Multidisciplinary Evaluation

Evaluation Dates: Wednesday, -- 00, 0000 & Thursday, -- 00, 0000 & Friday, --00, 0000
Name: John Doe
Utah License Number: xxxxxx-xxxx
Referral Source: UPHP

Identifying Information & Presenting History

XXX XXXX MD is a 00-year-old, ----------physician from xxxx, USA. He was requested to take a leave of absence from his workplace, ---------, by his supervisor, Dr. --------on 00, 0000 because he was displaying symptoms of bipolar disorder that adversely impacted his patients and colleagues ("non-linear thinking, pressured speech, no boundaries with patients…"). Dr. XXXX said prior to this leave, he "was in denial about having bipolar…people have said they were worried about me at work for months before that. I wasn't linear and I was talking very fast. I was reliving this trauma that I had never dealt with when I was young." Dr. XXXX was referred to the PHP. He was drug screened, and "my Peth test showed five times what is considered normal for alcohol." The PHP referred Dr. XXXX for a three-day fitness for duty evaluation, and he complied.

Confidentiality Waiver

In advance of the Multidisciplinary Comprehensive Evaluation, XXX XXXX MD was provided with informed consent of the non-confidential nature of the evaluation. He voluntarily waived his rights to confidentiality with written authorization that permitted disclosure of the assessment results to the PHP.

Dr. XXXX's confidentiality waiver covered all data sources used in the development of the Multidisciplinary Comprehensive Assessment, including: clinical and medical diagnostic interviews, clinical data, laboratory test results, psychological test performances, self-report inventories, and obtained collateral source information. In accordance with state and federal laws, Dr. XXXX was informed of (Name of Evaluation Center) team members' duty to report specific kinds of information if obtained. Without Dr. XXXX's written consent, under the terms of thisauthorization, further disclosure of this report is not permitted.

Social History

XXX XXXX MD was born in xxxx, USA on --- 00, 0000 to ----------His parents met in high school in --------, and he is an only child. He was raised----------but currently does not identify with any religion. Dr. XXXX's parents lived in several cities and states before settling in ----- when they first---------- --. He recalls moving with only his ----- to ---- at the age of 00 "because my ----- got in some ------- trouble; he ------ a lot of people over and they were coming after him. He was a ------ back then. I lived with him until I was 00. My dad was so f-----up he would make me---------- because it made him happy. He used to beat the sh-- out of me all the time. It is unforgivable behavior." Dr. XXXX's------ lived in and out of domestic violence centers with Dr. XXXX when he was under the age of 0, prior to his moving away. She would be coaxed to return to his father by his older brother, and the cycle of violence would begin again. Dr. XXXX explained about his father "----------
----------" Dr. XXXX's father took his paternal relatives with him to --------, while his ---------- brother

remained in---------- --. Dr. XXXX shared a painful memory when he was an adolescent, stating; "When I was 00-years-old,----------." Despite this trauma, Dr. XXXX said he was able to make "a lot of friends in ----------."

In high school, Dr. XXXX wrestled, played baseball, basketball, and took classes in ----------. He said he was popular in high school, but life changed in 00 grade when he ----------" Dr. XXXX admitted he gave up wrestling and basketball in 00 grade because he "began drinking, smoking weed, and stealing everything in sight for about three years…I was in and out of juvenile three times." Dr. XXXX recalls stealing items from people's homes and was arrested twice for grand theft auto and once for stealing jeans from a department store. He elaborated; "I----------

----------I was never arrested after the age of 00 years old." Dr. XXXX said he was "----------.----------"

Dr. XXXX was arrested for a second felony at the age of 00. He said; "My --------- came to court when I was arrested and he had a one-way ticket to-------- to rehabilitate me through punitive measures. The judge gave me----------."

He continued "I started undergrad at 00 and I studied for eight hours a day for two years straight." He said his "mentality was 'I want to beat you.' I wanted to be the most popular kid and liked and I was completely dedicated and was top in my class. I had a ton of scholarships because my grades were so good."

During medical school in India, Dr. XXXX said he studied 8-9 hours a day and did not drink much. He recalls sleeping only five to six hours a day." There was a lot trauma in ------. My ------ would get mad when I would score well because I was preparing to leave. ----------."

