients with controlled substances.
Q. Subsequent to the hearing having begun, did you look up how follow-on prescriptions are written?
A. I don't understand your question.
Q. Since this hearing started, did you go back and look how follow-on prescriptions are written for controlled substances?
A. I did not. I did have a discussion with the nurse from the Board of Medicine and we discussed the regulation being that a controlled substance may be written for one month's supply, and at the same time, there can be second prescription written to start a month later and a third prescription to be written to start two months later.
Q. What is the regulation, as far as you know, Dr. Levin, about what dates are written on the prescriptions?
A. I don't know.
Q. What is your experience, Dr. Levin, with

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patients suffering from drug addiction, or as it's also called, substance abuse?
A. I'm not a pain specialist. I don't treat patients who have substance abuse by myself. I have seen many patients over the years who have had substance abuse in a consultation capacity.
Q. Dr. Levin, I asked you specifically about drug addiction or substance abuse, not about pain.
A. Did I say pain? Excuse me. I misspoke.
THE MAGISTRATE: I'll accept the answer.
Q. (BY DR. PADMANABHAN) Because you said you were not a pain specialist.
THE MAGISTRATE: Dr. Padmanabhan, you have to pose questions. And I am accepting Dr. Levin's answer to your question.
Q. (BY DR. PADMANABHAN) Is it your opinion, Dr. Levin, that pain specialists always see patients with drug addiction?
A. No.
Q. Do all pain patients suffer from drug addiction?
A. No.
Q. Why do medical professionals refer to drug

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addiction sometimes as substance abuse?
MR. PAIKOS: Objection. Presumes -- no foundation, no -- he's saying that the medical professionals.
THE MAGISTRATE: I'll see if Dr. Levin knows.
A. I don't know.
Q. (BY DR. PADMANABHAN) Which term do you typically use in your professional capacity, Dr. Levin, drug addiction or substance abuse?
A. Substance abuse.
Q. Why?
A. I think it generally describes the condition that the patient is suffering from. The majority of people that I see with substance abuse have difficulties with more than one substance, so I would say that most people suffer from polysubstance abuse, alcohol plus other substances.
Q. Would you call them drug addicts as well?
A. Would I use the term drug addict in describing my patient?
Q. Somebody who uses alcohol and other substances.
A. I would not call or use the term drug

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addict to describe one of my patients, no.
Q. You stated yesterday that you have never ever ordered a tox screen, a urine tox screen. I would like to understand why.
A. That's incorrect. If I stated it, I was mistaken.
Q. Do you refer all pain patients to other physicians, if a patient comes to you in a neurology clinic and say Doctor, I have severe chronic pain?
A. Is the question in reference to pain or chronic pain?
Q. Pain or chronic pain. Suppose a patient comes in with severe pain. Would you automatically refer that patient to pain clinic?
A. No.
Q. If a patient comes in with a long history of chronic pain, would you refer that patient to a pain clinic?
A. Very likely.
Q. Are you aware, Dr. Levin, that the Board of Registration in Medicine has declared to the Supreme Judicial Court that neurologists --
THE MAGISTRATE: I'm going to stop you

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right there. That's not a proper question.
Q. (BY DR. PADMANABHAN) Dr. Levin, who are considered pain specialists?
A. Doctors who have specialized training and experience in dealing with patients who have chronic pain with -- including knowledge about proper treatment, including medications.
Q. If you have a patient who shows any sign of drug abuse, would you terminate your care immediately? Would you fire the patient?
A. It's a general question. I would have to know the specifics of the patient.
Q. Supposing you have --
THE MAGISTRATE: Excuse me, Dr. Padmanabhan. You can continue this line of question, but what would be helpful for me is this witness' understanding of the standard of care rather than his personal practice.
DR. PADMANABHAN: This witness has testified for three days about the standard of care, so I'm exploring --
THE MAGISTRATE: Dr. Padmanabhan, you can ask the witness along the line of questions of what his individual practice is. I am giving you

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an indication of what would be helpful to me.
DR. PADMANABHAN: The reason I'm asking these questions, Your Honor, if I may explain --
THE MAGISTRATE: No. You can proceed with your format of questions.
Q. (BY DR. PADMANABHAN) Have you fired any patient for being non-compliant or taking other drugs? In other words, if you found someone abuses cocaine, have you fired that patient?
A. Not that I can recall.
Q. Yesterday, we had some testimony about the mandated 30-day supply. What does mandated 30-day supply mean?
A. I can only comment on what the statement as you give it to me would seem to mean, and that would seem to mean that some authority has stated that you have to give a patient a 30-day supply.
Q. We discussed this specifically in the case of Patient E, who I fired, and you told Magistrate Bresler that my decision to give a 30-day supply at the time that I fired the patient was, quote, bizarre, unquote. Was my giving him a mandated 30-day supply within the law?
A. Would you like me to pull the record for

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Patient E to review that?
Q. Yes.
THE MAGISTRATE: While we're locating Patient E's records, Doctor, I've reconsidered. If you want to pose a question to Dr. Levin about what the Supreme Judicial Court has said, I will allow the question.
Q. (BY DR. PADMANABHAN) It states -- Patient E, Number 231, Bates 189 -- that the doctor does not state where the mandated 30 days came from.
A. I believe that the comment was made in regards to the prescriptions that were supplied to this patient. The date of your letter is May 13th, 2009. On May 14th, 2009, there was a prescription for methadone, ten milligrams, number 203, so that would be a 30-day supply. On May 22, 2009, there was a prescription for methadone, again, 240 tablets, which would imply a two-month supply, a 60-day supply. On May 14th, there was a prescription for Oxycodone, number 360, a 30-day supply. On May 22, there was a second prescription for Oxycodone, 360 tablets, for a second 30-day supply. I believe my response was in regards to

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prescribing 60 days as opposed to 30-days supply.
Q. Dr. Levin, we have photocopies here that you have testified about the dates. Do you know if these prescriptions were actually handed physically to the patient?
A. I would have no way of knowing that.
Q. When you looked at the patient records and you agreed to come and testify at this board hearing, did you ask them at the board for records, previous records regarding my performance as a physician?
A. I made no requests at all. I accepted the records they requested me to review with no further request.
Q. Did you look my profile up on the board website, Dr. Levin?
A. No.
Q. Not until today?
A. Sir?
Q. Never?
A. Never.
Q. Have you testified at board hearings before?
A. No.

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Q. This is your first time ever?
A. Yes.
Q. Have you had any training in reading and interpreting MRI's?
A. Yes.
Q. What training have you had, sir?
A. I've attended, I would have to guess, approximately five to seven courses on interpreting MRI. Prior to interpreting MRI's, I had trained during my residency and in my practice in interpreting other imaging procedures, including CT scans. And I've had experience in regular interpretation of MRI since MRI became widely available in the northeast, my guesstimate, approximately -- approximately 1982. I can be wrong on that date. So I've had experience in regularly interpreting, seeing reports, reviewing my own images for an extensive period of time.
Q. From 1982?
A. When it became available widely. I -- that's a guess as to the date. I could be wrong. It could be a different date.
Q. Were you accepted by insurance carriers as qualified to read and interpret MRI's?

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A. No.
Q. Do you give presentations to physicians or other staff about findings on MRI's at conferences and other such venue?
A. I don't give formal talks. On a regular basis, I discuss MRI's with colleagues. I review MRI's on a regular basis with radiologists in regards to patients that I've seen, to patients that I'm seeing in the office and in consultation. Not infrequently, I review MRI's with colleagues, discussing cases, sometimes instructing them, sometimes being instructed by them. I regularly review MRI images with my patients.
Q. Do you get contacted for second opinions to double-check a radiologist's findings on an MRI report?
A. Not to double-check, no.
Q. What is the American Society of Neuroimaging? Are you familiar with that organization?
A. I'm familiar with the name.
Q. Do you know anything about the American Society For Neuroimaging?
A. No.

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Q. So you wouldn't be able to tell the difference between the American Society of Neuroimaging and the Academy of Radiology or other such radiological societies?
A. I have no additional information.
Q. Okay. Did you provide the government with peer-reviewed articles about MRI findings for use at this hearing?
A. Would you repeat the question, please?
Q. Did you provide the government with peer-reviewed articles about MRI findings?
A. No.
Q. Did you reference any guidelines by various expert panels such as the Consortium of MS or the NIH?
A. No.
Q. May I ask why?
A. Didn't seem to be an appropriate thing to do.
Q. Not appropriate? Wouldn't that have been important to actually come with medical expert recommendations and guidelines to a hearing where you're going to testify about MRI findings?
A. I don't understand your question.

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Q. Would it not have been useful to come in with actual peer-reviewed criteria on how to interpret MRI findings?
A. It did not seem to be necessary.
Q. When you order MRI brain scans for patients, how often do you order sagittal FLAIR sequence?
A. I don't order specific sagittal FLAIR sequences, because the laboratories that I deal with, particularly the laboratory in my hospital that I work at, does this as a routine.
Q. So all the patients get sagittal FLAIR's?
A. Most of them. If there's any question, I would be concerned about getting sagittal FLAIR in the patients I'm concerned about the patients having MS, and my diagnosis would be rule out MS, rule out demyelinating disease. In the radiology department, the radiologist would know that under those circumstances, I want sagittal FLAIR.
Q. Do you insist on examining sagittal FLAIR images before deciding whether a patient does or does not have MS?
A. Under the usual course of circumstances, I like to see a patient's MRI before making the diagnosis of MS, and the FLAIR, sagittal FLAIR, is part of the overall study. It's not the only sequence that I base my opinion on.

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Q. Supposing a patient comes in to you for a second opinion, Dr. Levin, and they come in with an external CD of an MRI done outside and it does not include sagittal FLAIR's. Would that influence your diagnosis of that patient that day?
A. I couldn't say specifically. It would depend on the individual patient.
Q. Will you insist on having a second MRI done with sagittal FLAIR's?
A. Again, it would depend on the individual patient.
Q. If you really wanted to rule MS out, would you do it?
A. It would depend on the individual patient.
Q. That answer, do I understand correctly, Dr. Levin, that there are some patients that you would diagnose with MS even if they have not had sagittal FLAIR's done?
A. I don't believe I said that.
Q. Please explain, Dr. Levin. In what way does it depend on the individual patient?

