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DEC 18 2014

IDAHO STATE BOARD
OF MEDICINE

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Idaho State Bar No. 1763

Attorneys for the Board

BEFORE THE IDAHO STATE BOARD OF MEDICINE

| In the Matter of: | ) | |
|---|---|---|
| | ) | Case No. 98-045 |
| DAN E. DWYER, M.D., | ) | |
| License No. M-7188, | ) | **ORDER AMENDING BOARD'S** |
| | ) | **FINAL ORDER** |
| Respondent. | ) | |
| | ) | |

On November 17, 2014, Dr. Dwyer filed a request for modification of the Board's Final Order entered March 31, 2013. This matter came on for consideration by the Board at its regular meeting on December 5, 2014. Based upon Respondent's request for modification of Order and the Board's consideration of that request,

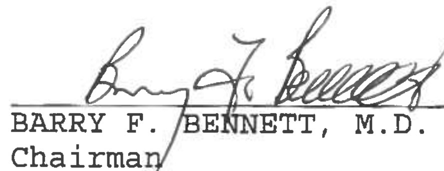
IT IS HEREBY ORDERED That the Final Order dated March 31, 2013, is amended to read as follows:

3. Respondent shall not practice medicine, e.g., psychiatry, as a solo practitioner nor shall he practice medicine in conjunction with any professional with whom he is related by blood, marriage or professionals employed by or in practice with such relatives or wife. Upon five (5) years total and full compliance with all terms and conditions of his probation, this Final Order and PRN contract, Respondent

may practice medicine, e.g., psychiatry, in conjunction with any professional with whom he is related by blood, marriage or professionals employed by or in practice with such relatives or wife upon Board Order. Paragraph 3 of the Final Order does not prohibit Respondent from working at a facility where his wife or other relatives have privileges. In addition, supervision by Respondent's wife or other relatives at a facility where they have privileges will be allowed to the extent required by the facility and subject to its Governing Bylaws, Medical Staff Bylaws and Rules and Regulations.

Paragraph 2 of the Final Order is amended to provide that Respondent shall be allowed to prescribe controlled substances for patients at Intermountain Hospital consistent with standing orders of Intermountain Hospital and for discharge orders for controlled substances for a period of time not longer than seven (7) days.

DATED This 15 day of December, 2014.



BARRY F. BENNETT, M.D.
Chairman

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Attorneys for the Board

RECEIVED
DEC 23 2014
IDAHO STATE BOARD
OF MEDICINE

BEFORE THE IDAHO STATE BOARD OF MEDICINE

| | |
|---|---|
| In the Matter of:<br><br>DAN E. DWYER, M.D.,<br>License No. M-7188,<br><br>Respondent. | Case No. 98-045<br><br>**CERTIFICATE OF SERVICE** |

I HEREBY CERTIFY That on the 22 day of December, 2014, I served a true and correct copy of ORDER AMENDING BOARD'S FINAL ORDER entered by the Board on December 15, 2014, upon the Respondent's attorney by depositing a copy thereof in an envelope addressed to:

Andrew Brassey
Attorney at Law
Brassey, Crawford & Howell, LLP
203 W. Main Street
Boise, Idaho 83702

JEAN R. URANGA

Cathleen M. Morgan, JD, ISB No. 5218
IDAHO STATE BOARD OF MEDICINE
1755 Westgate Drive, Ste. 140
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Attorney for the Board

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JUL 31 2013
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IDAHO STATE BOARD OF MEDICINE
COPY

**BEFORE THE IDAHO STATE BOARD OF MEDICINE**

| In the Matter of: | ) | |
|---|---|---|
| | ) | CASE NOS. BOM-1998-045 & BOM-02-120 |
| DAN E. DWYER, M.D., | ) | |
| License No. M-7188, | ) | **ORDER ON PETITION FOR RECONSIDERATION - FINDINGS OF FACT, CONCLUSIONS OF LAW AND FINAL ORDER** |
| Respondent. | ) | |

This matter was before the Idaho State Board of Medicine (hereinafter Board) upon Dr. Dan E. Dwyer's, aka Dr. Daniel Edward Dwyer (hereinafter Respondent), *Petition to Reinstate License* filed on April 29, 2011, following the surrender of his Idaho medical license on June 6, 2003. Prior to and at the evidentiary hearing conducted November 20, 2012 (hereinafter 2012 hearing), Respondent was represented by legal counsel as was the Board.

**BACKGROUND**

The record in this matter documents Respondent's many years of struggling with his multiple diagnoses of drug addiction and complex mental disorders and the serious consequences that ensued. Approximately a mere three (3) months after being issued an Idaho medical license in November of 1997, Respondent was charged with multiple criminal felonies consequent to diverting a controlled drug, i.e., Ritalin, for his own use. This criminal proceeding generated grave concern that Respondent was unable to practice medicine with reasonable skill and safety thus jeopardizing pubic welfare. As a result, formal proceedings were initiated against Respondent's medical license in October 1998. (*Recommended Findings of Fact and Conclusions of Law*, pps. 2-3.)

During the course of these formal proceedings, Respondent began his first of many futile attempts at treatment for his addictions and mental disorders. Respondent's first hospitalization was at Springbrook Northwest (hereinafter Springbrook) in Oregon, from October to November, 1998. (Exhibit 2.) The Final Discharge Summary notes that Respondent reported his use of alcohol, marijuana, Ritalin and Valium, with his drugs of choice being marijuana and Ritalin. (Exhibit 2, p. 2.) At Springbrook, Dr. Glenn Brasington conducted a Psychological Evaluation and diagnosed Respondent with "adjustment disorder with mixed disturbance of emotions and conduct; [redacted] [redacted]." Dr. Brasington also opined that Respondent "should be expected to be very challenging, particularly to staff, and to have significant passive aggressive tendencies." (Exhibit 2, p. 9.)

Respondent did not complete primary treatment at Springbrook; in fact, 'he was kicked out of treatment," he was primarily "struggl[ing] with multiple resentments focusing upon his need to be in treatment and treatment recommendations." (Exhibit 2, pps. 3 & 580.) For these reasons and his increasingly antisocial behavior, he had to be transferred to another facility, the Menninger Clinic in Kansas.

In 2009, Respondent went to the Betty Ford Treatment Center (hereinafter Betty Ford) in California but left "the evaluation process against medical advice." (Exhibit 2, p. 121.) While at Betty Ford, Respondent was diagnosed with "[redacted] . . .." (Exhibit 2, pps. 126 & 144.)

In 2011, Respondent went to Palmetto Addiction Center (hereinafter Palmetto) in Louisiana. There his DRUG HISTORY indicated in part, "ETOH. he started at age 13. His last drink was 10/24/2011 and he had 2 drinks on the plane flight here." and "EVIDENCE OF ADDICTION: Loss of control, obsessions, distortions in thinking, denial and continued use despite adverse consequences." (Exhibit 2, pps. 580 & 581.) Respondent's ASSESSMENT at Palmetto included, in part, "Alcohol Dependence; . . . History of Amphetamine Dependence; . . . [redacted]" (Exhibit 2, p. 583.)

## THE BOARD REJECTS THE *RECOMMENDED FINDINGS OF FACT AND CONCLUSIONS OF LAW*

Prior to its meeting to consider this matter, all members of the Board and COPD signed a Certificate of Approval averring their findings would be based exclusively on the evidence in the record of this case and on matters officially noticed in the 2012 hearing; to their knowledge and belief, they were able to fairly and impartially review the contents of the established record and were without conflict of interest.

After consideration and discussion at its meeting on May 3, 2013, the Board, concurring with the recommendations of the Committee on Professional Discipline (hereinafter COPD), respectfully rejected the Hearing Officer's *Recommended Findings of Fact and Conclusions of Law* issued on February 13, 2013, after concluding the Hearing Officer vastly over simplified the principal issues in this case.

The Board found the Hearing Officer failed to appreciate Respondent's long standing and significant mental health disorders. The Board noted Respondent's diagnosis of mixed personality disorder with [redacted], long-term conditions that may not be permanently cured but must be carefully monitored and treated.

