

## Editorial

# Sham Peer Review: Focused Professional Practice Evaluations (FPPE), Performance Improvement Plans (PIP), and Physician Health Programs (PHP)

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Although hospitals continue to employ tactics characteristic of sham peer review,<sup>1,2</sup> there has been an increasing trend in recent years for hospitals to use procedures that avoid providing due process and fundamental fairness altogether.

Focused Professional Practice Evaluations (FPPE) and Performance Improvement Plans (PIP) are now frequently implemented via “star chamber proceedings.” A definition from a legal dictionary defines a star chamber proceedings as:

[A]ny judicial or quasi-judicial action, trial, or hearing which so grossly violates standards of “due process” that a party appearing in the proceedings (hearing or trial) is denied a fair hearing. The term comes from a large room with a ceiling decorated with stars in which secret hearings of the privy council and judges met to determine punishment for disobedience of the proclamations of King Henry VIII of Great Britain (1509-1547). The high-handed, unfair, predetermined judgments, which sent the accused to The Tower of London or to the chopping block, made “star chamber” synonymous with unfairness and illegality from the bench.<sup>3</sup>

Some medical staff bylaws have even incorporated these kinds of proceedings into their bylaws. The bylaws may allow a select group of physicians or a committee to meet in secret and declare a physician “guilty” and inflict “punishment,” at times without allowing the physician to tell his side of the story or rebut the charges made against him. No formal fair hearing or appeal is allowed. In some cases, the only “hearing” that is allowed is one to determine whether the physician has complied with the sanctions and punishments imposed by the secret committee.

In a few cases, these FPPEs or PIPs are used as a form of perpetual harassment, in which the “goal posts” are constantly moved. A physician complies with the initial requirement and the committee then imposes another, then another and another in succession.

### FPPEs and PIPs

Some attorneys who represent physicians may try to negotiate a PIP or FPPE, for example, requiring only that the physician take some additional coursework as an alternative to the hospital pursuing an adverse action through a formal peer review. In the cases where that is successful, that is generally a good outcome for the doctor.

The physician needs to be aware, however, that although a FPPE or PIP is generally not reportable to the National Practitioner Data Bank (NPDB), the physician may be required to self-report a FPPE or PIP on applications for a medical license or applications for hospital privileges.

A FPPE or PIP that restricts privileges (does not allow for the independent practice of medicine/procedures/surgery) that goes beyond 30 days is reportable to the NPDB.

FPPEs and PIPs, like referrals to Physician Health Programs

(PHP), are often steeped in coercion.<sup>4</sup> The physician is typically told that either he can agree to the FPPE, PIP, or referral to the PHP, or face further disciplinary action including adverse action against his hospital privileges or loss of medical license. The physician essentially agrees to “plead guilty” and accept whatever terms the hospital committee or licensing board dictates or else his life and career will be ruined. Those in power wielding this coercion often claim there is no coercion at all because the physician “voluntarily” agreed to it.

Members of these clandestine committees also often require that the physician “take ownership” for his wrongdoing and “show remorse.” Having to “plead guilty” and “show remorse” for something the physician did not do results in moral injury and psychological damage to the victim.<sup>4</sup>

Sometimes, as part of a FPPE or PIP, the committee will require a Fitness For Duty Examination (FFDE), alleging “mental impairment” or “impairment due to alcohol or drugs.” The FFDE is often imposed without any “probable cause”—i.e., without objective, realistic or recognizable reason to think the doctor is mentally impaired or impaired due to alcohol or drugs.

A couple of recent cases illustrate what can happen when a physician is falsely accused and is coerced to submit to evaluation by a PHP, or to sign an agreement with a PHP. In one case, the physician’s life was totally disrupted based on an accusation that he was “impaired” because “he touched his nose a lot.” According to the lawsuit:

At the time his ordeal began, John M. Farmer, M.D., was a resident physician in family medicine at Baptist Health Madisonville (BHM) in Louisville, Kentucky. On Nov 4, 2019, he had just completed a routine appointment in the clinic with two children he had seen before. The children’s mother and her boyfriend were present. Nothing unusual occurred, and Dr. Farmer went home.<sup>5</sup>

“Unbeknownst to Dr. Farmer, immediately following the appointment, the mother of the children made a complaint to Stephanie Crick, the office manager of BHM, alleging that Dr. Farmer was ‘impaired.’ As evidence, she said that Dr. Farmer was ‘touching his nose a lot.’”

