

Chapter 10

Functioning as a Physician in a Regulatory Environment [Controlled by Medical Boards and the Medical Industrial Complex]

Eric A. Dover

“Unless we put medical freedom into the Constitution, the time will come when medicine will organize into an undercover dictatorship. To restrict the art of healing to one class of men and deny equal privileges to others will constitute the Bastille of medical science. All such laws are un-American and despotic and have no place in a republic ... The Constitution of this republic should make special privilege for medical freedom as well as religious freedom.”

Dr. Benjamin Rush

[George Washington’s personal physician]

How true Dr. Rush’s words ring today. They are no doubt prophetic. Then again, it seems Medicine, in the general sense, has been fighting this battle for centuries. Innovative and questioning “healers” have always fought uphill against the establishment and its restrictive “idea” of Medicine. The medical establishment, for various reasons including greed, pride, power and the demise of their closely held medical beliefs and treatments, has typically punished medical pioneers. These “pioneers” suffer greatly at the hands of those who control the medical system and wield immense power over them. Many have lost careers, families, and some even their lives, as a result.

INTRODUCTION

During the past few decades physicians have faced ever increasing challenges to the practice of medicine that I’m not sure even Dr. Rush could have fully envisioned. There have always been mental, physical and financial challenges. But now physicians deal with a “system” that is so overreaching in its effect and so wholly protected legislatively, that it can, without hesitation, destroy their careers and them. The labyrinth that physicians must maneuver, especially those in small groups or solo practice, is vast. The very essence of this “system” is to make all of medicine an allopathic algorithm and healthcare providers just a cog in it. The “system” is destroying the art of medicine and its advancement, patient lives and our country. The “system” doesn’t allow alternatives unless “blessed” by those in power, and still only as a substandard alternative to their allopathic treatments.

Little is written on the subject of Medical Boards, Physician Health Programs (PHP); or the Medical Industrial Complex and their adverse affects on physicians and other healthcare provider’s lives. There is rare media coverage of Medical Boards despicable behaviors directed towards physicians; yet, like police violence, it’s occurring on a daily basis. An occasional article or editorial is seen in a medical journal or blog regarding the subject. So, physicians suffer silently, typically alone and without support, as their lives and financial stability crumble around them. No one has researched the professional, social and psychological outcomes of physicians

who have been “disciplined”, nor is there research regarding patient outcomes post physician “discipline” by a Medical Board or other entity.

Impact of the Challenge

Most physicians lack a basic understanding or knowledge of their State’s Medical Practice laws, Medical Board process, State Administrative law, Federal law, the National Practitioner Data Bank (NPDB or just Data Bank), hospital peer review or any other oversight entity until they become entangled in its webs. Even then, most physicians lean heavily on their lawyer’s understanding of this overwhelming event and that knowledge can be quite variable. One thing lawyers overwhelmingly understand is that Medical Boards and other similar entities are politically and legally “protected”. Physicians are naïve to this, believing in the justice of the system to protect them.

The social and psychological upheaval the physician will experience dealing with Medical Board or other “oversight” entity investigation is sudden and dramatic. The physician will be caught completely off guard lacking any education, or time to educate themselves, with how to deal with such a catastrophic event. There will be a **loss of income** related to their practice of medicine for months, years or forever. The physician may become **financially destitute** as a result of legal costs, absence from work and mandated program costs. Physicians will probably suffer **marital and social discord**, no matter how strong their relationships, as a result of institutional intrusion, right or wrong. Many times there is associated **psychological damage** such as anger, alienation, social withdrawal, PTSD, depression and even suicide [1]. There will be **difficulty reintegrating into the work force** for those who lose their ability to practice medicine, especially older physicians who typically have no skills other than medicine. There will be **loss of faith in the system**, and the protections it should provide, as the physician finds they are helpless to these entities that are protected by the courts, administrative law, past legislative decisions, the media and politicians.

MEDICAL BOARDS

Brief History

The first medical board was established in Connecticut in 1792 by the state legislature. It consisted of a group of physicians who evaluated the competency of physicians wishing to practice in the State. Medical Boards eventually evolved and became very powerful with the addition of Medical Practice Acts containing a plethora of administrative rules. The Medical Boards stated mission was, and still is, the protection, health and safety of the public. State Boards formed a national group, the Federation of State Medical Boards (FSMB), in 1912. The FSMB was the first institution to publically list names of disciplined physicians in a monthly bulletin [2-3].

