2009 February 5th

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

Second of the two reports by Dr. Evan Murray written on February 5th 2009. He ordered the December, 18th, 2008 MRI and then perpetuated negligence as below. The doctor doesn't acknowledge the condition and doesn't give any palliative therapy for a clear gross presentation of medical toxicology. The typical treatment would be plasmapheresis or dialysis to remove or limit the toxicity. This toxicity results in multiple sclerosis (MS), which even after repeated attempts at asking for help in medical settings in Massachusetts is completely ignored (repeated clinical negligence and criminal fraud in medical settings to withhold treatment). It results in progressive MS (progressive neural atrophy and neurodegeneration). His negligence in medicine is specifically illegal due to the clearness of the medical pathology and his intent in malice is written in the report (a list of clearly inappropriate recommendations). Doctors are required to do additional tests (MRIs of both brain and spine, blood tests, CSF tests, and toxicology tests and tests for specific conditions like Multiple Sclerosis) and then stabilize the condition in a ER hospital setting. Nothing is done. The condition is never stabilized and the doctor ignores everything resulting in 11 years of negligence through criminal fraud in medical settings. The medical fraud thereafter is believed to be attempts to cover his negligence.

His Report is given below:

02/05/2009

REFERRING PHYSICIAN:
Richard Falzone, M.D.
Department of Psychiatry
McLean Hospital
115 Mill Street
Belmont, MA 02478

RE: JANA, NARENDRA N
MRN: 4668283
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 in follow up. As you recall, he is a 23-year-old right-handed Indian American male who is status post a McLean Hospital admission in 04/2008 for new onset psychiatric symptoms and memory difficulties starting approximately 3 years previously. The patient presents today in the company of his mother and father to follow up on the results of studies.

In the interim, he reports no new cognitive symptoms, but just persistent memory difficulties, lack of "thought coherence," poor motivation and an inability to understand why these things are happening. He denies auditory and visual hallucinations. He endorses occasional paranoia about people talking about him, but says that this is less frequent than previously. He keeps very irregular sleeping hours, sleeping much of the day, getting up in the late afternoon, eating 1 or 2 meals in a day and staying up at night. He endorses depression, but denies suicidal ideation or homicidal ideation. He denies auditory, visual and olfactory hallucinations. He expresses hopelessness about finding a treatment for his depression and thinking difficulties. He continues to endorse having less of a general sense of taste and smell. His parents indicate that when he talks his use of language is normal and his intelligence appears intact. At home he often "refuses to talk" and requires prompting to attend to basic activities such as brushing his teeth and showering. They observe that he spends most of his time in bed and over the past week was in bed almost entirely until today when he spontaneously got up, got dressed and was more interactive. He continues to occasionally visit with his friends. His parents observe that he goes out at night and drives to the local CVS to pick up vitamins and herbal supplements. He states that he uses only appropriate small amounts of these supplements. However, his parents sometimes observe that a newly purchased a bottle could be empty within a day or two. He does not describe the supplements, except to say that they are B complex and zinc, but his parents believe there may be additional supplements. He has had no difficulties driving except for one episode of slipping off the road in very icy circumstances in 12/2008. He does not exercise. He experiences headaches approximately 1 time each month, which are debilitating and cause him to be bed bound. These involve his whole head and are of a 7 out of 10 intensity with 10 being maximal discomfort. There is no retro-orbital pressure, but the headaches are pulsatile. They are associated with photophobia and phobia as well as nausea and sometimes severe vomiting. Headaches are not preceded by an aura and are not associated with any visual changes. His parents reveal that Narendra is very sensitive to all the medications that he has been tried on. Even small doses cause him to be very sedated. Narendra reveals that he is not interested in trying any medications and is not optimistic about them helping him.

MEDICATIONS: None.

MENTAL STATUS EXAMINATION: The patient is appropriately dressed and groomed and appears his stated age. His eye contact is intermittently reduced. 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 there is a slightly convoluted explanation of his experiences and an unusual usage of language. No overt delusions or psychotic symptoms are evident, except for a severe negativism about the possibility of getting better. His insight and judgment are reduced. Tests of orientation, language function and recent recall as discussed in the context of family matters is intact. Observation of cranial nerves 2-12 reveal no focality. Motor function, coordination and gait are within normal limits.

