Narendra Jana

Reference: E1-2621276254

GMC 23 July 2020 Response (left) and My Reply (on the right)

Original GMC Response	My Statement by Statement Response
23 July 2020 **In reply please quote: E1-2711476147** **Private: for addressee only** Mr Narendra Jana Dear Mr Jana Thank you for contacting us and taking the time to raise your concerns.	These reports are only written when there are severe and repeated situations where a clinician is trying to physically harm a

We have carefully considered your complaint, but while we appreciate your reasons for writing to us, we don’t feel that these are issues that would warrant further GMC action being taken. We are sorry if this is not the outcome that you were hoping for.	patient. In this case with knowledge of my immigration status, asylum. Its not a situation of casual “appreciation” (there is some consistency in the response by the GMC to downplay a non-trivial case).
It may be important to note that this decision shall only refer to the new matters which have been brought to our attention, as a substantive decision has been made and issued to you with regard to Dr Trip and Dr Aguero.	The case is against Dr. Trip and Dr. Catania and the clinicians at Addenbrooke’s Hospital, I have no idea who Dr. Aguero is (unmentioned anywhere). A lack of appropriate review in response by the GMC.
Our Role Our role is directly related to the registration of doctors. Our responsibilities are all connected to keeping the Medical Register. We oversee medical education; we give entry to the Register for those suitably qualified; we advise on good medical practice while registered; and we remove or restrict registration in response to fitness to practise concerns where there may be a risk to patient safety.	
An investigation can only be opened if the concerns raised are so serious that the doctor’s fitness to practise medicine is called into question to such an extent that action may be required to stop or restrict the way in which they can work to protect future patient safety. The purpose of an investigation is to determine if or to what extent we need to restrict the doctor from working. We are not a general	The investigating would warrant a restriction of the clinician, Dr. Trip, and now the clinicians at Addenbrookes who perpetuated clinical fraud since they have repeatedly showed intent to harm the patient in a clinical setting. If the clinicians aren’t appropriately restricted it becomes a case against the GMC for not fulfilling their role in the NHS. The GMC is simply a single avenue to restrain these clinicians, there are other avenues in police and law enforcement where

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complaints body and we have no legal powers to intervene in or resolve matters for patients.	these clinicals would be restrained from perpetuating harm in a person in asylum in the UK and when the GMC and the clinicians are replicating the basis of asylum. The basis of my asylum makes it additively non-trivial.
Our Decision	
In your correspondence, you raised concerns that you did not receive appropriate treatment and that clinical reports within the medical settings were falsified in order to uphold withholding medications. You also suggest the withholding of medication amounts to assault.	Assault isn't a "suggestion" its law (as stated by the police), when a clinician cites falsified diagnostic reports or writes false reports to uphold fraud and then withholds medications that's by legal definition assault by a clinician. The police simply needed the GMC to parse the medical data for charges of assault.
We understand that you attended the emergency department at the Royal Bournemouth and Christchurch Hospitals on 21 November 2019. It is documented that you attended with a flare up of your typical MS symptoms. Supporting information provided indicates that your current treatment was acknowledged, and it is noted that when flare ups occur you typically present to emergency departments to receive methylprednisolone IV with preceding blood tests on an outpatient basis to cover for a 3-weekly period. It is reported that following discussion with a senior ED registrar you were advised that this is not normal protocol for an emergency department and that the best course of action would be to attend his GP for referral to an appropriate specialist for further management of your MS.	General blood (liver and kidney) tests are done in the ER followed by immediate IV methylprednisolone in ER for 5 days. Follow-up medications (taper doses) are given outpatient. The normal protocol is to give IV methylprednisolone in ER; the GP couldn't be consulted since the Dr. Trip had already defined intent in clinical fraud at UCLH with explicit evidence of fraud. The initial GMC issue was raised due to an outpatient basis situation (Dr. Trip and Dr. Catania are outpatient) and the GP does not have the capability to give the IV medications (methylprednisolone) for a MS relapse. If there is an emergency situation pertaining to MS it will have to be addressed in a ER setting according to NHS guidelines. If the