The Board found the Hearing Officer failed to grasp Respondent's complete inability to comply with previous *Stipulations and Orders* with the Board as well as his contract with the Physician Recovery Network, Idaho Medical Association (hereinafter PRN) for treatment and monitoring of his drug addiction. Respondent entered into three (3) *Stipulations and Orders*, Case No. 98-045, in 1999, 2003 and 2004,

but violated the terms and conditions of each. These three (3) *Stipulations and Orders* were the Board's efforts to assist Respondent with his issues and continue to practice medicine with reasonable skill and safety but to no avail.

It was also determined that the Hearing Officer neglected to contemplate the many years Respondent asserted multiple times to the Board that he sincerely embraced recovery, was believed, and entered into three (3) *Stipulations and Orders* but failed to comply with each. Yet, based upon just the several days of the 2012 hearing, the Hearing Officer implausibly found Respondent to "be credible, sincere, and humble." (*Recommended Findings of Fact and Conclusions of Law*, p. 7.) The Board found that Respondent's long and documented history evidenced his insincerity and lack of credibility.

The Board found the Hearing Officer failed to grasp the fact that the Respondent has significant boundary issues were absolutely germane "to this reinstatement of license proceeding." (*Recommended Findings of Fact and Conclusions of Law*, p. 4.) The Board noted that patients who seek psychiatric treatment are often in uniquely dependent, anxious, vulnerable, and exploitable states. At the Board's request, Dr. L. Lundt reviewed the 2001 allegation that Respondent transgressed boundaries and concluded "[b]oundary violations were evident in treatment of this family." Dr. Lundt also concluded Respondent's "behavior falls below the current standard of care for the practice of psychiatry in the state of Idaho." (Exhibit 2, pps. 101-104.)

The Board also respectfully disagreed with the Hearing Officer's decision to allow Dr. Roberto Negron's testimony at the 2012 hearing over the Board's objections. Although the Hearing Officer recognized Idaho case law precludes experts from testifying as to the ultimate question of fact, he allowed it and expressed an opinion as to Dr. Negron's testimony. As Dr. Negron merely conducted a records review and interview for just two (2) hours but had not personally examined or evaluated the Respondent, the Board considered his testimony irrelevant as it did not assist the Board with its deliberations. (*Recommended Findings of Fact and Conclusions of Law*, p. 8.)

The Board certainly respects Respondent's right under Idaho Code § 54-1838 to petition for reinstatement of his Idaho medical license, however, the "practice of medicine is a privilege granted by the state of Idaho and is not a natural right of individuals." The Board's statutory mandate is to "assure the public health, safety and welfare in the state by the licensure and regulation of physicians, and the exclusion of unlicensed persons from the practice of medicine." Idaho Code § 54-1802.

Upon the grounds and for the reasons stated above, the Board, concurring with the recommendations of the COPD, determined the Respondent's Idaho medical license shall be reinstated, such medical license shall be revoked but such revocation stayed and probation ordered for a period of ten (10) years. Such probation is exceptionally necessary to insure Respondent is capable of practicing medicine with reasonable skill and safety and protection of the public. Such probation shall be under the control, supervision and care of the Board and Idaho's PRN. As a probationer, Respondent must be in complete and absolute compliance to the spirit and letter with the specific terms and conditions identified below. Any and all deviations from total and complete compliance to his probation/*Final Order* shall result in the stay being immediate rescinded and revocation of Respondent's medical license.

## ORDER

Based upon the foregoing, IT IS HEREBY ORDERED:

1. Respondent's Idaho medical license shall be reinstated, however, such medical license shall be revoked but such revocation stayed and probation ordered for a period of ten (10) years subject to the terns and conditions below unless otherwise noted.

2. Respondent shall not prescribe, administer, order, be in possession of, inject or ingest any controlled substances except as duly and appropriately prescribed for a legitimate purpose by his treating physician who is fully aware of Respondent's medical/mental history, this *Final Order* and with prior consultation with his treating psychiatrist. Such treating physician shall not be any professional with whom he is related by blood, marriage or professionals employed by or in practice with such relatives or wife.

3. Respondent shall not practice medicine, e.g., psychiatry, as a solo practitioner nor shall he practice medicine in conjunction with any professional with whom he is related by blood, marriage or professionals employed by or in practice with such relatives or wife. Upon five (5) years total and full compliance with all terms and conditions of his probation, this *Final Order* and PRN contract, Respondent may practice medicine, e.g., psychiatry, in conjunction with any professional with whom he is related by blood, marriage or professionals employed by or in practice with such relatives or wife upon Board *Order*.

4. Respondent shall be allowed to petition the Board for re-instatement of his controlled substance prescribing privileges after a period of two (2) years contingent upon total and full compliance with all terms and conditions of his probation, this *Final Order* and PRN contract as well as the full endorsement of the PRN. Upon these conditions and terms, Respondent's controlled substance prescribing privileges shall be reinstated upon Board *Order*.

5. Respondent shall enter into a contract with the PRN within five (5) days of the date of the last signature below and remain in total compliance of all terms and conditions of such PRN contract. Respondent shall sign a Release of Information permitting the PRN to provide written and/or verbal assessments of his compliance with his PRN contract, his probation and this *Final Order* to the Board. It is Respondent's responsibility to maintain a professional relationship with the PRN and diligently "work the program" to maintain recovery.

6. Respondent shall enter into a physician-patient relationship with a Board approved psychiatrist and receive mental health care and treatment. To this end, Respondent shall provide the names of potential psychiatrists to the Board for determination and approval. Respondent shall receive mental health care and treatment from this treating psychiatrist with at least one (1) therapeutic face-to-face visit per month for one (1) year from the date of the last signature below. After one (1) year, Respondent shall continue therapeutic face-to-face visits thereafter at the discretion of his treating psychiatrist. Respondent shall sign a Release of Information and request his treating psychiatrist to provide quarterly or as necessary written reports of his diagnoses, treatment plans and prescribed medications as well as assessments of Respondent's compliance with his probation and this *Final Order*

to the Board for three (3) years from the date of the date of the last signature below. After three (3) years and upon written request, Respondent's psychiatrist shall provide to the Board written reports of his diagnoses, treatment plans and prescribed medications including assessments of Respondent's compliance with his probation and this *Final Order*.

7. Respondent shall undergo a complete and standard form Micro-Cognitive Assessment of Cognitive Functioning (hereinafter MicroCog) administered at the Center for Personalized Education for Physicians (hereinafter CPEP) in Denver, Colorado, to evaluate whether or not cognitive impairment is an issue within six (6) months of the date of the last signature below. Respondent shall sign a Release of Information permitting the MicroCog results to be provided to the Board as soon as such results are available. Subject to the results of the MicroCog indicating signs of cognitive impairment, Respondent shall undergo further evaluation and treatment and/or be subject to further limitations/restrictions upon his medical license as articulated in MicroCog's results.

8. Respondent shall enter into a monitoring relationship with a Board approved practice proctor with whom he shall receive guidance with the care he provides, including, but not limited to, chart review and practice monitor. To this end, Respondent shall provide the names of potential practice proctors to the Board for determination and approval. Such proctor shall monitor Respondent's practice of medicine for a period of one (1) year from the date of the last signature below. On a weekly basis, such proctor shall conduct reviews of seven (7) medical records as well as discuss with Respondent the medical care provided to his patients, provided that compliance with this provision may be excused in the event of said proctor's unavailability (vacation. illness. etc.) and/or if Respondent is likewise unavailable. Such unavailability is not to exceed a total of thirty (30) days per year. Respondent shall sign a Release of Information and request his proctor to provide the Board with monthly or as needed written summaries of Respondent's ability to practice medicine with reasonable skill and safety as well as identify any concerns or problems.

9. Respondent shall comply with the recommendations of the CPEP evaluation of April 8-9 and May 26, 2010, as identified and attached hereto as *Findings of Fact, Conclusions of Law and Final Order* Exhibit A and incorporated herein. Such compliance shall be met upon Respondent's successful renewal of his medical license.