“The mother’s complaint was forwarded to Dr. Diana Nims, the Residency Program Director.”... Dr. Nims spoke with two attending physicians who were present in the clinic with Dr. Farmer, and they told her that Dr. Farmer was not impaired. One of the attending physicians responded. “He is not impaired, he is twitchy but that is Dr. Farmer.”<sup>5</sup>

Dr. Farmer was diagnosed with attention deficit hyperactivity disorder (ADHD) in 2005 and was being treated by his physician.<sup>6</sup> Interestingly, the two children he saw on that day in clinic were also being treated for ADHD.<sup>6</sup>

Under BHM’s Fitness for Duty Drug Testing Policy, any reasonable suspicion that a physician is under the influence of any substance that may impair judgment, coordination, skill, or alertness requires that the physician immediately be removed from the work area, informed of the suspicion, and tested for

alcohol and/or drugs. That policy was not followed.<sup>5</sup>

“Dr. Nims, who knew BHM’s policies well, did not inform Dr. Farmer about the complaint until the next morning, Nov 5, 2019. She had not required Dr. Farmer to return to BHM for immediate testing at the time the complaint was made on Nov 4, which would have confirmed that Dr. Farmer was not impaired at all and that the complaint about him was baseless.”<sup>5</sup>

On Nov 5 “Dr. Farmer asked why he had not been informed about the complaint the previous day, and Dr. Nims did not answer. Dr. Farmer asked to be given a urine drug screen (UDS) immediately, but Dr. Nims told him that it would not be done at BHM, and he needed to have it done at KPHF [Kentucky Physicians Health Foundation].”<sup>5</sup>

According to plaintiff’s trial brief, “Dr. Farmer asked to go to the lab 15 feet outside Dr. Nim’s office to get drug tested immediately. Dr. Nims denied Dr. Farmer’s request, citing privacy concerns. Dr. Farmer responded that he didn’t care about his privacy, and that he wanted to go to the lab. Dr. Farmer asked to be drug tested at the BHM facility at least five times during that meeting, and each request was denied.”<sup>6</sup> The brief continued:

Despite being told by Dr. Hargrove [one of Dr. Farmer’s supervising attending physicians] and Dr. Hatler [one of Dr. Farmer’s supervising attending physicians] that Dr. Farmer’s behavior was normal, Dr. Nims then spoke with Oglesby [Human Resources Director and Designated Institutional Officer], who told Dr. Nims to call Dr. Lipson [Chief Medical Officer] and to follow the Medical Staff Policy. Dr. Nims did not review the Drug Testing Policy. Dr. Hargrove, who sat on the committee that reviewed and updated BHM’s policies in 2018, testified at deposition that the Drug Testing Policy applied to Dr. Farmer and that it was not followed. . . .

Dr. Nims notified Dr. Lipson and Dr. Armstrong [president of Baptist Health Medical Group (BHMGM)] of the patients’ mother’s complaint. The evening of November 4, 2019, the three of them convened a meeting along with Robert Ramey, president of the hospital, and Rhonda Florida, the head of the medical staff office. Dr. Nims did not tell Dr. Lipson or Dr. Armstrong that multiple doctors who worked with Dr. Farmer that day had already told her that Dr. Farmer was not impaired. At the meeting, they considered whether to call Dr. Farmer back to the hospital to get tested for alcohol and/or drugs and ultimately decided not to test Dr. Farmer immediately and not to immediately inform Dr. Farmer of the complaint.<sup>6</sup>

On Nov 5, 2019, “Dr. Lipson and Dr. Nims ordered Dr. Farmer to immediately drive approximately three hours to Louisville and report to KPHF [Kentucky Physicians Health Foundation] that day. BHM placed Dr. Farmer on a leave of absence, pending an evaluation through KPHF.”<sup>5</sup>