In the 1980’s and 1990’s there were a number of high profile cases involving physicians and public safety. One such case, international in scope, concerned surgeon Dr. Jayant Patel. Significant news coverage regarding his surgical outcomes and knowledge resulted in the heightened questioning of Medical Boards and whether they were actually fulfilling their mission

of protecting public health and safety. The Oregon Medical Board (OMB) was scrutinized for allegedly “ignoring” 79 complaints, and at least three deaths, attributed to Dr. Patel’s surgical care from 1989 to 1998. The OMB abdicated all responsibility for the situation with a myriad of excuses for why they had no control over this physician or the HMO he worked for.

The OMB then came to the state legislature with a “fix” to supposedly prevent any further such incidents. The OMB advocated for greater authority over physicians and greater independence from government oversight. With the din of the press and public, the Oregon Legislature gladly granted the OMB their wish. Other states followed Oregon’s example [4-6]. Not a single individual associated with the OMB, whether administrative or board member was investigated in any meaningful way for their horrendous dereliction of duty. Not one of them had their license restricted, suspended or revoked for such serious offenses. None of them were ordered to pay out of pocket to go to “programs” for competency evaluations, psychological examinations or “courses” to help them become better board members. No one resigned, nor was anyone dismissed, from their position of power. The OMB’s inaction led to a number of deaths and numerous patients with chronic post-surgical medical disorders, yet all individuals involved with the OMB were protected from malpractice lawsuits

With cases such as Dr. Patel’s featured prominently in the mainstream media, Medical Boards nationwide came under intense public pressure and scrutiny as it became clear they were not fulfilling their mission of protecting the public’s health and safety. The public saw physicians as a privileged class, protected by their colleagues and Medical Boards. They were correct to a degree. Public safety groups like Public Citizen, who had been taking Medical Boards, hospitals and large clinics to task for years regarding what they felt was a lack of physician oversight and discipline, began ranking state medical boards based on how many disciplinary actions they handed out each year. In their 2011 report, **Public Citizen’s Health Research Group Ranking of the Rate of State Medical Boards’ Serious Disciplinary Actions, 2009-2011**, the authors made the erroneous assumption that the greater the number of physician “disciplines” (actions) per 1000 physicians, the better job that State’s Medical Board was doing. Therefore, at 6.79 actions per 1000 physicians, Wyoming was doing the “best” job and at 1.33 actions per 1000 physicians, South Carolina was doing the “worst” job [7-9].

Medical Boards vary remarkably from state to state. There are only two constants among them. First, each state has a Medical Board. Second, the Board makes all final decisions concerning licensees. Otherwise, there’s no consistency when it comes to what’s sandwiched in between. The Medical Board’s authority is grounded in the States Medical Practice Act, which gives them the authority to enforce laws for licensing, monitoring and disciplining physicians in the state. Every state has its own unique laws and processes, but every medical practice act covers the basics regarding oversight of physicians practicing medicine in the State. The U.S. Federation of State Medical Boards (FSMB) periodically issues guidelines on the essential elements of a medical practice act [10].

Medical Board Structures – “The Tale of Two Boards”

The great majority of States have in reality two Medical Boards. All States have a “Board Proper” and all but a handful have an “Administrative Board”.

The “**Board Proper**” is, depending on the State, made up of seven to sixteen individuals. There will be a President (Chairperson) and President Elect. The Board Members are “volunteers”, typically appointed by the State’s Governor. The individuals who constitute the Board vary greatly and are somewhat determined by the medical disciplines overseen by the Medical Board. Oklahoma presently separates the Boards overseeing Medical Doctors (MD) and Doctors of Osteopathy (DO) [11]. Other Medical Boards may oversee Physician Assistants (P.A.), Midwives, Respiratory Therapists, Podiatrists, Athletic Trainers, etc., who may, but typically don’t, have direct Board representation. All States have M.D.s on the Board. Some Boards are made up of all M.D.s. Others members of the Board may include D.O.s, P.A.s, Podiatrists, Midwives, Respiratory Therapists, a representative from the Secretary of State’s office, the Commissioner of State Boards or an Educational Director. Many, but not all Medical Boards, will have anywhere from one to three Public Members. Some States require Public Members come from a specific profession such as a lawyer or hospital administrator. Other States have no such qualifications; therefore the Public Member can come from any profession.

The “**Administrative Board**” is the other Medical Board. They run and supervise the operations throughout the year. Their personnel, structure and operation vary widely from State to State.

Most States have an Executive Director who supervises the Board. Some states, such as New Mexico [12] or Indiana [13], use a State Board Director who operates as the “Executive Director” for all State Boards. Pennsylvania uses a State Administrator in lieu of an Executive Director [14]. Individuals who fill these positions are typically legally or administratively trained and without any medical or scientific background.

Many States have a Medical Director who is a physician. Their tasks include working with Investigators, lending medical expertise and working on Board Committees. Some State Medical Boards, such as Delaware, don’t have a Medical Director [15].