Further to this you raised a concern, in relation to the April hospital admissions, that Physicians at Addenbrookes supported the conclusions reached by Dr Trip and Dr Catania by falsifying reports in order to deny medical treatment.	mediations aren't given or if Dr. Trip or Dr. Catania are cited in ER to withhold medications it would be automatically considered clinical assault by a physician in a ER setting (due to their history in clinical fraud). They are citing a clinician that practiced clinical fraud to make a false medical opinion to specifically harm a person in asylum (since Dr. Trip has full knowledge of the basis of my asylum, explained to him and written in his report). If this situation replicates citing Dr. Trip or the clinicians in Addenbrookes in another setting its another instance of assault.
We recognise that you feel that you were denied appropriate treatment during your hospital presentations. In considering this concern we took advice from a medically qualified colleague. They observed that in this context, treatment with the therapies discussed, specifically Methylprednisolone and/or plasma exchange, is indicated if there are clear clinical grounds. Having reviewed the information available it was noted that your diagnosis was uncertain and therefore neither therapy was indicated. Treatment is not mandated simply as a patient demands it, it would be for a doctor to use their clinical judgement to determine what treatment, if any is necessary.	The issue isn't that "treatment isn't mandated simply as patient demands it". The issue is gross clinical presentation and that I presented the entire clinical history and diagnostic reports of MS to the clinicians where they desperately tired to avoid reading it or acknowledging. Which indicates intent in a clinical setting. The clinicians in a desperate way tried to make false statements while ignoring diagnostic and medical reports (demonstrating intent in malice). Evidence of me presenting my clinical history is given in the full medical record below (which the GMC does not acknowledge): https://narenjana.com/police/case/full/fullrecord/

Our medically qualified colleague highlighted that neither of the therapies are risk free. They also pointed out that two neurology departments in the UK were not convinced that you have MS. It was their view that it would be highly inappropriate to start these treatments if the diagnosis is in doubt. Based on the information available and the advice of our medically qualified colleague we have not identified concerns in relation to treatments not being provided on the dates in question.	The issue is also the clinical fraud in Dr. Trip's medical setting (where the diagnostic reports are clearly falsified) cited to perpetuate clinical assault in another setting. The case summation is given below: https://narenjana.com/police/case/full/ The moment a clinician falsifies any diagnostic report its no longer a situation of "diagnosis was uncertain". It's a situation of using clinical fraud to mis portray the clinical condition of the patient and then harming the patient when it results in a emergency situation. The nature of the emergency situation and the medication response after the emergency situation also indicates the clinical condition of the patient. For clarification there was only a single setting of a neurology department (UCLH) and three settings of ER (November 2019 and twice in April 2020). UCLH practiced clinical fraud with clear evidence of clinical fraud. Clearly the clinical fraud in UCLH indicates intent and wouldn't fall under the category of "not convinced that you have MS", its fraud to mis portray the clinical condition to harm the patient and presented with clear evidence. Considering the clinical history reports (which the ER doctors repeatedly refused to look at for the sake of their false clinical statements in mis portrayal) I have repeatedly received IV methylprednisolone (35 times) and plasmapheresis (3 times) with no risk and no negative effects. The "medically qualified colleague" should have been intelligent enough to understand that an untreated MS relapse would cause damage to a person's central

information highlighted does not appear to have had any impact on the care received therefore we do not consider this issue requires further consideration.	clinicians in Addenbrookes are implicated in clinical fraud since they make clear statements of clinical falsification in their clinical reports.
You told us that Dr Fayad Ali indicates that treatment was not given due to your status in the UK, having reviewed the information provided we have been unable to locate such a statement. It is apparent that there is reference to your status at the time in the social history but there is no indication that this affected any decision for discharge. We have not identified concerns in respect of this matter that suggest further action is required.	With regards to Dr. Fayad Ali, the statement "It is apparent that there is reference to your status at the time in the social history but there….". This is a statement that further implicates the GMC and appears to be a desperate spin on the part of the writer of this response. How exactly would a clinician I have never met before have knowledge of "social history" and why would it be a valid reason to restrict medication is gross clinical presentation? I have no history in the UK as a new resident, am a new resident of Cambridge (by 4 months), and am not a public figure; how could "social history" be gathered in this situation? Dr. Fayad does indeed cite "status" in the ER setting when attempting to discharge me almost immediately on the 13th of April before the actual discharge on the afternoon of the 14th when in grave clinical condition in ER (I will upload more data to the "full record" link to substantiate it), this indicates that he was aware of my asylum status and that he was trying to perpetuate a illegality in those in asylum in a clinical setting. Indeed only knowledge of immigration "status" makes sense in this context (indicating a breach of patient privacy rights). Otherwise its illegal in medicine to mistreat or withhold treatment citing "social history" as well.