Dr. Farmer completed urine drug screening on Nov 5 and was then told that he would need to go to “an approved facility for a 96-hour evaluation.” He was also advised that he could not return to medical practice until the evaluation was completed.<sup>5</sup>

“On November 15, 2019, Dr. Lipson sent a letter to the KBML [Kentucky Board of Medical Licensure] stating that a patient had made an anonymous complaint against Dr. Farmer, and that BHM had referred Dr. Farmer to the KPHF. . . . On the basis of Dr. Lipson’s letter, KBML initiated an investigation into Dr. Farmer.”<sup>5</sup>

A KBML investigator interviewed Dr. Farmer and asked him to provide names of any witnesses who had worked with him on the

day in question, “but Dr. Lipson (who was present for Dr. Farmer’s interview) interjected and would not permit Dr. Farmer to provide any names of witnesses to the KBML investigator, even though Dr. Farmer wanted to do so to refute the baseless complaint.”<sup>5</sup>

According to Dr. Farmer’s Complaint in his lawsuit against the hospital:

Had he been permitted to identify witnesses, Dr. Farmer would have named Dr. Hargrove and at least three or four other physicians and other co-workers, including nurses who had worked with him many times, as well as on November 4, 2019. All of the witnesses would have confirmed and/or testified that there was nothing different about Dr. Farmer’s behavior and he did not demonstrate any evidence of impairment or of being under the influence. Dr. Lipson wrongfully and improperly prevented the KBML investigator from speaking that day with any of these exculpatory witnesses.<sup>5</sup>

The Medical Board subsequently required Dr. Farmer to sign an Interim Agreed Order, which “prohibited Dr. Farmer from engaging in the practice of medicine ‘until approved to do so’ by KBML.” The Medical Board reported that action to the National Practitioner Data Bank (NPDB),<sup>5</sup> stating that Dr. Farmer was “Unable to Practice Safely By Reason of Alcohol or Other Substance Abuse.”<sup>6</sup> The investigator said that Dr. Farmer needed to sign the Order, or the KBML would take emergency action against him.<sup>6</sup>

Dr. Farmer subsequently underwent an evaluation at Metro Atlanta Recovery Residences.<sup>5</sup>

Upon completion of that evaluation, Dr. Farmer signed a Contract Letter, at the recommendation of Dr. Greg Jones (KPHF medical director). The Contract required that Dr. Farmer “abstain completely from alcohol and mood-altering drugs, and submit to random drug screens, individual group therapy, and appointments with a psychiatrist.”<sup>6</sup> Dr. Farmer “had no choice but to sign the Contract Letter in order to return to work.”<sup>6</sup>

About a month later, Dr. Farmer signed another Letter of Agreement with the KBML to resolve the KBML’s investigation.

The Letter of Agreement extended the monitoring and abstinence period [from] three to five years. It required him to submit to periodic and unannounced drug screens (breathalyzer, blood, and urine), and continue to comply with all requirements of the Contract Letter with KPHF. Any violation by Dr. Farmer of the Contract Letter would constitute grounds for the KBML to initiate formal disciplinary charges against his medical license. Dr. Farmer was required to sign the Letter of Agreement in order to be cleared to return to clinical practice and complete his residency program.<sup>6</sup>

The lawsuit alleged that “Dr. Farmer’s job prospects have been severely diminished and he has experienced significant difficulty obtaining suitable employment as a physician, much less a position that would pay him at a normal salary for an individual in his area of practice coming out of a Residency Program.”<sup>5</sup>

On May 2, 2023, a jury awarded Dr. Farmer \$3.7 million.<sup>7</sup>

Another case involving an Indiana hospital<sup>8</sup> illustrates how a single false accusation can lead to a multitude of horrendous adverse consequences.

