

Sham Peer Review: Abuse of Consensus and Clinical Practice Guidelines

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Clinical practice guidelines (CPGs) are pervasive in medical practice today. CPGs were originally intended to reduce variations in care and to improve quality of care, based on best evidence. However, widespread conflicts of interest have corrupted guidelines to serve cost containment, profit maximization, and political purposes. CPGs also may contain contradictory recommendations, and are often misrepresented as the standard of care.

Hospitalists, in general, have embraced CPGs as they make “assembly line” workers more efficient. Hospitalists are “shift workers” who are often incentivized to maximize “production” (Resource-Based Relative Value Scale, RBRVS) units. Plugging a patient into a CPG protocol requires less thought and time for the physician, and eliminates unproductive time spent taking the patient’s individual circumstances, conditions, and needs into consideration so as to provide optimal care.

CPGs are also heavily used by mid-level employees (e.g., nurse practitioners), who do not possess the same knowledge, training, and experience as physicians.

Hospitals that conduct sham peer reviews have become adept at misusing CPGs to prosecute adverse actions against physicians’ privileges. These hospitals will routinely misrepresent consensus and CPGs as the “standard of care.” Hospitals that conduct sham peer reviews will routinely hire experts who will testify that the accused physician failed to provide care consistent with the consensus, as viewed by the expert, in the particular specialty. The expert will then equate consensus and CPGs as the standard of care and conclude that the accused physician did not meet that standard.

Prominent, innovative physicians have often been attacked and ruined via sham peer review. The history of medicine is replete with physicians who were subjected to sham peer review for their innovative ideas that turned out to be right.

The Ignaz Semmelweis Story

Dr. Ignaz Semmelweis was a Hungarian physician who was appointed to the obstetric clinic in Vienna in the mid-1800s.¹ Puerperal fever (childbed fever) was a severe problem at the time, with mortality rates averaging 25 to 30 percent.¹ Dr. Semmelweis observed that the maternal mortality rate was far lower in the section of the clinic where midwives delivered babies compared to the section of the clinic where physicians and medical students delivered babies.¹ He further observed that the maternal mortality rate increased following a policy change whereby medical students and obstetricians were mandated to perform autopsies on mothers who had died of puerperal fever. It was common practice in those days for medical students and attending physicians to go directly from the autopsy table to the delivery room. Surgical gloves were not invented yet, and all procedures were done with bare hands.²

Based on his observations, Dr. Semmelweis hypothesized that physicians and medical students who went directly from the autopsy table to the obstetric clinic were carrying to healthy mothers some type of agent (“cadaverous particles”³), which caused

them to become ill. Dr. Semmelweis set out to determine the cause. His investigation met with strong opposition from the chief of obstetrics, who, “like other continental physicians, had reconciled himself to the idea that the disease was unpreventable.”¹

The well-accepted consensus at that time was that puerperal fever was due to the “corrosive effects of bad air” (miasma).³ Bloodletting was considered to be the standard of care, though it did not cure the illness.²

Dr. Semmelweis tested his hypothesis by requiring physicians and medical students to wash their hands in chlorinated lime before attending mothers in the maternity ward.¹ The hand-washing procedure caused the maternal mortality rate to dramatically decrease from 18.27 percent to 1.27 percent.¹ During March and August 1848, there were no deaths from childbed fever in his division of the maternity ward.¹

Senior physicians were outraged and indignant that Dr. Semmelweis would suggest that the “unholy” hands of “holy” physicians were responsible for the deaths of mothers.² Senior physicians working at the clinic rejected and ridiculed the idea of handwashing because they considered “the grime and gore coating their hands a sign of their diligence and hard work.”³

In retaliation for being upstaged by Semmelweis’s remarkable discovery, and for certain political reasons, the chief of obstetrics refused to reappoint Semmelweis to the obstetrics clinic.³ Dr. Semmelweis subsequently worked for about 6 years at St. Rochus Hospital, where his hand-washing procedure reduced the maternal mortality rate to 0.85%.¹ In comparison, the mortality rate in Prague and Vienna at that time was 10 to 15%.¹

In 1861, Dr. Semmelweis published his groundbreaking work, “The Etiology, Concept, and Prophylaxis of Childbed Fever.”¹ His paper was soundly rejected both in Hungary and abroad. The editor of the journal that published his article wrote that “it was time to stop the nonsense about the chorine hand wash.”¹ Also, “at a conference of German physicians and natural scientists, most of the speakers—including the pathologist Rudolf Virchow—rejected his doctrine.”¹ When Dr. Semmelweis presented his findings to the physicians of Vienna, he was “rejected, ridiculed and shunned.... His ideas were met with hostility and openly mocked.”⁴

Dr. Semmelweis became increasingly frustrated, depressed, humiliated, angry, and bitter.¹ He often referred to those who refused to wash their hands before delivering babies as “ignorant murderers.”⁴ This undoubtedly did not endear him to his detractors.

