Editorial

Sham Peer Review: Abuse of Referrals for Psychiatric and Neuropsychological Assessment

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In 1692, a small village in colonial Massachusetts gained notoriety for its Salem Witch Trials. Those who were suspected of being witches were charged and put on trial. Hearsay and rumor were often sufficient to support an accusation. Various unusual tests were used to determine guilt.[1]

One such test was the "swimming test." The suspected witch was typically stripped naked and bound in the shape of a ball – right thumb to left toe and left thumb to right toe. A rope was tied around the suspect's waist and she was thrown into a deep pond or river. If the accused floated, she was guilty. If she sank, she was innocent. However, if those administering the test failed to pull the accused out of the water in time, she drowned. Those found guilty of being a witch were hanged. This test continued to be used up until the nineteenth century.[1] Any individual who stood out from the crowd or did not conform to the social norm was at risk for being judged a witch.[1]

More than 300 years later, physicians who stand out from the crowd (e.g., innovators, physician whistleblowers, successful competitors) or who fail to conform to official government narratives often face mandatory referrals for psychiatric (psych) or neuropsychological (neuropsych) testing imposed by hospitals, medical boards, and physician health programs (PHPs). These referrals fall under the general category of Fitness for Duty Evaluations (FFDE). Hearsay, rumor, and suspicion are often all that is needed to force physicians to undergo psych and neuropsych testing.

Referrals for psych and neuropsych testing are sometimes made for the purpose of stigmatizing the physician, damaging the physician's reputation, and harming the physician's psyche. No objective evidence is provided to support the referral, and the required testing is done for reasons other than quality care and patient safety.

In some cases, an unwarranted referral and subsequent assessment may end up producing psychopathology in the physician victim (e.g., anxiety, depression, paranoia). These iatrogenic psychopathologies, in turn, often influence how the physician interacts with others, including spouse, family, friends, and colleagues, which can lead to further problems that previously did not exist.

The information presented below is not intended as legal advice or opinion. It derives from my extensive study of relevant literature and court documents, from my own experience serving as an expert in sham peer review, and through my encounters on the AAPS Sham Peer Review Hotline. Physicians should seek legal advice and opinion from their attorneys.

Indications for Psych/Neuropsych Assessment

According to one review article, "Neuropsychology, the intersection of neurology, psychology, and psychiatry, is an applied science that examines the behavioral manifestations of brain dysfunction."[2]

Neuropsych tests are standardized tests that compare the subject's performance with others of a similar demographic. The results reference the standard deviation from the mean or a percentile.[2] Although "the definition of abnormality remains unsettled in clinical neuropsychological practice," a result is often reported as abnormal if it falls below one standard deviation from the mean or below the 16th percentile.[3]

Neuropsych testing typically takes four to eight hours and evaluates "general intellect, higher level executive skills (e.g. sequencing, reasoning, problem solving), attention, concentration, learning, memory, language, visuospatial skills, motor skills, sensory skills, mood, and personality."[2] Neuropsychological evaluation is often covered by insurance when deemed medically necessary…."[2] An appropriate diagnosis code is needed to establish medical necessity.

Note that there is no diagnosis code for "normal," and even if there were it would not constitute a valid reason for referral for neuropsych testing.

An "uncertain diagnosis" (e.g., suspected, rule out, questionable, compatible with, consistent with)[4] is not an acceptable reason for referral for neuropsych testing. The uncertain diagnosis code does not establish medical necessity for testing.

"Concern" is frequently cited as the sole reason for referring a physician for psych or neuropsych evaluation. Concern, however, is not an objective reason for referral. Objective evidence, such as impaired performance, is needed to justify referral for testing. The bar for mere "concern" is set so low that it could apply to anyone.

By way of analogy, in our legal system a prosecutor cannot simply decide on his own to prosecute someone. The prosecutor must submit evidence to a grand jury, and the grand jury must decide whether there is sufficient evidence to proceed with a prosecution. Although this grand jury system is not always successful in preventing prosecutorial abuse, that is its intended purpose. There is no similar "grand jury" system in peer review. As a result, "prosecutorial abuse" is rampant.