10. Respondent shall be responsible for all costs, expenses, assessments and fees associated with this *Final Order*, including his compliance and his PRN contract.

11. Respondent shall reimburse the Board costs and fees in the amount of nineteen thousand thirty-eight dollars and seventy-three cents ($19,038.73) within ninety (90) days of the date of the last signature below. Idaho Code § 54-1806 (9). Attached hereto as *Findings of Fact, Conclusions of Law and Final Order* Exhibit B and incorporated herein, is an accounting of the Board's costs and attorney's fees. Respondent may execute a Promissory Note with the Board for reimbursement of cost and attorneys' fees.

12. Respondent shall not change treating physicians or practice locations without prior written Board approval which shall not unreasonably withheld.

13. Respondent shall not supervise, utilize or employ a physician assistant pursuant to IDAPA 22.01.04, "Rules of the Board of Medicine for Registration of Supervising and Directing Physicians."

14. Respondent shall provide, within ten (10) days of the date of the last signature below, all employers, partners and the Administrator and Chief of Staff at each hospital where he has privileges with a copy of this *Findings of Fact, Conclusions of Law and Final Order*. If Respondent changes employment or applies for or obtains privileges at any other hospital, Respondent shall provide all future employers, future partners and the Administrator and Chief of Staff at each future hospital where he applies for or obtains privileges with a copy of this *Findings of Fact, Conclusions of Law and Final Order* at the time of the application for employment or privileges, or within ten (10) days of the application. Respondent shall provide the Board with written proof of compliance with this Paragraph by providing the Board with a copy of the notice or letter when it is provided to any employer or hospital.

DATED This ~~26th~~ 31st day of July 2013.

IDAHO STATE BOARD OF MEDICINE

[signature], MD

BARRY FRANKLIN BENNETT, M.D.
Chairman

## BEFORE THE IDAHO STATE BOARD OF MEDICINE

| | | |
|---|---|---|
| In the Matter of:<br><br>DAN E. DWYER, M.D.,<br>License No. M-7188,<br><br>Respondent. | )<br>)<br>)<br>)<br>)<br>)<br>)<br>) | **Case Nos. BOM-1998-045 & BOM-02-120**<br><br>**SCHEDULE FOR REVIEW OF ORDER ON PETITION FOR RECONSIDERATION FINDINGS OF FACT, CONCLUSIONS OF LAW AND FINAL ORDER** |

Pursuant to IDAPA 04.11.01.740.02 (Rule 740):

**a.** This is a final order of the agency. Any party may file a motion for reconsideration of this final order within fourteen (14) days of the service date of this order. The agency will dispose of the petition for reconsideration within twenty-one (21) days of its receipt, or the petition will be considered denied by operation of law. See Section 67-5246(4), Idaho Code.

**b.** Pursuant to Sections 67-5270 and 67-5272, Idaho Code, any party aggrieved by this final order or orders previously issued in this case may appeal this final order and all previously issued orders in this case to district court by filing a petition in the district court of the county in which:

i. A hearing was held,
ii. The final agency action was taken,
iii. The party seeking review of the order resides, or operates its principal place of business in Idaho, or
iv. The real property or personal property that was the subject of the agency action is located.

**c.** An appeal must be filed within twenty-eight (28) days (a) of the service date of this final order, (b) of an order denying petition for reconsideration, or (c) the failure within twenty-one (21) days to grant or deny a petition for reconsideration, whichever is later. See Section 67-5273, Idaho Code. The filing of an appeal to district court does not itself stay the effectiveness or enforcement of the order under appeal.

DATED this 31st day of July, 2013.

IDAHO STATE BOARD OF MEDICINE

CATHLEEN M. MORGAN, J.D.
Attorney for the Idaho State Board of Medicine

## CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 31st of July, 2013, a true and correct copy of the within and foregoing document was served upon:

Andrew C. Brassey, J.D.
Megan Goicoechea, J.D.
BRASSEY, CRAWFORD & HOWELL, PLLC
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Idaho State Board of Medicine
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Jean R. Uranga, J.D.
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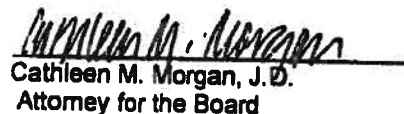
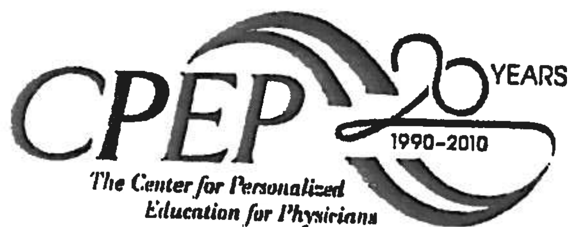
__XX__ by regular U.S. mail
______ by hand delivery
______ by facsimile
______ by overnight mail



Cathleen M. Morgan, J.D.
Attorney for the Board




# ASSESSMENT REPORT

**For**

**Dan E. Dwyer, M.D.**

**April 8 – 9 and May 26, 2010**

**NATIONALLY RECOGNIZED ▪ PROVEN LEADER ▪ TRUSTED RESOURCE**

**7351 Lowry Boulevard, Suite 100**
**Denver, Colorado 80230**
**Phone: 303-577-3232**
**Fax: 303-577-3241**
**www.cpepdoc.org**

# I. Executive Summary

## A. Overview

CPEP, the Center for Personalized Education for Physicians, designed this Assessment for Dan E. Dwyer, M.D. The Assessment was designed to evaluate Dr. Dwyer's practice of adult and child and adolescent psychiatry in the outpatient setting. Dr. Dwyer informed CPEP that he presented for a clinical skills Assessment prior to application to the Idaho State Board of Medicine (Board) for consideration for licensure reinstatement. His medical license was placed under Agreed Order of Suspension in August of 2004. Dr. Dwyer has not practiced medicine since that time.

*Note:* Due to difficulties in scheduling the final interview for Dr. Dwyer's Assessment, one of the structured clinical interviews took place at a later date. All of the interviews were conducted in person in the Denver area.

## B. Summary of Assessment Findings

During this Assessment, in the areas of *child and adolescent outpatient psychiatry* Dr. Dwyer demonstrated adequate overall knowledge, with some isolated exceptions. He demonstrated broad knowledge of the *adult outpatient psychiatry* topics discussed; however, his knowledge lacked sufficient depth. His clinical judgment and reasoning in both adult and child and adolescent psychiatry were inconsistent ranging from good to poor. Overall, his approach to clinical cases appeared disorganized. Dr. Dwyer's communication skills were generally effective with SPs and with peers. His documentation for the SP encounters was good; actual patient charts were not available for review. The educational needs identified in this Assessment are listed in *Section III. Assessment Findings.*

Review of Dr. Dwyer's health information and public record board documents indicated that Dr. Dwyer has a condition that could interfere with his practice of medicine. There was no information about the current status of his health condition or whether he is receiving on-going monitoring for the condition. Dr. Dwyer informed CPEP that he had completed MicroCog© cognitive testing three months prior to the Assessment. He provided four pages of results from the August 24, 2010, testing. The CPEP neuropsychology consultant was unable to interpret these results, as the information was much more limited than the data provided from MicroCog© testing completed at CPEP.

The CPEP staff, Associate Medical Director, consultants and SPs observed that Dr. Dwyer was distracted, disorganized, and tangential behavior during the clinical interviews. He also appeared extremely anxious. These behaviors were most apparent during the initial two-day Assessment, and less apparent but still present during the interview that took place May 26, 2010. In addition, the consultants provided additional comments referring to professionalism and inter-physician communication (see *Section III. C. 2.and D. Assessment Findings* below).

## C. Recommendations

### Considerations Related to Assessment Findings

CPEP recommends that Dr. Dwyer seek further assistance in defining strategies to maintain professionalism and boundaries. He could explore this further through intensive small group CME activities and/or with his Preceptor (see below).