Dr. Rebecca J. Denman is an obstetrician/gynecologist who was employed by St. Vincent Medical Group (SVMG), formerly Women’s Health Alliance (WHA).<sup>8</sup>

On the evening of Dec 11, 2017, Dr. Denman went to the

hospital to check on one of her patients. Dr. Denman was on call at the time. Dr. Denman was upset because a new nurse, “Andrea,” allegedly called one of Dr. Denman’s partners, who was not on call at the time, and told him that Dr. Denman had requested that he come into the hospital to evaluate her patient. Dr. Denman denied making that request.<sup>8</sup>

On arrival at the hospital, Dr. Denman went to the nurses’ station and expressed her displeasure with the situation of nurse Andrea having called one of her partners to come into the hospital. Nurse Andrea was not present at the time. Dr. Denman testified that the charge nurse, Hannah Thornton, who was present for the venting “was obviously angry” and “I could see it in her face.”<sup>8</sup>

Dr. Denman subsequently apologized to the nurses and went to check on her patient. Nurse Thornton accompanied her and reportedly “saw nothing unusual or concerning during the time that Dr. Denman was working with the patient.”<sup>8</sup>

Shortly after Dr. Denman left the hospital that night, nurse Thornton “told Meyerrose [another nurse who was present on the labor and delivery unit at the time of Dr. Denman’s venting] that she had smelled “an overwhelming smell of alcohol” on Dr. Denman’s breath during the encounter at the nurses’ station, and Thornton asked Meyerrose whether she had smelled it too; Meyerrose, however, stated that she had not... Meyerrose, however, stated that she told Thornton to report it as soon as possible to the Hospital’s Director of Nursing, Michelle Slayman.”<sup>8</sup>

Nurse Thornton, however, waited 12 full hours before reporting her complaint, a delay that deprived Dr. Denman of the opportunity to clear her name by immediately getting a blood test for alcohol on the evening in question. Thornton claimed that she was not aware at the time of the hospital’s policy, which was available on the hospital’s intranet, which required immediate reporting and assessment, including blood and urine screening, anytime there is a “reasonable suspicion that a physician is under the influence of alcohol or drugs at work.”<sup>8</sup>

“Thornton testified that she did not believe Denman was drunk that night and that she observed no signs of impairment.” As reviewed by the court, “There was no evidence that Dr. Denman consumed alcohol on either December 11 or 12 and no indication that her work during that time was affected by consumption of alcohol.”<sup>8</sup>

Between Dec 13 and 20, 2017, Dr. Aaron Shoemaker, SVMG chief medical officer, conducted what he characterized as a “peer review screening process.” He did not contact Dr. Denman, nurse Thornton, or anyone else present at the time of the encounter at the nurses’ station on Dec 11. Nonetheless, he concluded that “SVMG either had to report the complaint to Indiana’s medical licensing board or have the physician assessed by ISMA [Indiana State Medical Association].”<sup>8</sup>

On Dec 20, 2017, Dr. Denman was informed that she “needed to take a voluntary leave of absence.”<sup>8</sup> She was placed on paid administrative leave, and advised that she could not return to work until she went to ISMA’s Physician Assistance Program for assessment. She was presented with a Physician Assessment Agreement which she declined to sign. It was her understanding, however, that “there would be consequences, such as suspension or termination, if she did not comply.”<sup>8</sup>

Dr. Denman alleged that Dr. Shoemaker misrepresented to her that a peer review had been performed, when in fact, there had been no review by the PREC [Peer Review Executive Committee], and had she known that she never would have agreed to go to the

ISMA for assessment.<sup>8</sup>

Following an assessment by a third party recommended by ISMA, Dr. Denman was diagnosed with “alcohol use disorder—severe.” Further treatment was recommended. ISMA advised Dr. Denman that if she failed to complete treatment, they would notify the state licensing board.