According to a review article, appropriate indications for referral for neuropsych testing include: changes in memory (such as amnesia, poor short-term recall, frequently losing items, getting lost easily, and failing to recognize familiar persons); poor attention and concentration (such as not listening, getting confused in conversations, and doing poorly in complex situations); changes in language function (such as aphasia, agnosia, dysfluency); changes in visuospatial abilities (such as difficulty drawing, difficult navigating or understanding directions, misperceiving the environment); impaired executive function (such as perseveration, poor judgment, rigidity of thought); changes in emotional functioning (such as increased anxiety or depression and psychoses); and fluctuations in mental status (such as disorientation).[2]

Some neuropsychologists use a fixed battery of tests, such as Halstead-Reitan Battery or Luria-Nebraska Battery, while

others use selected individual tests (flexible testing) based on the "primary problem areas and diagnosis."[5] Irrespective of what specific battery or selected tests are used, the psych/neuropsych FFDE should conform to accepted standards,[6-8] and opinions concerning potential impairment of job performance should not be purely speculative and should take into account the frequency of "abnormal" test results in normal healthy individuals.[3]

One review article also recommended "specifically questioning the referral source about indicators of potential clinical competency concerns."[9] The evaluator has an ethical duty to make sure that the entity is referring the physician for a legitimate purpose as opposed to a purpose having nothing to do with furthering quality care.

Limitations of Neuropsych Testing

Using neuropsych testing of physicians to assess the possible impact of alleged behavioral issues on workplace performance is fraught with problems and severe limitations. One review article noted: "The contribution of such [neuropsych] screening in physicians with workplace behavioral issues is not established."[9]

There is great variability in the manner in which examiners perform testing. Interrater reliability is a severe problem. According to one review article:

> Using a survey of 654 members of the National Academy of Neuropsychology (NAN) and the International Neuropsychological Society, Hirst et al. found evidence that neuropsychologists are not equally consistent in employing validity testing practices recommended by NAN and the American Academy of Clinical Neuropsychology in neuropsychological assessments.[10]

A referring entity may use a "preferred" evaluator knowing that the history of the examiner's assessments tend to favor the goals of the referring entity. An entity's refusal to allow the accused physician to obtain an evaluation from an independent evaluator further unmasks bias of the referring entity.

The validity and reliability of neuropsych tests is highly questionable. One article stated: "Normative data for some neuropsychological tests are based on small samples or have limited validity or reliability data."[11]

A comprehensive study designed to look at the frequency of "abnormal" neuropsych scores in normal healthy individuals found:

> Regarding test score scatter, normative participants often have large discrepancies between best and worst scores. When "abnormality" was defined as a score more than one standard deviation below the mean, in test batteries with at least 20 measures, the great majority of normative participants had one or more abnormalities. Restricting samples to participants with above average IQ or educational levels and using more conservative definitions of abnormality, such as two standard deviations below the mean did not eliminate the presence of abnormal scores. We conclude that *abnormal* performance on some proportion of neuropsychological tests in a battery is psychometrically *normal*…. Obtaining some low scores from a battery of tests is the rule, not the exception.[3]

The researchers also noted that the probability of obtaining a single "abnormal" test score increases as the number of measures increase.[3] For more than two decades, the literature has cautioned against over-interpreting isolated low test scores.[3]

Coerced Illegitimate Psych/Neuropsych Fitness for Duty Evaluations are Unethical

The AAPS is strongly opposed to coerced illegitimate psych/neuropsych evaluations. In a Resolution passed by AAPS membership attending the 2019 Annual Meeting, Resolution 01-2019, AAPS:

1. Condemns the abuse and misuse of psychiatry in the process of physician psychological fitness for duty evaluation (PFFDE) and treatment;
2. Declares that the abuse and misuse of psychiatry occur in physician PFFDE when referrals or orders for evaluation, treatment, or monitoring are made to support illegitimate organizational, social, or political objectives;
3. Declares that abuse and misuse of psychiatry also occur in physician PFFDE when the evaluee is denied full due process and/or is wrongfully harmed by the limitation of due process by denial of knowledge of or timely access to available administrative and legal remedies in referral, evaluation, treatment, or monitoring;
4. Declares that all physicians who participate in physician PFFDE should strive to expose corrupt, incompetent, or unethical conduct in referring entities and practitioners in the field, and
5. Declares that all physicians who participate in physician PFFDE should strive to mitigate any harms to physician-patients that result from the medical regulatory, disciplinary, or coerced rehabilitation process.[12]

Neuropsychological Testing for Public Dissent from Official Government Narrative—Sluggish Schizophrenia

History teaches us a lot about government censorship and abuse of power. A historical review of sluggish schizophrenia provides information about how Soviet rulers handled dissent.

