In The Matter Of:

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

Bharanidharan Padmanabhan, M.D.

Vol. 7

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COMMONWEALTH OF MASSACHUSETTS

DIVISION OF ADMINISTRATIVE LAW APPEALS

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BOARD OF REGISTRATION IN MEDICINE

v DOCKET NO.

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

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BEFORE: Kenneth Bresler
Administrative Magistrate

Held at

Office of the Civil Service Commission

One Ashburton Place - Room 503

Boston, Massachusetts 02108

Friday, March 6, 2015

9:34 a.m. - 3:17 p.m.

Reporter: Carole M. Wallace, CSR

APPEARANCES:

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ALSO PRESENT:
Loretta Cooke, Nurse Investigator

I N D E X

* * * *

PETITIONER'S EXHIBITS

THE MAGISTRATE RETAINED THE ORIGINAL EXHIBITS

THE MAGISTRATE: We're going to go on the record. Good morning, everybody.

MS. COOKE: Good morning.

THE MAGISTRATE: Dr. Padmanabhan, I got the notice from a lawyer who is representing you. Is she here?

DR. PADMANABHAN: She is on her way here. She asks forgiveness.

THE MAGISTRATE: Do you have an estimate?

DR. PADMANABHAN: About a half hour she hopes.

THE MAGISTRATE: Half hour as of now?

DR. PADMANABHAN: As of ten minutes ago.

THE MAGISTRATE: Ten minutes ago she said half hour. Let me check back in ten minutes.

[Recess]

THE MAGISTRATE: Do you have anything to report to me, Dr. Padmanabhan?

DR. PADMANABHAN: She apologizes. She had to drop her son off. He is disabled, but she would be here. I can start with the cross examination of Dr. Levin. I can continue my cross.

THE MAGISTRATE: What's your best

guess -- What did she tell you about her arrival?

DR. PADMANABHAN: Sure, I am not sure. She is stuck in traffic and coming down from the North Shore.

THE MAGISTRATE: About a half hour ago she estimated she would be here in half hour. It's 10:03 now. Does she have an estimate?

DR. PADMANABHAN: No, Your Honor.

THE MAGISTRATE: I'm looking at her limited appearance, and it seems to me that Lisa Siegel Belanger is not seeking to conduct the cross examination for you. Is that your understanding?

DR. PADMANABHAN: Yes.

THE MAGISTRATE: Mr. Paikos, do you see any problems with starting without Ms. Belanger?

MR. PAIKOS: I think the confirmation that she is not representing him at this stage or finding of that nature, a confirmation that she is not representing him for purposes of Dr. Levin's testimony, cross examination of the testimony I think is important to get on the record. That way there is no issue relative to

him not being here with counsel. It would be best if we hear it from her as well.

THE MAGISTRATE: That is what I'm going to do is wait to hear from her. She is more than stuck in traffic, she is also dropping off, she is also dropping off --

DR. PADMANABHAN: But she is on her way here. There was a delay.

THE MAGISTRATE: Are you in touch with her? Do you have her cell phone number?

DR. PADMANABHAN: Yes.

THE MAGISTRATE: Can you call her and get the best estimate. I'll wait a minute or two on the bench.

[Pause]

DR. PADMANABHAN: Almost at Government Center.

THE MAGISTRATE: She is going to have to park. It's 10:05 now. Let me come back on the bench at 10:15.

[Recess]

THE MAGISTRATE: Back on the record. It's 10:16 and we're back on the record. Dr. Padmanabhan, do you have information from

your lawyer?

DR. PADMANABHAN: She's running from Government Center garage.

THE MAGISTRATE: I'm wondering whether to start. We have her motion which says she is making a limited appearance. We have Dr. Padmanabhan saying he is willing to start his cross examination. This proceeding has got to proceed. It's been delayed long enough.

MR. PAIKOS: I think we can proceed given that Dr. Padmanabhan has asserted that she is not going to represent, he is going to do the cross examination of Dr. Levin, whatever her role is.

THE MAGISTRATE: So let's proceed. I'm going to start the hearing officially. Today is March 6, 2015. This is the hearing of the Division of Administrative Law Appeals held at the Civil Certificate Commission, One Ashburton Place, Boston, Massachusetts. This appeal has the docket number RM 14-363. The petitioner is the Board of Registration in Medicine, the respondent is Bharanidharan Padmanabhan, MD. I am Administrative Magistrate Kenneth Bresler.

James Paikos, Esq. represents the petitioner. Lisa Siegel Belanger, Esq. has made an appearance, a limited appearance for Dr. Padmanabhan. She is not here right now. That conversation is on the record about her whereabouts.

All electronic devices that make noise should be off. There will not be and should not have been any recording devices or cameras used during the hearing. Members of the public, you are welcome to attend but you cannot record or use a camera. The decorum that you will give this proceeding is typical of a judicial court. You cannot address me in or outside of the hearing room.

The hearing will end at 3:30 today. The parties have to vacate expeditiously, they cannot linger. There is more that I wish to say, but I wish Ms. Belanger was here because I don't want to repeat myself, but I suppose I'm going to when she gets back here.

There will be no nodding of heads or shaking of heads by anybody in the hearing room in agreement or disagreement of anything that is

said.

With that I'll ask if the parties have any evidentiary short matters. This is an evidentiary hearing, not a motions hearing. Any preliminary matters before I swear in Dr. Levin?

MR. PAIKOS: No.

DR. PADMANABHAN: No, Your Honor.

THE MAGISTRATE: Both parties have said no. Dr. Levin, I ask you to stand.

BARRY LEVIN, MD, SWORN

THE MAGISTRATE: Please be seated. Dr. Padmanabhan has some questions for you.

CROSS EXAMINATION BY DR. PADMANABHAN

Q Good morning. Please turn to tab 9 of the petitioner's binder, the government's binder, Patient H, MR287, Bates 221.

THE MAGISTRATE: The exhibit again?

DR. PADMANABHAN: Tab 9, MR287, Bates 221.

[Woman enters]

THE MAGISTRATE: Are you Ms. Siegel Belanger?

MS. BELANGER: I'm sorry for the delay.

THE MAGISTRATE: Lisa Siegel Belanger?

MS. BELANGER: Yes.

THE MAGISTRATE: We were just about to start Dr. Padmanabhan's cross examination of Dr. Levin based on his representation that he would be handling it and based on my reading of your notice of appearance. Is he going to be conducting the cross examination?

MS. BELANGER: I will be allowing the doctor to be doing the cross examination of Dr. Levin. My purpose is to be able to represent during the examination, during my client's examination.

THE MAGISTRATE: You are also filing motions for him?

MS. BELANGER: Yes, I will be.

THE MAGISTRATE: So I'll be accepting motions from you and not from Dr. Padmanabhan?

MS. BELANGER: That's correct.

THE MAGISTRATE: Let me say some things that I did not say before. I addressed members of the public, more members of the public have joined us. There is no security officer here or court officer here and no bailiff. Members of the public will abide by decorum typical of a

judicial proceeding. If they do not, I will exclude them from the hearing room. I do not have a security officer, but there are state troopers in the lobby. If necessary, I will summon them to enforce decorum in this hearing room and to exclude people from the hearing room and the building.

I might ask questions of both sides. My asking questions does not mean that I have taken sides or that I have decided the case already. We will be doing a balancing act. We will get the benefit of the informality of an administrative law hearing but we will not discard all rules of procedure and evidence.

Ms. Belanger, I expect you to be familiar with 801 CMR as I have expected Dr. Padmanabhan, Standing Order 13.1 and DALA's website.

If anybody needs a break, let me know, I'm aiming to break for lunch around 1:00 o'clock. To remind the parties Standing Order No. 1 bars you from communicating with me by e-mail. You can communicate with me by fax or US mail, you cannot send the same thing by both methods. Do you not send me the same thing by

fax twice. Put a docket number on everything and send it to the other side.

I will not allow a party to refresh a witness's memory by showing a witness a document that he or she has never seen before. I will not allow a party to impeach a witness by showing a document that another person prepared recording that witness's words. I will not allow a party to ask one witness to comment on another person's testimony.

If you start a question with "would it surprise you," I will stop you. It's an improper cross examination question. "Would it refresh your memory if I told you," I'm going to stop you. That is not a way to refresh memory. "If I suggested to you," I'm going to stop that question, too. I'm allowed to see where a question, especially a leading question is going and stop it before a lawyer has led the witness.

I ask the parties to remember there is no jury, you don't have to make a point multiple times. The purpose of redirect examination is not to make your best point a second time. The purpose of recross examination is not to make

your best point a second time. I might allow one side to explore a subissue and decide it's not relevant and not let the other side explore it. There is no prejudice to the party because there is no jury.

With that, Dr. Padmanabhan, I'm going to ask you to resume your cross examination.

DR. PADMANABHAN: Thank you.

Q (By Dr. Padmanabhan) Dr. Levin, at the bottom of page MR287 there is a statement, "possibly flow related." I would be grateful if you would explain flow-related ischemia to Magistrate Bresler.

MR. PAIKOS: If I might get the Bates number again.

DR. PADMANABHAN: MR287, Bates.

THE MAGISTRATE: Dr. Padmanabhan, you dictated this, right?

DR. PADMANABHAN: Yes.

THE MAGISTRATE: Will you be testifying about this?

DR. PADMANABHAN: I can.

THE MAGISTRATE: Wouldn't it be more efficient for you to explain it?

DR. PADMANABHAN: He has commented on it once before, so I need to explore that on cross, the cross examination.

THE MAGISTRATE: Then you have explained it. He may answer.

MR. PAIKOS: May I confirm which patient?

DR. PADMANABHAN: Patient H, MR287, Bates 221.

A Brain functions on the basis of blood flow to the brain to major blood vessels called arteries. Two major blood vessels in front, the carotid arteries, major vessels in the back called vertebral arteries that come together to form the basal artery. The carotid arteries supply the brain in the anterior and mid portions. The vertebral vascular system supplies the blood flow to the back portion of the brain, the posterior portions of the brain and to the brain stem as well as to the cerebellum, the part of the brain that is involved with coordination.

When there is decreased blood flow to a portion of the brain, this will result in neurologic symptoms. It's commonly referred to

as a transient ischemic attack, "attack" meaning something that occurs suddenly. "Ischemia" is the medical term that means less than normal brood flow; "transient" means something that occurs and will reverse itself. So someone will present neurologic symptoms, perhaps weakness in one side of the body, slurred speech that will occur when there is decrease in blood flow. As the blood flow is restored, those symptoms will resolve. That is referred to as transient ischemic attack.

Q Why did I order a carotid Doppler?

A I can hypothesize and state why I would have ordered it, but I can't speak to your mind, sir.

Q Why would any neurologist order a carotid Doppler in this patient?

A To determine whether or not there was a problem with the carotid circulation.

Q Are you aware of the work by Luke Kaplan on positional cerebral ischemia?

A I actually know Dr. Kaplan. I'm aware of much of his work. I'm not sure -- I cannot state I specifically know what his work is on that particular diagnosis.

Q Are you aware that a severe carotid stenosis or occlusion can cause flow-related ischemia?
A Yes.
Q Have you heard of limb-shaking TIA?
A Yes.
Q Also known as Mike Pessin syndrome?
A I'm sorry, I didn't understand the last thing you said.
Q Limb-shaking TIA also known as Mike Pessin syndrome.
A I have never heard of Mike Pessin syndrome.
Q Are you familiar with patients with occlusive carotid disease?
A Yes.
Q Please turn to MR300, Bates 223. How often do you see radiology reports, Dr. Levin?
A On a daily basis.
Q When Magistrate Bresler asked you the difference between reason for exam and indication, you were unable to explain it. May I know why?
THE MAGISTRATE: You can pose it as a question.
Q Why did you not make clear to Magistrate Bresler that reason for exam is what is on the

requisition and indication is what the radiologist states for coding and billing purposes?

A I don't understand your question.

Q On the top of this page here Magistrate Bresler had a question for you about indication versus --

THE MAGISTRATE: Dr. Padmanabhan, I'm going to ask you to confirm that he remembers that. This hearing has been going on since January.

Q Let me ask again, Dr. Levin. On this page there is a reason for exam, and then there is an indication. Can you explain the difference between the two?

A Frequently I think that the reason for exam and indication for exam are terms that are used interchangeably.

Q Why would a radiology report consistently have both?

A I'm not sure.

Q In the middle portion of this page there is a sentence the radiologist has written, quote, the pattern is nonspecific, unquote. In your

opinion is that an objective finding or an impression?

A That is an objective finding.

Q The pattern is nonspecific?

A Yes.

Q The report states there is some involvement of the callosal-septal interface. What does that mean to you?

A That the region between the corpus callosum and the areas around the corpus callosum show some involvement of the white matter.

Q What does "less likely" mean to you?

A That the possibility of that occurring is less than you expect.

Q Does it shut the diagnosis out completely?

A No.

Q You had mentioned that this patient had no exacerbations and remissions. If that is true, why are we talking about a TIA?

THE MAGISTRATE: Again, Dr. Levin, if you don't remember the basis of the question, you can say so. I'm not saying that is not the case, but there has been, you've testified for days, so --

A I don't understand your question.
Q Never mind. You had told Magistrate Bresler that one needs symptoms involving both the left and right sides to be diagnosed with MS. Was that a hundred percent?
A I don't remember stating that.
Q Okay. I ask you today, Dr. Levin, does one need symptoms both for the left and right side to be diagnosed with MS?
A No.
Q Turn now to page 344 Bates 230. You said to Magistrate Bresler that my sentence here, "The sagittal flair sequence is extremely suggestive of multiple sclerosis" was incorrect because the radiology report did not mention it. Actually you said that Dr. P is wrong.
THE MAGISTRATE: You need to have a question rather than make statements.
Q How do you decide whether the neurologist is correct or the radiologist is correct?
A It is a generic question that I cannot answer.
Q In this case how can you opine that my diagnosis of MS of this patient based on my read of the MRI was incorrect because it was not in the

official radiology report?
A Reviewing the information about the MRI report March 7, 2008, the report --
Q Dr. Levin, how did you decide that the radiology report was correct and I was wrong?
MR. PAIKOS: Objection. He was answering that question.
THE MAGISTRATE: I'm going to take it as Dr. Padmanabhan is reasking the question. I'll allow him to reask the question.
THE WITNESS: Repeat the question.
Q Dr. Levin, how did you decide in this patient given these documents that the radiology report was correct and my read of the MRI was wrong?
A The March 7, 2008 brain MRI report from the radiologist indicates moderate amount of sub-centimeter T-2 hypertense fossae are scattered in the periventricular and subcortical white matter mostly on the frontal and parietal lobes. The pattern is nonspecific. No lesions demonstrate Dawson's fingers morphology pattern of multiple sclerosis, but there is some involvement of the white matter along the callosal-septal interface. There are no lesions

within the corpus callosum or posterior fossa.

The impression was moderate amount of nonspecific supertentorial white matter change. Common etiologies include chronic microvascular ischemia and/or idiopathic change. Less likely potential etiology includes demyelinating disease.

The report appears to be straightforward. The radiologist did not equivocate, and he is describing very specifically what he sees. The description is a common description of a type of MRI that we see. Oftentimes I will see it in the office sometimes on a daily basis where we see very small areas of increased T-2 signal. They are very tiny, they are nonspecific, and these are not the type of changes that one sees in multiple sclerosis. In multiple sclerosis the type of changes are very different.

The report that you described in your note was that the sagittal flair sequence is extremely suggestive of multiple sclerosis but should of course fit in with a lot of symptoms that she has had. She has quite a few lesions on the MRI, she has typical Dawson fingers

coming off the ventricle, she has some pericallosal lesions as well as one fairly large extracortical lesion and two very prominent lesions coming off the ventricle in the occipital lobes.

Q Were any of those lesions mentioned in the official radiology report?

A No.

THE MAGISTRATE: Dr. Padmanabhan, before you ask another question, when you are reading from the radiological report, is that in the exhibits?

THE WITNESS: Yes.

THE MAGISTRATE: Can you give me a Bates number, please.

DR. PADMANABHAN: It was the previous one, sir.

THE WITNESS: Page 300. I don't have a Bates number.

THE MAGISTRATE: Medical record 300.

THE WITNESS: Those were my notes from my, when I read through that particular report. I can go back to the report itself if you wish.

THE MAGISTRATE: Just for location in the

exhibits. Thank you.

THE WITNESS: Would you like me to complete my answer to your question?

DR. PADMANABHAN: No, thank you.

We are now on tab 21 in the respondent's exhibit binder.

Q Dr. Levin, on page two, tab 21 please read out loud just Report 1.

THE MAGISTRATE: Let me ask, have you seen this before?

THE WITNESS: No.

THE MAGISTRATE: Can he read it to himself?

