Editorial

Sham Peer Review: Undoing the Damage

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Previous editorials in this journal have dealt with the physical, psychological, reputational, and financial damage caused by sham peer review.[1-3] One editorial discussed a strategy to prevent damage by getting a preliminary injunction to prevent reporting to the National Practitioner Data Bank (NPDB).[4]

This editorial presents options for undoing the damage once a hospital or other entity has opened an investigation or after an adverse action has been reported to the NPDB.

Each case is different, with a unique set of facts and circumstances, and a careful analysis is needed to determine what actions may be successful. These options are best employed early, as once a databank report has existed for years, the prospects of removing it are poor.

Physicians should retain a knowledgeable attorney early on, and members can contact AAPS for helpful information.

Physicians also need to be aware of psychological trauma known as betrayal trauma, which can afflict victims of sham peer review.

The information presented in this editorial is not intended as legal advice or opinion. It derives from my extensive study of court documents and relevant literature, and from my experience serving as an expert in sham peer review for more than 20 years. Physicians should seek legal advice and opinion from their attorneys.

Withdrawal of Request for Corrective Action

When an official Request for Corrective Action is made, an investigation is opened, and an investigative committee is appointed. An official notice is sent to the physician. Physicians, experiencing the shock and awe effect of this notice, may not recognize that even at this early stage the physician suffers harm.

Even if the physician prevails in an internal peer review, he will still be required to self-report the investigation when applying for or renewing a medical license or hospital privileges. The physician will be required to explain the investigation for the remainder of his career.

Undoing the damage at this stage is possible, depending on the precise facts and circumstances, and with the help of a skilled attorney.

It is essential at this stage of the "attack" for the physician to set up a "war room" in his private office or home.[5] Documents need to be kept organized on folding tables so that they are readily accessible. The physician will also need to take time off from work if he is still working so he can fully focus on the actions needed to preserve his career and livelihood. This is not a part-time undertaking.

The strategy at this point is twofold: 1) Develop a written response to vigorously rebut the charges. The response should be civil and should present objective evidence. 2) Develop and implement ways to expose the hospital's wrongdoing in bringing false and/or fabricated charges.

The physician's written response to false/fabricated charges should be comprehensive, science-based where possible, and it should provide citations to the medical literature where available. At some point, the physician may be given an opportunity to make an oral presentation to the investigative committee and/or Medical Executive Committee (MEC). The physician must remain professional at all times, and needs to be prepared to respond to questions posed by the committee, which may be steeped in confirmatory bias.

If a charge of "disruptive physician" or unprofessional conduct has been lodged against the physician, the physician needs to be prepared to respond to questions from the committee, which may be designed to provoke him. A cool, calm, and collected approach is mandatory. Any angry outburst by the physician will reliably be used against him to "confirm" that he has an "anger management" problem and fails to communicate with others in a professional and respectful manner.

Ideally, the physician should practice his oral presentation before an ethical colleague who can test him with difficult questions. In making his presentation to the investigative committee or MEC, the physician should repeatedly emphasize that his highest priority is to ensure the proper care of his patients.

He should also emphasize that he is a "team player" and always seeks to work collaboratively with other team members in a professional and respectful manner. However, if in the physician's professional judgment, another team member advocates for doing something that may harm his patient, it is his professional ethical obligation to protect his patient from harm. As the "captain of the ship," the physician will ultimately be held accountable for poor outcomes as a result of improper or unsafe treatment. As the member of the team that has the highest level of training, experience, and expertise, the physician should emphasize he takes responsibility for educating other members of the team so as to provide the best possible care to patients. This is always done in a professional and respectful manner.

The physician should explain to the investigative committee/MEC that when certain team members (e.g. nurses, nurse practitioners, physician assistants, and operating room technologists) have formed strong opinions that disagree with the physician's rationale and treatment, it can result in an indignant and angry team member bent on retaliating against the allegedly "arrogant" physician for disagreeing with their opinions. This will often manifest as the team member "teaching the physician a lesson" by filing a complaint (often anonymous) against him. This provides the investigative committee with an explanation as to how these complaints come forth.

Simultaneously, while providing a vigorous science-based response to the investigative committee/MEC, the physician needs to initiate a "full exposure" campaign to highlight the hospital's wrongdoing and bad-faith motives. Sham peer review is conducted in secret behind closed doors, and other ethical colleagues at the hospital and in the community may be unaware

of what is transpiring. As increasing numbers of ethical physicians become aware of what the hospital is doing, the tide may turn.

