25| Neuropsych Essentials: Enhancing the Quality and Efficiency of Our Clinical Reports – With Dr. Jacobus Donders

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NAVIGATING NEUROPSYCHOLOGY

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Speakers: Jacobus Donders, Ryan Van Patten, John Bellone

Intro Music 00:00

Ryan Van Patten 00:17
Welcome, everyone, to Navigating Neuropsychology: A voyage into the depths of the brain and behavior. I'm Ryan Van Patten...

John Bellone 00:24

...and I'm John Bellone. Today we're bringing you our conversation about neuropsych report writing with Dr. Jacobus Donders who works at Mary Free Bed Rehabilitation Hospital in Grand Rapids, Michigan. He is board certified in clinical neuropsychology, the specialty pediatric clinical neuropsychology, and rehabilitation psychology. Jacobus has published the go-to book on the topic and you can go to our website navneuro.com/25 for a link to the “Neuropsychological Report Writing” book, if you're interested. We know how important it is for us to write good reports and we hope that today's discussion can help all of us improve in this area, from the trainee to even the seasoned clinician. So, now, we'll give you our conversation with Jacobus.

Transition Music 01:13

John Bellone 01:22

All right, well, Jacobus, thanks so much for joining us here on NavNeuro. We are very excited to have you.

Jacobus Donders 01:26

Nice to be here.

John Bellone 01:28

Just to keep things clear to our listeners, I think that these initial questions that we have for you should all focus on clinical cases exclusively, where our client is the patient, we're writing the report for the referring provider and/or for the patient and their family. We're going to briefly talk about forensic reports at the end if we have time, but we should maybe start at the top, in typical NavNeuro fashion, where we just look at the basics first. This might help bring everyone onto the same page before we get into the weeds a little bit. Just for our listeners who might not be as aware, what is the general purpose of the neuropsych report? Why do we spend all this time writing these reports?

Jacobus Donders 02:11

Well, we write a report because somebody asked us a question or asked us to see an individual for a certain purpose. The report is intended to answer that individual and answer that question. So there might be a question of, “Does this child meet criteria for a learning disability? Yes or no? And, if so, what do we do about it?” Or,

“This elderly person talks about memory loss. Are we dealing with dementia or depression or both, or something else? And, again, what do we do about it?” The report serves as the documentation of the professional activities that you spend trying to investigate that question and formulate a clear answer to that. That report then also becomes, in these days, a permanent record because everything is stored electronically now. So it can be later reviewed if the patient moves out of state or goes to a different doctor or something else. So [it] establishes at least a baseline for which to compare future evaluations.

John Bellone 03:14
What spurred your interest in educating people in our profession about report writing?

Jacobus Donders 03:19
Well, it was mostly frustration on my side with seeing a lot of reports that I consider to be very bad. That doesn't necessarily mean that my way of writing reports is the best way and the only way - my way or the highway. But I saw a lot of reports that were very long, of tedious detail - typically stuff that was already known to the reader. Like, if a neurosurgeon sent a person to me, and has already done a surgery or is already planning a surgery, I don't want to spend a page and a half describing where in the brain the aneurysm was and how long the hours of the operation took and all that. The neurosurgeon knows that already. Plus, the neurosurgeon doesn't have the time to read all that, again. Has no interest in it. Neurosurgeon wants to know, “Okay, is this person competent to make their own decision? Yes or no?” “Is this person at risk of postoperative memory decline if we're talking about a temporal lobectomy procedure?” I saw a lot of reports that were so long, tedious in detail, rehashing what was already in the medical record, extremely extended description of the tests that were used, discussion of minutiae in differences in scores. And then, after 7, 8 ,9, some last more than 12 pages, came a conclusion that a) did not tell the reader much new, or the conclusion was "Yes, the patient has brain damage". Well, we knew that already. Or the recommendations were so vague that it shouldn't have taken an eight hour eval to come to that. You did an interview, you did 6 hours worth of tests, you did an hour and a half of scoring and report writing, and then you say, "Yes, the child has a learning disability and needs special education for it." And that's it? I saw a lot of those reports. And I said, you know, we can do better than that and we should do better.

Ryan Van Patten 05:16

Yeah. That was helpful to get a sense as to where you're coming from in terms of your book on report writing, and putting some of these ideas out there. So, as you said, I know you've advocated for shorter neuropsych reports for quite some time. My bias is to do the same. To really focus on quality and enhancing efficiency of our reports, while culling the portions that are not typically read by the referral source. But I do want to think about the other side of the aisle as well. Some neuropsychologists do prefer to write lengthy reports. So it would be helpful for us and our listeners to get a sense as to what those reasons are, and then why we may not need them or why we may not need to write such long reports. So John and I will throw out a few justifications we've heard for more lengthy neuropsych reports and maybe you can give us your thoughts about them.

Jacobus Donders 06:19

Okay.

Ryan Van Patten 06:20

One thing I've heard is that longer reports with a lot of detail that are very comprehensive, you mentioned 6, 7, 8 pages or more, provide us with a lot of information in case we are ever deposed in a legal case years down the road. Can help with the documentation, it can help to jog our memory if we need that. Even without being deposed, if we retest someone 5 or 10 years later, it might help, again, bring us back to that person, their background, all those details. So what do you think with regard to that argument?

Jacobus Donders 06:55

Any information that is essential to the case should be in the report. The difference of opinion might be how much detail do you need to talk about those essential details? If it is known that a child has been subjected to physical or sexual abuse, that is important to note in the report. Is it necessary or even appropriate to go into extensive detail about the frequency of the abuse, the method of the abuse, who was the abuser? I've seen reports where that was described in more detail than in a gory dime novel. I don't think that's necessary. I don't think that protects the patient. I could say, "There's a known history of personal trauma involved in this child that has obvious implications with regard to the child's current presentation. But for reasons of confidentiality, I'm not going to go into details at this time." Anything else that's important should be discussed but you can go about it in a succinct manner.

Let's use another pediatric example. If you've done an extensive interview and you know that the child was born, after an uncomplicated pregnancy, and the birth went well, and all the developmental milestones were well within normal limits, do you really have to discuss in the report every single Apgar score, every month when the child starts to sit, stand, roll over, say the first words, put words together in sentences? Why don't you say, "I did a comprehensive history and the entire prenatal, perinatal, and early developmental history were entirely unremarkable." It captured the same thing.

With regard to the issue of depositions, any good lawyer will advise you during depositions to say as little as possible. The big mistake that most psychologists make during depositions is that they talk way too much.

John Bellone 09:05
[laughs] That's our tendency.

Ryan Van Patten 09:06
[laughs] Just in general, we probably talk too much.

Jacobus Donders 09:09
So it's important to have relevant information about the case. It is not necessary to have all the minutiae. And, again, think of the audience for whom you're writing. In the book, "Neuropsychological Report Writing", I deliberately solicited examples from different people - people who write for the schools, people who write for the courts, people who write for neurosurgeons in epilepsy centers. Not every environment, not every referral source is going to expect or prefer the same type of report. If I write an evaluation for the probate court about whether or not somebody who's now 17 and is approaching the age of 18 and has a significant neurologic history - can or can't that young man be his own legal guardian in six months, yes or no? That was actually the referral question for the case I saw today. I know what questions I really need to answer for the judge. My audience is not a physician, it's not a teacher. Now I have a judge, that judge is going to ask me to say some very specific things. On the other hand, if I have a 10 year old child and there's a debate whether the child does or does not have learning disability, not only will I give different tests but I need to look at different standards and I need to address those standards often with different language. So there's no one size that fits all.