EEG performed 12/18/2008 at McLean Hospital was a normal awake and drowsy study.
An MRI of the brain performed 12/18/2008 at McLean Hospital revealed increased signal within the globus pallidus on both sides on T1 images, which were felt to represent mineralization. There was a small region of hypointensity noted to the right of the 4th ventricle on T2 weighted image that was not seen on other sequences and was felt to be artifactual. The overall

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Dr. Murray has a hospital bias, he confuses interictal effects in a seizure with psychiatry. I never exhibited psychiatric symptoms but often complain of severe headaches from lesions (inflammation) in the cervical spine.

This is where gross medical negligence begins.

Author: Evan D. Murray, M.D.

impression was that there was no definite radiographic abnormality seen.
Laboratory evaluation 01/09/2009 revealed a white blood cell count of 7, hematocrit 44.2, platelets 281, glucose 80, BUN 11, creatinine 0.7, calcium 9.8, albumin 4.4, bilirubin 1.3 (normal limits 0.4-1.2), alkaline phosphatase 118 (normal being between 0-100), ALT 48 (normal being between 0-35), AST 33, iron 106, magnesium 2.2. Parathyroid hormone normal. Ferritin within normal limits. Ceruloplasmin within normal limits. Serum copper 0.96 within normal limits. Manganese within normal limits. A 24-hour urinary copper excretion within normal limits.

IMPRESSION: Mr. Narendra Jana is a 23-year-old male who presents with approximately 3-1/2 years of new onset cognitive difficulties, thought disorder and depressive symptoms that have been relatively refractory to management. He continues to experience difficulties motivating himself, organizing his activities and recalling recent events. His brief screening cognitive examination is unchanged compared to when he was last seen in clinic 12/04/2008. His screening cognitive testing has revealed only a slight suggestion of memory retrieval difficulty, which is felt to be most likely a function of his impaired attention. His elemental neurologic screening examination is unremarkable. His clinical history is not felt to be very suggestive of a neurodegenerative disorder or epilepsy. Additional screening labs were performed in order to exclude less common causes of mental status changes such as Wilson's disease, porphyria, iron metabolism disorders and heavy metal toxicity, none of which have been confirmed. The above described MRI findings of mineralization in the basal ganglia are a non-specific finding that may be seen in asymptomatic persons. Idiopathic basal ganglia calcification, or Fahr's disease, may be associated with behavioral changes and psychotic symptoms, particularly when manifesting at a younger age but, in this case, the extent of calcification seen on MRI brain is small compared to that more commonly seen in Fahr's disease. Also, there has been no evidence of movement disorder, which more often accompanies Fahr's disease and there is an absence of a family history of Fahr's disease which is more often autosomal dominant. There is no known family history of consanguinity.

It is felt at this time that Mr. Jana is experiencing a depressive episode with some intermittent psychotic features that are mild. He declines to try medication management at this time. I recommended and offered to escort him over for psychiatric evaluation today at McLean Hospital but he declined this. Further discussion of this matter should continue with Dr. Falzone. Treatments for depression can include SSRI's, tricyclics and MAOIs. If he is unable to tolerate SSRIs and tricyclics then an MAOI might be considered. Adjunctive treatment with neuroleptics might also be beneficial for treating depression with psychotic features. Adjunctive approaches can include cognitive behavioral therapy and participation in psychiatric day program activities. The patient and his parents have been counseled that excessive use of dietary supplements can be toxic. Electroconvulsive therapy has been discussed with the family and the patient as a possible effective treatment for depression. The patient has expressed a lack of interest in this treatment at this time. His clinical history also suggests migraine headaches occurring approximately 1 time per month, associated with nausea and vomiting. The patient again is not interested in trying medications. Attempts should be made to normalize his sleep cycle and this may have some benefits for improving or reducing the frequency of headaches. A headache diary could be kept documenting food items consumed within the 24 hours prior to a headache to identify possible precipitating factors. Prophylactic medications can be considered. Tricyclics such as Elavil and/or Pamelor can be effective for treating migraines, depression, improving nighttime sleep and reducing symptoms of anxiety. Mood stabilizing agents may also be effective for managing headaches, particularly Depakote. Abortive therapy for migraine headaches can include oral, nasal or SC sumatriptan. A nasal or SC form may be best as he often experiences significant nausea and vomiting associated with headaches. Sumatriptan should be used cautiously if the patient is being treated with SSRIs as there is a concern for an increased risk of serotonin syndrome. Recommend that the patient follow up with Dr. Falzone of Psychiatry for ongoing assessment of his psychiatric condition.