Medical Boards are divided regarding legal staff. Oregon has an Executive Director who is a J.D. along with additional in-house legal staff. They also rely heavily upon a single Assistant Attorney General from the State Department of Justice [16]. In Pennsylvania, all Boards use the Office of General Council for legally related issues [17].

Each State handles their Medical Board investigations differently. Some Boards have in-house investigators. They frequently are ex-police detectives with no medical background. California’s Investigators are called “Peace Officers” and they aren’t typically ex-police [18]. In North Dakota, the Board Members act as the investigative staff and will hire outside investigators if necessary [19]. In Delaware, investigations are handled for all boards in the state by the Division of Professional Regulation [20].

Anatomy of a Complaint

A complaint to a State Medical Board regarding a physician can arise from anyone. It could be a patient or their family, physician colleague or competitor, pharmacist, hospital personnel,

insurance company, Medicare, Medicaid, the legal system, IRS, Medical Board Member or staff, wife, partner, family member or neighbor. Again - anyone?

There are two types of complaints, legitimate and illegitimate. **Legitimate complaints** would be for offenses such as medical errors, drug abuse, sexual improprieties, prescribing concerns, abusive behavior or inability to practice safely. Examples of **illegitimate complaints** would be a medical insurance company unhappy with a physician because of disagreements over prescriptions or procedures; an unhappy spouse or family member, especially if there's conflict such as divorce or child custody; board members on a "crusade" against physicians utilizing evaluations or treatments not embraced by the Board and their allopathic algorithms (in Oregon this has occurred regarding assisted suicide and alternative medical care such as chelation or medical cannabis); physicians looking to remove competitors from their community; individuals with a personal vendetta against certain types of healthcare providers such as PA's, DO's, Family Physicians, Chiropractors; or retaliation by anyone who so chooses to cause harm.

Complaints are always anonymous. The Complainant is never directly named, although it may be obvious from Medical Board correspondence, questions or chart requests. Anonymous complaints from nowhere, not linked to a specific patient interaction, are most ominous because the physician is unaware of who made the complaint and what specifically it is based upon.

The potential for abuse is obviously very high. Two examples of this come from Texas. One is described in AAPS vs. Texas Medical Board. AAPS's (Association of American Physicians and Surgeons) complaint alleged abuses perpetrated on physician by means of anonymous complaints, harassment of doctors who complained about the Board, conflicts of interest by decision-makers and violation of AAPS members' constitutional rights. This case ultimately forced the resignation of the Medical Board's Executive Director [21]. The other example is the Texas Medical Board's and FDA's unending attacks on Dr. Stanislaw Burzynski and other alternative healthcare providers [22-23].

Another example is unfolding in Oklahoma where their Medical Board is seemingly being used to remove competition. This has prompted an investigation of the Medical Board and has one State Representative asking the Governor for the resignation of the Board's Executive Director [24-25].

Every Medical Board has an algorithm for processing a complaint from start through finish. Most don't have any diagrammatic depiction of their algorithm available on their website. Many Board websites have a brief written description of the process and others nothing at all.

When Medical Boards violate their own processes and procedures they almost never suffer any repercussions. These violations are easily kept from public view. Many times physicians and their lawyers aren't even aware of these violations, but even if they are, they usually won't complain. Any complaints about, or demands for, due process by a physician are termed "arrogant" by the Board. Most physicians' lawyers understand that you do whatever the Medical Board says, right or wrong, or else their client will lose their license.

The Investigative Process

The investigative process is the most critical step of the complaint progression. It determines whether the case moves forward with further scrutiny or is closed. Again, the individuals and "system" used varies from state to state. Medical Board members have become extremely reliant on investigators and administrative staff to "feed" them what they assume is reliable and well investigated case material.

A State audit of the Oregon Medical Board in 1996 found [27]:

- Investigators were overwhelmed with work
- Investigators had limited time available per case
- A significant number of cases were taking a very long period of time to close
- Investigators were doing a very poor job of documentation.

It has been almost twenty years since this audit was performed and these and other issues have not been revisited since.

When an Investigation is not “Closed”

If an investigation is not closed, then the case moves forward with further exploration of charts, witnesses, medical experts, etc. The process varies remarkably from state to state. In Delaware, the Division of Professional Regulation does the investigation up through the hearing, if needed [28]. In Minnesota, the Medical Coordinators on the Complaint Review Committee act as a mini Investigative Committee [29]. In Oregon, the complaint and investigation are moved to the Investigative Committee (IC) which consists of Board physicians, physician "expert(s)", an Assistant Attorney General that works directly with the Board on a routine basis, investigator(s), the Medical Director and Executive Director. These individuals conduct an “interview” (interrogation) of the physician in a Star Chamber setting where your lawyer, if you decide to bring one, is not allowed to intercede on your behalf [16].

