2017 April 7th and 2017 May 12th

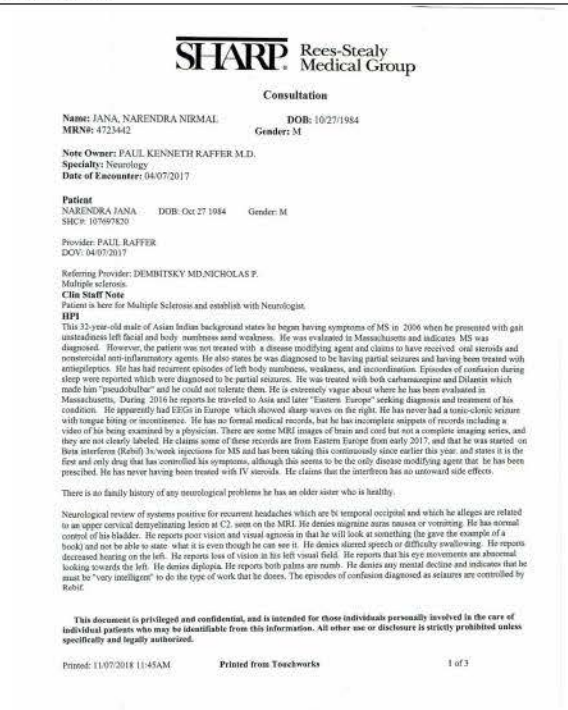
- **Dr. Paul Raffer – Sharp Hospital, San Diego, California**
  - **Criminal Negligence →**

2017 April 7th:

After my MRI done in Riga, Latvia I return to the United States and I moved from Massachusetts to San Diego California for a new job. An appointment with Dr. Paul Raffer takes place in Sharp Hospital in San Diego, California on April 7th 2017.

The doctor isn't aware that I already know most of the clinical reports from past diagnostic data in the US is fraudulated.

His report is below:



SHARP Rees-Stealy Medical Group

Consultation

Name: JANA, NARENDRA NIRMAL **DOB:** 10/27/1984
MRN#: 4723442 **Gender:** M

Note Owner: PAUL KENNETH RAFFER M.D.
Specialty: Neurology
Date of Encounter: 04/07/2017

Patient
NARENDRA JANA DOB: Oct 27 1984 Gender: M
SHC#: 107697820

Provider: PAUL RAFFER
DOV: 04/07/2017

Referring Provider: DEMBITSKY MD,NICHOLAS P.
Multiple sclerosis.
Clin Staff Note
Patient is here for Multiple Sclerosis and establish with Neurologist.
HPI
This 32-year-old male of Asian Indian background states he began having symptoms of MS in 2006 when he presented with gait unsteadiness left facial and body numbness and weakness. He was evaluated in Massachusetts and indicates MS was diagnosed. However, the patient was not treated with a disease modifying agent and claims to have received oral steroids and nonsteroidal anti-inflammatory agents. He also states he was diagnosed to be having partial seizures and having been treated with antiepileptics. He has had recurrent episodes of left body numbness, weakness, and incoordination. Episodes of confusion during sleep were reported which were diagnosed to be partial seizures. He was treated with both carbamazepine and Dilantin which made him "pseudobulbar" and he could not tolerate them. He is extremely vague about where he has been evaluated in Massachusetts, During 2016 he reports he traveled to Asia and later "Eastern Europe" seeking diagnosis and treatment of his condition. He apparently had EEGs in Europe which showed sharp waves on the right. He has never had a tonic-clonic seizure with tongue biting or incontinence. He has no formal medical records, but he has incomplete snippets of records including a video of his being examined by a physician. There are some MRI images of brain and cord but not a complete imaging series, and they are not clearly labeled. He claims some of these records are from Eastern Europe from early 2017, and that he was started on Beta interferon (Rebif) 3x/week injections for MS and has been taking this continuously since earlier this year. and states it is the first and only drug that has controlled his symptoms, although this seems to be the only disease modifying agent that he has been prescribed. He has never having been treated with IV steroids. He claims that the interferon has no untoward side effects.

There is no family history of any neurological problems he has an older sister who is healthy.

Neurological review of systems positive for recurrent headaches which are bi temporal occipital and which he alleges are related to an upper cervical demyelinating lesion at C2. seen on the MRI. He denies migraine auras nausea or vomiting. He has normal control of his bladder. He reports poor vision and visual agnosia in that he will look at something (he gave the example of a book) and not be able to state what it is even though he can see it. He denies slurred speech or difficulty swallowing. He reports decreased hearing on the left. He reports loss of vision in his left visual field. He reports that his eye movements are abnormal looking towards the left. He denies diplopia. He reports both palms are numb. He denies any mental decline and indicates that he must be "very intelligent" to do the type of work that he does. The episodes of confusion diagnosed as seizures are controlled by Rebif.

