BEFORE THE BOARD OF MEDICAL EXAMINERS
STATE OF MONTANA

IN THE MATTER OF CASE NO. 2016-MED-LIC-1123 REGARDING:

THE PROPOSED DISCIPLINARY TREATMENT OF THE LICENSE OF NATASHA SHALLOW, MD, Medical Doctor, License No. 50621.	) Case No. 1776-2017)) FINDINGS OF FACT;) CONCLUSIONS OF LAW; AND) RECOMMENDED ORDER

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I. INTRODUCTION

On January 20, 2017, the Department issued a Notice of Proposed Board Action, Summary Suspension and Opportunity for Hearing (Summary Suspension Notice), and served a copy on Natasha Shallow, M.D. The Department amended its Notice on April 7, 2017, and served a copy on Dr. Shallow. In the Notice, the Department asserted that Dr. Shallow is suffering from a psychotic mental health disorder that renders her unable to practice medicine safely, and that Dr. Shallow posed an imminent threat to the health and safety to her patients and the public. Dr. Shallow requested a hearing to contest the proposed disciplinary action against her medical doctor license on April 25, 2017.

The Department transferred the matter to the Office of Administrative Hearings (OAH) for the purpose of conducting the hearing. On May 3, 2017, Dr. Shallow requested the Department use her email for correspondence, and thereafter Dr. Shallow stopped responding to the Board and OAH. On May 3, 2017, the OAH issued a Notice of Hearing and Telephone Conference. On May 11, 2017, the Hearing Officer held a telephonic scheduling conference. The Department attended the conference by phone, but Dr. Shallow was not available at the telephone number she provided. The Hearing Officer left a message on Dr. Shallow's voicemail. The Hearing Officer and Department agreed upon the date of the hearing and other scheduling deadlines without input from Dr. Shallow as she could not be reached by telephone. The subsequent Scheduling Order set a July 17, 2017 hearing. On June 9, 2017, OAH issued a Notice of Reassignment of Hearing Officer and Resetting of Hearing Date. The hearing was rescheduled to July 27, 2017, all other dates in the Scheduling Order remained in effect.

On June 19, 2017, the Department filed a Motion for Rule 36 Admissions, Partial Summary Judgment or Default, as well as a supporting brief. The Department also filed a Motion to Compel Discovery Responses. Dr. Shallow did not file any pre-hearing motions or submit any responses to the Department's motions or discovery requests. The Hearing Officer issued a Notice and Order advising Dr. Shallow to respond to the Motion to Compel and Summary Judgment no later than July 7, 2017. On July 10, 2017, having heard nothing from Dr. Shallow, the Hearing Officer granted the Department's Motion for Rule 36 Admissions, Partial Summary Judgment or Default. The July 27, 2017 hearing was limited to what sanctions, if any, to impose against Dr. Shallow's medical license. Dr. Shallow was given the opportunity to show cause, at the hearing, as to why default should not also be entered in her case pursuant to Mont. R. Civ. P. 55.

On July 25, 2017, two days before the hearing, David Moore contacted OAH, indicating he was the significant other of Dr. Shallow, and explaining that she was in the process of being admitted to a medical facility. Mr. Moore did not provide requested information of his status as her power of attorney, nor did he provide information corroborating that she had been admitted into a medical facility.

On July 26, 2017, Mr. Moore stated Dr. Shallow could not have communication outside the facility where she had been admitted, but soon after that communication, OAH received an email from Dr. Shallow's email account requesting an indefinite postponement. See, August 1, 2017 Post-Hearing Order and Entry of Default.

On July 27, 2017, the Hearing Officer determined that he could not rely on the email purportedly from Dr. Shallow, because it conflicted with the message immediately preceding it. OAH was never provided any reliable information as to Dr. Shallow's whereabouts.

By previous order, the Hearing Officer ordered Dr. Shallow to show cause as to why her default for failure to participate in any way in these proceedings should not be entered. As Dr. Shallow did not appear at the hearing, the Hearing Officer entered Dr. Shallow's default and proceeded with the hearing.

Department's Exhibits 1 and 4 were admitted into the record and are sealed. Exhibits 2 and 3 were not offered. Exhibits 5 and 6 were not admitted but remain sealed. Dr. William Van Cleve and Michael Ramirez testified via Skype video-conferencing. Sarah Braden, LaVelle Potter, and Loretta Bolyard, Ph.D., also testified in person. At the close of the hearing, the Hearing Officer and counsel for the Department agreed that he would submit a proposed decision, including findings

of fact and conclusions of law, no later than September 29, 2017. Dr. Shallow had until October 20, 2017 to respond to the proposed decision. Shallow did not submit a response.