Historically, I've always said talk to your referral sources, ask them what they're looking for, ask them what they want. Then make sure you tell them something that

helps them with the question that they ask, and, if possible, helps them with new information that was not available before. So they might ask you, “Does this child meet criteria for an intellectual disability?” You can just answer that question. But if during the course of your evaluation, you've also found that this adolescent is clinically depressed, say, “Hey, you may not know this, but he's also clinically depressed and I recommend either an antidepressant or psychotherapy or whatever.” So you don't have to necessarily be completely constrained by the question that is asked of you but you better darn well make sure that you answer that question in a very clear and, in my opinion, succinct manner.

John Bellone 11:39

How about the case where you're doing a pediatric eval and a parent really wants you to go into depth and they're looking for that in the report. They're going to read it word for word and they want you to do a comprehensive job of the background. I mean, this is more rare for adult cases, but sometimes people are also very curious and they're looking to the neuropsychologist to really comprehensively write up that background and include everything that they feel is important. How would you respond to that?

Jacobus Donders 12:12

I have not had a parent or a patient complain to me yet that the report was not comprehensive enough. In fact, the only time I recall getting a complaint was actually for a legal case, where a court clerk informed me that my report wasn't big enough because he or she was used to these 20 page reports. I responded and I sent a letter to the justice, “Here. I can make a big report if you want me to, but what you really need to know is that this person is malingering. That's what it boils down to. I can tell you why [he] is malingering, how certain I am of that. But I can explain that to you in a paragraph. I can explain to you in a phone call in less than a minute.” And, of course, they went to motion and I was asked to write a one page review or response to that particular question.

However, in the case of patients or family members or parents in particular, you are doing a better job, I think, giving them time of day during the interview in terms of a) treating them with respect, b) really soliciting their input, meaning have them fill out questionnaires, have them talk at length about what I do, give them the time, make sure they're heard. I always finish every interview with, "Okay, you've been very clear, you've been very helpful. It was very helpful that you brought these forms in or this IEP or whatever they have. But is there anything else that is on your mind that we have not discussed yet? I'm not fishing for anything, but is there anything

else that we should talk about? We have plenty of time to do that." I think you're going to accomplish a lot more by making people comfortable that they're really being taken seriously, you're listening to their questions, that you're going to be answering their questions and you're going to do that during the feedback session. As opposed to them reading about how many steps Johnny could take when he was 13 months old versus when he was 15 months old.

Ryan Van Patten 14:09

Right. Yeah, I like to echo something you said earlier that really resonated, which is when development or abilities are intact, we really do not need to belabor the point. I find myself using words like, "Such and such was unremarkable or intact" and that's a very succinct way of summarizing what could otherwise be a very long list of like, check this box, check that box. So I really like that. But then, when there's complications - if, for example, early development is not typical or intact, that's when we would go into a bit more detail about scores and milestones, things like that. I'd like to step back for a moment and ask you to just give us and our listeners a general census to the length of your typical inpatient and outpatient reports so we can compare that to longer 8, 10, 15 page reports.

Jacobus Donders 15:08

My reports are typically two to three pages and then as an addendum with the test scores. That addendum is accompanied by a disclaimer, “Hey, these are only for professional use. You can not interpret these without looking at the whole report.” But the addendum is there so I don't have to discuss every single score. I'll often say in my body of the report, "I'm not going to talk about every single score. I'm not going to talk about every single test. I'm going to highlight the most significant findings." Just like a physician who orders a broad liver panel or a CBC or what have you, and you come back with all these blood tests, he's not going to say, "Well, blood sugar level was this and creatine was this and this..." No. They highlight what is important that stands out as abnormal or significant, particularly with regard to the condition of interest or the question that's being asked. You can often do that in a few pages. I was asked yesterday, there was a request on the AACN listserv, I think, from Dean Beebee at Children's in Cincinnati for sample reports that would be discussed during one of the workshops that he's going to do at AACN. I sent him one of my forensic pediatric neuropsych reports, which was four pages long. And that was a complicated case.

John Bellone 16:34

Wow.

Ryan Van Patten 16:34

Wow. Yeah. I'm sure those templates are really helpful for people as a lot of us work towards efficiency in shortening our reports.

John Bellone 16:43

We're going to get into it a little bit later, the exact sections of the report. But, yeah, everyone's going to be wondering, how do you write a forensic pediatric report in four pages?

Ryan Van Patten 16:55

Yeah, so we'll get to that a little bit. Along the lines of continuing to throw out arguments from the devil's advocate, I had a close colleague of mine who talked about her experience in a psychiatric hospital where often the neuropsych report was the only note in the patient's entire record where everything was brought together in a single document. And because of this, she found that it was relied upon heavily by people from multiple disciplines to provide a good narrative for the patient's history and the presenting problem. Of course, I don't see us as being responsible for doing this relative to any other health care provider, necessarily. But in cases where the other notes are sparse and piecemeal, do you see it as potentially being useful to have a longer neuropsych report that is comprehensive with respect to all the patient's history, even if it's a little redundant? Or not so much?

Jacobus Donders 17:56

Well, when I hear the word "redundant" I typically cringe. "As was stated above", that's a phrase I never want to see in reports. If you are aware of a pattern of historical events or facts about a patient's life that do not appear to be appreciated, you can summarize that very clearly. It doesn't mean you have to spend three and a half pages on it. I had a case fairly recently that involved a young adult with traumatic brain injury. There were lots of notes in the report about the duration of post-traumatic amnesia and what the first CT scan showed and their follow up MRI scan and blah, blah, blah. Nobody had bothered to ask this person about his past substance abuse. So I made the point of emphasizing in my report that it is clear that this person had a severe brain injury. The Glasgow Coma Scale score was only 8 and it doesn't seem like he was responding to verbal commands until four days post injury and all the neuroimaging showed various diffuse and focal intracranial lesions. I didn't go to a hell of a lot of detail about what those lesions were because it was known - the guy had a severe brain injury. Next paragraph, "However, on the basis of review of additional records and interview of the patient

and family, it is also clear that this brain injury did not occur in a vacuum because this man had a long standing history of polysubstance abuse with at least three residential treatment placements between 19-so and so and 20-so and so." That information needs to be taken into account with regard to not only identification of causation of whatever problem he has now, but also treatment. They had this guy already on an opioid which should have never happened given the substances that he abused as recently as nine months prior to the injury. You can do that in a very systematic, succinct manner. I don't have a problem at all with us trying to integrate information, with us trying to summarize things so that it's all in one nice place, but then keep it in one nice place.

The President of the United States gets briefed on whatever's going on in the world every day. That means a brief. It's a one page document that he reviews that's about whether North Korea is going to launch another missile. That's whether ISIS is rearing its ugly head again. That's whether we should declare a disaster zone in Oklahoma because of flooding, whatever. A one page document. You can summarize important information in a succinct manner. I have no problem with us taking some responsibility for that. I'm just arguing it doesn't have to add five or six more pages to a report.

Ryan Van Patten 20:50
Yeah, I'm with you. Something you said earlier that I really liked as well was the importance of us talking to our specific referral source and getting a sense as to what they're looking for. Having those conversations because, in each setting, the referral source will be a little bit different so they'll have their own preferences. They can tell us explicitly what information will be helpful for them. More often than not, they're going to tell us something we already have a good sense about, which is that they're not looking to read, as you say, 8, 10, 12 pages. They want the elevator pitch, the one page summary sort of deal. So I like the idea of having those conversations.

