

**2008 December 4<sup>th</sup>**

- **Dr. Evan Murray - Belmont, Massachusetts, USA**
  - **Criminal Negligence →**

Dr. Evan Murray is the initiator of medical negligence and malice in medical settings and in the long term the undoubted cause of the neurodegenerative sequel through medical negligence that eventually becomes criminal (criminal fraud and criminal clinical negligence in an international setting). Its important to look at his past behavior in order to demonstrate his malice in medical settings in the future. In future settings he is far more enthusiastic about intentional physical harm through inappropriate recommendations that cause neurological damage is a clear way. His initial negligence is the underlying cause in 11 years of gross medical negligence thereafter.

Narendra  
Jana

Author: Evan D. Murray, M.D. (checked by: Department of Psychiatry)

12/04/2008

Richard Falzone, M.D.  
Department of Psychiatry  
McLean Hospital  
1151 Mill Street  
Belmont, MA 02478

RE: JANA, NARENDRA N  
MRN: 4668263  
DOB: 10/27/1984

REASON FOR REFERRAL: Please evaluate the patient's psychiatric symptoms and cognitive deficits for a neurological cause.

Dear Dr. Falzone:

I had the pleasure of evaluating Mr. Narendra Jana this afternoon. As you know, he is a 23-year-old right-handed Indian American male without a previous medical history who is status post a McLean Hospital admission in 04/2006 for new onset psychiatric symptoms and memory difficulties starting approximately 3 years ago. The patient reports being in his 4th year at Penn State University studying electrical engineering and doing a semester abroad at Leeds University in England during which time his grades were quite good, being A's, until he began developing concentration difficulties. He came home for an Easter holiday and shared his difficulties with his parents at which time they contacted the university and he was allowed to come home early from the semester and complete his examinations at a later date. He still has several credits of course work to complete before graduating college. After returning home on Easter break from Leeds University, he was seen by his primary care physician who performed laboratory work revealing hypoglycemia (into the 40s) after meals. Mr. Jana was experiencing fatigue despite 10 hours of uninterrupted sleep and described difficulty completing school course work towards the last month or two at Leeds. He has no history of snoring, nighttime kicking or apnea. He would have to read things repetitively and still would have a hard time understanding what he had read and recalling the information. He has always been a very good student obtaining mostly A's and a few B's and his academic difficulties were new. He was having a difficult time following conversations and sometimes his father would speak to him and he would not be able to understand him and it would sound "garbled". His father states that he could repeat the question to Narendra several times and ultimately, he would answer "yes" or "no". He has no known history of seizures.

During his previous hospitalization at McLean Hospital, he was seen by the Neurology consultation service at which time Mr. Jana reported blurry vision and increased difficulty seeing at night. He also reported that sounds and music have less depth and richness. He reported a decreased ability to distinguish between different instruments and that he was experiencing no joy when listening to music anymore. He also had diminished sense of taste and smell stating that "everything tastes like to chalk." He felt a sense of "spatial non-awareness" of his left side greater than his right. He also stated that he had more trouble sensing his left side.

Today, he denies any difficulty with numbness, tingling, weakness, incoordination or gait problems. He denies any hallucinations. His father states that he is able to perform all of his activities of daily living; however, he needs prompting to get up out of bed in the morning and shower, shave and brush his teeth. During the day, he sits inside and watches television and plays computer games and sometimes has little recollection of the day. He is more awake at night and seems to be more interactive at that time. He describes a "bruised" feeling in the posterior aspect of the right side of his head. This sensation may shift over to the left side and may sometimes spread a little bit anteriorly on either side. He denies that this is painful or that it fluctuates or has triggers. He estimates its intensity is being 3/10 with 10 being maximal intensity. He denies symptoms of photophobia and is always a little bit sensitive to sounds.

In the summer of 2006, he began to experience episodes of nausea and vomiting, sometimes 2-3 times per week. His workup was extensive and included a normal EGD, a normal biopsy of the small intestine and a normal barium swallow. An antigliadin antibody was mildly elevated revealing an IgG of 104 and an IgA of 45, but a tissue transglutaminase that was within normal limits. His symptoms were described in available reports as being post-prandial.