"Sluggish schizophrenia" was a fictional diagnosis used in the Soviet Union following the Second World War. It was a political tool that the government employed to oppress anti-Soviet dissenters."[13]

> The theory was that anyone who opposed the Soviet regime was mentally ill, because there was no other reason for their behavior…. Individuals involved in the publication or distribution of anti-state literature or political activism were targets. Psychiatrists would incarcerate these individuals in mental institutions without any medical justification. Under Soviet law of the time, these people could be isolated in maximum security hospitals or prison camps…. Once doctors discharged someone with sluggish schizophrenia from the hospital, they would lose their civil rights and be unable to find employment.[13]

Now, decades later, the Biden Administration, medical boards, medical specialty boards and hospitals have adopted Soviet-style

censorship and oppression against "dissident physicians" who questioned, or, based on science, spoke out against the official government narrative (e.g. mask mandates, vaccine mandates, lockdowns, disparagement of effective early treatments of COVID with safe off-label medications) during the COVID era.

Acting in support of actual science and in the best interest of their patients, "dissident physicians" had hospital privileges and employment terminated, were subject to threats to revoke board certification, and had their medical license suspended.

In January 2022, a respected physician from Maine, Dr. Meryl Nass, had her medical license suspended because she criticized government for mask and vaccine mandates and its failure to acknowledge the role of natural immunity in fighting COVID; questioned events surrounding Emergency Use Authorization of the Pfizer COVID vaccine; and treated her patients who had early COVID with hydroxychloroquine and Ivermectin.[14]

With the apparent view that anyone who opposed the government regime must be mentally ill, the Maine medical board also ordered Dr. Nass to submit to a neuropsych evaluation.[14]

On August 16, 2023, Dr. Nass filed a lawsuit against the Maine Board of Licensure in Medicine; Maroulla S. Gleaton, M.D.; Holly Fanjoy, M.D.; Noah Nesin, M.D.; Renee Fay-LeBlanc, M.D.; Brad Waddell, M.D.; Gregory Jamison, R.Ph.; Noel Genova, P.A.; Lynne M. Weinstein; and Susan Dench.[15] Citing an interview Dr. Nass had done with Regis Tremblay, the lawsuit alleged:

> During the interview, BOLIM Member Fay-LeBlanc explained, Dr. Nass said things that BOLIM Member Fay-LeBlanc believed were outside of mainstream medicine and involved conspiracy language around certain organizations.[15, ¶50]

The lawsuit also alleged:

> By ordering that Dr. Nass submit to an examination under 32 M.R.S. §3286, and by providing this Order to the media, along with interviews with BOLIM Executive Director Dennis Smith, upon information and belief BOLIM falsely suggested to the public and Dr. Nass' patients that Dr. Nass was suffering from some type of mental health or other disorder and tarnished her reputation.[15, ¶57]

The AAPS Educational Foundation filed a lawsuit against the Biden Administration (Alejandro Mayorkas, Secretary, U.S. Department of Homeland Security), the American Board of Internal Medicine (ABIM), the American Board of Obstetrics & Gynecology (ABOG), and the American Board of Family Medicine (ABFM). The case is currently before the Fifth Circuit.[16]

In an alert to AAPS members, Dec 18, 2023, AAPS stated:

> [T]he Association of American Physicians and Surgeons Educational Foundation (AAPS) strongly objects to the censorship imposed by the Biden Administration and medical boards against physicians who speak out about COVID policies…. Medical boards control "board certification," which physicians need to practice medicine in hospitals and participate in insurance networks. Revoking board certification based on public statements by physicians, such as how best to respond to COVID-19, harms many thousands of patients…. AAPS is also suing the Biden Administration for dispersing rather than ending its censorship activities when it discontinued its failed Disinformation Governance Board.[17]

Do Referrals for Psych/Neuropsych Fitness for Duty Evaluations Comply with the Americans with Disabilities Act and §504 of the Rehabilitation Act?

According to the ADA.gov website:

> The Americans with Disabilities Act of 1990 (ADA) is a federal civil rights law that prohibits discrimination against individuals with disabilities in everyday activities, including medical services. Section 504 of the Rehabilitation Act of 1973 (Section 504) is a civil rights law that prohibits discrimination against individuals with disabilities on the basis of their disability in programs or activities that receive federal financial assistance, including health programs and services….
>
> Private hospitals or medical offices are covered under Title III of the ADA as places of public accommodation. Public hospitals and clinics and medical offices operated by the state and local governments are covered by Title II of the ADA as programs of the public entities. Section 504 covers any of these that receive federal financial assistance, which can include Medicare and Medicaid reimbursements. The standards adopted under the ADA to ensure equal access to individuals with disabilities are generally the same as those required under Section 504.[18]

Both the ADA and Section 504 apply to individuals with physical and mental disabilities.