This effort requires contacting as many ethical colleagues as possible. The physician should consider providing copies of his point-by-point rebuttal to the false charges with citations to the medical literature to support his position.

What has become increasingly clear over the years is that hospitals fear negative publicity much more than they fear lawsuits. In particular, hospitals hate having their wrongdoing in conducting sham peer review exposed.

When this exposure of wrongdoing results in a backlash of physicians against the hospital administration and those who instigated and conducted the sham peer review, it provides leverage to pressure the hospital to withdraw the Request for Corrective Action. When the Request for Corrective Action is withdrawn, the investigation is rendered null and void. The Request for Corrective Action is the action that triggers a formal investigation. Once the Request for Corrective Action is withdrawn, it is as if the investigation never occurred. That means it does not have to be reported on applications or renewals for medical licenses or hospital privileges.

When the hospital withdraws the Request for Corrective Action it is a big win for the physician, and the hospital also avoids the expense of prolonged litigation.

A knowledgeable and skilled attorney may also be able to provide further leverage based on strong facts in the case. A hospital, for instance, may not want to suffer the negative publicity of being sued for fraud and the risk of substantial damages if a lawsuit is filed.

Voiding Databank Reports by Court Order or Settlement Agreement

Voiding a NPDB report by court order or by settlement agreement requires leverage. A lawsuit that contains strong evidence, especially evidence of fraud, can successfully achieve a Void Report.[6] The court order or settlement agreement should specify a Void Report, not a Revision-to-Action report. In a Revision-to Action Report, the Initial Report remains in the databank and continues to harm the physician. The NPDB Guidebook provides:

> **49. How should a hospital report to the NPDB when an adverse clinical privileges action it took against a practitioner is changed by court order?**
>
> [I]f the court overturned the hospital's decision, the hospital should void the Initial Report.[7]
>
> *Example:* A state medical board submits an Initial Report to the NPDB when it revokes a physician's license. Six months later, the revocation is overturned by a state court. The state medical board must void the Initial Report.

In sham peer review, false, fabricated, and baseless charges are often brought against the physician. Baseless charges should not be maintained in the NPDB. In the *Van Boven* case in which AAPS filed an amicus brief with the Supreme Court of Texas,[8] the court ordered that the baseless Initial Report must be voided. Prior to that order, the Texas Medical Board had simply filed a Revision-to-Action Report. The court stated:

> Under the *Guidebook*, a Revision-to-Action Report allows the Initial Report to continue to be considered, but there is no reason to consider an Initial Report of a baseless action.
>
> Because the nature of the Final Order under Texas law was to determine that no basis for the Temporary Order had been proved, the Board was required to file a Void Report with the Data Bank. Officials' actions to the contrary were therefore ultra vires, and the officials are not immune from Van Boven's claims.[9]

Addressing Flawed Arguments Offered by Hospitals

In order to obtain a court order for defendants to void a databank report, the physician's attorney must file an application or motion for a preliminary injunction. Some hospital attorneys will argue that courts lack the authority to issue a preliminary injunction because the Health Care Quality Improvement Act (HCQIA) provides immunity from injunctions.

However, Section 11113 of HCQIA specifically references injunctive relief as being protective against a defendant's demand for attorneys' fees and costs. And, as discussed in the section above, the NPDB Guidebook also acknowledges court orders to void reports that occur as a result of an application for a preliminary injunction.

In the *Walker* case, the Court made it clear that the plaintiff physician has a right to injunctive relief under HCQIA:

> Upon careful consideration of all such evidence and arguments, the Court is persuaded that a preliminary injunction is both necessary and warranted to maintain the status quo and prevent Dr. Walker from suffering irreparable harm during the pendency of this litigation. Accordingly, Dr. Walker's motion is GRANTED.
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> [I]ssuance of a preliminary injunction is within the discretion of the Court. *Texas v. United States*, 809 F.3d 134 (5th Cir. 2015)….
>
> **A. Right to Injunctive Relief Under HCQIA**
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> As a threshold matter, the Hospital contends that the Court lacks authority to issue a preliminary injunction because HCQIA does not provide a private right to action. In pursuing this argument, the Hospital misreads the complaint and disregards binding Fifth Circuit precedent….
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> Second, the Fifth Circuit has made clear in *Poliner v. Texas Health Systems* that "[t]he doors of the courts remain open to doctors who are subjected to unjustified or malicious peer review, and they may seek appropriate injunctive and declaratory relief in response to such treatment." 537 F.3d368, 381 (5th Cir. 2008). The injunctive and declaratory relief sought by Dr. Walker in the present motion is precisely the sort authorized by *Poliner*. Rather than even address or distinguish this broad, binding precedent, the Hospital obfuscates the case law and urges the Court to rely on non-binding precedent from other district courts and state courts….The motion before the Court concerns only injunctive relief, which is not subject to HCQIA immunity….The injunctive relief that Dr. Walker seeks is very time sensitive, and the dissemination of this report throughout the relevant medical community is a bell that cannot be unrung.[10]

Hospitals will also claim that voiding a databank report is impossible or unlawful, claiming that none of the three reasons for voiding a databank report apply.

1. The report was submitted in error.
2. The action was not reportable because it did not meet NPDB reporting requirements.
3. The action was overturned on appeal.[7]

One might argue that a false report or a report containing baseless charges or a report that resulted from a peer review process where due process and fundamental fairness as specified in HCQIA were violated is a report that was filed in error and does not comply with NPDB reporting requirements. The NPDB Guidebook does not authorize making false reports. It is a crime to file a false report knowingly and willfully in the NPDB (18 U.S.C. §1001). And a hospital that knowingly provides false information in a databank report can lose immunity under HCQIA §11137(c). A court can also overturn an action if it determines there is no proven basis for the adverse action.[9]

In the *Walker* case, the Court found the hospital's argument that a court order to force defendant hospital to void the databank report would violate federal law to be not credible.

> [T]he hospital claims that a court-ordered injunction would force the Hospital "to violate federal law by not making the report." (Dkt. No. 10 at 13.) This is not a credible argument. It is the province of the federal courts—not the Hospital—to determine the requirements of HCQIA, a federal statute. Any injunctive relief ordered by the Court would compel the Hospital to comply with federal law, not violate it.[10]

Hospitals argue that they have a legal obligation to report adverse actions, and they would be subject to sanctions for failing to report. In the *El-Khalil* case, however, the Court stated:

> Detroit Medical Center (DMC) argues that it would be harmed because it has an obligation under HCQIA to report its decision. But an order from this Court could relieve DMC of that burden.[11]

Courts also have noted that an erroneously filed NPDB report causes immediate irreparable harm to the physician. In the Walker case, the Court stated:

> An erroneously filed report announcing to all interested parties that a physician has been sanctioned, suspended, or lacks adequate skill to practice medicine carries with it the potential to immediately and irrevocably harm that physician and his practice. The stigma and reputational harm poses a substantial threat to Dr. Walker's ability to gain or maintain employment to support his practice.[10]

Hospitals also argue that a court order forcing them to void a databank report would defeat the intended purpose of HCQIA, which is to restrict the ability of incompetent physicians to move from state to state without being detected. But, in the case where a hospital has knowingly filed a databank report containing false information, with no true nexus to professional competence or conduct, that report would restrict the ability of a competent physician to practice in a chosen area. That is the antithesis of the intended purpose of HCQIA. Moreover, the public interest is disserved by disseminating a false databank report. Such false reports may deprive patients of access to the services of a good physician.

Courts also have wide latitude when it comes to providing equitable relief to correct injustices and past wrongs. In the *Porter* case, the U.S. Supreme Court held:

> Unless otherwise provided by statute, all the inherent equitable powers of the District Court are available for the proper and complete exercise of that jurisdiction. And since the public interest is involved in a proceeding of this nature, those equitable powers assume an even broader and more flexible character than when only a private controversy is at stake….
>
> Moreover, the comprehensiveness of this equitable jurisdiction is not to be denied or limited in the absence of a clear and valid legislative command. Unless a statute in so many words, or by a necessary and inescapable inference, restricts the court's jurisdiction in equity, the full scope of that jurisdiction is to be recognized and applied. The great principles of equity, securing complete justice, should not be yielded to light inferences, or doubtful construction.[12]

Finally, with regard to settlement agreements, which include a provision whereby the defendant hospital is required to file a Void Report, it follows logically that if a court can order a Void Report, it can approve a settlement agreement that requires a Void Report.

