COMMONWEALTH OF MASSACHUSETTS

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Board of Registration in Medicine,
Petitioner

v. Docket No. RM-14-363

Bharanidharan Padmanabhan,
Respondent Date: March 10, 2016

INITIAL RESPONSE TO REMAND ORDER

On January 21, 2015, the Board of Registration in Medicine remanded my recommended decision in this case with five respectful requests.

I have amended my recommended decision but have not issued it yet. Before I issue it, I ask BRM for clarifications so that I may issue only one amended recommended decision.

• BRM has respectfully asked that I include credibility determinations in my recommended decision. (The remand order uses bullet points. To parallel the remand order, I use bullet points as well.) The following witnesses testified: Dr. Bharanidharan Padmanabhan, the respondent; Dr. Barry Levin, BRM's expert and the principal witness during the hearing; Adele Audet, the Assistant Director of the Prescription Monitoring and Drug Control Program of the Department of Public Health; and Patients C, D, H, I.

I did not assess Dr. Padmanabhan's credibility because this case does not turn on disputed facts, such as the sequence of treatments, what he told a patient, and so on, and the hearing did not present many opportunities to assess his credibility. To the extent that it matters to BRM's decisions on discipline, Dr. Padmanabhan's testimony and demeanor indicated to me

that he was a sincere witness. I will include this credibility determination in a recommended decision if this is the kind of determination that BRM meant in its remand order.

To the extent that BRM requests that I assess Dr. Levin's credibility, he appeared to me as knowledgeable and authoritative, which is why I consistently adopted his opinions. I will include this credibility determination in my amended recommended decision if in its remand order, BRM meant to request that I assess the credibility of an expert witness.

Ms. Audet testified about the procedure and logistics of Dr. Padmanabhan's drug registration. I did not assess her credibility because this case does not turn on disputed facts and the hearing did not present opportunities to assess her credibility. To the extent that it matters, Ms. Audet's testimony made sense and was internally consistent, and her demeanor indicated credibility.

I did not assess Patient C's credibility because Dr. Padmanabhan apparently called the patient to testify briefly that he was a good doctor, especially in comparison to other doctors, and that other doctors, whose second opinions he had sought, had verified Dr. Padmanabhan's opinions. (*E.g.*, Tr. VI-820.) To the extent that Patient C's testimony and credibility is relevant to BRM in determining Dr. Padmanabhan's discipline, I assess that he was sincere in believing that Dr. Padmanabhan was a good doctor. His demeanor indicated credibility.

I did not assess the credibility of Patient D, because Dr. Padmanabhan apparently called him to testify briefly that he is a good doctor and that the patient disagreed with Cambridge Health Alliance's dismissal of the doctor. (*E.g.*, V-754-55). To the extent that Patient D's testimony and credibility is relevant to BRM in deciding Dr. Padmanabhan's discipline, I assess that he was sincere in believing that Dr. Padmanabhan was a good doctor. His demeanor indicated credibility.

I did not assess the credibility of Patient H, because she testified briefly and BRM apparently called her as a witness to confirm events, diagnoses, and misdiagnoses that are recorded in exhibits. (*E.g.*, VI-830 (I said that I was "disinclined to take medical evaluations second-hand from a patient").) To the extent that Patient H's credibility is important to BRM, her testimony appeared consistent and her demeanor indicated credibility.

I did not assess Patient I's credibility because her testimony seemed barely relevant. Twice, I interrupted her testimony to question its relevance. (Tr. VIII-1124, 1128.) Dr. Padmanabhan apparently called Patient I as a witness to testify briefly that he was a good doctor and that other doctors had not been able to help her. (*E.g.*, Tr. VIII-1143, 1147.) I have no reason to question her assessment about Dr. Padmanabhan and other doctors. To the extent that Patient I's testimony and credibility is relevant to BRM in deciding Dr. Padmanabhan's discipline, I assess that she was sincere in believing that he was a good doctor and that other doctors had not been able to help her. Her demeanor indicated credibility.