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A. When I see a patient that I think has MS, it's a clinical diagnosis, so the most important thing for me in evaluating the patient is the clinical evaluation, what is the patient's history, is the history consistent with the diagnosis of MS, what does the examination look like, do I find abnormalities that would suggest to me that there is a neurologic dysfunction, do we see changes that are consistent with the changes of MS, but out of all of the things, it's the history that I would say are most important. Along with that, I'd like to know are there other problems the patient has, general history, the general medical background.
Q. Thank you, Doctor. Do you --
MR. PAIKOS: Objection. The doctor wasn't finished with his question. His answer.
THE MAGISTRATE: I'm going to allow Dr. Padmanabhan to pose the next question. He's collecting information and he has enough information for his purposes. Is that correct?
DR. PADMANABHAN: Thank you.
Q. (BY DR. PADMANABHAN) So you would not insist -- from your answer just now, you would not insist on looking for Dawson's fingers on the

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sagittal FLAIR? The history and exam is more important for you?
A. Once again, sir, it depends on the individual patient, the individual patient's circumstance. It is not unlikely that I would like to have a sagittal FLAIR sequence, but won't say that the sagittal FLAIR sequence by itself is going to cause me to diagnose a patient or not diagnose a patient with MS.
Q. Thank you. Did you consider, Dr. Levin, that your knowledge of MRI is sufficient to serve in a professional licensing hearing?
A. My knowledge of MRI is sufficient to make me a qualified individual, especially as a neurologist, to interpret MRI's.
Q. Right, but my question is about actually testifying at a board hearing. Do you think your level of knowledge about MRI's is sufficient?
A. Yes.
Q. Okay. Why did you not know, Dr. Levin, what FLAIR stands for when Magistrate Bresler asked?
A. Because I can never remember. I've looked it up a hundred times. I've written it down many,

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many times and I can never remember.
Q. Are you able to remember the expansions for the acronyms for any of the other sequences on MRI's?
A. Could you be more specific, please?
Q. Never mind. If we move to Patient G, MR 465?
THE MAGISTRATE: Bates 205?
DR. PADMANABHAN: Bates 205.
A. That was G as in good?
Q. (BY DR. PADMANABHAN) G as in good, if I am correct. I will actually double check. Yesterday, in response to Magistrate Bresler's question, you had reviewed the radiological images and reports, and you said, quote, the radiologist says the corpus callosum is normal; therefore, there are no Dawson's fingers. Do you recall?
A. Could you direct me to the page of the record, please?
Q. Medical Record 465 for Patient G. The MR report -- the MR report is on page 444.
THE MAGISTRATE: And the Bates number?
DR. PADMANABHAN: 201, sir.
A. Could you repeat the question, please?

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Q. (BY DR. PADMANABHAN) You testified that the radiologist says that sagittal FLAIR shows a normal corpus callosum, and therefore, there are no Dawson's fingers. Are Dawson's fingers always seen inside the corpus callosum?
A. No.
Q. Would you then be retracting your statement from yesterday?
A. Dawson's fingers are seen either at the corpus callosum or in the region of the corpus callosum. Reviewing the report from the doctor, going through the entirety of his --
Q. Correct, but the question before you, Dr. Levin --
THE MAGISTRATE: This answer I am going to allow to continue.
A. Looking at the entirety of the report, I interpreted the statement of a normal corpus callosum, given the other information that the doctor describes, that the corpus callosum and the surrounding region were normal. Since Dawson's fingers involve the corpus callosum itself and the pericallosal region, this led me to believe that he did not find Dawson's fingers. In addition, his

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impression was mild non-specific supratentorial white matter changes, and he does not make any mention of Dawson's fingers or any other abnormality on the MRI.
Q. Thank you, but my question to you specifically is about your testimony yesterday when you said repeatedly that a normal corpus callosum means no Dawson's fingers.
THE MAGISTRATE: And your question about this is whether that's correct?
DR. PADMANABHAN: Yes.
Q. (BY DR. PADMANABHAN) Do you agree with that statement?
A. That's incorrect.
Q. So are you retracting that statement, Doctor?
A. I believe I answered your question, sir.
THE MAGISTRATE: For my benefit, if you could answer it again?
A. Answer the question again?
THE MAGISTRATE: Yeah, whether you're retracting.
A. Would you please repeat it?
Q. (BY DR. PADMANABHAN) Yes. Your statement

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twice yesterday was a normal corpus callosum means there are no Dawson's fingers.
A. I would retract that statement.
Q. When explaining multiple sclerosis to Magistrate Bresler yesterday, you said that if -- that one diagnosed patients with MS if they had two lesions separated by place and time and that it was called the Poser criteria. Have you ever studied the Poser criteria?
A. I've reviewed the Poser criteria many times and actually discussed it with Dr. Poser.
Q. Have you ever heard of the Schumacher criteria?
A. I am familiar with the name. I don't know the specific criteria.
Q. Do you know the difference between the Schumacher criteria and the Poser criteria?
A. Once again, I do not off the top of my head know the Schumacher criteria.
Q. The explanation you gave Magistrate Bresler yesterday, Dr. Levin, was actually the Schumacher criteria.
MR. PAIKOS: Objection.
Q. (BY DR. PADMANABHAN) Two lesions separated

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by place and time.
THE MAGISTRATE: I'm going to -- you have to pose it as a question rather than a statement.
Q. (BY DR. PADMANABHAN) Dr. Levin, why do you not know the difference between the Poser criteria and the Schumacher criteria?
A. As previously noted, I do not know the Schumacher criteria.
Q. Dr. Levin, without knowing the criteria, why are you testifying about multiple sclerosis?
A. Because I'm experienced and knowledgeable in the diagnosis of multiple sclerosis.
Q. Without the use of the criteria, how have you been practicing all these years?
A. Quite adequately.
Q. From that answer, am I to take it, Dr. Levin, that you do not feel the need to know the criteria?
A. Which criteria are we speaking about?
Q. The Schumacher or the Poser.
A. The Poser criteria, I explained it to the best of my memory. It is a criteria that we use, as we do use other criteria, in diagnosing patients

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with MS. The information that I discussed is a fairly standard view of the diagnosis of multiple sclerosis from a neurologist.
Q. Fairly standard view in which era of medicine, Dr. Levin?
A. It was a standard view when the Poser criteria were being used, and when the McDonald criteria came to be, then that became the standard view.
Q. So would you say -- would you agree that two lesions separated by place and time which you identified as the Poser criteria is no longer the standard criteria?
A. It still can be the standard criteria. We don't necessarily have to have two lesions. If you -- if you have a patient that satisfies the McDonald criteria so that you can add the MRI criteria, then you may not need to have two lesions over space and time.
Q. Do you know the difference, Dr. Levin, between the Poser criteria and the McDonald criteria?
A. Yes, sir.
Q. What is the difference, sir?

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A. The McDonald criteria includes MRI data, includes having specific MRI changes that are consistent with the diagnosis of MS. The Poser criteria do not reference MRI data.
Q. What do the Poser criteria reference in place of the MRI?
A. They don't -- nothing in place of the MRI.
Q. Dr. Levin, have you ever heard of visual evoke potentials?
A. Yes.
Q. Have you ever heard of brain stem auditory evoke potentials?
A. Yes.
Q. Have you ever heard of somatosensory evoke potentials?
A. Yes.
Q. Have you ever ordered them on patients?
A. Yes.
Q. Why would one order those tests?
A. When you're looking to find whether there's dysfunction in a particular area of the nervous system, visual evoke potentials are looking for abnormalities in the visual pathways specifically related to the optic nerve, although it may be

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anywhere in the visual pathways. It goes back. Brain stem evoke potential, we're looking for evidence of brain stem dysfunction. In somatosensory evoke potentials, we're looking for abnormalities in the sensory pathway.
Q. In which diseases would you normally order these tests to confirm or reject?
A. Three different studies are used for many different diseases.
Q. Does hearing the name VEP help you recall the tests that are part of the Poser criteria?
A. It doesn't help me to recall anything specific. I know that there are additional aspects of the Poser criteria in addition to clinical information. I know that the Poser criteria also can include different studies that would suggest that there is involvement of another portion of the nervous system, including evoke potentials. It can also include other studies including spinal fluid examination.
Q. Thank you. Have you ever studied the Brecht's criteria?
A. Pardon me?
Q. Have you ever studied the Brecht's criteria

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for MS?
A. No.
Q. Do you know how many McDonald's criteria there actually are?
A. I'm not sure. It's been revised, and I don't recall if it's been revised once or twice. I'm not sure.
Q. So you haven't kept up with the revisions, Doctor?
A. Excuse me?
Q. Have you kept up with the revisions of the McDonald's criteria?
A. I believe so.
Q. Would you be able to tell the Court, what's the difference between the 2001 McDonald criteria and the 2010 McDonald criteria?
A. I'm not sure.
Q. Did you inform Magistrate Bresler that there are now three McDonald's criteria with significant changes along the way?
A. No.
Q. Why not?
A. Did not seem to be appropriate to the discussion.

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Q. Which McDonald's criteria do you use in your practice in diagnosing MS?
A. If you're talking about which revision I use --
Q. Yes.
A. I'm not sure.
Q. Yesterday, twice to Magistrate Bresler you testified that if you don't see specific MRI changes, you cannot diagnose MS. Can you reference Magistrate Bresler to where the McDonald criteria state that?
A. Could you please repeat what you stated was my testimony?
Q. Just a few minutes ago, when you described the McDonald criteria, you said that there were specific lesions on MRI that have to satisfy the McDonald criteria in order for a patient to be diagnosed with MS, and yesterday, twice, you testified to explain to Magistrate Bresler that if you don't see specific MRI changes, you cannot diagnose MS.
THE MAGISTRATE: Well, let's confirm the premise of those questions. Do you remember testifying?

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A. I do remember discussing the McDonald criteria. I remember discussing MRI's. I don't recall stating that if the patient does not meet the McDonald criteria, then you cannot diagnose MS. I believe I stated that it was helpful in diagnosing it and that the criteria can be useful in diagnosing multiple sclerosis. MS is ultimately a --
Q. (BY DR. PADMANABHAN) Dr. Levin --
THE MAGISTRATE: That's okay. I think Dr. Padmanabhan is ready for his next question.
Q. (BY DR. PADMANABHAN) The question was specific about something that you said five minutes ago, that the McDonald's criteria requires you to have specific lesions on MRI.
THE MAGISTRATE: Okay. Dr. Padmanabhan, you can ask about this subject, but we've already established what he testified to, what he remembers testifying to. You can use that to get his attention to a particular subject and then you can ask a question about it.
Q. (BY DR. PADMANABHAN) Dr. Levin, are you aware of what the McDonald criteria states about the necessity for specific lesions on MRI?