Due Process

Due process is guaranteed to American citizens by the Fifth and Fourteenth Amendments. The **Fifth Amendment’s** Due Process Clause applies to the federal government (“No person ... shall ... be deprived of life, liberty, or property, without due process of law”). The **Fourteenth Amendment’s** Due Process Clause applies to state and local governments (“nor shall any State deprive any person of life, liberty, or property, without due process of law”) [30].

Procedural due process is “a course of formal proceedings [legal proceedings] carried out regularly and in accordance with established rules and principles.” [31]. It focuses on fair and timely procedures.

Substantive due process is “a judicial requirement that enacted laws may not contain provisions that result in the unfair, arbitrary, or unreasonable treatment of an individual” [31]. It focuses on government regulation.

Consent Agreements/Stipulated Orders

Once the entirety of the “investigation” is finished, the Board can choose to close the case, send a letter of concern, or pursue discipline of the physician. Discipline can come in many forms such as a restricted, suspended or revoked license; evaluations of all types; refresher courses; proctors; and always a fine. Physicians are given the choice of **signing a "forced confession"** called a Consent Agreement or Stipulated Order, or requesting a hearing. By signing these Consent Agreements/Stipulated Orders, the physician admits their guilt to Medical Board charges made against them. These legal documents also preclude future litigation by the physician against the Board. With the threat of license revocation, the physician, under duress, will sign almost any document in the hope of placating the Medical Board and keeping their license. There are few, if any, compromises available to the physician, yet the entire deception gives those outside the process the illusion of compromise between the Medical Board and physician and an aura of integrity and fairness. If a physician is resolute in their innocence or demands due process they are labeled “arrogant” or “disruptive”. The Medical Board will then become “dogged” in their pursuit to exile the physician from Medicine forever. Therefore, physicians are apt to sign legal documents that may not have a modicum of truth to them and many times aren’t in their best interest.

Hearings

Hearings are offered to physicians by the Medical Board, or other governmental agency in charge at that juncture of the process, as a means to redress and contest the Board’s charges and decisions. The physician decides if they desire a hearing to challenge the Medical Board. Each State has a format for hearings. Hearings are held in an Administrative Law setting with an Administrative Law Judge (ALJ) presiding. Medical Boards are not bound by the ALJ’s decision and can ignore any or all parts of it. Many physicians see hearings as nothing more than a facade of due process with the actual intent being revocation of the physician’s license. A physician is very unlikely to “win” a hearing with their license fully intact. It’s very likely to be revoked.

Administrative Law has a separate set of rules/laws/procedures than trial court. There is no jury and very low evidentiary standards are allowed to determine the outcome of cases. “Administrative law uses the lowest evidentiary standard termed a “**Preponderance of the evidence**”. The evidence is not sufficient to free the mind wholly from all reasonable doubt, but is sufficient to incline a fair and impartial mind to one side of the issue rather than the other. “**Clear and convincing evidence**” involves evidence indicating that the [charge] to be proved is highly probable or probably certain. This is a greater burden than preponderance of the evidence, and is the standard applied in most civil trials, but is less than “**Evidence beyond a reasonable doubt**”, the [norm] in criminal trials” [32].

Post Hearing

A physician, if unhappy with the hearing outcome and the Medical Board’s Final Order, may appeal the Board’s decision. **Appeals** look at nothing but the process of the physician hearing. They do not retry the case.

All states have an appeal process. In most states you appeal directly to an Appellate Court and then onto the State Supreme Court if indicated. In a handful of states, such as Nevada or New Hampshire, you appeal to the State Supreme Court. Some Supreme Courts decide whether the case should be referred to the Appellate Court or closed. Other Supreme Courts actually hear the appeal if they don't close the case [33].

It is uncommon to win an appeal of a Medical Board decision. Physicians in Oregon have never won a State appeal of a Medical Board decision (at least in recent decades) except one where only the fine was overturned, not the Medical Board's decision. The OMB is quite proud of this as they boast in their self generated 2013 performance document [34].

The Entirety of the Process – Complaint to Discipline

Unfortunately, even with State and Federal laws and rights in place to supposedly protect physicians, there are in most cases no protections. The process is typically opaque, secretive and extremely psychologically and financially taxing to the physician and their family. Going through a hearing or appeal at this point in time should be avoided if possible. The cards are stacked in the Boards favor, and no matter how wrong they may be or how right the physician is, it is a monumental battle in any Court to overturn a Medical Board decision. **“No physician should expect that there is, or will be, a ‘day in court’ that exonerates them or provides them with justice.”**[35].