When asked about any serious relationships during that time he replied "I had a steady relationship with a girl during medical school that I wanted to marry." He reported his girlfriend was ---------- and her father did not want them together. "I stopped talking to her because she was so distraught over it." He shared that his is presently sporadically in touch with her and she is regrets the end of their relationship.

When asked about prior manic episodes, Dr. XXXX said he had an episode in 0000 when he was 00-years-old during his first year of medical school. I didn't sleep for two months then. I got beat up by ---------- and ---------- was beating me up too at the time. I was put on an anti-depressant medication and became hypomanic for years. I didn't go to school for two months I think. I don't really remember. I think I couldn't sleep because I was worried about being beat up by ----------."

Dr. XXXX moved to ---------- for a residency in ----------from ages 00 to 00. In retrospect, he presently realizes his "mania got worse there because people would talk about it more and more. I wasn't sleeping as much, I was alone. I was working 90 hours a week." When asked about his substance use during this time he replied, "My drinking was sporadic and maybe on the weekends I would have four to five drinks. I couldn't really tolerate more than five drinks usually beer." During this time in ---------- Dr----------reported he was bored and began playing "---------- for a few years. When I wanted to dominate, I'm all in. I won like $000,000. I won tournaments. I was going to quit medicine to become ----------." He reported he eventually stopped playing "I quit because it was a big waste of time. I dominated already and now it's boring to me." He began to compare himself to Michael Jordan relaying how Mr. Jordan dominated basketball and then went to baseball. "I didn't give two sh--- about------, I just wanted to dominate you."

In ----------, after residency, Dr. XXXXX was offered a position at ----------
He said he had a dream of ----------and moved----------.
Dr. XXXX married approximately --------- years ago and divorced in 0000 after 00 months of marriage. He said; "I was never forthright with my wife. I would lie to her ----------

-------- Dr. XXXX's drinking increased on weekends and sometimes weekdays when he began drinking more heavily and use cocaine with ----------. He said; "When I used cocaine the trauma memories became very vivid. I used marijuana and CBD on a few occasions." He said he used substances for the mania and side effects of the psychotropic medications; "I had akathisia and I was restless and I would drink to try and calm down."

On_____, Dr. XXXX was asked to take a leave of absence from his workplace by his supervisor. He was displaying symptoms of mania/hypomania to include "pressured speech and lack of linear thinking." His workplace said Dr. XXXX is a good physician but has had a number of losses in the last several years that have concerned his colleagues. He was divorced in 0000 and he lost ----------suddenly to ----------

Legal

DUI -0000

Current Psychiatric Symptoms

Mania/Hypomania (mixed states)

Family Psychiatric History

Mother –- - - - - - - - - - - - - - - -
Brother – - - - - - - - - - - - - - - - -
Father –- -

Psychiatric History

Bipolar I Disorder with mixed states–symptoms to include insomnia, gambling, over-spending, fighting, and substance abuse

Adolescence –Unspecified Disruptive, Impulse-Control, and Conduct Disorder

Social History

Emotional Abuse –Throughout childhood
Physical Abuse - Throughout childhood
Sexual Abuse – Endorsed
Work History – -
Military History –None
Education – -
Employment -
Religious/Spiritual History – None
Socioeconomic Status/Financial Stressors – "I make $000,000/year and I am broke…I spend all my money."

Mental Status Examination/Behavioral Observations

Appearance: Dr. XXXX is a ---------- male who was dressed casually. He had----- hair, dressed and acted younger than his stated age.He made good eye contact. He was cooperative, animated, and over-familiar as he winked at examiner and would talk with himas though we had long been friends
Orientation: X3
Gait: Without limitations
Mood & Affect: "Calm" and affect appeared elevated and labile; he would quickly get emotional and on the verge of tears as he talked about his trauma
Speech and Tone: Verbose, fast, nearly pressured at times, volume a bit loud, no word finding difficulties or paraphasic errors
Thought Content and Progression: Circumstantial and at times tangential, frequently required redirection
Attention and Concentration: Preoccupied, distractible
Suicidal Ideation: Denied
Hallucinations: Denied
Delusions & Paranoia: Denied
Homicidal Ideation: Denied (Note: He has no guns now though he does have a concealed weapons permit and goes to the shooting range at times)
Insight: Limited
Judgment: Limited
Fund of Knowledge: Fair
Language: Disinhibited as he used curse words, a racial slur, and sexual language in interview
Cognition: Grossly intact although had difficulty with specific details with respect to his historical timeline.
Motor activity: Fidgety and restless at times
Interview Behavior: Child-like