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A. I cannot recite the McDonald criteria to you.
Q. Do you know, Dr. Levin, how MRI is used for trials for MS drugs?
A. It can be used in many different ways.
Q. Can you please name some?
A. Oftentimes, trials will look at the number of new T2 FLAIR signal lesions, look at black holes, can look at contrast-enhanced lesions, can look at the number of lesions in different areas of the central nervous system. Those are a few that come to mind.
Q. Do you know, Dr. Levin, how endpoints are designed for trials of MS drugs?
A. No.
Q. When looking at the result of MS trials, which is one of the responsibilities of a physician --
THE MAGISTRATE: That's not in evidence, so you can pose the question without that.
Q. (BY DR. PADMANABHAN) Looking at results of trials of MS drugs, would you be able to understand the results without understanding the endpoints?

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A. I don't understand your question.
Q. When you look at the result of an MS trial, so a study is done and a result is issued at a conference in San Francisco, for example, would you understand the result of the trial without understanding the endpoints used to derive the result?
A. If I -- in reviewing a trial, then I would look at the endpoint of the trial as an important part of the trial.
Q. What effect does the endpoint have on the final result?
A. I don't understand your question.
Q. Have you ever designed trials, Dr. Levin?
A. No.
Q. Do you participate in journal clubs with students and residents on a regular basis to discuss trial results?
A. No.
Q. Are you famous -- are you familiar with the famous benefit trial from back in 2005?
MR. PAIKOS: Objection as to famous.
Q. (BY DR. PADMANABHAN) Well-known.
A. I --

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THE MAGISTRATE: I'll allow it.
A. I know the term the benefit trial. There have been many, many medication trials in MS. My guess is that I'm quite familiar with it, but I don't off the top of my head remember which is the benefit trial.
THE MAGISTRATE: Doctor, if I could interject? Is it famous, in your opinion?
A. It's a well-known trial.
Q. (BY DR. PADMANABHAN) The object of the benefit trial, the endpoint of the benefit trial was the appearance of a second lesion.
THE MAGISTRATE: You have to pose a question rather than making a statement.
DR. PADMANABHAN: Right. I'm getting there.
THE MAGISTRATE: But if you could, pose it as a question.
Q. (BY DR. PADMANABHAN) Do you know the object of the benefit trial in terms of the endpoint?
A. Only in what you just said.
Q. Okay. Are you aware that the FDA gave priority to clinical evidence over MR images in

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deciding a second lesion had actually occurred?
A. I don't remember that.
Q. Are you aware of the acronym RIS?
A. Yes.
Q. What does RIS stand for?
A. It's radiologic isolated syndrome.
Q. Are you familiar with the state of the art in MS regarding RIS?
A. I don't know.
Q. The work of Darin Okuda?
(Reporter clarification.)
Q. O-K-U-D-A, Darin Okuda.
A. No.
Q. On a weekly, monthly basis, do you review RIS or early MS research papers?
A. Not specifically.
Q. On an annual basis, how much time do you spend reading about MS?
A. Couldn't answer that. I don't know.
Q. From your CV, Dr. Levin, I see that you do EMG's.
A. Yes.
Q. So do you mostly spend time reading about EMG's and related muscle disorders?

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A. No.
Q. What do you spend time catching up with?
A. I do reading about many different areas of neurology. I frequently will read about MS, since it's an area that I've been interested in. I read about many different areas of neurology.
Q. Could you turn to MR 465, also in Patient G?
THE MAGISTRATE: And the Bates number, please?
DR. PADMANABHAN: Sorry, sir. 206. I apologize. Because he doesn't have the Bates number, I keep forgetting to mention it.
Q. (BY DR. PADMANABHAN) Yesterday, you stated that this patient, Patient G, does not have MS because she does not have exacerbations and remissions. Do you have any scientific evidence to support that statement?
A. The only evidence that I have is your records.
Q. Once again, Dr. Levin, your statement was that she could not have MS because she did not have exacerbations and remissions?
A. I believe that my statement was that the

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patient did not appear to have MS and the only -- I have no independent information or knowledge of this patient. The only information I have is based on the medical records.
Q. And your statement, based on this one note, was because it did not record exacerbations and remissions, she could not have MS?
A. I'd have to go back and look and see how many notes were before that.
THE MAGISTRATE: Dr. Levin is checking his notes, which is fine.
A. That was not the only note in the record.
THE MAGISTRATE: I'm sorry. He's checking the medical records, not his notes.
A. So checking the medical records and my notes, the -- there were other records prior to this at a date of 4/13/2010.
Q. (BY DR. PADMANABHAN) My question, Dr. Levin, is can a person have MS even if she does not have exacerbations and remissions.
A. Yes.
Q. So are you retracting the statement you made yesterday --
A. No.

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Q. -- to Magistrate Bresler?
A. No.
Q. They're completely contradictory, Dr. Levin.
MR. PAIKOS: Objection.
THE MAGISTRATE: Dr. Padmanabhan, you cannot argue. You have to pose questions.
Q. (BY DR. PADMANABHAN) Would you not agree, Dr. Levin, that your statement today is the opposite of the statement you made yesterday?
A. No. May I respond? You asked me if a patient can have a diagnosis of MS without having exacerbations and remissions, and my answer was a patient can have a diagnosis of MS without exacerbations and remissions. If a patient has primary progressive disease, they frequently do not have exacerbations or remissions. They may have a clinical course that is progressively downhill.
Q. Yesterday, did you explain primary progressive disease to Magistrate Bresler?
A. No.
Q. You further declared that this patient's imbalance was due to her fibromyalgia. Quote, when the fibro got better, the imbalance got better. Do

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you have any evidence that fibromyalgia causes or is related to imbalance?
A. My statement related to your record. I was only quoting information from your report.
Q. You were commenting on my report, Dr. Levin, and your comment was --
THE MAGISTRATE: Okay, Dr. Padmanabhan. Ask --
DR. PADMANABHAN: I will get there.
THE MAGISTRATE: Pose it as a question.
Q. (BY DR. PADMANABHAN) Given your comment yesterday that when the fibro got better, the imbalance got better as a means of explaining to Magistrate Bresler why it was not related to MS, can you explain how fibromyalgia is related to imbalance?
A. In general, fibromyalgia is not related to imbalance.
Q. Why, Dr. Levin, did you make this association yesterday?
A. I made the association based on your note.
Q. Where in my note does it say that the fibro got better and the imbalance got better?
A. Some weeks she is better in terms of the

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fibromyalgia. Her balance then is also better.
Q. Is there a causal relationship, in your mind, Dr. Levin?
A. It does appear to be so, according to your note. I was only quoting your note, sir.
Q. Are you aware, Dr. Levin, of the concept of underlying disease?
A. I have heard the concept. It's not one that I typically use.
Q. Please explain to Magistrate Bresler what your understanding of underlying disease is.
A. It's a general term that I believe can relate to someone presenting with a specific symptom and that the symptom may relate to some underlying -- other underlying condition. For example, a patient may present with a neuropathy and it turns out they have diabetes, so the underlying disease would be diabetes that is contributing to the neuropathy.
Q. So when one treats the underlying disease, what happens to the symptom?
A. The question is too general for me to answer.
Q. In the case of --

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THE MAGISTRATE: Dr. Padmanabhan, if I could ask a follow-up question? How clear are you in your definition of underlying disease?
A. It's a very general term. I'm trying to come up with an example to satisfy the question, but it's a very general term.
THE MAGISTRATE: Thank you.
Q. (BY DR. PADMANABHAN) Does treatment of diabetes help the peripheral neuropathy?
A. It depends on the individual patient.
Q. Is it possible that treatment of the underlying diabetes will help the neuropathy?
A. Yes.
Q. Is it possible that treatment of the diabetes will prevent the return of disease?
A. Yes.
Q. In the binder, there's a note from PubMed about the Swanton criteria, because it was mentioned in one of the notes, but I find that yesterday, you did not pass any comment about the Swanton criteria. Would you like to comment about the Swanton criteria today?
A. I don't know what the Swanton criteria are. There is an article that I was able to find. I

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looked up Swanton because of seeing the Swanton criteria listed. The article that I found was an article published by Dr. Swanton, where he describes a study, he describes impressions about multiple sclerosis. I did not see anywhere that it said these were called the Swanton criteria. I did not know if Dr. Swanton had published other articles, if there were other impressions that he had in other places. All I had was a single article published by Dr. Swanton.
Q. Have you ever discussed this article with MS specialists?
A. No.
Q. It's Josephine Swanton. It's a woman, just as a --
THE MAGISTRATE: Dr. Padmanabhan, it has to be questions.
Q. (BY DR. PADMANABHAN) Is it your testimony, then, sir, that you don't know the difference between the Swanton criteria and the 2001 or 2005 McDonald's criteria?
A. I have no information --
MR. PAIKOS: Objection --
THE MAGISTRATE: Overruled.

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MR. PAIKOS: -- that there is a criteria.
THE MAGISTRATE: Overruled. The doctor can answer.
A. I have no information about the Swanton criteria.
Q. (BY DR. PADMANABHAN) Yesterday, you used an image downloaded from the Internet. Do you know the source of the image?
A. I did not.
Q. Why did you agree to use an image for which you did not know the source?
A. It was downloaded by the legal nurse from the Board of Medicine. She is a reliable source.
THE MAGISTRATE: And Doctor, if you need the source of that, let us know.
DR. PADMANABHAN: I still haven't received a copy.
THE MAGISTRATE: If you need the source of it, let us know.
Q. (BY DR. PADMANABHAN) Did you choose said Internet image?
A. Did I personally choose it?
Q. Yes.

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A. No.
THE MAGISTRATE: If I could interject a question, as long as we're on this, just to make it easier so I don't have to come back, the image -- what was shown you from the Internet, did you consider that a representative image?
A. Yes.
THE MAGISTRATE: Did you think it was instructive?
A. Yes.
Q. (BY DR. PADMANABHAN) Just as a follow-up question, would you consider the legal nurse from the board sufficient to maintain your credibility as an expert witness in this proceeding?
A. Could you restate your question?
Q. You allowed a legal nurse to choose an image that you presented testimony with?
A. Yes.
Q. And did it meet your specs?
A. Once again, please.
Q. Did it meet your standards?
A. Did the image meet my standards?
Q. Did the choice that the legal nurse made meet your standards?