The “peer review committee” of the day (his hostile colleagues) launched a plan to trick Semmelweis in to going to the “physician health plan” of the day—an insane asylum. By the time Semmelweis realized what they were doing, it was too late. When he attempted to leave, he was taken by the guards and confined in the asylum.¹

In the asylum, the “clinical practice guideline” of the day was administered. He was severely beaten, “doused with cold water and force-fed laxatives.”⁴ While defending himself from a beating, he suffered a wound on his hand which became infected and gangrenous, and he died two weeks after entering the asylum at

age 47.⁴ Ironically, he saved many lives by reducing infections and died of an infection that was a “side effect” of his “treatment” in the asylum.

On Nov 7, 1969, the Semmelweis University of Medicine was named after the “savior of mothers,” Ignaz Semmelweis. And, in the late 1990s, it was renamed Semmelweis University.⁵

The Michel Mirowski and Morton Mower Story

In 1969, working in the basement of Baltimore’s Sinai Hospital, doctors Michel Mirowski and Morton Mower set out to develop an implantable cardioverter defibrillator device (ICD).⁶ Colleagues at the time considered the idea to be sheer lunacy.⁶ “Bernard Lown, a renowned Harvard University cardiologist, denounced the idea in a 1972 medical-journal article and warned that the device might electrocute people.”⁶

The consensus of colleagues at Sinai Hospital was that these innovators were “crazy.” In a 2015 interview with *The Lancet* medical journal, Dr. Mower said, “It was the talk of the whole hospital that these two crazy guys are going to put in an automatic defibrillator.”⁷ He also told *The Lancet*, “We were these two crazy guys who wanted to put a time bomb in people’s chests, so to speak.”⁶

Their “crazy” idea was soundly rejected by peer-reviewed medical journals. “Convincing the cardiology community was even harder; manuscripts were routinely rejected by specialists in the field, and experts scoffed at the idea.”⁸

The medical elites of the day, holding fast to the consensus that such an implantable device would pose an imminent danger to patients, did their best to discredit Dr. Mirowski and Dr. Mower. Had these two physicians been practicing in one of today’s hospitals that use sham peer review to end the careers of innovative physicians who challenge the “accepted” consensus, “hundreds of thousands, if not millions, of lives” which have been saved would have been lost.⁶

In 2002, these two physicians, along with two other colleagues who helped develop the ICD, were inducted into the National Inventors Hall of Fame.⁸ In 2005, Baltimore’s Sinai Hospital named a medical office building after Dr. Mower.⁷ The medical elites, who did their best to discredit Dr. Mirowski and Dr. Mower, as in the Semmelweis case, deserve to be in the “Hall of Shame.”

Abuse of Consensus Continues during COVID Era

Unfortunately, abuse of consensus and accompanying rejection and corruption of science has continued during the COVID era.

Recently, it was revealed that four top U.S. health officials, Dr. Anthony Fauci, Dr. Vivek Murthy, Dr. Rochelle Walensky, Dr. Francis Collins, and the White House vaccine coordinator, Dr. Bechara Choucair, met in secret behind closed doors with four other invited experts in October 2021, to determine official COVID vaccination policy and the impact of natural immunity.⁹ The *Epoch Times* reported:

The discussion didn’t lead to a change in U.S vaccination policy, which has never acknowledged post-infection protection. Fauci and other U.S. officials who heard from the experts have repeatedly downplayed that protection, claiming that it’s inferior to vaccine-bestowed immunity. Most studies on the subject indicate the opposite.⁹

Indeed, “Research indicated that natural immunity was long-lasting and superior to vaccination.”⁹

A professor of medicine at Stanford University, Dr. Jay Bhattacharya, criticized “how such a consequential discussion took place behind closed doors with only a few people present.”⁹ Dr. Bhattacharya stated: “It was a really impactful decision that they made in private with a very small number of people involved. And they reached the wrong decision.”⁹

Doctors Fauci and Walensky repeatedly downplayed natural immunity, and doctors Murthy and Collins consistently held that natural immunity was inferior to immunity provided by the jabs.⁹ This consensus was used to support harsh lockdowns, which severely damaged the economy and ruined many lives, and the mantra that everyone should get vaccinated, which damaged the health of many and which failed to prevent infection or reinfection.

