BEFORE THE BOARD OF MEDICAL EXAMINERS
STATE OF MONTANA

IN THE MATTER OF CASE NO. CC-09-0136-MED REGARDING:

THE PROPOSED DISCIPLINARY	)	Case No. 443-2013
TREATMENT OF THE LICENSE OF	)	
ADAM REISS, M.D.,	)	
License No. 11189.	)	
	)	

PROPOSED FINDINGS OF FACTS; CONCLUSIONS OF LAW; AND RECOMMENDED ORDER

I. INTRODUCTION

Adam Reiss, M.D., petitioned the Board of Medical Examiners for reconsideration of the Board's Final Order suspending Dr. Reiss's Montana medical license. The Department of Labor and Industry (Department) objected to any alteration of the Board's Final Order. A contested case hearing began on January 10-11, 2013, and was concluded on January 28. Dr. Reiss appeared pro se and the Department was represented by Michael L. Fanning. Bowman Smelko, Ph.D; Matt Kuntz, J.D.; Delbert Fischer, L.C.S.W.; Mickey Boysza; MPAP Participant 205; David Healow, M.D.; MPAP Participant 170; Robert Caldwell, M.D.; Michael Ramirez; Steve McNeece; and Dr. Reiss testified under oath. Exhibits 1-8, 10-29, 30, 30A, 31, A and B were admitted through Dr. Reiss. Exhibits 1, 2, 8, and 17, Dr. Reiss's medical/mental health records, are sealed from public disclosure.

Department counsel argued that:

> given the extraordinary complexity of this case, and the Department's need for detailed explicit findings of fact, these findings of fact are broken down into segments: digested findings presented below and comprehensive findings with exhaustive citations to the record which are included in the attached appendix. For brevity, only the digested findings are included in the body of this document, but the Department seeks the Hearing Examiner's ruling on the findings in both the digest and appendix.

The hearing officer declines counsel's offer to engage in fact-finding beyond the scope of the issue before him.

The Department submitted 114 proposed findings of fact and 192 "annotated facts" and Dr. Reiss submitted 54. Those findings not included herein are specifically rejected as repetitive, mere citations of testimony, or irrelevant to a determination of whether Dr. Reiss's request for reconsideration should be granted. Mont. Code Ann. § 2-4-623(4) has been construed as not requiring a separate, express ruling on each proposed finding of a party, as long as the agency's decision and order on such [*193] party's proposed [***19] findings are clear. *Montana Consumer Counsel v. Public Serv. Comm'n*, 168 Mont. 180, 192-193, 541 P.2d 770, 777 (1975) (citing *National Labor Rel. Bd. v. State Center Warehouse & C. S. Co.*, 9 Cir., 193 F.2d 156; *American President Lines, Ltd. v. N. L. R. B.*, 9 Cir., 340 F.2d 490).

In addition, some of the findings of fact made here are the same or similar to those proposed by the parties. The Montana Supreme Court has ruled that findings of fact which are "sufficiently comprehensive and pertinent to the issues to provide a basis for decision, and which are supported by the evidence," will not be prejudicial merely because the court followed proposals of counsel. *Donnes v. State*, 206 Mont. 530, 538 (Mont. 1983) (citing *In Re the Marriage of Parenteau*, 204 Mont., 664 P. 2d 900, 903 (1983)).

II. ISSUE

The issue in this matter is whether the Montana Board of Medical Examiners should reconsider its September 17, 2010 order suspending Dr. Reiss's license and allow him an alternative form of treatment.

III. FINDINGS OF FACT

A. Dr. Reiss's medical history and interaction with MBE and MPAP

1. Dr. Reiss has suffered lifelong bouts of depression, but did not regularly begin taking medication until he was in his thirties. During medical school, he was required to see a therapist because of problems he encountered including attention deficit, impulse control, and processing dyslexia. He began taking an antidepressant and other drugs which improved his interaction with classmates.

2. Once out of medical school, Dr. Reiss, on his own, discontinued his medications. When he discontinued his medications, his former problems returned

including being misunderstood and saying "inappropriate things." Consequently, Dr. Reiss was required to seek professional treatment during his residency.

3. In 2006, after completing his residency and beginning his practice in Montana at the Community Hospital of Anaconda, Dr. Reiss again discontinued his medications and treatment. Soon he found himself becoming more and more depressed "and things spiraled out of control." Dr. Reiss then began using marijuana to control his anxiety and depression. No evidence was offered to show that Dr. Reiss's marijuana use was legal.

4. In September 2007, Dr. Reiss was assaulted during a potluck at a local bar and suffered significant injuries. As he convalesced, he disclosed to a co-worker that he used marijuana. That co-worker reported Dr. Reiss's marijuana use to the hospital administrator, Steve McNeece.

5. As a result of the assault, Dr. Reiss was hospitalized at Sacred Heart Hospital in Spokane, Washington, where he was diagnosed with PTSD, major depression and anxiety, and admitted his marijuana use. Dr. Reiss had some problems with his patients and co-workers prior to his injuries on September 1, 2007, but he was a capable and effective physician in his employment at Anaconda Medical Center (AMC).

6. Upon Dr. Reiss's return from Sacred Heart, Steve McNeece met with him and demanded that Dr. Reiss contact the Montana Professional Assistance Program (MPAP) or be fired on the spot.