THE WITNESS: I'm not sure -- Would you like me to read the page to the right? I have no specific information. I think this is tab 21?

DR. PADMANABHAN: Tab 21, page 2, Report 1.

THE WITNESS: Beginning with "from Thomas Glick"?

DR. PADMANABHAN: Yes, that is page 1. Page 2 his report.

THE WITNESS: I have one page.

THE MAGISTRATE: Dr. Padmanabhan, you are pointing to Report 1 about three quarters of the way down?

DR. PADMANABHAN: Yes.

THE WITNESS: For the sake of knowing whether I have seen this before or not, Doctor, is this the same MRI report that I reviewed previously?

DR. PADMANABHAN: No, sir, you have not seen this before.

THE MAGISTRATE: While Dr. Levin reads that, Dr. Padmanabhan, let me ask you, how many cross examination questions will be based on exhibits that Dr. Levin has not seen?

DR. PADMANABHAN: About five pages total. Total number of questions is probably a dozen.

THE MAGISTRATE: Let's see how it goes.

THE WITNESS: I have read the report.

Q (By Dr. Padmanabhan) If you turn to page 1 and start from the last paragraph from the arrow pointing down.

THE MAGISTRATE: Page 1 of tab 21?

DR. PADMANABHAN: Yes.

THE MAGISTRATE: He just read page 2 at

your direction.

DR. PADMANABHAN: Yes, the official radiology report.

THE MAGISTRATE: Now you are asking him to read a second part of the exhibit?

DR. PADMANABHAN: Correct.

THE MAGISTRATE: Starting?

DR. PADMANABHAN: My read of this man's MRI.

THE MAGISTRATE: The complete page 1?

DR. PADMANABHAN: No, sir, at the bottom.

THE MAGISTRATE: Dr. Levin, do you see that?

THE WITNESS: Yes. Excuse me, would you like me to read the second report as well?

DR. PADMANABHAN: I would like you to read the last paragraph of page 1 going onto page 2. After that I would like you to read Report 2.

THE WITNESS: I completed this information.

Q (By Dr. Padmanabhan) Please tell Magistrate Bresler what conclusions you draw with the official radiology report.

A I did not draw any conclusions. I have not seen the images.
Q In the case of the previous patient, Patient H, you were confident enough to declare to Magistrate Bresler that this patient does not have multiple sclerosis without reviewing the images yourself. Why do you need to review the images --
THE MAGISTRATE: Dr. Padmanabhan, I need you to ask questions, not make statements.
Q Why do you need to see the images in this case, Dr. Levin, when you did not need to see the images for Patient H?
A My preference is to see the images. The images were not available for Patient H. You asked me to comment on the two reports that you just gave me in this binder. My response was it was difficult for me to comment on this not knowing anything about the patient. Just looking at the reports whether or not the reports are accurate, I couldn't comment on that without actually seeing the images.
Q Thank you.
A May I put this binder aside?

Q We are going to deal with more pages. Please describe to Magistrate Bresler the difference between Report 1 and Report 2.

A Report 1 patient's name is OH, study date April 25, 2008. MRI of the brain without contrast. Clinical indication, new onset psychosis. Study was performed of the brain without contrast. Findings were scattered areas of T-2 hyperintensity in the central white matter, but these are nonspecific. Otherwise, the signal intensity of the brain parenchyma appears normal throughout. No evidence of hemorrhage, massive infarct or midline shift. Mild atrophy is noted and there is loss of tissue in the brain. The major arterial and venous flow voids appear normal, so the circulation to the brain appears normal.

The visualized portions of the mastoids, orbits and calvarium appear unremarkable. Minimal sphenoid sinusitis changes are noticed, so minor changes within the sinuses.

Summary was nonspecific white matter changes. The differential diagnosis includes idiopathic white matter demyelination, small

vessel chronic disease and post infection.

So this is a nonspecific MRI of the type that I described previously. There are mild scattered areas of T-2 hyperintensity that are felt to be nonspecific. The doctor lists possible diagnoses as is done with nonspecific studies. It does not mean he is making a diagnosis, he says these are nonspecific, minor changes and possible diagnoses.

Exam 2, first exam was April 25, 2008. Report 2 is 5-8-2008. There is no patient name listed, no date of birth, no ID, there is nothing else that identifies the patient in any way on this report. It just says Report 2.

Exam was MRI of the brain in contrast. Reason for the exam is sagittal flair of entire brain. History is follow up to brain MRI done on 4-25-2008 for sagittal flair sequence.

The sagittal sequence is the sequence of the brain where we look at the brain from the side. So this image is now going to be from the side. The flair sequence is the sequence that is used for looking at different types of brain tissue. It's quite helpful when you are looking

at white matter disease.

It should be noted that neither of these studies were done with contrast material, so that would leave out the possibility of seeing any areas that show enhancement as we would see with active MS lesions.

The findings are sagittal T-1. That is a particular sequence that is helpful to look at anatomic changes, particularly loss of tissue, but it shows a lot of other matter as well. And sagittal flairs sequences are obtained. MRI of 4-25-2008 is reviewed as described on prior MRI of 4-25-2008, and moderate T-2 hyperintensity. I'm reading verbatim.

THE MAGISTRATE: I'm going to ask you to interpret it, if you could, because I do have it in front of me.

THE WITNESS: Moderate T-2 hyperintensity is seen on the periventricular and central white matter, so there are areas of increased T-2 signal on the flair sequence that would show up as white, areas of white abnormality. So areas would be whiter than the surrounding brain which would be gray or black. So T-2 hyperintensity

would be increased signal. They look white on the periventricular region which is around the normal fluid-filled spaces of the ventricles, so it's around the ventricles and the central white matter. So around the ventricle going further out is the white matter areas outside of the ventricles as well which is mostly confluent, meaning that the areas of T-2 signal are rather large and that the specific areas are coming together to form confluent areas of T-2 signal of increased white seen on the study including high signal emanating from the septal-callosal interface. There is increased signal seen at the corpus callosum and the area round it, the septal-callosal interface. The corpus callosum is the area in the brain that connects the two hemispheres in the brain and enables signals to go back and forth from one hemisphere to the other corpus callosum.

There is thinning of the body of the corpus callosum with involvement of the undersurface and more prominent involvement in the splenium of the corpus callosum. That is a portion of it.

Impression. Limited study done as follow-up imaging with only sagittal T-1 and sagittal flair sequences performed. What that states to me is this is a limited study. The radiologist does state that the MRI from 4-25-2008 was also reviewed, so the doctor would have the previous images from the entire study of 4-25-2008 plus the additional sagittal T-1 from the side looking at the T-1 sequences looking at the anatomy, sagittal flair sequences as described. Again seen is moderate white matter hyperintensity which is mostly confluent involving the septal-callosal interface and corpus callosum as described above. Multiple sclerosis is in the differential diagnosis and clinical correlation is required.

These interpretations are quite different. It isn't clear to me why there would be such radically different interpretations of two studies. The interpreting radiologist of the second study does have additional sequences, but with additional sequences I would not expect there to be such a difference in the interpretation of these two studies.

The doctor reading the second study -- Again I'm assuming that this is the correct patient. I don't know that this is the correct patient because I have no identifying information, neither name, initials, birth date, anything telling me that this is indeed the same patient. Assuming it's the same patient, I cannot explain why there would be such a radically different interpretation by the two doctors.

The diagnosis, multiple sclerosis, is a differential diagnosis. I don't know if this is a man or woman. Is stating it's a possibility, but the clinical correlation is required that the study is clinically significant as relates to this particular person. If this information, the study relates in the appropriate fashion, this patient may have multiple sclerosis.

Q Thank you --

THE MAGISTRATE: Dr. Padmanabhan, I have a question for you, if I may: Is this a patient who appears in the Statement of Allegations?

DR. PADMANABHAN: No, sir, but Dr. Levin has testified about the accuracy of reports that

he takes the official radiology report as accepted and that my read is inferior, so therefore we are supposed to cross examine him on the accuracy of radiology reports and whether we should hang our hat on him.

THE MAGISTRATE: This is not to refute the Statement of Allegations?

DR. PADMANABHAN: It is to refute the Statement of Allegations, please, with Patient H.

THE MAGISTRATE: Is this about Patient H?

DR. PADMANABHAN: The radiology report is about Patient H.

THE MAGISTRATE: Is this a radiology report --

DR. PADMANABHAN: No, no, no. This is a report about a different patient, Your Honor, but he has declared to you that the official radiology report does not say this person has multiple sclerosis, therefore Dr. Bharani's conclusion is incorrect. Therefore, I think it's fair that we should look at two official radiology reports on the very same patient done a week apart.

THE MAGISTRATE: This is far afield. You know what? We're done with tab 21. This is taking a lot of time. It's not directly related to the Statement of Allegations.

DR. PADMANABHAN: One question more, Your Honor?

THE MAGISTRATE: No. We're done with tab 21. We spent enough time on it which does not have to do with the Statement of Allegations.

DR. PADMANABHAN: It has to do with Dr. Levin's statement that it was the --

THE MAGISTRATE: Next question.

Q (By Dr. Padmanabhan) Please turn to tab 18.

A May I remove the binder that you gave me?

Q No, tab 18 in that binder.

THE MAGISTRATE: Which patient does this have to do with?

DR. PADMANABHAN: Has to do with my ability to read MRIs which is the Statement of Allegations.

THE MAGISTRATE: Does it have to do with a particular patient?

DR. PADMANABHAN: The Board has declared that I don't know how to read MRIs and I have

harmed Americans by misdiagnosing them with multiple sclerosis because I read MRIs incorrectly; therefore, in my defense I have to show that I have, that I know how to read MRIs.

THE MAGISTRATE: You cannot disprove the Statement of Allegations by proving that in other circumstances you performed well as a doctor. That is not what the hearing is about.

DR. PADMANABHAN: Your Honor, the state has declared that the official report --

THE MAGISTRATE: Dr. Padmanabhan, the Statement of Allegations are patient specific. I have not let you and I will not let you now introduce evidence to prove that in other circumstances you have not provided standard of care or above standard of care.

DR. PADMANABHAN: Your Honor, in Patient H I have also provided the same standard of care that I provided to all my other patients, and it is imperative that I show that the official radiology report should not be depended on exclusively.

THE MAGISTRATE: I understand your position, but you are not introducing evidence

to show in other circumstances of other patients you did not provide substandard care.

DR. PADMANABHAN: There was a series of patients --

THE MAGISTRATE: Dr. Padmanabhan, next question. That is not about tab 18. This is not new.

DR. PADMANABHAN: Just as with Patient H, Your Honor, --

THE MAGISTRATE: Dr. Padmanabhan, next question. I have been telling you this since the prehearing conference.

Q (By Dr. Padmanabhan) Tab 9, please. Dr. Levin, you have stated today and previously that no contrast was provided so one cannot find active multiple sclerosis lesions. Is that a hundred percent true statement?

A It's a difficult question to answer. There is -- It is not a yes or no question.

Q Your statement to Dr. Levin was quite categorical, no contrast was given so one cannot find active MS lesions. Is that a hundred percent true statement?

THE MAGISTRATE: Dr. Padmanabhan, you can

ask a question and confirm that he said that, but that is a premise that, I'm not going through the transcripts to confirm that he said that. Ask a question, please, rather than a statement about what Dr. Levin testified to. You may be correct, but I'm not confirming that.

Q (By Dr. Padmanabhan) Dr. Levin, do we need contrast to find active MS lesions?

A Under most circumstances in almost all patients, yes.

Q Do we see a lot of patients with multiple sclerosis and active lesions these days?

A It's a generic question that I cannot answer.

Q Can there be active lesions that are contrast negative?

A Yes.

Q In tab 9 if you go down to the assessment and plan section.

THE MAGISTRATE: Dr. Padmanabhan, tab 9 is about which patient?

DR. PADMANABHAN: Tab 9 is about a different patient of mine. We are looking at the radiology report.

THE MAGISTRATE: Is this a patient who is

in the Statement of Allegations?

DR. PADMANABHAN: No, but it's about contrast required to look at active lesions, so it's very clear responding to his testimony.

THE MAGISTRATE: You can ask him about the subject matter but not about tab 9 because we are not looking at other documents related to patients that are not in the Statement of Allegations.

Q Dr. Levin, can there be patients with massive multiple sclerosis attacks and no contrast enhancement on MRI?

A Yes.

Q Do you always give contrast for your multiple sclerosis patients when you send them for MRI scan?

A Yes, unless there is a contraindication to giving contrast.

Q What is the contraindication to giving contrast?

A The rare complication of allergy. If there is kidney dysfunction, someone's function is not normal, it may prevent them from having this as well.

DR. PADMANABHAN: We now turn to the

image that you showed Magistrate Bresler that was downloaded from the internet.

THE WITNESS: May I move your binder aside?

DR. PADMANABHAN: Yes. I'll take it back, with permission, Your Honor.

THE MAGISTRATE: Yes.

DR. PADMANABHAN: Do you have the image, sir?

THE WITNESS: I do not.

THE MAGISTRATE: Is there an exhibit number?

MR. PAIKOS: I don't remember the exhibit number. It was looked at electronically during the hearing, and I sent it on Tuesday, a paper copy.

THE MAGISTRATE: It's a date of March 3. The Petitioner's Third Supplemental Exhibit List with Attachment and MRI showing Dawson's fingers and the cover letter?

MR. PAIKOS: Yes.

THE MAGISTRATE: I have that in front of me.

Q (By Dr. Padmanabhan) You previously told

Magistrate Bresler that the patient's record does not have the features present on the single image from the internet. Please show Magistrate Bresler the corpus callosum on this image.

A Holding up the image to show it to you, demonstrating this is a sagittal view of the brain, a view of the brain from the side. The patient's eyes would be here, this is the mouth, this region is the sinuses. This is the front, the back portion. This is the brain, this area the cerebral cortex. This is the normal fluid-filled space referred to as the ventricle. Looking superiorly from this ventricle this is a lateral ventricle --

THE MAGISTRATE: Let me make a comment here for the record. Dr. Levin has pointed to a large area in the middle of the image that is dark, a few inches across and is curved. Thank you.

Q Dr. Levin, please show Magistrate Bresler the corpus callosum.

A Looking at the lateral ventricle, just above the lateral ventricle is a white area coming around. That should be representing the corpus callosum

in this particular patient. I would need to have further images to go back and forth to establish information about it, but I do believe that is the corpus callosum above the lateral ventricle.

THE MAGISTRATE: You are pointing to a roughly crescent-shaped dark area in the middle of the image, is that right?

THE WITNESS: Yes.

THE MAGISTRATE: The corpus callosum is the dark image or is the white area above it?

THE WITNESS: The white area above it. The black area is the lateral ventricle.

Q (By Dr. Padmanabhan) Is it your testimony, Dr. Levin, that that area is the corpus callosum?

A Yes.

Q Have you seen MRI images before of the brain, Dr. Levin?

A Yes.

Q Do you know what a corpus callosum looks like, Dr. Levin?

A Yes.

Q Is that a corpus callosum, Dr. Levin?

A I think it is. As I said looking at this image,

it's difficult for me to say. It is in the region of the corpus callosum but very thin. I do not have a good view of it looking at this particular image. I think it may very well be the corpus callosum, but I'm not sure. It may be a lining of the ventricle.

Q Dr. Levin, how many years have you been practicing as a neurologist?

THE MAGISTRATE: That is on the record. Next question.

Q Why are you not sure if that is a corpus callosum or not?

A I only have a single image and I would need to have further images and look at the actual images to go back and forth to be able to establish what the exact structure is.

Q Dr. Levin, is it not the standard of care that we should as a neurologist be able to identify structures on a single image of the brain?

A The standard of care is that we be able to look at images of a study to be able to go back and forth and look at all of the appropriate images of a study to be able to identify structures and other areas of that particular study.

Q Dr. Levin, is it not required of us as neurologists to know what each image is as far as structures of the brain go?

A Yes.

DR. PADMANABHAN: Thank you. For the record this image does not contain a corpus callosum.

THE MAGISTRATE: Dr. Padmanabhan, as in the past, you cannot make statements, you can testify under oath.

Q Is it fair to say, Dr. Levin, when you looked at this image, you were guessing that this is the corpus callosum?

A As I stated previously --

THE MAGISTRATE: This has been asked and answered. There is testimony before me and I understand his answer.

Q Given that you were testifying about the corpus callosum, Dr. Levin, would it not have been imperative to show Magistrate Bresler an image with a corpus callosum in it?

THE MAGISTRATE: That is for Mr. Paikos to decide. Next question.

Q Dr. Levin, you said that a patient does not have

exacerbations and remissions. Is it necessary to have exacerbations and remissions for diagnosis of multiple sclerosis?

A Not always.

Q Would you say that your previous statement was not one hundred percent correct?

THE MAGISTRATE: I'm not going to allow you to ask that question. Next question.