Substance History & Compulsive Behaviors

Alcohol –First drink at age 00, and currently drank 6-8 drinks/week, but stopped drinking one week prior to the MCAP. He has drank alcohol in a binge style (six drinks at one time). He reported intermittent binge drinking of alcohol and cannabis use "all the physicians that I know drink heavily and smoke weed…"

Dr. XXXX reported that while he used to drink alcohol heavily at times, he was able to cease use of alcohol for several months during exams, and later on also stopped drinking whenever he would commit to an exercise regimen. His longest period of sobriety was ------months. He stopped drinking eight days ago.

Cannabis –First tried cannabis at age 00, smoked daily in high school, stopped smoking in college and medical school. Recently smoking three times a week to include CBD edibles.

Stimulants –Had a history of being prescribed Amphetamines but only tolerated them for three weeks and discontinued due to side effects. First tried intranasal cocaine in 0000, recognized that

this had a profound effect on him and could become problematic, he refrained from using it again until about one year later. He endorsed infrequent use of intranasal cocaine since then, stated that he last used 0 lines about five weeks ago. Uses cocaine "on and off again."

Benzodiazepines – Occasionally uses Xanax for sleep,, but "a bottle lasts me a year." For three or four weeks he was recently taking clonazepam, which did not help him, but the Washington PHP suggested propranolol, "which seems to have helped."

Opiates –"Accidently took a Vicodin from my dentist three years ago…" Refuses to take opiates because he "liked the feeling too much…" after taking two Percocet years ago.

Illegal Substances –Kratom, ETC, GHB, MDMA one time each

Tobacco - Sporadic use of tobacco, smokes cigarettes infrequently and cigars a couple times/week

Gambling - Dr. XXXX stated that won about $000,000 over a period of 0 years. He reported some rituals of wearing the same ---- and ------ when playing as he recognized that it helped with his winning streaks, he denied any ongoing recurrent thoughts or rituals that interfere with his day-to-day functioning.

Spending - Dr. XXXX said, "I've never been good with money."

Exercise - Dr. XXXX shared that he has always been "obsessed" with staying in shape, been diligent about working out regularly to maintain his physique. He denied any problematic feeding or eating habits including compulsive overeating, bingeing, purging or restricting behaviors.

Other Risk-taking Behaviors- Queried as to risk-taking behavior, Dr. XXXX said that he has engaged in risky behaviors." Dr. XXXX denied any sexually compulsive behavior, denies any history of problematic video-gaming behaviors.

Psychiatric Assessment, xxxx-xxxx MD

XXX XXXX is a 00-year-old ----------MD who presents for an evaluation on the recommendation of the ----- PHP after he was found to have an elevated PETH test. Of note, the following history is from Dr. XXXX's self-report and his self-report is concerning for being unreliable due to thought disorganization and limited insight likely from uncontrolled bipolar symptoms. Dr. XXXX states that he "had a manic episode three months ago." He says that he has been "hypomanic my whole life and I was on ----------." He says he "started drinking a little bit more than usual when I was manic." He also says he was "smoking weed ---------- times per week" which was more frequent than before. He says "All the docs around us drink and smoke weed. It's like ----------. If you did a PETH test on any of us it would be positive."
He states that he realized he was "pressured and nonlinear so I got some curbside ---------- but it didn't work." He said his patients have been worried about him for a few months. "They

are my friends. I wasn't listening to them at all. I was just talking. My clinic manager called some of them and they told her something is not right with him. I was talking with my patients about my own---------- They said it was hard to get a word in edge wise with him and they had to interrupt him because he was not listening. He says people at work started asking if he was okay too. He was sent home by his medical director in ------- telling him he should take time off. He decided to see a psychiatrist for the first time in his life because maybe he did have bipolar. He was started on ---------- but as the dose was increased he experienced akathisia. He was switched to ---------- but the akathisia worsened. "I was restless and couldn't sleep." He states he started drinking 2-3 drinks per day to help the akathisia.