There's a different sort of setting or situation that I'd like to ask you about, which is report writing for students in training. So I've often thought about this issue. Personally, I like the idea of early graduate students writing very thorough reports that are quite long, specifically in order to practice some of the skills that we have under the surface - you know, case conceptualization, knowledge of tests, what they're measuring, all the things that are going on in our heads that we don't need to put in our reports when we're in actual practice. I felt like it could be helpful for graduate students to be writing that out, and then their supervisor can see where they're at and judge their progression, their knowledge, their neuropsych skills at

that time. Obviously, this is a very different scenario from what we've been talking about, which is when we are full fledged professionals in a medical setting. So I'm curious, do you agree with me? Do you think that it's helpful for grad students to write these very thorough reports? Or not so much?

Jacobus Donders 22:43
It can potentially be. To clarify, I do run a training program. We have undergraduate as well as graduate practicum students through our department. We also have an APA approved postdoctoral residency program. So I'm familiar with the concept of training. I have no problem at all to say, "Okay, well, you write your report so you can show me your thinking, and then we'll go through it together, and it helps me figure out where you are wrong." My question, though, is, "Do you have to bother the reader with that? Do you have to bother the neurosurgeon who just wants to know, is this person or is this person not at risk for postoperative cognitive decline, if I'm going to take the hippocampus away in the left temporal lobe because of the seizure disorder?" You can talk with your student about how good or bad our tests are differentiating verbal from visual memory and so forth. We could talk about if this is a significant change, or the reliable change index, minimally clinically important difference where you can discuss all of that. But does that have to be in the end report? My argument will be that supervision is the time where you really need to dive into those things. It shouldn't come down to a report.

My concern about training in a lot of facilities is that supervision is not always taken sufficiently seriously. I'll go see this patient and I'll stop by and poke my head in the door, and I'll read your report. No, that's not good enough. With my trainees, I previewed the case with them, say, "Here's this case coming up here. Have you seen it? No, okay, you haven't. Here are some articles I want you to read. This patient is quadriplegic. A lot of tests that we usually use, we can't do. Start thinking about a test that you might substitute." On the day of evaluation we have frequent check-ins about how it's going and if something new comes up or a new hypothesis about things we should address. Then during the face to face supervision, we discuss all these things. "Well, what do you know, this is a repeat evaluation. Can you tell me how we determine if this is clinically a statistically significant change, yes or no? Or variables go into that? So how can you differentiate the impact of the brain injury versus the prior substance abuse? How can you tell whether this is dementia or Alzheimer's disease? And if not Alzheimer's disease, what other dementias could you consider? And did you ask all those questions? So what questions would you ask if you were considering Lewy body disease?" All those things can be addressed in the context of supervision. It doesn't have to be spelled out item by item in a report that is really intended for the reader, not for the writer.

Ryan Van Patten 25:29
Right. Yeah, that's a great argument.

John Bellone 25:32
I like that level of supervision as well. Can you also walk us through how reports might differ in a few of the common neuropsych settings, like an outpatient hospital clinic, a rehab hospital, psychoeducational testing? How we might write for different audiences because I often find that I have to write a little bit more, because this report is not only going to be read by the neurologist who referred this person, but also to the patient. So we might have to do a little more explanation. How do you balance the different audiences in the different settings?

Jacobus Donders 26:02
Again, it comes back to finding out who your referral sources are and potential future referral sources. If my referral source currently is a physiatrist, or a physical medicine rehabilitation doctor, in the context of a brain injury, I also need to keep in mind that I'm living in a state where there's no fault law, there's a fair amount of litigation going on. Eventually, this might also come in front of a judge or jury. But I also need to use language that a non-psychologist can understand. So I can, for example, say, "Well, this person did very poorly on a test of problem solving called the Wisconsin Card Sorting Test and he was very perseverative." Period. Well, the physiatrist will know what that means. If I know that this report is also going to be read by some other people, [I'll add], "Which means that this person really did not benefit from even frequent, but very succinct, feedback about his performance or he did not learn from his mistakes." I might phrase it in those words.

But it comes back to who you're writing for primarily. The neurosurgeon who's contemplating a temporal lobectomy really only wants to know one thing, "Is this person at risk, yes or no, for postoperative cognitive decline?" And maybe, "Is there any discrepancy between your neuropsych findings in terms of laterality from what I already know, from a Wada or from our fMRI or whatever else I've done?" That's what a neurosurgeon really needs to know. If on the other hand you're writing for a rehabilitation setting - let's say we see that same patient. The patient has had his temporal lobectomy, there was an anoxic event during surgery, all kinds of things went wrong and now we have a diffuse encephalopathy and we're going to try to put this person's life back together. Now, if you do a neuropsychological evaluation, it's more geared towards, "Okay, we're not thinking about risk of additional surgery. This was what we were dealing with three or four or five months after the incident. Where do we go with this person from here? Can we identify strengths and

weaknesses? Can our findings tell us something about the type of approach to treatment that might work relatively best? Is this a visual learner or verbal learner? Is there complicating depression, yes or no?" Whatever. That's a very different report you're going to write.

In the case of a psychoeducational evaluation, you better be familiar with federal as well as state laws with special education eligibility. Because there's a federal definition of what qualifies for traumatic brain injury or for learning disability and states cannot make a more restrictive definition, but it can make a more expansive one. For example, in some states, you can get special education services under qualification of traumatic brain injury, even if it was an anoxic injury, like he fell in the water and he almost drowned. In other states, you cannot. You need to know that. If you think about a guardianship for that 17 year old I saw earlier today and I need to figure out if he can be his own guardian, yes or no. In the state of Michigan, there are two ways to file for guardianship - that's a developmental disability or an intellectual disability. Developmental disability would apply to anybody who incurred their disability prior to the age of 21. Doesn't matter that they were 14 and had a pre-morbid unremarkable history before the brain injury occurred. Injury was incurred before the age of 21, I need to file the paperwork under developmental disability. That is not the case in some other states. But it's very important to understand your audience and also to understand your context. Is that the legal system? Is that a school system? And by what rules do they work? And those rules are not written by psychologists. They are typically written by lawyers or other officials.

John Bellone 30:01
Yeah, gotcha. So for each case, we're really just thinking up front, who is going to be reading this, who's the target audience, and then tailoring the report to that audience. I think that makes a lot of sense.

So maybe now it'd be helpful to go kind of section by section through a typical report. What I think might be helpful is to talk through each of these sections in terms of what information tends to be most relevant. What language can we usually cut, or you would advocate cutting, without sacrificing the quality of the report. So to start out with, most neuropsychologists include identifying information, referral source, reason for referral right up front. How do you approach that section? Any pearls of wisdom there?

Jacobus Donders 30:46

Again, very succinctly. You can basically say this is - I'm just going from the case I saw earlier today - a 17 year old, Latino young man who sustained a severe traumatic brain injury at the age of X, whose last neuropsychological evaluation was four years ago, and who is now approaching the age of majority. There are questions about his ability to function as his own legal guardian. He's on no routine prescription medications, he's not receiving any form of therapy. He's being homeschooled by his mother. There have been no recent, unrelated psychosocial stressors, past preferences for him for that he needs to carry. That's what they need to know. I can, later in the report, talk about what happened during that primary psychological evaluation. I can refer to previous documents where I've already talked about how severe this brain injury was. All we need now, this is what we're dealing with and these are the main facts.

Ryan Van Patten 31:42

Yeah, that sounds good. Moving on. First, the presenting problem. And then next, the background and history, including information from the clinical interview, records review, and collateral interview.