7. MPAP is not a treatment program. It is a diversion program. Doctors who self-report or who may be subject to disciplinary action are assessed by third-party providers to determine an appropriate treatment plan. At that point, MPAP requires the physician to sign an agreement that requires them to complete the treatment program. If the physician does not sign an agreement or violates its terms, MPAP is required to report them to the Montana Board of Medical Examiners (Board). The Board may then institute disciplinary proceedings against the physician. The Board is administratively attached to the Department of Labor and Industry which maintains a contract for MPAP's services on behalf of the Board. The Board could itself manage the treatment of impaired physicians, but has had MPAP provide those services since its inception.

8. Dr. Reiss contacted Michael Ramirez of MPAP. Ramirez first suggested that Dr. Reiss attend an evaluation program focused on addiction, but when

Dr. Reiss protested that while he was an abuser of marijuana he was not addicted, Ramirez relented and agreed to a referral to the Professional Renewal Center (PRC) which was geared more toward mental health issues. Ramirez did not consult with MPAP's medical director, any of Dr. Reiss's physicians at Sacred Heart, or any other licensed medical health professionals before making his recommendations.

9. Dr. Reiss entered PRC in November 2007. He was fired from his position at AMC by its administrator, Steven McNeece, on January 31, 2008, days before he was scheduled to be released from the PRC. After learning of Dr. Reiss's termination, PRC staff suggested Dr. Reiss extend his stay so that they could help him develop plans for dealing with the loss of his job and the associated financial impacts. Dr. Reiss agreed and was ultimately released on February 12, 2008. Prior to his release, his treating physicians had noted that MPAP refused to contact McNeece to advocate for Dr. Reiss's continued employment at Anaconda Medical Center, based upon Ramirez's determination that Anaconda Medical Center was not a suitable work environment for Dr. Reiss. Anaconda had 32 bars and no coffee shops during Dr. Reiss's time there. Reiss was on call frequently and had limited social opportunities.

Ramirez reasonably made the decision to not support Dr. Reiss's return to AMC because of discussions he had with Dr. Reiss that indicated that he thought Bozeman would be a good location, because of limited social opportunities for doctors who are often on call outside of their regular hours and the fact that he was aware of Dr. Reiss's diagnoses and reasonably concluded that it would not be a good place for Dr. Reiss. With his 18 years of experience, Ramirez knew that "as a freshly minted family medicine physician, there were ample opportunities for [Dr. Reiss] to find a suitable placement in family medicine somewhere else in Montana." Ramirez also knew that other physicians in Anaconda had difficulties working in a small town atmosphere and that a fresh start would be a better option. Ramirez also reasonably believed, based on his relationships with leadership physicians and with administration throughout the state, that he could help Dr. Reiss find employment in another community.

10. PRC's diagnosis of Dr. Reiss included generalized anxiety disorder; marijuana abuse; dysthymia; panic disorder; ADHD; learning disability; "major depressive disorder, severe, in remission on discharge;" and personality disorder. PRC's report included the opinion that "critical to his personal and professional success will be a structured aftercare plan."

11. From late February 2008 through May 29, 2008, Ramirez encouraged Dr. Reiss to sign an MPAP agreement, enroll in the program, and begin treatment. During this time the proposed agreement was amended, Dr. Reiss's father died and Dr. Reiss had difficulty obtaining legal review. Dr. Reiss signed the MPAP agreement in late May 2008. Ramirez believed Dr. Reiss had an obligation to comply with the MPAP agreement beginning March 27, 2008, but the agreement was not fully executed until May 29, 2008. Just as Ramirez had no obligation to advocate for Dr. Reiss until there was a signed MPAP agreement, Dr. Reiss had no obligation to comply with its terms.

12. When selecting treating professionals and psychiatrists, MPAP and Ramirez rely on recommendations from people in the network, reputation of those individuals, the ability to work within MPAP's public safety charge for reporting, real-time reporting of any symptoms or conditions that may pose a risk to public safety, and a willingness to work within the framework of an MPAP agreement.

Dr. Kenneth Olsen was recommended to be Dr. Reiss's treating professional because Ramirez worked with him many times and because Olsen had served as treating psychiatrist for 8 to 10 physicians over the years. Dr. Olsen had also served as chairman of the Provider Care Committee at Bozeman Deaconess Hospital and he and Ramirez had presented on the stressors of medical malpractice at an MPAP retreat so MPAP was familiar with Dr. Olsen and he was familiar with MPAP.

13. Under the original aftercare agreement, Dr. Reiss was required to see Peggy Barta, a therapist in Bozeman, once a week and Dr. Olsen once a month. Barta moved to Billings so Dr. Reiss and Ramirez agreed that Dr. Reiss would see Steve Whitney instead. He saw Barta three times before she moved. Dr. Reiss never saw Whitney or Olsen. At hearing, Dr. Reiss testified that he objected to Olsen because of some alleged misconduct in Olsen's past. Dr. Reiss did not raise this objection regarding Olsen in 2008 when Ramirez recommended him.

14. If a participant breaches his MPAP contract, refuses treatment, suffers relapse, or is unable to practice with reasonable skill and safety, Ramirez is obligated by statute, administrative rule, and contract to report that fact to the Board. On July 21, 2008, after cautioning Dr. Reiss that MPAP must report noncompliance, Ramirez reported Dr. Reiss's breach of the MPAP agreement to the Board of Medical Examiners (Board). The Board then initiated discipline for unprofessional conduct.