Previous testing has included a negative heavy metal screen, nonreactive RPR, normal thyroid functions, B12 and folate. He underwent an evaluation by Dr. Sandeep Kumar of the Beth Israel Deaconess Medical Center Department of Neurology who found no neurological cause for the patient's symptoms. An MRI of the brain in late 2006 was read as normal and an EEG in 2007 was also read as normal. Previous trials of medications have included Effexor, Sam-E, amitriptyline, Abilify, selegiline, Provigil and amphetamine all of which have not been very helpful.

Neuropsychological testing performed at the Beth Israel Deaconess Medical Center 02/21/2007, revealed weaknesses in attention and executive functioning, which were felt to result in attention-based memory problems. Visuospatial function was

The bruised feeling is due to a lesion (inflammation) the cervical spine typical of multiple sclerosis. The inflammation causes progressive neurodegeneration of the cervical spine that diagnosticians in the future try to hide in order to support Dr. Murray's negligence. Counter to the report I was vocal about the physical pain that it caused and persistently caused thereafter till 2017 when the medications were given appropriately in a ER setting abroad.

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The visuospatial statement indicates optic neuropathy, which is typical of multiple sclerosis.

I believe he has an inherent bias since he works in a psychiatry hospital. I never exhibited psychiatric symptoms as Dr. Falzone stated. He later uses his bias to ignore gross features in a neurodegenerative condition.

Immediately after this appointment its apparent that I have gross inflammation in the brain in the next MRI, the doctor ignores it. The 11 years of neurodegeneration thereafter was preventable by this neurologist.

I believe Dr. Murray is trying to attach random symptoms to the typical interictal and preictal effects in seizures due to bias in his medical setting. I never exhibited these symptoms.

*Author: Christopher Murray, MD, (Director of Neurodegeneration)*

felt to be a weakness also. There was globally slowed processing speed. The relative weaknesses in visuospatial functioning were felt to possibly represent a long standing neurodevelopmental substrate. Psychological assessment revealed thought disorder with depressive symptoms.

Over the past several weeks, Mr. Jana has reported symptoms of paranoia sometimes feeling that the things that people say to him or around him "sound sinister." He also will look at objects and occasionally feel threatened by them or have threatening thoughts, being fearful that these objects may somehow hurt him. He reports "strong recollections of random memories" during which he will see an environment such as a pizza parlor, which he has been in previously, and experience it in a very vivid fashion even smelling the food. He has had episodes of briefly mistaking light poles for being people, but denies hallucinations. He is depressed at this time, but denies suicidal ideation. He attended the McLean partial program in 02/2008, but was discharged because he missed activities.

**PAST MEDICAL HISTORY:** In 04/2008, he underwent an evaluation at the University Of Massachusetts Memorial Medical Center for tachycardia. At that time, an echocardiogram was reported to be normal.

**ALLERGIES:** None.

His medications include Zyprexa 5 mg per day and lamotrigine 100 mg per day.

**SUBSTANCE ABUSE/DEPENDENCE:** His last drink of alcohol was 2 years ago. He tried marijuana one time. He denies any use of cocaine, ecstasy, LSD or other drugs. He does not smoke.

**SOCIAL HISTORY:** He was born in India and came to the United States at the age of 9. His older sister lives in San Francisco. He currently lives with his parents and does not have friends. His father reports that he has withdrawn from social activities. The patient states that his friends no longer live in the area. He has no HIV risk factors. He was born full term without complications and had normal developmental milestones.

**FAMILY HISTORY:** He has a maternal uncle with bipolar disorder and an aunt who might have had a brain tumor. No seizure disorders, multiple sclerosis, or other neurological conditions.