### Recommendations related to Health and Neuropsychological Evaluation

- If not completed already, CPEP recommends that Dr. Dwyer undergo a comprehensive health evaluation with a physician health program or psychiatrist experienced in treating physicians in order to determine his ability to return to practice and whether on-going health monitoring would be needed.
- CPEP defers the interpretation of the MicroCog© testing that Dr. Dwyer completed in August 2009, as well as any recommendations regarding those results, to the organization that administered the test.
- It is unclear if the behaviors observed during this Assessment are related to health issues. CPEP recommends the available information from the CPEP Assessment Report be considered at the time of his comprehensive health evaluation.

The comprehensive health evaluation, including review of the neuropsychological data and CPEP Report observations, should be completed prior to Dr. Dwyer returning to clinical practice or engaging in remedial education activities.

### Educational Recommendations

Based on the findings of this Assessment, CPEP recommends Dr. Dwyer participate in structured, individualized education to address the identified areas of need. Such an Intervention would likely require moderate time and effort on the part of Dr. Dwyer.

- Educational Preceptor: Dr. Dwyer should establish a relationship with an experienced educational preceptor and meet regularly to ensure integration into practice and application of the knowledge that Dr. Dwyer demonstrated during this Assessment. This relationship with a preceptor, as an educational process, not as practice-monitoring, would give him the opportunity to analyze his consistent use of his judgment and reasoning skills. His decisions related to psychodynamics and psychotherapy referrals could also be discussed.
  - Due to the length of time that Dr. Dwyer has been out of practice, CPEP recommends that he initially practice in a setting where he can review cases at the end of each day with a supervisor or preceptor.

- Continuing Medical Education (CME) and Self-Study: Dr. Dwyer should engage in CME courses and self-study which include, but are not limited to, the topics indicated in areas of demonstrated need.

CPEP can provide information about the development of an Educational Intervention including educational objectives reflective of Dr. Dwyer's areas of need, specific educational activities, timeframes, and evaluation processes. A CPEP Associate Medical Director would actively monitor progress and compliance with the plan.

**(The remainder of this page is intentionally blank.)**

## II. Assessment Overview

### A. Introduction

The Assessment was designed to evaluate Dr. Dwyer's practice of outpatient adult and child and adolescent psychiatry through use of specialty-specific individualized testing tools. An Associate Medical Director oversaw the Assessment to ensure that the process was reflective of the physician-participant's practice of psychiatry while taking into account any noted reason for referral. Results from the physician-participant's performance in each assessment modality were incorporated into the findings of this Assessment Report. Please refer to *Appendix I: Participant Background* for information about Dr. Dwyer's education, training, and practice history.

### B. Assessment Design

The table below outlines the processes and test modalities used in Dr. Dwyer's Assessment and how each modality contributed to the Assessment. (See *Appendix III: Description of Evaluation Tools* for more information.)

| Assessment Components | Pertinence to ACGME Core Competencies | | | | | | |
|---|---|---|---|---|---|---|---|
| | Medical Knowledge | Patient Care | Practice-based Learning | Communication Skills | Professionalism | Systems-based Practice | Other |
| **Pre-Assessment Components** | | | | | | | |
| Telephone Interview with Participant | | | | ♦ | ♦ | | |
| Written Intake Questionnaire | | | ♦ | ♦ | ♦ | ♦ | |
| Participant Practice Profile | | | | | ♦ | ♦ | |
| Participant Education, Training and Professional Activities | | | ♦ | | ♦ | ♦ | |
| Referral Source Information | | ♦ | | ♦ | ♦ | | |
| **Assessment Components** | | | | | | | |
| Clinical Interviews | ♦ | ♦ | ♦ | ♦ | ♦ | ♦ | |
| Simulated Patient Encounters | ♦ | ♦ | | ♦ | ♦ | | |
| Simulated Patient Encounter Note Analysis | ♦ | ♦ | | ♦ | ♦ | | |
| Health Information Review | | | | | | | ♦ |
| Observations of Participant Behavior | | | | ♦ | ♦ | | ♦ |

### C. Personalization of Assessment Process

- ***Patient Charts:*** Because Dr. Dwyer has been out of practice, he was unable to submit charts for this Assessment. All testing activities were based on hypothetical case presentations.

- ***Clinical Interviews:*** Four clinical interviews were conducted by board-certified psychiatry physicians. The consultants based the interviews on hypothetical cases, and topic-based discussions.
- ***Simulated Patient Encounters:*** The exercise included two 30-minute interviews with Simulated Patients (SPs). The SP cases were selected to represent conditions typically seen in a psychiatry setting, and included a patient with a history of anger management issues and a patient with anxiety/post-menopausal symptoms.

*Limitations*

CPEP's Assessment is intended to provide an evaluation of Dr. Dwyer's clinical abilities in psychiatry. The Assessment does not look at issues related to fraudulent or unethical practice patterns. In addition, the Assessment is not designed to evaluate the consequences of physical or mental health disorders.

### D. Reasons for Assessment

Dr. Dwyer informed CPEP that he presented for a clinical skills Assessment prior to application to the Idaho Board (Board) for consideration for licensure reinstatement. Dr. Dwyer has not practiced medicine since 2004. His medical license was placed under Agreed Order of Suspension in August of 2004. Dr. Dwyer would like to reactivate his medical license and then apply for licensure to practice in Idaho. He states that, from his CPEP Assessment, he hopes to identify any weaknesses in his capacity to provide competent care and to provide a context in which to address any weaknesses.

## III. Assessment Findings

CPEP's Assessment findings are based upon our review of initial documents provided by the physician-participant, the referring agency or institution, Assessment activities, reports, interviews and meetings with the physician in question.

This Assessment is intended to provide an evaluation of Dr. Dwyer's clinical abilities in psychiatry. An Assessment such as that done by CPEP does not involve direct observation of the participant-physician at work. Our conclusions, therefore, can address only whether the physician possesses the knowledge and judgment necessary to perform. We cannot predict actual behavior. CPEP's Assessment conclusions are based solely upon the performance of the participant during the Assessment process. Our findings are not based upon indications for referral or the determinations or conclusions of peer review, judicial or state licensing bodies.

The educational needs listed below are only intended to provide a foundation for Dr. Dwyer's education; other areas pertinent to Dr. Dwyer's practice may be identified as he engages in educational endeavors.

## A. Medical Knowledge and Patient Care

The CPEP findings of Dr. Dwyer's Medical Knowledge and Patient Care are based, clinical interviews, and an SP documentation exercise. Please refer to *Appendix II: Clinical Content of the Assessment* for a detailed list of the cases and topics addressed during the clinical interviews.

### 1. Medical Knowledge

#### *Child and Adolescent Psychiatry*

During this Assessment, Dr. Dwyer demonstrated adequate overall knowledge of child and adolescent psychiatry with some isolated exceptions. He did well describing the signs and symptoms of anxiety, Tourette syndrome and attention deficit hyperactivity disorder (ADHD), as well as the pharmacologic management of those disorders. He adequately described the side effects of Abilify. Dr. Dwyer provided appropriate discussions of psychometric tests and their indications. He adequately stated the indication for psychotherapy in the management of adjustment disorder reaction.

Dr. Dwyer demonstrated isolated knowledge gaps. For example, during a discussion of a 14 year-old boy with concerns about going to school, a consultant opined that Dr. Dwyer suggested an incorrect medication for the first-line pharmacologic choice in management of bipolar disorder. Another consultant noted that during a discussion of an eight year-old boy presenting with problems at school, Dr. Dwyer did not provide thorough lists of criteria for the diagnosis of Asperger's disorder and autism. He also did not discuss the role of psychotherapy in the management of a child who presented with cutting behaviors, which the consultant opined would have been warranted.

#### *Adult Psychiatry*

Dr. Dwyer demonstrated broad overall knowledge of most topics discussed during the hypothetical adult psychiatry cases; however, his knowledge lacked sufficient depth.

Dr. Dwyer appropriately discussed many topics. During a discussion of a 48 year-old male with depression, he adequately described the effect of alcohol on sleep and the prognosis for a patient with depression and alcohol abuse. He also adequately stated the role of Antabuse and Campral in the management of alcoholism. During a discussion of a 37 year-old patient with somatic complaints, Dr. Dwyer adequately described the evaluation, management, and prognosis for a patient with somatoform disorder. He also did well during a discussion of a 21 year-old man who was depressed in which Dr. Dwyer appropriately explained the signs and symptoms, pharmacologic management and evaluation of bipolar disorder and ADHD.