According to *The Epoch Times*, Dr. Bhattacharya indicated that “it was already clear in 2020 that natural immunity protected against both severe disease and reinfection.... The fact that the head of the CDC and the surgeon general both seem to have ignored these basic scientific facts is a scandal... and it resulted in countless Americans losing their jobs for nothing.”⁹ Eventually, when the CDC was apparently no longer able to ignore scientific facts, it acknowledged that natural immunity is superior to vaccination; however, the CDC has refused to update its “scientific brief” stating that “the body of evidence for infection-induced immunity is more limited than that for vaccine-induced immunity.”⁹ Irrespective of truth and facts, those who promulgate the government narrative are reluctant to completely abandon their cherished consensus.

Clinical Practice Guidelines: Limitations and Conflicts of Interest

CPGs are based entirely on consensus. They are often influenced or driven by profit, cost containment, and politics, and may vary widely depending on the underlying incentives of the entities that develop them. Increasing alliances between physician groups and insurers have exacerbated the problem. A recent *Wall Street Journal* article highlighted the problem.

“What UnitedHealth and Humana have proven is that you can double your profit per patient if you’re both the plan and the doctor group,” said John Ransom, an analyst at Raymond James. Making the combinations especially attractive, he said, the margins on the doctors’ side aren’t crimped by federal rules requiring that the lion’s share of insurance premiums go toward the cost of care.

Strict adherence to clinical practice guidelines developed by the alliance is one way by which these increased profits are realized. Cost containment is the objective. Cost containment has been a consistent goal of government (e.g., Agency for Healthcare Research and Quality) and health insurers.

CPGs promulgated by professional specialty societies also have significant conflicts of interest with the pharmaceutical industry, and should not be considered unbiased.¹⁰

With respect to conflicts affecting the World Health Organization (WHO), another author noted:

[Clinical practice] guidelines are consistently wrong. The World Health Organization, which receives more than fifty percent of its funding from the pharmaceutical industry and the Gates Foundation, along with the CDC and FDA, are plainly corrupted.¹³

CPGs also have a number of inherent problems that limit their usefulness:

- Ongoing research and advancement of knowledge create a moving target causing many guidelines to become quickly outdated.
- CPGs often conflict with each other.
- “Many of the guidelines lacked the requisite scientific evidence to support their recommendations. One study found that 90 percent of guidelines failed to describe formal methods of how guideline authors reconcile scientific evidence with expert opinion, and more than 25 percent failed to cite any references”¹⁰—referring to Shaneyfelt et al.¹²
- Clinical practice guidelines often recommend newer, more expensive medications over older, cheaper off-patent alternatives.¹⁰

Another significant inherent problem with CPGs is that they only consider evidence from controlled trials, excluding other types of evidence and clinical judgment. One author noted:

For example, according to evidence-based medicine [evidence-based clinical practice guidelines], one could not recommend vitamin B-12 supplementation to treat pernicious anemia, penicillin for streptococcal pharyngitis, or biopsy to diagnose vasculitis, as these were not proven through controlled trials, although other types of evidence exist. EBGs [evidence-based guidelines] are irresponsible, and should not be recommended.¹³

Conflicts of interest can also include intellectual conflicts. Intellectual conflicts, which can be difficult to identify, would include “academic activities that create the potential for an attachment to a specific point of view that could unduly affect an individual’s judgment about a specific recommendation.”¹⁴

A review of disclosure statements for the GOLD guideline for treatment of chronic obstructive pulmonary disease (COPD), as viewed in 2018, illustrates just how conflicted guidelines can be. All of the GOLD board members except one (92 percent) reported conflicts of interest greater than \$10,000. Pharmaceutical companies that produce medications used to treat COPD were prominently featured as the source of payments to GOLD board members. And, all of the Science Committee members of GOLD, who develop the guidelines, reported conflicts of interest—the amount of payments was not disclosed. Again, pharmaceutical companies that produce medications used to treat COPD were prominently featured as the source of payments to GOLD Science Committee members who author the guideline. It is noted that these disclosure statements, previously available at <http://goldcopd.org/disclosure-statements/>, are no longer available at this URL; however, we have retained a print copy.