60 minutes of time was spent interviewing the patient and his parents, reviewing medical records and performing a very focused examination. 30 minutes of time was spent counseling the patient and his parents on the recommendations. His review of systems was otherwise negative except as documented above.

Addendum: Mr. Jana E-mailed stating that he had taken possibly 10-15 grams of an over the counter manganese supplement and he wonders whether this has caused his symptoms. History reveals that he took this supplement after the onset of his symptoms not before and therefore this is not thought to be etiologic. He has been instructed to stop taking herbal supplements and alternative medicines as he is not taking them responsibly.

Evan D. Murray, MD

cc:

DD: 02/05/2009
TD: 02/07/2009 12:52:03

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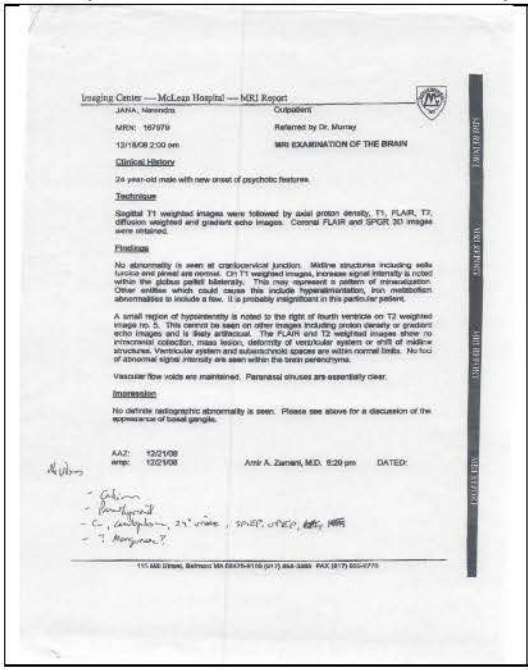
These features are never seen in asymptomatic persons. Dr. Murray also explicitly knows that the feature is a manganese toxicity since he writes it in the MRI report in his handwriting:



Imaging Center — McLean Hospital — MRI Report

JANA, Narendra — Outpatient
MRN: 187979 — Referred by Dr. Murray
12/18/08 2:00 pm — MRI EXAMINATION OF THE BRAIN

Clinical History

24 year-old male with new onset of psychotic features.

Technique

Sagittal T1 weighted images were followed by axial proton density, T1, FLAIR, T2, diffusion weighted and gradient echo images. Coronal FLAIR and SPGR 3D images were obtained.

Findings

No abnormality is seen at craniocervical junction. Midline structures including sella turcica and pineal are normal. On T1 weighted images, increase signal intensity is noted within the globus pallid bilaterally. This may represent a pattern of mineralization. Other entities which could cause this include hyperalimentation, iron metabolism abnormalities to include a few. It is probably insignificant in this particular patient.

A small region of hypointensity is noted to the right of fourth ventricle on T2 weighted image no. 5. This cannot be seen on other images including proton density or gradient echo images and is likely artifactual. The FLAIR and T2 weighted images show no intracranial collection, mass lesion, deformity of ventricular system or shift of midline structures. Ventricular system and subarachnoid spaces are within normal limits. No foci of abnormal signal intensity are seen within the brain parenchyma.

Vascular flow voids are maintained. Paranasal sinuses are essentially clear.

Impression

No definite radiographic abnormality is seen. Please see above for a discussion of the appearance of basal ganglia.

AAZ: 12/21/08
emp: 12/21/08 — Amir A. Zamani, M.D. 8:26 pm — DATED:

- Calcium
- Parathyroid
- Cu, Ceruloplasmin, 24 hr urine, SPEP, UPEP, ANA, HMA
- ? Manganese ?

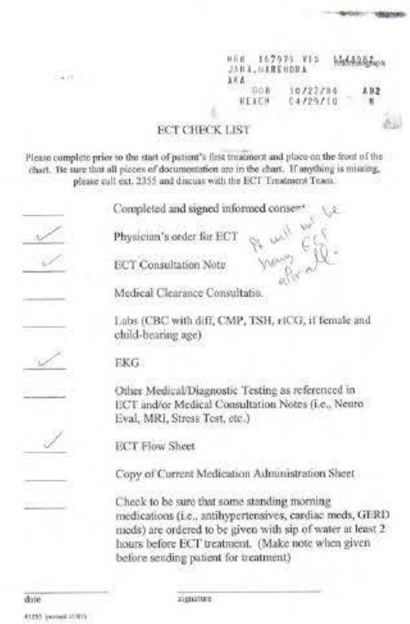
115 Mill Street, Belmont MA 02478-9106 (617) 855-3000 FAX (617) 855-2770

The last statement is a ?Manganese? He didn't need a urine test, I told him were the toxicity came from. It was by accident on my part. It required immediate emergency care in 2008 and 2009 which never happened in 2008 or 2009 even with repeated attempts.