However, the consultants noted that while Dr. Dwyer seemed to have an overall awareness of pharmacologic management and biologic basis of disease, he lacked understanding of the importance of psychodynamics and psychotherapy. One consultant expressed concern about Dr. Dwyer's lack of sensitivity to issues involving patients' feelings. During the discussion of the

depressed male patient (mentioned above), Dr. Dwyer did not provide an adequate discussion of the psychodynamics involved with alcohol abuse. In addition, he did not convey the importance of interventions and of the role of family support for this patient with alcohol abuse. During a discussion of a 26 year-old woman who recently returned from military service in Iraq, he did not provide a thorough discussion of the psychotherapeutic options for the management of posttraumatic stress disorder (PTSD). In addition, a consultant opined that Dr. Dwyer did not address the patient's feelings, which the consultant noted would have been important in the management of PTSD. During a discussion of a 65 year-old woman with symptoms of depression and confusion, he did not provide an understanding of the importance of the psychosocial etiology of an individual's depression. In addition, he did lacked an adequate approach to treating loss.

Dr. Dwyer also demonstrated some limited knowledge deficits in other areas. Regarding alcohol abuse, he was not aware of the criteria for outpatient alcohol detoxification. A consultant opined that he did not convey a thorough knowledge of the pharmacologic options to treat PTSD. Regarding eating disorders, a consultant noted that Dr. Dwyer was unaware of the differences between anorexia and bulimia. In addition, he did not consider the important distinction between dementia and pseudodementia in the case of the 65 year-old woman with depression and confusion.

Additional limited educational needs were identified and are listed below.

## Educational Needs – Medical Knowledge

### *Child and Adolescent Psychiatry*

- Personality disorders:
    - Role of psychotherapy in the management of cutting behavior;
- Pharmacology:
    - First-line pharmacologic choice for bipolar disorder;
    - Initial dose of Abilify;
- Developmental disorders:
    - Criteria for Asperger's disorder and autism;
    - Differential diagnosis of school problems;
- Trauma and abuse:
    - Differential diagnosis of symptoms social withdrawal;
    - Signs and symptoms of dissociation.

### *Adult Psychiatry*

- Borderline personality disorder:
    - Evaluation;
- Substance abuse:
    - Criteria for outpatient versus inpatient alcohol detoxification;
    - Psychodynamics and role of family support, interventions and physical exam in the evaluation and management of alcoholism;

- Eating disorders:
    - Differential diagnosis of eating disorders;
    - Differences between anorexia and bulimia;
- PTSD:
    - Psychotherapeutic options for the management of PTSD;
    - Psychodynamics of PTSD and role of psychodynamics in the management of PTSD;
    - Pharmacologic management;
- Depression:
    - Role of screening for multiple substances of abuse in the laboratory evaluation of depression;
    - Differentiation between dementia and pseudodementia;
    - Psychodynamics and management of patients who have experienced loss;
    - Psychodynamics of depression.

## 2. Clinical Judgment and Reasoning

Dr. Dwyer's clinical judgment and reasoning, as demonstrated during this Assessment, were inconsistent ranging from good to poor. His overall approach to the clinical cases appeared disorganized.

Dr. Dwyer did consistently well demonstrating clinical judgment and reasoning in some areas of psychiatry. He was able to appropriately consider the potential acuity of situations and suggest appropriate plans. For example, during a discussion of a 15 year-old girl who had a history of cutting behavior, Dr. Dwyer appropriately considered the child's safety and would admit her to the hospital if there were any significant risks identified. He was also able to consistently shift his thinking as scenarios changed. For example, during a discussion of a 21 year-old man who presented with depression, Dr. Dwyer was able to modify his approach as the consultant changed the scenario to include more signs and symptoms of ADHD than depression. Dr. Dwyer demonstrated awareness of his limitations and indicated appropriate use of consultants. For example, he acknowledged that he does not feel comfortable with patients with eating disorders or borderline personality disorder and would refer them to colleagues who treat those conditions.

However, Dr. Dwyer demonstrated inconsistent clinical decision-making overall. His ability to gather adequate pertinent clinical information varied. For example, he gathered sufficient information during the discussion of a 37 year-old woman with somatic complaints, but did not gather adequate information during a discussion of an eight year-old child who was withdrawn. He was similarly variable in his ability to draw logical conclusions based on acquired data. For example, during a discussion of a 21 year-old man who was depressed and suicidal, Dr. Dwyer was able to make logical conclusions regarding the diagnosis. However, during a discussion of the withdrawn girl mentioned previously, Dr. Dwyer indicated he would consider the possibility of abuse if the child drew a picture of her family in which the she portrayed the father diminutively and the mother as a large figure. The consultant opined such a conclusion would be inappropriate without significantly more information. Dr. Dwyer was also inconsistent in his ability to provide a structured approach to differential diagnosis. He was able to present a

structured approach to the differential diagnosis of ADHD, psychosomatic disorders, schizophrenia and depression, but was disorganized when discussing the differential diagnoses of developmental disorders, withdrawn patients, eating disorders and patients exhibiting unusual behaviors.

Since patient charts were not available for this Assessment, CPEP is unable to comment about Dr. Dwyer's application of knowledge in actual patient care.

**Educational Needs – Clinical Judgment and Reasoning**

- Consistent ability to gather adequate information in a logical, organized and complete fashion;
- Consistently deduce logical conclusions based on data provided;
- Consistently use a structured approach when formulating differential diagnoses.

## 3. Patient Care Documentation

### a. *Review of Documentation – Simulated Patient (SP) Encounter Notes*

Dr. Dwyer's patient care documentation was evaluated solely on the basis of notes written at CPEP, as charts from his former practice were not available. For this reason, no assessment of his ability to manage and organize a complete chart can be made.

Dr. Dwyer was asked to document a progress note for each SP encounter. His notes were dictated. The notes were in a history and physical format. In the history, Dr. Dwyer consistently included a presenting complaint, history of present illness, past medical history, medication list, substance use history (tobacco use, alcohol use, illicit substance use), family history, and review of systems. He included allergies in one of the two notes.

Dr. Dwyer included a mental status exam and documented an assessment, with a differential diagnosis. Dr. Dwyer included plans in both notes. He documented patient education in one of the two notes. He recorded prescriptions in one note where it was pertinent, and recorded the name, dose, and instructions; however, he omitted the number to be dispensed, and number of refills authorized. Timing for follow-up was indicated in both notes.

Overall, Dr. Dwyer's SP documentation was good. He demonstrated that he understood most of the components of acceptable single encounter patient documentation.

**Educational Needs – Documentation**

- Consistent documentation of allergies;
- Documentation of the number of pills dispensed and number of refills allowed when prescribing a medication.

### B. Practice-based Learning

Dr. Dwyer provided to CPEP minimal information regarding the content of his recent professional education activities. He reported acquiring approximately 75 hours of medical education in the past three years. It was not clear how much, if any of this CME was evidence-based, as CPEP did not request the data in this format. He did describe a variety of medical information resources, including the use of medical content Internet sites.

**Educational Needs – Practice-based Learning**

- Maintain an appropriate amount of CME.

### C. Communication Skills

#### 1. Physician-Patient Communication Evaluation

During the SP interviews, Dr. Dwyer demonstrated positive communication skills. He introduced himself and addressed the SPs by name. He allowed the SPs to respond and ask questions without interruption. His interviews were logically sequenced utilizing open and closed questions. Dr. Dwyer explained to the SPs the mini mental status exam prior to performing the exam. He utilized understandable language throughout the interviews. He provided good education in easily understandable language.

However, both SPs stated that they perceived significant anxiety from Dr. Dwyer and they were uncomfortable with his perceived nervousness. Both SPs stated that they would not return to him and they rated his empathy as minimal. Additionally, the communication consultant observed that Dr. Dwyer displayed body movements suggestive of nervousness.