Although CPGs often explicitly state that these are not fixed protocols and should not be used as “cookbook medicine,” many physicians simply ignore or disregard that caution. A National Institutes of Health (NIH) publication, titled “Clinical Practice Guidelines,” stated the following:

These guidelines are not fixed protocols that must be followed, but are intended for health care professionals and providers to consider. While they identify and describe generally recommended courses of intervention, they are not presented as a substitute for the advice of a physician or other knowledgeable health care professional or provider.¹⁵ As noted by one author:

[M]edical decision-making is complex, and requires consideration of many variables, including clinical presentation, severity, progression, coexisting

conditions, genetic or biologic variations, susceptibility to complications, and allergies to medications. It would be impossible to design trials that compare all the options. We need expertise and clinical judgment.¹³

Another author stated:

Without clinical expertise, practice risks becoming tyrannized by evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient.... Evidence based medicine is not “cookbook” medicine. Because it requires a bottom up approach that integrates the best external evidence with individual clinical expertise and patients’ choice, it cannot result in slavish, cookbook approaches to individual patient care. External clinical evidence can inform, but can never replace, individual clinical expertise and it is this expertise that decides whether the external evidence applies to the individual patient at all and, if so, how it should be integrated into a clinical decision.¹⁶

Rigid Adherence to Clinical Practice Guidelines Harms Patients

Rigid adherence to CPGs—cookbook medicine—can result in harm and death of patients. One author noted:

A good example of how EBGs [evidence-based guidelines] distort the decision process is the recently issued practice parameters for the Guillain-Barré syndrome. The guidelines recommend treatment with intravenous immunoglobulins (IVIg) for nonambulatory patients, but do not recommend earlier intervention in progressive cases to prevent loss of ambulation, even though the treatment can limit the disease and prevent permanent damage. This is akin to withholding antibiotics from patients with worsening infection until they become septic.¹³

Another author detailed how patients were severely harmed by physicians by following CPGs guidelines for dialysis patients:

The economic course of dialysis in the U.S. is a case study in the malign effects of price controls, EBM [evidence-based medicine], and guidelines.... To remain profitable, dialysis units shortened treatment times (“high efficiency dialysis,” which was a disaster for patients though EBM suggested otherwise), and made margins selling injectable drugs such as Epogen, iron, and vitamin D analogues. Profits were driven by volume, and algorithms promoted by the industry led to extremely aggressive dosing of these agents to achieve numerical targets. The targets were defined in the Dialysis Outcomes Initiative (KDOQI) practice guidelines. That National Kidney Foundation created this guideline group with a very large and open-ended grant from Amgen, the manufacturer of Epogen.... The guidelines held sway, and dosages and sales of Epogen (and dialysis profits) soared. The guidance was amplified by CMS [the Centers for Medicare and Medicaid Services] including the hemoglobin target of 11-12 g/dl as a “clinical performance measure.” It all came crashing down in November 2006 with the publication of two key prospective studies in the *New England Journal of Medicine* showing poor outcomes at higher targeted levels of hemoglobin in anemic patients with chronic kidney disease (CKD).¹⁷

In a recent case a physician was prosecuted in a sham peer review and criticized for deviating from a CPG because, with the

patient's informed consent, he continued a drug to treat cancer beyond what the guideline recommended. The patient lived many years beyond the consensus-predicted prognosis. Incredibly, the doctor was criticized for successfully extending the patient's life with a treatment that violated the guideline, and thus he must have gotten the diagnosis wrong because the consensus was that people with that type of cancer just don't live that long. Apparently, the accusers would have been happier had the patient died years earlier by strictly following the guideline. The doctor's privileges were subsequently revoked.

There are numerous other examples of how rigidly following CPGs have severely harmed patients.

Guidelines Misrepresented as the Standard of Care—Sham Peer Review

The term standard of care is actually a legal term, not a medical term. Standard of care is used in malpractice litigation and in peer review. One author noted:

There is no medical definition for standard of care, although the term is firmly established in law and is defined as "the caution that a reasonable person in similar circumstances would exercise in providing care to a patient..." In wider terms, a physician has a duty to exercise the degree of care expected of a minimally competent physician in the same specialty under the same circumstances.¹⁸

The concept of standard of care dates back to the landmark case in English law, *Bolam v. Friern Hospital Management Committee*.¹⁹ In that case, the court made it clear that there may be more than one acceptable way to treat a patient with a specific condition. These represent legitimate professional differences of opinion, and a physician should not be faulted for holding one view over another. The court also acknowledged that competent physicians do not always agree on a single standard of care. The court found:

[E]ven today, there is no standard settled technique to which all competent doctors will agree.... A man need not possess the highest expert skill at the risk of being found negligent.... There may be one or more perfectly proper standards; and if a medical man conforms with one of those proper standards then he is not negligent.... In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion, and one man clearly is not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown [citing *Hunter v. Hanley* (1) (1955) S.L.T. 213 at 217].... A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.... Putting it another way around, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view.¹⁹

A more recent case in the United Kingdom, *Suzanne Lane v. Worcestershire Acute Hospitals NHS Trust et al.* stated:

[I]n the realm of diagnosis and treatment, negligence is not established by preferring one respectable body of professional opinion to another. [Citing *Maynard v. West Midlands Regional Health Authority* (1984) 1 W.L.R. 634, at 639].²⁰

In a recent court decision, granting an injunction in the case of *Tracy Hoeg et al. v. Gavin Newsom et al.*, the U.S. District Court for the Eastern District of California stated:

Another equally plausible (or perhaps equally implausible) interpretation is that any time a doctor's conduct contradicts the scientific consensus, it is therefore contrary to the standard of care. Such a reading would distort the existing meaning of the term "standard of care" by creating an additional statutory definition in the context of COVID-19.²¹

One author noted that there is no clear link between consensus, CPGs, and standard of care. The author also noted that CPGs are subject to bias and abuse.

Thus with no clear medical definition for standard of care, it remains unclear how this mainly legal concept of standard of care weighs up and compares in status to consensus statements or clinical guidelines that are secured in evidence-based medicine and produced by a representative organization or authoritative medical body.... The difficulty inherent in guidelines that are based in part on consensus is that biases of the experts may shape the guideline and either exclude reasonable choices or incorporate personal favorites as preferred options.... Therefore the term standard of care should be used with caution. Currently, it can be self-awarded either by a group of like-minded individuals or by a specialist society or organization and is a term which can be abused with the intention of providing impact and authenticity to a point of view.¹⁸

As noted by one author:

Even though the creation of practice guidelines was not intended to set the standard of care, artful attorneys have found that these widely published standards, despite their many pitfalls, could be persuasive to juries in malpractice litigation, especially those guidelines created by professional medical societies.¹⁰

Attorneys that represent hospitals in sham peer review cases have similarly portrayed CPGs as the standard of care. The outcome, whether it be a malpractice case or peer review hearing, often comes down to dueling experts and which expert appears to be more authoritative and persuasive.

The standard of care may vary somewhat based on geographical location and setting (e.g., rural hospital vs. academic medical center, specialist vs. generalist). Different standards of care based on geographic location is known as the locality rule. One author described it as follows:

Black's Law Dictionary defines the locality rule as "a term in medical jurisprudence where the physicians of an area must maintain standards of practice.... The locality rule requires defendant physicians to provide the same degree of skill and care that is required of other physicians practicing in the same community."¹⁰

As board-certification examinations test on the same information irrespective of geographic location, the number of jurisdictions still using the locality rule has declined over the years. By 2017, only five states (Arizona, Arkansas, Idaho, New York, and Pennsylvania) still applied the locality rule in standard of care.¹⁰

The misrepresentation of consensus and CPGs as the standard of care is widespread in the realm of sham peer review. Misrepresentation of the standard of care, in fact, is a tactic which

is characteristic of sham peer review.²² Some experts, hired by a hospital in a sham peer review case, may come up with a consensus after the fact, and use that in testifying that the accused physician did not meet the standard of care. This is arbitrary, capricious, unreasonable, and fundamentally unfair. The accused physician would have no way of knowing what standard would apply at the time of treating a patient. This is akin to a police officer pulling a motorist over and giving him a ticket for speeding, and arbitrarily choosing a speed limit and posting the speed limit sign afterward.

During the COVID era, we have seen sham peer review on an unprecedented scale, as government, medical boards, professional medical societies, hospitals, and other entities have sought to punish physicians who hold views contrary to the official narrative promulgated by government health officials. Open scientific debate has been suppressed and censored.

Disinformation Governance Board, California AB 2098, and Team Halo

In what is likely the largest and most well organized sham peer review in history, authoritarians during the COVID pandemic have sought to discredit, ruin, and punish physicians who would dare hold a view contrary to the “official narrative.” Taking a page from George Orwell’s *1984*, the Biden administration established its own version of “The Ministry of Truth” called the Disinformation Governance Board (DGB).

In violation of the First Amendment, the DGB was intended to censor information not conforming to the official government narrative, and to cancel physicians or others holding disfavored views. It would serve to further encourage and embolden medical boards and specialty boards to take actions to revoke the licenses or board certifications of physicians who express an independent, science-based opinion that is disfavored by the government. It would suppress open scientific debate. The favored government narrative would largely be derived from consensus-driven CDC or FDA guidelines.