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A. Yes. She chose an image with an excellent representation of Dawson's fingers.
Q. You explained to Magistrate Bresler that CellCept is chemotherapy that is used for cancer when Magistrate Bresler asked you what CellCept is. Is chemotherapy for cancer the main indication used for CellCept?
A. I believe so. I would have to go back and look at the reference on CellCept that I have.
Q. Please do.
THE MAGISTRATE: And Dr. Padmanabhan, if you could point us to the exhibits?
DR. PADMANABHAN: One second, sir. I have it here. It is Tab 23B.
THE MAGISTRATE: Tab 23 what?
DR. PADMANABHAN: Yes, sir. B.
Q. (BY DR. PADMANABHAN) My question to you is did you ever look up the FDA package insert for CellCept prior to coming here to testify.
A. I looked up the information on Up To Date.
Q. Is that considered sufficient as opposed to looking at the official FDA package insert?
A. I felt that for the purposes of my review that that was sufficient.

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Q. After reviewing the Up To Date printout, is it correct that you came and testified that CellCept is chemotherapy used for cancer? I don't mean now, Dr. Levin. I mean before you testified yesterday.
THE MAGISTRATE: Well, I will allow you to -- him to refer to his testimony as an introduction to your next question, but not a question about his testimony, what he actually testified to.
DR. PADMANABHAN: May I ask a question, Your Honor?
A. Would you like me to respond to your question, sir?
Q. (BY DR. PADMANABHAN) I will repeat my question. After reviewing and printing out this Up To Date printout, did you feel that CellCept is chemotherapy for cancer?
A. If I testified so, that was an error.
Q. Do you retract that statement, that CellCept is chemotherapy for cancer?
A. Yes. Would you like me to further discuss the indication?
Q. No, thank you. You further said that you

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have never seen CellCept used, but the Brigham & Women's Partners MS Center does use it on an experimental basis for a few patients. When the government hired you to testify against me, did you look up my credentials?
A. No.
Q. Have you ever seen my CV?
A. No.
Q. Was it not important for you to look up my CV before you came here to testify?
A. No.
Q. So I take it it is true that when you came here on Monday, you were not aware that I have done a three-year fellowship in neuroimmunology at the same Brigham & Women's MS Center?
MR. PAIKOS: Objection.
A. No.
THE MAGISTRATE: I'll allow it.
Q. (BY DR. PADMANABHAN) Would you agree that a person who trained at the Brigham & Women's MS Center for three years in neuroimmunology would be a doctor experienced in immunosuppressant therapy?
A. Yes.
Q. And that would meet the criteria in your Up

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To Date printout, that only health care providers experienced in immunosuppressive therapy may prescribe CellCept?
A. Yes.
Q. Thank you. Have you routinely treated MS patients with cyclophosphamide?
A. No.
Q. Are you comfortable with treatment protocols and managing patients on cyclophosphamide?
A. No.
Q. Have you routinely treated patients with Rituximab?
A. No.
Q. Are you comfortable with treatment protocols and managing patients on Rituximab?
A. No.
Q. Have you treated patients with daclizumab?
A. No.
Q. Are you comfortable with the treatment protocols and managing patients on daclizumab?
A. No.
Q. You explained to Magistrate Bresler that you had not known until you came here what anti-RNP

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was. How many years have you been in practice, Dr. Levin?
A. Thirty-seven.
Q. As a neurologist, have you ever had to rule out the rheumatological conditions in patients seen in the neurology clinic?
A. The only time I worked in the neurology clinic was as a resident, and then during my -- excuse me. Would you repeat the question?
Q. As a neurologist, have you ever had to rule out rheumatological conditions in patients who come to see you for a neurological evaluation?
A. Yes.
Q. Are there any rheumatological diseases that cause neurological involvement?
A. Many.
Q. Would you then agree that knowing which rheumatological labs to order would be part of the standard of care for any practicing neurologist?
A. Yes.
Q. Would you agree that not ever ordering anti-RNP for any patient falls below the standard of care for any practicing neurologist?
A. No.

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Q. Why is that, Dr. Levin?
A. It's not a standard test used by most neurologists.
Q. Is there any evidence to support that statement?
A. There are -- there are many other studies that we use to screen patients for rheumatologic disorders. That is not one of the standard screening tests.
Q. Would you be surprised that someone at --
THE MAGISTRATE: I'm going to stop you right there. I don't know if you remember. I said that's the kind of cross-examination question I'm not going to allow.
DR. PADMANABHAN: I was going on.
THE MAGISTRATE: I think I've told the parties twice, if you start a question with would it surprise you, I'm going to stop you right there.
Q. (BY DR. PADMANABHAN) Would you consider it consistent that someone who trained for three years in neuroimmunology at the Brigham would be likely to order a test like anti-RNP?
MR. PAIKOS: Objection.
THE MAGISTRATE: Overruled.

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A. Since I'm -- was not familiar with the test and I had no information in regards to your background, I could not have made that assumption prior to this moment.
Q. (BY DR. PADMANABHAN) In the binder presented by the government here, there are a few pages about anti-RNP. Did you supply that document?
A. I did.
Q. Would you consider Wikipedia a credible source for a professional license hearing?
MR. PAIKOS: Objection as to for professional license hearing.
THE MAGISTRATE: Overruled.
A. I consider Wikipedia to be a reasonable source to obtain very basic information about a test.
Q. (BY DR. PADMANABHAN) Why would one need only basic information for a professional board hearing?
A. The specific area covered by this particular test was a very tiny part of all the 2,000 some -- excuse me; I believe perhaps 6,000 records that I reviewed. The information that I

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received from reviewing Wikipedia seemed to be sufficient for me to understand it and to understand your interpretation of the test.
Q. From the record, what was your understanding of my interpretation of the test?
A. May we go back to your note?
Q. Yes. It's Patient G, MR 465.
A. 465?
Q. Yes.
DR. PADMANABHAN: One second, Magistrate Bresler.
Q. (BY DR. PADMANABHAN) 466, Bates 206.
A. Your note indicates the only blood marker that was firmly positive was anti-RNP of greater than eight, with a normal of zero to 0.9, which is very suggestive, given her sister has lupus. I interpreted your note as indicating that this was suggestive that the patient had a rheumatologic disorder, given that her sister has lupus and that this is a strongly positive test for a rheumatologic disorder.
Q. Have you ever diagnosed lupus in a patient?
A. I'm not sure.
Q. Not sure?

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A. Correct.
Q. So you may have diagnosed someone with lupus, but you don't recall?
A. Correct.
Q. How many patients with lupus do you have in your practice, Dr. Levin?
A. I don't believe I have any at this point.
Q. How many patients with lupus have you ever treated, Dr. Levin?
A. I'm not sure.
Q. Yesterday, Magistrate Bresler asked you if you looked up anti-SM after you came across it in the record, and you said you did not. Please explain why you never looked it up.
A. It did not seem to be important in the context of the medical records. We were not trying to, or I was not trying to make a rheumatologic diagnosis. There was the information that the patient had a strongly positive anti-RNP, and again, reading your notes, that this was very suggestive. I assume you were stating suggestive of a rheumatologic disorder.
Q. Did you look up anti-SM yesterday after Magistrate Bresler asked you about it?

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A. No.
Q. Without looking it up, how would you interpret the statement here in this note, Dr. Levin, that thankfully, the anti-SM is negative?
A. That you were pleased that the anti-SM was negative and this helped you to rule out a more serious disorder.
Q. Would it not be important to understand it, Dr. Levin, to see whether or not my diagnosis of MS met the standard of care?
A. I didn't believe that the SM or the RNP were directly related to the diagnosis of MS.
Q. Would you agree that they are related to ruling out other conditions?
A. Yes.
Q. Would you say that not ordering anti-SM antibody in any patient ever falls below the standard of care and that some patients may have been left undiagnosed as a result?
A. Not for a practicing neurologist, no.
Q. Would it be below the standard of care for a practicing neuroimmunologist to never test for anti-SM?

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A. I have no knowledge about the standard of care for a neuroimmunologist.
Q. What is your understanding of a neuroimmunologist, Dr. Levin?
A. I have limited understanding as to what a neuroimmunologist is.
Q. What is SLE?
A. Systemic lupus erythematosus.
Q. Why would someone focusing on MS want to know about lupus?
A. Patients with lupus can present with neurologic changes similar to patients with MS.
Q. So if one is a practicing neurologist who has ten to 15 MS patients in his practice, would it not be useful to know how to rule out lupus?
A. Yes.
Q. How does one rule out lupus?
A. On the clinical history, looking for clinical history to suggest lupus, looking at a careful examination, looking for evidence of skin changes, of joint changes, and then doing laboratory studies including sedimentation rate, ANA, RA, and if I'm suspicious that a patient has lupus, I will obtain a consultation with a

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rheumatologist.
Q. So you would not rule out lupus yourself?
A. If I was suspicious, I would refer to a rheumatologist.
Q. Is it correct, then, Dr. Levin, that you have never ordered lupus tests to rule out lupus?
A. I don't recall specifically doing that myself. Usually, it would be I would refer the patient and the rheumatologist would be ordering a lupus panel.
Q. Would a physician who has never ruled out lupus be considered qualified to express an opinion about standard of care in a professional board hearing?
MR. PAIKOS: Objection.
THE MAGISTRATE: Overruled.
A. I can't answer that question.
Q. (BY DR. PADMANABHAN) Dr. Levin, when you were invited to testify at this hearing, what was your understanding of the role that you were to play?
A. That I was to review the records, have discussions with the nurse and the attorney and give them an objective opinion as to my findings on

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the records, and then provide testimony, giving objective opinions at -- through the testimony and submitting to cross-examination.
Q. Does that not also involve interpreting the notes?
A. Yes.
Q. How does one correctly interpret the notes without knowing what is written here?
A. There were, again, many thousands of pages, and this was a single word or a single abbreviation of a test within those many thousands of records. Given the total review that I did of these records, this did not appear to be essential for me to review to give an opinion.
Q. Is it not correct, Dr. Levin, that every record is important?
A. Could you clarify your question, please?
Q. Is it not important that every record requires the same level of attention as every other record?
A. No.
Q. How do you decide, Dr. Levin, which record to give more attention to?
A. The records that are important are in

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general records that contain clinical information.
Q. Are lupus tests and --
MR. PAIKOS: I don't believe the doctor was done answering the question.
THE MAGISTRATE: Was there more?
A. There was.
THE MAGISTRATE: Okay. We're going to allow more of his answer. There's no standard formats -- formula as to whether I will, you know, continue the question or not. This one I will continue.
A. The important records are records that contain clinical information. In reviewing the records, there were many records that contained repetitive information. Some of the records contained basic information about the patient's basic data that has nothing to do with the clinical information, or very little. There are many pages that had repetitive information about his continued medication, about phone encounters, records indicating no care advice was given. These records would not be as important, for example, as page 466, page 465, given your evaluation of the patient.