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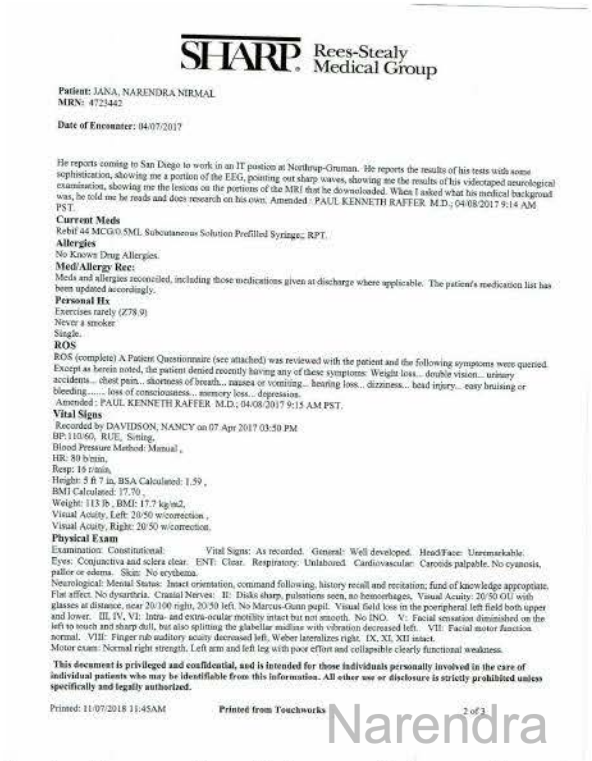
There is a clear dementia from the level of mistreatment taken place at this point so mental decline is prevalent (I downplayed it). Dr. Raffer tries to down play any diagnostic done in a foreign nation when the fraudulence in the US is far greater that which had taken place abroad at that point.



SHARP Rees-Stealy Medical Group

Patient: JANA, NARENDRA NIRMAL
MRN: 4723442

Date of Encounter: 04/07/2017

He reports coming to San Diego to work in an IT position at Northrup-Grumman. He reports the results of his tests with some sophistication, showing me a portion of the EEG, pointing out sharp waves, showing me the results of his videotaped neurological examination, showing me the lesions on the portions of the MRI that he downoloaded. When I asked what his medical background was, he told me he reads and does research on his own. Amended : PAUL KENNETH RAFFER M.D.; 04/08/2017 9:14 AM PST.

Current Meds
Rebif 44 MCG/0.5ML Subcutaneous Solution Prefilled Syringe;; RPT.
Allergies
No Known Drug Allergies.
Med/Allergy Rec:
Meds and allergies reconciled, including those medications given at discharge where applicable. The patient's medication list has been updated accordingly.
Personal Hx
Exercises rarely (Z78.9)
Never a smoker
Single.
ROS
ROS (complete) A Patient Questionnaire (see attached) was reviewed with the patient and the following symptoms were queried. Except as herein noted, the patient denied recently having any of these symptoms: Weight loss... double vision... urinary accidents... chest pain... shortness of breath... nausea or vomiting... hearing loss... dizziness... head injury... easy bruising or bleeding..... loss of consciousness... memory loss... depression.
Amended : PAUL KENNETH RAFFER M.D.; 04/08/2017 9:15 AM PST.
Vital Signs
Recorded by DAVIDSON, NANCY on 07 Apr 2017 03:50 PM
BP: 110/60, RUE, Sitting,
Blood Pressure Method: Manual ,
HR: 80 b/min,
Resp: 16 r/min,
Height: 5 ft 7 in, BSA Calculated: 1.59 ,
BMI Calculated: 17.70 ,
Weight: 113 lb , BMI: 17.7 kg/m2,
Visual Acuity, Left: 20/50 w/correction ,
Visual Acuity, Right: 20/50 w/correction.
Physical Exam
Examination: Constitutional: Vital Signs: As recorded. General: Well developed. Head/Face: Unremarkable. Eyes: Conjunctiva and sclera clear. ENT: Clear. Respiratory: Unlabored. Cardiovascular: Carotids palpable. No cyanosis, pallor or edema. Skin: No erythema.
Neurological: Mental Status: Intact orientation, command following, history recall and recitation; fund of knowledge appropriate. Flat affect. No dysarthria. Cranial Nerves: II: Disks sharp, pulsations seen, no hemorrhages, Visual Acuity: 20/50 OU with glasses at distance, near 20/100 right, 20/50 left. No Marcus-Gunn pupil. Visual field loss in the poertgheral left field both upper and lower. III, IV, VI: Intra- and extra-ocular motility intact but not smooth. No INO. V: Facial sensation diminished on the left to touch and sharp dull, but also splitting the glabellar midline with vibration decreased left. VII: Facial motor function normal. VIII: Finger rub auditory acuity decreased left, Weber lateralizes right. IX, XI, XII intact.
Motor exam: Normal right strength. Left arm and left leg with poor effort and collapsible clearly functional weakness.