Federal Courts Can Order the Department of Health and Human Services (HHS) to Void a NPDB Report

Federal courts have the power to order HHS to void a wrongful databank report. In the *Simpkins* case, Judge Royce Lamberth (the same judge who presided over *AAPS v. Clinton*) addressed a number of common themes that have repeatedly surfaced over the years. These include the Chevron Doctrine, which defers to the expert judgment of federal agencies; HHS's claim it has no obligation to review the accuracy of a databank report; and HHS's claim that a physician's ability to submit a Subject Statement in a databank report resolves all concerns and issues. The Court's analysis and discussion are well worth reading:

> The Court shall first consider plaintiff's allegations under the Administrative Procedure Act ("APA"), 5 U.S.C. §§ 501 et seq. Plaintiff argues that the defendants' actions with regard to the Adverse Action Report were "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. 706(2) (A). Plaintiff claims that HHS's review of the Adverse Action Report was improper, and that a more thorough examination by HHS would have revealed that neither of the predicate conditions for a Data Bank report, as established by Section 11133 of the HCQI Act, were present. Defendants respond that judicial review of HHS's actions under the APA is highly deferential and that HHS's obligations under the HCQI Act are narrow and limited.
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> Defendants correctly point out that judicial review of administrative action under the APA is limited to the administrative record before the agency at the time the agency issues its decision. See *Camp v. Pitts*, 411 U.S. 138, 142-43, 93 S. Ct. 1241, 36 L. Ed. 2d 106 (1973). Defendants assert that under the APA the "standard of review is a highly deferential one, which presumes the agency's action to be valid." *Environmental Defense Fund, Inc. v. Costle*, 657 F.2d 275, 283 (D.C.Cir.1981) (citations omitted). Nevertheless, the D.C. Circuit in *Costle* also asserted:
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> [W]e must be assured that the agency action was "based on a consideration of the relevant factors," and

that "the agency has exercised a reasoned discretion, with reasons that do not deviate from or ignore the ascertainable legislative intent." Our inquiry into the facts must also be searching and careful....

42 U.S.C. §11133(a) (1). The Board of Medical Examiners is required to submit this information to the Secretary or, in the Secretary's discretion, to an appropriate private or public agency. See 42 U.S.C. § 11134.

Defendants appear to argue that they did not need to review the accuracy of the information submitted to the Data Bank. The defendants phrase this argument as support for the contention that plaintiff was given meaningful notice or opportunity to contest his listing in the Data Bank. Nevertheless, this court disagrees with the implication of defendants' argument, namely that the Secretary could resolve all concerns about a Data Bank report by simply "noting that a dispute exists about the accuracy of the information and including a brief statement by the physician or practitioner setting forth the disagreement regarding the information." Def. Mem. at 9 (citing H.R. Rept. No. 903, 99th Cong., 2nd Sess., at 19, reprinted in 1986 U.S. Code Cong. & Admin News at 6402). As defendants recognize, the HCQI Act requires HHS to establish procedures to govern disputes concerning the accuracy of information contained in the Data Bank. 42 U.S.C. § 11136(2). Pursuant to this requirement, HHS issued 45 C.F.R. § 60.14, which describes how to dispute the accuracy of Data Bank information. These regulations provide that if the reporting entity does not revise the reported information, the Secretary will, upon request, review the written information submitted by both parties, and if the Secretary concludes that the information was incorrect, send corrected information to previous inquirers. See 45 C.F.R. § 60.14. This indicates that in certain circumstances the Secretary's duties under the HCQI Act are broader than the defendants imply.

Moreover, this court is convinced that regardless of what HHS's obligations may or may not be to review whether a reporting entity acted correctly in a peer review action or an entity's investigation of a doctor, it has a duty to determine whether the events that transpired should have resulted in a Data Bank Report.[13]

Based on violation of the Administrative Procedure Act (APA), and the Court's determination that the report should not have been filed, the Court ordered HHS to void the databank report.[13]

Supreme Court Overturns Chevron Doctrine

On June 28, 2024, the deep state took a deep hit when the U.S. Supreme Court struck down the Chevron Doctrine in the case of *Loper Bright Enterprises et al. v. Raimondo, Secretary of Commerce et al*.[14]

This ruling will dramatically change how courts analyze agency actions under the APA and may make it easier for physicians to force HHS to void wrongful databank reports.