Q In the year 2015 is it still necessary to have exacerbations and remissions for diagnosis of MS?

A Not always.

Q Is that a no?

A Not always. The standard of care still is for a patient to have more than one exacerbation, although in patients with clinically isolated syndrome we are able to make a diagnosis of MS sometimes with a single episode of neurologic dysfunction.

Q You had told Magistrate Bresler that the patient's imbalance is due to her fibromyalgia, quote, when the fibro got better, the balance got better, unquote. Please state one source that fibromyalgia causes balance trouble or

ataxia.

A I don't believe that I stated that her balance problem was due to her fibromyalgia. I was quoting your report, sir.

DR. PADMANABHAN: How do I cross examine direct testimony, Your Honor?

THE MAGISTRATE: I'm not here to -- Next question.

THE WITNESS: May I ask a question? Are we still on Patient H, or have we moved to a different patient?

DR. PADMANABHAN: We are going to go to MR364, Bates 198.

THE WITNESS: May I ask the question one more time? Are we still on Patient H, or have we moved to a different patient?

DR. PADMANABHAN: Different patient.

THE MAGISTRATE: We are on Patient G, correct?

DR. PADMANABHAN: Patient G, tab 8.

MR. PAIKOS: Bates 198. Page 364, tab 8.

DR. PADMANABHAN: First page in tab 8.

Q (By Dr. Padmanabhan) Dr. Levin, --

A Just to clarify, this is the page with the top

title Emergency Service Evaluation Form?

Q MR364, tab 8.

A I have page 364.

Q You described this page to Dr. Levin, to Magistrate Bresler as a progress note. How credible is your statement, Dr. Levin?

A At the top of the page it states progress notes.

Q Is that what you based your assessment on?

A Yes.

Q Would anyone believe you are a practicing neurologist when you look at this and say, oh, look, --

THE MAGISTRATE: I'm not going to allow that question. Next question.

Q Is this a progress note, Dr. Levin?

THE MAGISTRATE: Asked and answered. Next question. Asked and answered. Next question.

Q We now move to MR434, the next page, Bates 199. You told Magistrate Bresler who asked you a question what are these numbers, and you said these are CPT codes. Is that one hundred percent correct, Dr. Levin, that these are CPT codes?

A Would you be more specific in your question?
Q Magistrate Bresler pointed out the numbers next to the diagnoses. Migraine is 346, fibromyalgia is 748. You testified to Magistrate Bresler who asked you a question about the numbers that followed the diagnoses on this page, and your answer was these are CPT codes. Is that correct?
A These are diagnostic codes. I must admit I always get confused between CPT and the other types of codes. These are the diagnostic codes that are used to report the patient's diagnosis for billing.
Q So it wasn't a hundred percent correct that these were CPT codes?
THE MAGISTRATE: Next question. Dr. Padmanabhan, this proceeding has got to proceed. It started 50 minutes late.
DR. PADMANABHAN: Understood.
Q We have here a diagnosis, inflammation of the central nervous system with an ICD9 code of 323.9C. Do you know what the ICD9 code stands for?
A No.

Q If an ICD9 code exists for a diagnosis, would you accept that the diagnosis --

THE MAGISTRATE: No, you cannot ask it. You cannot feed him information. Ask a question.

Q You told Magistrate Bresler that this diagnosis, inflammation of the central nervous system, 323.9, is a pathology diagnosis and not a clinical diagnosis. Can you prove that?

THE MAGISTRATE: Next question.

DR. PADMANABHAN: Your Honor, --

THE MAGISTRATE: You can ask a question about it but not proving it.

DR. PADMANABHAN: It goes to his testimony, Your Honor.

THE MAGISTRATE: No. Dr. Padmanabhan, I'm asking you to ask another question. I am not asking you for an argument about my ruling. You can ask a question about that not involving the word "prove." Restate the question.

Q (By Dr. Padmanabhan) Is it true, Dr. Levin, that ICD9 code 323.9 is a pathology diagnosis and not a clinical diagnosis?

A It's an ICD9 code, and ICD9 codes are clinical

diagnoses.
Q You say that your statement was not correct, that this is a pathology diagnosis and not a clinical diagnosis?
A No.
Q Are you sticking by your statement that this is a pathology diagnosis and --
THE MAGISTRATE: He is. Next question. You can follow up on this, but not that question.
Q Magistrate Bresler asked you how Plaquenil worked, and you said you did not know. Have you looked it up since, this past month?
A No.
Q What class of drug is Plaquenil?
A Used for rheumatologic disorders.
Q What class of drug is it?
A I'm not sure.
Q What is the generic name for Plaquenil?
A Hydroxychloroquine.
Q Can you name similar drugs?
THE MAGISTRATE: Next question.
Q Are you aware that patients are placed on Plaquenil daily for the rest of their life?

A The question is beyond my expertise.
Q You explained to Magistrate Bresler that multiple sclerosis involved one peripheral nerve called the optic nerve. Is the optic nerve a peripheral nerve?
A It's an interesting nerve. It's a nerve that has the origin embryologically within the brain itself. As the brain develops, the optic nerve is an outpouching of the brain covered by the same lining as the brain and spinal cord and meninges but comes out as a nerve. Strictly speaking, the optic nerve is not a peripheral nerve but is commonly referred to as such.
Q Commonly referred to as such by whom, Dr. Levin?
A Practicing physicians.
Q Is that knowledge a minimal level that even the average neurologist should be expected to know that the optic nerve is not a peripheral nerve?
A As I stated, strictly speaking the optic nerve is a cranial nerve. Peripheral nerves are typically nerves that come off the spinal cord and into the arms and the legs. But the optic nerves oftentimes is referred to as peripheral nerve. It is not a nerve that is involved with

peripheral nerve disease, it's a nerve that is involved with disease of the cranial nerves and more specifically of the optic nerves.

Q What are oligodendrocytes?

A Oligodendrocytes are cells in the central nervous systems. Their function is to produce myelin.

Q What are Schwann cells?

A Schwann cells are also cells that produce myelin in the peripheral nervous system.

Q What is the oligodendrocyte Schwann cell transition zone?

THE MAGISTRATE: Dr. Padmanabhan, where are you going with this question?

DR. PADMANABHAN: His statement that the optic nerve is a peripheral nerve, and he has come to testify as an expert.

THE MAGISTRATE: This is far afield.

DR. PADMANABHAN: MR466 Bates 266, please.

THE MAGISTRATE: I'll reconsider, you can ask that question.

Q (By Dr. Padmanabhan) Pertaining to that question, Dr. Levin, what is the oligodendrocyte

Schwann cell transition zone? MR466 Bates 266. Magistrate Bresler asked you a question, any thought of being diagnosed on MS, and you said yes, it is a significant problem. Do you have any evidence from this record that the patient was troubled by the diagnosis? Patient G, MR466.

A I would need to go back and review a large amount of record to answer your question.

Q I refer you to the assessment and plan portion of the page 466.

A Which portion?

Q Assessment and plan, A/P. There is a paragraph that says she is relieved. Have you read it?

A Yes.

Q Does that sound like a patient who is upset with the diagnosis of MS?

A No.

Q Thank you. How comfortable are you, Dr. Levin, that the genuine MS patient who had been feeling better under my care is now consigned to a psychiatrist on the basis of inexpert neurologic opinion?

A I can't answer that question, sir. It's a very

general question.
Q This was your testimony about this patient, Patient G?
THE MAGISTRATE: You can ask a question, but you cannot make statements, Dr. Padmanabhan.
Q Moving on, you told Magistrate Bresler that the prescription for methadone is not written for pain. Is that one hundred percent true?
A Excuse me, have we moved to a different patient?
Q We are discussing your testimony now.
A May I put these papers away regarding this patient?
Q Please.
A Is there a different record that you would like me to pull out?
Q No, thank you. You testified to Magistrate Bresler that methadone is not written for pain. Is that one hundred percent true?
A No.
Q Why did you tell Magistrate Bresler that methadone is not written for pain?
A I would have to have the statement that I made read back to me if it is possible.
THE MAGISTRATE: I don't believe it is

possible.

DR. PADMANABHAN: We now move to Patient I. That is tab 10.

Q Dr. Levin, how many times have you as a physician stopped yourself from diagnosing someone with MS because the radiology report said MS is less likely?

A I can't answer that question. It's a generic question and I can't answer.

Q If you suspect a patient with multiple sclerosis and the radiology report says less likely, would you stop yourself from diagnosing that patient with MS?

A I would need to have the specific clinical circumstances and the specific patient to answer your question.

Q This is a patient that you examined and you think she had MS and the MRI comes back as less likely, would you diagnose that patient with MS?

A I would need to know a lot more information about the patient, why I would make the diagnosis about specifically what the MRI showed, what studies have been done, what other testing had been done. It would not be possible

for me to answer that hypothetical question.
Q Dr. Levin, supposing you are convinced in your heart of hearts that the patient has MS but the MRI report says less likely, would you go ahead and diagnose this person with MS?
THE MAGISTRATE: Asked and answered. Next question.
Q How often does MRI show inflammation, Dr. Levin?
A Not infrequently.
Q Your testimony to Magistrate Bresler about Patient I was that if the MRI did not show inflammation, she does not have it. Is that one hundred percent correct?
A I don't understand your question.
Q Your testimony to Magistrate Bresler was that as the MRI did not show inflammation, the patient does not have inflammation. Is that one hundred percent true?
A Your question is nonspecific, and I can't answer it.
Q If the MRI does not show inflammation, can the patient still have inflammation?
A "Inflammation" is a term that relates to the reaction of the body to any outside insult.

Inflammation can occur in any portion of the body. It can occur in someone's hand and cause an MRI that does not show inflammation, would not rule out inflammation anywhere in the body.

Q It's a simple yes or no question, Dr. Levin. If the MRI does not show inflammation --

THE MAGISTRATE: I'm going to strike that. Just ask your question. It does not occur to me as a simple yes or no answer.

DR. PADMANABHAN: His statement was categorical.

THE MAGISTRATE: Dr. Padmanabhan, do not make statements; ask questions.

Q (By Dr. Padmanabhan) How often does inflammation show up on MRI?

A Not infrequently.

Q Is MRI the gold standard test to rule out inflammation?

A Are you referring to inflammation in the brain?

Q Inflammation in the central nervous system.

A The MRI is an important tool to assess a patient who is felt to have inflammation of the central nervous system.

Q Is MRI the gold standard test to rule out

inflammation?
A I'm not sure specifically what you mean by "gold standard test."
THE MAGISTRATE: For what it's worth, I don't know if this is necessary for the record, Ms. Belanger is conferring with Dr. Padmanabhan during cross examination. I will allow it, but I do note it.
Q The government counsel asked you if a head CT would show inflammation, and you said possibly. Can you cite any sources to support this statement that the head CT shows inflammation?
A No.
Q How often have you treated patients with IVIG?
A Infrequently.
Q Were you aware before you came to testify in this professional Board hearing that I trained in IVIG therapy under Dr. Roper at the National GBS CIVB Center?
A No.
Q Magistrate Bresler asked you if IVIG was reasonable in Patient I, and you said no. On what basis did you say no?
A The patient who had many different diagnoses.

I'm looking at a list of diagnoses in your records. This patient was diagnosed with greater occipital neuralgia, neck pain, back pain, cervical dystonia, systemic inflammation, CNS inflammation, migraines, mixed connectivity disorder, fibromyalgia versus undifferentiated connective tissue disease, and reactive muscle spasm. I did not find a specific diagnosis that would be an indication for treatment with IVIG.

Q Is IVIG used only for specific diagnoses?

A Yes.

Q On the basis of what knowledge do you make that statement?

A On the basis of my experience as a practicing neurologist and my years of practicing as well as my background.

Q Would it be possible that there are people trained in IVIG who use IVIG for other diagnoses that you are not aware of?

A It is a general question that I can't answer.

Q Would you now move to MR1494. That is Bates 360. At the same time MR1565 which is Bates 366.

A That was 1494?

Q Yes, and 1565. Looking at page 1565, Bates 366, where is this conversation taking place?
A In a treatment room.
Q Looking at 1494 Bates 3630, where is this conversation taking place?
A I don't know. It's not indicated in the records that I can see.
Q In page 1565 does it say where this conversation is taking place?
A Yes.
Q Where?
A In the second-to-the-last line under Ruth Crouse, RN, middle of the line, "Dr. Bharani came into treatment room to briefly talk with (Patient I's name)." My assumption is the treatment was given in the treatment room.
Q The government's lawyer stated that I briefly talked to the patient and ordered IVIG on the basis of a brief conversation, and you concurred that my care was substandard as a result. Is that a true representation of the facts?
THE MAGISTRATE: You may answer.
A Yes.
Q Please read line one in Nurse Crouse's note on

page 1565.
A "This is Patient I's third IVIG infusion."
Q Since it's her third infusion, I did not start her on IVIG that day, correct?
A That is the assumption, yes.
Q Why is it an assumption, Dr. Levin?
THE MAGISTRATE: Next question. Please don't make faces at my rulings.
DR. PADMANABHAN: No, no, it's not about your ruling, Your Honor. I'm just perplexed.
THE MAGISTRATE: At the beginning of the hearing as I have done on every day, I have asked people not to shake their heads, make faces or otherwise react to what is said in the hearing room.
DR. PADMANABHAN: Understood.
Q (By Dr. Padmanabhan) The government's lawyer asked you joint pain is a rheumatological issue and you said yes, is that correct?
A Yes.
Q Is joint pain a rheumatological issue?
A Can be.
Q Is it a rheumatological issue as you stated?
THE MAGISTRATE: Next question.

Q Do you agree that it is legitimate for a subspecialty-trained neuroimmunologist to include joint pain among his concerns?
A Yes.
Q During your testimony you told Magistrate Bresler that fatigue and joint pain are side effects of IVIG, and Magistrate Bresler had you look it up and you were unable to prove it. Have you confirmed that fatigue and joint pain are not side effects of IVIG?
A I have no additional information.
Q You say that your statement was incorrect, sir?
A I don't recall looking up the information. If you wish, I could go back and review my sources once again.
Q You told Magistrate Bresler that IVIG itself is most concerning as a cause of the patient's headache. Is this true that IVIG itself is the cause of the patient's headache?
A I don't know.
Q Is there any indication from 2000 pages of that record that you have that this patient got aseptic meningitis on an ongoing basis from her IVIG?

A No.
Q Thank you. You told Magistrate Bresler that this case, Patient I, was the first time that you heard of monthly Solu-Medrol and IVIG staggered every two weeks. Would you say that speaks to your lack of expertise in this area?
A I once again need to know the specific context that you are quoting, sir.
Q Monthly Solu-Medrol and IVIG staggered every two weeks as I had for Patient I.
A Given the clinical circumstances of Patient I, particularly that there appeared to be no indication for treatment of this patient with either IVIG or Solu-Medrol, the fact that she received this medication on a staggered basis every two weeks appeared to be incorrect, and I could find no reason for this treatment.
Q Is this the first time you heard of staggering monthly Solu-Medrol and IVIG for any patient?
A I'm not sure.
Q What is the standard dose of IV Solu-Medrol prescribed by neurologists?
A A thousand milligrams.
Q Do you agree that decreasing generalized pain

and improving quality of life and daily functioning is important?

A Yes.

Q Do you agree that a physician should put in an effort to treat the patient's underlying condition and improve the quality of her life?

A Yes.

Q Do you agree from this record that the patient is being helped and she is happy for it?

A I don't know if she is being helped. I can't tell that. She states that she is feeling better, and she does indeed on the one particular page you pointed out to me she is happy for it.

Q Would you agree that this patient is engaged in a good-faith effort of treating her underlying condition and not simply demanding narcotic medicines?

A I can't speak to good-faith effort. That relates to your thinking, sir.

Q Magistrate Bresler asked you if it was the standard of care to write a prescription for Percocet daily if the patient had pain between visits, and you said yes. Given that you have

repeatedly testified that you never write pain medication for anyone no matter what --

THE MAGISTRATE: Dr. Padmanabhan, go right to your question, please.

Q Since you do not write pain prescriptions for anybody, is that not below the standard of care?

A No.

Q If a patient is in pain and needs pain relief --

THE MAGISTRATE: Dr. Padmanabhan, this is about your standard of care, not Dr. Levin's.

DR. PADMANABHAN: I'm done.

THE MAGISTRATE: This is it for your cross examination?

DR. PADMANABHAN: Thank you.

THE MAGISTRATE: Mr. Paikos, redirect? Does anybody need a break? Ten-minute break.

[Recess]

THE MAGISTRATE: We're back on the record. Are we ready to resume?

MR. PAIKOS: Yes.

REDIRECT EXAMINATION BY MR. PAIKOS

Q Dr. Levin, on cross examination you were asked about various criteria. What are criteria used for?