After the leave, he realized he was not ready to return to work and asked for an additional 0 weeks. He went to report to the PHP.

Regarding developmental history, he states ----------

Regarding psychiatric history, he states ----------

In 0000, he started seeing a psychiatrist in residency. This person continued ----------and gave him ---------- to take as needed. He thinks they may have tried ----------again as well. He was told by many people in residency that he was "hypomanic." His symptoms were most noticeable after a night call. He remembers he was "pressured." He could not sleep well in residency. He was sad because no one seemed to like him in residency and he had been so popular all his life. He was not sleeping much.

Since residency he had not received any formal treatment until he started CBT about 0 years ago but did not regularly attend until last year. He says this therapist recommended he see a psychiatrist. He saw the psychiatrist who started ---------- about 0 years ago. He says the medication "gave me hypertensive urgency. I was jittery so I stopped the medication." About ---------- ago the psychiatrist told him he had bipolar disorder and gave him samples of ----------, which he felt helped. He felt stabilized and people told him he seemed calmer on ----------. He eventually stopped the ---------- on his own because he didn't want to pay the co-pay of 00 dollars. H says he has no money and would be foreclosed upon if he can't work soon.

In ---------- he stopped seeing his CBT therapist and psychiatrist. He had ---------- prescribe ---------- as a curbside. He feels---------- made him gain weight but did help him sleep. He decided he should stop ---------- about 0 months ago and he increased ---------- to 00mg. He still was not doing well as he was only sleeping 1 hour per night. Additional symptoms he can identify when he gets manic include continued high sexual interest, impulsive with spending money including "buying ----------(00,000 in credit card debt), more talkative and social, and a couple of months ago I was overly sensitive and everything seemed meaningful so I was crying incessantly and suddenly and was labile." He denies any psychotic symptoms. He denies any PTSD symptoms. He denies any suicidal or homicidal ideation. He denies any patient errors were made.

Regarding substance use, he says he was tried cocaine 0 times in his life. He has tried Molly once. He has used alcohol and marijuana on and off for years but has long periods of sobriety. He denies any opiate use.

Psychological Assessment, xxxx PhD

Psychological Test Instruments
Beck Anxiety Inventory (BAI)
Beck Depression Inventory-Second Edition (BDI-II)
Comprehensive Individual Clinical Diagnostic Assessment
Drug Abuse Screening Test (DAST)
Emotional Eating Scale (EES)
Life Events Checklist (LEC)
Michigan Alcohol Screening Test (MAST)
Millon Clinical Multiaxial Inventory-III (MCMI-III)
Mood Disorder Questionnaire (MDQ)
Pain Numeric Rating Scale (PNRS)
PTSD Checklist-Civilian Version (PCL-C)
Practical Risk Assessment
South Oaks Gambling Screen (SOGS)
Suicide Behaviors Questionnaire-Revised (SBQ-R)

Clinical Impressions / Psychological Test Results –

The primary reasons Dr. XXX XXXX presents for assessment center on psychotropic non-compliance, excessive alcohol use, self-reported illicit drug use, and their impact on Dr. XXXX's ability to practice safely family medicine.

Drinking, excessively as Dr. XXXX's PeTH biomarker indicates, while consuming ---------- could result in toxic body alcohol levels and/or increase drowsiness, both of which provide impairments for practicing medicine safely.

During his assessment interview, Dr. XXXX demonstrated a tenacious level of denial about his alcohol consumption and a level of naiveté about his recreational drug use as he compared his alcohol consumption with that of his colleagues, indicating repeatedly that his drinking is

normative. What is normative is for one to be in denial and to deceive oneself about one's character flaws and habitual maladaptive behavioral practices. Dr. XXXX will benefit from recognizing the normative nature of denial; learn the skills to disabuse himself of denial; replace denial patterns with acceptance and problem-solving; confront, regulate, and manage the emotions that underlie denial; proactively engage problem-solving in circumstances that elicit denial by electing consciously to choose an adaptive solution (Gorski, 2003). Of more profound concern is Dr. XXXX's long term denial of his bipolar condition.