II. FINDINGS OF FACT

1. The Montana Board of Medical Examiners (Board) issued Dr. Natasha Shallow's medical license, license number 50621, on August 15, 2016. Dr. Shallow's medical license is currently suspended.

2. Dr. William Van Cleve (Dr. Van Cleve) is an attending physician at the University of Washington Medical Center. He completed his subspecialty in pediatrics in 2009, and anesthesiology in 2014. Hrg. Tr. at 13:17. He is Board-Certified in both subspecialties. Id. at 14:1. He is also the Associate Program Director of the Residency Program in Anesthesiology at the University of Washington. Id. at 14:6.

3. Dr. Van Cleve has known Dr. Shallow since 2011, when they both began subspecialty training in anesthesiology, which they both completed in 2014. Id. at 14:12. To the best of Dr. Van Cleve's knowledge, Dr. Shallow practices anesthesiology. Id. at 14:18.

4. A colleague of Dr. Van Cleve, Dr. Ronald Pauldine, approached Dr. Van Cleve asking what to do about documents Dr. Pauldine had received from Dr. Shallow. Hrg. Tr. at 16:20. Those documents included a handwritten note to Drs. Kim and Coleman (Ex. 1 at 008) and a letter written by Dr. Shallow to the Chicago FBI. Ex. 1 at 019. The writing in these documents indicated to Dr. Van Cleve that Dr. Shallow was suffering from an uncontrolled mental illness. Hrg. Tr. at 16:25.

5. The documents from Dr. Pauldine included the statement:

> I have been persecuted by a powerful government entity. It appears I have a microchip implanted in me (RFID chip) that occurred after I was drugged and assaulted within the year. It also appears that the chip allows--superhuman--(I know how that reads and how surreal this sounds) control of myself and amazingly those around me.

Ex. 1 at 008.

6. After reviewing these documents, Dr. Van Cleve became concerned for Dr. Shallow's safety and spoke with Dr. Shallow's mother. Id. at 19:6. After speaking with Dr. Shallow's mother, Dr. Van Cleve did not believe Dr. Shallow was receiving necessary treatment for what he believed to be an uncontrolled mental illness. Id. At that point, Dr. Van Cleve was concerned for the safety of Dr. Shallow's patients. Id. at. 19:13.

7. Dr. Van Cleve has frequently had to refer physicians who may be unsuited or unable to practice to Washington State's version of MPAP. Hrg. Tr. at 17. Dr. Van Cleve found Dr. Shallow was living in Montana and he contacted the "Montana physicians health organization." Id. at 19:21 (Subsequent testimony by Mike Ramirez, Director of the Montana Physicians Assistance Program (MPAP), establishes that while Dr. Van Cleve states he contacted the "Montana physicians health organization," he actually contacted MPAP).

8. Several weeks after speaking with Dr. Shallow's mother, Dr. Van Cleve received a letter directly from Dr. Shallow. Hrg. Tr. at 15:23. The letter alluded to the conversation Dr. Van Cleve had with Dr. Shallow's mother and had not discussed with anyone else. Id. at 17:7. This letter was similar to the documents Dr. Van Cleve was given by Dr. Pauldine. Id. at 17:20. Both documents displayed evidence that Dr. Shallow was suffering from a mental health disorder, and alluded to her belief that she was being persecuted and controlled by external forces. Id. The second letter increased Dr. Van Cleve's concerns for Dr. Shallow's safety because it alluded to Dr. Shallow's intent to harm herself if she could not obtain relief from symptoms that were troubling to her.

9. The letter to Dr. Van Cleve included the following statements:

> I am caught in circumstances that make the lay public see 'mental illness', 'acute persona change' Alzheimer's like disease' 'controlled automaton' 'frozen puppet'…when actually all these changes are programmed through RFID, and…
>
> I have nearly 3 months of conditioned info boding bad outcomes for me secondary to an RFID chip in my brain. The bad 'outcomes' include:
>
> Major trauma. Shortened life span, Neurodegeneration, loss of autonomic regulation, loss of coordination, blindness, deafness, etc. This is clearly psychological torture. Is it true? Unclear where rfid chip is, suggestion that in brain (lateral sagittal sinus?) via vasculature. May cause local reaction including inflammation, cancer, hemorrhage, may be adhered. (I know I have

> it. I ring through door sensors at Court Hall, Walmart, and other security systems, never before 1/1/16). I am trying to get it removed covertly.
>
> There is a time to die, even if young. I don't want kept alive against any circumstances listed. My parents aware I have wish for Euthanasia if morbidity occurs soon, but they can't have decision making capacity.