Medical Boards are given broad latitude and treated as if they are infallible by the government, courts, media and public. Most Medical Boards have **little, if any, effective oversight**. Most States have **no system, let alone functional ones, for public or physician complaints** regarding their Medical Board. In addition legislation and courts have granted **these Boards immunities unimaginable to the general public**. This creates a recipe for disaster that has and is playing out in many states, some mentioned previously. Medical Boards control all information regarding physician cases and only their opinions are published for public consumption. Medical Boards have every opportunity to do “damage control” regarding their poor judgment, sloppy work and criminal actions. Physician's licenses are routinely restricted, suspended, or revoked for much less, but Medical Boards almost never suffer any repercussions for their extraordinary malfeasance.

State legislatures throw softball questions and criticisms at Medical Boards, but seem reticent to question their decisions. These legislatures are politically paralyzed; unable or unwilling to implement effective oversight or reforms of their Medical Boards. Federal Courts, in particular the District Courts, have been unwilling to question the constitutionality of State Medical Practice Acts or address physician charges of Medical Boards acting unconstitutionally.

Source: David Ogle, MD v Ralph Yates, DO; et al (2011) [36]. There have been a limited number of cases that have gone to Federal Appeals Courts and rarely to the Supreme Court.

Medical Board members and associated governmental figures are in general granted "absolute immunity" for any wrongdoing or errors no matter how serious they may be or how adversely

their actions effect physicians, their families and patients. Immunity is not constitutionally warranted. The Courts state that the Eleventh Amendment gives these Boards immunity. First, the **Fourteenth Amendment** supersedes the Eleventh Amendment as was the intent of Congress. Section 1 of the Fourteenth Amendment reads “All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. **No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws**” [37].

Second, the Eleventh Amendment reads, “The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens of another State, or by Citizens or Subjects of any Foreign State [38]. Nowhere in this Amendment does it state that a citizen can’t sue their State for constitutional violations against them; nor does it claim immunity for government or even use the word immunity. The Eleventh Amendment is the result of the Supreme Court case **Chisholm v. Georgia (1793)** which permitted a suit to be brought by a citizen of South Carolina against the state of Georgia. Fearing that other states would follow suit, the amendment was proposed on March 4, 1794. It was ratified by 12 of the then 15 states on Feb. 7, 1795. South Carolina ratified the Amendment in 1797; New Jersey and Pennsylvania did not ratify the Amendment [39]. The Federal Courts subsequently perverted the 11th Amendment and extended undeserved immunity to State actors.

One recent case appealed to the Fifth Circuit Court of Appeals was a victory for physicians. The Fifth Circuit on **December 2, 2010**, in the case **AAPS v. Texas Medical Board (2010)**, ruled against the Texas Medical Board (TMB), allowing landmark litigation by the Association of American Physicians and Surgeons (AAPS) to proceed to prove wrongdoing by the Board [40]. Unfortunately, in 2013 this all came to an end when the District Court Judge made a bench decision and dismissed the case. AAPS was not financially able to appeal the decision a second time.

Medical Boards Targeting of "Outliers"

On January 9, 2015 Alex M. Siegel, J.D., Ph.D., who is Director of Professional Affairs for the Association of State and Provincial Psychology Boards spoke to the Oregon Psychology Board. He stated that “outlier” psychologists, who don’t fit in with the mainstream herd mentality and organizations, are going to be the target of Board investigations and discipline. As repugnant as his words were, they were truthful and insightful. This same doctrine holds true for Medical Boards who target what they consider to be “outlier” health professionals.

Their primary targets have been [41-46]:

- Solo practitioners
- Alternative medicine adherents who utilize such treatments as chelation, medical cannabis and other non-allopathic medications and procedures
- Those who question vaccines

- Those working outside the mainstream insurance model
- "Loners"
- Those not involved in mainstream medical associations
- Assisted suicide advocates
- Mavericks and nonconformists
- Physicians working with malpractice lawyers
- Whistleblowers
- Possibly race as accused in California

Medical Board Overreach

Medical Boards have morphed into a disciplinary arm of the State and Federal government for non-medically related issues. Medical Boards control the means of a physician's livelihood via their license. This holds true for any "licensed" profession. Medical license suspensions and revocations are occurring for non- medically related issues such as non-payment of child support [47], default on student loans [48-50], IRS problems or for not participating in a State medical insurance program as has been threatened in Massachusetts [51].

