ASSESSMENT REPORT EXAMPLE

SAMPLE TREATMENT DISCHARGE SUMMARY FROM PROFESSIONAL RENEWAL CENTER (PRC), KANSAS

This treatment discharge summary is a sample work product of the Professional Renewal Center. All identifying information has either been omitted or disguised for purposes of confidentiality.

March 14, 2003

William Reynolds, MD
United States Physicians Health Program
123 Sunset Way, Suite 100
Anytown, USA 45678

RE: Ian Frank, MD

Dear Dr. Reynolds:

I am writing in regard to Ian Frank, MD, a 29-year-old third year surgical resident who recently completed a multidisciplinary assessment and treatment process at the Professional Renewal Center (PRC) in Lawrence, Kansas. Dr. Frank came to PRC for a multidisciplinary assessment on January 27, 2003, and then transitioned into our intensive day treatment program for professionals on February 3, 2003. He was discharged on March 14, 2003.

The members of Dr. Frank's assessment and treatment team included Bruce Parsa, DO, board certified psychiatrist; Loree Cordova, MD; family medicine physician; Scott C. Stacy, PsyD, licensed clinical psychologist; Mary Yanics, PhD, licensed clinical psychologist; George Athey, PhD, consulting psychologist; Sue Porter, MSW, LSCSW, licensed specialist clinical social worker; Jeffery Lewis, LSCSW, BCIAC, licensed specialist clinical social worker; Scott Campbell, CARN, RN, BC, certified psychiatric and addictions nurse; and Peter Graham, PhD, director of the team and consulting psychologist. The members of Dr. Frank's assessment team formulated diagnostic conclusions and recommendations for his care through a process leading to consensus.

Waiver of Confidentiality

Dr. Frank has provided us with written authorization that permits us to disclose to you the results of his treatment. This summary was prepared with Dr. Frank's full knowledge and informed consent and integrates information gathered over the course of his treatment. This information includes: 1) clinical interviews; 2) results of psychological testing; 3) disclosures made by the patient during interviews and on self-evaluation questionnaires and written assignments; and 4) information obtained from collateral sources including other professional evaluations. Dr. Frank was informed of the

treatment team's duty to report certain information, if obtained, in accordance with state and national laws.

Further disclosure of this report and any other medical information is not permitted under the terms of this authorization without Dr. Frank’s expressed written consent.

Caution in the Use of this Report

The conclusions of this treatment process were derived from the information provided by the patient and collateral sources. We have not attempted to ensure the accuracy of all collateral information obtained or provided. Dr. Frank was given the opportunity to provide any collateral information felt to be relevant and helpful in order for our team to conduct an objective assessment. Concerned parties, and in particular the referring party, were provided with the same opportunity.

The diagnostic conclusions, opinions and recommendations contained herein are based upon this data, and are stated with a reasonable degree of medical certainty unless otherwise indicated. Additional information not disclosed to us by Dr. Frank or provided by collateral sources could alter the findings outlined in this report. The team reserves the right to amend its opinions and conclusions in such situations. Natural limitations in the treatment process and our state of knowledge are acknowledged. Therefore, we cannot fully and accurately predict Dr. Frank’s future behaviors or actions.

Collateral Information Reviewed:

1. Referral information provided via telephone from William Reynolds, MD, of the United States Physicians Health Program
2. Detailed timeline of events during internship and residency, summary description of employment situation, and personal inventory of problems written by Ian Frank, MD
3. Adverse Action Recommendation letter dated November 13, 2002, from Dr. O’Reilly, Director, Surgery Residency Training Program, Dr. Lester, Interim Chair, and Dr. Rosenblitt, Director, Graduate Medical Education, of the State University Department of Medicine to Dr. Frank
4. Cover letter dated November 18, 2002, from Dr. Rosenblitt to Dr. Frank
5. Letter dated November 26, 2002, from Robert Stone, MD, Dr. Frank’s personal psychotherapist, to Dr. O’Reilly
6. Dismissal letter dated December 2, 2002, from Dr. O’Reilly to Dr. Frank
7. Letter of reference in support of Dr. Frank, undated, from Michael Johnstone, MD, presumably sent to Dr. O’Reilly
8. Letter of reference in support of Dr. Frank, dated December 18, 2002, from Emily Campbell, MD, presumably sent to Dr. O’Reilly
9. Letter of reference in support of Dr. Frank, dated December 18, 2002, from thirty members of the State University Medical Center Surgery Residency class to the Hearing Panel of the Office of Graduate Medical Education, State University Medical Center