Ex. 1 at 003.

10. After reviewing the letter from Dr. Shallow, Dr. Van Cleve again contacted the "Montana physicians' health organization." Id. at 20:6.

11. An anesthesiologist is responsible for evaluating the health of patients who are presenting for operative or procedural care that requires medications that modify their level of consciousness and treat pain. Hrg. Tr. at 20:24. Anesthesiologists care for those patients during those periods, providing medication and support for their physiology, breathing, circulation, and the medications anesthesiologists give frequently have dangerous effects on those body systems. Id. at 21:1.

12. To function safely, an anesthesiologist must have the ability to evaluate objective evidence; pay close attention to moment to moment, second to second changes in a patient's physiologic state; and the ability to objectively integrate data and make treatment decisions on a very rapid basis.

13. Sarah Braden is the managing paralegal for the Department. Hrg. Tr. at 23:11. After the Screening Panel summarily suspended Dr. Shallow's medical license on January 20, 2017, Mrs. Braden attempted to have notice of that decision personally served on Dr. Shallow through the Cascade County Sheriff's Office. Id. at 24:7. The Sheriff's Office made two unsuccessful attempts to serve Dr. Shallow at her address in Cascade, Montana; one on January 20, 2017, and one on January 23, 2017.

14. After the Sheriff's Office was unable to serve Dr. Shallow, Mrs. Braden mailed the Summary Suspension Notice to Dr. Shallow by certified mail, to her Chicago, Illinois, address on file with the Board, and her Cascade, Montana, address that was listed in documents that were provided to Mike Ramirez by Dr. Van Cleve. Hrg. Tr. at 25:6; see Ex. 1. Dr. Shallow signed the certified mail receipt for the Summary Suspension Notice sent to the Cascade, Montana, address, on February 13, 2017.

15. Dr. Shallow responded to the complaint March 3, 2017. She attached documents to her response, including a discharge summary from Bellin Psychiatric Hospital dated October 11, 2016. Id. at 28:14. The discharge summary indicates Dr. Shallow was prescribed Seroquel. Ex. 4 at 026. In her response, Dr. Shallow states: "I have no psychiatric diagnosis, no ongoing treatments, nor routine medications. . . ." Ex. 4 at 1. Dr. Shallow also states in her response,

> After review of my medical records, you will find I have never and do not currently have an intrinsic so-called 'thought disturbance.' I have been a victim of an outstandingly rare extrinsic cause of thought disturbance.

Id. at 57:24, and Ex. 4 at 002.

16. Dr. Shallow then recommends that the Board begin their own investigation, indicating that it might take them to the "federal level" stating, "THIS PROCESS MAY ENDANGER YOU AND YOUR FAMILIES AS IT HAS MINE." Emphasis in original, Ex. 4 at 002.

17. On April 24, 2017, Dr. Shallow requested a hearing by email to the Department. Id. at 28:17. Dr. Shallow requested in that email, and in her March 2nd response to the Board, to be contacted by email for correspondence. Id. at 29:20.; Ex. 4 at 002. Braden sent every communication and filing to Dr. Shallow's email, return receipt requested, marked urgent, and received notification that delivery of each email was made. Id. at 29:1. Braden does not know whether Dr. Shallow opened the emails. Id. at 29:7. In addition to email service, Braden continued to send all documents and pleadings to Dr. Shallow's physical addresses in Cascade, Montana, and Chicago, Illinois. Id. at 29:9.

18. Loretta Bolyard, Ph.D. is a clinical psychologist. Hrg. Tr. at 30:25. She obtained her doctorate in clinical psychology from the University of Montana in 2011, focusing on the field of neuropsychology. Id. at 31:8. She earned a master's degree in cellular neuroscience in 2010. Id. at 31:11. As part of Dr. Bolyard's doctoral program, she completed a one year clinical internship at the Veterans Administration in Puget Sound from 2010 to 2011, 50 percent of which was spent specializing in assessments. Id. at 31:18.

19. Dr. Bolyard completed two years of post-doctoral training in assessment including 1,600 hours at the Veterans Administration in Seattle, and an additional 3,000 hours under the supervision of a Board-Certified neuropsychologist. Hrg. Tr. at 32:1.

