FICTITIOUS INDEPENDENT
EVALUATION

Date: June, x, xxxx
Client Name: John Doe
Utah License Number: xxxxxx-xxxx

IDENTIFYING INFORMATION: Dr. John Doe is a 55-year-old divorced Caucasian male, Physician, Board Certified in xxxx, living in xxxx, Utah alone. He has no present significant partner. His Utah license is currently Active, issued on xxxx, 19xx, and without record of public complaints or disciplinary actions. He also holds a Clear and Active xxxx Physician license, issued xxx x, 19xx, and also without record of public complaints or disciplinary actions. He has previously been under investigation by DOPL and received a Letter of Concern with no other disciplinary action, and he has had no other disciplinary actions in any other state and has never been monitored by any state's Professional Health Monitoring Program. For the past five years, he has been employed by xxxx, working at xxxx Hospital and xxx Hospital approximately 140 hours per month. Secondary to an incident in the workplace on xxx, 20xxx with suspicion of impairment and a positive alcohol test, he has been terminated without cause with allowance for xxx days of remaining employment with his scheduled completion of his employment on xxxx, 20xx. Dr. Doe self-reported to UPHP on xxxx, 20xx and is referred by UPHP for this present Evaluation to assess his physical and mental health, possible Substance Use Disorders, possible Psychiatric/Psychological Disorders, possible Chronic Pain issues, and his safety to practice.

SOURCES OF INFORMATION:
1. Telehealth Interview, xxxxn, MD, MRO, DABAM, on xxxx, 20xx.
2. Utah Division of Occupational and Professional Licensing website.
3. xxxx Office of the Professions website.
4. xxxx Practitioner website.
5. Email Communication, Kelli Jacobsen, LCSW; UPHP, dated xxxx, 20xx.
6. Phone Interview,xxxx, Father, on xxxx x, 20xx.
7. Phone Interview xxx, MD, Friend, on xxxx xx, 20xx.
8. 17-Panel Urine Toxicology, UPHP/Spectrum, performed xxxx, 20xx.
9. HairStat-10+EtG, UPHP/Spectrum, performed xxxx.
10. PEth Blood Study, UPHP/Spectrum, performed xxxx.

WAIVER OF CONFIDENTIALITY: Dr. Doe was given a written waiver of confidentiality, which he signed and dated xxxx. The written statement was verbally reviewed by Dr. Doe and me, in which he was informed that this forensic independent medical evaluation was being performed at the request of UPHP and that he was here of his own free will. He was further advised that this evaluation did not constitute the creation of a typical doctor-patient relationship and that the information provided and possibly corroborated would form the basis of a written report to be forwarded to UPHP. He understood that this report would become a matter of her record with UPHP. Dr. Doe was advised and understood that he could terminate this evaluation at any time. It was stipulated and understood by Dr. Doe that this evaluation and any subsequent

recommendations are based on currently known information and that subsequent to its completion, should further information be ascertained, this assessment and its recommendations may be amended. Having agreed to all the aforementioned, he elected to proceed with the evaluation.

PRESENTING PROBLEM/HISTORY OF THE PRESENT ILLNESS:

Dr. Doe self-reported to UPHP secondary to an incident in the workplace with suspected impairment and providing a positive Blood Alcohol Level. Records indicate that contact was made with Dr. Doe on xxxx, where he reported that a physician with whom he was working believed he was intoxicated as he was slurring his words and could smell alcohol on his breath. He submitted to testing, claiming that test revealed the presence of alcohol, and he was sent home. He claimed that he had consumed "two or three" beers while at dinner and prior to beginning his shift, but did not think he was impaired. He also reported that in xxxx, he had been charged with public intoxication and disorderly conduct. The Disorderly Conduct charge was dropped and he pled no contest to public intoxication. He claimed that he had obtained his own Substance Abuse Assessment following the incident with reports that there was no evidence of a Substance Use Disorder and with recommendations that he attend individual therapy sessions to help him to cope with a break-up, which he claims he had already engaged in and completed. He also noted that he had self-reported the incident to DOPL, resulting in a Letter of Concern, but no other actions. Although recognizing the serious nature of the incident, it was believed he was minimizing his use of alcohol and "ambivalent" as to his alcohol use, claiming that "I really don't drink." Although initially claiming he had not consumed alcohol since the incident at work, he subsequently admitted that he consumes beers while watching sporting events or during other social events. Dr. Doe also then reported that in xxx, he had gone through a break-up and was drinking to "forget about" the loss of the relationship. Dr. Doe indicated that at that time he began to drink to "numb" his feelings claiming that he was drinking daily after work, up to 6-7 beers, and that this pattern continued until he was terminated from his employment.