10. Letter outlining the decisions and recommendations of the Hearing Panel of the Office of Graduate Medical Education, State University Medical Center, dated December 20, 2002, from the members of the Hearing Panel to Dr. Frank
11. Letter requesting a meeting with Dr. Frank, dated December 23, 2002, from Dr. O'Reilly to Dr. Frank
12. Routine Corrective Action Plan for Ian Frank, MD, dated January 8, 2003, as signed by Margaret O'Reilly, Director, Surgery Residency Training Program, Harvey Lester, MD, Interim Chair, and Ian Frank, MD
1. Letter dated January 23, 2003, from Dr. Frank to Dr. O'Reilly and Dr. Lester
13. Phone and face-to-face interviews with Dr. Frank's wife
14. Phone interview with Dr. Frank's mother
15. Phone interview with Dr. Robert Stone

Summary of Treatment:

Over the course of seven weeks, Dr. Frank participated in various forms of assessment and treatment to explore and resolve his difficulty with disruptive behavior and unprofessional conduct with colleagues and peers and aggressive, intimidating behavior toward his wife. These difficulties were addressed within the context of various modes of treatment including:

1) Twice weekly individual treatment coordination and psychotherapy meetings with this writer
2) Psychopharmacological evaluation and medication monitoring under the care of Dr. Parsa
3) Biofeedback and Alpha-theta neurofeedback treatment with psychological processing conducted by Mr. Lewis
4) Eye-movement desensitization and reprocessing (EMDR) therapy, expressive-supportive psychodynamic psychotherapy and couples therapy with Ms. Porter
5) Daily Group psychotherapy
6) Daily Professional Ecology group
7) Daily Roles and Relationships group
8) Daily Studies in Transformation recovery group
9) Daily Integration and Wrap-Up group
10) Individual discharge and relapse prevention planning with Mr. Campbell

The assessment team recommended that Dr. Frank enter into an intensive treatment program for professionals to address the issues of his disruptive, devaluing behavior and the underlying anxiety and depression with which this behavior was understood to be an attempt to cope. The team believed that it would be crucial for him to immerse himself in a treatment program, rather than try to address the clinical issues identified in his assessment in a weekly outpatient psychotherapy process. Such an outpatient treatment, while supportive and focused on the pertinent issues, simply had not proven to be sufficiently intensive or to have the required degree of behavioral leverage to successfully alter his complex pattern of emotional vulnerability and compensatory defensiveness.

Two central components that were recommended to be incorporated in his treatment included: 1) helping him to address the underlying psychological issues that fueled his disruptive misconduct; and 2) examining those vulnerabilities in himself that led him to compromise his better judgment. The team recommended a multi-modal treatment process that incorporated: 1) an educational component covering professional boundaries and ethics that emphasizes the definition and behavioral limits of the role of physician; 2) victim empathy exercises; 3) cognitive-behavioral interventions aimed at disentangling faulty lines of logic that predispose him to compromised judgment; 4) Eye Movement Desensitization and Reprocessing (EMDR) and Alpha-Theta Neurofeedback training to assist him in developing a greater degree of control over the process of regulating his emotional states of mind and a higher threshold of stress-tolerance; 5) expressive-supportive psychodynamic psychotherapy aimed at helping him to begin to address those underlying developmental issues that hinder him from forming meaningful, supportive, and healthy collegial and intimate relationships; and 6) the consideration of possible psychopharmacological interventions to assist in mood and affect regulation.

Dr. Frank was seen for individual psychotherapy for a total of 13 individual hours and for one hour of therapy with his wife and two hours of conference calls with his wife. Dr. Frank was initially referred for individual therapy with the thought that there might be some benefit from using EMDR (Eye Movement Desensitization and Reprocessing) to strengthen internal resources that could be utilized when he becomes flooded with intense negative feelings. During the course of his assessment he spoke of his shame and guilt about the level of anger that he had experienced in his relationship with his wife. His realization that he was nearing a point of possibly losing control in his interactions with his wife was a key element in his motivation for committing himself to the treatment process.

