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Sham Diagnosis Is Sham Peer Review's Evil Twin

Dr. Lawrence Huntoon succinctly delineates one of sham peer review's lethal mechanisms: National Practitioner Data Bank (NPDB) reporting.[1]

The effect of NPDB reporting is comparable to being wrongfully placed on the national sex offender registry. One's defense is a protracted and costly ordeal and generally futile. Litigation entails confronting a rigged prosecution and a court that operates under the Health Care Quality Improvement Act's (HCQIA's) cloak of immunity. The effects are dire: permanent reputation damage; psychological devastation; career derailment; loss of means of livelihood, frequently accompanied by family and community disruption; professional bankruptcy and even complete destitution.

Dr. Huntoon rightly emphasizes the psychological damage as one of the most crippling aspects. Dr. Jonathan Shay's concept of "moral injury" describes the debilitating embitterment and new or aggravated emotional illness that ensues when one has been betrayed so profoundly by peers in an unjust system.[2] Even if there were a professional pathway forward, the cynicism, avoidance, and despair resulting from such unfairness leaves nearly all physician victims professionally and psychologically crippled.

We must educate the physician community about these paired pernicious phenomena, which are effectively concealed from scrutiny behind the dual protections of immunity and the false banner of "protecting patient safety. "While HCQIA proposes the reassuring aspiration that peer review will be conducted with due process and without hostile animus, a study of case decisions indicates that these are dangerously false assumptions. Power players in the medical world have found ways to conceal their sometimes vicious motives and their dishonest means of orchestrating sham peer review. Worse, as these court decisions indicate, even hostile motive doesn't disqualify the unfair process.

There's a similarly reprehensible pattern in so-called physician health programs (PHPs) operating under the pretense of being legitimate psychiatric entities that assess allegations of impairment. We have postulated that PHPs operate collectively with medical licensing boards (MLBs) and peer review entities as a virtual "medical regulatory therapeutic complex."[3] Monopolistic PHPs, often funded through licensure surcharges by medical boards and hospitals, conduct medical board- or hospital employer-ordered psychological fitness-for-duty exams. Often unlicensed and not adhering to essential diagnostic criteria, they may assert de novo the existence of a substance abuse, mental illness, or characterological diagnosis that is alleged to be potentially impairing and that could jeopardize patient care. The correspondence between potential impairment and documented substandard care is rarely substantiated. The invoked moral panic is as contrived as the diagnosis.

This sham diagnostic process (frequently erroneously designated as "peer review") is conducted in an environment devoid of due process, governmental oversight, and medicolegal accountability. It frequently employs laboratory tests impermissible for these purposes, as the Substance Abuse and Mental Health Services Administration (SAMHSA) has explicitly stated, thus recruiting a presumptively legitimate scientific laboratory process into its sham diagnostic racket. Evidence strongly suggests that there is rampant abuse of such testing, whose inflated costs are borne by the subject physician. Physicians are routinely denied access to their own PHP files in order to contest a false diagnosis, yet they may then be ordered to submit to a costly extended evaluation, treatment, and monitoring scheme under the guise of "protecting the public" or be reported to the medical licensure board for noncompliance and then to the NPDB for resultant license or privilege restriction. Compulsory referral, also without any grievance mechanism, is imposed through exclusive use of PHPs' network of privately owned "preferred programs." Here too the network inclusion criteria remain obscure, as do the effectiveness and patient satisfaction

criteria. Throughout, independent qualified professional consultation and independently chosen assessment and treatment alternatives are rejected.