Excerpts from the embedded syllabus highlight and summarize this landmark ruling:

Held: The Administrative Procedure Act requires courts to exercise their independent judgment in deciding whether an agency has acted within its statutory authority, and courts may not defer to an agency interpretation of the law simply because a statute is ambiguous; *Chevron* is overruled. Pp. 7–35.

(a) Article III of the Constitution assigns to the Federal Judiciary the responsibility and power to adjudicate "Cases" and "Controversies"—concrete disputes with consequences for the parties involved….

As relevant here, the APA specifies that courts, not agencies, will decide "*all* relevant questions of law" arising on review of agency action, 5 U. S. C. §706 (emphasis added)—even those involving ambiguous laws….

And by directing courts to "interpret constitutional and statutory provisions" without differentiating between the two, §706, it makes clear that agency interpretations of statutes—like agency interpretations of the Constitution—are *not* entitled to deference….

(c) The deference that *Chevron* requires of courts reviewing agency action cannot be squared with the APA. Pp. 18–29….

Chevron cannot be reconciled with the APA by presuming that statutory ambiguities are implicit delegations to agencies. That presumption does not approximate reality. A statutory ambiguity does not necessarily reflect a congressional intent that an agency, as opposed to a court, resolve the resulting interpretive question….

The Framers anticipated that courts would often confront statutory ambiguities and expected that courts would resolve them by exercising independent legal judgment. *Chevron* gravely erred in concluding that the inquiry is fundamentally different just because an administrative interpretation is in play….

At best, *Chevron* has been a distraction from the question that matters: Does the statute authorize the challenged agency action? And at worst, it has required courts to violate the APA by yielding to an agency the express responsibility, vested in "the reviewing court," to "decide all relevant questions of law" and "interpret… statutory provisions." §706 (emphasis added). Pp. 26–29….

And rather than safeguarding reliance interests, *Chevron* affirmatively destroys them by allowing agencies to change course even when Congress has given them no power to do so….

By overruling *Chevron*, though, the Court does not call into question prior cases that relied on the *Chevron* framework.[14]

Overcoming Betrayal Trauma

According to a recent article:

Betrayal trauma occurs when an individual's well-being is threatened by an important person or institution in their life. They will have had a close relationship, dependence, or trust with the person or institution who betrayed them.

An individual affected by betrayal trauma endures not only the traumatic events but also a violation of the trust they had in the person or institution responsible for hurting them.[15]

The concept of betrayal trauma clearly applies to victims of sham peer review in which there is a betrayal of trust in the peer review process; betrayal by colleagues who initiate, instigate or participate in sham peer review; and betrayal of basic principles of due process and fundamental fairness. It is another form of irreparable harm that impacts the physician victim.

When a physician sues the perpetrators, he may also encounter betrayal by the legal system in which judges may fail to follow the standard of review for motions for summary judgment or may demonstrate bias in favor of the hospital. This betrayal by the legal system effectively deprives the physician of his day in court. The physician victim may also be shocked to learn that under HCQIA law, he is presumed "guilty" unless and until he can prove his "innocence" by a preponderance of the evidence.

Sham peer review involves both interpersonal and institutional types of betrayal trauma. From an institutional standpoint, physicians are often dependent on a hospital for their livelihood. A physician may trust a hospital to follow its own medical staff bylaws in conducting peer review. Sadly, hospitals do not always do that.

From an interpersonal standpoint, physicians often naively believe that professional colleagues won't use false, fabricated, and/or trumped-up charges to destroy their careers. Physicians may believe that their colleagues will treat them fairly.

A published definition of institutional betrayal is as follows:

> Institutional betrayal occurs when an institution causes harm to an individual who trusts or depends upon that institution. There are parallels between interpersonal and institutional betrayal….
>
> Betrayal may be actively committed by institutions [This is sometimes reflected in medical staff bylaws that are specifically designed to deprive a physician of due process in peer review or place the physician at severe disadvantage.]….
>
> Institutional betrayal may remain unchecked when performance or reputation is valued over, or divorced from, the well-being of members….
>
> In order to protect their reputations, institutions will often go to great lengths to ensure "damage control" when allegations of abuse surface rather than admit wrongdoing.[16]

A common claim that physicians file against hospitals in sham peer review cases is breach of implied covenant of good faith and fair dealing. The accused physician may assume that the hospital will act with integrity and fairness only to suffer institutional betrayal when the hospital employs an "end justifies the means" approach to peer review.