Once Ramirez reported the violation and referred the case to the Board, MPAP's role ceased.

15. In November 2009, while the disciplinary proceedings were ongoing, the parties, in consultation with Ramirez, agreed that Dr. Reiss would go through another evaluation, this time at the Betty Ford Clinic, with MPAP arranging a discounted rate and offering a $1,000 "scholarship." The Betty Ford Clinic reached a diagnosis nearly identical to that offered by PRC including major depressive disorder, moderate recurrent with psychotic features, in partial remission, dysthymia early onset, and marijuana abuse. Neither the PRC or Betty Ford found that Dr. Reiss was medically dependent on marijuana, but each found that he abused it as that term is medically defined.

16. On September 17, 2010, the Board issued a Final Order in Dr. Reiss's disciplinary proceeding that was based on a stipulation reached by the parties. The stipulation recognized Dr. Reiss's concerns about his ability to pay for the required treatment. It further provided for a suspension of his medical license, but stayed that action for six months to allow Dr. Reiss to regain his financial footing and then re-enroll in MPAP. Dr. Reiss did not ultimately enter into a new MPAP agreement and his license was suspended according to the terms of the parties' stipulation and the Board's Final Order.

17. The Board adopted and incorporated the facts in the parties' stipulation without change.

18. Among the Board's findings was that Dr. Reiss had completed an evaluation at the Professional Renewal Center (PRC) that was reported to the Montana Professional Assistance Program (MPAP). PRC recommended follow-up care with a qualified psychiatrist and therapist – terms incorporated into Dr. Reiss's MPAP Aftercare Agreement dated May 29, 2008. The 2008 MPAP contract required Dr. Reiss to treat with an MPAP-approved psychiatrist and an MPAP-approved therapist.

19. Instead, Dr. Reiss, without MPAP approval, sought treatment from professionals at the Western Montana Mental Health Center in Anaconda, Montana (WMMHC). One reason Dr. Reiss requested to use an alternate psychiatrist, Dr. Terry Lanes, and mental health professional, Del Fischer, L.C.P.C., from the Western Montana Mental Health Center, was because they accept Dr. Reiss's health insurance, the Montana Mental Health Services Plan, and were thus affordable to him.

20. The order further provided that Dr. Reiss must re-enroll in MPAP to be eligible to lift the suspension and resume active clinical practice. Dr. Reiss was unable

to secure any medical employment or regular remunerative employment of any kind. He did not abide by the Final Order, did not re-enroll in MPAP, and, after six months, on April 17, 2011, the stay was terminated in accordance with the Board's Final Order and Dr. Reiss's medical license was suspended.

21. At hearing, Dr. Reiss argued that he signed the stipulation under duress. The hearing officer finds from Dr. Reiss's testimony that what Dr. Reiss was arguing was that he was subject to economic duress. Economic duress sufficient to set aside a contract (the MPAP agreement) requires: 1) a wrongful act that; (2) overcomes the will of a person; (3) who has no adequate legal remedy to protect his interests. *Hoven v. First Bank* (N.A.), 244 Mont. 229, 234 797 P.2d 915, 919 (1990). Dr. Reiss was under pressure as his license was at stake and his ability to earn a living was at risk. The Board was fulfilling its responsibility to the public to ensure that those practicing medicine are safe to do so. The stipulation and the Board's order are consistent with the Board's duties to protect the public. Neither action was an unlawful or wrongful act. Dr. Reiss's medical and psychological problems, while not his fault, certainly required the Board ensure that Dr. Reiss would be safe to practice medicine. His care at WMMHC has been proven to be less than successful and while it is within his means, it does not provide sufficient guarantees of recovery that MPAP or the Board can offer it as a substitute for the care that the Board, MPAP, and Dr. Reiss (with benefit of counsel) agreed to undertake. Dr. Reiss had legal counsel when he signed the stipulation. Dr. Reiss had an adequate legal remedy as an alternative to signing the stipulation. He could have instead moved forward to a hearing on the allegations against him.

22. On July 13, 2012, Ian Marquand, Executive Director of the Board of Medical Examiners, received a letter from Dr. Reiss. Dr. Reiss's letter first described the circumstances of his medical practice in Anaconda and the September 1, 2007 assault. Dr. Reiss's letter then stated:

> Since returning to Anaconda, however, I was terminated by the hospital; I have been unable to find employment as a doctor in Montana and have been unable to fully satisfy the stipulations of the Montana Professional Assistance Program because of my financial limitations.

Dr. Reiss's letter denied any drug use and alleged that his "primary problems" had been depression and anxiety. Dr. Reiss concluded the letter to the Board by pleading for "an alternative treatment recommendation and advocate" rather than MPAP.

23. The Department deemed that letter to constitute an application for reinstatement under Mont. Code Ann. § 37-1-314, or as an application for reconsideration under Mont. Code Ann. § 37-3-324. The Department resisted Dr. Reiss's application. Dr. Reiss personally appeared at the Adjudication Panel meeting held July 20, 2012 to argue his application. The Board ruled that "the Adjudication Panel is not authorized to receive evidence in a contested case setting and Dr. Reiss's petition itself is devoid of facts that could support his position." Since the Board is vested with the discretion to take action on the application or hold a hearing on the application, the Adjudication Panel moved to:

a) Deny Dr. Reiss's application for an order granting his application for relief from the existing Final Order; and
b) Grant Dr. Reiss an opportunity to present evidence to a Hearing Examiner supporting his application for reconsideration of the Board's Final Order.