Jacobus Donders 31:54

Yeah. What I can obtain from the interview will depend and vary, the amount of information will vary by case. In this case, it was somebody who is known to me. I have seen that child since he was originally injured at the age of six. I've seen him a few times. I didn't have to talk about developing rapport. I didn't have to talk about his history a lot. What I really need to focus on is what is going on in this child or this young man's world right now. He's made some questionable choices with regard to behaviors that, for reasons of confidentiality, I'm not going to elaborate on here, but that potentially could get him into trouble [and] that stand in great contrast with how well he can actually talk about what is right or wrong. He knows what's right or wrong, and can tell you why you should do one thing. But, guess what? He always ends up doing the wrong thing. That's a major thing and that needs to be in my history or the interview that I obtained. Whether or not he likes milk chocolate versus dark chocolate, doesn't matter. I only have to document that he denies any and all substance abuse. I don't have to go on about alcohol and tobacco and you name it. Bring it back to the referral question. Okay, he's here to be determined if he can be his own guardian. I need to document that he understands why he's being evaluated. That's part of the assent process in this case. Does he understand what guardianship means? He can actually say, he can actually describe, "Yeah, that means my mom will still be my boss." And does he think he can be his own legal

guardian? He says he's not sure but he thinks he can do it for school things, he can do it for money because I asked him about all those things. Maybe not so much with medications. And, well, that's important. You interview the parents, “Well, no, he cannot do any of those three things and let me tell you why.” And they give certain examples. I won't give all those examples in the report but I'll say there's a big discrepancy between what so and so thinks he needs, what his parents [think he] needs. Then his parents bring up specific examples of questionable choices that could have legal implications or safety concerns and he reluctantly agrees that that might have happened, but he doesn't take full ownership of it. That's all that needs to be in the report at that point because that is what's most relevant for the question at hand.

Ryan Van Patten 34:12

One specific question that has come up for me with regard to the background is, we have two primary sources of information when we're writing these sections. The first is our records review, EMR. And the second is the interview, including the patient and collateral source interview. I've seen two different models of how these are written out in a presenting problem and background. The first is that they are integrated together. The second is that they're actually pulled apart where the background is given for the records review, and then the background is given for the interview. I believe one reason for this is that occasionally there will be disagreements. Patient says that they've never been depressed, yet we see that they were prescribed SSRIs and inpatient hospitalized in the past for depression. There's a lot of different examples of potential disagreement between records review and the patient. But, my general question is, do you advocate for integrating them together or pulling them apart?

Jacobus Donders 35:24

If you integrate them together, at least document that you do so. Say, "The following is information obtained from the combination of records review and patient report and collateral information." Particularly if there are discrepancies I will highlight those. "It should be noted that Mr. So and So reported he's not only on Keppra, but also on Gabapentin. However, I do not see Gabapentin mentioned in any of the neurologist’s records." I can't tell. I'm not going to call this guy a liar and say, "You're not taking Gabapentin." He's pretty sure he takes Gabapentin, but it's not mentioned in the neurologist’s record, and I'm writing for the neurologist. Just say, "Hey, that's what he says, but I don't see it anywhere. It's something you should know." Or, "Although the patient reports being completely independent with the management of her medications, the parents report that she needs reminders at

least two thirds of the time." Okay. It's more important that you clarify any discrepancies where it's between the records and interview or between different sources. I think that's more important than having a separate section for each or going to integrate them. Either way it would work but you need to indicate does it all fall together? Yes. Everybody's in agreement and the verbal reports are consistent with the medical records. Or are there discrepancies? And those discrepancies, describe those in a thoughtful manner. Don't try to call anybody a big, fat liar. Don't say I trust her more than him. No. These are just the facts. This is what I'm seeing.

John Bellone 36:59

In terms of your approach to the records review, do you typically summarize a neurologist's notes or neuroimaging, the radiologists report? Or do you advocate to quote it verbatim?

Jacobus Donders 37:13

If I'm going to quote verbatim, it will be the main conclusion. So I'm not going to read, every line out of that radiologist's reports line by line about whether ventricles are normal in size or not, or whether there are any periventricular hyperintensities yes or no, or whether they're perpendicular to the ventricles, yes or no. I basically say that, "The neuroradiologist interpreted the MRI as consistent with the likely history of MS because of the presence of T2 hyperintensities in the subcortical white matter, many of them which were perpendicular to the ventricles." Boom. I'll say that. I don't go on for a page and a half.

Now, if it's something I'm not familiar with I'll look it up. I want to know what they're talking about. I remember many years ago, when I first heard the term "forceps major" used in an imaging report. I said "What the heck is that?" I said, "Oh, it's a band of white matter in the posterior part of the brain." Okay. Now, I know that. But it's more important that you just summarize things in a meaningful manner. And if things are not relevant, don't include them in your report. I've seen reports where people summarized X-rays of the cervical spine, thoracic spine, lumbar spine, in the case of a mild head injury, but the individual was asked, "Does a person have post-concussion syndrome?" I'm not an expert on the cervical or thoracic or lumbar spine. That has no place in my report. Now, if that person had a fracture, I'd say, "Listen, the patient had a spinal fracture and is now quadriplegic." Boom. That's relevant. But I don't need to go into detail, particularly if the results are normal, about all those different tests that are not my area of expertise.

John Bellone 39:04
Yeah, right. I think for some neuropsychologists, especially early career professionals, I think we might feel that we're not doing our job if we don't do what we think is a comprehensive overview of the records or include everything. Or even, like, if we fail to say - let's say, “There was no tobacco use” when saying "No substance use" would suffice in that situation. I don't know. Sometimes I feel like if I don't mention this, if I don't mention that there was no urinary incontinence or something like that, am I not doing my job? That's, I think, something that others can sympathize with.

Jacobus Donders 39:43
Well, let's take urinary incontinence for example. When would that be relevant? Well, it's not going to be relevant in the case of mild head injury in an 18 year old. If on the other hand, you have an 81 year old and you're faced with a differential diagnosis of dementia and you're considering the possibility of normal pressure hydrocephalus, yes, then you definitely want to talk about that. You want to talk about the triad, is there cognitive impairment, is there gait disturbance, is there a urinary incontinence. Just like if you do an evaluation of a 6 year old, you're not going to ask about their substance abuse because most 6 year olds don't engage in substance abuse.

Ryan Van Patten 40:23
I hope not.

Jacobus Donders 40:24
It needs to be relevant to the patient and the question at hand. So I'm not saying you can never talk about this, you can never talk about that. Talk about what's relevant, and do so in a manner that you can basically explain as if you - and I always play this game with my residents. Just imagine you're a first year resident and I'm a grouchy attending and we're walking from one end of the hall down to the other, you better get your story out in a coherent manner, fill me in, before we reach the end of the hall. That typically gives you about a minute and a half, maybe two minutes. That's all you have, okay? Or you're going to call somebody and you need to leave a confidential voicemail. The voicemail cuts you off after two minutes. Practice it. You can write it in an email, but the email is just like a tweet. You're limited to 180 characters. Practice it. I'm not saying that all our reports have to be in the form of tweets.

John Bellone 41:28
[laughs]

Ryan Van Patten 41:28
[laughs]

Jacobus Donders 41:28
I am saying try to formulate your thoughts in a coherent manner so that you can address the question that has been asked of you and also provide supplemental incremental information that may not have been known to the reader yet.

John Bellone 41:46
It would save me a lot of time If I could just tweet the results to the referring physician.

Ryan Van Patten 41:51
[laughs] In 180 characters.