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Q. (BY DR. PADMANABHAN) Thank you, Dr. Levin. Please tell Magistrate Bresler why you did not give that same level of attention to page 466.
A. I did give the same level of attention to that page.
Q. Would a trained neuroimmunologist be expected to have more of an interest in this subset of patients, patients with lupus, you know, other rheumatological conditions, than, say, a regular practicing neurologist?
MR. PAIKOS: Objection.
A. I have no information about the abilities of a neuroimmunologist.
Q. (BY DR. PADMANABHAN) The question was would a neuroimmunologist be expected to have more of an interest in immunological disorders.
A. I have no specific information about the interests of a neuroimmunologist.
THE MAGISTRATE: Dr. Padmanabhan, if you would indulge me, let me interject a question to Dr. Levin. So we have Bates numbers that are consecutive, you may realize it, and medical records that have not been introduced into evidence. I don't know if you're aware of that.

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A. I am.
Q. Did you help choose which pages were going to become exhibits?
A. I did.
Q. And on what basis did you choose?
A. Because there was something on the page that caught my attention.
Q. And caught your attention because it was important, unimportant?
A. When I review medical records, anything that catches my attention that I think may be potentially important, I will flag. Sometimes it turns out at the end of an evaluation that what I had gone through indeed was not important or may have been repetitive, but anything that I thought was potentially important, I flagged, and those were the pages that subsequently were pulled for the records.
DR. PADMANABHAN: Thank you, Your Honor. In fact, that was going to be my next question.
Q. (BY DR. PADMANABHAN) Please turn to page 439.
THE WITNESS: I wonder if I might take

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a break.
THE MAGISTRATE: Five minutes? Ten minutes? Whatever people prefer.
THE WITNESS: Five minutes.
THE MAGISTRATE: Five minutes? A five-minute break.
(Off the record.)
(Recess taken from 2:54 to 2:59.)
THE MAGISTRATE: Okay. We're back on the record.
Q. (BY DR. PADMANABHAN) Dr. Levin, we are now at Patient G, MR 439, Bates 200. Yesterday, we discussed your comment about this note, and it inadvertently became known that there was the remainder of this note on a second page which was not in the official binder, MR page 440.
You testified that you were the one who chose the notes, so I would like to know why you chose only 439 and not 440.
THE MAGISTRATE: If you could back up and ask Dr. Levin if he was responsible for that?
DR. PADMANABHAN: He just told me that.
THE MAGISTRATE: No. It could have been a simple error. It could have been a decision

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that Mr. Paikos made.
DR. PADMANABHAN: Actually, I'll rephrase.
Q. (BY DR. PADMANABHAN) Dr. Levin, Magistrate Bresler asked you if you helped choose the medical records, and you said yes, you chose pages that caught your attention?
A. Correct.
Q. Would I then be correct in understanding that page 439 caught your attention, but page 440 did not?
A. No.
Q. Was it a simple error, then, that page 440 was not included?
A. I'm looking at my notes. My notes indicate pages 439 to 440. I did write down all of the pages from all of the records that I recommended be pulled. I cannot state if perhaps someone did not pull that page number by mistake.
Q. What do your notes indicate, Dr. Levin? Did you include page 440 to be included?
A. Yes.
Q. When you discussed page 439 here yesterday, did you tailor your opinions only to what was on

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page 439, or did you notice that one page was missing?
A. No. My opinion was based on 439 and 440.
THE MAGISTRATE: Which you do have in front of you?
A. Yes, sir.
DR. PADMANABHAN: Has the government given you page 440?
MR. PAIKOS: I have not. I was waiting for a break where we discuss procedural issues. I've provided one to Dr. Padmanabhan and I have another copy here.
THE MAGISTRATE: All right, so I'm now going to admit into evidence Patient G's Medical Record 440. There is no Bates number, but I'm going to insert it between Bates 200 and Bates 201.
MR. PAIKOS: I think we've noted at the bottom Bates 200A.
THE MAGISTRATE: 200A. Thank you. And I'm also noting we're talking five substantive words, will start Plaquenil and test ordered.
(Exhibit admitted into evidence.)
Q. (BY DR. PADMANABHAN) Dr. Levin, is it not true that you have testified on numerous notes that

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the notes were incomplete?
A. Yes.
Q. Would it not have been important, then, to note that this note was incomplete inadvertently?
THE MAGISTRATE: We don't have evidence that it was incomplete inadvertently. The doctor doesn't know.
DR. PADMANABHAN: Page 440 was missing and Dr. Levin gave his comment about --
THE MAGISTRATE: Dr. Padmanabhan, I'm ruling. We do not know why the page was missing. And it could have been an error; it could have been a decision by Mr. Paikos.
THE WITNESS: May I comment, Your Honor?
THE MAGISTRATE: There's no question in front of you.
THE WITNESS: I had the page.
THE MAGISTRATE: That -- that's in evidence, that you recommended the page; that you have it in front of you and you recommended the page.
THE WITNESS: All right.
Q. (DR. PADMANABHAN) We now move to

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Patient D, MR 173, Bates 134.
A. D as and David?
Q. David, yes. And Magistrate Bresler asked you if --
MR. PAIKOS: Doctor, what was the page?
DR. PADMANABHAN: D as in David, MR 173, Bates 134.
Q. (DR. PADMANABHAN) Ready?
A. Yes.
Q. Magistrate Bresler asked you if each progress note is standalone or could reference a previous note, and you said yes, referencing previous notes is standard of care. Correct?
A. Yes.
Q. Would it not then be important in an evidentiary record that the previous notes all be present?
A. Yes.
THE MAGISTRATE: I'm going to take that as a legal question and I'm going to leave that for you to argue legally and Mr. Paikos to argue legally. This is not Patient D's entire record for reasons I ordered at the prehearing conference. I didn't want the entire record. I wanted the

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relevant pages.
DR. PADMANABHAN: But since his commentary is about the fact that X is missing, Y is missing --
THE MAGISTRATE: Dr. Padmanabhan, I am speaking. If you want to bring to my attention medical records that are not in evidence, you may do so. You have the entire medical records for all these patients, right?
DR. PADMANABHAN: No, Your Honor.
THE MAGISTRATE: You were given the opportunity to obtain them all?
DR. PADMANABHAN: No, Your Honor.
THE MAGISTRATE: We'll talk about that in your discovery motions, but if you contend that there are missing medical records that are important to your case, you can introduce them as exhibits.
DR. PADMANABHAN: Your Honor, I'm not contending that they're missing from me, but when we are discussing the content and the fact that Data X is missing, Data Y is missing from the record in front of us, then I would think it important that whatever is missing, we should make

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sure that it's not missing inadvertently.
THE MAGISTRATE: Dr. Levin has testified that he's gone through the entire record for each of these patients and identified the relevant documents. If you disagree with that assessment that they're relevant, you can bring other documents to my attention, but I asked the parties not to show me every single document identified with the patient and to do the sorting that --
DR. PADMANABHAN: I understand.
THE MAGISTRATE: -- Dr. Levin and Mr. Paikos have done.
Q. (DR. PADMANABHAN) Dr. Levin, you testified --
A. May I clarify that I have the correct chart? Is this D as in David or E as in Edgar?
Q. We've moved on. You explained to Magistrate Bresler that you have never used NKDA, the acronym, in your notes?
A. No.
Q. What do you say?
A. Well, after reviewing this, I was instructed that that means that the patient has no

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allergies. My note would say no allergies.
Q. Is it your testimony, sir, that you have never come across this term NKDA before in your 33 years of practice?
A. I think it's very likely that I have, but I did not or was not able to remember it when I saw it.
Q. Do you see patients in a hospital in-patient facility?
A. Yes.
Q. Do you write notes in a hospital chart?
A. Yes.
Q. Before hospitals went electronic, did you write them on paper?
A. Yes.
Q. Did you review paper charts when you went to consult on patients?
A. Yes.
Q. What would the allergy box usually contain?
A. I don't remember.
Q. Are you familiar with electronic medical record systems?
A. Yes.
Q. Which electronic medical system -- record

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system do you typically use on a daily basis in your practice?
A. Centricity.
Q. Are you familiar with the structure of the electronic medical record systems?
A. I don't understand your question.
Q. Are you familiar with how notes and encounters are organized in the electronic medical record system?
A. There are many electronic record systems and notes appear to be organized in different ways.
Q. Okay. Would it be fair to say that if you came across a computerized printout from a non-Centricity electronic medical record system, it would be unfamiliar to you?
A. No.
Q. So even if people use different electronic medical records systems, the output would still be familiar to you?
A. Yes, I would anticipate so. I'd have to see the specific medical record before I could definitively comment on that, but in general, medical records include similar types of information.

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Q. You have gone through 6,000 pages of notes, you have testified. Are you familiar with the computerized printout format of these notes?
A. As reviewed, yes, although I have to admit that there sometimes is some confusion. Sometimes the notes are difficult for me to understand. That doesn't relate specifically to your notes, but there are other notes that are sometimes hard for me to understand.
Q. Are you familiar with the dates and time stamps and, you know, all the other verbiage that comes in in addition to a doctor's note?
A. In general, yes.
Q. When we moved from paper charts to electronic charts, did the number of pages that became part of the record increase?
A. Yes.
Q. When an electronic medical record outputs a printout, what other material gets printed along with the doctor's note?
A. That varies from electronic medical to -- electronic medical record from doctor's note to doctor's note.
Q. But at your facility and your practice,

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typically, what is contained in your note?
A. The past history, medications, allergies. The prescriptions are printed out as they are sent to the pharmacy or as they're written or written into the computer. The basic information about the patient, their name, their address, other basic data about the patient. I'm sure I'm missing other things.
Q. Would it not be important to include all of those printouts when recording in a physician's note?
A. I don't understand your question.
Q. When people input data into the electronic medical record, do they input data into simply one open page, or do they put it into separate windows?
A. I can't speak for every medical record.
Q. How about with Centricity, the one you use every day?
A. Do you have a specific question about that?
Q. Right. How is the data input into the GE Centricity system?
A. Data is put in in different ways. There are different windows to put in the basic data about the patient, their address, their phone

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number, their age, referring doctor, basic information about their insurance. And then information is put in in different windows to provide a full history, including review of systems, detailed review of systems, to put in vital signs. We have separate windows for every portion of the neurological examination, so when I do my notes, I have a separate section for mental status, motor examination, sensory examination, reflexes, cerebellum, gait. These all have separate sections. There's a separate section for impression and discussion and that includes diagnoses. There's a separate section for plan that includes medications that are prescribed, and then when you do prescribe a medicine, it will print out below the -- below the plan and there's a section to put in copy to different referring physicians.