Dr. Doe was born in xxxx to married parents and is an only child. His father worked as a professor at a local University. He graduated High School in xxxx and then completed five years at the University of xxx, graduating in xxxx with a BS in xxxx. He then attended xxxx College School of xxxx, graduating in xxx with a degree in Medicine. He completed an internship and two years of Residency in xxxx at xxxx Hospital. Following completion of his Residency, he moved to Utah, where he was employed by xxxx and has worked since his termination.

During his education, he denies any academic or behavioral issues. He reports only one employment termination (his most recent) but denies any history of suspensions, formal write-ups, or verbal reprimands. He denies any issues regarding his clinical abilities or behavioral issues in the workplace and is unaware of any peer complaints. He also denies any history of charting deficiencies or documentation problems as well as any history of excessive absenteeism or tardiness. He denies any history regarding his prescribing practices nor any history of suspicion or diversion of medications in the workplace. He does admit to his one episode of impairment in the

workplace. He has never been denied hospital privileges nor has he ever had his privileges restricted and he denies any malpractice claims. He has never held an academic appointment nor performed any teaching of residents. He was Board Certified in xxxx and completed his recertification in xxxx. He claims he loves his practice in xxxx and helping people.

He emotionally reports that the last year has been “rough” indicating he has been devastated by the loss of his relationship that ended after seven years. He initially denied his alcohol use played a role in the end of his relationship but later indicated that there were a few times she complained he was argumentative when he drank. Since the break-up he reports sleep disturbance, periods of feeling down and as noted, admits he has been drinking to “numb” his sadness.

As to the incident on xxxx, he reports he was scheduled to work a x p.m. shift and arrived late, as he states he wasn’t feeling like going in. He had felt particularly sad that day and met a friend for dinner. He states he consumed at least 1-2 beers around xxx p.m. until arriving at the hospital. He did not believe he was intoxicated, but now believes that he was, and coworker believed he was slurring his words and smelled of alcohol. A BAL and urine toxicology screen were performed and a ride was called for him and he was sent home. He received a call from HR a few days later, claiming that he had had a positive alcohol test. Two weeks later, he heard from his employer that they were terminating him, at which point he claims he contacted DOPL and was informed he could self-report to UPHP.

Regarding public intoxication and disorderly conduct charges that occurred xxx, he states “I was at BBQ with some friends. My ex-girlfriend showed up with another guy. I drank too much and got into an argument. Someone called the police.” As a requirement of his public intoxication charge, he was ordered to pay a fine and complete six hours of community service, which he states he completed. As noted, he underwent an evaluation and it was recommended he attend individual therapy to address his break-up.

He reports that he began seeing a therapist around xxxx, whom he stopped seeing a few months before his workplace impairment. He claims that they mostly focused on the break-up and didn't' really discuss his alcohol use.

He first consumed alcohol at age xxx without intoxication and denies any use of alcohol while in high school. He states he drank on the weekends or parties in college stating "I didn't drink much because I was really trying to get good grades so I could get into medical school." During his medical education, he began drinking on weekends, no more than two-three beers every "few months" and his drinking pattern continued throughout his internship and Residency, where he claims he occasionally would have a "beer or two" on occasion. He states when he moved to Utah his drinking increased due to the demands of his job to approximately a 4-5 beers over the course of a weekend. During the past year, due to the break-up of his long term relationship, he reports he started drinking after work, aswell as having a "beer or two" with lunch and would have another "few beers" when he would get off shift and before he slept. He claimed that he would drink a "few six packs" a week and would increase his consumption on days when he was not working and when returning from his shift. He also notes that he would binge at least "once a month" on a fifth of vodka at a time. He reports he presently drinks 3-4 beers per day, after his shift and more on his days off. He denies ever experiencing a blackout but as noted, does admit to early morning drinking after finishing a night shift. He states lately he has experienced cravings and denies any history of abstinence withdrawal symptoms including shakes, sweats, insomnia, or actual seizures. There has never been a family intervention due to his drinking, although as noted, he reported that his ex-girlfriend complained on more than one occasion that he is "argumentative" when he drinks. He claims he last consumed alcohol the day prior to our meeting, when he consumed "one or wo beers" to help him sleep. He still remains somewhat ambivalent as to whether or not he has an alcohol problem.