• I accepted into evidence a consultant's report (the Greeley report) and a transcript of a hearing, both of which related to Dr. Padmanabhan's employment at and dismissal from the Cambridge Health Alliance (CHA). I gave them no weight, which is why I did not cite them in my recommended decision. Not only were they hearsay and not subject to cross-examination or my questions, but they were irrelevant. I conducted a hearing on the Statement of Allegations, which was not about Dr. Padmanabhan's history at CHA. Although Dr. Padmanabhan wanted to turn the hearing before me into a reexamination of his dismissal from CHA, I declined to let him do so. His history at CHA was irrelevant, as I have said, and I suspected that he was trying to use the BRM proceeding as a way to obtain material that he could not obtain in the prior proceeding involving CHA. I did admit into evidence the consultant's report and transcript in the unlikely

event that they were relevant to the Statement of Allegations. Once I confirmed that they were irrelevant, I did not allow the parties to digress further into them. For example, I did not allow Dr. Padmanabhan to discover the identity of the Greeley report's author or authors.

• Regarding evidence contrary to Dr. Levin's expert testimony, Dr. Padmanabhan did not call an expert; I did not allow him to testify as his own expert; he barely contested Dr. Levin's opinions about the substandard state of his medical records, if at all; and as for Dr. Levin's opinions about Dr. Padmanabhan's misdiagnoses, Dr. Padmanabhan testified conclusorily that his diagnoses were correct.

• BRM has asked me to "explain the apparent inconsistency between Dr. Levin's testimony and the Magistrate's Conclusion of Law that the Respondent did not render substandard care to Patients A, B, E, and I." The accompanying footnote reads, "The Board notes that, with respect to Patients A, B, E, and I, Dr. Levin opined that the Respondent's care on at least one day for each respective patient, was below the standard of care."

Regarding Patient A, Dr. Levin opined many times that Dr. Padmanabhan's medical records were below the standard of care. I agree with that opinion and I recommended a finding based on it. I am unaware of Dr. Levin's opining that Dr. Padmanabhan's care was otherwise substandard. If the Board points to my recommended decision or the record where Dr. Levin opined that Dr. Padmanabhan's care of Patient A was substandard, apart from the state of the medical records, I will revisit this topic in my amended recommended decision.

Regarding Patient B, Dr. Levin opined many times that Dr. Padmanabhan's medical records were below the standard of care. I agree with that opinion and I recommended a finding based on it. Apart from the state of the medical records, Dr. Levin opined that on April 28, 2010, Dr. Padmanabhan's care for Patient B was below standard because he did not examine the

patient or order a chest x-ray. I did not make this finding for two reasons. It did not appear in the Statement of Allegations, which focused on his management of Patient B's prescriptions for OxyContin, Oxycodone, and Xanax. And Dr. Padmanabhan was not "guilty of conduct which places into question the physician's competence to practice medicine, including...gross negligence on a particular occasion or negligence on repeated occasions." G.L. C. 112, § 5, ninth para. (c); 243 CMR 1.03(5)(a)(3). Dr. Padmanabhan did not commit gross negligence on April 28, 2010.

Regarding Patient E, Dr. Levin opined many times that Dr. Padmanabhan's medical records were below the standard of care. I agree with that opinion and I recommended a finding based on it. Apart from the state of the medical records, I wrote:

> No explanation exists in the evidence why Dr. Padmanabhan wrote four prescriptions for Patient E after saying he would no longer write prescriptions; why he wrote two prescriptions on May 14, 2009 with a fill date of May 23, 2009; or why he wrote 30-day prescriptions with a fill date of May 23, 2009 and also wrote 30-day prescriptions for the same medications a day earlier, on May 22, 2009, which gave Patient E a 60-day supply of both medications. (Levin testimony, Tr. II-315.)

and

> I find that Dr. Padmanabhan's medical records for Patient E were substandard. I do not find Dr. Padmanabhan's actual care of Patient E was substandard, specifically his management of Patient E's prescriptions for OxyContin and Oxycodone. (Ex. 1.)

In its remand order, BRM asks me to explain the apparent inconsistency between Dr. Levin's testimony and my conclusion that Dr. Padmanabhan did not render substandard care to Patient E. Dr. Levin did not testify that Dr. Padmanabhan rendered substandard care to Patient E by saying he would no longer write prescriptions – and then writing prescriptions.

Apart from maintaining substandard medical records, I am unaware of Dr. Levin's opining that Dr. Padmanabhan's care of Patient E was substandard. If the Board points to my

recommended decision or the record where Dr. Levin opined that Dr. Padmanabhan's care of Patient E was substandard, apart from the state of the medical records, I will revisit this topic.