A further concern is raised that doctors involved in your care made false claims within reports to uphold clinical fraud. You refer to Dr Fayad Ali, Dr Rhys Roberts, Dr Alasdair Coles and Dr Dunecan Massey in relation to this concern. After careful consideration of the information documented within the medical records. It is apparent that there have been tests and investigations conducted and that the doctors involved have appropriately considered your medical history. It is reasonable to allow that a doctor must reach their opinions on a patient's diagnosis and treatment based on the information before them and their own medical opinion. Our medically qualified colleague has reviewed the information provided and did not identify issues that they considered to meet the threshold for investigation. Taking this into account and after	In other medical systems (which aren't public healthcare systems) social (economic) status is stratified according to ability to pay for private medical consultation without insurance but in the UK its public health care system where everyone is entitled to the same level of medical care regardless of "social history". It's a stipulate in the NHS that racial background, "social history", political status, immigration status, and social/economic status of the patient are irrelevant and illegal to consider in a clinical setting or to determine level of care in a clinical setting. This desperate spin by the GMC only further implicates both the clinician and the GMC in supporting clinical malice; and is an awkward and unrealistic spin by the GMC. The attempt at a spin simply furthered that Dr. Fayah Ali was referring to immigration (asylum) status in the UK and is implication by the GMC. With respect to the other clinicians including Dr Fayad Ali, Dr Rhys Roberts, and Dr Dunecan Massey (as stated in the complaint the GMC) the full medical history with all diagnostic reports were repeatedly presented to the clinicians (with recording that they were presented). The reports presented are detailed and explicit as well. But the clinicians repeatedly refused to look at any past ER reports or clinical reports only citing the clinically fraudulent reports by Dr. Trip (it indicates the intent and direction of the doctors). Not only were the reports presented but I read a medical note aloud to Dr. Dunecan (presented to the GMC as well). This isn't a situation of medical "opinion", its malice in a clinical setting by ignoring medical history and diagnostics. Explicit evidence of me presenting my clinical history is given below: https://narenjana.com/police/case/full/fullrecord/

consideration of the information available, we have not identified that the doctors identified have failed to take appropriate action or found evidence to support that they have falsified information or acted dishonestly in reaching their decisions.	So the situation is: 1) The doctors intentionally ignored all clinical history when presented with clear evidence of ignoring clinical history. 2) The doctors in ER ignore clear gross presentation in the ER setting and wrote false reports to skirt responsibility. 3) The doctors cited a doctor that practiced clinical fraud (Dr. Trip) to harm the patient from another setting. With clear evidence of medical falsification given in the link above and a denial by the GMC of the falsifications by the GMC, these statements implicate the GMC with clear evidence.
You highlight that Dr Dunecan Massey breached patient privacy laws by speaking to Dr Trip when asked not to and by being involved in the transfer of your medical records. It appears you also consider it inappropriate that Dr Massey mentioned immigration contact information within medical records	It's a typicality in medical reports to include the patient's contact information. Its atypical for medical reports to include the contact information of anything outside medicine or the patient. It demonstrates a lack of appropriate judgement or reasoning on the part of Dr. Dunecan. Dr. Dunecan didn't have appropriate judgment and reasoning in contacting Dr. Trip either. Immigration and home office are closed systems where only the immigrant is allowed to contact the office; this information should be erased from the medical record; it's not useful anyway.
Again, in considering these issues we sought the advice of a medically qualified colleague. They commented that Dr Massey is entitled to seek out any relevant medical information and then make a judgement on its relevance. Further to this they observed that a doctor is entitled to record anything they feel is relevant in the records, they advised that there is no reason why the doctor would not include it.	In seeking the advice of a colleague (Dr. Trip) outside of the immediate emergency setting when repeatedly told not to do so and explaining why the clinician (Dr.Dunecan) should not contact Dr. Trip (due to clinical fraud) and when the patient is in clear