Q. So a complete printout from a computerized electronic medical record system would then include data from all of these separate windows on one package of sheets?

A. That's correct.

Q. So if only one or two pages are used from

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that five or six-page set, it would be an incomplete record?

THE MAGISTRATE: For medical purposes. For legal purposes --

DR. PADMANABHAN: For medical purposes.

THE MAGISTRATE: -- I ordered this.

DR. PADMANABHAN: No, I know.

A. I'm not sure I understand your question.

Q. (DR. PADMANABHAN) If there is a six-page printout, when you order the medical record system to print out a note and six pages print out, if only one or two pages are analyzed, is that a complete record?

A. You said analyzed. I'm sorry. Did you mean analyzed or printed?

Q. Six pages are printed, but only two are used or presented in a hearing. Is that a complete record?

THE MAGISTRATE: No, that's a legal question. Documents are incomplete because I ordered them.

DR. PADMANABHAN: I understand, Your Honor.

THE MAGISTRATE: Then move on with the

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next question.

DR. PADMANABHAN: Dr. Levin has testified that I don't --

THE MAGISTRATE: Dr. Padmanabhan, move on to the next question. These documents are not incomplete for purposes of the legal proceeding.

DR. PADMANABHAN: Okay.

Q. (BY DR. PADMANABHAN) Is it your testimony, Dr. Levin, since you do possess the complete record as opposed to the evidence binder, that when you noted in all of my notes over the past three days that no drugs were noted, no allergies were noted, I do not know what prescriptions were given, I do not know how many pills were dispensed, that they were not present in the remaining four or five pages of the computerized printout?

A. To the best of my knowledge, they were not.

Q. So when those six pages were printed, the remaining pages were then blank?

THE MAGISTRATE: No, that's not the case. Next question.

Q. (BY DR. PADMANABHAN) When Magistrate Bresler asked you what Lorazepam was, you said that Lorazepam is Xanax. Is that correct?

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A. I did say that. It is not.

Q. Do you retract that statement?

A. I do.

Q. Do you know the generic or chemical name for Xanax?

A. I do, but I cannot think of it at the moment.

Q. Do you ever prescribe Xanax?

A. Rarely.

Q. Do you always use the brand name?

A. I rarely prescribe the medication.

Q. Do you -- when you write prescriptions, do you usually use the brand name?

A. No. Very frequently, I use the generic.

Q. When Magistrate Bresler asked you about Patient E, you said that the patient is on both Percocet and Oxycodone and there was no indication that he was previously on Oxycodone. So this would be Patient E, MR 66. I don't know the Bates number. I apologize. I will get that.

A. This is Patient E as in Edgar?

Q. Bates 153, Edgar, 66. You were commenting on the statement and the impression that he will stay on the Oxycodone for now and you told

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Magistrate Bresler that there was no indication that he was previously on Oxycodone.
A. I don't recall the statement.
Q. Are you aware that Percocet and Oxycodone are the same?
A. No.
Q. What is the generic or chemical name for Percocet, Dr. Levin?
A. I don't know.
Q. You then stated that because the patient was prescribed Dilaudid, he was now prescribed three separate opioids. Would you retract that statement?
A. If indeed Percocet and Oxycodone are the same medication, and that is assuming that the patient had not been prescribed another opioid such as OxyContin, I would retract that statement.
Q. What is the difference, Dr. Levin, between Oxycodone and OxyContin?
A. I believe OxyContin is shorter-acting, but I'm not a hundred percent sure.
Q. Dr. Levin, you knew you were coming to testify about pain management. Would it not have been important to look those up in advance?

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A. I was coming to testify about my impressions of the medical records that I reviewed.
Q. The medical records included the names Oxycodone, Percocet and OxyContin. Would it not have been important to look them up?
A. In the context of the records that I reviewed, I felt that the review that I did was sufficient.
Q. You testified to Magistrate Bresler that Duragesic is not a narcotic drug. What is the generic name for Duragesic?
A. I don't know.
Q. Once again, did you not feel that it was important for your review and for your testimony here to know what Duragesic is?
A. I know that Duragesic is a medicine that's used for pain. It's given as a patch. I believe I saw it as one prescription in the context of many, many medical records and many, many medicines prescribed. It did not seem to be a medicine that there was a concern about.
Q. Have you ever prescribed Duragesic for a patient?
A. I'm not sure.

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Q. Do you have patients with cancer in your practice?
A. None that I take care of as a primary physician. I have patients with cancer who come to see me with neurological problems in addition to their cancer.
Q. So you have never provided end-of-life care or followed a cancer patient to the end?
A. I have never been the primary physician to care for a cancer patient or provide end-of-life care.
Q. Have you ever been part of a care team for a cancer patient in the last six months of his or her life?
A. Not in a formal sense.
Q. Have you ever prescribed fentanyl lozenges or lollipops?
A. No.
Q. You explained to Magistrate Bresler that the main indication for Botox is spasticity. This would be Patient E, MR 211, but you don't need to look at it. When did spasticity become an official FDA indication for Botox?
A. Don't know.

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Q. The way you explained it to Magistrate Bresler --
THE MAGISTRATE: If it is.
DR. PADMANABHAN: It is.
THE MAGISTRATE: Doctor, you're not allowed to testify just yet and it's not in evidence. The question stands and there is no assumption that -- about the FDA.
DR. PADMANABHAN: That will be the next question.
Q. (BY DR. PADMANABHAN) Dr. Levin, when you indicated to Magistrate Bresler that the main indication for Botox is spasticity, what did you mean by main indication?
A. That is not -- I don't believe that's what I stated. I believe I stated that Botox had a number of indications, and I did review some of the indications for the use of Botox --
Q. I understand, but --
A. -- one of them being spasticity, but not that that was the main indication.
DR. PADMANABHAN: Thank you. Is it possible to look up testimony from yesterday or the day before?

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THE MAGISTRATE: I don't know whether it's possible, but we're not going to stop to do that. You will get a transcript and if there's something you want to compare, you can bring it to my attention in the post-hearing brief.
Q. (BY DR. PADMANABHAN) Dr. Levin, do you care for any patients with severe anxiety?
A. Not as a primary treating physician for their anxiety.
Q. Do you have any patients with severe anxiety?
A. Yes, sir.
Q. What does severe anxiety mean to you?
A. It's a condition where an individual feels very anxious, very nervous, and that this would be a high level, likely would be present much of the time. It would be interfering with their life. Probably has somatic symptoms along with that, maybe jitteriness, sweating, maybe other symptoms like abdominal upset that go along with that, a person who is in lay terms very, very nervous.
Q. What is the difference, Dr. Levin, in your understanding between severe anxiety and panic disorder?

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A. I'm not a psychiatrist, so I don't know that I can offer you an accurate explanation of that.
Q. Excuse me one second. I'm trying to find a particular phone message.
THE MAGISTRATE: Dr. Padmanabhan, do you have a next question? Maybe you can return to this when you find the phone message.
DR. PADMANABHAN: I think I will do that. Thank you.
Q. (BY DR. PADMANABHAN) In the case of Patient B, did you look through the complete record in your possession to see if he indeed transferred to Dr. Gorski's care? The actual page --
A. This is B as in boy?
Q. Boy, yes. Page MR 81, Bates 71.
THE MAGISTRATE: And while Dr. Levin is looking for that record, if you want to look for the phone message on the other patient?
A. I have record B. What was your question, sir?
Q. (BY DR. PADMANABHAN) On MR 81, Bates 71, my note states, I informed Patient B that I am transferring Patient B to Allison Gorski of

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Fall River for chronic pain management. Did you look through the complete record in your possession, including papers that are not referenced here, to see if he did indeed transfer to Dr. Gorski's care?
A. I did review the complete record. I don't recall whether or not the patient was transferred to Dr. Gorski's care.
Q. Wouldn't that have been important to know?
A. If you like, I can look to see if there is any record of it. I don't remember. I'm not answering your question, sir. I'm saying that I don't know whether or not the patient transferred --
Q. Thank you.
A. -- to Dr. Gorski's care.
Q. That's fine. On your board profile, Dr. Levin, it states that you work in a mental health facility.
A. No.
Q. It does. I have it here.
A. Oh, does it say that? I'm sorry. I'm not familiar with my board profile.
THE MAGISTRATE: Dr. Padmanabhan, you

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cannot testify until you're sworn in as a witness. Right now, you have to pose questions. You cannot make statements on what the board profile says, what the FDA says, what a regulation says. You're giving me the thumbs up, so I see you understand.
DR. PADMANABHAN: I agree. I'm new to this, Your Honor.
Q. (BY DR. PADMANABHAN) When was the last time you looked up your board profile, Dr. Levin?
A. Probably a few years.
Q. Did you send information to the board yourself or did you delegate it to somebody else?
A. I would have sent it myself.
Q. Would the board substitute information that you did not send them to appear on a board website?
MR. PAIKOS: Objection.
THE MAGISTRATE: Sustained. Next question.
Q. (BY DR. PADMANABHAN) If you did not write mental health facility, would you explain how it shows up on your profile?
A. I cannot explain it. It is incorrect.
Q. When you renew your license every two years, Dr. Levin, how do you renew it?

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A. The last few times, I renewed it online.
Q. So you review your profile every two years when you go to the website, to the OLR system?
A. I renew it online. I have, I think, the last two times.
Q. And this note that you work in a mental health facility did not catch your eye?
MR. PAIKOS: Objection.
THE MAGISTRATE: Overruled.
A. This is the first that I'm aware of that.
DR. PADMANABHAN: I have a whole bunch of other questions, but maybe start tomorrow?
THE MAGISTRATE: What is your best estimate as to the length of your questions?
DR. PADMANABHAN: I think about two hours more.
THE MAGISTRATE: Is there a reason to stop now?
DR. PADMANABHAN: It's an organization issue, Your Honor.
THE MAGISTRATE: I'd prefer to keep going to 3:55 and then deal with scheduling and any procedural -- minor procedural issues.
DR. PADMANABHAN: Fair enough.