Regarding Patient I, Dr. Levin opined many times that Dr. Padmanabhan's medical records were below the standard of care. I agree with that opinion and I recommended a finding based on it. I wrote:

> Aside from the medical record, a diagnosis of central nervous system inflammation didn't merit the medications prescribed for Patient I, considering the high doses and potential side effects. Dr. Levin opined that cyclophosphamide, an anticancer drug, is rarely prescribed for neurological problems, although it is sometimes prescribed for multiple sclerosis. It is not prescribed as a first-line drug, is not indicated for central nervous system inflammation, and has many serious side effects. (Levin testimony, Tr. IV-584-90).

and

> The BRM did not prove by a preponderance of the evidence that Dr. Padmanabhan's care of Patient I was below the standard of care or that he misdiagnosed Patient I's condition as inflammation. Dr. Levin testified conclusorily that Patient I did not have that condition. (Tr. IV-594.) With Dr. Padmanabhan making multiple diagnoses, inflammation was probably incorrect, but, again, the BRM did not prove it.
>
> Nor did the BRM prove that Dr. Padmanabhan's management of Patient I's prescriptions for anti-inflammatory medications, immunological medications, and opiates was below the standard of care. In its post-hearing brief, the BRM did not press this part of the Statement of Allegations.

Apart from maintaining substandard medical records, I am unaware of Dr. Levin's opining that Dr. Padmanabhan's care was substandard. If the Board points to my recommended decision or the record where Dr. Levin opined that Dr. Padmanabhan's care of Patient I was substandard, apart from the state of the medical records, I will revisit this topic.

• BRM has asked me to "clarify apparent inconsistencies as to whether the Respondent rendered substandard care to Patient H." The corresponding footnote reads that "on page 2 and 92 of the Recommended Decision the Magistrate states that the Respondent misdiagnosed

Patient H but does not state that the Board proved that the care rendered to Patient H was substandard."

I did not have the benefit of Dr. Levin's expert testimony on some points, but I assume:

- correct diagnoses are the standard;
- misdiagnoses are therefore below the standard of care; and
- Dr. Padmanabhan's prescription of medications based on his misdiagnosis of Patient H was part and parcel of his misdiagnosis and was not a separate incident of substandard care.

Therefore, Dr. Padmanabhan's misdiagnosis of Patient H's condition did constitute substandard care.

I note two additional points. Dr. Padmanabhan's prescription of specific medications could constitute substandard care, but BRM did not prove this, as I have previously written ("BRM did not provide sufficient evidence to prove that the medications were inappropriate to treat MS"). And, as I have previously written:

> If a doctor misdiagnosed condition after condition, I might recommend discipline. However, I have found that Dr. Padmanabhan misdiagnosed two patients' conditions. Because I am aware that doctors – and all human beings – err, I do not recommend discipline because of Dr. Padmanabhan's misdiagnosis of MS in Patients G and H.

To the extent that is necessary to say so, these forthcoming changes are corrections of my scrivener's errors and are not substantive:

- On pages 2 and 4, I have changed the references to "appeal."
- On page 13, Finding of Fact 70, "decreased" is the correct word.
- On page 13, Finding of Fact 70, I have changed "her" to "his."
- On page 20, Finding of Fact 128, I have changed the date to "June 13, 2008."

◦ On page 23, Finding of Fact 143, I intend the date that I included, August 13, 2008. (If BRM believes it should be another date, I am willing to revisit this determination.)

◦ On page 23, Finding of Fact 161, I have changed "In November and December 11, 2009" to "In November and December 2009."

◦ On page 30, Finding of Fact 206, I have changed "January 28, 2008" to "January 28, 2009."

◦ On page 44, I have added the word "care" after "substandard."

◦ On page 44, I have deleted the incomplete sentence and stray reference to "A complete medical record is necessary." (My complete finding on this topic appears on page 6, Finding of Fact 11.)

◦ On page 73, I have changed "Patient E" to "Patient G."

◦ On page 92, I have changed "Patient H" to "Patient I."

I intend this Initial Response to Remand Order to serve as requests for clarifications from the Board of Registration in Medicine, not a reason for the parties to file substantive motions or reopen aspects of the case. I do not preclude the parties from responding to me about this Initial Response to Remand Order but I urge them to make any such responses moderate in length and tone, non-substantive (for example, I doubt that I will change my tentative credibility findings of witnesses or view of the Greeley report based on submissions from the parties), and to recognize that this process, at least regarding a hearing and a recommended decision, is largely over and largely out of my hands.

DIVISON OF ADMINISTRATIVE LAW APPEALS

Kenneth Bresler
Administrative Magistrate

Sent to: Bharanidharan Padmanabhan, M.D.
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