20. Dr. Bolyard has been practicing for six years with 95 percent of her practice focused on psychological and neuropsychological assessment. Hrg. Tr. at 32:16. As a provider for the community, she conducts various assessments for neurologists or primary care doctors. Those referrals tend to be related to brain injuries, dementias, strokes, or differential diagnosis for mental disorders. Id. at 32:22. As a forensic psychologist, she provides guardianship evaluations, fitness to proceed evaluations, or opinions about state of mind. Id. at 33:1.

21. Dr. Bolyard consulted at the Oregon State Hospital for one year providing forensic evaluations for individuals who were committed or adjudicated mentally ill. Hrg. Tr. at 33:13. She worked at the Montana State Hospital for two years providing psychological and neuropsychological assessments and providing group therapy. Id. at 33:21.

22. Dr. Bolyard has performed over 800 psychological or neuropsychological assessments, approximately 200 of which were for individuals who have serious and persistent mental illnesses. Hrg. Tr. at 34:23.

23. Dr. Bolyard has also provided treatment to hundreds of patients suffering from persistent mental illness. Hrg. Tr. at 35:3. While working in the Forensic Unit at the Montana State Hospital, Dr. Bolyard had up to 30 patients on her caseload at all times. Id. at 35:8. Most of those patients had some sort of psychotic disorder, such as schizophrenia or schizo-affective disorder, bipolar, or serious depression, to the point that they were suicidal. Id. at 35:17.

24. Dr. Bolyard reviewed and analyzed Exhibit 1 which includes a letter written by Dr. Shallow to the Chicago FBI, and Exhibit 4 which includes a discharge summary for Dr. Shallow from Bellin Psychiatric Hospital. Hrg. Tr. at 37:8. Dr. Bolyard was not able to meet with Dr. Shallow. Id. at 37:21. This is not uncommon in her practice in the forensic world, nor is it uncommon with fitness to proceed evaluations, guardianship evaluations for the elderly, or parenting evaluations, when individuals flatly refuse to participate. Id. at 38:2.

25. Dr. Shallow began to have the emergence of what appears to be a psychotic disorder as early as October 2014. Hrg. Tr. at 39:22. In documents written by Dr. Shallow she makes references to concerns about her personal safety around October of 2014, and begins to see her neighbors as part of a bigger network of people investigating or spying on her. Id. at 40:12; Ex. 1 at 013, 023.

26. Dr. Bolyard opined that entries from December of 2015, that correspond to a trip to New Orleans, show increased distrustfulness, paranoia, anxiety, and

perceptual disturbances. Hrg. Tr. at 41:2; Ex. 1 at 024. Dr. Bolyard further opined that across the next month, Dr. Shallow begins to decompensate, referring to numerous dark, unmarked, out of state, unlicensed cars following her, regardless of whether she's driving her car or her grandparents' car. Id. at 41; Ex. 1 at 025-027. Dr. Shallow mentions that she continues to encounter odd individuals who seem to be investigating her or gathering information about her, and refers to "neighbors" that appear to be trying to get fingerprints off a key. Id. at 42:5; Ex. 1 at 026.

27. Dr. Bolyard opined that Dr. Shallow begins to show "thoughts of reference" (when one interprets innocuous or coincidental events as being personally relevant to one's self) (Hrg. Tr. at 42:11; Ex. 1), has issues with sleep, and describes vibrating noises and pounding through the wall. Id. at 43:3; Ex. 1 at 025. After what, in Dr. Shallow's timetable, appears to be three days without sleep, Dr. Shallow is referred by the police to the emergency room (Id. at 44:18) and agrees on January 3, 2016 to "go to ER to be admitted to psych hospital for overnight sleep and safety." Ex. 1 at 025.

28. Dr. Bolyard opined that Dr. Shallow exhibited delusional beliefs as evidenced in the letter Dr. Shallow drafted to the Chicago FBI in January 2016. In this letter, Dr. Shallow refers to an "Acute (one month) personal intimidation by a network of harmful people." Hrg. Tr. at 45:4; Ex. 1 at 020. Dr. Shallow also refers to a cyber security breach by the Federal Government and to neuropsychological control. Id. at 45:18.