He denies use of any illicit substances or abuse of any prescribed medications. He has never engaged in a formal treatment process for substance abuse and has never attended any community support meetings such as AA or NA. He has never previously asked for any help related to his drinking, and he does not work any type of Recovery program.

Dr. Doe currently lives alone. He reports a good relationship with her father but notes that his mother died at age 74 secondary to a stroke, and they had a close relationship. His father was strict and he describes he was held to high expectations. Most of his friends are from work. His free time in the past has been spent rock climbing and watching various porting activities, however, he notes he has not rock climbed much the past six months due to working. His hobbies include rock climbing and playing guitar. He would like to return to his profession and is worried that he has "ruined" his career. He has no plans to begin dating or have a new partner. He denies any significant religious affiliation. He was raised Catholic but states once he began college, he stopped practicing and has no plans to return. He loves the outdoors and is conflicted as to a Higher Power.

Dr. Doe reports his mood as "sad" and believes he may be suffering from depression since the break-up. He states for most of his life he has been happy but states as he looks back he can see

that following his mother's death his mood has progressively become more down and his break-up was "icing on the cake." Currently he is feeling sad, some hopelessness and worthlessness, but denies any current or past history of suicidal ideation or attempts at suicide. He denies any irritability or anger, although notes that when he drinks he does become more irritable and angry. He has some difficulty with sleep and has little appetite. He denies any racing thoughts, mood swings, or episodes of mania and denies any memory or concentration deficits. He also admits to mild symptoms of anhedonia and is struggling with negative self-image. He denies any hallucinations.

PREVIOUS MEDICAL HISTORY: He denies cardiac, pulmonary, GI, GU or other disorders. He denies infectious diseases including HIV, hepatitis, or tuberculosis. He denies any chronic pain issues.

MEDICATIONS: He denies he is currently taking or prescribed medications.

PREVIOUS SURGICAL HISTORY: ACL surgery, 19xxx

ALLERGIES: Denies.

TOBACCO HISTORY: Denies.

FAMILY HISTORY: He denies any immediate or extended family history of substance abuse or mental health illnesses.

MENTAL HEALTH/PSYCHIATRIC HISTORY: He has never consulted with a psychiatrist nor been prescribed any psychotropic medications in his lifetime. As noted, he was involved with therapy once or twice a week, discussing his break-up. He denies any psychiatric hospitalizations, involuntary commitments, episodes of self-harm or mutilation, or frank suicide attempts. He denies any history of physical or sexual abuse. He denies any history of traumatic incidents.

SUBSTANCE USE DISORDER TREATMENT HISTORY: He denies any formal outpatient, inpatient, ordetoxification admissions for substance abuse.

SOCIAL HISTORY: His father worked as Professor at local University where he grew up. His mother was a stay at home mother. He states their marriage was "good" and that they appeared to be happy and loving. He was treated well, although notes that his father had high expectations of him academically. All of his needs were provided for and believes he was loved by his parents. There was no violence or abuse in the home. He believes he was outgoing and did well in school without any behavioral issues, always receiving A grades. He was anexcellent high school student where he participated in track and field.

He has had two serious lifetime relationships, the first beginning in high school and lasting four years. His second relationship lasted seven years, ending early last year. He indicates that the

relationship ended as she wanted to get married and he was not ready to commit to marriage. He now regrets that he didn't take that step and notes that she has since moved on. Again, he denies his alcohol use played a role in the break-up, but admits she complained about his alcohol use.

He claims his honesty and loyalty are his main character assets, and that his independence is his main character flaw.

EDUCATIONAL HISTORY: He received medical degree in xxx and remains Board Certified in xxx. He is also current on his CME requirements.