A For the establishment of the diagnosis.
Q When you are using a criteria, do you recall the entire, all of the parts of a criteria or do you reference some? How do you go through it when you are using a criteria?
A Depends on the criteria. Some are easy and I might know them off the top of my head. Frequently criteria are more complex and it would not be uncommon for me to go back and review the criteria for a diagnosis in order to properly use that criteria.
Q Do you have all the criteria memorized?
A No.
Q Did you review -- I think we discussed the Swanton criteria relative to Patient G. Following your cross did you review any materials regarding Swanton, written by Dr. Swanton?
A I did.
Q Did you apply the criteria in those materials to Patient G?
A Yes.
Q What was your conclusion whether they were correctly applied by Dr. Padmanabhan?

A They were not correctly applied.
Q What were the criteria and how were they applied?
A Swanton criteria were a group of MRI criteria that were used as an addendum, as an adjustment if you will, to the McDonald criteria. The McDonald criteria are a group of criteria that were established for the, to aid in diagnosing patients with MS. The criteria were first established, if I recall the first year, I believe 2001 and revised in 2005 and again in 2010. The McDonald criteria were developed to help doctors make an accurate diagnosis of MS. It can sometimes be difficult to diagnose patients with MS. They added MRI criteria to the clinical diagnosis. The McDonald criteria are difficult to use, very complex. You have to go through a large number of different areas, go through very specific statements to try to help to make your patient's diagnosis.

The Swanton criteria were developed by Dr. Swanton and his colleagues to modify the McDonald criteria and to make it easier and perhaps more accurate to diagnose patients with

MS. The specifics with regard to these criteria as the Swanton modifications to the McDonald criteria, a number of things are stated. First is that this is criteria for patients with clinically isolated syndromes, so patients who present with a single episode of neurologic dysfunction that may represent the first signs of MS. But in order to diagnose MS in the past, we needed multiple episodes in space, "multiple episodes in space" meaning more than one area of the central nervous systems is involved, multiple episodes in time meaning that more than one occasion occurs. The patient will have an episode now, perhaps another episode of neurologic dysfunction in three months or six months, a year. So multiple episodes in space, multiple episodes in times.

Clinically isolated syndrome means they have a single episode, a single episode of neurologic dysfunction. The most important thing both for the McDonald criteria and the Swanton criteria as specifically laid out is that patients' symptoms and presentation should be unambiguously typical of those seen in

multiple sclerosis. They give several examples of patients who present with a diagnosis that is absolutely typical of multiple sclerosis, and this includes unilateral optic neuritis, so involvement of the optic nerve --

THE MAGISTRATE: I'm going to interrupt. Do you have another question?

Q In applying these to Patient G, did that patient meet the Swanton criteria for MS?

A No.

Q Why not?

A I'll perhaps continue but try to go a little more concise. Patients need to have an unambiguous and typical of patients seen in MS, unilateral optic neuritis, involvement in the brain stem or partial involvement in the spinal cord. That's an important criteria. This patient did not fit that criteria.

This patient first of all did not have clinically isolated syndrome, and secondly, this patient had vague and multiple neurologic symptoms that were not consistent and were not typical of patients with multiple sclerosis and that would not fit the criteria.

DR. PADMANABHAN: Objection.

THE MAGISTRATE: Basis?

DR. PADMANABHAN: He is reading things now after testifying under oath in a licensing hearing against a trained specialist --

THE MAGISTRATE: I need a quick objection. What is the basis of your objection?

DR. PADMANABHAN: Lack of knowledge. We are not here --

THE MAGISTRATE: Overruled.

Q (By Dr. Padmanabhan) Doctor, you have talked about clinical presentation, clinical, I'm not sure if you said "symptoms." What does a clinical presentation mean in plain English?

A Clinical presentation would be typically broken down into two parts, patient's symptoms and patient's signs, and along with the patient's symptoms would be the patient's history. Symptoms are what the patient reported to you what they are feeling and what their problems are medically, and along with that would be the past history of the medical problems.

The clinical signs are what you observe. So in assessing the patient you listen to their

story, you feel what is bothering them and then you examine the patient, putting the two together and you hopefully will be able to come up with a diagnosis. That is known as a clinical impression or clinical diagnosis.

Q How do MRIs fit into that when diagnosing MS or any other condition?

A It's ancillary information. It's information that the MRI as well as any other medical test that you get gives you additional information for the patient that you are assessing. May give you information that confirms your diagnosis, may suggest another diagnosis, may tell you that your diagnosis is incorrect. MRI is particularly helpful in patients with multiple sclerosis given the type of disease MS is.

Q Doctor, relative to MS, have you yourself been involved in any MS societies?

A Yes.

Q What are those?

THE MAGISTRATE: That is on the record.

Q Doctor, do neurologists treat pain?

A Yes.

Q Do you treat pain?
A Yes.
Q Are narcotics the only thing that can be used to treat pain?
A No.
Q You were questioned if you remember about the difference between oxycodone and Percocet. Do you remember being questioned about that?
A Yes.
Q Did you confirm whether or not they were the same drug and if so, how?
A I did confirm they are not the same drug.
Q How did you do that?
A By looking at drug information on the, I think it's called Lexi, I think Lexi-Comp.
Q What is Lexi-Comp?
A Online database for medications.
Q There was a finding in one patient regarding anti-Sm, and you were asked questions about what that meant. Did you do any research as to what that was?
A Anti-Sm is an antinuclear antibody. It's used in assessing patients for possible rheumatologic disorders. It has a fairly high sensitivity for

lupus, but has a low sensitivity. Typically anti-Sm is after a patient comes back with a positive ANA, then you would go on secondarily to do the Anti-Sm. It could be helpful particularly in looking at patients you think have lupus. If it's positive, then there is a likelihood, but it's only seen in somewhere between twenty and fifty, perhaps thirty percent would be the average for patients with lupus.

Q And did Dr. Padmanabhan do follow-up relative to the anti-Sm finding?

A There was no indication in the records that he did.

THE MAGISTRATE: Mr. Paikos, which patient are we talking about?

MR. PAIKOS: I believe Patient G.

Q Doctor, the American, we talked briefly about the American Board of Psychiatry and Neurology as providing Board certification to neurologists and neurosurgeons. Are there subspecialties in neurology that you are aware of?

A Yes.

Q Is there one subspecialty certification for MS?

A No.

Q Is there one for pain?
A Yes.
Q Are there any other specialties that commonly used medication notes?
A Yes.
Q Is that neurology?
A No.
Q What are the other, what other specialties if any, is it common in?
A The only one I know of is psychiatry.
Q In your practice do you review notes of other physicians, neurologists and other specialties?
A Yes.

THE MAGISTRATE: What are medication notes?

THE WITNESS: It would be a note for a visit that is specifically for medications. For example a patient would come to see a psychiatrist, would not be a long follow-up note or therapy session, it would be a session where the doctor talked to the patient, see how they are doing on medication, see if they are having side effects, do a very brief evaluation, make a decision whether the medicine should be

continued or changed, and that would be documented. It would not be the usual fifty-minute session, for example, that psychiatrists would have but rather a shorter session and a shorter note.

Q Doctor, when we look at that examplar MRI, when you in practice when you get an MRI finding versus a report, the actual MRI, is it just one picture or multiple pictures?

A Multiple pictures. And the images themselves are not static images, this would be a series of images that you would go through almost like a slow-motion motion picture so you go from one image to another, so you are essentially trying to visualize the presentation within that image pattern.

Q Do you see different slices of the brain consecutively to get that motion picture?

A Yes. There are some studies where you can move them. For example, when you look at blood vessels, you can actually move the blood vessels around and look at the blood vessels in moving fashion.

Q And that MRI examplar that we saw in paper and

on the computer in January, that's the same one that showed Dawson fingers?

A Correct.

Q Do you remember for Patient I reviewing records that were subsequent to Dr. Padmanabhan's care for Patient I?

A No.

MR. PAIKOS: I have no further questions.

THE MAGISTRATE: Do you have any follow-up questions to Mr. Paikos' questions?

DR. PADMANABHAN: Yes, thank you.

RECROSS EXAMINATION BY DR. PADMANABHAN

Q Dr. Levin, you just testified that you see multiple pictures and images but as a slow-motion movie or motion picture. How many years in your practice have you had this capability to see images as a slow-motion movie?

A I don't believe that I said I see a slow-motion movie. I believe what I said was it was similar to seeing repetitive images as you might see in a slow-motion movie. I do not see a slow-motion movie.

Q How many years have you been able to do that, Dr. Levin?

A I don't understand your question.
Q How many years have you been able to move images electronically and seeing them as if in a slow-motion movie?
A I'm not sure. At least 2010 if not much longer.
Q Before you had the capability of looking at images electronically, how did you view MR images?
A With sheets of repetitive images.
Q Would you say that there are sheets of static images?
A Yes.
Q So each single slice would be a separate image?
A Correct.
Q And we would be required to read each individual slice as a separate image?
A Yes.
Q Similar to this picture here, this exemplar?
A Yes.
Q Why, then, did you not know that this does not contain the corpus callosum?
A As I mentioned before when I looked at images --
THE MAGISTRATE: This has been asked and answered. You cross examined him on this.

Q Dr. Levin, is it not the standard of care that a neurologist must be able to use static images on film?

A Yes.

DR. PADMANABHAN: Thank you.

THE MAGISTRATE: Is that it for your questions, Mr. Paikos?

MR. PAIKOS: Yes.

THE MAGISTRATE: We are done with Dr. Levin's testimony?

MR. PAIKOS: Yes.

THE MAGISTRATE: Thank you for your testimony, Dr. Levin.

[The witness was excused]

THE MAGISTRATE: Do you need a couple of minutes for Dr. Levin to collect his things?

MR. PAIKOS: Yes.

THE MAGISTRATE: While he is doing that, I know there has been discussion in past hearings as to the next testimony. Is that it for the Board's case?

MR. PAIKOS: Yes, it is.

THE MAGISTRATE: Dr. Padmanabhan, are you ready to testify for your case?

DR. PADMANABHAN: Yes.

THE MAGISTRATE: And you are the next witness?

DR. PADMANABHAN: I am.

THE MAGISTRATE: While Dr. Levin is leaving the hearing room, I'm looking at the witness chair. Should the table be moved?

MR. PAIKOS: We can do whatever setup works for Dr. Padmanabhan and his counsel. We can move our items. We can do that and sort of take a lunch break probably now and rearrange the room, or whatever works.

THE MAGISTRATE: Just a question of moving the table, right, slightly?

MR. PAIKOS: Yes.

THE MAGISTRATE: Why don't you take a minute to do that.

Ms. Belanger, do you think he will need the table to testify from documents?

MS. BELANGER: Do you need the table, Dr. Padmanabhan? It would be nice.

THE MAGISTRATE: We are going to move this table and then try to get that small table back there. We're doing a balancing act, giving

Dr. Padmanabhan a little bit of space but also trying to keep the parties separate to preserve their confidentiality and paperwork as well.

Mr. Paikos and Ms. Cooke, whatever works for the balancing act wherever the table is going to be.

Are you ready to proceed?

MS. BELANGER: Before we proceed with Dr. Padmanabhan as a witness, I would like to make an objection as to Dr. Levin's testimony as an expert witness, that his testimony shows that he does not qualify for an expert witness for the allegations alleged.

THE MAGISTRATE: Okay.

BHARANIDHARAN PADMANABHAN, MD, SWORN

MR. PAIKOS: I apologize for not bringing it up. I sent in additional exhibits which Dr. Padmanabhan filed an objection to, so I don't know if it makes sense to address them now or start with Dr. Padmanabhan's testimony.

THE MAGISTRATE: Let's take his testimony.

You may proceed, Ms. Belanger, direct examination.

MS. BELANGER: Sitting is appropriate for the questioning?

THE MAGISTRATE: You can stand if you want to stretch your legs if you are used to standing, or you can stay seated.

DIRECT EXAMINATION BY MS. BELANGER

Q Dr. Padmanabhan, could you please describe your education, qualifications, please.

A I did my MD Ph.D. together between '89 and '95, graduated summa cum laude. My Ph.D. was in multiple sclerosis. I then applied for residency training, and I was accepted at the Boston City Hospital program. The Boston City Hospital program merged with Tufts, so it became the Tufts amalgamated neurology residency program, and I graduated there in 2000 as a neurologist after four years of residency training.

I was accepted into Dr. Howard Weiner's prestigious lab at the Center for Neurological Diseases where I did a three-year fellowship in neuroimmunology specifically looking at chemokine, C H E M O K I N E, receptors, specifically CXCR6 and also the role of Vitamin

D. I did three years there with Dr. Weiner at the Brigham at the Partners MS Center, and I did an additional one year of purely clinical fellowship training in multiple sclerosis where I saw only MS patients at UMass Memorial in Worcester with Dr. Peter Riskind, professor of neurology at UMass.

Then I was hired by a group practice in southern Massachusetts in 2004 to set up in the Taunton area because they had a lot of MS patients down in the Taunton area with no trained MS specialist. Within a year I had 751 MS patients in my practice. It was the biggest practice between Boston and Providence. I did it solo, I didn't have a nurse or physician assistant. I worked from dawn to dusk. My patients were happy.

And in 2007 I was hired by Dr. Thomas Glick, professor of neurology at Harvard who wanted to set up the neurology service at Whidden Hospital because they didn't have any in-house neurologist at all and they were trying to make JCAHO standard. So in 2007 July I moved my practice to the Whidden Hospital in Everett.

I sent 400 of my MS patients to Dr. Sal Napoli whom I had hired as a fellow when I was a fellow at the Partners MS Center. He did a fellowship two years behind me. And I set Dr. Napoli up in Foxborough with his new MS center, and about 250 of my MS patients came to me at the Whidden to continue their care. They lived all over the state and they still do, and I have patients who came in from Holyoke, Chicopee, Dennis on the Cape. I was there at Cambridge Health Alliance, Cambridge Public Health Commission at Whidden Memorial Hospital from 2007 to 2010.

Q You spoke about having done a fellowship. How many fellowships have you done?

A Two in MS.

Q Again where specifically were those two fellowships?

A The first one was three years at Harvard Brigham and Women's Hospital Partners MS Center, Center for Neurologic Diseases, and the second one was one year at University of Massachusetts Memorial Medical Center in Worcester.

Q Are you able to describe the significance of being granted a fellowship?

A Yes, it was an extremely prestigious position. I was extremely blessed to have gotten that in Dr. Weiner's lab. I had seen Dr. Winner when I was in Budapest in 1994, and it was a dream come true to be his fellow in 2000.

A fellowship in MS used to be quite rare because most people didn't think that MS was particularly lucrative. They would rather do EMG fellowships because you could make a thousand dollars per patient ten times a day. MS fellowships were basically for people who really were interested in helping people with MS, and there weren't that many fellowships. When I joined in 2000, there are were only about five MS programs in the entire country, so it was a rare opportunity and blessing and I was very lucky.

Q Can you give an approximation about the percentage of doctors that are granted fellowships?

A Extremely small percentage going to MS fellowships. I think now in this country about a dozen a year out of a country of 330,000,000.

Q Have you published any articles?

A Yes, I have, in peer-reviewed journals.
Q Can you describe some of those articles, please.
A Some of the articles were pure immunology articles that I published when I was a fellow at Dr. Weiner's lab, XCl4 and XCl3. And I have also published other articles about MS, epidemiology. When I was a Ph.D. student, for example, my very first paper came out in 1997 and it looked at seasonality of MS. There have been numerous papers along the way. I published a paper in the Harvard Review of Psychiatry about a patient with epilepsy. So it's not just about MS that I have published. I have 20 papers or so to my name.
Q You spoke about when you started at the MS Center in southern Mass. Is it true that there were a number of patients that followed you to that place?
A About 250 patients followed me --
THE MAGISTRATE: Asked and answered. Next question.
Q In your opinion is that a common experience for a doctor to have patients --
THE MAGISTRATE: Let's move on. We have

a lot of substantive allegations to address. I take that as a compliment to Dr. Padmanabhan and the loyalty of his patients.

Q When did you start working at the Whidden Hospital?

A 2007, July.

Q Please describe again the manner in which you began working --

THE MAGISTRATE: Not describe again. We need to cover more material. Ask him another question.

Q Can you specifically state how you were hired to work at Whidden Hospital?

A Dr. Glick was reaching out for people who were willing to work for Whidden because it was a poor, underserved area of immigrants, and not many people were willing to work there.

Q Could you please state what Dr. Glick's position at the Whidden Hospital was.

A Chief of the division of neurology, and he was professor of neurology at Harvard.