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I do explain the diagnostics of the condition well to Dr. Raffer, which as a medical profession he should be able to understand.

SHARP Rees-Stealy Medical Group

Patient: JANA, NARENDRA NIRMAL
MRN: 4723442

Date of Encounter: 04/07/2017

Coordination: normal right finger-nose-finger, rapid alternative movements both coarse, slowe and clumsy on the left.
Gait: Slow with poor toe and heel walking left, tandem poor reaching to wall support, able to balance on each foot independently and able to clear the ground hopping on the right greater than left leg. Romberg absent.
Reflexes: Symmetrically hypoactive (1-2+/4+). Abdominal reflexes intact. Tone normal. Toes down.
Sensation: Normal to light touch pin position vibration on the right. Decreased pinprick touch and vibration in the left in the hand and foot. Intact position sense. Poor graphesthesia the palms bilaterally. Inconsistent left hemibody extinction to double simultaneous touch.
No Lhermitte sign.

Amended : PAUL KENNETH RAFFER M.D.; 04/08/2017 9:22 AM PST.
Assessment
History of MS, with functional motor and sensory examination.

?Partial seizures controlled by Rebif.

Discussion: The examination is very functional. The MRIs on his laptop include images without formal signed interpretations or labeling of sequences. They may show occipital parietal T2 lesions and possibly cervical cord lesions but they are not complete. He has never had a spinal tap. The EEGs may have shapr waves with some sharp waves but he was unsuccessfully treated for seizures with carbamazepine and phenytoin, yet controlled with Rebif.

He needs a baseline workup. I have ordered an MRI scan of the brain, cervical, and thoracic cord with and without contrast. He'll also have a spinal fluid examination for oligoclonal bands, IgG synthesis, and IgG index. If his tests confirm MS Rebif will be continued. There are just so many red flags: no long tract signs, functional weakness, and hyporeflexia with retained abdominal refleses, that I am skeptical of the diagnosis. Amended : PAUL KENNETH RAFFER M.D.; 04/08/2017 9:30 AM PST.
Signature
Electronically signed by : NANCY DAVIDSON LVN; 04/07/2017 3:58 PM PST; Co-participant.
Electronically signed by : PAUL KENNETH RAFFER M.D.; 04/07/2017 5:07 PM PST; Author.
Electronically signed by : PAUL KENNETH RAFFER M.D.; 04/08/2017 9:30 AM PST; Author.

Since the last MRI was done in January 10th 2010 and this appointment takes place in April 7th there should be no reason for another MRI. Moreover the MRIs in the US are expensive (2500 dollars per region of the body scanned so 7500 USD for an MRI of brain and cervical thoracic spin).
What I did instead was simply give Dr. Raffer a CD with the MRI data so he could review it.
Dr. Raffer looks at the MRI data and ignores it or pretends to not be able to view it. The USB drive contains a video of how he ignored or feigned to not see the data.

A state by statement explanation is given below:

1

04.07.2017-Sharp-Dr. Paul Raffer Summary Original Text	Statement by Statement Negation
Clin Staff Note Patient is here for Multiple Sclerosis and establish with Neurologist. HPI This 32-year-old male of Asian Indian background states he began having symptoms of MS in 2006 when he presented with gait unsteadiness left facial and body numbness asnd weakness. He was evaluated in Massachusetts and indicates MS was diagnosed. However, the patient was not treated with a disease modifying agent and claims to have received oral steroids and nonsteroidal anti-inflammatory agents. He also states he was diagnosed to be having partial seizures and having been treated with antiepileptics. He has had recurrent episodes of left body numbness, weakness, and incoordination.	
Episodes of confusion during sleep were reported which were diagnosed to be partial seizures.	Partial absence seizures.
He was treated with both carbamazepine and Dilantin which made him "pseudobulbar" and he could not tolerate them. He is extremely vague about where he has been evaluated in Massachusetts, During 2016 he reports he traveled to Asia and later "Eastern Europe" seeking diagnosis and treatment of his condition.	Pseudobulbar is a typical effect in those who have MS, usually worsened if antiepileptics are given.