Dr. Frank had a difficult time with the EMDR. He reported that he had a lot of anxiety about "doing it right". Guided imagery was used to reduce this anxiety. In processing what the anxiety was about, he was able to say that he had a difficult time allowing himself to trust that EMDR could be helpful for him. This brought up the fact that it is hard for him to accept and ask for help in general. He believed that if he needed to correct something that was wrong with him he did not need to use any means that would "make things easier." He believed that he had to do it himself. To ask for or to accept help meant to him that he was "weak, dependent, and vulnerable;" a view of himself that he came to understand as being central to his shift into a more belligerent attitude. In the past he had rejected taking an antidepressant medication for this very reason. In examining the issue with him, it seemed more productive to work on his "internal critic" and his masochism than to push him into an EMDR process that he was not finding useful.

During the psychotherapy process, Dr. Frank was able to become more aware of how growing up in an angry, critical family environment had played a role in his anxiety and anger management problems. He learned that he had internalized a very strong "critic" that expected nothing less than perfection from him. In order to "cover up" those aspects of himself that he considered less than perfect, he became overly critical and judgmental

of others. He was exquisitely sensitive to anything that he perceived as critical from peers and staff. He worked very hard on developing an awareness of when "the critic" was being activated and then creating ways to "turn down the volume" or turn the critic off altogether. He learned that when the critic is activated he is more vulnerable to reacting to real or imagined rejection from his wife or criticism from colleagues. He began to realize that being aware of what makes him vulnerable to acting out is central to reducing the potential for violence in his marriage and anger management problems in the workplace.

Dr. Frank moved from the position of blaming his parents for causing his problems to starting to take more responsibility for his actions. During most of his treatment, he took a "vacation" from talking with his parents on the phone in an attempt to begin to practice having more emotional distance from them. He e-mailed them weekly to maintain contact. He did this because conversations with his mother were so triggering and distracting for him that he would spend large amounts of time obsessing about what had been said. During the last two weeks of treatment he re-established phone contact and handled what he perceived to be his mother's attempts to make him feel guilty in a calm, quiet manner without the usual anger and frustration he had experienced in the past. He stated that he was well aware that there would be many times when he would be drawn back into old behaviors but he felt that he now had some hope that things could change.

Dr. Frank will need to continue working on being aware of the functioning of his "internal critic" in the service of learning ways to be less masochistic in his efforts to appease the associated feelings of responsibility and guilt that he consistently feels. He tends to feel that he must become over-confident about what he has learned and then feels guilty, angry and disappointed when things go wrong. He is more aware of just how ingrained his perfectionism is, how he "beats himself up" when he falls short of perfect, and how pursuing perfection is a compensation that, in many ways, may be less than necessary at this point in his life.

During the course of Dr. Frank's treatment, the team continued to evaluate his diagnostic picture. Over the course of six weeks of treatment and observation, the team concluded within a reasonable degree of certainty that Dr. Frank does not suffer from either an intermittent explosive disorder or a bipolar condition. While he remained vulnerable to strong emotional reactions of anger, as well as guilt and shame, the team did not believe that explosiveness was a chronic and persistent feature of his behavior. It was also the team's opinion that the aggressiveness that he had shown in the past could be better accounted for as being a feature of his other diagnoses. The team also agreed that he did not show sufficient evidence either in his history or in his current behavior for a diagnosable manic aspect to his mood disorder. To the degree that he manifests irritability, expansiveness, or inflated self-esteem, the team believes that these are better accounted for as features of his depression, anxiety disorder, and the related compensatory features of his personality. Dr. Parsa addressed his anxiety and depression with medication. The possible addition of a mood stabilizer was considered with the patient, but it was agreed that he would continue with the current trial of Paxil and that a mood stabilizer would remain an option available to him in the future if he were to

experience any significant increase in his difficulties in regulating the intensity and fluctuations of his mood and affects.

Dr. Frank actively participated in the Psychophysiological Self-Regulation Program. He completed hand temperature training and the Alpha-Theta brainwave training. He found this process helpful in facilitating his ability to reflect on potential stressors without becoming reactive. Various visualizations were incorporated in the Alpha-Theta brainwave training process. The themes embedded in his visualizations were employed to support him in addressing and resolving issues associated with anger, intense feelings of vulnerability, childhood conflict, resentment, isolation, and avoidance.