The AAPS Educational Foundation took immediate action and filed a lawsuit ([tinyURL.com/y3arw78t](https://tinyurl.com/y3arw78t)) to end retaliation by specialty boards, and to stop the blatant violation of the First Amendment by the Biden administration. These AAPS efforts to bind down government authoritarians by the chains of the Constitution were detailed recently in an article published in our journal by AAPS General Counsel Andrew Schlafly.²³

After AAPS filed the lawsuit, the Biden administration disbanded the DGB. Recognizing that authoritarians will often wait until the furor over their unconstitutional acts dies down so that it can be brought back again, AAPS stands at the ready to act if and when it is needed in the future.

In California recently, Gov. Gavin Newsom launched his own version of the “Ministry of Truth,” AB 2098, designed to prompt the state medical board to revoke the licenses of physicians who spread “misinformation” or “disinformation.” Who defines “truth”? Government, of course. The standard of “truth” would be defined as “contemporary scientific consensus”—in other words, mainly CDC/FDA guidelines. According to the AB 2098 law:

It shall constitute unprofessional conduct for a physician and surgeon to disseminate misinformation or disinformation related to COVID-19, including false or misleading information regarding the nature and risks of the virus, its prevention and treatment; and the development,

safety, and effectiveness of COVID-19 vaccines....

“Misinformation” means false information that is contradicted by contemporary scientific consensus contrary to the standard of care. [Note how the law equates consensus with standard of care.]

“Disinformation” means misinformation that the licensee deliberately disseminated with malicious intent or an intent to mislead [i.e., if one voices a scientific view contrary to the official narrative, one has committed a malicious act].²⁴

In a recent action, seeking a preliminary injunction to prohibit enforcement of AB 2098, the U.S. District Court for the Eastern District of California found the law to be “unconstitutionally vague under the Due Process Clause of the Fourteenth Amendment.”²¹

On Jan 25, 2023, the same court granted the preliminary injunction, which, pending the final resolution of the action, prohibits the enforcement of AB 2098.²¹ However, the injunction applies only to enforcement actions taken against “plaintiffs, plaintiffs’ members, and all persons represented by plaintiffs.”²¹ The case is headed for the U.S. Court of Appeals for the Ninth Circuit, where AAPS plans to file an amicus curiae brief supporting the Constitutional right of physicians to engage in free speech and express their professional opinions regarding decisions that affect patient diagnosis and treatment.

In what may be an attempt to establish a “globalist-public health program,” in 2020 WHO established Team Halo.²⁵ Team Halo was established as part of the UN’s Verified Initiative in partnership with the United Kingdom’s Vaccine Confidence Project run by the University of London’s School of Hygiene and Tropical Medicine.²⁵ Support for both is provided by the Rockefeller Foundation.²⁵

Team Halo trains and deploys scientists and doctors around the world on TikTok to deal with COVID “disinformation.”²⁵ The Team Halo website contains links to videos that teach people how to file complaints with medical boards and nursing boards against medical professionals who express views contrary to the official narrative.²⁵ Some medical workers have been harassed, and some have even received death threats against themselves and their children.²⁵

According to *The Epoch Times* article, one Team Halo member, identified only as “Dr. Jon,” has fixated on Dr. Peter McCullough as his “primary attack focus.”²⁵

In a video posted on Oct 7, 2022, “Dr. Jon” celebrated Twitter’s suspension of Dr. McCullough’s account, and wrote, “Good luck Peter with your ABIM [American Board of Internal Medicine] certification—you’re going to need it.”²⁵

Dr. McCullough, who is a leader in the early treatment of COVID-19 with repurposed drugs and has been courageous in exposing the risks of the new mRNA COVID vaccines, and whose ABIM certification is unfairly under attack, told *The Epoch Times*:

[Team Halo] is an extension of what we termed the biopharmaceutical complex.... And at the top, we think, is the World Economic Forum, the World Health Organization, the Rockefeller Foundation, the Wellcome Trust. And then it spreads out from there. And it’s unsurprising that there would be extensions from this. Private contractors who are working to discredit top scientists in order to advance the false narrative.²⁵

According to *The Epoch Times*, the Vaccine Confidence Project, of which Team Halo is a partner, receives funding from various pharmaceutical companies including Johnson & Johnson,

GlaxoSmithKline, Merck, and the European Federation of Pharmaceutical Industries and Associations.²⁵

Vaccine Confidence partners include the CDC, WHO, the World Health Summit, Africa CDC, and Facebook.²⁵

The Wisdom of Claude Bernard

French physiologist and founder of experimental medicine, Claude Bernard (1813-1878), made several astute observations that apply to today's abuse of consensus and guidelines:

When we meet a fact which contradicts a prevailing theory, we must accept the fact and abandon the theory, even when the theory is supported by great names and generally accepted.²⁶ [Note how "health officials" were often very reluctant and took a long time to admit when the facts did not support their theory about COVID vaccines protecting one from getting infected and spreading COVID to others and the protective effects of natural immunity.]