Consequently, the matter was referred to the Hearings Bureau to conduct a hearing on Dr. Reiss's application under Mont. Code Ann. § 37-3-324.

24. In 2012, Dr. Reiss began working at the Warm Springs Addiction Treatment & Change Program (WATCh) which requires him to work directly with clients who have severe substance abuse and criminal behaviors. He is functioning very well in his present position.

25. Today, Dr. Reiss offers a number of reasons why he not did treat with the MPAP-approved providers he agreed to see in his MPAP contract. However, when he initially sought reconsideration of the Board's Final Order, his "petition" simply stated he could not afford them. The Board's Final Order recognized his complaint of financial hardship and allowed him a period of time to work in a nonclinical setting, but he never found work. Now, Dr. Reiss claims that he must have a special program because he does not trust Ramirez and he does not like the providers he agreed to see. This revised claim is not credible.

B. <u>Delbert Fischer, L.C.P.C., and Western Montana Mental Health Center</u>

26. Since August 2008, Dr. Reiss's principal therapist has been Delbert Fischer, L.C.P.C., of Western Montana Mental Health Center in Anaconda, Montana (WMMHC). Other than Dr. Reiss, Fischer has no experience in treating physicians' mental health disorders, physician chemical dependency abuse issues, or in physician health programs, generally. Fischer is qualified as an expert in professional counseling,

but was not qualified as an expert in any other field, including treatment of impaired physicians.

27. Fischer believes that Dr. Reiss is being punished by the Board of Medical Examiners and MPAP because he was the victim of an assault and afterward, while in an altered state of consciousness, admitted marijuana use on one occasion. Fischer blames the Board for Dr. Reiss's depression, hopelessness, and institutionalization.

28. Dr. Reiss misled Fischer about his mental health history, current mental health status, and current marijuana use. Fischer's intake notes describe problems of a "couple of weeks" duration that centered on sleep schedule, lack of appetite, anxiety, etc. The chronic and serious nature of Dr. Reiss's condition was ignored. After intake and three counseling sessions, Fischer made a premature declaration that Dr. Reiss was fit to practice on September 16, 2008, and, in spite of the evidence to the contrary, maintains that opinion to this day.

29. In four and one-half years of treatment with Fischer, Reiss never improved, was always assessed with MDE (major depressive episode), and was hospitalized twice in crisis.

30. Fischer devoted his energy to writing letters to those with authority seeking to reverse Dr. Reiss's suspension. Due to misstatements by Dr. Reiss, those letters contained misleading allegations that omitted the severity of Dr. Reiss's mental health issues and omitted the extent of Dr. Reiss's marijuana use. Those letters never mentioned that all of Fischer's notes indicate that Dr. Reiss continued to suffer from major depression and never mentioned his hospitalization during two crises. Fischer's mental health treatment plan seems largely to have been to communicate with an attorney, send letters seeking supporters, and to contact a legislator.

31. Unlike MPAP, which has a duty to the Board and to the public, Fischer only has a duty of confidentiality to Dr. Reiss and a duty to act in Dr. Reiss's best interests.

32. Fischer's letters seeking support for Dr. Reiss that were incomplete or misleading suggest that he places Dr. Reiss's interests over the public's interest.

33. Terry Lanes, M.D., the psychiatrist at WMMHC, did not testify to defend or support his current or future treatment of Dr. Reiss.

34. Neither Fischer nor Dr. Lanes presented a treatment plan for Dr. Reiss that would resolve his diagnoses.

C. Michael J. Ramirez, M.S.

35. Michael J. Ramirez is the clinical coordinator of the Montana Professional Assistance Program. Ramirez earned a Master of Science degree in rehabilitation counseling from MSU, Billings, in 1992. Ramirez is not licensed as a mental health professional or a health care provider. Ramirez is considered the medical director's "medical assistant" which gives him the ability to perform duties that would not otherwise be allowed by an unlicensed person. Ramirez was hired by MPAP in 1995. In 2012, he published a professional paper on Montana's outcomes with "disruptive" physicians. Ramirez served on the taskforce that created the Federation of State Physician Health Programs' Physician Health Program Guidelines, published in 2005. Through MPAP, Ramirez has provided retreat workshops for MPAP participants and families. Additionally, he provides educational outreach to medical staffs and hospitals throughout Montana and has assisted hospitals with crafting bylaws and protocols for addressing physician impairment. In over 17 years with MPAP, Ramirez has worked with licensees suffering many forms of mental health issues, substance abuse, and sexual misconduct, often with a combination of these conditions. Ramirez has worked roughly 450 referrals and has managed about 200 contracted MPAP participants. Ramirez is active with the Board of Medical Examiners' Screening and Adjudication Panels and has testified before the Legislature many times. Montana has been a leader nationally in physician health programs (PHP) and Ramirez has been active in that role. Ramirez was qualified to speak as an expert in PHPs.

36. While Ramirez is not qualified to determine whether a psychiatrist will effectively treat a patient, he has the authority to select the treating psychiatrists and treating professionals in an MPAP aftercare agreement.