Dr. Frank progressed rapidly through the hand temperature training. He was able to increase his hand temperature to 95.4 degrees with autogenic training and diaphragmatic breathing skills leading to a greater capacity to decrease his autonomic arousal and better manage his reaction to potential stressors in his environment. He also demonstrated the ability to observe and recall imagery without censoring the information. He was intrigued by how much of his own internal dialogue he was unaware of before starting his psychophysiological self-regulation training. The main theme in his initial imagery centered on thoughts and feelings of vulnerability and anger. The recall of imagery around these issues supported him in discussing the origins of these feelings. This led to an increased capacity to become more comfortable with owning feelings of anger and vulnerability as well as a greater capacity to share these feelings with others in a reflective rather then reactive and hostile manner. His awareness of how he carried psychological stress in physical form in his body increased dramatically. He demonstrated the ability to integrate this new information into skills improving his ability to be more aware of his autonomic arousal when confronted with potentially stressful situations. He experienced an increase in his capacity to understand how his own critical and judging nature negatively impacted his ability to communicate with others. He was able to create and modify visualizations that helped him transform these negative views of himself. This helped him develop a greater capacity to communicate with his peers in a reflective and nonjudgmental manner. The main theme of his imagery in the last phase of his training centered around ideas of self-acceptance and integration of all aspects of his being. His awareness and processing of these images with the group resulted in his ability to adopt a more appropriately assertive style of communication. He stated at the end of his training he felt an increased confidence in his ability to communicate his true thoughts and feelings with others in a reflective and assertive manner. He developed various skills and techniques that he will continue to use to maintain the gains made in his training. Dr. Frank successfully completed the Psychophysiological Self-Regulation Alpha-Theta brainwave training process on March 3, 2003.

Dr. Frank's involvement in the group aspects of the treatment process was active and earnest. He developed constructive and mutually beneficial relationships with his peers. He appropriately encouraged and confronted them and was admirably open to their constructive feedback to him. He developed a much greater awareness of the impact of his own personal life and internal emotional states on his performance and relationships in the work setting. He learned about the internal and environmental factors that

contribute to his ambient stress level and ways in which he can more proactively regulate the level of stress under which he will work. He gained a much clearer appreciation of the role that he plays in the hospital setting as a physician, the responsibilities inherent in that role and the importance of being aware of his self-presentation and of knowing how he fits into a functioning unit or team that requires careful attention from him in order to function optimally. He also learned how to differentiate between various types of relationships, both professional and private, how to set appropriate boundaries with others and with himself, and the importance of remaining clear about motivations and the need to keep the task at hand well defined, whether he is involved in learning, teaching, treating, or relating to his wife or family.

In the treatment coordination relationship, Dr. Frank developed a detailed appreciation of the ways in which his efforts to avoid painful feelings of inadequacy and unworthiness were instrumental in his taking on the aggressive and belligerent stance that had become so problematic for him. His careful engagement in the process of writing a detailed description of the events surrounding his episodes of disruptive behavior at work gave him an empathic perspective of his wife's and his colleagues' experience of his anger that he had not had previously. He became much more aware of the function of self-esteem regulation in his angry behavior. He came to understand the myriad painful emotions that he had covered over with anger and haughtiness. This allowed him to gain a better understanding of his need for ongoing support and mentoring from his teachers and colleagues as opposed to increasingly isolating himself in a defensive, superior stance. He created a list of the disruptive and coercive behaviors from which he will need to abstain on a permanent basis. He also was able to develop a concrete definition of the situations in which he is most at risk for relapse and created a list of specific behaviors in which he will be able to engage to minimize the likelihood that he will relapse. He also completed his individual work by creating a plan for what he will do if he or others believe that he has relapsed.

Dr. Frank successfully completed his primary treatment process with PRC and returns home with a very clear understanding of what he will need to continue working on in his treatment and monitoring relationships, in his marriage, and in his relationships in the residency training program. He has a much better awareness of the factors that have contributed and will continue to contribute to his vulnerability to act disruptively. The treatment team believes, however, that with continued support, treatment and active commitment on his part, he will be able to successfully complete his residency training and become an extremely effective and collaborative surgeon.

Physical Evaluation/Laboratory Studies:

Dr. Frank had a physical examination during his assessment week at the Professional Renewal Center. No additional physical examination was indicated or performed during his treatment process.

Over the course of Dr. Frank's treatment process, he received random seven-panel urine drug toxicology screening (following chain of custody protocol) for substances of abuse and random breathalyzer testing for alcohol. Drs. Cordova and Parsa reviewed these laboratory results and communicated their findings to this writer. All urine drug screens and breathalyzer tests were negative.