Jacobus Donders 41:52
We do that to my in-house physicians. At least I will routinely send them a little email, and the email is typically bullet pointed. “This is the gentleman you saw in clinic four weeks ago. Complicated mild traumatic brain injury. You will get a full report but here's the bottom line. A) There's really no significant cognitive dysfunction. B) I'm much more concerned about post-traumatic stress disorder. C) He's also narcotic medication seeking. D) I don't believe he is malingering. And, E) Here's my recommendation on what you do with it.”

I can guarantee you that my physicians, because I've asked them this, they really liked those emails. Most of the time, they won't read my reports. My reports are only there for future documentation. The email is not saying it all. Never going to say everything in the electronic form. But the formal report goes into a little bit more detail for future reference or if it ever goes to a lawsuit or anything like that. But what they really want to know is in the email.

John Bellone 42:54
Yeah, and that's how they write their reports. I've noticed there's such a discrepancy between how we write and how physicians typically write. Like when I review the neurologist's summary of the patient visit, I mean, it is bare bones. It's

bulleted, and maybe they spent a half hour with this patient and they write two sentences about it. I mean, I'm not advocating that we do that. But I think there's a major discrepancy there that's interesting.

Ryan Van Patten 43:23
Yeah, there could be a middle ground, certainly, between that and 15 or 20 pages. A middle ground, as we're talking about today. 2, 3 ,4 pages, something like that. That is probably a good landing spot for us.

John Bellone 43:35
Yeah.

Jacobus Donders 43:36
Yeah. Again, ask your referral sources what [they're] looking for. Many years ago, the first time I wrote anything about writing short reports was a paper I published in 1995. I've been at this for a while. And at that time, I actually canvassed the people that refer to me the most. I said, "What do you do when you read this report? Do you read the whole thing or do you read parts of it?" And 95% of them said, "Oh we flip to the last page, because that's where you usually say what I need to hear." And they never read anything else. And I said, "Okay, why am I doing this? Why am I writing this dang long report, which at that time was only seven or eight pages, but nobody reads?" So I stopped doing that. But, again, find out for your referrals. If you have a referral source that says, "I really want all this detail. I really want all this, at least in a clinical context." Go ahead. You want to keep your referral sources happy. I would caution that forensic reports do not necessarily have to be all that much longer. The more you say, the more you write down, the more you can get questioned.

John Bellone 44:41
Yeah, I've heard you talk about the idea of the inverted pyramid and the technique where you spend most of the time on the summary, the impression, the recommendations, and you be progressively briefer in terms of the background and the other parts that aren't going to be read quite as frequently. That's my understanding of that inverted pyramid.

Jacobus Donders 45:07
The inverted pyramid basically means that - you know that the pyramid rises to the top. The top is where you want to get, that's where everything comes together.

That's the image that we use. In reality, everything is buried underneath a pyramid but that's a different story. But you want to get to the top. So what is the top? At the top is, “This patient does not have Alzheimer's disease. This person does not have any other kind of dementia. This person is simply depressed.” That's my top. Okay. And then I need some pillars to support that top. Well, first of all, I have several test results that suggest low average/normal to normal memory test performance that effectively completely normalizes under a multiple choice recognition format that will be very unusual in Alzheimer's disease. And I also see no difficulties with naming to confrontation or with semantic verbal fluency that will also be very unusual in Alzheimer’s disease. And I have information from a PHQ or a Beck Depression Inventory that a patient is endorsing not only feelings of depression, but thought of being better off dead. Those are my main supports.

Okay, I need to put some other window dressing around it. Of course I need to talk about family history. No, there's no family history of Alzheimer's disease. There's a family history of depression. Is there a premorbid history of depression? No. But the psychosocial context is over the last year this person has experienced multiple losses. He lost half of his foot because of complications from diabetes. And his spouse of 53 years died. This person is depressed. And now here is what we're gonna do about it. That is the inverted pyramid. Where you start with a main conclusion, look for some supporting major facts, and then supplementary details as necessary.

John Bellone 47:01
How about the behavioral observations? How do you approach that section?

Jacobus Donders 47:05
Again, a lot of behavioral observations are from my psychometrists or from my postdoctoral residents. That means you need to train them well. Both of my psychometrists are very good, masters level prepared. They are trained to look for behaviors. I'm very impressed with a young woman I just hired because she was hired to cover for somebody who went on maternity leave. And within a month, she was on her own doing assessments and she picked up on the fact that one patient had a slight exotropia of one eye, she described it as a lazy eye. Yeah, but she found it. I'd seen that during the interview, but she picked up on it. She had another patient in which she could pick up on the fact that that patient was neglecting half of the side page. She initially had never heard of neglect. I get a lot of information from them.

I also get a lot of information from doing the interview. My interviews are about 40 minutes with an uncomplicated patient, about 50 minutes to an hour with a more complicated one. We spent a lot of time with patients. We can hear a lot about the prosody of their language, how they make eye contact, do they pick up on social cues or interpersonal cues, particularly if they're subtle. Do they monitor the volume of their voice? Is there any kind of tremor? I mean, you can see a lot during that time. And that in my behavioral observations that I've finally put into report, I will say, “Speech, affect, and effort were unremarkable. However, I did see significant symptoms of Parkinsonism. And this is what they were. And those can potentially be significant because the patient also reported during the interview symptoms that were suggestive of early evening visual hallucinations, and a nighttime REM sleep behavior disorder.” Well, do I still need to tell you this person has Lewy body disease? Oh, you don't need to tell. You need a neuropsych for that. But I emphasize what is important in the context of the case.

John Bellone 49:02

How about in terms of the tests administered and results section? You said that you include an appendix with the table of results, which I also prefer to do. Sometimes people will summarize cognitive domains, you know, they go domain by domain writing out a written explanation. It sounds like you probably just summarize the main findings.

Jacobus Donders 49:26

I will summarize the main findings. So I prefer not to go through language, visual spatial functioning, memory, attention, problem solving, because people can fail a specific test for a variety of reasons. Oh, you think that the Rey Osterrieth is a measure of visual perceptual abilities? Oh, maybe it is. Or maybe it's also an issue of executive skills, they can't organize or plan things. Maybe a thread to this whole assessment process, you had all these test results in concert, and every time you have this person do something with their hands, they slow down. I see it on the grooved pegboard. I see it on Coding on the WAIS. I see it on Trail Making A. However, when you make the test more complex, there's really no further worsening. For example, Trails B is actually really not all that much worse than on Trails A. In fact, the performance relative to the peers is actually better. I see no slowness of performance on other tests that are timed such as verbal fluency under time pressure on the COWAT. So we really have a motor problem. Okay, that's not my motor problem paragraph. And why is that important? Because I have a person with motor slowness, and this person happens to be a truck driver. And now I'm getting concerned about this person's reaction time. Okay, now I'm going to throw in

a reaction time test. I'll give him a CPT and not only is his reaction time a little slow, but we actually can get slower as the test progresses. So there's some mental fatigue. Now I have to put that into context. Now this guy's not only a truck driver, he's a long haul truck driver. He makes long hours, and he's slow and his attention and his reaction time fatigues rapidly. That's concerning to me. Okay. So that's now my whole motor versus mental reaction time paragraph. I may not do that for every patient. I'm not going to do that if I'm talking about the difference between Alzheimer's disease and depression. [For] Alzheimer's disease and depression, I'm going to make different distinctions. So, whatever it is, talk about what it really is. What does the data really tell you? You can go through every single test or score in isolation - almost, say, in 99% of my reports, I start the results section with, "Listen, I have attached a list of all the tests that were administered and the results of them. I'm not going to discuss all of those. I'm just going to highlight the most significant findings." What those most significant findings are depends on the nature of the case.