37. MPAP was created in the mid-1980s in response to a national trend of an unacceptably large number of physicians facing discipline and revocation due to drug and alcohol problems as well as numerous suicides by physicians facing discipline. The traditional 30-day treatment model led to unacceptably high relapse rates, intolerable to boards of medical examiners or to the public. Dr. Douglas Talbot created a treatment program based on an extended treatment model that allowed long-term observation to allow toxicity of alcohol and drugs to clear and permit study of psychiatric issues in a peer group setting. The Talbot model achieved unheard of recovery success, became the standard nationwide, and was copied and employed at

the Professional Renewal Center and the Betty Ford Clinic, the facilities Dr. Reiss attended.

38. MPAP is a discipline diversion program which allows a participant to recover and continue to enjoy the privilege of practicing medicine in Montana. MPAP monitors participants' conduct through a contract that requires adherence to treatment recommendations and, in exchange, advocates for that participant by reporting compliance to the Board, medical staffs, credentialing bodies, malpractice carriers, the DEA, etc.

MPAP obtains an assessment, diagnoses, and treatment recommendations from third party medical professionals. MPAP's role is then to assure that the expert's treatment recommendations are implemented and the participant adheres to those conditions. However, it is third party medical treatment professionals who provide the treatment – not MPAP.

39. MPAP's role is to get participants to accept responsibility for caring for themselves in a way to assure their continued fitness to practice. Dr. Reiss's cycle of crisis followed by treatment followed by abandonment of care strongly suggests that he has not accepted responsibility to ensure his own care in a way that assures his fitness to practice.

40. Treatment might involve "actual implementation of diagnostic findings and the recommendations relative to those" by a psychiatrist, psychologist, or counsel. MPAP never enters that type of treating relationship. As advocates for participants, MPAP acts as a "guide" to navigate the unfamiliar "geography" of Medical Board procedure and culture, treatment centers' operation, ethical and legal boundaries.

41. MPAP commonly sends individuals out of state for evaluations because the specialists with the expertise to perform the diagnosis and treatment do not reside in Montana.

42. MPAP selects evaluation centers and local treating professionals based on referral, professional reputation, experience, and willingness to report progress or concerns to MPAP.

43. The MPAP model is patterned after the Federation of State Physician Health Program, Inc.'s Physician Health Program Guidelines. The Guidelines are not mandatory, but are an evolving recommendation for programs which MPAP follows within the constraints of Montana's budget.

44. The Physician Health Program Guidelines state that a psychiatrist's expertise "is necessary during the initial evaluation, in the understanding and implementation of treatment recommendations, and in the clinical monitoring of the psychiatric disorder."

45. MPAP does not have a psychiatrist on staff or otherwise formally affiliated with the organization. It would benefit MPAP to have a psychiatrist on its staff. While recommended, it is not essential for MPAP staff to have training on the treatment of psychiatric conditions. MPAP relies on and consults with third parties with such expertise to diagnose and treat physicians.

46. The Board of Medical Examiners commissioned an audit of the MPAP program to assure that it was performing as expected. That audit contained some constructive criticism, such as recommending staffing with a mental health focus, but on the whole was very positive. The auditor found MPAP well-managed with good leadership, and commitment which provided significant benefit to medical professionals. Strong leadership is provided by Michael Ramirez, who is very compassionate, clinically competent, and politically astute. He is tough but fair and treats his participants with respect. He demonstrates diplomacy and effective communication skills.

This audit was conducted by Dr. Hankes who had served with Ramirez on the taskforce which authored the Federation of State Physician Health Program, Inc.'s Physician Health Program Guidelines.

47. MPAP has attempted to obtain psychiatric expertise, but mainly due to fiscal constraints it has been unsuccessful.

48. MPAP utilizes Ramirez to conduct initial patient intakes and refer the patients to treatment. Ramirez would be allowed to evaluate a patient as an assistant under Healow's license.

49. MPAP may use a treatment professional with which a participant has an existing relationship as long as there is not a significantly more favorable alternative. If MPAP does use this professional, it will monitor the relationship and look at records to see what is going on in the relationship. The treating professional must be willing to partner with MPAP and to report regularly on the progress the participant is making.

50. MPAP denied Dr. Reiss's request to use Dr. Lanes as his psychiatrist in the Aftercare Agreement. Dr. Reiss did not show that Dr. Lanes would partner with MPAP or regularly report on Dr. Reiss's treatment.

51. MPAP had approved Dr. Lanes to work with another MPAP participant.

52. Ramirez decided, on behalf of MPAP, to deny Dr. Reiss's request to use Fischer as his mental health professional in the Aftercare Agreement. Ramirez did not consult with Healow or any other mental health provider before making his decision. Based on his many years of experience in working with impaired physicians and those that treat, Ramirez decided that Fischer was not likely to aid Dr. Reiss's recovery and return to safe practice. It is more likely than not that his subjective judgment was right.

53. Dr. Reiss did not show that Fischer would work with MPAP in monitoring Dr. Reiss's treatment.

54. MPAP has no objective standards to determine whether a psychiatrist or mental health professional is qualified to treat MPAP program participants.

55. MPAP relies primarily on subjective "word of mouth" referrals to determine whether a clinician is qualified to treat MPAP applicants.

56. Dr. Reiss was never compliant with his MPAP contract because he did not seek care with the counselor and psychiatrist he agreed to see.

57. Ramirez's role as clinical coordinator centers on intake and referral and he reports to Dr. Healow.

58. The standard MPAP contract is consistent with generally accepted standards of practice nationwide.

D. David G. Healow, M.D.

59. Dr. Healow is a licensed anesthesiologist in Billings, Montana, and is MPAP's medical director. He is board certified in anesthesiology, board certified in pain management, and was certified by examination in addiction medicine. Dr. Healow devotes about five to ten hours per month serving MPAP.