29. Dr. Bolyard reviewed a discharge summary for Dr. Shallow from Bellin Psychiatric Hospital dated October 11, 2016. Hrg. Tr. at 69:20; Ex. 4 at 026. The discharge summary is incomplete, lacking the purpose of the admission, course of hospitalization, or discharge diagnosis. Id. at 48:3. The summary does show Dr. Shallow had her medication adjusted and was prescribed Seroquel (an antipsychotic medication). Id. at 48:20. Dr. Bolyard also found it significant that the discharge summary included the instructions to seek out psychological treatment upon returning to Montana, and standard recommendations for a "thought disturbance." Id. at 49:2. Those recommendations from the discharge summary include: to have no guns in the home, take all medications, attend follow up appointments, manage illness symptoms, and call the doctor if the voices tell you to hurt yourself or others or if you see things that aren't there. Id. at 49:12; Ex. 4 at 027-028.

30. Dr. Bolyard reviewed a letter written in November 2016 to Dr. Kim and Dr. Coleman. Hrg. Tr. at 49:23; Ex. 1 at 008. Dr. Bolyard opined that Dr. Shallow's writing in this document is highly consistent with active psychosis, and contains

evidence of paranoia, bizarre delusions, thought insertion, thought withdrawal, somatic delusions, and hallucinations. Id. at 50:8.

31. A bizarre delusion is a fixed belief that is not based on reality. Hrg. Tr. at 43:21. Dr. Bolyard opined that Dr. Shallow exhibits a bizarre delusion when she writes to Drs. Kim and Coleman:

> I have been persecuted by a powerful government entity. It appears I have a microchip implanted in me (RFID chip) that occurred after I was drugged and assaulted within the year. It also appears that the chip allows--superhuman--(I know how that reads and how surreal this sounds) control of myself and amazingly those around me.

Id. at 51:11; Ex. 1 at 008.

32. Dr. Bolyard identified other statements in which Dr. Shallow displayed significant symptoms in her handwritten letter to Drs. Kim and Coleman:

> Because there has now been at least a year of neurostimulating effects on my system, there may be effects of removing that stimulator. In short, I may be placed in a triangular type position where I am given the following options:
>
> One, killed;
>
> Two, be disabled (neurodegeneration and die);
>
> Three, made to appear to need psychiatric care for schizophrenia or behavioral changes;
>
> Four, be exploited as a political pawn;
>
> Five, another unknown that I cannot foresee, given that I am not an expert in this military terror technique known as mind control.

Id. at 51:24; Ex. 1 at 009.

33. Thought insertion is a cardinal feature of psychotic disorders such as schizophrenia. Hrg. Tr. at 50:17. A thought insertion is when one has a belief that others can insert thoughts into one's mind. Thought withdrawal is when one has the belief that others can read one's mind or take thoughts out of one's mind. Id. at 50:18. Dr. Bolyard opined that Dr. Shallow exhibits thought insertion and

withdrawal when she writes: "Mind control in my experience can force thoughts in and out of mind. I've made statements my family immediately agrees I would never think, say, or act on." Id. at 52:23; Ex. 1 at 012.

34. A somatic delusion is the false belief that one's body has become abnormally diseased, or abnormally changed in some way. Hrg. Tr. at 53:10. Dr. Bolyard opined that Dr. Shallow exhibits somatic delusions when she writes:

> I have multiple involuntary neurological symptoms, twitching and movement of all face, movement of hands and limbs, autonomic changes such as heart rate, breathing pupils, lacrimation, urination/defecation, ejaculation; my adrenergic tone seems disruptive.

Id. at 54:16; Ex. 1 at 012.

35. Dr. Shallow exhibits auditory hallucinations, another cardinal symptom of schizophrenia, when she writes, "I have the beeping in my ears and static that comes from my head. Sounds like a radio is playing . . . ." Hrg. Tr. at 54:15; Ex. 1 at 012.

36. Symptoms of paranoia, bizarre delusions, thought insertions and withdrawals, somatic delusion, and hallucinations are characteristic of schizophrenia. Hrg. Tr. at 54:6.

37. Dr. Shallow's letter to Dr. Van Cleve indicates symptoms of schizphrenia:

> I have nearly three months of conditioned info boding bad outcomes for me secondary to an RFID chip in my brain. The bad outcomes include major trauma, shortening life span, neurodegeneration, loss of autonomic regulation, loss of coordination, blindness, deafness, etc. This is clearly psychological torture. Is it true? Unclear where rfid chip is, suggestion that in brain (lateral sagittal sinus?) via vasculature. May cause local reaction including inflammation, cancer, hemorrhage, may be adhered. (I know I have it. I ring through door sensors at Court Hall, Walmart, and other security systems, never before 1/1/16). I am trying to get it removed covertly.

Hrg. Tr. at 55:9; Ex. 1 at 003.