Ryan Van Patten 52:08
How about impressions and recommendations? What are some tips you can give us in terms of how you approach these sections?

Jacobus Donders 52:16
When you start writing your impressions or recommendations, again, then we get to the top of the pyramid, it's where you eventually want to end up. First, bring it back to the referral question. Who sent you this patient? Who's your audience? What question are they asking? Patient is sent by a primary care physician and the question is, is this normal aging? Is it Alzheimer's disease? Is it depression? Is it something else? Is it all the above? And basically, you need to answer that question in a very clear manner. The preceding report should provide the foundation for that. So you've already discussed about affect. He didn't do all that badly on the CVLT-3. The long delay free recall was a -1, cued recall was a -0.5 - and I'm talking about CVLT-2, so now we're talking about standard scores in CVLT-3, but bear with me - and actually normalize this to a 0 under multiple choice recognition format. That does not look like Alzheimer's disease. You've already discussed affect. I can say, "Mr. Jones came here for a differential diagnosis. Based on history and current test results, I do not believe that he meets criteria for Alzheimer's disease or any other type of dementia. I'm not even convinced that he meets criteria for mild cognitive impairment because he has only a very few low scores and are occurring with a base rate that is not unusual for the general population. I'm relatively much more concerned about the fact that he's very depressed, and that depression is currently

not being treated and that depression is distracting him.” So that’s the kind of language you want to use. If I should tell it to a patient, "That causes you to have a brain fart in daily life." In the report I might say that, “The distraction is causing lapses of memory in daily life, but not organic and are related to depression. And here's what we're going to do with that depression. But answer the referral question and then give meaningful recommendations.

So with this particular gentleman, I might say, “Listen, I'm a little bit concerned about the fact that this person is depressed. I don't think he's suicidal. I don't think he's psychotic. But his depression is also accompanied by a poor appetite and he's not eating very well, he’s actually lost some weight. And he's also not sleeping at night. So you may want to think about an antidepressant that addresses all those symptoms, maybe something like Remeron, however, that choice is up to the attending physician because they're going to manage it.” I'll always put that caveat in. That's okay. Okay, he's depressed, so treat the depression. Well, maybe I can get some more recommendations based on what I know about depression. I can talk about whether the patient is a good or a bad candidate for psychotherapy. I can talk about other agencies that we should get involved to support this patient to do home visits or whatever.

Whatever is relevant to not only answer the question, but to facilitate further care for this patient in a manner that's not just a dismissive cookie cutter tone. Like, “Oh, yeah, the patient needs oversight or supervision.” How much oversight? What kind of supervision? “Patient needs special education.” Okay, under what qualification? Why? How? Be specific in your recommendations and make them manageable. I see some of these reports, particularly in pediatrics where there are two or three pages of recommendations and they go, I count them up and there's like 30, 40 different recommendations. I said, “Oh my God, where does anybody start with this?” Make it manageable. There are reasons why phone numbers are only seven numbers. There are reasons why social security numbers are nine numbers. People have a hard time memorizing them. Keep things simple and focus on the most important issues.

John Bellone 56:01

Yeah. I've gone back and forth between, in terms of the recommendation section, being very concise, bulleted, and then the other end, using complete sentences and giving color. For example, like being concise just saying, “Continue with mental health.” Period. Or, “Continue with mental health because this person is suffering from anxiety and they tried psychotherapy.” How much do you think we need to elaborate there in terms of that section?

Ryan Van Patten 56:30
And justify? Right?

John Bellone 56:31
Sure, yeah. That's more of what I'm doing, right, is the justification.

Jacobus Donders 56:35
Well, it depends on what I know of the patient. So I know the person's already in treatment, it matters a heck of a lot to me if I have some idea of what's going on with their treatment. If I don't have treatment records, I'm at a disadvantage. If it's a patient who appears to be a good historian, okay. But if a patient was not a reliable historian because of some confusion, I'm also at a disadvantage. I may sometimes say, “I think it's important to realize two things. Yes, this person is on medication for depression. Yes, this person is seeing a counselor. However, my concerns are that depression is currently not under optimal control. This person still gives me a raw score of 17 on a PHQ-9, which is in the moderately severe range of severity and he has occasional thoughts have been better off dead. In that context, it's concerning to me that he tells me that he's seeing his counselor only once a month, and the psychiatrist once every six months. I don't know if that's accurate. I don't know the rationale about that. My concern at this point is simply his depression is suboptimally controlled. I'm very hesitant to suggest what other medication he should be tried on because I don't know what he's been tried on in the past and to what degree of success. I'm very hesitant to discuss what kind of therapy he should have because I don't know what kind of therapy is provided to him.” It's okay to say, “Look, that all being said”, or “With the understanding that I'm at a disadvantage, I think that with this particular individual, a relatively more activating than sedating type of antidepressant should be considered.” Or, “If he's already failed SSRIs, has consideration ever been given to an SNRI?” Or, “It is not clear to me what kind of approaches to psychotherapy is being used, but the patient tells me now [unintelligible]. The patient tells me that therapies are open ended and discusses experiences over the last week. I'm not necessarily opposed to that, but what he really needs is also a cognitive behavioral approach to combat these negative thoughts and there needs to be some cognitive restructuring involved. I'm not saying that that's not happening, but that should also be part of therapy.” Sometimes I will try to work proactively. I had a phone call yesterday with somebody's psychotherapist - he gave me written permission to talk to that woman, the psychotherapist, because I was concerned about the fact especially not only in the history of stroke, but he was also a hoarder, which he did not recognize and I was not entirely clear whether that hoarding was being addressed in the context of

psychotherapy because he was basically initially not telling me the truth about it. I ended up talking to the psychotherapist. She was well aware of it. She had very good therapeutic approaches. So when I want to sign off on this report, when it comes back to the transcription, I like to say, “I did hook up with Dr. So and So. Her approach to treatment is entirely appropriate and I'm going to defer to her for further follow-up.”

John Bellone 59:46
Yes, you elaborate. You err on the side of elaborating more for the recommendations, which I agree, I do that as well.

Jacobus Donders 59:52
If necessary.

John Bellone 59:54
If necessary.

Jacobus Donders 59:54
If necessary.

John Bellone 59:54
Yes, sure. Yep. That's a good caveat.

Jacobus Donders 59:56

Sometimes I have had cases where I'll say it in a report, “This is really a case of where if something ain't broke, let's not try to fix it further. There's a good support system in place, there's a good IEP in place. We don't need to reinvent the wheel. Keep going as is. The only recommendation that I have would be this.” And that's it.

John Bellone 1:00:19
Do you see it as personal preference whether you put the summary and recommendations up front, or at the very end?

Jacobus Donders 1:00:27

Well I don't do a summary. I don't rehash. I don't write a summary where I rehash the preceding report. My reports are short enough as it is, they don't need an extra summary. But where do you put your conclusions and recommendations up front or

at the end? That's a personal preference. I don't really care. Again, I would ask my referral sources, “How do you want this done?” I don't think there's a law about that.

John Bellone 1:00:50
What do you think is a reasonable turnaround time for the typical clinical report?

Jacobus Donders 1:00:55
I tell my trainees they have to be out the door within 10 days. And they have to be out the door within 10 days unless there's a reason to get them out sooner - they have another doctor's appointment coming up or their insurance is running out at the end of month or whatever. That means we need to have supervision very soon after seeing the patient, typically the next day. You start writing your report real quick. You get to me within three days, I can get back to you within 24 hours, and then you can do your revisions.