A case decided by the Fifth Circuit in 2016, found that Section 504 of the Rehabilitation Act authorizes employment discrimination lawsuits filed by independent contractors.[19] It also confirmed that physicians who are employed by a hospital can sue under Title I of the ADA.

Dr. Rochelle Flynn was a pediatrician who was an independent contractor for a company (Distinctive Home Care, Inc.), which, in turn, contracted with a military medical center to provide pediatric services at an Air Force base. Dr. Flynn was diagnosed with autism spectrum disorder, mild, formerly known as Asperger's Syndrome. An officer at the Air Force base expressed concerns with her performance, including failure to report to work on time and failure to timely complete patient charts. The officer directed that she be removed from providing services at the Air Force base. Dr. Flynn asked for accommodations, but the government responded it could not accommodate her request. The company that employed her, Distinctive, then informed her that they could not retain her as an independent contractor. Defendants argued that Section 504 did not apply because Dr. Flynn was not an employee.

The Fifth Circuit found: "In sum, we conclude that Section 504 of the Rehabilitation Act permits employment discrimination suits by independent contractors…. Thus, Section 504 "broadly prohibit[s] discrimination"—including employment discrimination—"against disabled persons in federally assisted programs or activities" [citation omitted].[19]

Unfortunately, courts of appeal are split as to whether Section 504 covers employment discrimination claims, and the U.S. Supreme Court has yet to resolve these differences.[19]

The Fifth Circuit, citing subsection (d) of Section 504, found that the underlying standards in Section 504 are the same as those in the ADA:

> The standards used to determine whether [Section 504 of the Rehabilitation Act] has been violated in a

complaint alleging employment discrimination under this section shall be the standards applied under Title I of the Americans with Disabilities Act of 1990 (42 U.S.C. 12111 et seq.) and the provisions of sections 501 through 504, and 510, of the Americans With Disabilities Act of 1990 (42 U.S.C. 12201 to 12204 and 12210), as such sections relate to employment.[19]

Physicians who are not hospital employees but who have privileges to practice at a hospital are considered independent contractors.

Physicians who are employees of hospitals can sue under Title I of the ADA. As noted in the Fifth Circuit decision:

> Title I is the subchapter of the ADA that prohibits employment discrimination. Title I prohibits any "covered entity" from "discriminat[ing] against a qualified individual on the basis of disability in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment."

A "qualified individual" is basically an individual who has a disability and who with or without reasonable modifications would otherwise meet the eligibility requirements "for receipt of services or the participation in programs or activities provided by a public entity."[20] It is also noted that Title II applies to medical boards as they are an "instrumentality of a State."[20]

The Fifth Circuit in the Flynn case went on to explain:

> However, not every entity that hires employees counts as an "employer" within the meaning of Title I; Congress defined the term to exclude entities with fewer than fifteen employees; and the United States and corporations wholly owned by the United States; Indian tribes; and a limited subset of tax-exempt organizations….
>
> Although this Circuit has not directly addressed the issue, other federal circuit and district courts overwhelmingly agree that a plaintiff may only sue a defendant under Title I of the ADA if the plaintiff is an employee, rather than an independent contractor, of the defendant.[19]

Another case found that Title III of the ADA applies to physicians who are independent contractors.[21]

Dr. Nolan Hetz had applied for privileges at Aurora Medical Center of Manitowoc County, and the hospital declined to grant him privileges. In his lawsuit, Dr. Hetz alleged that: "[T]he defendants violated the ADA and Wis. Stat. § 106.52 by denying his application for medical staff privileges at Aurora because of his bipolar disorder and sleep apnea."[21]

The Court denied defendant's Motion to Dismiss and found:

> I conclude that, under the plain language of the statute, Title III does provide protection for an independent contractor in such a situation, irregardless of whether such an individual could be considered a "client or customer" of the place of public accommodation. Moreover, I conclude that, even if I were to accept the defendant's narrow interpretation of Title III's protections, Hetz could still properly be classified as a "client or customer" of the hospital. Such being the case, Hetz as an individual who was not being paid by the hospital for his services and was using the hospital's facilities primarily for his own benefit, is protected by Title III. This conclusion is supported by the plain language of Title III, its expansive purpose, and interpretative guidelines promulgated by the U.S. Department of Justice.[21]