2

04.07.2017-Sharp-Dr. Paul Raffer Summary Original Text	Statement by Statement Negation
He apparently had EEGs in Europe which showed sharp waves on the right. He has never had a tonic-clonic seizure with tongue biting or incontinence. He has no formal medical records, but he has incomplete snippets of records including a video of his being examined by a physician. There are some	They are absence seizures.
MRI images of brain and cord but not a complete imaging series, and they are not clearly labeled. He claims some of these records are from Eastern Europe from early 2017, and that he was started on	The MRIs are clearly labeled.
Beta interferon (Rebif) 3x/week inject ions for MS and has been taking this continuously since earlier this year. and states it is the first and only drug that has controlled his symptoms, although this seems to be the only disease modifying agent that he has been prescibed. He has never having been treated with IV steroids.	Rebif only marginally reduced the symptoms of physical pain.
He claims that the interfreon has no untoward side effects. There is no family history of any neurological problems he has an older sister who is healthy.	Rebif causes initial dose effects including sever body pains unless its taken consistently. Which is also why it shouldn't ever be stopped.
Neurological review of systems positive for recurrent headaches which are bi temporal occipital and which he alleges are related to an upper cervical demyelinating lesion at C2. seen on the MRI.	Its from C2 to C4, T1 and T2 lesions.

3

04.07.2017-Sharp-Dr. Paul Raffer Summary Original Text	Statement by Statement Negation
He denies migraine auras nausea or vomiting . He has normal control of his bladder. He reports poor vision and visual agnosia in that he will look at something (he gave the example of a book) and not be able to state what it is even though he can see it. He denies slurred speech or difficulty swallowing. He reports decreased hearing on the left. He reports loss of vision in his left visual field. He reports that his eye movements are abnormal looking towards the left. He denies diplopia. He reports both palms are numb. He denies any mental decline and indicates that he must be "very intelligent" to do the type of work that he doees. The episodes of confusion diagnosed as seizures are controlled by Rebif.	Not migrains but bilateral headaches from lesions in the cervical column (over the sides of the head).
He reports coming to San Diego to work in an IT postion at Northrup -Gruman. He reports the results of his tests with some sophistication, showing me a portion of the EEG, pointing out sharp waves, showing me the results of his videotaped neurological examination, showing me the lesions on the portions of the MRI that he downloaded. When I asked what his medical background was , he told me he reads and does research on his own.	Yes, visual agnosia is apparent because there is a lesion directly in the occipital lobe (visual processing center) of the brain (making it hard to process, translate, and rapidly shift from one visual imagery to another). Considering that this appointment is coming from ER which reports loss of eyesight the immediate recommendation by the doctor should be a VEP and an optic test to check for optic neuropathy. The doctor could have flashed a light into the back of my eyes and determined the optic neuropathy due to its prominence at that point. Not mental decline but confusion and disorientation form seizures and neuroinflammation, there is a dementia as a secondary effect of MS at this point. Intelligent but work is difficult due to MS at this point.

4

04.07.2017-Sharp-Dr. Paul Raffer Summary Original Text	Statement by Statement Negation
Amended : PAUL KENNETII RAFFER M.D .; 04/08/2017 9: 14 AM PST. Current Meds Rebif 44 MCG/0.5ML Subcutaneous Solution Prefilled Syringe;; RPT. Allergies No Known Drug Allergies. Med/ Allergy Rec: Meds and allergies reconciled , including those medications given at discharge where applicab le. The patient's medication list has been upda ted according ly. Personal Hx Exercises rarely (Z78.9) Never a smoker Single. ROS ROS (complete) A Patient Quest ionnaire (see attached) was reviewed with the patient and the following symptoms were queried.	Exercises frequently.