Men who have excessive faith in their theories or ideas are not only ill prepared for making discoveries; they also make very poor observations. Of necessity, they observe with a preconceived idea, and when they devise an experiment, they can see, in its results, only a confirmation of their theory. In this way they distort observation and often neglect very important facts because they do not further their aim. [Think about studies conducted in the COVID era that were designed to demonstrate toxicity of a medication (by giving toxic doses) or ineffectiveness of off-label medications used in the early treatment of COVID by giving the medications late in the course of the disease.]

It is what we know already that often prevents us from learning.²⁶ ["Health officials" arrogantly clinging to consensus as "truth" have impeded or prevented the investigation of effective treatments for COVID.]

Conclusion

It is abundantly clear that consensus is not a substitute for actual science and evidence. One cannot establish that Earth is round by simply voting on it.

Guidelines, which are based on consensus, are not the "standard of care." The misrepresentation of clinical practice guidelines as the standard of care, and prosecuting physicians in a sham peer review based on CPGs, is unjustified and abhorrent.

Rigidly following CPGs, "cookbook medicine," places patients at risk for harm or death by failing to take into consideration an individual patient's comorbidities, situation, and needs. It substitutes "assembly line care" for optimal individualized care.

Those who develop consensus and CPGs are often highly conflicted. Insurers, pharmaceutical companies and hospitals utilize CPGs to control costs and maximize profits.

Questioning what some claim is "settled science" and challenging consensus by self-proclaimed purveyors of "truth" is how progress is made in science and medicine.

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REFERENCES

1. Zoltan I. Ignaz Semmelweis. Britannica.com; Dec 30, 2022. Available at: <https://www.britannica.com/biography/Ignaz-Semmelweis>. Accessed Feb 10, 2023.
2. Tyagi U, Chander Barwal K. Ignaz Semmelweis—father of hand hygiene. *Indian J Surg* 2020;82(3):276-277. Available at: <https://doi.org/10.1007/s12262-020-02386-6>. Accessed Feb 10, 2023.