She subsequently underwent six weeks of inpatient treatment at the Positive Sobriety Institute (PSI) in Chicago.<sup>8</sup>

On Mar 23, 2018, more than three months after this ordeal began, Dr. Denman was allowed to return to work. However, as a condition of her return to work, “SVMG required her to agree to ISMA’s five-year alcohol monitoring agreement, which required breathalyzer tests several times per day, random urine screens, group and individual therapy, and AA meetings. In addition, Dr. Denman cannot drink any alcohol during the term of the monitoring agreement.”<sup>8</sup>

On Jan 16, 2020, a jury found in favor of Dr. Denman and awarded \$4.75 million in damages for the harm caused by a completely unjustified accusation: from the hospital, \$1,000,000 for presumed damages and \$1,000,000 for compensatory damages for defamation, and \$500,000 for tortious interference with an employment relationship; from SVMG, \$1,000,000 for fraud, \$1,000,000 for constructive fraud, and \$250,000 for negligent misrepresentation. Post-trial motions and appeal resulted in this amount being modified.<sup>8</sup>

## Physician Health Programs

Physician Health Programs (PHPs) historically have provided a viable means for a physician addicted to alcohol or drugs to obtain necessary treatment so as to be able to return to the practice of medicine. PHPs have been very beneficial in this regard.

However, over the years, medical boards and state medical associations have developed exclusive relationships with “preferred” evaluation and treatment programs/centers. The evaluation and treatment of physicians for alcohol, drug, mental, or behavioral issues is a lucrative business. Treatment centers/programs often recommend further treatment at their center based on the evaluation performed at the very same center. There are significant conflicts of interest.

Confirmatory bias also plays a role as a treatment center for alcohol/drugs may presume that the doctor has an addiction problem—why else would a medical board/medical society refer the doctor to their addiction treatment center? Thus, accusations alone seem sufficient in many cases to recommend treatment.

Often conspicuous by its absence is any type of “probable cause analysis” (i.e., there may be no actual objective evidence (e.g., lab testing) to suggest that the doctor was alcohol/drug impaired while on duty). In referrals made to a PHP there is no grand-jury-type system to help prevent “prosecutorial abuse.”

Accusations of impairment, whether by alcohol, drugs, mental or behavioral conduct, are accompanied by significant stigmatization. There is both self-stigmatization and external stigmatization by others. This stigmatization and moral injury accompanying false accusations can result in new psychopathologies that previously did not exist (e.g., anxiety or depression).<sup>4</sup>

## Professionalism Agreements and Medical Board Contracts

Physicians also need to be aware of some of the adverse terms that may be contained in professionalism agreements and

PHP contracts. Star chamber-like committees at hospitals may impose a professionalism agreement as part of a FPPE or PIP. Not surprisingly, some of these agreements seek to deprive physicians of due process. One professionalism agreement, for example, contained the following provision:

Except as it pertains to any corrective action arising from a breach or failure to comply with this Agreement, I understand that this Agreement does not limit my ability to challenge a corrective action as permitted by the Bylaws and the Fair Hearing Plan.

Thus, if the secret committee determines that the doctor has breached or not complied with the terms of the agreement, adverse action can be taken against the doctor's privileges, and the doctor is not entitled to any hearing or appeal on that adverse action. This particular professionalism agreement also required the doctor to supply the committee with all of his medical and mental health records, although no one accused him of having any physical or mental impairment.

With regard to medical board contracts, physicians need to be aware that some provisions of a contract may result in the medical board essentially "owning" the physician's body for the rest of his medical career. Some contract provisions, for example, may require that the doctor get permission from the medical board for certain medications (e.g., all controlled substances) before being able to take a medication legitimately prescribed by the doctor's physician. The provision may specifically state that the requirement continues indefinitely beyond the term of the contract.

Physicians unfortunately often have little choice other than to agree to these professionalism agreements or medical board contracts, under threat of loss of hospital privileges or loss of medical license if they refuse to submit.

## Conclusion

It may be beneficial for attorneys representing physicians in sham peer review cases to negotiate a FPPE or PIP early on, not requiring any proctoring/restriction of privileges, as opposed to a hospital recommending or implementing an adverse action and going through a formal peer review process. Being alert to

provisions which can deprive the physician of due process rights is essential.

Likewise, physicians and their attorneys should be alert to medical board contract provisions under which the medical board essentially "owns" the physician's body for the rest of his medical career.

Both hospital-imposed professionalism agreements and medical board contracts are the product of coercion in which the hospital or medical board holds all the power. Nonetheless, every effort should be made to mitigate, insofar as possible, terms that inappropriately affect the physician in an adverse manner.

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