The neurocognitive deficits exhibited in Dr. XXXX's M-CAP neuropsychological test results are congruent with empirical findings that suggest cumulative impact of lifetime Bipolar Disorder. Another plausible alternative explanation offered for Dr. xxxx demonstrated cognitive limitations may be, in part, explained by a lack of early detection, or more precisely in Dr. XXXX's case, early detection of Bipolar disorder with treatment compliance. Dr. XXXX's neurocognitive performance is consistent with meta-analyses that indicate Bipolar disease among euthymic individuals is characterized by a moderate level of neurocognitive impairment (Arts et al, 2007; Bora et al., 2009; Kurtz and Gerraty, 2009).

Dr. XXXX reported a combination of recurrent childhood maltreatment types, including physical abuse, verbal, and emotional abuse in his childhood and adolescent family milieu, as well as sexual abuse during his adolescence. The Adverse Childhood Experiences (Felitti, Anda, et al. 1998: ACE) research program (Edwards et al., 2003) results suggest that emotionally abusive family settings attenuate decreases in mental health outcomes and, as would be expected, increased childhood maltreatment is correlated with greater decrements in mental health results in adulthood. The overall conceptual framework of the ACE research program indicates the strong relationships of ACE to risk factors for both physical and psychiatric disease, including suicide, across the lifespan.

Clinicians have suggested that early developmental stage, recurrent, multi-dimensional trauma perpetrated by caregivers is an antecedent to substance abuse (Wartenberg, 2017). Dr. Wartenberg submits that a traumatized individual needs to metabolize trauma in order to prevent recurrent relapses. Furthermore, according to Dr. Wartenberg, Dr. XXXX is likely more vulnerable to PTSD as a result of a deficit of resilience or protective variables, "which itself is partly a reflection of early-life nurturance (Wartenberg, 2017)" or lack thereof. While Dr. XXXX's PTSD Checklist-Civilian Version (PCL-C) test protocol did not provide a positive screen for PTSD, clinical observations suggested perhaps mild dissociation as he reviewed his childhood trauma and the trauma of two female acquaintances that shared trauma that mirrored his.

Dr. XXXX expressed a desire to change and to focus more on others. "I want to make changes." Dr. XXXX possesses a noble heart and a fine mind. However, besides neurochemical, neuroanatomical, and genetic, there appear to be several variables that dispossess Dr. XXXX of his mind and alter to dysfunction his mood: (a) being formerly undertreated a substantially sustained period of time for his bipolar spectrum condition; (b) non-compliance with his psychotropic regimen; (c) alcohol and substance abuse; and (d) sleep deprivation/sleep disturbance. Dr. XXXX reported a 00 month period of going without sleep. All of the variables indicated above were implicated in his---------- work episode that raised alarm and led to Dr. XXXX's M-CAP. According to Dr. XXXX, he has never been psychiatrically hospitalized.

Dr. XXXX was administered the Beck Depression Inventory-Second Edition (BDI-II) and endorsed a Minimal level of depressive symptomatology (BDI-II Scale Range: 0-63, Minimal Range: 0-13, Total Score: 8). Dr. XXXX's BDI-II test protocol was absent suicidal ideation. For his BDI-II Changes in Sleeping Pattern, Dr. XXXX endorsed both of the following responses: "I sleepa lot more than usual" and "I sleep a lot less than usual." The author was not able to question Dr.
XXXX about his response, but suggest that it is consistent with Dr. XXXX's statement of why he presents for a M-CAP, that is, "I had mania and depression in ----------."

For the Beck Anxiety Inventory (BAI) response protocol, Dr. XXXX endorsed a Minimal level of anxiety symptoms (BAI Scale Range: 0-63, Mild Range: 0-7, Total Score: 3). Dr. XXXX endorsed a mild levels of: "fear of the worst happening," "nervous," and "scared."

Test results from the Suicide Behaviors Questionnaire- Revised (SBQ-R) revealed an absence for: lifetime suicide ideation and/or suicide attempts, threat of suicide attempt, and self-reported likelihood of suicidal behavior in the future.