The medical malice of Dr. Murray is present in this report. Though there is a feature of gross inflammation in the MRI that he knows is a metal toxicity that needs immediate emergency care his immediate recommendation is inpatient medications that would have no effect in medical toxicology.

This is a situation where a emergency room visit would be required and where no clinician would recommend convulsive therapy in a person with large T1 inflammation in an MRI a few weeks earlier. If ECT was given it would cause recurrent seizures and rapid neurodegeneration; which it predictably did. Its specifically never recommended in those who have multiple sclerosis; demonstrating malice.

In the future (2010) there are two instances were Dr. Murray aggressively recommends electroconvulsive therapy. I deny it the first time understanding that there was something wrong with the doctors behavior when he recommends it:



MRN 167975 VIS [illegible]
JANA, NARENDRA
AKA
DOB 10/27/84 AB2
REACH 04/29/10 M

ECT CHECK LIST

Please complete prior to the start of patient's first treatment and place on the front of the chart. Be sure that all pieces of documentation are in the chart. If anything is missing, please call ext. 2355 and discuss with the ECT Treatment Team.

- ___ Completed and signed informed consent
- ✓ Physician's order for ECT
- ✓ ECT Consultation Note
- ___ Medical Clearance Consultatio.
- ___ Labs (CBC with diff, CMP, TSH, rHCG, if female and child-bearing age)
- ✓ EKG
- ___ Other Medical/Diagnostic Testing as referenced in ECT and/or Medical Consultation Notes (i.e., Neuro Eval, MRI, Stress Test, etc.)
- ✓ ECT Flow Sheet
- ___ Copy of Current Medication Administration Sheet
- ___ Check to be sure that some standing morning medications (i.e., antihypertensives, cardiac meds, GERD meds) are ordered to be given with sip of water at least 2 hours before ECT treatment. (Make note when given before sending patient for treatment)

Pt will not be having ECT afterall.

date signature

#1255 (revised 4/07)

The note states "Patient will not be having ECT afterall". I wasn't aware the doctor was trying to physically harm me through medical coercion then but you could define it by his behavior.

Dr. Murray appears to have eventually coerced the patient into electroconvulsive therapy by

1) not giving any appropriate treatment options for medical toxicology or neurology
2) by taking advantage of the patients mental state due to his physiology/neurological condition

The headache complained about is due to lesions in the cervical spine that cause gross neurodegeneration by Dr. Murray's negligence. They aren't migraines, they are persistent 24/7 headaches due to inflammation in the cervical spine. With T1 lesions (inflammation) in the brain, Dr. Murray already knows the cause of headaches. He's ignoring a severe pathology.

Imaging Center — McLean Hospital — MRI Report

JANA, Narendra — Outpatient

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Impression

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AAZ: 12/21/08
emp: 12/21/08 — Amir A. Zamani, M.D. 8:20 pm — DATED:

115 Mill Street, Belmont MA 02478-9106 (617) 855-3385 FAX (617) 855-2770

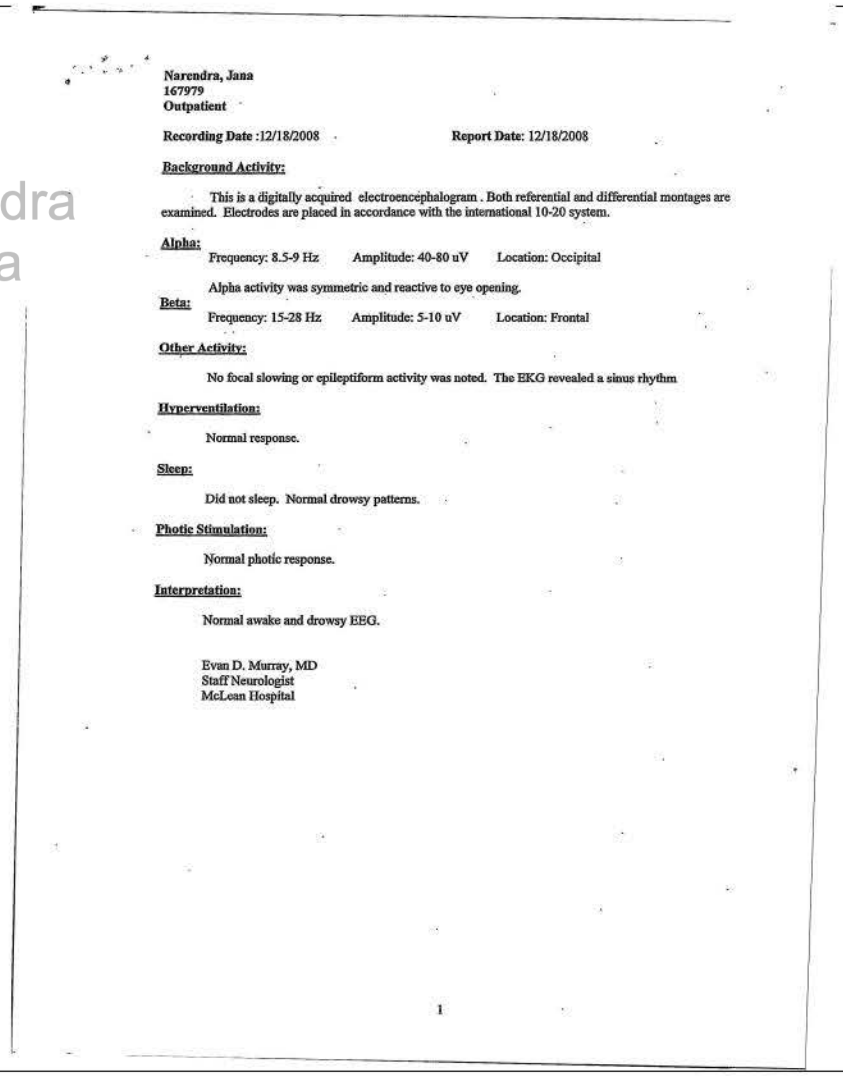
The doctors ignores the feature is the MRI report stated:

"An MRI of the brain performed 12/18/2008 at McLean Hospital revealed increased signal within the globus pallidus on both sides on T1 images, which were felt to represent mineralization. There was a small region of hypointensity noted to the right of the 4th ventricle on T2 weighted image that was not seen on other sequences and was felt to be artifactual. The overall impression was that there was no definite radiographic abnormality seen."

The radiological finding is a gross abnormality only found in those that have specific neurological conditions or toxicological conditions. The doctor couldn't have had a grosser finding in an MRI requiring immediate treatment. Emergency treatment would be required immediately but he completely ignores it.
He negligence is the underlying cause of long term neurodegeneration through malice in medical settings (clinical criminal fraud and criminal negligence).

Author: Evan D. Murray, M.D.

TR: 3579442
BackJob ID: 894849
VoiceJob ID: 35129449



Narendra, Jana
167979
Outpatient

Recording Date :12/18/2008 Report Date: 12/18/2008

Background Activity:

This is a digitally acquired electroencephalogram . Both referential and differential montages are examined. Electrodes are placed in accordance with the international 10-20 system.

Alpha:

Frequency: 8.5-9 Hz Amplitude: 40-80 uV Location: Occipital

Alpha activity was symmetric and reactive to eye opening.

Beta:

Frequency: 15-28 Hz Amplitude: 5-10 uV Location: Frontal

Other Activity:

No focal slowing or epileptiform activity was noted. The EKG revealed a sinus rhythm

Hyperventilation:

Normal response.

Sleep:

Did not sleep. Normal drowsy patterns.

Photic Stimulation:

Normal photic response.

Interpretation:

Normal awake and drowsy EEG.

Evan D. Murray, MD
Staff Neurologist
McLean Hospital

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A 15 minute EEG was done but the report may be falsified.

For two reasons:

First is that the metal toxicity unregulates GABA transmission in the brain. GABA controls inhibition in seizures. Thus I would either be having seizures during this test or would eventually develop it, biology dictates that I would. Its mathematical.

EEG reports are falsified in the future (with clear evidence of doing so), thus it would show the same pattering in this report, that it may be falsified.

Considering the other inappropriate recommendations in Dr. Murray's appointment report with clear (later demonstrated) intentional intent in criminal malice, that may be the case.