Q As you began working at the Whidden Hospital, from your observations what did you determine the quality of the radiology department to be of

the brain MRI scanning department?
A Very soon after I joined, I showed to Dr. Glick numerous repeated examples of very poor radiology reads, the reports were unreliable and I felt that patients were being harmed, documented in one report which is tab 19 in this binder something that he called a smoking gun. This was the report that I had Dr. Levin read this morning.
Q Specifically how did Dr. Glick interact with you in terms of dealing with your observations about the MRI department?
A Dr. Glick was extremely grateful that I had the expertise to read MRI images correctly and pointed out the various mistakes in the official hospital radiology report. He took it up as chief. I merely mentioned my complaints to him, I did not go to the radiology department at that time. And Dr. Glick tried very hard to improve matters at the radiology department, but they rebuffed him completely and we never had a sit-down meeting to discuss our concerns.
Q What specific actions did Dr. Glick take in advising the department about your observations?

THE MAGISTRATE: Ms. Belanger, have you had a chance to read the transcript in the case so far, specifically the transcript of the prehearing conference?

MS. BELANGER: I'm familiar.

THE MAGISTRATE: Have you read the transcript in the prehearing conference?

MS. BELANGER: Yes.

THE MAGISTRATE: I will allow Dr. Padmanabhan through you to explore reasons why he may have been targeted or may be out of favor with the medical establishment and the Board of Registration in Medicine. However, Whidden Hospital and other doctors are not on trial here, and I put that in quotes. This is not a hearing about them. I will give you some leeway, but we are not going into this extensively. This hearing is about the Statement of Allegations against Dr. Padmanabhan.

MS. BELANGER: A lot of my questions will be about the allegations and directed toward the sufficiency of the allegations, so I will be directing my line of questions toward the

sufficiency. May he answer the question as to specifically what did --

THE MAGISTRATE: I'm going to give you some leeway, but you need to move into the allegations against him and not Dr. Padmanabhan's allegations against other doctors.

MS. BELANGER: Correct. This is specifically geared to the sufficiency of the complaints against Dr. Padmanabhan.

A Dr. Glick approached Dr. Carol Hulka, the chief of radiology, and Dr. David Bor, the chief of medicine, to try to get an all-chief meeting to improve the quality of the reads at Cambridge Health Alliance, and he was unable to do so.

Q Who is the doctor that you said you reported it to?

A I reported it to Dr. Glick.

Q Who did Dr. Glick report it to?

A Carol Hulka, the chief of radiology, and Dr. David Bor, the chief of medicine.

Q What was their response?

A There was none.

Q Can you please describe the series of events

that occurred after your reporting your observations to Dr. Glick.

A Eventually it culminated in my being thrown out by security guards in 2010. Prior to that we do have through discovery e-mail from Dr. Hulka to the leadership asking how I may be thrown out.

Q What was the response that you received?

A I was summarily suspended and terminated in 2010.

Q And what avenues did you pursue in response to that?

A I did apply for a fair hearing, and there was a full fair hearing which I received testimony in evidence under oath for three days, and I was exonerated and the fair hearing panel ruled there was no evidence, credible evidence to support my termination.

Q At the fair hearing what were the bases of the allegations that were made against you in that hearing?

A The allegations of the fair hearing are exactly the same allegations that the Board has presented in its Statement of Allegations and exactly the same patients, too. They all

derived from Dr. Rachel Nardin who was the new chief of the division of neurology, they are identical.

Q Prior to 2010 had you been previously reported to the Board of Medicine, to the Medical Board?

A Yes, I have, in 2006. A patient of mine whom I had diagnosed with MS went to see Dr. Revere Kinkel at the Beth Israel Deaconess MS Center. Her MRI has been ordered by a different physician in my same group practice, and he thought it was extremely suggestive of multiple sclerosis and sent her to me for a second opinion. I concurred, but MRI was extremely suggestive of the MS, in fact it looked very bad.

Her niece went to see Dr. Kinkel and she suggested that he see her for a third opinion. She did and never came back to me. I assumed she had switched her care to the Beth Israel. All of a sudden I received a docket number from the Board saying that a complaint has occurred. Dr. Kinkel told her she does not have MS and she complained to the Board that I diagnosed her wrongly, probably because I was in the pocket of

Big Pharma. The Board investigated and did an independent investigation and they dismissed the complaint out of hand.

Q When was the first time that you became aware of the complaint made to the medical Board in 2010?

A When the hospital threw me out, they gave me a piece of paper that said that they had reported this to the Board of Medicine, and the Board of Medicine followed up with a letter stating that the hospital had made allegations, the actual allegation was prescribing drugs to known drug addicts.

Q Do you remember what month that was in 2010?

A That was around November of 2010, December of 2010.

Q When did you receive a formal complaint from the medical Board?

A In January of 2013 I was called in by Counsel Paikos to a Complaint Committee hearing. Between December of 2010 and January of 2013 I had been repeatedly sending by certified mail letters to the Board asking them to finish up their investigation quickly as an open docket from the Board prevented me from earning a

living and I was living off my savings throughout that time period.

One week prior to the Complaint Committee hearing in January of 2013 which was January 28, so on the 21st I received a phone call around 4:40 in the evening from Counsel Paikos who informed me he had done a comprehensive independent investigation of the allegations that had been raised against me by Cambridge Hospital, and he had found them to be completely credible and I was a danger to public safety and he was going to recommend to the full Board that my license be summarily suspended for being imminent danger to public safety, but if I agreed to plead guilty and agreed to five years of probation, he would be prepared to entertain an immediate stay on said suspension, and if I also agreed to monthly assessment of my skills by a physician chosen by Counsel Paikos with better clinical skills than me. At that same phone call I informed Counsel Paikos was scratching my head trying hard, I really was, but for the life of me I couldn't think of a single physician in Massachusetts with better

clinical skills than me, and Counsel Paikos hung up the phone.

I came into the Complaint Committee on January 28, 2013 where Counsel Paikos stood up and repeated verbatim from a report called the Greeley Report paid for by Cambridge Hospital in July of 2011. It was commissioned by Cambridge Hospital, paid for by Cambridge Hospital and had the same allegations that went to the fair hearing and got debunked. And the same patients, too, the exact same allegations and patients are now from the Greeley Report in the Board of Registration in Medicine's Statement of Allegations in January 2013, exact same words. And I recorded in that a document that was sent by certified mail to the Complaint Committee, and they did acknowledge receipt of that letter and promised me that they would further investigate.

I did not hear back from the Board until May of 2014, an additional 14 months, at which time I completely ran out of my personal savings and funds and became completely broke.

Q Between December of 2010 until January of 2013

when you heard from Attorney Paikos, were you ever questioned by any investigators from the Board?

A Never, not once.

Q From the time period from the conversation that you described with Attorney Paikos, what was the next thing that happened?

A We had a Complaint Committee hearing a week later and after that nothing happened until May of 2014 when I was pulled in front of the Complaint Committee hearing again. Dr. Healy who had been chairman of the Complaint Committee has since been taken off the Board and Dr. Marian Felice was now the chairperson for the committee. I really felt it was like Groundhog's Day. It was the same all over again as January of 2013, identical. And at that point the next day they issued a Statement of Allegations which is what I am now facing today.

Q Did you ever make the Medical Board aware about your feeling that you had been targeted because of your having made, exposed problems with Whidden's radiology department?

A Yes, I made the Board fully aware of everything.

I sent them chapter and verse. The Board has documents and photocopies of everything in my professional life. They are fully aware of that and of the evidence that is false. They are fully aware that Cambridge Hospital --

THE MAGISTRATE: I'm going to cut you right there. I'm not taking that testimony what they are aware of. I'm accepting your testimony that you sent it. Next question.

Q What manner did you inform them?

A I sent them all by certified mail.

Q Did you ever have conversations with Attorney Paikos about the content of those letters?

A I have informed Counsel Paikos that I sent those letters. He has never discussed them with me.

THE MAGISTRATE: For the record what Mr. Paikos has discussed with Dr. Padmanabhan or not is not going to be the subject of my decision. Mr. Paikos, you don't have to find a witness to testify to what you may or may not have discussed with Dr. Padmanabhan.

Q (By Ms. Belanger) Can you please describe for me your opinion as to the testimony provided by Dr. Levin.

THE MAGISTRATE: As I said, I'm not going to allow a party to ask a witness to comment on the testimony of another witness.

MS. BELANGER: May I have Dr. Padmanabhan be able to also be, given his qualifications or established to be a better witness?

THE MAGISTRATE: No.

MS. BELANGER: May I be able to state for the record that is the reasons for his not being able to be allowed to testify as an expert?

THE MAGISTRATE: He is a party.

MS. BELANGER: And therefore I would submit that goes to credibility and not admissibility.

THE MAGISTRATE: That is my ruling.

MS. BELANGER: Please note my objection for the record.

Q (By Ms. Belanger) Can you please describe for me, please describe for me the standard of care that is required or the minimal standard of care as a neurologist diagnosing MS.

THE MAGISTRATE: I'm not going to allow the question. You are asking him to testify as an expert.

Q Can you please tell me your understanding what the standard of care is as of your practicing as a neurologist and diagnosing MS.

THE MAGISTRATE: I'm going to disallow the question.

MS. BELANGER: Please note my objection of not being allowed to have the doctor testify as to what the standard of care he used or what he understands to be the standard of care in applying his practice.

THE MAGISTRATE: He can testify how he met the standard of care but not what the standard of care is, not directly or indirectly can he testify to that. He is not an expert.

Q (By Ms. Belanger) Can you please describe the standard of care that you used with the patients that are alleged here in this matter.

A Yes, the patients in this Statement of Allegations that derive from Cambridge Hospital's paid-for Greeley Report fall into three main categories. One is --

THE MAGISTRATE: I'm going to strike that. That is not in the record. I need you to testify about the allegations, not the Greeley

Report.

A One is patients with pain that I had followed for years and years, and the other is diagnosing patients with MS based on my reading of MRIs and disregarding or overruling the erroneous reports from the hospital. The patients that I have followed for years I view them very closely. Three of them came and testified here and one shall come on Monday. I went all out to help them and they understand and appreciate it. I improved their quality of life and improved their health, and I did everything humanly possible that a physician can legally to get them the access to treatment that they needed and required, both in terms of proper diagnostic testing and in proper treatments.

The training that I received at Tufts New England Medical Center emphasized that neurologists should always look at his own scans. That was reinforced by my involvement as a witness in a very massive malpractice lawsuit conducted by Lubin & Meyer where the neurologist came or trying to testify that it was the standard of care for a neurologist to simply

depend on the radiology report. They lost, naturally.

THE MAGISTRATE: I'm going to strike that.

A All those --

THE MAGISTRATE: Dr. Padmanabhan, I'm not done ruling. I'm finding this irrelevant to the hearing.

You can ask Dr. Padmanabhan how he met the standard of care patient by patient with the standard of care being established by Dr. Levin; but what happened in a malpractice trial in a civil case, that is not relevant.

MS. BELANGER: Only relevant as far as case law establishing what the standard of care is.

THE MAGISTRATE: The standard of care in this case is what Dr. Levin has testified to. If you want to elicit testimony about how Dr. Padmanabhan met the standard of care for the patients in the Statement of Allegations, I'll allow you to do that.

MS. BELANGER: Is it permissible to be able to attack the credibility as to what

Dr. Levin states to be the standard of care?

THE MAGISTRATE: Directly or indirectly Dr. Padmanabhan is not going to testify as an expert. That is my ruling.

MS. BELANGER: Would you please take judicial notice of the exact case that Dr. Padmanabhan has been, has cited to.

THE MAGISTRATE: Under 30A I am not allowed to.

MS. BELANGER: Not allowed to --

THE MAGISTRATE: That is my ruling, counselor.

MS. BELANGER: Am I able to have a break?

THE MAGISTRATE: We just took a break less than an hour ago. The purpose of a break, may I ask?

MS. BELANGER: To organize my questioning of the patients.

THE MAGISTRATE: Again I have been trying to keep this proceeding proceeding. We are twenty minutes away from a scheduled lunch break. If it's okay with the parties, we'll take a lunch break now.

MR. PAIKOS: Yes, that is fine.

MS. BELANGER: I appreciate it.

THE MAGISTRATE: We'll be back in an hour. No matter what people's watches say, we'll be back in an hour.

MS. BELANGER: I appreciate it.

[Lunch Recess]

THE MAGISTRATE: Back on the record and ready to resume?

MS. BELANGER: Yes.

THE MAGISTRATE: Dr. Padmanabhan, you are still under oath.

THE WITNESS: Yes.

MS. BELANGER: Is it all right to use my iPad for notes?

THE MAGISTRATE: Yes, as long as it doesn't make noise that is fine.

MS. BELANGER: Before we continue with the testimony, I just want to ask about the CME certificate. I believe that the motion for the subpoena to get Dr. Levin's CME certificate was allowed.

THE MAGISTRATE: It was allowed, and it has been submitted to me. Have you received it?

DR. PADMANABHAN: No.

MS. BELANGER: We have not received it.

THE MAGISTRATE: I'm going to show you what I have. You can approach. (Document handed).

MS. BELANGER: May I please give it to my client to review?

THE MAGISTRATE: Is he going to testify to it right now?

MS. BELANGER: No, he doesn't have to testify to it right now.

THE MAGISTRATE: If he is going to testify to it right now, the answer is yes, but this is an evidentiary hearing and if you didn't get this and he needs to review it, I don't want to stop.

MS. BELANGER: Okay. So I'd like to reserve to be able to discuss, to have my client be able to review it and be able to discuss it later.

THE MAGISTRATE: If there are key documents that you don't have, you've got to tell me rather than just say where are these documents.

MS. BELANGER: I believe that we just

received it recently.

THE MAGISTRATE: So you did receive them.

MS. BELANGER: No, no, the allowance of the motion.

THE MAGISTRATE: Can I see that?

MS. BELANGER: (Document handed).

THE MAGISTRATE: This is dated February 26.

MS. BELANGER: What was the allowance date?

THE MAGISTRATE: Let's proceed with the evidence. That is what we are here for. If you are missing documents, don't wait to the last minute to tell me.

MS. BELANGER: For ease of speaking purposes, is it okay if I refer to the doctor as Dr. Bharani?

THE MAGISTRATE: Yes.

MS. BELANGER: Because I have trouble saying his last name. Thank you.

Q (By Ms. Belanger) Dr. Bharani, what is your standard procedure that you use for diagnosing MS?

A First you have to get a full detailed history

from the patient, you have to go in minute details.

THE MAGISTRATE: When you are talking about "you," are you answering what you, I, do?

THE WITNESS: I do.

A I do that. And then I do a complete classical neurological examination as I was taught, and then any tests that are absolutely necessarily, so now this day and age MRI is absolutely necessary to confirm the diagnosis of MS.

THE MAGISTRATE: I'm going to take your testimony that that is what you do. I am not taking the testimony not that that is absolutely necessary because that is expert testimony.

A I always make sure they get a high quality MRI, preferably three tests done, and I make sure that I look at the images myself when I order the scan. I always make sure that the sagittal plane sequence is ordered and I specify from edge to edge because in many centers they order sagittal plane sequence, they do six or seven cuts through the brain which is too thick of a slice so you can't see much. You have to have contiguous slices from edge to edge.

In the past they used to be printed as films, and you go through each image one by one, static images one by one and you had to read each image separately. Now they are available in digital forms and you can go through slice by slice on one setting. And in many cases for a new patient you do wait two to three months and get an MRI scan again, and you have to compare the two scans slice by slice to see if there has been any change in any particular slice over time. So I always make sure the patients go back to the same MR machine so the technical parameters are the same and the same slices, same slice thickness matches up to make a meaningful comparison between the first scan and the second scan. It's a very detailed labor-intensive, time-intensive process.

You also have to make sure that you rule out other diseases that can cause similar symptoms and so you have to know, I have to know which blood test to order, rule out numerous other confirming diseases, and I make sure I do all of that in all of those patients every single time.

The way I was trained, we were taught that a neurologist would never depend on the radiology report, and so I have learned to read MRI scans myself. And in fact for a time in 2004/2005/2006 I was actually paid by Blue Cross Blue Shield of Massachusetts to read MRI scans based on my training and expertise.

Q When you began working in 2010 -- I'm sorry, when you started working with Whidden, could you tell me about the manner in which notes for the patients took place.

A Yes. Back then the Whidden was still completely paper-chart based so the initial visit note would be dictated into the telephone and a transcript would be provided that you would then correct and it would be put into the chart. The follow-up notes were all written by hand in paper notes and paper charts. And invariably patients of mine very variably would be followed by other physicians at the Whidden because they were my patients, thought of as my private patients, they followed me from other parts of the state, so they really had nothing to do with the other physicians and unlikely to be seen by

any of the other physicians in the hospital. It was like a small private practice within the hospital system. I always made sure my notes were very complete, and I could always instantly recall even in minute details about my patients and about their lives.