The Court went on to explain:

> [T]itle III Technical Assistance Manual distributed by the U.S. Department of Justice, Civil Rights Division, offers the following as an example of a situation covered by Title III:
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> A committee reviews applications from physicians seeking "admitting privileges" at a privately owned hospital. The hospital requires applicants, no matter their specialty, to meet certain physical and mental health qualifications, because the hospital believes they will promote the safe and efficient delivery of medical care. The hospital must be able to show that the specific qualifications imposed are necessary.
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> U.S. Dep't of Justice, Civil Rights Division, The Americans with Disabilities Act: Title III Technical Assistance Manual P 4.1100, illus. 4 (Nov. 1993).[21]

Defendants had argued that ADA Title III should not apply because it refers to "clients and customers," and they argued Dr. Hetz was neither. The Court explained:

> [T]he plain language of Title III does not limit Title III's protections to only "clients or customers." Rather, Title III's "broad general rule contains no express 'clients or customers' limitation. [Citing *Martin*, 532 U.S. at 679]. Title III uses only the general term "individual," which on its face appears to cover a doctor applying for staff privileges….
>
> The use of the general term "individual" rather than "client or customer" accurately reflects the expansive purpose of the ADA. As noted by the court in Martin, "Congress enacted the ADA in 1990 to remedy widespread discrimination against disabled individuals." 532 U.S. at 674….
>
> [T]he relationship between the hospital and the physician seeking staff privileges fits squarely within the language of Title III, as the physician is seeking the enjoyment of the hospital's facilities….
>
> In the case at hand, Aurora offers to the public both the privilege of receiving medical services, as well as the privilege of using the hospital's facilities for a doctor's personal practice.[21]

In a first-of-its-kind study published in 2018, authors sought to determine whether descriptions of indications for physician-employee referrals on Physician Health Program (PHP) websites complied with the ADA. Shockingly, they found:

> Very few, if any, of the 571 descriptions appeared to provide sufficient evidence for employers to request an examination under the ADA. About 14%, however, could refer to physicians attempting to defend themselves, assert their ADA rights, or otherwise complain about the hospital; and 27% either described physicians who complain or else had discriminatory effects in one of several different ways.[22]

Hospitals may follow the same or similar descriptions/indications for referring physicians for psych and neuropsych FFDEs.

The article points out that mental illness is not equivalent to physician impairment, although American Medical Association (AMA) policies and State laws treat them as such.[22]

The AMA's policies have also encouraged physicians

and employers to abide by medical board regulations and state laws, instead of the ADA, when considering how to respond when they suspect that a colleague or employee might be impaired (AMA, 2004; AMA, 2013). In these respects, standard practice in the medical profession does not appear to comply with the ADA.

According to the article, the ADA, which was passed in 1990, "provides clear guidance to prevent unwarranted examinations of any employee who has or is suspected of having a mental disorder, but who is not impaired."[22]

Note that the ADA applies not just to those who have a known mental disorder, but also applies to those whom others view as having a mental disorder or suspect of having a mental disorder.

> Title I of the ADA prohibits an employer from requesting mental health information from, or requiring a mental health evaluation of, an employee without a reasonable belief based on objective evidence that
>
> 1. the employee is unable to perform essential job functions because of a mental disorder; or
>
> 2. the employee will pose a direct threat to safety due to a mental disorder.
>
> *Direct threat* is defined as a high risk of substantial harm to self or others in the workplace that cannot be reduced or eliminated through reasonable accommodation, and a speculative or remote risk is not sufficient (US EEOC, 1997).[22]

Further explanation of the terms "disability" and "regarded as having an impairment" is provided in the ADA, as reviewed by the Cornell Law School Legal Information Institute. Citing 42 U.S. Code § 12102:

> The term "disability" means, with respect to an individual—(C) being regarded as having such an impairment (as described in paragraph (3))….
>
> (3) For purposes of paragraph (1)(C): (A) An individual meets the requirement of "being regarded as having such an impairment" if the individual establishes that he or she has been subjected to an action prohibited under this chapter because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity.[23]