Despite recommendations to appear less anxious, Dr. Dwyer exhibited generally effective physician-patient communication skills when conducting SP interviews.

#### 2. Inter-Professional Communication Skills

One consultant noted that Dr. Dwyer inappropriately referenced personal information during the clinical interview session.

**Educational Needs**

***Physician-Patient Communication Skills***

- Maintain professional demeanor when communicating with patients.

***Inter-Professional Communication Skills***

- Maintain personal boundaries when communicating with colleagues.

### D. Professionalism

During one interview, a consultant noted that Dr. Dwyer indicated, in jest, that a therapist might be reluctant to take on a patient with borderline personality disorder; the consultant opined that this might reflect a potential bias against patients with borderline personality disorder. Similar comments about borderline personality disorder patients were noted in a different interview. In a discussion of a hypothetical case of a grieving patient, the consultant opined that Dr. Dwyer focused on the pharmacologic treatment and did not convey empathy; the consultant made similar comments about Dr. Dwyer's discussion of a hypothetical patient with PTSD. Dr. Dwyer may wish to consider how such comments might be perceived or what he might be conveying about his attitudes during conversations with peers.

### E. Systems-based Practice

The Assessment yielded inadequate data upon which to accurately comment on Dr. Dwyer's awareness of the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

### F. Other

#### 1. Review of Health Information

Dr. Dwyer submitted a copy of a history and physical exam conducted in August of 2009. Review of this documentation revealed that Dr. Dwyer has health conditions that could impact the practice of medicine.

#### 2. Cognitive Function Screen

During the Assessment, on April 9, 2010, Dr. Dwyer indicated that he did not wish to take the scheduled MicroCog© cognitive function screening test and informed CPEP that he had completed the MicroCog© elsewhere approximately three months prior to this Assessment. Dr. Dwyer informed CPEP that he would provide these results to CPEP. After the Assessment, Dr. Dwyer submitted 4 pages of results from a MicroCog© cognitive function (without an interpretation) conducted on August 24, 2009, that recorded the examiner as Magdalena Lenoir. (For comparison, the typical results from MicroCog© testing completed at CPEP includes over 20 pages of data.) CPEP forwarded these results to our neuropsychology consultant for review. The neuropsychology consultant was unable to provide an interpretation of the limited data provided. Since this testing was conducted by another institution, CPEP defers any determination about interpretation or implications to the organization that administered the test.

#### 3. Observations of Behavior and Additional Considerations

Dr. Dwyer's behavior appeared to be different during the initial three interviews, which occurred April 8 – 9, and the final interview, which occurred on May 26th. The initial clinical consultants and the CPEP Associate Medical Director observed that Dr. Dwyer appeared distracted,

disorganized, and tangential. He also appeared extremely anxious at that time. During the final interview, which was several weeks later, Dr. Dwyer appeared more attentive and organized and was not tangential. However, signs of anxiety persisted.

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## IV. Signatures

The Assessment Report reflects the effort and analysis of CPEP's Medical Director, Associate Medical Directors, and administrative staff. The electronic signatures below authenticate the content of this Revised Assessment Report dated this 9th day of September (original Report released on the 22nd day of June, 2010).

**CPEP Representatives**

Deborah S. Presken, M.D.

Deborah Presken, M.D.
Associate Medical Director

Elizabeth J Korinek

Elizabeth J. Korinek, M.P.H.
Executive Director

# Appendix I

## Participant Background:
## Review of Education, Training, Professional Activities, and Practice Profile

CPEP obtained this information from conversations with and documents provided by Dr. Dwyer.

**Education**

| School | Degree | Years Attended |
|---|---|---|
| University of Kansas, School of Liberal Arts & Science, Lawrence, Kansas | B.A. | 1982 – 1986 |
| University of Kansas, School of Medicine, Kansas City, KS | M.D. | 1987– 1991 |

**Post-Graduate/Residency Training**

| Specialty/Institution | Dates Attended |
|---|---|
| Pediatric Internship, University of Kansas Medical College, Kansas City, KS | 1991 – 1992 |
| Adult Psychiatric Residency Program, University of Southern California (USC), Los Angeles County, Los Angeles, CA | 1992 – 1996 |
| Fellowship Child and Adolescent Psychiatry, University of Southern California (USC), Los Angeles County, Los Angeles, CA | 1994 – 1996 |

**Certification**

None

**Licensure**

| Licensing State(s) | Status |
|---|---|
| Idaho | Surrendered |
| California | Inactive |

**Practice History**

Years/Description/Location

2001 – 2004: Medical Director, Affinity, Inc., Boise, ID

1996 – 2004: Psychiatrist, private practice, Boise, ID

1993 – 1997: Psychiatrist, Department of Emergency Psychiatry, Los Angeles County-University of Southern California Medical Center, Los Angeles, CA

1995 – 1996: Psychiatrist, Desert Counseling, Dual Diagnosis Program, Bakersfield, CA

1993 – 1996: Medical Dental Staffing, Inc., Ogden, Utah

**Previous Practice Profile**

Dr. Dwyer worked five days per week and saw approximately 15 patients per day in the office.

Commonly Encountered Diagnoses

Mood disorder, attention deficit hyperactivity disorder, anxiety disorder, eating disorder, personality disorder, addiction, behavior disorder, sleep disorder

Outpatient Procedures (monthly volume)

No outpatient procedures

**Continuing Education**

Dr. Dwyer reported earning a total of 75 hours of professional education activities in the last 36 months.

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# Appendix II

## Clinical Content of the Assessment

### A. Patient Charts Reviewed

Dr. Dwyer informed CPEP that he was unable to submit charts for this Assessment. All testing activities were based on hypothetical case presentations.

### B. Clinical Interviews

The clinical consultants were board-certified psychiatry physicians. The consultants based the discussion on hypothetical case scenarios and other topics.

### Child and Adolescent Psychiatry

**Hypothetical Case Discussions**

The consultants presented hypothetical cases for discussion. The following list describes the cases and outlines the topics covered during the discussion.

- **A 14 year-old boy presents with worries about going to school and is nervous around his friends:**
  - Information gathering;
  - Signs and symptoms of anxiety;
  - Indicated psychometric tests;
  - Use of consultants;
  - Pharmacologic management of anxiety;
  - Initial dose and side effects of Abilify.

- **An eight year-old boy presents due to trouble in school in which he frequently gets up to walk around and has trouble following directions:**
  - Information gathering;
  - Indicated psychometric testing;
  - Differential diagnosis;
  - Signs and symptoms of attention deficit disorder;
  - Pharmacologic management of attention deficit disorder;
  - Side effects and management of side effects of medications to treat attention deficit disorder.

- **An eight year-old boy presented with problems at school and parental disagreement about whether there was an issue of concern:**
  - Family dynamics;
  - Differential diagnosis of school problems;
  - Information gathering;
  - Criteria for Asperger's disorder and autism.

- **An eight year-old girl presented with symptoms of being withdrawn:**
  - Differential diagnosis;
  - Information gathering;
  - Role of abandonment issues and abuse;
  - Signs and symptoms of dissociation;
  - Role of a family tree;
  - Importance of evaluating safety of the child in situations of abuse;
  - Role of protective services.

- **A 15 year-old presents for follow-up from an emergency room visit in which she had cutting behavior:**
  - Importance of a safety evaluation;
  - Role of secondary gain;
  - Importance of evaluating the progression of her disease;
  - Information gathering;
  - Indication for hospitalization;
  - Role of psychotherapy in the management of cutting behavior;
  - Treatment of cutting behavior with Lexapro;
  - Signs and symptoms of mania;
  - Importance of pregnancy evaluation;
  - Information gathering after being presented with symptoms of mania;
  - Role of Lexapro in bipolar disorder;
  - Pharmacologic options in the management of bipolar disorder;
  - First-line pharmacologic choice for bipolar disorder.

- **A 10 year-old boy presented with tics:**
  - Signs and symptoms of Tourette syndrome;
  - Pharmacologic treatment of Tourette syndrome.