60. In the mid-1980s, Dr. Healow began abusing intravenous fentanyl and faced discipline by the Montana Board of Medical Examiners. His recovery was unsuccessful with local providers and a 30-day in-patient program. Dr. Healow finally was successfully treated at a specialty clinic in Atlanta focusing on physician health. Dr. Healow signed an MPAP contract and was monitored for 10 years. He served on MPAP's board of directors and assumed the medical director role in 1992.

61. Dr. Healow was qualified to testify as an expert in addiction medicine, physician health programs, and supervising case management of impaired physicians.

62. Physicians are difficult patients because they want to participate in the diagnostic decision making and they want control. This creates difficulty in the diagnostic and treatment process, particularly when the physician "outranks" a counselor as is the case with Reiss and Fischer.

63. Dr. Healow does not know standards of psychiatry or what a psychiatrist's role is in terms of therapy.

64. Dr. Healow is not aware if "an assessment of the validity eligibility of a [MPAP Program] referral" occurs in each of MPAP's intake interviews as required under MPAP's contract with the Department of Labor.

65. Dr. Healow provides Ramirez with little direct supervision and is infrequently involved in the intake process or aftercare management. Dr. Healow's primary role with respect to Ramirez is to serve as a consultant in cases where Ramirez desires his expert opinion.

66. Dr. Healow is familiar with Dr. Reiss's case and concurred in the monitoring program designed for him. The MPAP contract Dr. Reiss signed is routine and similar to MPAP's standard contract.

67. Dr. Reiss has never complained to Dr. Healow about Ramirez or his MPAP contract. None of Dr. Reiss's supporters contacted Dr. Healow to discuss Dr. Reiss's case.

68. Dr. Healow is familiar with Fischer's letter from September 16, 2008, opining that Dr. Reiss could safely return to work. Testifying as an expert, Dr. Healow challenged that opinion letter because it omitted any diagnosis, any plan for ongoing care, any reconciliation of medications, any mention of Fischer's

experience with physician health, or even what medical records Fischer studied. Dr. Healow opined that currently Dr. Reiss is not fit to practice with reasonable safety and there is no current assurance of competence or public safety.

69. MPAP would not permit an impaired physician to design his own treatment program and discipline. However, if Dr. Reiss were to reapply, MPAP would accept him back and offer him an appropriate monitoring contract.

Healow testified that Dr. Reiss could have chosen not to go through MPAP and instead had the Board manage his case. Healow is either mistaken or was referring to the disciplinary track versus the diversion track. In either case, Admin R. Mont. 24.156.432 provides:

> PROTOCOL FOR SELF-REPORTING TO A BOARD ENDORSED PROFESSIONAL ASSISTANCE PROGRAM
> (1) If a licensee or license applicant chooses to self-report to the board-established professional assistance program, and the professional assistance program has determined that the licensee or license applicant needs assistance or supervision, the licensee or license applicant shall be required to:
> (a) enter into a contractual agreement with the professional assistance program for the specified length of time determined by the professional assistance program; and
> (b) abide by all the requirements set forth by the professional assistance program.

When Dr. Reiss originally self-reported to MPAP in 2007, he was required by the above rule to "enter into contractual agreement with *the* professional assistance program . . ." (Emphasis added). MPAP is *the* professional assistance program. When Dr. Reiss self-reported, he did not have the option of having the Board manage his case, he could only sign a contract with MPAP.

In 2010, Dr. Reiss signed a stipulation in which he agreed to form a new aftercare agreement with MPAP and "scrupulously adhere to its terms." When this settlement was reached, Dr. Reiss was no longer on the voluntary diversion track, he was on the disciplinary track. By entering into the stipulation, Dr. Reiss gave up any rights to have the Board itself manage his case.

E. Robert Caldwell, M.D.

70. Dr. Caldwell graduated from medical school in 1979, completed his psychiatric residency in 1983, and has been licensed to practice medicine in four states. He maintains a Montana license and practices in Helena. Dr. Caldwell is board certified by the American Board of Psychiatry, and certified in addiction medicine by the ASAM, American Society of Addiction Medicine. Dr. Caldwell served on the faculty of the University of California, Davis, and the University of New Mexico.

71. Dr. Caldwell has particular experience in treating health care professionals, having served as medical director of an Oregon facility that specializes in the care of health care professionals. In New Mexico, he served as the medical director of that state's monitored treatment program which is a diversion program similar to Montana's MPAP program.

72. Dr. Caldwell is intimately familiar with the MPAP program. He served two terms on MPAP's board of directors and has treated an MPAP patient in his private practice. Dr. Caldwell is not now affiliated with MPAP.

73. Dr. Caldwell was qualified to testify as an expert in psychiatry, alcohol monitoring, and physician health programs.

74. Dr. Caldwell is familiar with Dr. Reiss's recent treatment. He studied Dr. Reiss's medical records from the Professional Renewal Center, Betty Ford Clinic, and Western Montana Mental Health Center. Other than his role as an expert, Dr. Caldwell has had no relationship with Dr. Reiss.

75. Because physicians minimize symptoms, self-diagnose, and may have greater standing than their providers, physicians are challenging patients. For this reason, it is important for the treating provider to have experience treating physicians.