Medications at Discharge:

1. Zyrtec 10 mg po q day
2. Paxil CR 25 mg po q day
3. Advil prn knee pain

Diagnoses:

The treatment team has agreed upon the following diagnoses for Dr. Frank based upon DSM-IV-TR criteria and psychological test data:

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<tr><td>Axis I:</td><td>296.35</td><td>Major Depressive Disorder, Recurrent, In Partial Remission</td></tr>
<tr><td></td><td>300.00</td><td>Anxiety Disorder, NOS with posttraumatic features (exaggerated startle response, hypervigilance, irritability and outbursts of anger, efforts to avoid thoughts, feelings and activities related to traumatic memories, physiological reactivity on exposure to internal and external cues that symbolize or resemble an aspect of the traumatic situation)</td></tr>
<tr><td></td><td>V62.2</td><td>Occupational Problem (disruptive behavior)</td></tr>
<tr><td>Axis II:</td><td colspan="2">Narcissistic and Obsessive-Compulsive features</td></tr>
<tr><td>Axis III:</td><td colspan="2">S/P wisdom teeth extraction and aseptic meningitis (both age 19), history of wrist and knee injuries, carrier of hemachromatosis</td></tr>
<tr><td>Axis IV:</td><td colspan="2">Suspension and threatened expulsion from medical residency</td></tr>
<tr><td>Axis V:</td><td colspan="2">Current GAF 80; Highest GAF Past Year estimated at 80</td></tr>
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Conclusions and Recommendations:

The treatment team provides the following conclusions and recommendations:

1. With a reasonable degree of psychological certainty, the treatment team finds Dr. Frank fit to return to the practice of medicine with skill and safety provided he follows the recommendations outlined below.

2. Dr. Frank will remain in compliance with State University Medical Center bylaws and any rules and/or regulations of the center at all times. He will also remain in compliance with the conditions of the corrective action plan dated January 8, 2003, and signed by Dr. Frank on January 13, 2003.

3. Dr. Frank will interact with hospital employees, physician colleagues or other healthcare providers in an appropriate and courteous fashion. He will refrain from aggressive and disruptive behavior and from raising his voice during a disagreement or using profanity in these contexts. He will also refrain from making derogatory or devaluing remarks about colleagues.

4. The Program Director of the Surgery Residency Training Program and Dr. Frank will agree upon an appropriate physician mentor from the program faculty. This individual will be available to Dr. Frank and to administrative staff to discuss any concerns regarding Dr. Frank's behavior. Additionally, this individual will be available to Dr. Frank to serve as an appropriate individual to whom Dr. Frank might address any concerns that he has regarding administrative functions within the hospital, issues with staff, disagreements on clinical matters, etc.

5. Dr. Frank will maintain contact with his faculty mentor in person at least once weekly for the remainder of his involvement in the residency program.

6. Dr. Frank will refrain from expressing excessive concern regarding the functioning of the hospital or the performance of another clinician within the worksite. He will take his concerns about difficulty within the workplace or about the performance of another clinician to his designated faculty mentor.

7. Dr. Frank agrees to respond in an appropriate and courteous manner to nursing staff's questions or contact through the paging system. He agrees to interact and collaborate in an appropriate and courteous manner with faculty, colleagues, fellow residents and trainees, and other clinicians.

8. In the event of a suspected or actual behavioral incident, the following will take place:
   a. Dr. Frank and his mentor will be notified of the event/incident
   b. Dr. Frank will discuss the issue with his faculty mentor
   c. The event will be reviewed by the Executive Graduate Medical Education Committee, including Dr. Frank's faculty mentor
   d. Upon review, if the Executive committee, including his mentor, considers Dr. Frank's behavior to be disruptive, he will be immediately dismissed from the residency program

9. Dr. Frank will make voluntary contact with Dr. Graham of the Professional Renewal Center. This contact will be verbal contact weekly for one month, biweekly for one month, followed by once monthly for six months.

10. Dr. Frank will make voluntary contact with the United States Physicians Health Program at a frequency agreed upon with Dr. William Reynolds of the USPHP.

11. Dr. Frank will engage in at least weekly psychotherapy with Dr. Robert Stone for the remainder of his time in the residency program

12. Dr. Frank will follow through with recommendations made by the Professional Renewal Center and the United States Physicians Health Program.

13. Dr. Frank will return to the Professional Renewal Center in approximately six months from the signed date of this contract for one week of follow-up assessment.

14. If Dr. Frank is unable to comply with this contractual arrangement, it is agreed that he will be referred for ongoing assessment at a program recommended by the United States Physicians Health Program.

The treatment team at the Professional Renewal Center has appreciated the opportunity to work with Dr. Frank. If we can be of additional help to you in any way, whether providing you with additional information or consultation, please feel free to contact us at your convenience.