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Q. (BY DR. PADMANABHAN) Return to Patient A. That would be page 35. In the impression section, I have written that he will take as many as he needs during the course of a day. He may need six or seven pills some days. I have increased his OxyContin pills to two pills four times a day, meaning eight pills a day. When you see a note following that he may need six or seven pills a day, what comes to mind when he's prescribed eight pills?
A. That he may require six, seven or eight pills a day.
Q. Now to page 233, Patient A.
A. 233?
Q. 233, Bates 46. You had testified on this page that there's no information on the medicine given and there is no pain agreement. Did you look for the pain agreement?
A. There is no indication of a pain agreement on this page. The prescription for the medication does give the information about OxyContin.
Q. Did you look for a pain agreement on Patient A in your records?
A. I don't remember.

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Q. Page 232, the previous page, are you familiar with the concept of refill visits, Dr. Levin?
A. Yes.
Q. Since you do not prescribe Oxycodone, OxyContin, Duragesic, or any controlled pain substances, how many patients of yours have to come in once a month for a refill, a hard copy refill?
A. None.
Q. So you have no experience with what notes are kept for drug refill visits?
A. Correct.
Q. So when you said that this note is below the standard of care, would you agree that you did not know the standard of care?
A. No.
Q. You do not agree that you do not know the standard of care?
A. Correct.
Q. What is the standard of care for a refill visit?
A. I believe I've already answered that question, that I am not familiar with refill visits.

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Q. How would you then know what is the standard of care for a note documenting a refill visit?
A. I would not.
Q. You rendered an opinion on this note, Dr. Levin. You said it was below the standard of care, so I need to know what standard you applied.
A. This is listed as an interdisciplinary progress note. I do not see anything on here indicating that this is a refill visit. This appears to be a standard visit for follow-up neurological care. My opinion was rendered in regards to the adequacy of a note for standard neurological care. This note is below the standard of care for a usual neurologic follow-up, especially for a patient with a pain problem. I cannot comment further, since there is no information on here indicating that this is a routine refill visit.
Q. Before hospitals became computerized, are you -- were you familiar with the different types of blank pages that we use to write notes on?
A. That's a very general question that I cannot answer.

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Q. What does interdisciplinary progress note mean to you?
A. That this is a progress note and that different disciplines can use it; doctors can use it, a nurse may use it, a physical therapist, a speech therapist. Different medical professionals may use the same note.
Q. Does a note written on this piece of paper have to be a standard neurological visit?
A. A progress note should be a standard neurological visit unless indicated otherwise.
Q. If a respiratory therapist writes a note, would you still apply that same standard?
A. I believe your question related to you. I'm not testifying in regards to any other medical professional, indeed anyone except for you.
Q. Dr. Levin, you said you based your standard on the fact that the key words are printed on top on a blank piece of paper that is used by numerous disciplines. Does the fact that it says progress note automatically imply that anything written on this page is a progress note?
A. Yes.
Q. Are you familiar with specific papers used

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for refill visits?
A. No.
Q. Would you expect that they would say a refill visit on top?
A. I believe I've answered your question and I am not familiar with that.
Q. From your vast experience, how would you look at a note like this and differentiate between a regular follow-up office visit and a monthly refill visit?
A. I have no experience in the standard of care for a refill visit. This is below the standard of care for a neurologic follow-up visit.
Q. Would this be the standard of care for a monthly routine refill visit?
A. As already answered, I believe several times, I have no knowledge of the standard of care for a refill visit.
Q. If one were to testify that this is a monthly routine controlled substance hard copy prescription refill visit, would you revise your comment?
A. No.
Q. Why?

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A. I don't understand your question.
Q. If one were to testify under oath that this was not a routine office progress note visit, but a monthly hard copy prescription refill visit, would that change your opinion?
THE MAGISTRATE: I'm going to tell you. Who is testifying? Who is one who is testifying? Are you asking him to speculate if that in fact were the case?
DR. PADMANABHAN: I would be happy to testify, but the point is --
THE MAGISTRATE: No, the question is are you asking him to assume that fact.
DR. PADMANABHAN: He has already testified that different people can write different notes.
THE MAGISTRATE: Dr. Padmanabhan, is that the question to him?
DR. PADMANABHAN: Yes.
Q. (BY DR. PADMANABHAN) If this were a routine refill visit, would this meet spec?
A. Once again, I do not know what the standard of care is for a routine refill visit.
Q. Thank you. That's it.

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THE MAGISTRATE: Dr. Padmanabhan, before you move on, if I could ask --
DR. PADMANABHAN: Yes.
THE MAGISTRATE: -- a question of Dr. Levin? If this were the note of a monthly refill visit and it did not note that, in your opinion, would it confuse -- possibly confuse another doctor?
A. Yes.
THE MAGISTRATE: Do you have an opinion as to whether the standard of care would be to mark something that is supposed to be monthly refill note as a monthly refill note?
A. Yes.
THE MAGISTRATE: And your opinion is what?
A. That the notes should be -- it should indicate on the note to what the note is. If this is a refill visit and therefore the standard of care is different, then this should be specifically marked as a refill visit.
Q. (BY DR. PADMANABHAN) Dr. Levin, since you have no experience in monthly refill visits, on what experience or knowledge do you base that

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statement?
A. I was answering the magistrate's question.
THE MAGISTRATE: That statement was about -- not whether this is or is not a monthly refill visit, but whether it should be marked --
DR. PADMANABHAN: If it should be marked.
THE MAGISTRATE: Excuse me, Dr. Padmanabhan. About whether it should be marked. That was -- you can follow up on that.
Q. (BY DR. PADMANABHAN) Are you familiar with refill visits that are exclusively marked by the treating physician as a routine monthly refill visit?
A. No.
Q. How many times in your career as a physician have you come across progress notes, a paper with a notation saying routine monthly refill visit?
A. I don't know.
Q. Please turn to page 70, Patient A, Bates 19.
A. What was the page?
Q. Page 70, Patient A, MR 70, Bates 19.

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A. I'm sorry. Page 19 or 70?
THE MAGISTRATE: He's giving the Bates number as 19.
A. Oh, sorry.
Q. (BY DR. PADMANABHAN) Under the heading result summary, do you see something called notes?
A. Yes.
Q. And what is written below notes?
A. Progress notes.
Q. The two sentences that follow below that heading progress notes, do they look like progress notes to you?
A. No.
Q. And yet they appear under the heading of progress notes. How would you explain that, Dr. Levin?
A. I can't explain it. I did tell you that there were different aspects of this particular medical record that I found confusing. That is one of them.
Q. So if a piece of paper states progress note on top, does it automatically signify that it should be a progress note?
A. I don't know. According to this medical

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record, I can't answer that question. May I further elaborate?
Q. No, sir. Patient B, page 137, and that would be Bates 79.
A. The page number again, please?
Q. 137. Ready?
A. Yes.
Q. You had testified that this note caused you grave concern and raised a red flag, because the patient had gone to an appointment at a pain clinic, the nurse saw him, took vitals, and then he left. He did not wait to see Dr. Hummell, because he wanted to see Dr. Gorski. Can you please explain why it raised a red flag?
A. It was unusual behavior.
Q. Why was it unusual?
A. You have referred this patient to a pain clinic. You were concerned about the patient continuing to have his medication, to have care for his chronic pain problem. You had referred the patient to a place that you considered to be a good place, that you thought was an appropriate referral. The patient agreed on that, went to the referral, and then decided once he got there that

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he didn't want to see the doctor, and so after the vital signs were taken, the patient just walked out. The patient just left. Any time a patient does that, especially a patient who is under controlled substances, that would raise some concern. Doesn't necessarily mean there is a problem. What he did may be perfectly reasonable, but it was unusual enough that it would raise a red flag, could be a problem.
Q. Staying on MR 137, please turn to Patient B, MR 81.
THE MAGISTRATE: And the Bates number?
DR. PADMANABHAN: 71. Sorry.
THE MAGISTRATE: 71. Thank you.
Q. (BY DR. PADMANABHAN) Please read the fourth sentence in my note.
A. I informed Mr. --
Q. Patient B.
A. -- that I am transferring his care to Dr. Allison Gorski of Fall River for chronic pain management.
Q. Is there anywhere in this note that I am transferring him to a certain facility?
A. No.

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Q. Please turn back to MR 137. What does it say about why he left?
A. He did not -- it states he did not waited (sic) to see Dr. Hummell. He wants to see Dr. Gorski, so they booked him an appointment with Dr. Gorski at Fall River for 6/29/2010, and --
Q. Thank you. So when you stated that it raised a red flag because I had booked him an appointment at a facility and he went there and he left --
A. There was additional information that you prevented me from reading. May I read the rest of the sentence?
Q. No, sir.
A. The rest of the sentence answers your question.
Q. No, sir. When you testified that this raised a red flag because he left and walked out and you thought his behavior was very strange and worrisome for drug abuse, which is your testimony, does the fact that he had agreed to see Dr. Allison Gorski and had been booked to see a different patient change that assessment?
A. The concern over a red flag had to do with

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this entire note. What you are asking me about is a portion of the note, but indeed, the red flag had to do with the entire note.
Q. What is causing a red flag in this entire note?
A. The beginning portion that we've already discussed. He had an appointment at Fall River with Dr. Gorski, 6/29/2010, and he call and cancel because he stated that he was having a heart attack. No one at the clinic told him to go to ER. He said he was waiting for his son to take him. If you have any question, call Norwood Hospital Pain Management.
This is a peculiar note. There are some peculiar things going on here. Everything that happened may have a perfectly reasonable explanation, and this does not indicate that the patient has an abuse problem, but the question of could this be a red flag, could this be something to state, perhaps we should watch this patient closely, maybe there is something going on in terms of his abuse of controlled substances, maybe not. A red flag does not indicate that there is a problem. It only indicates this is something you

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should pay attention to.
Q. What is your experience with patients who abuse drugs?
A. It's a general question. I can't answer it.
Q. Do you have any experience with patients who abuse drugs?
A. Yes, sir.
Q. The first half of the sentence states that he left on 6/28 because he wanted to see Dr. Gorski and he had been booked with somebody else. What does that make you think?
A. It raises a concern. If a patient has a significant chronic pain problem and needs to have chronic opioids, that in general, they're going to want to see any doctor or a doctor who can help them. It's not clear to me that you explained to him that the only doctor he should see is Dr. Gorski.
Q. Now, please turn back to page MR 81.
MR. PAIKOS: Objection. Please. The witness was completing his sentence and his answer.
THE MAGISTRATE: Okay. I think it's on the record.