Some examples of inappropriate reasons for referral for FFDE cited in the PHP ADA study include: defensiveness about, denial of, or unreasonable sensitivity to normal criticism of peers; conflicts with colleagues, particularly authority figures; involvement in litigation against the hospital; a tendency toward overreaction or irritability; an appearance of never being happy or satisfied; making rounds late or at unusual hours; excessive working; social withdrawal (noting that this is a common reaction to discrimination); continually asking for special accommodations; multiple or unusual medical problems or disabilities; financial problems; a history of unemployment or getting fired; attention deficit hyperactivity disorder; and making complaints about the hospital (clearly designed to discourage physician whistleblowers).[22]

Nine PHP websites "described alcohol on a physician's breath, which would permit a urine drug screen, and a referral examination only if positive."[22]

As reviewed in the fall 2023 issue of our journal, following an encounter at a nurse's station where she was critical of a nurse's handling of a situation, the charge nurse accused Dr. Rebecca Denman of having alcohol on her breath in the hospital. In violation of hospital policy, she did not report that complaint until 12 hours later. Despite lack of objective evidence of alcohol consumption, and the presence of another nurse during the encounter who said she did not smell any alcohol on Dr. Denman's breath, the physician was coerced to go to a PHP. No positive blood alcohol result was ever obtained. Nonetheless, her evaluation by the PHP resulted in a 5-year alcohol monitoring agreement, alcohol breathalyzer tests several times per day, random urine drug testing, and mandatory attendance at Alcoholic Anonymous (AA) meetings.[24]

The PHP ADA study accurately observes:

> [T]hese PHP referral criteria create a wide net, imply mandated reporting, and then ensnarl victims within a Kafkaesque nightmare of no escape through their affiliations with employers and state medical boards. There are many reasons to doubt that these descriptions actually promote the safety and welfare of patients.[22]

Unfortunately, evidence suggests that osteopathic medical boards are no better than allopathic medical boards in complying with ADA.

> Many state osteopathic medical licensing boards do not comply with ADA requirements regarding mental health, according to recent research in the JAOA [*Journal of the American Osteopathic Association*]…. Both the AOA [American Osteopathic Association] and the Federation of State Medical Boards have policies urging boards not to ask applicants about their mental health history and instead focus on current impairments. But Drs. Wagner and Lincoln found that boards in 14 states were "grossly out of compliance."[25]

The Plight of the Ethical FFDE Evaluator

As a threshold matter, the ethical evaluator who has been asked to perform a psych/neuropsych FFDE should make a determination as to whether the referral is valid and justified or whether it violates ADA or Section 504 of the Rehabilitation Act.

If the referring agency is unable to provide objective evidence to justify the referral, then the ethical evaluator should not proceed with the FFDE. This is especially true if the referral agency refuses to provide necessary information concerning the reason for referral or if there is strong suspicion based on evidence provided that the psych/neuropsych exam is being requested for some purpose other than furthering quality health care and patient safety.

Blindly proceeding with a psych/neuropsych FFDE is like subjecting a patient to exploratory surgery just to see if there is something inside that could be treated.

Unfortunately, when an ethical evaluator refuses to proceed with the evaluation when justification cannot be confirmed, the referring agency may simply seek out another evaluator who will not be inhibited by ethics.

It should also be noted that if an evaluator proceeds with an FFDE that violates the ADA or Section 504, he too may be held liable for that violation.

Conclusions

There is clear evidence that physicians being inappropriately referred for psych/neuropsych FFDEs is a widespread problem in

our nation today. Inappropriate referrals have been "weaponized" and are being utilized by hospitals, medical boards, and PHPs.

Inappropriate referrals are often done for the purpose of stigmatizing, punishing, and harming physicians who are innovators, physician whistleblowers, or successful competitors, or those who fail to conform to an official narrative promulgated by government, hospitals, or medical boards. Personal animus, professional jealousy, discrimination, and other improper motives may also form the basis for an inappropriate referral. Inappropriate referrals for FFDE evaluations violate the ADA and/or Section 504 of the Rehabilitation Act.

Objective evidence to support a referral for psych/neuropsych FFDE is required in order to comply with ADA or Section 504 of the Rehabilitation Act. A vague statement of "concern" or speculative potential harm is not sufficient.

Evidence demonstrates that the reliability and validity of neuropsych tests is highly questionable, noting that results labeled "abnormal" often occur in normal healthy individuals.

Coerced illegitimate referrals for psych/neuropsych FFDEs are unethical. The AAPS is strongly opposed to coerced illegitimate psych/neuropsych evaluations.

Physicians who have been victimized and damaged by an inappropriate referral for psych/neuropsych FFDE may be able to hold the perpetrators accountable for violation of the ADA and/or Section 504 of the Rehabilitation Act.

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