MILITARY HISTORY: Denies.

CRIMINAL HISTORY: He has had one arrest for public intoxication and disorderly conduct in xxxx, disorderly conduct charges were dropped and he was convicted of public intoxication.

LEGAL HISTORY: He has never been married and denies a history of bankruptcy, civil litigations, malpractice lawsuits, judgments, or IRS issues.

FINANCIAL HISTORY: He is self-supporting. He has savings and multiple retirement plans as well as a pension plan. He owns a home with a mortgage as well as one vehicle. Indebtedness is limited to student loans, and he has current health insurance.

EMPLOYMENT HISTORY: See History of Present Illness.

SUBSTANCE USE HISTORY:

1. **Alcohol:** See History of the Present Illness. He last consumed alcohol the day prior to the evaluation.
2. **Cannabis:** Denies.
3. **Cocaine:** Denies.
4. **Amphetamines:** Denies
5. **Methamphetamine:** Denies.
6. **MDMA (Ecstasy):** Denies.
7. **Hallucinogens:** Denies.
8. **Inhalants:** Denies.
9. **Dissociatives:** Denies.
10. **Opiates/Opioids:** In xxx, he underwent ACL surgery and was prescribed one week of Percocet and/or Lortab. He denies any positive mood-altering effects nor intravenous or intranasal use. He has never experienced cravings and denies any opiate withdrawal symptoms.
11. **Benzodiazepines/Sedatives:** Denies
12. **Caffeine:** He drinks coffee on a daily basis but denies any energy products.
13. **Tobacco:** Denies.

MENTAL STATUS EXAMINATION: He appeared for the Telehealth Interview in a timely fashion, appropriately dressed and well-groomed with short black hair. Gait and posture on

entrance appeared normal. He had an average build, appeared of average stature, and did not appear overweight. He appeared his stated age. He was entirely receptive to the evaluation and cooperative fully with a mostly pleasant demeanor. There was no observed excessive perspiration and he made adequate eye contact. Facial expressions appeared appropriate, but pupils and sclera could not be assessed. There were no abnormal grimaces or tics and sitting posture was upright. There was no obvious hyperactivity or hypervigilance, and movements were all coordinated. There were no signs of psychomotor agitation or retardation. He described his mood as "somewhat depressive" and his affect was somewhat restrictive and flat, congruent with his mood. There was no evidence of irritability, anger, or fear, and he did not appear anxious. He appeared mostly open and honest without attempts at deception or guardedness. Speech was of normal rate, tone, flow, and volume.

He spoke clearly without slurring and responded to questions appropriately. Attention and concentration appeared normal. Immediate, short, and long-term memories were assessed and appeared normal. He was oriented to time, place, person, and situation. Insight remained somewhat superficial, and judgment continues poor due to his continued use of alcohol. Thinking was coherent, relevant, linear, and goal oriented. Content related to his desire to return to work. There were no flights of ideas, loose associations, ideas of reference, tangentially, rapid thoughts, or circumstantial thinking. Vocabulary and ability to abstract appeared normal. Fund of knowledge was above-average. He had full command and understanding of the English language. There were no perceptual disturbances or delusions, and he did not appear to be responding to any internal stimuli. He denied any suicidal or homicidal thoughts.

COLLATERAL INFORMATION:

1. Phone Interview xxx, Father, on xxx. Mr. Doe reports he sees his son “a few times per year” when either Dr. Doe comes to visit or he fly’s to Utah to visit. He believes he drinks in a recreational fashion but does not use any other substances. He reports that he has observed when he visits in Utah or when Dr. Doe visits him in xxx that Dr. Doe will drink a “beer or two” at dinner. Mr. Doe indicates his son doesn’t seem to have much of a social life since his break-up, noting he works “all the time.” He has never witnessed him impaired nor intoxicated, but also reports that during his last visit to Utah, he observed his son stayed up later and when he woke up, there were 6-7 empty beer cans in the trash. He notes he has appeared more down than usually since his break-up.