- **A 19 year-old male presented with symptoms of withdrawal and occasional unintelligible language in college:**
  - Signs and symptoms of schizophrenia;
  - Differential diagnosis.

- **An eight year-old girl presented after moving to another state with her mother due to a recent divorce:**
  - Risk of adjustment reaction;
  - Management of adjustment disorder with psychotherapy;
  - Use of consultants.

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## Adult Psychiatry

**Hypothetical Case Discussions**

The consultants presented hypothetical cases for discussion. The following list describes the cases and outlines the topics covered during the discussion.

- **A 48 year-old divorced male presents with a two-year history of poor job performance, depression and low energy:**
  - Information gathering;
  - Effect of alcohol on sleep;
  - Laboratory evaluation for depression;
  - Differential diagnosis of depression;
  - Alcohol detoxification;
  - Role of family support, interventions and physical exam in the evaluation and management of alcoholism;
  - Role of Remeron in the treatment of an anxious type depression;
  - Side effects of Remeron;
  - Role of Antabuse and Campral in the management of alcoholism;
  - Prognosis for a patient with depression and alcohol abuse.

- **A 37 year-old woman presents with a 10-year history of depression, anxiety and multiple somatic complaints:**
  - Differential diagnosis of somatoform disorder;
  - Information gathering;
  - Laboratory evaluation;
  - Role of psychometric testing;
  - Role of therapy and medication in the management of somatoform disorder;
  - Prognosis of a patient with somatoform disorder.

- **A 25 year-old single woman presenting with a 10-year history of bingeing and purging:**
  - Use of consultants;
  - Differential diagnosis of eating disorders;
  - Differences between anorexia and bulimia.

- **A 21 year-old man presents with depression and suicidal ideation:**
  - Information gathering;
  - Differential diagnosis;
  - Signs and symptoms of bipolar disorder;
  - Pharmacologic management of bipolar disorder;
  - Laboratory evaluation;
  - Adverse effects of Lamictal;
  - Signs and symptoms of attention deficit and hyperactivity disorder;
  - Pharmacologic management of attention deficit and hyperactivity disorder.

- **A 65 year-old woman presents with symptoms of depression and confusion:**
  - Differentiation between dementia and pseudodementia;
  - Pharmacologic management of dementia;
  - Adverse effects of Cymbalta and Aricept;
  - Pharmacologic management of depression;
  - Approach to treating loss;
  - Psychosocial etiology of an individual's depression.

- **A 26 year-old woman presented with symptoms of anxiety and trouble sleeping six months after being discharged from the military where she had served in Iraq:**
  - Signs and symptoms of PTSD;
  - Information gathering;
  - Psychotherapeutic options for management of PTSD;
  - Role of discussing the patients feelings in the management of PTSD;
  - Pharmacologic management of PTSD.

- **An 18 year-old woman presented with symptoms of self-mutilation:**
  - Information gathering.

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# Appendix III

## Description of Evaluation Tools

Selection of the testing modalities varies with each Assessment, using the specific components that are determined to be appropriate for each participant's situation.

### Structured Clinical Interviews

Clinical Interviews are oral evaluations of the physician-participant conducted by physician-consultants in the same specialty area. Each consultant is certified through a Board recognized by the American Board of Medical Specialties. The interview is conducted in the presence of the Associate Medical Director. The consultant asks about patient care management based on charts submitted by the participant and hypothetical case scenarios. Radiologic studies or videotapes of surgical procedures may also be used in the interview process. These ninety-minute oral interviews are used to evaluate the physician-participant's medical knowledge, clinical judgment, and peer communication skills.

*Note:* On occasion, physician-participants are unable to provide charts from their practice, either because they have not been in practice for a number of years or because the facility at which they work is unable or unwilling to release them. In these situations, hypothetical case scenarios are used as the basis for the interviews.

### Electrocardiogram (ECG) Interpretation

Physician-participants whose practice includes reading ECG tracings are presented with eleven ECG tracings and asked to provide an interpretation and course of action for each.

### Fetal Monitor Strip Interpretation

Physician-participants providing obstetric care in their practice are asked to read twelve fetal monitor strips and provide an interpretation and course of action for each strip.

### Physician-Patient Communication Evaluation

Effective communication and formation of therapeutic physician-patient relationships are assessed through the use of Simulated Patient (SP) encounters. The physician-participant conducts patient interviews in an exam-room setting. The patient cases are selected based on the physician-participant's specialty area. Both the SPs and the physician-participant evaluate the interaction. The patient encounters are videotaped and analyzed by a communication consultant.

### Patient Care Documentation

Physician-participants are asked to submit redacted copies of patient charts. The charts are reviewed for documentation legibility, content, consistency and accuracy. The physician's attention to pertinent medical details is noted.

### Review of Documentation – Simulated Patient Encounter Progress Notes

Following the Simulated Patient (SP) encounters, the physician-participant is asked to document each interaction in a chart note. The physician may hand-write the notes on plain lined paper provided by CPEP, dictate the notes, or use templates that he/she brings from his/her practice.

### Cognitive Function Screen

MicroCog™, a computer-based assessment of cognitive skills, is a screening test to help determine which physician-participants should be given a complete neuropsychological work-up. The test is viewed as a *screening instrument only* and is not diagnostic.

> *This screening test does not require proficiency with computers; a proctor is available to answer questions about test instructions. Test performance or expected test performance can be impacted by a number of factors, including normal aging and background. A neuropsychologist analyzes the test results, taking these factors into account.*

### Review of Health Information

The physician-participant is asked to submit the findings from a recent physical examination as well as hearing and vision screens. If indicated, program staff requests information related to specific health concerns.

# Formal Proceedings No BOM-2012-592

## Formal Proceedings Costs

**Respondent:** Dan Edward Dwyer

| Date | Vendor / Investigator | Description | Amount |
|---|---|---|---|
| 4/3/2013 | CATHLEEN WAGNILD MORGAN | Conference Call | $24.74 |
| 6/19/2012 | Connie Pyles | Cont case review/chronology | $139.50 |
| 6/20/2012 | Connie Pyles | Cont case review/chronology | $139.50 |
| 6/26/2012 | NANCY KERR | Scan JU letter | $7.50 |
| 6/27/2012 | Connie Pyles | Discuss hearing/pleading w/ DP | $11.63 |
| 8/17/2012 | NANCY KERR | Scan JU letter re: rx records | $0.41 |
| 9/7/2012 | NANCY KERR | Review and scan response to Supp. Memo | $8.12 |
| 1/29/2013 | FELICIA KRUCK | scanning files | $24.48 |
| 6/18/2012 | Connie Pyles | Case review begun | $162.75 |
| 4/3/2013 | CATHLEEN WAGNILD MORGAN | 2nd Final Order | $65.96 |
| 5/20/2013 | Connie Pyles | Review, S&O checklist | $46.50 |
| 4/4/2013 | CATHLEEN WAGNILD MORGAN | Let to Atty Brassey | $16.49 |
| 4/14/2013 | CATHLEEN WAGNILD MORGAN | Case review | $98.94 |
| 4/15/2013 | CATHLEEN WAGNILD MORGAN | Case review, ORDER preparation, letters | $98.94 |
| 4/15/2013 | CATHLEEN WAGNILD MORGAN | Order Vacating Final Order; Let to Chairman | $49.47 |
| 4/16/2013 | CATHLEEN WAGNILD MORGAN | 2 Lets to Atty Brassey | $24.74 |
| 4/16/2013 | CATHLEEN WAGNILD MORGAN | Memo & record preparation for meeting | $65.96 |
| 4/23/2013 | CATHLEEN WAGNILD MORGAN | Let to Atty Brassey | $16.49 |
| 1/30/2013 | FELICIA KRUCK | copying and paginating | $36.72 |
| | | Total | $1,038.82 |