I do my own reports 95 to 99% of the time on the day of assessment. Why do I do that? Because I typically have two neuropsychological evaluations per day and if I let them pile up, I cannot keep one person straight from the other anymore. The more they pile up, the less of a good job I do. I'm also in the habit of giving feedback to the patient on the day of the evaluation. I see a lot of patients who drive more than an hour away. I don't think it's proper to expect them to come back two weeks later for a 10 minute visit where they get the results and then drive another hour back. In 95 to 99% of the time, I can do feedback that same day. Sometimes I need to say, “Hey, I've requested the school records. I still don't have them. If they come back and they change my opinion, I'll call you.” Or, “That report from a CT scan that was apparently done yesterday, I don't have it yet. [If] that will show me something I don't know yet, I'll call you.” But most of the time, I can do feedback that day. At that time, I've pretty much given them the top of the pyramid. So that then within an hour or two hours after that, I do my report, I basically have done all that thinking already. Everything we bill 96132 now and sometimes 96133. But integration evaluation of test results? I've already done that. So it's very easy for me to dictate that report. And pretty much to dictate the report, I'm needing about 20 to 25 minutes.

Ryan Van Patten 1:02:53

What are your thoughts with regard to the inclusion or exclusion of psychological medical jargon in reports? Should we write reports so that a lay audience could read them? So that our patients and family can always fully understand them? Or is

that not necessary given that, obviously, the referral source is a healthcare provider?

Jacobus Donders 1:03:13

Not all referral sources are healthcare providers and not all referral sources who are physicians will understand some of our jargon. If you talk about semantic paraphasias versus other types of paraphasias, not everybody reads that. There's disagreement. Should we talk about letter paraphasias or phonemic paraphasias or talk about word substitutions or semantic paraphasias? It's okay to give an example, "The patient's speech was hesitant with frequent word finding difficulties, and occasional word substitutions or semantic paraphasias, such as saying dog instead of cat." Okay, then you put it in context. Again, it depends who I am writing for. If I'm writing for a neurosurgeon in an epilepsy clinic, I can talk about the hippocampus. I can talk about reliable change because they know about that sort of stuff. They know the terminology, they know the structures. I'm not going to use that same language when I'm writing for a school system about a kid who may or may not have a learning disability.

John Bellone 1:04:22

You had said just a minute ago that you dictate in about 20 minutes or so. That's going to be quite surprising to a lot of people that you can finish a report that quickly. I know that you've done a lot of work on the front end, thinking through your conclusions and integrating the results mentally before you ever speak the first word, right?

Jacobus Donders 1:04:46

Yeah, I feel very strongly about that. You should not, whether you type, write, or dictate, you should not put a single word into action until you know in broad terms what you are going to say. A lot of people start writing, typing or dictating, and hope that miraculously at some point divine inspiration will meet them in the middle but that turns into verbal diarrhea. You need to have a good understanding of what you're going to say. If you ever listened to a presidential debate, all those questions are being filed at these candidates? They have a pat answer for them. They know exactly what they're going to say because they practice and they thought it through already.

In your case with your particular patient, I bring it back to why is this person here? What question have I been asked? How do I answer that question? And can I tell the reader or the listener something else that they don't know already? And I try to

phrase that in my mind. I tried to then go back and see what are the most important supportive points of information, and what is some window dressing that needs to go around that? Once I've done that, and I have a good - Okay, in this particular case, I just need to explain that, yes, this person had a prior psychiatric history. They have been treated on an outpatient basis for depression with medication and with psychotherapy for at least two and a half to three years and I can tell that from the medical records. However, there's also no doubt that this patient sustained a real brain injury in this accident. There were acute care scan findings of an epidural hematoma. That's a complicated [unintelligible] evacuation. And that person was acutely aware that his passenger died in this accident while he was a driver. He has enormous guilt, and feels posttraumatic stress about that. Those are the main things. Those are the findings that I really need to put in a row. And, therefore, I think that we need to do this with this patient. But, that's where, if you start off with that, you have that clear in your mind, then you can go back and how do I support that? And then you can do your dictation in considerably less than a half an hour.

Ryan Van Patten 1:07:14

What role, if any, does your report play in the feedback session? Some neuropsychologists would hand the patient a copy and go through it with them. Others use an abbreviated patient summary report - although your reports are already so brief, that we may not need to abbreviate them anymore. And then others just prefer simply a conversation that's not anchored in some document.

John Bellone 1:07:40

Like I said, he kind of answered it, because you provide - you said, Jacobus, that you provide feedback the same day, right? So you don't have the report.

Jacobus Donders 1:07:49

Yeah, I don't have the report yet. In the vast majority of cases, 95 to 99% of the time, I won't have to report yet. There's some occasional situations, like I have a dental appointment that afternoon and I can't do feedback that day, or something else happens. But most of the time, I will not have a document. I will tell them, say, "What I'm going to tell you is basically what I'm going to tell Dr. So and So. And it's the nitty gritty version of it. There will be a lot more detail in that report, you're going to get a copy of that. And you're going to get it in 10 days. If you read something in there you don't understand, don't agree with, you think it's out of left field, whatever, call me. Here is my card, my number will also be on that report." So I won't have it in hand but I will reference it. But it basically says you're going to get the same information that goes to your doctor who sent you here.

Ryan Van Patten 1:08:38

Right. Yeah. You had mentioned that a lot of your patients live an hour or more away, so it certainly makes sense the idea of providing feedback on the same day. But it sounds like based on your answer that even if your patients live five minutes away and could easily come back for a later formal feedback session in a week or two, that you would still lean away from using the report as an anchor in the feedback session. Is that correct?

Jacobus Donders 1:09:04

Yeah, I don't see a reason to bring people back if I don't have to. They take time off from work already. They take sick days. They need to drive. If I can do one stop shopping, I prefer that. If I go to my primary care physician for my yearly checkup, and they say, "You know what? I'm just feeling something weird in your spine. I'd like to get a chest X-ray or I'd like to get this. Well, we can actually do that across the hall." I'd rather prefer that than say, "Okay, come back in two weeks. Or go to that other place 17 miles across town." I want all my shopping in one place. That's why we go to the large grocery stores. When I was a very little kid, we had on one end of the street corner where we had the baker, on the other end we had a butcher, two blocks down was the grocery store and you went to all those different places. Now we go to supermarkets because we get everything in one spot. I think there's something to be said for that. It's one stop shopping and it's convenient for the patient. I also get it done in one time. So if I do that inverted pyramid model, and I do my report right away after that, that's when it's most fresh in my mind, that's when I can help the patient the best.

John Bellone 1:10:20

Excellent. I know our time with you is running short, I want to ask you one professional question. We have a couple of bonus questions. But was there anything else you wanted to add very quickly about forensic reports? I think you covered it, you pretty much addressed it - write it the same way you would a normal report.

Jacobus Donders 1:10:38

The only thing that will be different for forensic reports is you often get a lot more records to review.

John Bellone 1:10:43

Right.

Jacobus Donders 1:10:44

So you might need to elaborate a little bit on that. And, again, I am not a fan of reviewing every single doctor's visit. The patient visited the Dr. So and So on that date, and then Dr. So and So on that date, and they go to proctologists, or a podiatrist, irrelevant for what my expertise is. Focus on what's relevant. The other very important thing about forensic reports is to try not to be an advocate. You are hired to give an expert opinion. You're not there to win the case for the patient or for defense. You're not there as a crusader. So stick to the facts and let the chips fall where they may. It's also very important to understand that you are probably a very small part of the puzzle. Usually there's other experts involved in different disciplines. And, above all, realize it's not about you and maintain professionalism. If you have a disagreement, let's say this patient had another neuropsychological evaluation by a different neuropsychologist or self-proclaimed neuropsychologist, and you think the other person's work is a piece of garbage. Leave it out. Don't say, "Oh, this guy doesn't know a cucumber from a frontal lobe. He's incompetent. Besides, he's not board certified like I am." No, "I respectfully disagree with Dr. So and So and here are the facts." Okay. Stay neutral. Stay scientific. And stay professional.