2. Phone Interview xxx MD, Friend, on xxx. Dr. xxx reports he has known Dr. Doe for over 5 years as they have worked closely together. They remain friends and they talk at least once or twice a month. He reports that Dr. Doe does drink alcohol, which he believes he is using as a coping mechanism, and they previously had consumed alcohol together socially, observing that he did drink 5-6 beers when they would get together. He has had some concerns about excessive drinking and has seen him intoxicated a few times. Behaviorally, he notes that Dr. Doe is outgoing and is mostly very calm; however, he notes he hasn’t appeared to be himself the past few months.

3. Attempted Phone Interview xxx, MD; HospitalDirector, xxx, was unsuccessful due to xxx

refusal to answer any questions and suggested referral to Human Resources.

4. Attempted Phone Interview xxx, colleague, was unsuccessful on multiple attempts.

5. Collateral information from UPHP, (see history of presenting illness)

TOXICOLOGY STUDIES:

1. 17-Panel Urine Toxicology, UPHP/Spectrum, performed xxxx, **NEGATIVE** for all substances tested including amphetamines, barbiturates, benzodiazepines, cannabinoid, cocaine, oxycodone, oxymorphone, PCP, methadone, propoxyphene, meperidine, tramadol, ethanol, EtG, and nitrite. Validity testing is WNL.

2. HairStat-10+EtG, UPHP/Spectrum, performed xxx, is **NEGATIVE** for barbiturates, benzodiazepines, cocaine, methadone, opiates, PCP, oxycodone, propoxyphene, cannabinoids, amphetamines, and POSITIVE for EtG at xxx ng/mL.

3. PEth Blood Study, UPHP/Spectrum, performed xxxx, is **POSITIVE** at 91 ng/mL.

MULTIDIMENSIONAL ASSESSMENT:

Dimension I (Acute Intoxication and/or Withdrawal Potential): Dr. Doe displays no signs of intoxication and neither endorses nor displays any signs or symptoms of an abstinence withdrawal syndrome. Despite his history consistent with an Alcohol Use Disorder, he continues to drink and therefore his current risk is **moderate.**

Dimension II (Biomedical Conditions and Complications): Dr. Doe is in excellent general medical health and is not prescribed medications. His risk is **low.**

Dimension III (Emotional, Behavioral, or Cognitive Conditions and Complications): Dr. Doe denies any psychiatric intervention, but notes significant depressive symptoms over the course of the past 12 months. He describes his current mood as "moderately depressive" and his affect is somewhat flat and restrictive, consistent and congruent with his mood.He displays no signs of anxiety and there is no evidence of any cognitive impairments. He denies any significant history of emotional trauma. Although his symptoms would not interfere with his ability to engage with the recommended level of treatment, his depression symptoms increase his risk for continued alcohol use.

Dimension IV (Readiness to Change): Dr. Doe has never engaged in any formal treatment for his Alcohol Use Disorder and continues to not fully recognize the significance of his usage of alcohol. He has yet to avail himself ofany community mutual support structure such as AA. Based on his self-reports and her current positive PEth and Hair toxicology, he continues to drink in a problematic fashion, and I believe he is in Contemplative Stage of Change.

Dimension V (Relapse, Continued Use, or Continued Problem Potential): Based on his self-reports and his positive toxicology, Dr. Doe has not been able to abstain from alcohol and without appropriate intervention and professional monitoring, it is unlikely he will be able to cease his use of alcohol. His untreated depressive symptoms increase his risk in this dimension. His risk in this dimension is **High**.

Dimension VI (Recovery Environment): Dr. Doe is not currently engaged in any Twelve Step or other community support structure and has no significant formal Recovery program. It is also noted he has a minimal family social support structure. He is now unemployed but appears to have stable finances and a stable home living environment. His risk in this dimension is **Moderate.**

DISCUSSION/DIAGNOSTIC FORMULATION:

Dr. Doe self-reported to UPHP due to his impairment in the workplace, his positive alcohol toxicology study, and his subsequent termination from his employment due to his impairment. He previously had reported his public intoxication arrest occurring in xxx, when he received a Letter of Concern from DOPL but with no further disciplinaryaction or recommendations other than that he engage in therapy. He has provided conflicting histories as to his alcohol usage, at one point

claiming he does "not drink at all" and at another point claiming he is a daily drinker ofmultiple drinks. Despite his negative consequences, including his criminal charges and termination from the workplace due to his impairment, he continues to drink and has been unableto cease his use of alcohol. His positive PEth and hair toxicology at greater than four times the acceptable cutoff indicative of problematic and risky alcohol use certainly indicates his continued use of alcohol in a risky and problematic fashion.