Medical Board Oversight

Let's be bluntly honest. There is none. Yes, there's plenty of rhetoric about government oversight and supposed legal protections for physicians, but in practice they are non-existent. Most States have no system to file a complaint against a Medical Board; and if they do it's dysfunctional and ineffective. Many physicians have contacted all levels of State and Federal government, but to no avail. Usually, the government just doesn't respond. It is a rare, almost extinct, government servant who will stand up against State Medical Boards and Administrative Law [52]. Without oversight - there is no accountability. No accountability means absolute power and, as we all know, "absolute power corrupts absolutely".

THE MEDICAL – INDUSTRIAL COMPLEX

A Brief History

The term Medical Industrial Complex was first coined in 1980 by Arnold S. Relman, M.D. who was at the time editor-in-chief of The New England Journal of Medicine. He adopted the concept from President Dwight Eisenhower's farewell address which warned of the dangers of the Military Industrial Complex [53]. With government meddling in medicine and the extreme amounts of money at stake, so was born the Medical-Industrial Complex. It is now a behemoth in size and reach, both politically and financially. It becomes more powerful each year as it further insulates itself politically and legally.

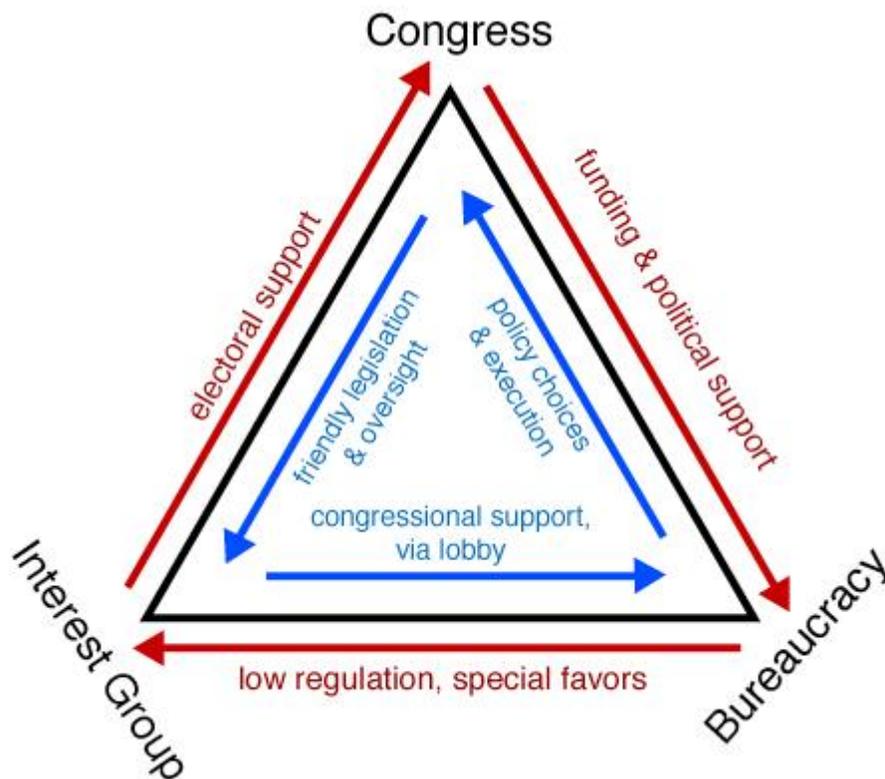
"The driving principle of medicine is revenue generation," says Diane Meier, MD, who directs the Center to Advance Palliative Care at Mount Sinai Health System. [54] Health care spending in the U.S. for 2014 was somewhere between \$3-4 trillion depending on whose numbers you use.[55] That's an unfathomable sum of money flushing through the system. Each year it grows,

especially with an aging population. For comparison, the U.S. defense budget averages about 700 billion a year; about a fifth of healthcare expenditures [56].

Doctors in the classical sense don't exist anymore. They have been reduced to technicians who follow only the allopathic medical regiments allowed by the medical industrial complex and its political servants that dominate the profession. Doctors have lost control of their profession. According to Alexandra Meyer Tien, M.D "Everyone but the doctors is involved in big policy issues related to medicine — politicians, hospital administrators, bureaucrats, insurance companies and the pharmaceutical industry. Doctors' incomes have decreased while nonclinical medical bureaucrats' incomes have skyrocketed. We are refashioning primary care into a field that will be dominated by so-called physician extenders, who have far less training than physicians. What does this say about what we value as a society in our health care?" [57].

Who is responsible for the current state of medicine? I would propose that everyone is to some extent; the government, hospitals, HMOs, pharmaceutical industry, insurance companies, Wall Street, physicians and even the public. Shareholders aren't concerned about medical care; they want profits, even at the expense of their family, friends, neighbors and fellow citizens well being.