38. Dr. Bolyard also reviewed Dr. Shallow's response to the complaint in which Dr. Shallow states, "I have no psychiatric diagnosis, no ongoing treatments, nor routine medications . . . ." Hrg. Tr. at 57:18; Ex. 4 at 1. In the same correspondence she states:

> After review of my medical records, you will find I have never and do not currently have an intrinsic so-called 'thought disturbance.' I have been a victim of an outstandingly rare extrinsic cause of thought disturbance.

Id. at 57:24; Ex. 4 at 2.

39. In her response to the Board, Dr. Shallow recommends the Board begin its own investigation, indicating that it might take them to the "federal level" and further states, "THIS PROCESS MAY ENDANGER YOU AND YOUR FAMILIES AS IT HAS MINE." Emphasis in original, Hrg. Tr. at 58:4; Ex. 4 at 2. This statement was significant to Dr. Bolyard because it speaks to Dr. Shallow's ideas of paranoia, suspiciousness, and feeling as though she is being persecuted (Id. at 58:20) and indicates that Dr. Shallow's reality is compromised by delusion. Id. at 58:22.

40. Dr. Bolyard opined that throughout 2016 there was a clear decompensation in Dr. Shallow's mental state. Hrg. Tr. at 59.16. Dr. Bolyard opined that in November, possibly later, Dr. Shallow was acutely psychotic, paranoid, suspicious, hallucinating, and not sleeping. Dr. Bolyard was most alarmed by Dr. Shallow's present lack of insight into the severity of her illness. Id. at 59:23.

41. The lack of insight is a cardinal feature of schizophrenia and one of the biggest obstacles to providers attempting to treat that schizophrenia. Hrg. Tr. at 60:1. Dr. Bolyard explained that providers can stabilize patients in the hospital, but those patients often discontinue needed medication after returning home due to unwanted significant side effects. Id. Such patients, who lack insight into their illness, can become "frequent flyers," going in and out of the hospital many times in a year. Id. at 60:12. Dr. Bolyard testified that multiple hospitalizations in a year can lead to a guarded prognosis, and there is some emerging evidence indicating repeated relapses can cause changes in the brain leading to long-term consequences such as higher risk for dementia. Id. at 61:1.

42. Dr. Bolyard testified to a reasonable degree of medical certainty Dr. Shallow suffers from a psychotic disorder. Hrg. Tr. at 61:13. Dr. Bolyard is hesitant to name that psychotic disorder because she has not met with Dr. Shallow, but can say that Dr. Shallow presents similarly to individuals who suffer from schizophrenia or schizo-affective disorder. Id. at 60:14.

43. Dr. Bolyard further opined Dr. Shallow has a mental disability that renders her unable to practice medicine with reasonable skill and safety. Hrg. Tr. at 61:24.

44. Dr. Bolyard opined Dr. Shallow presents a great threat to the safety of the public for the foreseeable future in her current state. Hrg. Tr. at 62:3.

45. Dr. Bolyard testified she is particularly worried about Dr. Shallow practicing the specialty of anesthesiology as it is described by Dr. Van Cleve. Hrg. Tr. at 62:23. Dr. Bolyard testified that schizophrenia is thought to be a disorder of the frontal lobe (the part of the brain that is responsible for organizing, planning, reasoning, problem solving, and preventing any sort of impulsive action). Id. at 62:17. Dr. Bolyard testified she worries about Dr. Shallow's ability to act on her feet on a moment to moment or second to second basis, especially should she experience breakthrough psychotic symptoms at the same time. Id. at 62:22.

46. Michael Ramirez is the Clinical Director of MPAP. Hrg. Tr. at 70:18. MPAP was created to serve two roles: first, to protect patients and the public from practitioners with conditions that if left untreated may impair their ability to practice with skill and safety; and second, to provide a forum for the rehabilitation of those practitioners. Id. at 72:3; see Mont. Code. Ann. § 37-3-203(2)(a).

47. Mr. Ramirez holds a Master of Science Degree in Rehabilitation Counseling from Eastern Montana College (now Montana State University Billings). Id. at 71:3. He is a member of the Federation of State Physician Health Programs, and serves as a board member and member of the ethics committee for that organization. Id. Ramirez has served as Clinical Director of MPAP for 22 years.

48. Ramirez has supervised approximately 2,000 cases dealing with physicians. Hrg. Tr. at 71:11. While MPAP was primarily created to address substance use related disorders, about 60 percent of MPAP's cases involve co-morbid clinical conditions, which were formerly designated Axis I. Hrg. Tr. at 71:16. About 15 to 18 percent of MPAP's caseload has dealt with primary clinical disorders other than substance use, such as: mood disorder, thought disorder, and/or personality disorder. Id. at 71:20.