76. Based on Dr. Reiss's evaluations from PRC and Betty Ford Clinic, Dr. Caldwell opined that Dr. Reiss's ability to practice safely could be impaired by his major depressive disorder, marijuana abuse, and personality disorder.

77. Dr. Caldwell opined that Dr. Reiss's care at Western Montana Mental Health Clinic was not acceptable. His psychiatrist, Dr. Lanes, declared that Dr. Reiss is "ok to practice" after just two sessions with Dr. Reiss. Dr. Reiss's appointments with Dr. Lanes were no longer than 15 minutes. Dr. Reiss testified they were 10

minutes long. Caldwell opined that these sessions were too short to be effective. His therapist, Delbert Fischer, declared that Dr. Reiss was fit to practice after just four sessions.

78. Dr. Caldwell opined that Dr. Reiss's psychiatric care was substandard. Instead of notes related to Dr. Reiss's psychiatric management, the notes refer to Dr. Reiss's struggles with MPAP, and his inability to find an attorney. Dr. Reiss continued to suffer from severe depression without proper medical intervention. Dr. Caldwell further opined:

> Nobody asks why this is occurring. Nobody says, "Maybe the treatment should be different." He's just changed from one SSRI to another.
> It makes no sense. It could be construed as having treatment resistance depression, but nobody treats him like that.
> Nobody offers other treatment strategies, other types of antidepressants, adding other medications that might be expected to have augmenting or boosting actions.
> Question the diagnosis. Nobody does anything. He's just allowed to cruise.
> It is not active treatment.

Tr. 477. L. 10-22

79. Dr. Caldwell opined that Dr. Reiss's counseling by Delbert Fischer was substandard. Fischer accepted Dr. Reiss's statements "at face value" without studying the experts' opinions in the PRC report. Fischer offered sympathy for Dr. Reiss's "supposed plight with getting a raw deal from MPAP." Fischer did not address Dr. Reiss's underlying emotional or mental health issues. Instead, Fischer wrote letters to lawyers and offered empathy to Dr. Reiss. Dr. Caldwell was asked about Fischer's treatment and opined as follows:

> Q. Is that accepted treatment for this case?
> A. No.
> Q. Is it substandard treatment?
> A. It would not be substandard treatment for a different problem. For this problem, it is.

Tr. P. 479 l.16-21

80. Caldwell opined that in four and one-half years of care at WMMHC for depression, Dr. Reiss never attained the goal of sustained remission.

81. Dr. Reiss designed his own treatment team through WMMHC. Based on WMMHC's performance, Dr. Caldwell opined that the Board would be unlikely to accept it as an appropriate substitute for MPAP monitoring under a standard contract.

82. Dr. Caldwell is unable to say whether Dr. Reiss can now safely practice medicine.

F. Bowman Smelko, Ph.D.

83. Dr. Smelko is an experienced and accomplished psychologist, but has no expertise or experience with physician health programs, MPAP, or even Dr. Reiss. His testimony was not persuasive on any relevant issue.

G. Matt Kuntz, J.D.

84. Matt Kuntz, J.D., the executive director of the National Alliance on Mental Illness – Montana, testified in support of Dr. Reiss. While sincere, Kuntz's testimony was based on misinformation presented by Del Fischer and a misunderstanding of MPAP's role, generally, and MPAP's role in Dr. Reiss's case, specifically.

85. Del Fischer recruited Kuntz's assistance through a letter dated October 26, 2011.

86. Kuntz is not a medical professional, counselor, or expert in physician health programs. Kuntz did not suggest that Dr. Reiss is safe to practice medicine.

H. Mickey Boysza

87. Mickey Boysza is employed as a case manager and employment specialist. She is not a mental health professional or a health care provider. Ms. Boysza has no expertise in medicine, mental health, physician health programs, or MPAP.

88. Ms. Boysza was aware of the Board's Final Order suspending Dr. Reiss, but believed her role as an advocate was to "get around" the terms of that Order for Dr. Reiss's benefit.

I. Steve McNeece

89. Steve McNeece is the chief executive officer at Community Hospital of Anaconda whose duties included hiring and firing of physicians. Much of McNeece's testimony lacked credibility especially when it involved the reasons for terminating Dr. Reiss's employment. McNeece's testimony was either intentionally vague or his recall failed him in many instances. Ultimately, most of his testimony was not relevant to whether the Board should reconsider its sanction of Dr. Reiss's license to practice medicine.

What can be gleaned from McNeece's testimony and that of others with knowledge of Dr. Reiss's performance at AMC is that he was doing reasonably well as a physician, he did not always get along with his colleagues, and his background and disorders sometimes led to poor communications with others. McNeece did not like the fact that Dr. Reiss spent time in Anaconda's bars, but the community offered few choices for socialization, especially while Dr. Reiss was on call.

J. Additional Facts

90. While WMMHC has psychiatrists, licensed mental health therapists, and licensed addiction counselors on its staff and is capable of ensuring that Dr. Reiss is regularly tested for marijuana, the expert medical testimony received at hearing indicate without doubt that WMMHC has not successfully treated Dr. Reiss in the four and one-half years Dr. Reiss has been a patient.

91. There is no evidence that care through WMMHC can assure the public that Dr. Reiss is compliant with treatment, regular with his medication, free of chemical abuse, mentally healthy and fit to practice medicine in the State of Montana.

92. Dr. Reiss has failed to present facts that warrant reconsideration of the Board's Final Order and has failed to present an alternative to the MPAP program that would adequately treat his mental health needs and assure the Board and the public that he is safe to practice medicine in Montana.