THE IRON TRIANGLE



For "Interest Group" insert any healthcare related entity such as Insurance companies, the AMA, pharmaceutical corporations, Medicare, etc [58].

Pharmaceutical and Insurance Industries

These two powerful components of the Medical-Industrial Complex are well known. Medical dollars flow through and are controlled by Insurance companies. Medicare and Medicaid dollars now flow to and through private insurance companies via government privatization projects. Insurance companies decide which treatments, surgeries, medications, services or providers they will or won't pay for.

Pharmaceutical companies, along with the FDA, determine which allopathic medications are available to the public. The pharmaceutical company's tentacles reach deeply into medical schools, research facilities, physician offices, family's homes, hospitals, medication formularies, the FDA and other government institutions and leaders. These companies pay for advertising in multiple venues including healthcare journals, mainstream magazines and newspapers, television, radio and the internet. They sponsor public events for diseases that their medications treat. They subsidize Continuing Medical Education (CME) conferences for physicians while they lobby them from their sales booths. The pharmaceutical corporations pay medically related institutions and physicians to research their drugs and thereby contractually control all information that comes from that research. Therefore, they completely control all information that's outputted to physicians and the public regarding the benefits and side-effects of any particular treatment.

"Now we have the private sector providing funding for our instruments of health care. We see companies that supply medical devices, drugs, insurance, electronic medical records and companies that support lobbying efforts and data mining and richly-paid oversight entities. Today, however, the budget is much, much larger for medicine than the military. Our health care industrial complex has grown into the monster it is today with a supporting flotilla of corporate, special interest, regulators and oversight entities, with doctors and patient's swept up by its wake.", according to cardiologist Wes Fisher MD [58].

Anti-Physician Acronyms

"There are numerous agencies, entities and authorities who earn their living regulating, auditing, monitoring, disciplining, prosecuting and punishing physicians. Any action by them against a physician will be costly to defend, may be career ending and may even place the physician's liberty at stake.



Medical records are reviewed, audited, analyzed and scrutinized at an ever increasing rate by these entities and many others. Most complaints, and the resulting investigation and actions, are initiated by and predicated upon the negative conclusions derived from review of medical records. This is done without any direct discussion with the physician.

Source: Michael J. Schoppmann Esq., Kern, Augustine, Conroy & Schoppmann, PC [59]

Physician Health Programs (PHP)

Once a "need" is in place, there is financial incentive to fill it. Nature abhors a vacuum, especially if money is involved. In this case we had a "need" to fix "broken" physicians. PHPs were developed to fill that void. The "need" and the programs have grown congruently. PHPs are now an "industry" ingrained in the system. This has made it difficult, if not impossible, to extricate or even prune back these programs. The "industry" now requires a steady diet of "broken" physicians, otherwise it financially collapses.

In 2013, North Carolina State Auditor's Office (NCOSA) audited the PHP that North Carolina's Medical Board "refers" their "broken" physicians. What they found was lack of oversight of the PHP and plenty of room for exploitation [60].

PHPs are now solidly established in the Medical-Industrial Complex web. They see physicians as "food" that they drain of financial resources. It's only once the physician is drained of all assets and is no longer able to find work in medicine that their carcass is disposed of.

Healthcare Quality Improvement Act of 1986 (HCQIA)

The Healthcare Quality Improvement Act of 1986 (HCQIA) was the destructive handiwork of Congressman (now Senator) Ron Wyden of Oregon. (Title 42 of the United States Code, Sections 11101 - 11152). Representative Wyden introduced HCQIA legislation in response to a federal antitrust suit brought by Surgeon Timothy A. Patrick, M.D., who practiced in Astoria Oregon, against the city's only hospital and members of The Astoria Clinic. Dr. Patrick, the plaintiff, claimed antitrust actions were affected through the mechanism of peer review in the hospital. Dr. Patrick's suit claimed the Astoria Clinic initiated the action due to an ongoing dispute between himself and the clinic. Dr. Patrick had worked for the Astoria Clinic for one

year. When offered a partnership in the clinic he declined and opened an independent practice. That is when the attacks by the Astoria Clinic and Columbia Memorial Hospital (CMH), began. In 1979, Dr. Gary Boelling, a partner of the Astoria Clinic, complained to CMH's executive committee about Dr. Patrick. This complaint was forwarded to the Oregon Medical Board (OMB) where Dr. Franklin Russell, another partner at the Astoria Clinic, chaired the Investigative Committee of the OMB. The Investigative Committee criticized Dr. Patrick's medical practices to the full OMB, which then issued a letter of reprimand that had been drafted by Dr. Russell. The OMB retracted their letter in its entirety after Dr. Patrick sought judicial review of the OMB proceedings [61].