Dr. Wes Boyd, a knowledgeable vocal critic of PHPs' unethical operation, recently labeled this well-coordinated scheme "extortion."[4]

For several years now, we have focused on PHPs' use of so-called fitness-for-duty exams and costly four-day evaluations compulsorily funneling physicians into costly non-insured lengthy treatment and extended monitoring, derailing the physician's career with false diagnoses and unfounded assessments of impairment and patient risk. The parallels to the sham peer review cascade and its adverse career impact are striking. But the psychological trauma and moral injury are possibly even more crippling. Even if one were to emerge from this fraudulent system after years of duress and hundreds of thousands of dollars in costs, the coerced acceptance of sham diagnosis and treatment almost inevitably produce post-traumatic stress disorder (PTSD) and lifelong embitterment.

Whatever the hostile motivation, whether sham peer review or sham diagnosis, we must redouble our efforts to confront such heinous behavior. It is antithetical to our core values as professionals devoted to healing and as citizens entitled to fairness to permit a system that intentionally inflicts such irreparable psychological and occupational harm on colleagues. We must push for laws to protect physicians from this abuse and hold individuals and institutions accountable for participating in such reprehensible behavior.

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Sham Peer Review

We appreciate Dr. Lawrence Huntoon's further elaboration of the varied tactics of sham peer review (SPR).[1] We continue to experience the identical unjust tactics that make all Australian Health Registrants vulnerable to regulatory and political abuse discussed earlier by Ng et al.[2]

In Australia, the standard of proof differs between civil and criminal matters with the former based on the "balance of probabilities" and latter on "beyond reasonable doubt." However, in the issues of Briginshaw High Court case,[3] the civil standard of proof applied was higher than just a "mechanical comparison of probabilities" but "an actual persuasion of its occurrence."

In our view, this higher level of persuasion is more appropriate in adjudicating health-related cases. However, the evidence-based Briginshaw standard is valid only for courts, and not for the panels and tribunals that currently are mainly used for health registrants, and where far too frequently inexact proof (i.e. evidence and irregularities otherwise not admissible or allowable in courts) prevails.

On this basis, we feel that administrative and/or extra-judicial summary suspension of registrants (including Dr. Leong Ng) based on the "reasonable belief" of a regulator, is unwarranted. As with any ad hoc administrative, non-evidence-tested suspension, the public may perceive the action as a deliberate "blacklisting," which can adversely affect the suspended registrant for life. It smacks of an intentional deeply ingrained bullying culture directed at registrants, which aims to circumvent the applicable law and rules of justice for the expedience of the regulator.

We report that despite his recent suspension and restoration, Dr. Ng has maintained his innocence, and the published conclusion is misleading. The onerous undertakings were sufficient to retire his practice in Australia.

In Australia it is routine for state and federal governments to insist that forms must be filled for any registrant's application for any appointment, which include questions on any suspension that has taken place. This is the Australian equivalent to the U.S. Health Care Quality Improvement Act of 1986 (HCQIA), and it has the same negative effect as the National Practitioner Data Bank (NPDB) in the U.S.

The failure of the Australian health regulator to properly adopt natural justice and the Briginshaw standard of proof in all stages of all matters is the root cause of SPR. This long-standing civil standard in law is increasingly ignored and/or challenged.[4] Injustices in Australia resulting from disregarding rules of evidence parallel the 2007 change in law in the UK,[5] which has resulted in a massive dysfunctional "knee-jerk" response to the unrelated Bristol paediatric surgical deaths[6] and the Dr. Harold Shipman debacles two decades ago.[7]

SPR is still widespread in Australia and bears a remarkable similarity to that present in many jurisdictions internationally. Australia has an additional challenge with its continued dependency on overseas-trained doctors.[8] So far, no official study has been performed on the prevalence of SPR on these doctors though plenty of anecdotal evidence exists.

SPR is one of the many issues that negatively affect the Australian national health system. Justice for registrants has fallen apart in major aspects.[9] For this reason, we have made the following public statement: "It is time for a Royal Commission into healthcare, to seriously analyse our health care problems from top to bottom, in the most transparent and fair dinkum [transparent and honest] way for all health professionals, and to seriously reform the healthcare system in our nation."