**MENTAL STATUS EXAMINATION:** The patient is appropriately dressed and groomed and appears his stated age. His eye contact is good and there is no unusual behavior. His speech is hypophonic intermittently, but fluent with a regular rate and rhythm. His affect is constricted. His thought process is mostly linear, but at times he has convoluted explanations of his experiences demonstrates an unusual use of language. No delusions or psychotic symptoms are evident. His insight and judgment appear fair to reduced. Tests of orientation, following 3 step commands, language repetition, naming, reading, writing, and comportment are within normal limits. Serial 7's are performed very slowly. He is able to spell the word "earth" forwards quickly, but is slow spelling it backwards and very slow alphabetizing it. Clock drawing reveals mild difficulty with planning of number placement. There is no evidence of spatial neglect. He registers 4/4 memory items on the first attempt and after 5 minutes recalls 3 spontaneously and one more with cuing. Cranial nerves II through XII are intact. Motor strength, bulk and tone are normal. There is no pronator drift. Sensation is intact to light touch and sharp. He is Romberg negative. Coordination testing reveals a normal finger-to-nose, rapid alternating movements, fine motor control and heel-to-shin examinations. Gait testing reveals a normal toe, heel and tandem walk, although his arm swing is mildly reduced on both sides. Reflexes are 1+ in the bilateral upper extremities, 2+ at the knees, 1 at the ankles and both toes are downgoing.

**IMPRESSION:** Mr. Narendra Jana is a 23-year-old male who presents with approximately 3 years of new onset cognitive difficulties, thought disorder and depressive symptoms that have been relatively refractory to management. He continues to experience difficulty motivating himself, organizing his activities and focusing on school work. More recently, he has been experiencing symptoms of paranoia. His cognitive examination today reveals a constricted affect, mildly convoluted explanations of symptoms (suggestive of thought disorder), unusual word usage, mild attentional difficulties, slowed processing speed and mild planning difficulties on clock drawing. There was only slight suggestion of memory retrieval difficulty; however, this is likely a function of impaired attention. Language function and comportment are intact as is his visuospatial function. His elemental neurological examination is unremarkable. These findings mainly localize to dysfunction in frontal lobe circuitry. His clinical history is not very suggestive of a neurodegenerative disorder or epilepsy. A very early neurodegenerative condition cannot be entirely excluded at this time. His new onset of nausea and vomiting starting approximately 3 years ago appears to be attributed to "post prandial symptoms", as per her medical records. It may be reasonable to pursue additional screening for porphyria as psychotic symptoms can sometimes be associated with this condition. Additionally, celiac disease is an entity that has been associated with cognitive and behavioral changes; however, his workup does not appear to be very supportive of celiac disease as seen by a normal small bowel biopsy. His previous neurological workup included an MRI and an EEG, which were reportedly both within normal limits. The likelihood of a neurological disorder being causative of his present constellation of symptoms is low; however, further workup is reasonable due to the refractory nature of his symptoms. It is possible that his constellation of symptoms represents a prodrome for a psychotic disorder; however, I will defer on a final diagnosis until additional workup is complete.

I recommend a repeat MRI of the brain to assess for interval change, focal atrophy or lesions in limbic regions. An EEG should be performed recording minimally the awake and drowsy states to ensure that there is no evidence of slowing or epileptiform activity.

I recommend ongoing pharmacologic management of depressive symptoms and paranoia. Cognitive behavioral therapy may

Narendra  
Jana

AUTHOR: Evan D. Murray, MD, (408) 255-1111

be beneficial for managing symptoms of depression and paranoia if insight is present. Repeat psychodiagnostic testing may be considered. He will follow up with me in the clinic after completion of the recommended studies.

Sixty minutes of time was spent interviewing the patient and his father, reviewing medical records and performing the examination. Thirty minutes of time was spent counseling the patient on the evaluation and management recommendations. His review of systems was otherwise negative except as documented above.

Sincerely,

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Evan D. Murray, MD

cc:

DD: 12/04/2008  
TD: 12/05/2008 11:16:53  
TR: 3579255  
BackJob ID: 655078  
VoiceJob ID: 34130509

Narendra  
Jana

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