# Case No 2010-BOM-6685

## Cost Summary

**Respondent:** Dan Edward Dwyer

| Date | Vendor / Investigator | Description | Amount |
|---|---|---|---|
| 6/27/2012 | Connie Pyles | Rec pleadings on hearing | $4.65 |
| 3/30/2012 | URANGA & URANGA | PROFESSIONAL FEES AND COSTS MARCH 2012 | $50.00 |
| 4/17/2012 | NANCY KERR | Discuss with JU/DP | $7.50 |
| 4/19/2012 | NANCY KERR | Review and scan JU letter | $3.75 |
| 4/23/2012 | DARLENE PARROTT | Review records/copied to JU | $11.31 |
| 5/30/2012 | URANGA & URANGA | PROFESSIONAL FEES AND COSTS | $100.00 |
| 6/4/2012 | NANCY KERR | Review and scan JU ltr | $3.75 |
| 6/18/2012 | Connie Pyles | Case review 06/12/12-06/15/12 | $372.00 |
| 5/2/2011 | URANGA & URANGA | PROFESSIONAL FEES AND COSTS | $37.50 |
| 6/22/2012 | URANGA & URANGA | PROFESSIONAL FEES AND COSTS FOR 6/12 | $137.50 |
| 11/3/2011 | NANCY KERR | Review and scan pleading | $3.75 |
| 6/28/2012 | Connie Pyles | Rec corr from JU, email chronology to her | $9.30 |
| 7/12/2012 | KENNETH L MALLEA | CASE #98-045 | $93.75 |
| 7/16/2012 | Connie Pyles | TC X 2 with JU to set up meeting | $4.65 |
| 7/17/2012 | Connie Pyles | Meet with JU, case rev/reorganize file, DP | $93.00 |
| 7/26/2012 | URANGA & URANGA | PROFESSIONAL FEES AND COSTS | $387.50 |
| 8/7/2012 | KENNETH L MALLEA | CASE #98-045 | $31.25 |
| 8/15/2012 | Connie Pyles | Case Review | $69.75 |
| 6/20/2012 | Connie Pyles | Case review, chronology | $139.50 |
| 9/15/2011 | NANCY KERR | Review and scan JU letter | $3.75 |
| 5/27/2011 | URANGA & URANGA | PROFESSIONAL FEE AND COSTS | $137.50 |
| 6/28/2011 | URANGA & URANGA | PROFESSIONAL FEES AND COSTS FOR JUNE 2011 | $425.00 |
| 7/28/2011 | URANGA & URANGA | PROFESSIONAL FEES AND COSTS | $50.00 |
| 8/12/2011 | NANCY KERR | Review and scan letter | $11.25 |
| 8/17/2011 | NANCY KERR | Review and scan JU letter | $3.75 |
| 9/6/2011 | NANCY KERR | Review and scan JU Staff Response | $3.75 |
| 9/8/2011 | NANCY KERR | review and scan JU letter | $3.75 |
| 2/28/2012 | NANCY KERR | Review and scan JU letter | $1.88 |
| 9/15/2011 | NANCY KERR | Review and scan eval | $18.75 |
| 12/1/2011 | URANGA & URANGA | PROFESSIONAL FEES AND COSTS | $362.50 |
| 9/26/2011 | NANCY KERR | Review and scan JU Response Brief | $11.25 |
| 9/28/2011 | URANGA & URANGA | PROFESSIONAL FEES AND COSTS | $863.20 |
| 10/5/2011 | KENNETH L MALLEA | CASE #98-045 | $1,093.75 |
| 10/12/2011 | NANCY KERR | Review and scan JU letter and release | $11.25 |
| 10/17/2011 | BEVERLY A. KENDRICK | Review of file | $45.62 |
| 10/26/2011 | NANCY KERR | Review and scan JU ltr to RX center | $3.75 |
| 10/27/2011 | URANGA & URANGA | PROFESSIONAL FEES AND COSTS | $1,167.48 |
| 8/30/2012 | URANGA & URANGA | PROFESSIONAL FEES AND COSTS FOR AUGUST 20 | $1,231.10 |
| 9/12/2011 | NANCY KERR | Review and scan letter and subpeonas | $7.50 |
| 3/7/2013 | KENNETH L MALLEA | CASE #98-045 | $1,259.38 |
| 8/20/2012 | Connie Pyles | Case Review | $23.25 |
| 2/19/2013 | Connie Pyles | Files & CD | $13.95 |
| 2/20/2013 | Connie Pyles | Files & CD | $46.50 |
| 2/21/2013 | Connie Pyles | Files & CD | $69.75 |
| 2/25/2013 | Connie Pyles | Files & CD | $23.25 |
| 2/26/2013 | Connie Pyles | Files & CD | $69.75 |
| 2/27/2013 | Connie Pyles | Files & CD | $23 25 |
| 2/14/2013 | CATHLEEN WAGNILD MORGAN | Memo & Certificates of Approval | $98.94 |
| 2/28/2013 | Connie Pyles | Files & CD | $69.75 |
| 2/4/2013 | Connie Pyles | Journal | $6.98 |
| 3/12/2013 | CATHLEEN WAGNILD MORGAN | Preparation of Final Order | $280.33 |
| 3/13/2013 | CATHLEEN WAGNILD MORGAN | Conference call | $82.45 |
| 3/25/2013 | CATHLEEN WAGNILD MORGAN | Research, memo, Certificates of Approval | $395.76 |

7/31/2013

# Case No 2010-BOM-6685



## Cost Summary

**Respondent:** Dan Edward Dwyer

| Date | Vendor / Investigator | Description | Amount |
|---|---|---|---|
| 3/27/2013 | CATHLEEN WAGNILD MORGAN | Preparation of Final Order, letter & fax | $362.78 |
| 3/27/2013 | URANGA & URANGA | PROFESSIONAL FEES AND COSTS | $87.50 |
| 3/27/2013 | URANGA & URANGA | PROFESSIONAL FEES AND COSTS | $1,643.61 |
| 3/28/2013 | CATHLEEN WAGNILD MORGAN | Finalization Final Order & Certif of Service | $82.45 |
| 4/30/2013 | URANGA & URANGA | PROFESSIONAL FEES AND COST FOR APRIL 2013 | $137.50 |
| 2/27/2013 | URANGA & URANGA | PROFESSIONAL FEES AND COSTS | $262.50 |
| 11/29/2012 | URANGA & URANGA | PROFESSIONAL FEES AND COSTS | $1,876.00 |
| 7/1/2013 | URANGA & URANGA | PROFESSIONAL FEES AND COSTS | $50.00 |
| 9/10/2012 | Connie Pyles | Rec Ju Resp to Resp Supplemental Memo, Fax/Review | $11.63 |
| 9/12/2012 | KENNETH L MALLEA | CASE #98-045 | $531.25 |
| 9/24/2012 | Connie Pyles | Review, Scan | $23.25 |
| 10/2/2012 | URANGA & URANGA | PROFESSIONAL FEES AND COSTS | $337.50 |
| 10/9/2012 | KENNETH L MALLEA | CASE #98-045 | $687.50 |
| 10/30/2012 | URANGA & URANGA | PROFESSIONAL FEES AND COSTS | $125.00 |
| 2/14/2013 | Connie Pyles | Findings of Fact & COL | $11.63 |
| 11/15/2012 | Connie Pyles | Case review, TC | $34.88 |
| 8/28/2012 | Connie Pyles | Review pleading | $13.95 |
| 12/17/2012 | Connie Pyles | Corres JU | $2.33 |
| 12/17/2012 | RESOURCES NORTHWEST INC | case of Dan e. Dwyer | $613.50 |
| 12/28/2012 | URANGA & URANGA | PROFESSIONAL FEES AND COSTS | $125.00 |
| 1/16/2013 | Connie Pyles | case review/req | $34.88 |
| 1/22/2013 | Connie Pyles | case review/BOP | $9.30 |
| 1/28/2013 | Connie Pyles | BOP, Disc w/ DP, Copies | $9.30 |
| 1/29/2013 | Connie Pyles | Case copies | $23.25 |
| 1/30/2013 | URANGA & URANGA | PROFESSIONAL FEES AND COSTS | $1,512.50 |
| 11/14/2012 | Connie Pyles | TCX3 | $6.98 |
| | | Total | $18,096 41 |