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[References at end of section]

As former long-time credentials chair at a major U.S. academic institution both before and after enactment of the HCQIA of 1986, I can confirm that the effect of an adverse action report (AAR) in the NPDB is exactly as described by Dr. Huntoon.[1] This effect is well known to health and hospital administrators, and used to their advantage both in litigation and in separation negotiations.

And yet, there is "plausible deniability" of the effect of NPDB reporting because it is so common in the medical malpractice arena, where it quite often means literally nothing. Nonetheless, I have certainly seen NPDB reports of trivial settlements in spurious cases being used against physicians who

dared to question a sham peer review.

As discussed in a recent op-ed[10] on the rampant expansion of the field of hospital administration, it seems obvious that among other health administrative growth enhancers, the HCQIA is a most potent form of Miracle-Gro. And unfortunately, many physicians have been treated with "gRound Up." Ironically, the exact same tactics are regularly used by hospitals and health systems against whistleblowers as are used by DuPont, Monsanto, big tobacco, big pharma, and other industry giants, here to bully and to financially devastate physician litigants. And given the very clear identification of physicians with their ability to practice the profession of healing, alongside the death knell of an NPDB adverse action report (AAR), it is not at all surprising that physician suicides regularly occur in the face of such financial and emotional devastation.

By way of the HCQIA, health and hospital administrators have been given a virtual license to kill—and even a cover story: it is all being done in the name of "patient safety."

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After reading Dr. Huntoon's latest essay on sham peer review,[1] asserting the obvious harm caused by SPR and malicious discipline that results in reports to the National Practitioner Data Bank, I compiled an archive of earlier essays and video presentations, posted at https://aapsonline.org/sprarchive/, for the benefit of interested lawyers and physicians.

I appreciate Dr. Huntoon's insight into the Stalinist methods that are now running amok in hospital organizations due to the political and economic problems created by corporate "healthcare" organization dominance, including Accountable Care Organizations (ACOs), physician employment, aggressive hospital administrations, a failed legal system in matters of medical professional discipline, and peer review that denies physicians due process and fairness.

I am grateful for the advocacy AAPS offers on behalf of physicians in a jungle created by medical regulations and a hostile corporate environment.

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Further Evidence of Ulterior Motives of Environmentalist Activists

Negative space is a concept well known to artists and is defined as the space not comprising objects, but around and between objects. M. C. Escher and other artists used this concept in many of their works.

The concept applies also to the critical assessment of professional literature. Look not only at what is published, but also at what is not published. The gaps in published analysis, the finding of nothing when one can reasonably expect to find something, tell a very important story.

In the excellent editorial "The Physician and 'Climate Change,'" [1] physician activists who allegedly seek a more environmentally friendly profession are described as arguing for reducing energy use and toxic emissions. Temporarily accepting their premise as correct—that energy conservation and toxic waste control should be improved—there is an obvious blank space in the professional literature.

Infections have been deadly in prior centuries, and the use of sterilization and hygiene have dramatically improved survival from surgical procedures and from severe illnesses. But in recent decades, there have been advances in metallurgy and in plastics that suggest that much of the solid medical waste that is discarded out of concern for infection control can be sterilized and reused safely. A strong sterilizing solution that would corrode all metal and dissolve all plastic in a former era might work perfectly on new alloys and plastics, allowing the safe reuse of respiratory tubing, catheters, and other allegedly disposable devices.

I am not aware of any research on converting the disposable to the reusable, even though benefits to the environment would exist due to a lesser quantity of solid goods manufactured for the same health benefit. Additionally, transport of such goods from manufacturer to patient and from patient to landfill would be lessened if such research were to become successful, reducing energy use.

Environment activists, therefore, are not primarily interested in protecting the environment and in conserving energy. They seem to prefer to impose barriers to the simple process of providing medical care, diverting attention from the irreducible problems of how to diagnose patients and treat them when the diagnoses become known, and diverting attention to any available paradigm for creating complications and thereby calling attention to themselves.

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