93. Ramirez cannot presently assure that Dr. Reiss is reasonably safe to practice medicine, and cannot assure that he is currently competent.

94. To assure public safety, Dr. Reiss must have effective monitoring.

95. Dr. Reiss has a long history of depression, including major depression, dysthymia, generalized anxiety disorder, ADHD, obsessive-compulsive disorder, and marijuana abuse. He also has a long history of obtaining treatment for those disorders only to abandon that treatment and relapse. MPAP, with its experience and success, is best poised to oversee Dr. Reiss's long-term treatment to ensure that he continues his medications and therapeutic alliances until the point where competent professionals determine that he is ready to resume practicing medicine. Over the last four and one-half years, Dr. Reiss has essentially designed his own treatment plan which has failed to ensure his ability to safely practice medicine.

96. MPAP and Ramirez have helped numerous physicians, dentists, and other medical professionals recover from their illnesses and regain their practices. This fact was borne out by the testimony of MPAP participants 170 and 205, whose circumstances closely mirror those of Dr. Reiss, and the testimony of Dr. Healow.

97. Caldwell testified that while he is not taking anymore medicare patients, he might consider taking on a physician. Dr. Reiss and Caldwell interacted well at the hearing in this matter.

98. Dr. Reiss is an obviously intelligent man with difficulties that appear to be treatable. Unfortunately, those difficulties, especially when untreated, often cause him to act against his own interests. Dr. Reiss has made his situation worse, but his problems are not insurmountable. Dr. Reiss's difficulties with Ramirez are similar to those which he has had with other professionals. Ramirez has helped many other doctors in similar situations as Dr. Reiss and despite Dr. Reiss's perceptions, working with him and MPAP is his best option. Ramirez told Del Fischer that Dr. Reiss could regain his license to practice medicine by executing a new agreement with MPAP, repaying MPAP any amounts he already owes MPAP, and at some point undergoing another fitness for duty evaluation. Ex. 28. If that option is still available, Dr. Reiss should take it, as he has not proven that the care he has been receiving over the last five years is helping him get better. Nor has he proven that MPAP has failed him or that it is incapable of working with him to help him regain his career.

From the findings of fact above, the hearing officer enters the following.

IV. CONCLUSIONS OF LAW

1. The Board of Medical Examiners has jurisdiction over this matter. Mont. Code Ann. § 37-3-203(1)(b).

2. This matter was properly referred to the Hearings Bureau for a contested case hearing. Mont. Code Ann. §§ 37-1-131(1)(b); 37-1-121(1); 37-3-324.

3. Dr. Reiss was not subject to economic duress when he signed the stipulation that led to the Board's September 21, 2010 order. *Hughes v. Pullman*, 2001 MT 216, P23 (Mont. 2001) aff'd in *Hughes v. Mont. Bd. of Med'l Examiners*, 318 Mont. 181, 80 P.3d 414 (2003).

4. The Board of Medical Examiners is vested with discretion on whether to confirm its existing order or reconsider and take further action on its original final order. Mont. Code Ann. § 37-3-324. *Hughes v. Mont. Bd. of Med'l Examiners*, 318 Mont. 181, 80 P.3d 414 (2003).

5. "To determine which sanctions are appropriate, the board shall first consider the sanctions that are necessary to protect or compensate the public. Only after the determination has been made may the board consider and include in the order any requirements designed to rehabilitate the licensee or license applicant." Mont. Code Ann. § 37-1-312(2). The Board properly placed concerns of public safety foremost when it ordered Dr. Reiss to enroll in MPAP as a precondition to practicing medicine.

6. As the moving party, Dr. Reiss has the burden of persuasion. *Mont. Envtl. Info. Ctr. v. Mont. Dep't of Envtl. Quality*, 2005 MT 96, 112 P.3d 964. Dr. Reiss has failed to meet his burden of proof that the Board's September 17, 2010 Final Order should be overturned or amended.

7. The Board is obligated by statute to "establish a medical assistance program to assist and rehabilitate licensees who are subject to the jurisdiction of the board and who are found to be physically or mentally impaired by habitual intemperance or the excessive use of addictive drugs, alcohol, or any other drug or substance or by mental illness or chronic physical illness." Mont. Code Ann. § 37-3-203(2). MPAP fulfills that obligation.

8. Dr. Reiss has failed to demonstrate an alternative to MPAP that fulfills the Board's duty to assure public safety.

Based on the foregoing Findings of Fact and Conclusions of Law, the hearing officer recommends the following.

V. PROPOSED ORDER

1. Adam Reiss, M.D.'s petition under Mont. Code Ann. § 37-1-314 and/or §37-3-324 for reconsideration of the Board's September 17, 2010 Final Order in this case is DENIED.

2. The Board's September 17, 2010 Final Order remains in full force and effect.

DATED this 18th day of July, 2013.

DEPARTMENT OF LABOR & INDUSTRY
HEARINGS BUREAU

By: /s/ DAVID A. SCRIMM
DAVID A. SCRIMM
Hearing Officer

NOTICE

Mont. Code Ann. § 2-4-621 provides that the proposed order in this matter, being adverse to the licensee, may not be made final by the regulatory board until this proposed order is served upon each of the parties and the party adversely affected by the proposed order is given an opportunity to file exceptions and present briefs and oral argument to the regulatory board.