Test scores from Dr. XXXX's Pain Numeric Rating Scale and Abbreviated PTSD Checklist-Civilian yielded a negative screen, and did not indicate a noteworthy probability for a clinical level of problems with pain or posttraumatic stress disorder**.** Dr. XXXX's test scores from the Michigan Alcohol Screening Test (MAST), Drug Abuse Screening Test (DAST), and South Oaks Gambling Screen (SOGS) generated negative screens and did not suggest a noteworthy probability for a clinical level of problems with: posttraumatic stress disorder, alcohol use disorder, substance abuse disorders, physical pain or gambling addiction**.** The Emotional Eating Scale (EES) self-report protocol revealed a primarily Moderate range for an endorsement of eating in relationship to mood. Dr. XXXX will benefit from mindful eating strategies that will assist to: identify, implement, and establish individualized CBT techniques in order to manage adaptively all distressing emotions presented; to enhance and broaden CBT skills toward adaptively self-regulating distressing emotions and heightened arousal levels. Dr. XXXX completed the Mood Disturbance Questionnaire (MDQ) protocol that screens for Bipolar Spectrum Disorder. Dr. XXXX's completed MDQ protocol met all three criteria required for a positive screen.

Dr. XX's Millon Clinical Multiaxial Inventory-Third Edition (MCMI-III) revealed a deeply rooted need for social approval and commendation." Dr. XXXX's efforts were, in some fashion, successful as no clinical diagnosis of Bipolar Disorder was noted from his Millon protocol, despite Dr. XX's diagnosis of Bipolar I Disorder for 00 years. Millon Axis II diagnoses revealed the following personality constellation: Depressive Personality Features and Obsessive Compulsive Personality Features.

Neurocognitive Assessment, xxxxx PsyD

Procedures

Wechsler Adult Intelligence Scales-4
Wechsler Memory Scales-4
Rey Auditory Verbal Learning Test
Boston Naming Test
Auditory Consonant Trigrams
Judgment of Line Orientation

Serial Digit Learning Test
Controlled Oral Word Association
Trail Making Test
Wisconsin Card Sorting Test
Stroop Color Word Test
Grooved Pegboard Test
Clinical Interview

Test Results
In response to item content on the WAIS-4, the patient scored in the average range, for a person of his age, in the normative group, on tests of vigilance and speeded visual motor integration. He scored in the low average range on tests measuring visual conceptual ability and constructional praxis. Memory testing revealed immediate verbal recall to be in the average range. After a 30-minute delay retention of previously memorized verbal material was in the low average range. Immediate visual recall was in the superior range. After a 30-minute delay there was low average recall of the visual material. On a test of verbal learning there was average performance in the area of initial auditory registration. Cumulative learning over 5 trials was in the average range. Retention of learned information after an interference measure was introduced was in the low average range. Supraspan recall was average. His ability to recall rote verbal information over a distractor was in the average range.

On tests of frontal lobe, executive type functioning the patient performed as follows: He scored in the impaired range on a test of verbal fluency. He scored in the normal range on a test measuring attention to more than one aspect of a stimulus situation simultaneously. He scored in the borderline range on a test of the inhibition of an over-learned response when a novel response was required simultaneously. He scored in the average range on a test requiring the formation, maintenance, and shifting of mental set.

Examination for aphasia and related language disorders demonstrated fluent spontaneous speech with adequate expression, repetition, and comprehension of language noted. There were no signs of anomia or word finding difficulties in response to a confrontation naming task.

The expected relationship was found between dominant and non-dominant hands on a test of manual dexterity. Judgment of line orientation was performed in the normal range.

Diagnostic Summary
The patient performed in the impaired range on frontal lobe tests measuring verbal fluency and behavioral inhibition. Short term visual and verbal recall were in the low average range, which is somewhat below what would be expected given his age and level of education. He appeared to have difficulty concentrating, due perhaps, to a subclinical extension of the mania remaining from his most recent episode. The patient would likely benefit from more time to recover and adjust to his current psychopharmacological regime before returning to work. He could be retested in 2 to 3 months to track his progress.