Q Were there any notes taken by Dr. Glick on your patients?

A No, Dr. Glick did not write any of the notes on my patients.

Q Regarding Patient A, could you please tell me what the allegations are against you.

THE MAGISTRATE: I have that in front of me. Go to your next line of questions, please.

Q Could you please tell me specifically what your procedure that you used in diagnosing and treating Patient A.

A Patient A an old patient of mine. He was my patient for seven or eight years prior to 2010. He was one of the patients who followed me from my previous practice to the Whidden Hospital. He was a roofer who fell off a roof and broke his back in two places. He was thus on pain medication on a daily basis. He was in his

thirties at the time so he needed to work. He took pain medication to fulfill his activities of daily living. He was a teacher for at-risk youth. He taught softball and baseball.

He had had a history of drug abuse. He was a wild teenager and he then participated in an antidrug use programs for youth and through the sports collaborations. Patient A used to see me every three months to fill his pain prescription. I never had any problems with him at all. His exam was very stable throughout. He was physically very fit, and he never caused me any problems or complaints.

In 2010 after Dr. Nardin became the new chief of the division of neurology, Dr. Nardin compelled me to discharge all of my pain patients, patients that I had followed for years and was following essentially for back pain, and he was one of the patients that I had discharged.

About a month after I had discharged him or six weeks after I discharged him, he suddenly died, and his death was used by the hospital to suspend and terminate me. The allegation was

that he died because of overprescribing by me of pain medicines, narcotics, but before the fair hearing in 2011 we were able to prove --

THE MAGISTRATE: We are going to talk about the allegations in front of me rather than the hospital's proceedings.

A We have in the evidence binder a sworn affidavit from the pharmacy that documents that when this patient passed away he was not my patient and he had not filled any prescription from me at all and his death was entirely unrelated to me. He was a former patient who unhappily died.

THE MAGISTRATE: What exhibit is the affidavit, do you know?

THE WITNESS: Tab 6, Your Honor.

THE MAGISTRATE: That is your tab?

THE WITNESS: Yes.

THE MAGISTRATE: Thank you.

Q (By Ms. Bresler) Could you please describe the manner of your monitoring Patient A.

A I saw Patient A every three months. I gave a full interview with him regarding the prior three months, how his life was, what the medicine was doing for him, what has pain level

was, if he was happy with his prescription. Generally the goal is to keep the patients about 80 percent pain free. One cannot go and should not go for a full hundred percent. He was generally pleased with the level of pain relief he was on and was able to continue being employed. He was a foreman on a construction site and he was able to do that with the pain medication. The pain medication allowed him to get on with the life. Every three months he came in like clockwork. I never had problems with him or calls from the pharmacy saying there was something strange about him or the company he kept. He never called and said his dog ate the prescription or it fell down the drainpipe or nothing. He was very reliable, stable patient.

Q Can you please describe the procedures that you took in notetaking for Patient A.

A I saw him every three months. They were primarily medication visits because there was nothing else that was going on in his neurological status. That was one of the reasons that Dr. Nardin stated for compelling me

to discharge Patient A, because I was essentially treating him for his pre-existing pain condition. He did, however, have difficulty getting other practitioners to take over prescribing his pain medication. It is very, very difficult to transition patients to pain clinics in Massachusetts, and it took many months for me to transfer many of my patients. He was one of the patients that I was able to transfer to his primary care physician.

Q Did you, regarding Patient A in your notes, did you document your reasons for prescribing the medications that you had?

A Always, that he had a broken back and he was a roofer. The documents that I have included in the evidence binder for the government are incomplete. He has numerous records that he came to from the Whidden Hospital from my prior practice which are also not present.

THE MAGISTRATE: Ms. Belanger, do you intend to introduce more records into the record that are allegedly incomplete?

MS. BELANGER: Assuming that I have been retained on, within such a short period of time,

I'd like to be able to discuss with my client as to exactly what exhibits there are, so I haven't had the ability to go through that yet. I'd like to be able to have the opportunity to do that.

THE MAGISTRATE: The hearing began in January. What I'm hearing is allegations that the records are incomplete but no records are being offered. I'll leave it as that. I'm not sure I'm going to accept them at this late date, and I'm not sure I'm going to accept the allegations that the records are incomplete.

Q What was your standard procedure, what was the procedure that you did use when diagnosing and treating Patient B?

A Patient B is also an old patient of mine who was my patient when I was down in Taunton and he chose to follow me to the Whidden Hospital. He was a cook who slipped in an ice room in his restaurant carrying a 50-pound sack of potatoes and threw his back out and was seen by Jules Nazzaro, N A Z Z A R O, at Boston Medical Center who was to operate on his back. His back pain was quite severe, radiating down the leg and had

a classic lumbar radiculopathy. He went for all the physical therapy and aqua therapy and everything else, but he needed to be on a certain level of pain medication to get through his life.

I transitioned him to Dr. Allison Gorski at the Caritas Norwood Pain Clinic and he is now presumably being followed there. He is a former patient of mine, he was a former patient of mine in 2010 when the allegations were sent to the Board. He was in very good health. I took complete care of him. He was extremely happy with my care, and I did not foresee any trouble at all going forward.

Q Can you please describe your procedure in note taking for Patient B.

A I saw Patient B regularly, sometimes once a month, sometimes once every three months. He never missed an appointment. I always did an exam on Patient B to make sure there was nothing else that was new. He had had changes on his exam in the early days when I was still down in Taunton before I moved to the Whidden, but by the time they followed me to Whidden Hospital,

his exam had been rock steady for at least a year and there was absolutely nothing else that could be done by us for him.

Dr. Nazzaro had left Boston and moved to Nebraska or Kansas, one of the two, and he really was not going to go in for back surgery at that point. He had to lose weight and other things. So his exam was stable. I saw him every month or every three months, depending on the timetable. I filled his prescriptions, and again with him he went to the same pharmacy, he never ran short of pills. In fact, he used to take as little as possible to get through the day.

His daughter was a head nurse in the ICU at Jordan Hospital in Plymouth, and she took care of him as well. It was a completely stable patient relationship with no red flags of any sort. In fact, I spoke to his pharmacist and his pharmacist was happy with him. There was no trouble at that end as well.

Q In the patient's records did you document the reasons for prescribing the medicines that you had?

A I did. Back in 2005 when he first became my patient, those are the records that are currently not in the government's binder because Cambridge Hospital did not give them.

THE MAGISTRATE: I'm going to strike that. We have no knowledge of that. If you want to try to supplement them for your exhibits, but the same comment as before, allegations of missing documents but no effort to supply them.

Q (By Ms. Belanger) At any time was the Medical Board made aware of records not being complete?

A The Medical Board never contacted me ever, not once, not between 2010 and 2013, not again in 2013 or 2014 to ask me about any of these patients or these allegations.

THE MAGISTRATE: The issue is whether documents are complete in front of me.

Q Could you please describe the procedure that you used in diagnosing and treating Patient C.

A Yes. Patient C was a patient, is a patient of mine. He came and testified here. He is a patient of mine from a very long time when I was in my previous practice in Taunton. He had a

rollover car accident and had a severe root stretch injury of his cervical roots as a result of that whiplash rollover. He also went to numerous tests, full neurological exam documented by me when I saw him in my clinic in Taunton. Those records are also not available to me. He had EMG testing and numerous imaging studies done, he has second opinions in Boston hospitals. He has been on pain medicine ever since and continued to be employed and used to make corsets and -- what is the word? -- splints and other medical support devices for children for stabilizing the scoliosis. And he was, is, remains a very stable patient.

I know his family and I know his wife, his son. I know his pharmacist. He has never had any trouble filling his prescriptions. He never runs short. I have never had any complaint about him from his pharmacy in the last ten years, and it's a very stable relationship.

Q Could you please describe the procedure that you used in monitoring Patient C.

A Purely clinical. I did not do random urine

screens on him because that is not the standard of care according to the American Pain Society and numerous other authorities --

THE MAGISTRATE: It's not what you did is the testimony I'll take.

A -- including the Federation of State Medical Boards which I --

THE MAGISTRATE: Did you hear me? I'm accepting that that is not what you did but I'm not accepting your testimony about what other Boards and standards are.

THE WITNESS: I was merely stating, Your Honor --

THE MAGISTRATE: Dr. Padmanabhan, next question from your lawyer.

Q (By Ms. Belanger) Can you please describe any further monitoring that you did on Patient C.

A He has had imaging studies which did show the injuries in his neck. I have not done any other tests after that because there was nothing warranted. His exam had not changed very much in the last eight years. He continues to be on much lower dose of pain medication than he was. Initially he was on a pretty high dose because

he was in excruciating pain. Even turning his head slightly left or right would make him go into the spasms from the pain. He is very stable on a much lower dose now than he was eight or nine years ago. I foresee no reason to subject him to urine tox screens or tests or anything like that at this point.

Q And you have regularly followed up with him?

A Every month, every three months, usually every month, sometimes every week.

Q Can you please state whether you documented in the records your reasons for prescribing the medications that you had?

A Yes, I did, I documented the record completely.

Q Can you please describe the procedure of diagnosing and treating Patient D.

A Yes. Patient D is a patient of mine. He also came and testified here at this hearing. He was a person at a construction site, building a concrete garage in which a beam fell on him. He has had numerous back surgeries. He goes in every three months to have steroid injections placed by an interventional anesthesiologist in Quincy, and I have also been supplementing his

pain relief with pain medication ever since. He has been my patient since around 2005.

As the Magistrate saw, he is a very stable person. He came here to testify. I have never had any problems with him. His exam has changed in the meantime in terms of other problems. He does have deep vein thrombosis in his leg. His third attack of deep vein thrombosis was last week and he had a pulmonary embolism as a result. He is back on Coumadin which causes problem because on the Coumadin he cannot go and get his back pain shots.

He is a person who came in to see me, and the government's lawyer alleged that I gave the terribly poor standard of care because I counseled him on his knee pain and I tried to help him with the rash on his leg. He came to me because he has absolute faith in my care and I was able to refer him to other physicians for those conditions. He had bilateral knee replacement done at the same time at the Baptist and went to Braintree Rehab for rehab and did wonderfully. His pain medication requirement fell significantly after his knees were

replaced.

He is also a person of impeccable integrity. I have never had trouble with him in terms of his filling his pain prescriptions. He goes to the same pharmacy for 30-odd years as he testified here. The pharmacist knows him very well. He has never, the pharmacist has never complained to me about him or the company he keeps, and I have not done urine tox screens on him because I know this patient inside and out.

Q Can you please describe the manner in which you followed Patient D.

A We speak on the phone at least every three days. I see him about every two weeks or so and when I was at the Whidden, I used to see him every month or three months depending on the circumstances. Sometimes he had emergencies. He would come in and I would see him on an emergency basis as an add-on patient. I am always available to see my patients. I never make them wait three months.

Q Did you document in the record for Patient D the reasons for your prescribing the medications that you did?

A I always have.
Q Could you please describe the standard in which you treated and diagnosed Patient E.
A Patient E was a younger gentleman who had had a traumatic injury to his back. He was discussed at the fair hearing extensively by Dr. Carol Warfield who is a real expert in pain medicine. Patient E was someone who I followed what I was taught at the state-mandated opioid training course which teaches people that one should never give up on pain patients just as one should never give up on diabetics who are not compliant with their sugar control. We should not fire them because they come back with a high A1C. Similarly, I did not fire this patient initially because I thought I should work with him, it was my duty as a physician; however, it turned out to be unsalvageable.

I did a urine tox screen on him, sprung it on him, and his urine tox screen was positive for cocaine. I discharged him from my practice according to the regulation of Massachusetts Board of Registration in Medicine. Any time you discharge a patient, you are mandated to give

them a thirty-day supply of whatever medicine at the same dose that they were on so they would have the same dose before they would go and see a different physician and transition their care. That is what I did with this young man.

THE MAGISTRATE: I'm taking it as your understanding of the regulation rather than evidence of the regulation.

Q (By Ms. Belanger) Can you please describe the manner in which you followed Patient E (sic).

A Patient E (sic) was a patient who had been through numerous physicians who all had discounted her symptoms. This was a woman with numerous exacerbations and remissions throughout the course of her life. She had severe fatigue that was central in nature, meaning not related to actual physical exertion. She had whole body pain, balance trouble and they all came and went in waves as a cycle. When her fatigue was worse when he her whole body pain was worse, her balance was actually worse, she would walk into walls and have to walk using the wall for support which would last for two or three weeks at a time and then remit. She would get better

for a month or two or three.

These are clinically, very classic symptoms of patients with MS. When she came in, she also had a very strong family history with numerous other close first-degree relatives with other neurological diseases including lupus. Type 1 immunological diseases of which MS is one usually travel in packs, so it is very, very common to have a patient with MS and a sister with arthritis and a grandmother with lupus and a son with bipolar disorder. It is absolutely normal; it is in keeping with the disease.

Therefore, it was nothing untoward or different about this patient when she came to see me. Her neurologic exam was reasonably good. It doesn't mean it precludes a diagnosis of MS. One does not have to be paralyzed in one arm or one leg to be diagnosed with it.

She did have an MRI done as is my practice. I read the MRI correctly carefully myself, and she did have numerous signals of classic MS form on her sagittal flair sequence which is the gold standard. And I diagnosed her with MS. She was happy with the diagnosis,

informing her feeling that there was something going on that other people have poo-pooed as a psychological or psychiatric illness that was all in her head. And she was better. I treated her symptomatically for her symptoms and she felt much better.

THE COURT REPORTER: Could I clarify, which patient was that?

DR. PADMANABHAN: Patient E. No, sorry, Patient F -- It was Patient G who I was describing. My mistake. Patient F I have not talked about.

THE MAGISTRATE: Your prior testimony just now was Patient G?

DR. PADMANABHAN: Yes.

THE MAGISTRATE: Dr. Padmanabhan, what is it you are looking at now? For the record what is it you are looking at?

DR. PADMANABHAN: Order to Use Pseudonyms and Impound Medical Records, so I know who is Patient G.

I can talk about Patient F.

Q (By Ms. Belanger) Can you please describe the manner and procedure which you diagnosed and

treated Patient F.

A Patient F was a patient that I saw very simply for attention deficit disorder. This was a person with a history of drug abuse and numerous other psychiatric illnesses. However, she did have a history of attention deficit disorder as a child. When I saw her as is my practice and as is usually historically the practice, I took --

THE MAGISTRATE: I want to take your practice and not what the historical practice is.

A -- I took the patient at her word and proceeded on the basis of the history and exam, gave her a prescription for low dose of Adderall. She came back much improved. She reported that the clarity of her thoughts was much better, she was not rushing things or forgetting things or not leaving things half done and she was happy with my care and in that regard. I saw her for a very brief period before I was thrown out.

Q Could you please describe the manner in which you followed Patient F.

A She came in for a follow-up visit so I could

explore what the Adderall was doing for her in terms of effect and side effects. We had a complete and detailed conversation about all of the factors that she noted that were different when she was on the medicine. The medicine doesn't last very long. The usual effect of an immediate release dose of Adderall is about four hours tops, so she could actually feel it wearing off and she could tell the difference how it was when it was on and how it was when it was off, and we went through a whole detailed history for that.

Q In your notes and documenting for Patient F did you document the reasons for prescribing the medications that you had?

A Yes, both in my initial notes and in follow-up visits.

Q I know that we had, just to clarify regarding your procedure in diagnosing and treating Patient G, could you please describe to clarify --

A She received a full history, very detailed history from childhood, all of her symptoms, all of her conditions. However, many times she had

exacerbations and remissions over the course of years, and what other symptoms that she had that with were transient in nature, what symptoms she had that day, what she had been told by numerous other physicians along the line and what her neurologic exam was physically in the exam and again with a detailed MR scan that I read myself. We also went through numerous blood test results for her and her family because a very detailed exam, detailed evaluation.

Q Is it correct that you had testified that you in following Patient G, that you decided to do --

THE MAGISTRATE: I'm going to cut you off because the sequence is confusing. Ask a question about what he did rather than what he testified to.

Q With Patient G did you conduct a screening, urine screening test?

A No, with Patient G I did not because she was not put on any narcotic medicine that I prescribed. I did do various immunological blood tests because I'm trained in immunology because antibody tests and other things that are necessary to rule out various other immunologic

conditions, especially with her strong family history, I did all of those.

Q Did you incorrectly diagnose Patient G with multiple sclerosis?

A I did not incorrectly diagnose Patient G with multiple sclerosis. I am trained in multiple sclerosis, I have a Ph.D in multiple sclerosis, I have four years of fellowship training in multiple sclerosis, and there are only a handful of doctors in the states with my level of expertise.

Q Is there documentation supporting your diagnosis of multiple sclerosis?

A There is ample documentation of that in the record both in the Cambridge Health Alliance notes and in the tests.