3. ScienceAlert Staff. Who Is Ignaz Semmelweis? ScienceAlert; n.d. Available at: <https://www.sciencealert.com/ignaz-semmelweis>. Accessed Feb 10, 2023.
4. Naylor D. The tragic life of Ignaz Semmelweis—thrown into an asylum after saving lives. *Mirror Online*; Mar 20, 2020. Available at: <https://www.mirror.co.uk/science/tragic-life-ignaz-semmelweis-thrown-21724212>. Accessed Feb 10, 2023.
5. Semmelweis University: a short history of the university. Available at: <https://semmelweis.hu/english/about-semmelweis-university/history/>. Accessed Feb 10, 2023.
6. Hagerty JR. Morton Mower helped create device to prevent cardiac arrest. *Wall Street J*, May 6, 2022. Available at: <https://www.wsj.com/articles/morton-mower-helped-create-device-to-prevent-cardiac-arrest-11651852209>. Accessed Feb 10, 2023.
7. Associated Press. Co-inventor of lifesaving heart device dead at 89. *NY Post*, May 2, 2022. Available at: <https://nypost.com/2022/05/02/morton-mower-co-inventor-of-implantable-defibrillator-dead-at-89/>. Accessed Feb 10, 2023.
8. The Mirowski legacy: one family's history of tenacity, ingenuity and generosity. *Johns Hopkins Medicine*; Nov 4, 2018. Available at: <https://www.hopkinsmedicine.org/news/articles/the-mirowski-legacy-one-family-history-of-tenacity-ingenuity-and-generosity>. Accessed Feb 10, 2023.
9. Stieber Z. Inside the secret government meeting on COVID-19 natural immunity. *Epoch Times*, Feb 2, 2023. Available at: https://www.theepochtimes.com/inside-the-secret-government-meeting-on-covid-19-natural-immunity_5023439.html?ea_src=ai&ea_med=search. Accessed Feb 10, 2023.
10. Cooke BK, Worsham E, Reisfield GM. The elusive standard of care. *J Am Acad Psychiatry Law* 2017;45:358-364. Available at: <https://jaapl.org/content/jaapl/45/3/358.full.pdf>. Accessed Feb 10, 2023.
11. Amerling R. Conscious medical re-education. In: *The Next Wave is Brave*. Aspen, Colo.: Pierucci Publishing; 2022:163-196.
12. Shanefelt TM, Mayo-Smith MF, Rothway J. Are guidelines following guidelines? The methodological quality of clinical practice guidelines in the peer-reviewed medical literature. *JAMA* 1999;281:1900-1904. Available at: <https://jamanetwork.com/journals/jama/fullarticle/190067>. Accessed Feb 10, 2023.
13. Latov N. Evidence-based guidelines: not recommended. *J Am Phys Surg* 2005;10:18-19. Available at: <https://www.jpands.org/vol10no1/latov.pdf>. Accessed Feb 10, 2023.
14. Tunkel DE. Payments, conflicts of interest, and trustworthy otolaryngology clinical practice guidelines. *JAMA Otolaryngol Head Neck Surg* 2018;144(3):201-202. doi:10.1001/jamaoto.2017.2740. Available at: <https://jamanetwork.com/journals/jamaotolaryngology/fullarticle/2666770>. Accessed Feb 10, 2023.
15. NIH. Clinical Practice Guidelines. Available at: <https://www.nccih.nih.gov/health/providers/clinicalpractice>. Accessed Feb 10, 2023.
16. Sackett DL, Rosenberg WM, Gray JA, Haynes RB, Richardson WS. Evidence based medicine: what it is and what it isn't. *BMJ* 1996;312(70230):71-72. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2349778/pdf/bmj00524-0009.pdf>. Accessed Feb 10, 2023.
17. Amerling R. The window of opportunity to save independent medical practice is closing. *J Am Phys Surg* 2015;20:40-42. Available at: <https://www.jpands.org/vol20no2/amerling.pdf>. Accessed Feb 10, 2023.
18. Strauss DC, Thomas M. What does the medical profession mean by "standard of care?" *J Clin Oncol* 2009;27(32):e192-e193. Available at: <https://ascopubs.org/doi/pdf/10.1200/JCO.2009.24.6678?role=tab>. Accessed Feb 10, 2023.
19. *Bolam v. Friern Hospital Management Committee*, 1 W.L.R. 583, 587 (1957). Available at: <https://imlindia.com/downloads/Bolam.v.Friern.Hospital.Management.Committee.pdf>. Accessed Feb 10, 2023.
20. *Suzanne Lane v. Worcestershire Acute Hospitals NHS Trust et al.* High Court of Justice Queen's Bench Division Birmingham District Registry [2017] EWHC 1900 (QB). Available at: <https://medicalnegligencenow.files.wordpress.com/2021/11/lane-v-worcestershire-acute-hospitals-nhs-trust-anor-2017-ewhc-1900-qb-24-july-2017.pdf>. Accessed Feb 10, 2023.
21. *Tracy Hoeg et al. vs. Gavin Newsom et al.* U.S. District Court, Eastern District of California, Case No. 2:22-cv-01980 WBS AC. Available at: <https://lc.org/PDFs/Attachments2PRsLAs/2023/012723OpinionHoegvNewsom.pdf>. Accessed Feb 10, 2023.
22. Huntoon LR. Tactics characteristic of sham peer review. *J Am Phys Surg* 2009;14:64-66. Available at: <https://www.jpands.org/vol14no3/huntoon.pdf>. Accessed Feb 10, 2023.
23. Schlafly AL. Ending retaliation by specialty boards that certify physicians. *J Am Phys Surg* 2022;27:82-86. Available at: <https://www.jpands.org/vol27no3/schlafly.pdf>. Accessed Feb 10, 2023.
24. California Assembly Bill No. 2098; 2022. Available at: <https://openstates.org/ca/bills/20212022/AB2098/>. Accessed Feb 10, 2023.
25. Spence K. UN initiative targets and doxes doctors and nurses who don't follow COVID-19 narrative. *Epoch Times*, Jan 31, 2023. Available at: https://www.theepochtimes.com/un-initiative-targets-and-doxes-doctors-and-nurses-who-dont-follow-covid-19-narrative_4989210.html. Accessed Feb 10, 2023.
26. Claude Bernard Quotes. Available at: https://www.azquotes.com/author/1304-Claude_Bernard. Accessed Feb 10, 2023.