Trauma Assessment, xxxx, MSW, LCSW

History of Present Problem: --

Some Strengths / Liabilities: Resilience, currently desiring to work through the past. Preoccupied with----------. Suddenly startled, somatic reactivity, intrusive upsetting memories, emotional distress with reminders of past abuse, risky behavior, inability to remember parts of abuse, aggression in earlier life, hypervigilent, functional impairment- home, work and socially.

R/O F43.10 Post-Traumatic Stress Disorder, Chronic

Medical Assessment, xxxxx MD

Past Medical History:
Seasonal allergies

Past Surgical History: none

Past Psychiatric History: no hospitalizations, resistant to diagnosis of Bipolar Disorder, denied suicidal ideation, suicide attempts, homicidal ideation.

Tobacco: 0 cigars weekly

EtOH: none since 0/00/0000

Family History:
Father, alive, ----------
Mother, alive ----------
Brother, ----------
---------- children

Immunizations: up to date through the hospital

ROS: "The ---------- bothers me but otherwise I'm perfect."

Physical Examination: 124/82 heart rate 64

Medical Impression:
Alcohol use disorder:

Stimulant use disorder:

Undertreated bipolar disorder:

Medications

Allergies

NKA

Drug Screens

Urine Drug Screen – Monday, --- 00,0000 - *Negative*
Hair Drug Screen – Monday, ---------- 00,0000 – *Positive for amphetamines, MDMA, cocaine, cannabinoids and alcohol (highly positive for cocaine)*
PETH – Monday,---------- 00,0000 - *Positive (131ng/ml; cut-off 20ng/ml)*
(See attached results)

Labs

Collateral Information

Collateral information was gathered with written and verbal permission from xxxx MD.The following individuals may or may not have been contacted:

Summary

XXX XXXX MD is a 00-year-old, ----------physician from xxxx, USA. He was requested to take a leave of absence from his workplace, ---------, by his supervisor, Dr. --------
on May 00, 0000 because he was displaying symptoms of bipolar disorder that adversely impacted his patients and colleagues ("non-linear thinking, pressured speech, no boundaries with patients…"). Dr. XXXX said prior to this leave, he "was in denial about having bipolar…people have said they were worried about me at work for months before that. I wasn't linear and I was talking very fast. I was reliving this trauma that I had never dealt with when I was young." Dr. XXXX was referred to the PHP. He was drug screened, and "my Peth test showed five times what is considered normal for alcohol." The PHP referred Dr. XXXX for a three-day fitness for duty evaluation, and he complied.

Regarding substance use, Dr. XXXX states he tried cocaine 00 times in his life, albeit this last time in a binge fashion. He has tried------- once and used alcohol and marijuana on and off for years but has long periods of sobriety, he added. However, Dr. XXXX's drug screens were highly positive for alcohol (peth) and cocaine (hair), plus cannabis and ------ , and he admitted during his mania the last several months he did over-use and abuse both alcohol and cocaine, which was uncharacteristic for him, though he has had other periods of alcohol abuse. He met

four criteria in the DSM V: (1) Alcohol and cocaine is often taken in larger amounts or over a longer period of time than was intended; (2) There is a persistent desire or unsuccessful efforts to cut down or control us, (3) Recurrent use resulting in failure to fulfill role obligations at work, (4) Tolerance. Four criteria is Alcohol and Stimulant Use Disorder –Moderate. His use of cannabis was up to three times a week recently in an effort to medicate his mania, he said. However, he does have a history of smoking cannabis daily in high school. Dr. XXXX swears he has only used 0 and believes the cocaine he used may have been "laced with ---- ," which may explain the positive drug screen for -- --.

Dr. XXXX has a family history of substance use disorder and bipolar disorder and believes has "been bipolar since 0000," but only recently has accepted the diagnosis and treatment. The untreated bipolar symptoms have resulted in a history of gambling, insomnia, over-exercising, over-spending, risky behaviors and financial debt. The symptoms of mania and hypomania are improving with medication management, but two problems continue. First he is only in partial remission, which most likely led to him performing in the impaired range on frontal lobe tests measuring verbal fluency and behavioral inhibition. His short term visual and verbal recall were in the low average range, and he appeared to have difficulty concentrating, due perhaps, to a subclinical extension of the mania remaining from his most recent episode. The second problem is a Tegretol blood level that is too high, meaning medication management is ongoing. He is advised to be followed closely by a psychiatrist that can adjust his medications, and retake the neurocognitive testing in no less than two months.