Having considered this advice and reviewed the details provided in relation to this matter we have not found that Dr Massey's actions indicate concerns that would require further action.	immediate gross presentation Dr. Dunecan demonstrates his intent to mistreat the patient. This combined with clearly falsified statements of Dr Rhys Roberts makes it an easy to demonstrate case in any legal setting of the intent and motivation of mistreating the patient. In the example of Dr. Roberts, a starting false statement in the report (with clear evidence) indicates Dr. Robert's intent is falsification in the subsequent basic neurology test (the neurology test is counter to all the other neurology tests in this clinical setting). In effect Dr. Roberts defined intent, ignores gross presentation, and then falsified the neurology test with clear evidence of falsification to skirt responsibility. The discharge on the 14th is predicated on the false statements by Dr. Robert (in an attempt to absolve responsibility). Dr. Dunecan is a gastroenterologist (when quizzed he had little knowledge of anything with respect to neurology) and is not qualified to interpret the statements of a clinician that did practice clinical fraud, Dr. Trip, (he explicitly stated his lack of qualification in ER ward as well).
Within the complaint you refer to a discharge summary reported by a Dr Pippa Leighton and raise a concern that you were never seen by this doctor. Our medically qualified colleague advised that a discharge summary is written from the notes and that they can be written by any ward doctor even if they have not seen the patient. With this in mind, we have not found that this matter suggests concerns that would indicate further action is appropriate. After careful consideration of your concerns, review of the information provided and having taken account of the advice of our medically qualified colleague, we have not identified concerns about the doctors	In reference to Dr Pippa Leighton, certain statements made in the reports are only what the observing clinician could be able to write in the clinical report. Its illogical to state that a completely unrelated clinician could write the report with no background or knowledge.

involved that would indicate further action is required to remove are restrict their registration. Please be assured that we have carefully considered all of the information that you have provided, and we have sought the advice of a medically qualified colleague before reaching our decision. However, we do not feel that the GMC are the appropriate organisation to take your concerns further at this time. We can therefore confirm that we are closing your enquiry; we are sorry if this is not the outcome that you were hoping for. Yours sincerely **FTP Complaints and Correspondence Team** 3 Hardman Street Manchester M3 3AW **Email:** FPDDecisions@gmc-uk.org **Phone:** 0161 240 8216 Complaints and Correspondence Team Working Hours are Monday – Friday 9am – 5pm **Please note, our offices have been affected by the Covid-19 pandemic, we are following government advice and as such, our access to postal services may be impacted. In this circumstance, we would advise you to contact us by email, or phone where possible.**	Rather then ameliorate the situation against the clinicians in Addenbrookes or Dr. Trip and Dr. Catania this response by the GMC further implicates both the clinicians and the GMC with explicit detail and evidence. You are dealing with an person in asylum where all these responses would be represented in another legal setting. This situation only occurred because the GMC didn't restrict Dr. Trip in the initial complaint and thus he predictably perpetuated further harm in another setting. With respect to my condition at that time I luckily I had some remaining medication at home (IV methylprednisolone) to self-administer to rehabilitate from the MS relapse, which predictably worked as intended and similar to all past instances of MS relapses presented in ER settings. Self-administration puts me at further risk and harm without liver, kidney, and blood tests (the clinicians created this risk). Medicine is a science and its not a debatable medical "opinion" from fraudulent diagnostic reports. And there is more evidence then I would ever need to show intent. Refusal to investigate cases of intentional harm in clinical settings by ignoring clear gross evidence implicates the GMC.

	nervous system which is far greater than the risk of medications; the risk is also mitigated and nullified by simple blood, liver, and kidney tests. In the ER setting its clear beyond a doubt that I have progressive hemiplegia due to a MS relapse from April 11th to April 14th but that the clinicians aggressively tried to evade acknowledging the gross clinical presentation and progression in an attempt to uphold Dr. Trip. Dr. Roberts for example clearly falsified his neurology test when in gross presentation, which is also fraud in a clinical setting. Its also clear that im completely conscious and fluent in the ER setting (full recording of the entire situation), indicating that the only part of my CNS that was effected by the MS relapse was a section of the spinal column or brain stem that effects motor movement in the right hemisphere of my physiology (which your colleague should have recognized). Its no longer a situation of being "convinced that you have MS", it's a situation of citing falsified clinical reports (by Dr. Trip) to create a false diagnosis and then further harming the patient in a clinical setting using falsified clinical statements and withholding medications. The diagnosis of MS is without a doubt but the intent of clinical fraud in Addenbrookes is now also without a doubt; to harm the patient while evading responsibility by using false diagnostic reports and ignoring immediate clinical presentation.
Within the information provided, you highlight that information that Dr Joseph Moneim documented within the medical records, relating to your background, was inaccurate. While we recognise that you dispute the information there is nothing to suggest that if the information was inaccurate there was any malicious intent. It is reasonable to allow that there may have been a misunderstanding of details provided. The	Dr. Joseph Moneim isn't implicated in fraud (as stated in the complaint) though he does omit some information. The other

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