He has appropriately admitted to his usage of alcohol for mood alteration as he has experienced the death of his mother five years ago and the break-up of a long term relationship last year. During the interview process, he displayed tearfulness and admits to his depressive mood.

I believe that Dr. Doe meets DSM-5 criteria for a Severe Alcohol Use Disorder based on his use in larger amounts and/or over a longer period than intended, his unsuccessful efforts to control his use, his recurrent use resulting in his failure to fulfil his role obligations at work, his loss of his occupational activities due to his use, his use in physically hazardous conditions, such as at work, and his use despite knowledge of a persistent psychological problem. It is recommended that Dr. Doe engage in an ASAM Level 3.5 Residential level of treatment with a treatment provider with expertise in treatment of the healthcare professional. It is also advised that once completion of the initial phase of treatment, that he then step down to an IOP level of treatment. It is also strongly recommended, but not as a requirement for safety to practice, that initiation of treatment with long-acting naltrexone via Vivitrol be instituted tosupport him in his attempts at Recovery. He will need to engage in community support structure through AA or a similar community support system and that he obtain a sponsor/mentor who he diligently works with for his Recovery program. He will require monitoring by UPHP to attest to his continued Recovery program, his ability to remain abstinent from all mood-altering substances, and his continuing safety to practice.

As part of his treatment process, he should have a Psychiatric Evaluation to address his ongoing depressive symptoms with possible institution of psychotropic medications. It is also recommended that he engage in Individualized Therapy with a licensed Master's level clinician with expertise in CBT and possibly EMDR methods of therapy.

It is my opinion at the present time that Dr. Doe is not able to continue his practice of medicine with the required safety until he has completed the recommended levels of treatment and has the approval of his treatment providers and of UPHP as to his safety to practice. It is suggested that he be successfully monitored for at least a three-month period once completion of residential treatment and prior to returning to work in order to attest to his ability to remain abstinent. He will need to be appropriately monitored by UPHP and remain fully compliant with all terms and conditions. He should provide a negative PEth toxicology study prior to any consideration of returning to the workplace.

DIAGNOSIS:
Alcohol Use Disorder, severe
Depressive Disorder
Stressors Include: Employment,
Economic, Professional,
Licensure, and Substance Use

RECOMMENDATIONS:

1. That Dr. Doe engage in an ASAM level 3.5 or PHP with housing level of care with a UPHP approved treatment provider with expertise in treatment of the healthcare professional. Length of treatment should be based on his progress in treatment and the recommendations of his treatment provider. It is suggested that following completion of the initial phase of treatment, that he step down to an IOP level of treatment and that during treatment, institution of long-acting naltrexone (Vivitrol) therapy be considered. He should undergo a thorough Psychiatric Evaluation during his treatment process with possible institution of psychotropic medications.

2. That following completion of treatment, Dr. Doe be monitored by UPHP under an SUD/Mental Health Monitoring Contract for a period of time to be determined by the UPHP Clinical Leadership Team. Monitoring requirements should include the need for attendance at live, peer-facilitated, community mutual support groups. Toxicology monitoring should include frequent usage of EtG/EtS, and she should have PEth testing performed at least quarterly. Should he be placed on anypsychotropic medications, he will require a Psychiatric Medication Management component to his monitoring,and it is also recommended that he engage in Individualized Therapy with a licensed Master's clinician with expertise in treatment of SUDs. The treatment milieu should consider usage of CBT and EMDR as therapeutic options.

3. That Dr. Doe be considered not able to continue his practice of medicine at the present time until he has completed the recommended levels of treatment and has the approval of all treatment providers and of UPHP asto his safety to return to the workplace. He will need to be appropriately monitored by UPHP and he should provide a negative PEth toxicology study prior to any consideration of returning to the workplace.

Thank you very much for allowing me to participate in the evaluation of Dr. Doe. Please do not hesitate tocontact me should there be any further questions or concerns.

Dr. XXXX