According to the Cornell Law School Legal Information Institute:

> Implied covenant of good faith and fair dealing (often simplified to good faith) is a rule used by most courts in the United States that requires every party in a contract to implement the agreement as intended, not using means to undercut the purpose of the transaction. The rule applies in the performance of a contract, and the rule applies to generally any contract automatically without being stated in the agreement [emphasis in original]….
>
> Typically, courts find that a party breaches this rule when they act in ways that obviously undermine the benefits to the other party from the contract or if one party attempts to sabotage another in performing their end of the agreement.[17]

In most states, medical staff bylaws are a contract between the physicians on staff and the hospital board of directors. The medical staff bylaws contain provisions for conducting peer review, which the hospital should follow.

There are stages the physician victim goes through in processing betrayal trauma. These are essentially the same as the Kubler-Ross stages of grief with the exception that there is no bargaining stage in betrayal trauma and two additional stages are identified.

The Kubler-Ross stages include denial, anger, depression, and acceptance.[15] Two additional stages of betrayal trauma include shock and obsession.[15]

At the time of a sham peer review attack, most physicians experience a "shock and awe" effect. This, along with isolation, is often an intended result sought by the perpetrators. Later, a physician may be obsessed with what was wrongfully done to him and may constantly replay the events in his mind.

Concordant with the stages of betrayal trauma, in the short term this will manifest as a painful "open wound." Over time, that will heal and leave a "scar." The "scar" will always be there as a reminder of what was done to the victim. This is true even if the physician wins his case at trial or achieves a favorable settlement.

It should be noted that in some cases, betrayal trauma can cause physical illness, anxiety, depression, dissociative symptoms, post-traumatic stress disorder, and substance abuse disorder.[15] It can also result in suicide.

Healing from betrayal trauma takes time. Each case is different. It begins with an acknowledgement of what has happened so that the physician can move on with his life. Physician victims need to understand that evil exists and there are evil people who do evil and malicious things to harm others. And addressing these wrongful actions via the legal system does not always result in justice. Life is not always fair.

If at all possible, the physician needs to distance himself from the perpetrators. Even if a physician prevails at some point, returning to practice in the same hospital will likely result in the perpetrators doing it again albeit with more devastating effect the next time. At the same time, surrounding oneself with ethical colleagues is beneficial. The physician should recognize the good things he still has in his life, including family and friends.

From a practical standpoint, the physician victim must find a way to make a living so as to support himself and his family. This may involve establishing an outpatient, third-party-free, opted-out (of Medicare) practice, or if the physician is a surgeon, practicing at an independent, physician-owned surgery center. AAPS has held numerous seminars to show physicians how to thrive, not just survive in such a practice model (posted on the AAPS website).

Talking through what happened with an ethical colleague will help validate the sense of wrong that was done and help build resilience. In some cases where there is significant anxiety and/or depression, or other psychological reaction, seeking help from a therapist who is specifically trained in dealing with betrayal trauma may be needed.

And, finally, it is important for those who have gone through a sham peer review to educate other physicians, raise awareness

about sham peer review, and assist other colleagues who are under "attack." A physician who has been through sham peer review can provide helpful information to others currently going through the same trauma. Helping others can contribute to the healing process.

Ethical physicians must always support other ethical physicians and seek ways to attach a social stigma to unethical physicians who bring false, fabricated, trumped-up charges against a good physician and who instigate and participate in sham peer review.

Conclusions

Various options are available for undoing the damage caused by sham peer review.

The best possible outcome can occur early on with a negotiated withdrawal of the Request for Corrective Action. This renders the investigation moot, which means it is not subject to self-reporting on applications and renewals for medical licenses and hospital privileges.

Once an adverse action has been taken and has been reported to the NPDB, there may be the possibility of voiding the databank report by court order or by settlement agreement. That eliminates the most severe reputational and financial damage done to the physician victim. Knowing how to successfully address flawed arguments of hospitals seeking to prevent a Void Report is key.

All victims of sham peer review are subject to betrayal trauma of varying degrees and duration. This includes physicians who prevail at trial or who achieve a favorable settlement agreement as well as physicians who are decimated by a sham peer review.

Healing from betrayal trauma is possible with the right approach, individualized for each physician. Helping to educate other physicians about sham peer review, providing information a physician has learned from his own case, and helping other physicians under "attack" can be part of the healing process.

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