THE MAGISTRATE: For the record if it's necessary, Dr. Padmanabhan is not testifying as a multiple sclerosis expert.

Q (By Ms. Belanger) Those documents that you are referring to, are they in exhibits here?

A The initial visit note is. I don't think all the notes have been included in the evidence binder.

Q But there are exhibits here that do show?
A Yes.
Q Are you able to refer to those, please.
A Are we talking about Patient F?
Q Patient G.
A We have here two follow-up notes written by me, one from March of 2010 which is MR439 Bates 200, and we have a second follow-up note from April 2010 which is MR465 Bates 205.

THE MAGISTRATE: You can go right to the Bates number. Dr. Padmanabhan will just use the Bates numbers at this point.

A The initial visit note is not in this record, and I am forced to wonder why.

THE MAGISTRATE: I'm going to strike that. We have discussed this extensively at previous days of hearing.

Q Do you recall seeing that document?
A I have not seen the document for the last four years.

THE MAGISTRATE: And it's in evidence why he hasn't seen it.

Q Is there any one particular test to diagnose MS?
A There is not one particular test to diagnose MS,

but the MRI comes pretty close if it is read properly.

THE MAGISTRATE: Let me clarify, it is not in evidence why Dr. Padmanabhan hasn't seen the document; what is in evidence is that Dr. Padmanabhan has declined to look at all the documents that were turned over to him by the Board of Registration in Medicine.

MS. BELANGER: I object to the characterization of "declined."

THE MAGISTRATE: Have you read the transcripts of all days of the hearing?

MS. BELANGER: I have read the transcript.

THE MAGISTRATE: Have you read all the transcripts of all the days of the hearing?

MS. BELANGER: Yes, I believe so.

THE MAGISTRATE: I note your hesitation, and I overrule your objection.

MS. BELANGER: Can I then have you state for the record your exact reason for coming to the conclusion that he declined?

THE MAGISTRATE: Next question.

Q (By Ms. Belanger) Dr. Padmanabhan, did you

decline taking a look at the exhibits?

THE MAGISTRATE: We're not going to rehash this.

MS. BELANGER: Please note my objection.

THE MAGISTRATE: If you want to pursue it on the record, put it on the record. Dr. Padmanabhan talked about it in his role as an advocate. If you want to do it with sworn testimony, sure.

A The Board sent me documents in electronic form and I informed the Board that I need the paper records. The Board declined to send me paper records. I am totally suspicious of anything electronic from the people I do not trust, and I do not trust the Massachusetts Board of Registration in Medicine; therefore, I did not bring their CDs anywhere near any computer of mine. The fact that that document is not in this evidence binder, however, is extremely damaging to me because it is impossible to discuss --

THE MAGISTRATE: That is not testimony. Now we have facts on the record but not argument from the witness stand. Next question.

Q (By Ms. Belanger) Could you please describe the procedure and the manner that you used in diagnosing and treating Patient H.

A Patient F is a very dear patient of mine. She came in with a history of stroke. She had been seen in South Carolina a few months before she came up to see me at the Whidden Hospital. She had had one-sided weakness for a few days and she was in a hospital in South Carolina but discharged herself because she didn't think they were doing very much.

The initial visit note which is present in the government's evidence binder clearly documents that I took her history of stroke seriously. I gave her a full exam and took a full history. The full history did make me wonder if the stroke diagnosis was correct; however, in order to be complete, I sent her for carotid Doppler studies and MR studies and other studies to fully investigate from all angles what exactly her affliction was.

When she returned after the tests were done and I went through the MR images myself with my knowledge and training and reading MR,

and with my knowledge and training in MS --

THE MAGISTRATE: I'm going to strike that.

A -- it actually became very clear that she had numerous other issues in her brain that could not be related to that one episode of single-sided weakness when she was down in South Carolina a few months prior. I therefore reluctantly diagnosed her with MS, and she was put on treatment for it.

She remained stable throughout the time she was my patient which was a very short period in my life, about two years or so. Most MS patients that I followed, I actually followed for much longer. She remained happy with my care, and she came and testified here that she has not been seen by anybody since I left.

Q Dr. Padmanabhan, did you incorrectly diagnose Patient H with MS?

A Absolutely not. I started out with the feeling that she may have been properly diagnosed with stroke, but a careful evaluation showed that the stroke diagnosis was incorrect and she had had MS all along. Happily she had a mild form of

MS, so she is not paralyzed or in a wheelchair at this point, but it is MS nonetheless.

Q What clinical observations led you to conclude she had multiple sclerosis?

A She had numerous other symptoms that were not related to the stroke. She has the spasms and cramps which the Board's witness said were not from MS and that MS does not cause muscle spasms. MS caused muscle spasms, and she had them in droves. I put her on Baclofen which is a common drug given to patients with MS for muscle spasms. Her quality of life improved significantly and she was quite happy.

The government also alleged that I harmed her economically --

THE MAGISTRATE: Wait for the next question. If there are electronic devices in the hearing room, they have to be turned off. Any sound making has to be turned off. Electronic devices can stay on.

Dr. Padmanabhan, if you want to testify along that line, I will allow that without a question.

A The government states in the Statement of

Allegations that I harmed Patient H economically, saddling her with an expensive co-pay which is something that Patient H denied when she came to testify here under oath.

THE MAGISTRATE: Do you have any facts on that rather than summarizing from the witness stand what another witness said.

A The patient, all MS patients that I treated I pay close attention to the economics of it. I am fully aware that MS drugs have become expensive over the course of years, four or five times more expensive now than they used to be when I started in this business. However, in her case she had secondary insurance. It was fully paid for, and she had no financial exposure at all.

MS. BELANGER: That was Patient G?

DR. PADMANABHAN: Yes. No, it was Patient H.

MS. BELANGER: Okay.

Q (By Ms. Belanger) I'd like to go back to Patient G. Can you please state the specific clinical observations that led you to believe that Patient G had MS.

A The history of exacerbations and remissions, the severe fatigue that she had --

THE MAGISTRATE: Just to confirm, we haven't reviewed this yet with Patient G?

MS. BELANGER: We did do G. I'm going back to ask that question that I didn't ask.

THE MAGISTRATE: I'm confirming that we haven't asked this question with this patient.

MS. BELANGER: That is correct.

A Based on the history, her exam and the MRI findings, I diagnosed her with MS. It was not something that I was going to diagnose her with as she walked through the door, it was as a result of a comprehensive evaluation of her or her family history, her exam, her MRI and the blood work.

Q And there were clinical symptoms that you relied on?

A The clinical symptoms were the histories of exacerbation in remission and the fatigue.

Q Could you please describe the procedure and manner in which you treated and diagnosed Patient I.

A Patient I is a young woman. She is still a

young woman. She had a birthday on Sunday. She will be testifying here under oath on Monday. This is a patient who was extremely bright in school but over the course of some time she just couldn't get out of bed. She had severe fatigue, whole body pain, cramps, shooting pain down her arms. She went to numerous physicians but did not find any relief at all. She was referred to me by her primary care doctor who was a senior physician within the Cambridge Health Alliance leadership. Because of my experience in neuroimmunology, Patient I received a very thorough, very far-reaching evaluation, both in terms of physical exam and in terms of history and in terms of thinking about numerous possible mechanisms that could explain her conditions.

None of her conditions fit into a particularly neat category. Again most neuroimmunological syndromes don't fit into neat categories, and it is imperative that one not give up on a patient but keep trying and try until we find something that works.

In the case of Patient I we did settle on

monthly Solu-Medrol and monthly IVIG staggered every two weeks which worked wonderfully. Seventy-five percent of her symptoms resolved. Her fatigue disappeared, her mental clarity improved, she was able to participate fully in the care of her two young daughters. Her activities of daily living increased. She clinically improved significantly.

Her entire family came to thank me. I met all of her sisters and her brother and the father of her children. This is a patient that took an enormous amount of effort and time on my part because of my experience and expertise in neuroimmunology and my commitment that no patient should be left behind. I put in an enormous amount of effort to make sure that we found something that worked, and it worked.

Q Dr. Bharani, did you incorrectly diagnose Patient I with inflammation?

A She had inflammation then and she has inflammation now. I completely correctly diagnosed her with inflammation and it is absolutely wrong to declare that inflammation of the central nervous system is a pathological

diagnosis and not a clinical diagnosis. It is a clinical diagnosis that is used for people trained in neuroimmunology, and that is why it carries a corresponding ICD9 code.

Q On what specific clinical observations did you come to the conclusion diagnosing Patient I with inflammation?

A Because the inflammation was far reaching and present in almost all areas of her body; however, most of these conditions are associated with inflammation within the brain. So if you look at fibromyalgia points, they disappear and change on a daily basis. They don't disappear and change on a daily basis because there is inflammation locally that goes up and down, it is all mediated by pain networks in the brain.

I put her on Solu-Medrol to reduce the inflammation in the central nervous system, and it worked. The intravenous immunoglobulin was to bind up all the floating antibodies that were causing inflammation, all the complexes that were causing inflammation, and again it worked. She was markedly better.

Q Could you please describe the manner in which

you followed the care with Patient I.

A She came into the clinic every two weeks. I saw her. I eyeballed her and I spoke with her every two weeks. She came in once a month for a proper examination and also used to come in every two to three months for trigger point injections in her neck. We would coordinate those trigger point injections with the days she came in for her infusion so she wouldn't have to drag in extra specially just for that. I made sure that the timetable suited her so she could come in for trigger point injections.

Initially as the IVIG and Solu-Medrol kicked in, she needed them less and less which proved the point that they were symptoms of an underlying inflammation; and as the underlying inflammation was improved with the Solu-Medrol and IVIG, the need for trigger point injections went down.

Q In your notes and records for Patient I did you document the reasons that you prescribed the medications that you had?

A Yes. I discussed them extensively with the patient. She was fully informed and completely

informed of all the choices and all the possibilities, the risks and the benefits, what the thinking was behind choosing these medicines. She was fully aware and approved and agreed, and I documented them in the record. They may not be present in the evidence binder here, but they are certainly present in the record.

Q Dr. Bharani, is it your understanding that it is within your practice of medicine and your specific field of being able to treat people for pain management?

A Yes. I have been trained to treat chronic pain because MS patients are chronic inflammatory patients, so a person trained in MS automatically is a person trained in treating, chronic diseases and everything that follows with the chronic illnesses including chronic pain spasticity, depression, family dynamics, marriage counseling and all of that. Furthermore, the Board of Registration in Medicine has declared the Supreme Judicial Court --

THE MAGISTRATE: I am going to stop you

right there.

DR. PADMANABHAN: You allowed me to state this before, Your Honor.

THE MAGISTRATE: You have a lawyer who is asking you a question. You are testifying as a factual witness. If you said it before, that is another reason not to say it again. Let's move on.

DR. PADMANABHAN: Actually, Your Honor --

THE MAGISTRATE: Do you know what? Wait for the question from your lawyer.

Q (By Ms. Belanger) Have you ever received your certification -- Did you receive certification by Massachusetts to prescribe controlled substance medications?

A Yes, years ago, I think in 2001.

Q Have you ever been served a recall notice for your Massachusetts Controlled Substance Registration Certificate?

A The last time I was served a recall notice was in 2009. I responded to that notice and they sent me a new certificate. Did not receive a recall notice after that.

MS. BELANGER: I'd like to be able to

call your attention to the exhibit that you presented to Dr. Levin pertaining to the internet scan.

DR. PADMANABHAN: MRI scan.

THE MAGISTRATE: Do you need a copy?

DR. PADMANABHAN: (Indicating).

MS. BELANGER: Yes, that's the one.

Q (By Ms. Belanger) Can you please tell me whether that shows the corpus callosum?

A It does not show it. That is a slice, sagittal slice of the brain that is not through the midline structures of the brain. The corpus callosum is found in the middle of the train, not seen in this image at all, absolutely not at all.

Q Can you describe if it were there, what it would look like.

A Impossible to tell. This shows Dawson's fingers coming off the lateral ventricle of the brain but not the corpus callosum, even in the trace in the front or back or side, nothing at all, so is no way to tell anything about the corpus callosum in this person on this date.

Q The patient that you treated -- Strike that.

Excuse me if I mispronounce this drug. What are the reasons that you as doctors would prescribe Somnote?

A Somnote is an old medicine, very old, 1930s. The other name is chloral hydrate and it used to be the mickey in the drink. Somnote is a medicine that is used to cause people to fall asleep. We used to give it to children and adults when we did EEG exams and they sleep for half an hour and wake up. The good thing about Somnote, it doesn't change the brain EEG rhythms unlike benzodiazepines which do, and therefore you got a very clean EEG. Somnote is also preferred by neurologists because it goes away clean in the morning and does not give people a hangover and does not react with numerous other medicines that they may be on including seizure medicines. Somnote is a sedative, so it sedates. Sedation is the main indication and the main action, it is not a side effect.

THE MAGISTRATE: I'm going to take the testimony for just why Dr. Padmanabhan prescribed it, his understanding of it but not, I take none of his testimony as that of an

expert.

MS. BELANGER: Objection.

THE MAGISTRATE: Your objection is on the record. The hearing is being transcribed, and I'm not saying anything new, but I want to make sure if I don't strike anything, that still doesn't mean that I'm accepting Dr. Padmanabhan as being his own expert witness.

Q (By Ms. Belanger) When did you learn about the Swanton criteria?

A I learned about the Swanton criteria the month Nicholas Swanton published it. I was part of the original vetting team at the Brigham in Dr. Weiner's lab. We were the team that looked at the McDonald criteria before it was published for average neurologists to read them and try to apply that into the practice. I was one of the team that looked at the McDonald criteria and found it severely wanting; therefore, the Swanton criteria was invented. Everybody --

THE MAGISTRATE: I'm going to stop you there. It doesn't have to do with the Statement of Allegations. Next question.

Q Can you please refer to tab 8, page 364.

THE MAGISTRATE: Can you refer to Bates numbers at this point, please, Ms. Belanger. Do you have Bates numbers?

MS. BELANGER: I don't have the actual exhibit before me. My client does, Your Honor.

DR. PADMANABHAN: What is the page number?

MS. BELANGER: 364.

DR. PADMANABHAN: Patient H. I have the wrong page. Yes, Bates number is 198, Your Honor.

THE MAGISTRATE: Thank you.

Q (By Ms. Belanger) For the record could you please state what the caption or the label for that document is.

A The first line says "result summary," in brackets "continued" and "notes" and says "progress notes."

Q Are you familiar with that document?

A I am familiar with this document.

Q And you have read it?

A I have read this document.

Q Is that a progress note?

A Absolutely not a progress note.

Q Why is it not a progress note?
A Just because a piece of paper says "progress note" on top doesn't make it a progress note. A progress note has to be a progress note, has to document an actual visit with the patient and has to have a history, an exam, impression. What this document is is a record of a patient who came into a clinic and had an Imitrex injection, so this is a note that is actually an operations note or an injection note, so this records that she came in for -- And I should explain that I worked in a clinic in a hospital in a teaching hospital, a Harvard teaching hospital.

THE MAGISTRATE: I'm going to ask you to go back and answer the question.

A Patients would come in for the infusion center --

THE MAGISTRATE: Dr. Padmanabhan, I'm going to ask you to go back and answer the question about whether it is a progress note.

A This is not a progress note.
Q I think the follow-up sequence was how you knew it was not a progress note?

A Because it documents a procedure, and you actually see the nurse's note that says "procedure tolerated well." So this is somebody who came in for an Imitrex injection because she did not have a prescription for it at home. She lives near the hospital, so she came in and we gave it to her.

Q How does the notation of "progress notes" generate onto that document?

A Automatically generated by the computer. Because of history of how notes were in patient charts, in patient charts we always had three types of papers. The first was progress --

THE MAGISTRATE: I'm going to stop you there. It was automatically generated, is that your answer?

Q Automatically generated in what means?

A By the computer, the computer system, the electronic medical records.

Q For specifically what computer system?

A Epoch, the electronic medical records system.

Q Is that the system for the hospital?

A Yes.

Q From your practice what manner can IVIG be used?

A IVIG is used to decrease inflammation in the body in various diseases.

THE MAGISTRATE: What do you use it for?

THE WITNESS: I use it to decrease inflammation in the body with people in neuroimmune diseases, so mixed connective tissue disease as in Patient I, Guillain-Barré syndrome.

THE MAGISTRATE: Did Patient I have that?

THE WITNESS: No.

THE MAGISTRATE: We're not going to talk about that. You say in your practice you prescribe it for that?

THE WITNESS: Yes. I trained at the Guillain-Barré Center. I have seen hundreds of people with Guillain-Barré syndrome.

Q (By Ms. Belanger) Are you aware of other doctors who use IVIG for neuroimmunological diseases?

THE MAGISTRATE: I'm going to disallow the question.