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(Last answer read back.)
MR. PAIKOS: I would ask that the -- Dr. Levin be allowed to complete his answer. He's being interrupted in the middle of his testimony.
DR. PADMANABHAN: The answer is not to point.
THE MAGISTRATE: I'm going to allow Dr. Padmanabhan to ask his next question, but first, I want to interject and put something on the record. We are looking at Bates 79. In case anybody is reading the transcript and is not looking at this exhibit, it's not written by Dr. Padmanabhan. It's for his office, but it's written by Carmen Lugo.
Q. (BY DR. PADMANABHAN) Please turn back to MR 81, Bates 71. It says I informed Patient B that I'm transferring his care to Dr. Allison Gorski. What does that mean to you, Dr. Levin?
A. That you are transferring his care to Dr. Allison Gorski for chronic pain management.
Q. Correct. Is there anywhere here that does not make it clear to you that I am transferring his care to a particular physician?
A. No.

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Q. So you are clear, Dr. Levin, that I am transferring his care and I wish him to be seen by one particular physician?
A. I understand that.
Q. Thank you. Does that now cast a different light on the fact that the patient was unhappy that he was not scheduled to see Dr. Allison Gorski on the 28th?
A. It makes his response understandable.
Q. Is it also not listed in this note on MR 137 that he left after getting an appointment with Dr. Gorski?
A. Yes.
Q. Does that cause a red flag?
A. That does not.
Q. So the red flag is cancelling the clinic -- the appointment the next day because he had symptoms of a heart attack. Did you check to see if he actually had a heart attack?
A. No.
Q. Have you any experience with patients with severe anxiety?
A. Yes.
Q. What symptoms do patients with severe

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anxiety sometimes feel?
A. There are many symptoms.
Q. Please list some.
THE MAGISTRATE: We already have that, I think, on the record during your cross-examination.
A. Yes.
DR. PADMANABHAN: No, sir.
A. I did previously list them. I believe it was in answer to your question what are the symptoms or what happens to somebody with severe anxiety.
Q. (BY DR. PADMANABHAN) Does severe anxiety sometimes cause chest tightness and feelings of chest pain?
A. Yes.
Q. In a patient with an existing diagnosis of severe anxiety, would symptoms of chest pain or symptoms of a heart attack or a patient feeling that he is suffering heart attack be unusual?
A. No.
Q. Would it be strange?
A. No.
Q. Would it be strange if he was waiting to be

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taken to the ER by his son?
A. The whole note is strange.
Q. Please explain, Dr. Gorski. Dr. Levin.
A. Once again, we have a patient who has a chronic pain problem who wants to get cure cared. You have informed the patient that you are not going to be caring for him any more, so you --
Q. (BY DR. PADMANABHAN) Dr. Levin, I have to stop you. Where in my note does it say that I will not be caring for him anymore?
A. I informed patient that I am transferring his care to Dr. Gorski.
Q. But you have reviewed the entire record, have you not?
A. This particular note states I am transferring the patient to Dr. Gorski for chronic pain meds.
Q. But you have reviewed the entire record, have you not?
A. Yes.
Q. So when you testified about page 137, you had already reviewed the entire record, had you not?
A. No.

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Q. When did you review the entire record of Patient B, Dr. Levin?
A. After I completed the review after page 137. I read the records in chronological order.
Q. My question, Dr. Levin, is when did you go through the chart on Patient B.
A. I don't understand your question.
Q. Before you testified at this hearing, did you go through the entire medical record provided to you about Patient B?
A. Yes.
Q. So did you have a complete mental image about Patient B?
A. I had reviewed the records and I had impressions about Patient B, yes.
Q. Did you know that he had severe anxiety?
A. I don't remember.
Q. Did you recall seeing Patient B's MR number 112, Bates 74?
THE MAGISTRATE: Dr. Padmanabhan, if you're going to be asking Dr. Levin about another document, I'm going to suggest that this is a good time to stop. It's five minutes before 4:00, and I

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want to turn to procedural matters.
DR. PADMANABHAN: Okay.
THE MAGISTRATE: So we're going to end evidence for today.
We're still on the record. Is there anything quick procedurally before we talk about scheduling? I know there are discovery motions pending.
MR. PAIKOS: Not -- I have a revised transcript of Dr. Gorski, which I believe I've given to Dr. Padmanabhan, that's redacted and has the direct and cross-examination.
DR. PADMANABHAN: It's not Dr. Gorski. It's Warfield.
MR. PAIKOS: Yes, Dr. Warfield.
THE MAGISTRATE: And that is the respondent's exhibits. Remind me of the numbers. Is that one or two?
DR. PADMANABHAN: Two.
THE MAGISTRATE: Okay. And that's acceptable with you, Dr. Padmanabhan?
DR. PADMANABHAN: Delighted, sir.
THE MAGISTRATE: Okay, so I'm accepting as Respondent's Exhibit Number 2 the full

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transcript of the fair hearing, day three, volume three, January 24th, 2011.
MR. PAIKOS: I don't believe it's the full. I believe it starts at the beginning of an expert, Dr. Warfield. It has something before that.
THE MAGISTRATE: More complete than before?
MR. PAIKOS: It has the direct and cross-examination.
THE MAGISTRATE: Okay.
MR. PAIKOS: It's not the full hearing transcript.
THE MAGISTRATE: Thank you. Not the full hearing transcript. It's been accepted as an exhibit.
(Respondent's Exhibit 2 admitted into evidence.)
THE MAGISTRATE: Okay, so Dr. Padmanabhan, your best guess is you have an hour and a half more of cross-examination for Dr. Levin?
DR. PADMANABHAN: At least, yes.
THE MAGISTRATE: You're -- okay. At

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least. What's your best estimate?
DR. PADMANABHAN: I would say an hour and a half to two hours. No more than that.
THE MAGISTRATE: And Mr. Paikos, you're still planning on calling how many witnesses after Dr. Levin?
MR. PAIKOS: We are planning on calling one or two. We received a call at lunch from one of the patients, Patient H, from her husband, who left us a voicemail that she can't be in tomorrow. We reached out to him, but we haven't heard what the circumstances are.
THE MAGISTRATE: So ideally, how many witnesses would you be calling tomorrow?
MR. PAIKOS: We may not be calling any, because of the cancellation, or potential cancellation of this patient. I think at the most, one.
THE MAGISTRATE: Which would be Patient H?
MR. PAIKOS: Yes. Yes.
THE MAGISTRATE: So if Patient H is available, you will be calling Patient H?
MR. PAIKOS: Yes.

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THE MAGISTRATE: If Patient H is not available, you won't be calling any witnesses?
MR. PAIKOS: No.
THE MAGISTRATE: You're planning on -- you will be resting your case in chief?
MR. PAIKOS: Yes.
DR. PADMANABHAN: Your Honor --
THE MAGISTRATE: Yes.
DR. PADMANABHAN: -- there's a statement of allegations that I was prescribing -- writing prescriptions after my Massachusetts controlled substance license registration had expired, and they were going to call Adele Audet from the DPH to testify about that, so if she is not going to testify, how will I rebut?
THE MAGISTRATE: If they don't put in evidence about that, then they haven't proved their allegations and you have nothing to rebut.
MR. PAIKOS: We would rely on the documents that are part of our exhibits, and in part, some of the things that Dr. Padmanabhan has submitted.
THE MAGISTRATE: So they're going to rely on documentary evidence rather than live

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testimony. That's what you can rebut. You can rebut through documents. You can rebut through your own testimony. Do you plan on testifying?
DR. PADMANABHAN: I would hope to.
THE MAGISTRATE: Okay. How long do you think your testimony will be?
DR. PADMANABHAN: Whatever they ask.
THE MAGISTRATE: Excuse me?
DR. PADMANABHAN: Whatever they ask.
THE MAGISTRATE: No. You will be deciding. It will be your -- presenting your case.
DR. PADMANABHAN: Oh, okay. How long? Probably 30 minutes tops.
THE MAGISTRATE: So will you be prepared to testify tomorrow after the Board of Registration in Medicine ends its case?
DR. PADMANABHAN: I would be prepared to testify after I present my patients.
THE MAGISTRATE: But the patients aren't going to be here tomorrow.
DR. PADMANABHAN: I could get them in if you wish.
THE MAGISTRATE: Okay, so -- well, in that case, tell me how long you think it will be

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for your three patients.
DR. PADMANABHAN: I would have to see if they're available. One is certainly available. He will be able to come, and that will be Patient D. Patient C will not be able to come on Friday due to babysitting issues, but he will be available next week. And Patient I also for babysitting issues will be available next week. I was not aware until you informed me yesterday that Monday is a holiday.
THE MAGISTRATE: So let me back up. It looks like this appeal will be going to a hearing on a sixth day after tomorrow. I'm looking at my calendar and the earliest I can do is January 29th, a Thursday. You don't have to give me an answer now, especially if you don't have your calendars, but Dr. Padmanabhan, if you can consult with Patients C and I and see if they're available on January 29th? Then I'll have to talk to the Civil Service Commission and see if this room is available. Okay.
DR. PADMANABHAN: Thank you.
THE MAGISTRATE: Now, back to tomorrow. You're planning on calling Patient D?

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DR. PADMANABHAN: I will do my best.
THE MAGISTRATE: I know you prefer to testify after your patients, but to fill up tomorrow, I might ask you to present your case, your testimony, and then be subject to cross-examination.
DR. PADMANABHAN: I'll try.
THE MAGISTRATE: Assuming this goes to a sixth day of hearing, does the board want to call Patient H?
MR. PAIKOS: Yes.
THE MAGISTRATE: Okay. Dr. Padmanabhan, we might take direct testimony in the board's case out of order. Depending on Patient H availability, I might allow them to present Patient H on January 29th or whenever the sixth day of hearing is. Okay. Anything else for today?
MR. PAIKOS: No.
THE MAGISTRATE: Okay, so we'll resume at 10 o'clock tomorrow. Thank you.
(Off the record.)
(Whereupon the proceedings were suspended for the day at 4:02 p.m.)

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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 IV, Pages 522-732, is a true and accurate transcription of my stenographic notes taken on Thursday, January 15, 2015, in Boston, Massachusetts.

Dated this 27th day of January, 2015.

Marianne R. Wharram
Certified Shorthand Reporter
CSR No. 1426S96
Registered Professional Reporter
Notary Public
My Commission Expires:
July 29, 2016

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