John Bellone 1:12:15

Yeah, I like that a lot. So just to get to a quick professional question. So you're double boarded, or I guess some people would say triple boarded because you have the clinical neuropsych board certification, the subspecialty in pediatrics, and then also rehab psychology board certification. I'm curious about the rehab psych certification. You work in a rehab hospital so, obviously, it's relevant there. When should neuropsychologists in rehab settings consider becoming boarded in that area as well?

Jacobus Donders 1:12:46

Definitely for anybody [who] works in a rehab environment where the focus is not so much on diagnosis, where the focus is not on predicting postoperative cognitive decline, where the focus is not necessarily on differentiating between Alzheimer's and depression, where the focus is on, “Okay, how are we going to get this person back to a productive life? And how can we inform the treatment team about approaches that may or may not work?” Those people probably should all pursue ABPP in rehab psych. I’ve seen a lot of neuropsychological reports where the reasoning about neuropathology is excellent to the point of superb. Very good insights. People even have good psychometric insights. And they can't write a single coherent, logical, plausible recommendation if their life depended on it.

That's a real problem in neuropsychology. A lot of reports that I see the recommendations are so bland, they are so cookie cutter, and I say cookie cutter because I see reports with the same recommendation, every single patient, maybe sometimes a little tweaking, but basically the same recommendations. Use psychological data to think about what we are actually going to do with this patient from here on in terms of compensatory strategies, in terms of intervention, in terms of adjusting to systems. That is a whole different ball game and for people who really want to do that, yes, the best evidence of competence will be ABPP in rehab psychology.

John Bellone 1:14:27

Excellent. Well, we could talk to you for another hour or two about report writing, but we've got to get to these bonus questions. The first one is if you can improve one thing about the field of neuropsychology, what would that be?

Jacobus Donders 1:14:40

I would like us to get more people out the door a little quicker. Our graduates spend an average of seven years in graduate school right now. That's unheard of. Compare that to medicine when they get them a lot quicker. And guess what? Physicians make a lot more money. I think there is also, at the graduate level, unfortunately, not enough emphasis anymore on assessment. I'm not opposed to people learning about diversity, cultural differences, whatever your specialty or your pet topic is, but if [there's] anything we can bring to the table, compared to psychiatry or to neurology - anybody can do a MoCA, anybody can do a mental status exam. But we are experts in formal, standardized assessment. And I'm not sure that that's being taught with sufficient depth anymore. So I would say, make sure we get them out quicker and with less debt, and make sure we give them a broader and deeper foundation in assessment.

Ryan Van Patten 1:15:49

Great advice. Moving on to the next bonus question, what's one bit of advice that you wish someone had told you when you were training or that maybe someone did tell you that really made a difference? We're looking here for one actionable step that trainees can take that they may not have thought of that could improve their training experience and performance.

Jacobus Donders 1:16:13

Looking back on my career, I wish that somebody had told me earlier that my job and the goal of my neuropsychological evaluation is not so much to showcase how

smart I am and how I know the case better than the next person, but that my job is really there to serve the patient. So if I had learned earlier in my career, that it's not about me. If I learned earlier in my career that my reports don't have to be full of jargon, that they don't have to be very long, but I need to be meaningful, I would have come to that conclusion a lot sooner. I wish, in retrospect, that I had gotten some feedback early in my career, "Hey, you know, that's all fine that you know all these big words and it's all fine and dandy that you also know some about neuroanatomy, but you really don't have to put all that in that report." Think about why we're doing that report. We're doing that report to help the patient. Start helping the patient.

Ryan Van Patten 1:17:15

Yep. And our last question, now that we've covered advice for trainees, we'll finish up by asking for advice for early career professionals. Specifically, we know that the healthcare landscape is changing very quickly. We want neuropsychology to remain relevant and useful. So once we are established as neuropsychologists, what steps can we take to ensure that we're providing cutting edge science and clinical services for the next decades, 10, 20, 30 years?

Jacobus Donders 1:17:48

One thing we need to do is collect data that show that we actually have something to offer that cannot be ascertained on just the basis of a medical records view or a standard neurological or psychiatric evaluation. I have a paper in press with The Clinical Neuropsychologist about that, about the incremental value of neuropsychological assessment. In other words, what do we bring to the table that shows our added value? That's been one of the most frustrating papers I've ever written because, as a profession, we've done a horrible job proving our worth. If you look at the number of papers that really convincingly demonstrate, "Hey, you actually get something from a neuropsychological evaluation that you don't get anywhere else. It's actually going to change prediction of outcome, or those outcomes themselves." There's not a huge literature on that. And, of course, we think we're very smart. We think we're doing very good work. We care about our patients and we spend much more time with patients than most of these other professionals. But, again, if you look at how much we have demonstrated that we actually can move the needle, we have not done a very good job about that. I think we need to do more of that.

I think we need to come up with new approaches to our assessment. You know, I looked at test results today from the same young man 17 year old who knocked the

Wisconsin Card Sorting Test out of the park. Well, I found out he's been playing a game called Blink, which is like the Wisconsin Card Sorting Test, which is commercially available. Think about it. The Wisconsin Card Sorting Test has been out since 1948. In 1948, the standard for neuroimaging was the pneumoencephalogram. Okay. If a neurologist right now was using pneumoencephalograms, that would run him out of town. But we do a lot. The Trail Making Test is from the first World War. It doesn't make them all bad tests but we have not done a good job at making use of the advances in neuroscience and in cognitive neuroscience, incorporating those in our assessments. So be more innovative. I think the only major change in tests that I've seen over the last couple of years - of course, I've started using performance validity tests - the only major change was when the D-KEFS came out with that fourth trial of the Color Word, the Color Word Inhibition-Switching. It was the first time I actually saw a new version of that test. Okay, that seemed to be interesting. But we don't do enough of that. I think we need to do more of that. And I think we need more research that actually shows that we're making a difference. And it's not that different. It's not that difficult. You can do that by collecting data on your own patients.

Ryan Van Patten 1:20:34
Right. Well, thanks for the advice, Jacobus. We really appreciate the whole conversation. Report writing is obviously a very important part of our job as neuropsychologists and your insights and advice are very appreciated and helpful. So thanks for taking the time.

Jacobus Donders 1:20:50
It was all my pleasure.

John Bellone 1:20:51
Thanks again.

Ryan Van Patten 1:20:52
Take care.

Jacobus Donders 1:20:53
Have a good day.

John Bellone 1:20:56
You too. bye.

Ryan Van Patten 1:20:56

Well, that's it for our conversation with Jacobus. However, because there's so much territory to explore in this area, we've decided that we're going to release a companion episode to this one where we add in our own commentary. In this companion episode, we will explore several of the important topics that we discussed today in detail. We'll provide new relevant information from a recently published survey, the stakeholders project in neuropsych report writing, and we'll add in our own personal experiences writing reports and working with various neuropsychologists all towards the goal of writing high quality reports as efficiently as possible. So, as always, join us next time as we continue to navigate the brain in behavior.

Exit Music 1:21:43

John Bellone 1:22:07

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Ryan Van Patten 1:22:18

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