5

04.07.2017-Sharp-Dr. Paul Raffer Summary Original Text	Statement by Statement Negation
Except as herein noted , the patient denied recently having any of these symptoms: Weight loss ... double vision ... urinary accidents ... chest pain ... shortness of breath ... nausea or vomiting ... hearing loss ... dizziness ... head injury ... easy bruising or bleeding ..... loss of consciousness ... memory loss ... depression. Amended: PAUL KENNETH RAFFER M.D.; 04/08/2017 9:15 AM PST. Vital Signs Recorded by DAVIDSON, NANCY on 07 Apr 2017 03:50 PM BP: 110/60, RUE, Sitting , Blood Pressure Method: Manual , HR: 80 b/min, Resp: 16 r/min, Height: 5 ft 7 in, BSA Calcu lated: 1.59 , BMI Calculated: 17. 70 , Weight: 113 lb, BMI : 17.7 kg/rn2, Visual Acuity, Left: 20/50 w/correction , Visual Acuity, Right: 20/50 w/correction.	Double vision is prominent.

6

04.07.2017-Sharp-Dr. Paul Raffer Summary Original Text	Statement by Statement Negation
Physical Exam Examination: Constitutiona l: Vital Signs: As recorded. General: Well developed . Head/Face: Unremarkable. Eyes: Conjunctiva and sclera clear. ENT: Clear. Respiratory: Unlabored. Cardio vascular: Carotids palpable . No cyanosis, pallor or edema. Skin: No erythema. Neurological: Mental Status: Intact orientation, command following, history recall and recitation ; fund of knowledge appropriate. Flat affect. No dysarthria . Cranial Nerves: II: Disks sharp , pulsations seen, no hemorrhages, Visual Acuity: 20/50 OU with glasses at distance, near 20/100 righ t, 20/50 left. No Marcus-Gunn pupil. Visual field loss in the poeripheral left fie ld both upper and lower. III, IV, VI: Intra- and extra-ocular motility intact but not smooth . No INO. V: Facial sensation diminished on the left to touch and sharp dull, but also splitting the glabellar rnidline with vibration decreased left. VII: Facial motor function normal. VIII: Finger rub auditory acuity decreased left, Weber lateralizes right. IX, XI, XII intact.	. A optic neuropathy should have been immediately ordered.

7

04.07.2017-Sharp-Dr. Paul Raffer Summary Original Text	Statement by Statement Negation
Motor exam: Normal right strength. Left arm and left leg with poor effort and collapsible clearly functional weakness. Coordination: normal right finger-nose-finger, rapid alternative movements both coarse, slowe and clumsy on the left. Gait: Slow with poor toe and heel walking left, tandem poor reaching to wall support, able to balance on each foot independently and able to clear the ground hopping on the right greater than left leg. Romberg absent. Reflexes: Symmetrically hypoactive (1-2+/4+). Abdominal reflexes intact. Tone normal. Toes down. Sensation: Nonnal to light touch pin position vibration on the right. Decreased pinprick touch and vibration in the left in the band and foot. Intact position sense. Poor graphesthesia the palms bilatera lly. Inconsistent left hemibody extinction to double simultaneous touch. No Lhermitte sign.	The neuro test is an extension of the MRI series. The MRI series indicates why I would be slow and clumsy on the left side of my physiology. It's a generalized effects in sensory responses.

8

04.07.2017-Sharp-Dr. Paul Raffer Summary Original Text	Statement by Statement Negation
Amended: PAUL KENNETH RAFFER M.D.; 04/08/20 17 9:22 AM PST. Assessment History of MS, with functional motor and sensory examination. ?Partial seizures controlled by Rebif. Discussion: The examination is very functional. The MRis on his laptop include images without formal signed interpretations or labeling of sequences. They may show occipital parietal T2 lesions and possibly cervical cord lesions but they are not complete. He has never had a spinal tap. The EEGs may have shapr waves with some sharp waves but he was unsuccessfu lly treated for seizures with carbamazepine and pbenytoin , yet controlled with Rebif. He needs a baseline workup. I have ordered an MRI scan of the brain, cervical, and thoracic cord with and without contrast.	The sequences are labeled. The response with Rebif indicated it's a neuroinflammatory response.

9		
04.07.2017-Sharp-Dr. Paul Raffer Summary Original Text	Statement by Statement Negation	
He'll also have a spinal fluid examination for oligoclonal bands , IgG synthesis, and IgG index. If his tests confirm MS Rebif will be continued. There are just so many red flags: no long tract signs, functional weakness, and hyporeflexia with retained abdominal refleses, that I am skeptical of the diagnosis. Amended: PAUL KENNETH RAFFER M.D.; 04/08/2017 9:30 AM	The diagnosis is eventually shown to be secondary progressive MS.	

The result of negligence in this setting is an ER appointment in the same hospital soon afterwards where negligence is further perpetuated. The ER appointment is a form of assault (withholding medication in a sever clinical state). What the US collectively did from hospital to hospital and state to state is criminal fraud and criminal negligence now.