Dr. XXXX discussed an extensive history of emotional and physical abuse, ----------, conduct and impulse-control behaviors in adolescence that led to ---------- Dr. XXXX succeeded and became a physician, and believes his trauma history "has finally caught up with me…" and he is advised to begin intensive psychotherapy with EMDR to address this considerable burden on his psyche.

Dr. XXXX was exceptionally cooperative and forthcoming, and is eager to return to a state of optimal wellbeing. He worries about ---------- but he said he will comply in order to return to the practice of medicine.

Safety Assessment

XXX XXXX MD is currently not safe to practice medicine with reasonable skill and safety.

Diagnostic Impression

1. 296.45 (F31.73) Bipolar 1 Disorder, mixed episode in partial remission
2. 303.90 (F10.20) Alcohol Use Disorder -Moderate
3. 304.20 (F14.20) Stimulant Use Disorder (Cocaine Type) – Moderate
4. R/O 305.20 (F12.10) Cannabis Use Disorder –Mild
5. 312.9 (F91.9) Unspecified Disruptive, Impulse-Control and Conduct Disorder – byhistory – resolved
6. R/O 309.81 (F43.10) Post-Traumatic Stress Disorder, Chronic
7. Cluster C Personality Features and Features
(Results from *Millon Clinical Multiaxial Inventory-III)*
8. Seasonal Allergies

Treatment Recommendations

1. Treatment for Dual Diagnoses in a Treatment Program for Professionals

Dr. XXXX is advised to immediately begin treatment for dual diagnoses in a treatment program for professionals approved by the Physician Health Program, and follow all discharge recommendations following treatment.

2. Professional Monitoring

Dr. XXXX is advised to participate in professional monitoring with the PHP following discharge from treatment.

3. Individual Psychotherapy

Dr. XXXX is advised to engage in individual psychotherapy following treatment in a professional's program with a psychotherapist approved by the PHP. CBT and traumafocused therapy (EMDR) is advised for distressing emotions and trauma resolution.

4. Implementation of Nonchemical Coping Skills

Dr. XXXX is advised to implement non-chemical coping skills to reduce anxiety andimprove sleep, i.e. meditation, mindful exercise, yoga, etc.

5. Support Groups

Dr. XXXX is advised to participate in regular 12 Step meetings with a sponsor and alocal Caduceus or physician's support group.

6. Ongoing, Regular Consultation with a Psychiatrist

Dr. XXXX is advised to regularly consult with his psychiatrist for medicationmanagement and ongoing assessment of mood.

7. Neurocognitive Re-testing

Dr. XXXX is advised to be retested by a neurocognitive psychologist prior to his returnto work.

Clinicians

- Initial Psychiatric Interview, xxxx
- Medical Assessment, xxxx MD
- Psychiatric Assessment, xxxx MD
- Psychiatric Assessment, xxxx MD
- Trauma Assessment, MA, LCPC
- Neurocognitive Assessment, xxxx PsyD
- Psychological Assessment, xxxx, PhD
- Medical Director, xxxx MD
- Collateral Information, xxxxx , MSW, LCSW
- Labs – Hair, Peth, urine drug screens
- Psychological Testing: *Beck Depression Inventory-Second Edition (BDI-II), Beck AnxietyInventory (BAI), Comprehensive Individual Clinical Diagnostic Assessment, Drug Abuse Screening Test (DAST-20), Life Events Checklist (LEC), Michigan Alcohol Screening Test (MAST), Millon Clinical Multiaxial Inventory-III (MCMI-III), Mood Disorder Questionnaire (MDQ), Pain Numeric Rating Scale (PNRS), PTSD Checklist-Civilian Version (PCL-C), Practical Risk Assessment, Suicide Behaviors Questionnaire-Revised (SBQ-R), Rey Auditory Verbal Learning Test, Wisconsin Card Sorting Test, Trail MakingTests Parts A & B, Controlled Oral Word Association Test, Grooved Pegboard Test, Digit Symbol test, CNS Vital Signs*