MS. BELANGER: In terms of I'm asking for his personal knowledge if he is aware of other doctors using it.

THE MAGISTRATE: That is exactly the

question I'm not allowing to ask.

MS. BELANGER: That is not a question about imposing an expert opinion.

THE MAGISTRATE: Counselor, next question.

MS. BELANGER: Objection for the record.

Q (By Ms. Belanger) Are there treatises that you are aware of on the applications --

THE MAGISTRATE: I'm going to disallow that question.

MS. BELANGER: It's his personal knowledge, Your Honor.

THE MAGISTRATE: You are trying to get into his expertise, and I'm not going to allow that.

MS. BELANGER: I'm getting into his understanding.

THE MAGISTRATE: Counselor, --

Q (By Ms. Belanger) In your practice could you please state your reasons why you have used IVIG.

A I have used IVIG to decrease inflammation in people with neuroinflammatory conditions.

Q How did you know to do that?

THE MAGISTRATE: I have ruled. I'm constantly getting challenged by you and by the doctor. I'm not going to be fighting you on this issue. I have ruled.

MS. BELANGER: It's the basis on which I have to know how he came to his conclusion. It's factual information, not an opinion.

THE MAGISTRATE: I have ruled. Move on. Ask factual questions.

MS. BELANGER: I have no more questions.

THE MAGISTRATE: Mr. Paikos I'm sure has questions for you.

CROSS EXAMINATION BY MR. PAIKOS

Q Would you go to Exhibit 20 of the large binder that was provided to you. Is that the letter that you received from Cambridge Health Alliance at the time that you started working there showing what your privileges were?

A Yes.

Q And you have clinical privileges in neurology?

A Yes.

Q You listed in your CV which is at Exhibit 17 that you were an instructor at Harvard Medical School until January 24, 2011?

A Yes.
Q Were you teaching there or was that an appointment based on your working at Cambridge Health Alliance?
A It was an appointment based on my employment at Cambridge Health Alliance. I also taught medical students and residence at the hospital.
Q Your privileges if you go to Exhibit 22, you were terminated on November 11, 2010?
A 2010.
Q You were suspended, your medical staff privileges were suspended at that time?
A Actually November 11 was not the date. November 9 was the date. The medical community met and summarily suspended my privileges on the 9th.
Q And you received notice on the 11th?
A Yes.
Q And that is on Exhibit 22. I mean Exhibit 22, that is your notification of it? Exhibit 21.
A Yes.
Q And Exhibit 22 is your request for a fair hearing?
A One of my requests for a fair hearing.

Q There was a fair hearing, and you said there was a finding in your favor?
A Yes.
Q Have you submitted any written documentations in your binder showing that?
THE MAGISTRATE: Mr. Paikos, we're not going into this hearing. It's background.
THE WITNESS: The Board has documented to me that they received a copy of the fair hearing --
THE MAGISTRATE: Dr. Padmanabhan, wait for the next question. I disallowed the question.
Q (By Mr. Paikos) Are you aware that your Board profile lists that you currently accept new patients?
A Yes.
Q And that you also accept Medicaid?
A I don't accept Medicaid any more, not since 2010.
Q Are you aware that your profile says that?
A No.
Q Did you review your profile at the time that you renewed your license?

A I did.
Q You are certified by the American Board of Psychiatry and Neurology in Neurology, correct?
A Yes.
Q You don't hold any subspecialties from that Board, do you?
A No.
Q And there is a subspecialty on that Board in pain, correct?
A Correct.
Q You are not Board certified by any of the other certifying Boards, are you?
A No.
Q Are you Board certified in any subspecialty dealing with neuroimmunology?
A Other than fellowship training for four years, no.
Q But you are not certified by any Board in that specialty?
A I'm unaware of any Board for immunology.
Q And Dr. Shalnov, we saw his name in some of the records. He was a pain physician at Cambridge Health Alliance?
A Physiatrist.

Q And did he have a subspecialty in pain?
A I don't believe so. I don't think so.
Q Currently you practice, how many patients do you have?
A Fifty.
MS. BELANGER: Objection.
THE MAGISTRATE: Basis?
MS. BELANGER: Basis on the ruling that being told that we have to stick to the allegations.
THE MAGISTRATE: This has come up on previous days. I'm allowing it.
Q Cervical dystonia, one of the symptoms of cervical dystonia is that the head is tilted to one side where it goes to the shoulder?
A You asked Dr. Levin that, and he said yes.
THE MAGISTRATE: Dr. Padmanabhan, listen to the question carefully.
THE WITNESS: I --
THE MAGISTRATE: I'm not done yet. Listen to the question carefully and answer on the basis of your knowledge rather than what Dr. Levin testified to.
A Cervical dystonia there is increased muscle tone

in one muscle around the neck or numerous muscles around the neck and when the muscle tone increases, the muscle contracts and you can't pull the neck in any number of ways. It is different from head drop.

Q Does it pull the head to the right onto the shoulder or to the left onto the other shoulder?

A Depends on what muscle is being pulled.

Q Is cervical dystonia the result in the head pulling toward one of the two shoulders?

A It doesn't have to. If you have cervical dystonia, it is 360 degrees on the neck and they have a stiff neck that they can't turn the head at all.

Q Is inflammation a tissue disease?

A It is present in every part of the body in the central nervous system and peripheral nervous system and musculoskeletal system and inside the organs.

Q Based on your training are you qualified to provide things like marriage counseling?

A As part of training for multiple sclerosis and treating chronic disease, yes, it is something that we were exclusively trained in during my

one-year fellowship training at UMass. It was purely clinical. MS patients have a fifty-percent divorce rate. Usually the husband leaves the patient wife, but the opposite can occur as that happened to patients of mine. It is absolutely imperative --

THE MAGISTRATE: Dr. Padmanabhan, wait for the next question. It looks like Mr. Paikos is reviewing his notes.

Q Were you ever, following any conversations with anyone working for the Board, were you ever served with a Motion for Summary Suspension?

A What is a Motion for Summary Suspension?

Q You are not familiar what a Motion for Summary Suspension is?

A No.

Q Were there any proceedings in front of the Board where the Board was considering you being summarily suspended?

A Yes, the Complaint Committee hearing with you on January 13.

Q Did anyone at that time talk about suspending you at that moment?

A Nobody did.

Q And, Doctor, you talked about the Greeley Report. There are ten patients that were reviewed in that report, correct?
A Yes.
THE MAGISTRATE: Mr. Paikos, I'm generally not accepting testimony about the Greeley Report. It's not important.
MR. PAIKOS: It gets to some of the allegations relative to the defense of Dr. Padmanabhan relative to some sort of collusion or conspiracy that resulted in the Statement of Allegations, so I'm asking him about how many patients there were in the Greeley Report.
THE MAGISTRATE: I'm going to disallow this line of inquiry.
Q (By Mr. Paikos) Are you familiar with the Board of Medicine's Prescribing Guidelines?
A Yes.
Q Would you agree that any time there is a change in medication, that that should be documented and that the changes or doses should be explained?
A Yes.

Q And that is some of the rudiments of a complete medical record?
A Yes.
Q For Patient I, the last time that you saw her at Cambridge Health Alliance, was that the day before, November 10, 2011?
A Yes. Do you have a page number?
Q Bates 393. November 10, 2010. Excuse me.
A I see.
Q Was the last date that you saw her at Cambridge Health Alliance?
A It must be.
Q Because the next day you were served with a Notice of Termination, correct?
A Yes.
Q You referred her to pain management and rheumatology for tissue disease, correct?
A I returned her to the care of her primary care physician, Dr. Stout, for pain management and rheumatology and tissue disease.
MS. BELANGER: Which patient was that?
MR. PAIKOS: Patient I.
Q You talked about materials that you submitted to the Board prior to the issuance of the Statement

of Allegations. Were those the materials attached to your Motion to Dismiss and in your binder, found in your binder as well?

A The materials I submitted to the Board were much more voluminous than these.

Q Are the ones that you submitted here, were those also included in the materials that you provided to the Board?

A Yes.

Q In one of those materials at tab 18 the title of that e-mail is Just Like Tuskegee. Is that a reference to experiments that were done on African-American men who had venereal disease?

A Syphilis.

Q And they were men who were essentially used for a study but were never told what was going on?

A Untreated for years.

Q And you were comparing what was going on at Cambridge Health Alliance to that study relative to African-American men?

A Relative to this particular gentleman.

THE MAGISTRATE: What tab are you on?

MR. PAIKOS: Tab 18.

Q And this was a circumstance that happened over

decades, correct?
A Forty years.
THE MAGISTRATE: The doctor's tab 18?
MR. PAIKOS: Yes.
Q Doctor, you never entered into any kind of consent agreements, did you?
A Never.
Q You made two separate presentations to the Complaint Committee at the Board of Medicine, correct?
A Once in January 2013 and once in May 2014.
MR. PAIKOS: I don't have any further questions.
THE MAGISTRATE: Any follow-up questions?
MS. BELANGER: Yes, I do.
THE MAGISTRATE: Based on Mr. Paikos' questions?
MS. BELANGER: Yes.
REDIRECT EXAMINATION BY MS. BELANGER
Q Dr. Bharani, can you please describe specific observations and facts on which you based that there is substandard care going on regarding the radiology brain MRI department.
THE MAGISTRATE: I'm going to disallow

it.

MS. BELANGER: If I may state that counsel had opened the examination pertaining to the study.

THE MAGISTRATE: We have some preliminary testimony from the doctor about his views of the hospital and some quick follow-up questions, but we are not going into it.

MS. BELANGER: Then can we strike the testimony?

THE MAGISTRATE: No. You want to strike the testimony of the doctor as well?

MS. BELANGER: No, I would like --

THE MAGISTRATE: Counselor, I have ruled. Next question.

Q (By Ms. Belanger) Can you please describe when your medical privileges were suspended, what the events were after the hearing, the fair hearing.

A My medical privileges were suspended on a normal night but nobody implemented it for 48 hours so I continued to come in and see patients even after a summary suspension.

THE MAGISTRATE: This isn't part of the Statement of Allegations. Next question. I

know you are incredulous and you can't believe that I just ruled that way, but I just ruled.

MS. BELANGER: I'm going directly based on the cross examination.

THE MAGISTRATE: Do you have another question?

Q (By Ms. Belanger) Is there any existing certifying Board for neuroimmunology?

A Not that I'm aware of.

THE MAGISTRATE: Asked and answered. Do you have another question?

Q (By Ms. Belanger) In your practice when changing medication dosage or changing medications, did you document those in your patients' records?

A I always did.

MS. BELANGER: No further questions.

THE MAGISTRATE: Mr. Paikos?

MR. PAIKOS: I have no further questions.

THE MAGISTRATE: I have some questions for Dr. Padmanabhan.

EXAMINATION BY THE MAGISTRATE

Q You have fifty patients?

A Yes.

Q Do they pay you?

A No, sir. I see my patients for free for the last four years.
Q What is the status of your medical license?
A Active. Unmolested.
Q Why do you not charge them?
A MS patients are poor. I cannot charge them. If insurance reimburses me, I would get paid. Insurance cannot reimburse me as long as the Board docket is open. The Board docket has been open and it has been open for four year; ergo, I have not been paid.

THE MAGISTRATE: Any follow-up questions to mine?

RECROSS EXAMINATION BY MR. PAIKOS

Q Have you applied to be on the list for any insurance company to get paid?
A I spoke with them on the phone. All of them told me that if I apply, I would be rejected and it could constitute a fresh complaint to the Board. I did not want another complaint to the Board. I did apply with locum tenens agencies, temporary work for doctors, and I have documentary e-mails from them saying they would not, their in-house lawyers would not allow them

to hire me until the Board docket was closed, so I cannot get even locum tenens work.

THE MAGISTRATE: Any follow-up questions?

MS. BELANGER: No.

THE MAGISTRATE: Thank you, Dr. Padmanabhan. That is it for testimony today?

MS. BELANGER: Yes.

THE MAGISTRATE: There is one more witness on Monday?

DR. PADMANABHAN: Yes.

THE MAGISTRATE: And that will be it for the doctor's case?

DR. PADMANABHAN: Yes, Patient I.

You can step down if you wish.

[The witness is excused]

THE MAGISTRATE: Ms. Belanger, you moved to in effect have Dr. Levin de-expertized, to be declared not an expert. If you want to file that in writing, you can by a week from today.

Mr. Paikos, assuming that it gets filed, how much time would you need to respond?

MR. PAIKOS: A week to two weeks.

THE MAGISTRATE: Two weeks. Presumedly

you made it orally because you have a handle on that. Mr. Paikos does not know what is coming in, so I'll give you a week to file that in writing and Mr. Paikos, two weeks to respond.

MS. BELANGER: May I ask that because the transcript not being able to be produced for two weeks, that the motion be allowed to be a week from when I get the transcripts up to today?

THE MAGISTRATE: Yes. One week from when the transcript becomes available.

Mr. Paikos, there was a motion you had pending?

MR. PAIKOS: I filed additional exhibits which are, as you may recall Patient H testified that she was seen at Cambridge Health Alliance and at MS Center. The physicians, neurologists, that she testified to indicated that she did not have multiple sclerosis. I think there was an issue raised by you that, generally which makes sense that a patient can't testify as to the medical care they received or the quality of care or things similar. And based on that, I obtained and I'm seeking to file these records which support what she is saying and I think

show that in some ways support the underlying allegations about failing to properly diagnose.

THE MAGISTRATE: And you are proposing them as Exhibits 28 and 29?

MR. PAIKOS: Yes, yes, on the order from my exhibits.

THE MAGISTRATE: Ms. Belanger.

MS. BELANGER: I believe my client posed, filed an objection to that.

THE MAGISTRATE: After you made an appearance to file a motion is what I'm asking you.

MS. BELANGER: He filed it before I got my appearance.

THE MAGISTRATE: I got your appearance before I got the motions.

DR. PADMANABHAN: I actually gave them to the Board.

THE MAGISTRATE: I'm telling you when I received them. Ms. Belanger made an appearance on the docket of DALA before the motions came. So unless I'm hearing no objection, I'm going to admit these.

MS. BELANGER: May I please, either time

for me to do my own motion for my understanding that my client had sent it before I faxed my appearance, so in order for me to properly object, I wish I could be given the opportunity to do so. I was relying -- I had, I had not prepared one myself because he sent it out.

THE MAGISTRATE: I'll give you a week to file an opposition. But if the basis is the lateness, it actually makes sense, you can spend resources if you want, but it seems to make sense to admit these.

[Exhibit 28 admitted into evidence]

[Exhibit 29 admitted into evidence]

THE MAGISTRATE: Anything else procedurally?

MR. PAIKOS: The only I guess questions as to Ms. Belanger's role, we have a last witness coming in. To whom am I supposed to file any motions, pleadings, closing briefs?

MS. BELANGER: You can file it all with me.

THE MAGISTRATE: Will you be filing the brief?

MS. BELANGER: Yes.

THE MAGISTRATE: Any future motions you must be familiar with what I can and cannot do as administrative magistrate. I have no more authority to report doctors or lawyers for alleged perjury or corruption than any other citizen does.

MR. PAIKOS: If she is filing motions, will Dr. Padmanabhan do the direct of Patient I and filing additional motions? I want to be able to understand what everyone's role is.

THE MAGISTRATE: My understanding is Dr. Padmanabhan's ability to file motions has now ended now that he has a lawyer.

MS. BELANGER: I will do the examination.

THE MAGISTRATE: You will do the direct examination of the remaining witness?

MS. BELANGER: Of the remaining witness, yes.

THE MAGISTRATE: Anything else?

MR. PAIKOS: Nothing.

THE MAGISTRATE: Thank you, Ms. Wallace.

THE COURT REPORTER: Thank you.

THE MAGISTRATE: Just to remind the parties, we have to be out of here by 3:30. You

can't linger or use the hearing room as follow-up office.

MR. PAIKOS: One other issue. If we have one witness who I don't imagine will take that long, should we start later in the day rather than 9:30? I say that partly for my own reasons.

MS. BELANGER: That would be helpful for myself as well.

DR. PADMANABHAN: The patient will probably not be here until 11:00 in the morning.

THE MAGISTRATE: That is useful information. We have been starting at 9:30 because we had to vacate at 3:30. We are not going to be going until the end of the day. Shall we start at 11:00?

MR. PAIKOS: That is agreeable to us.

THE MAGISTRATE: The witness will be here at 11:00?

DR. PADMANABHAN: Yes.

THE MAGISTRATE: 11:00 o'clock is when we will resume.

* * * *

C E R T I F I C A T E

I, Carole M. Wallace, Certified Shorthand Reporter, do hereby certify that the foregoing transcript is a true and accurate record of my stenographic notes taken to the best of my skill and ability on March 6, 2015.

Carole M. Wallace, CSR