49. MPAP's process has several components: intervention; referral for evaluation and/or treatment; reintegration and reentry; and advocacy on the bases of a practitioner's performance in monitoring. Hrg. Tr. at 72:16.

50. Once a decision to proceed with intervention is made, Ramirez assembles an intervention team with the idea of approaching the practitioner in a respectful way, to provide for their safety, and to try to get the practitioner to see that it is in their best interest to go along with what is being suggested. Hrg. Tr. at 72:24.

51. In the referral phase, MPAP seeks to establish qualifications or criteria for evaluation and/or treatment providers. Hrg. Tr. at 74:12. The evaluation usually involves a multidisciplinary team that is experienced in evaluating high functioning health professionals and understands and accepts the fiduciary responsibility the Board has in determining fitness to practice. Hrg. Tr. at 21. Evaluators must also understand the Board's need for reliable information and timely information with which to make an informed decision regarding safe return to practice. Id. at 75:1.

52. A fitness to practice evaluation is very specialized and must factor in the essential functions of the job for physicians delivering care. Hrg. Tr. at 75:20. Those performing a fitness to practice evaluation for a physician must know a great deal about the physician's specific practice and understand the unique challenges in dealing with this high-level practitioner. Hrg. Tr. at 76:18.

53. In order to assist and monitor reentry into the workplace, MPAP first evaluates the extent to which a practitioner has met its standard of care with respect to evaluation and treatment. Hrg. Tr. at 79:1. Then MPAP incorporates evaluation recommendations into a continuing care plan that defines minimum acceptable requirements to safely return to practice. Id. at 79:6. A continuing care plan defines conditions such as: frequency of follow up with a treating professional, contingency for reporting of decompensation, quarterly surveillance reporting from a monitoring network (which includes a workplace monitor and professional monitor), and an agreement to take medication as prescribed. Id. at 79:9.

54. Once a practitioner has done what is necessary to be safe, MPAP will advocate on his or her behalf to the Board, credentialing bodies, hospitals, medical staffs, specialty boards, insurance companies, and other entities. Hrg. Tr. at 81:22. Mr. Ramirez was unable to provide these services to Dr. Shallow. Hrg. Tr. at 82:12. After reviewing written information indicating Dr. Shallow was paranoid and delusional, he contacted Dr. Shallow's mother before trying to reach Dr. Shallow directly. Id. at 82:20. Ramirez then called Dr. Shallow directly and left messages for her. Id. at 83:24. After receiving no response from Dr. Shallow, Mr. Ramirez checked with the hospital in Great Falls and learned that Dr. Shallow had privileges there. Hrg. Tr. at 84:9. Ramirez then filed a complaint with the Board to protect public safety. Id. at 84:15. That written complaint, in the form of a letter to the Board, is included in Ex. 1. Id. at 86:10.

55. To ensure the safety of Dr. Shallow's future patients, MPAP would need the ability to refer Dr. Shallow for a biopsychosocial multidisciplinary evaluation that involves: psychiatry, psychology, psychometric testing, and clinical interview, from a qualified facility. Hrg. Tr. at 86:22. Ramirez identified the Menninger Clinic

Professionals in Crisis Program in Houston, Texas, as one such qualified facility. Id. at 87:15. Ramirez testified that Dr. Shallow could not practice while obtaining this evaluation. Id. at 87:19. MPAP would need the authority to: craft an agreement with Dr. Shallow, compel compliance, and to change that agreement as circumstances require. Id. at 89:10. Dr. Shallow's return to medical practice would need to be conditioned on the full support of MPAP, and continued practice would need to be conditioned on the continued support of MPAP and her compliance with recommended treatment. Id. at 89:19.

56. LaVelle Potter has been a Compliance Specialist for the Montana Department of Labor and Industry for the past 20 years. Hrg. Tr. at 96:23. She processes complaints from their inceptions to the Screening Panel, and ultimately to the Adjudication Panel where sanctions are determined. Id. at 97:4. Mrs. Potter has witnessed the Board decide sanctions in cases where a licensee has been found to have a disability that renders them unable to practice with reasonable skill and safety (Id. at 97:9) and where the specific disability is a mental illness. Id. at 97:14.

57. In two recent cases dealing with mental illness, the Board indefinitely suspended the physicians, and set conditions for them to meet before being allowed to apply to have the suspension lifted. Id. at 97:25. One condition was that the physician have the support of MPAP in order to petition the Board to have the suspension lifted. Id. at 98:4. The Board has also applied conditions to a physician's continued practice once their licensure is reinstated, through mandatory agreements with MPAP. Id. at 98:16. MPAP is also given the ability to change conditions as circumstances change, either through the Board and/or through the MPAP contract itself. Id. at 98:22.

III. CONCLUSIONS OF LAW

1. The Board has subject matter jurisdiction and legal authority to bring this contested case under Mont. Code Ann. § 37-1-131, 37-1-136, 37-1-307, 37-1-309, 37-1-312, and Title 37, chapter 3.

2. The Department bears the burden of proving by a preponderance of the evidence that the licensee committed an act of unprofessional conduct. Ulrich v. State ex rel. Board of Funeral Service, 1998 MT 196, 289 Mont. 407, 961 P .2d 126.

3. The Department must also show that any sanction which it seeks is appropriate under the circumstances of the case.

4. The Hearing Officer may use his or her experience, technical competence, and specialized knowledge in evaluating the evidence. Durbin v. Ross, 276 Mont. 463, 476-77, 916 P.2d 758, 766 (1996); Mont. Code Ann. § 2-4-612(7).

5. Upon a decision that a licensee has violated Title 37, chapter 1, part 3 of the Mont. Code Ann. or is unable to practice with reasonable skill and safety due to a physical or mental condition, the Board may issue an order imposing sanctions, including license revocation. Mont. Code Ann. § 37-1-312. "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." Id.

6. The board 's summary suspension of Dr. Shallow's license to practice medicine was proper. Mont. Code Ann. § 2-4-631.

7. Dr. Shallow has committed unprofessional conduct as defined by Mont. Code. Ann. § 37-1-316(11) by "having a physical or mental disability that renders the licensee or license applicant unable to practice the profession or occupation with skill and safety"; and, discipline of Dr. Shallow's medical license is appropriate in this contested case pursuant to Mont. Code Ann. § 37-1-312. Imposing substantial sanctions is necessary in this contested case to protect the public.

8. Montana Code Annotated § 37-3-203(2)(a) provides:

> The board shall 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.

IV. RECOMMENDED ORDER

Based on the foregoing findings of fact and conclusions of law, the Hearing Officer recommends:

1. That Dr. Shallow's license to practice in the state of Montana be indefinitely suspended.

2. That Dr. Shallow shall complete each of the following conditions, timely and completely, to the sole satisfaction of the Board or its designee:

a. Dr. Shallow shall surrender her Montana medical license within 24 hours of receiving notice of the Board's Final Order. Mont. Code Ann. § 37-1-312(4). The license shall be sent to:

Montana Department of Labor and Industry
Attn: LaVelle Potter, Compliance Specialist
Board of Medical Examiners
P.O. Box 200514
Helena, MT 59620-0514

b. To be eligible to petition the Board to lift the suspension and return to the active practice of medicine, Dr. Shallow must have the advocacy of the Montana Professional Assistance Program (MPAP), undergo all recommended evaluations, successfully complete all recommended treatment, and be fully compliant with all resultant aftercare contracts.

c. Dr. Shallow must scrupulously adhere to the terms of her MPAP Continuing Care Agreement as it may be amended from time-to-time in the professional judgment of the program or its successor. Any violation of this term shall be deemed a material breach of this Order and grounds for a new unprofessional conduct complaint under Mont. Code Ann. § 37-1-316(8).

d. To return to the practice of medicine, Dr. Shallow shall be required to petition the Board and present sufficient proofs and to comply with certain conditions as may be required by the Board in its discretion at the time of her petition for reinstatement.

e. In order to petition for reinstatement in the future, Dr. Shallow must, in the interim, renew her suspended license or it will lapse, expire, and terminate. Admin. R. Mont. 24.101.408. Should the license terminate, Dr. Shallow would not be eligible for reinstatement and would have to apply for licensure as a new applicant.

3. The Board shall consider any reapplication submitted by Dr. Shallow pursuant to Mont. Code Ann. § 37-1-314 and Admin. R. Mont. 24.159.1253. The

Board may deny Dr. Shallow's reapplication or accept it (with or without restrictions, limitations, or conditions).

DATED this 1st day of November, 2017.

DEPARTMENT OF LABOR & INDUSTRY
OFFICE OF ADMINISTRATIVE HEARINGS

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.