In 1981, at the request of Astoria Clinic surgeon Dr. Richard Harris, the executive committee of the CMH's medical staff initiated a review of Dr. Patrick's hospital privileges. The committee voted to recommend the termination of Dr. Patrick's hospital privileges on the grounds that the care of his patients was below the standards of the hospital. Dr. Patrick demanded a hearing, as provided by hospital bylaws. A five-member ad hoc committee, chaired by Dr. Boelling, heard the charges and defense. Dr. Patrick requested that the members of the committee testify as to their personal bias against him, but they refused. Before the committee rendered its decision, Dr. Patrick resigned from the hospital staff rather than risk termination.[61] Dr. Patrick, during the course of these proceedings filed an antitrust lawsuit in the Oregon Federal District Court where he eventually prevailed in a jury trial and was awarded \$650,000. This decision was later overturned by the Ninth Circuit Court of Appeals on the grounds that existing Oregon statutes already protected the peer review committee members from prosecution and that these protections should extend to federal antitrust suits brought by individuals for monetary, but not injunctive, relief.[62] Congressman Wyden then imprudently introduced HCQIA to extend state peer review immunities on a federal level. "However, the consequences of the Act have instead helped promote an environment that protects those physicians on a peer review committee when they distort the review process for their own gain, by maliciously disciplining those physicians that may be in political or economic competition." [63].

Dr. Patrick took his case to the Supreme Court. The Supreme Court justices ruled in favor of Dr. Patrick, but by then Congress had passed Wyden's damaging legislation that would negatively impact all future physicians legal attempts. The system had learned well from Dr. Patrick's lawsuit and immediately adjusted. Wyden's legislation is responsible for the ultimate tyrannical, totalitarian power that all medical boards, and other peer review healthcare related entities, now wield. HCQIA is what gives the governmental entities of the Medical Industrial Complex their ultimate power – **unconstitutional legal immunity**.

"HCQIA has provided a shield of nearly absolute immunity for bad faith, malicious peer reviewers." Lawrence R. Huntoon, MD, PhD, F.A.A.N. Chairman, AAPS Committee to Combat Sham Peer Review [64].

National Practitioner Data Bank (NPDB)

The NPDB, also known as the Data Bank, was written into HCQIA. It is the national database for all adverse physician reports. Entities that are required to report physicians to this government program are [65]:

- Medical malpractice payers
- State health care practitioner licensing and certification authorities
- Hospitals
- Health entities with peer review (HMOs, group practices, managed care organizations)
- Professional societies with formal peer review
- Federal and State Government agencies
- Health insurance companies

The information collected by the NPDB includes [65]:

- Medical malpractice actions against a healthcare provider
- Any adverse licensure actions by Medical Boards or peer review entities, including revocation, reprimand, censure, suspension, probation or dismissal or closure of any proceedings by reason of the practitioner surrendering the license or leaving the State or jurisdiction.
- Adverse clinical privileging actions
- Adverse professional society membership actions
- Private accreditation organization negative actions or findings against health care practitioners
- Criminal convictions that are health care-related
- Exclusions from Federal or State health care programs

Entities that can query the NPDB include [65]:

- Hospitals, health care entities and professional societies with formal peer review
- State health care practitioner licensing and certification authorities
- Agencies or contractors administering Federal health care programs
- State agencies administering State health care programs
- State Medicaid Fraud Units
- U.S. Comptroller General, U.S. Attorney General and other law enforcement
- Self query by health care practitioner
- Plaintiff's attorney/pro se plaintiffs, but under limited circumstances
- "Quality Improvement Organizations"
- Researchers (statistical data only)
- Federal and State Government agencies
- Health plans

Once a physician is reported to the NPDB, their career, if they still have one, is dramatically changed forever. There is no ex-pungement process to remove defamatory physician reports, whether true or not. The stain is there forever. You have the opportunity to write a rebuttal for what it's worth – unfortunately, not much – but it should still be done. Actions reported to the National Practitioner Data Bank by one entity will most likely trigger cross investigations and actions by other entities [59]. It is easy to comprehend the simplicity of destroying a physician's

career, psyche and family with the untenable protections afforded by HCQIA to those responsible for the destruction.

Hospitals and Sham Peer Review

An excellent reference and starting point for a physician regarding peer review is: The Basics: What Every Physician Needs to Know About Medical Staff and Other Types of Disciplinary Proceedings, by Thomas R. Bradford [66].

From the Association of American Physicians and Surgeons (AAPS):

“Traditionally, physicians have reviewed the medical care provided by other physicians with the goal of improving the quality of care. That is known as **peer review done in good faith**.

Sham peer review is peer review **done in bad faith** for some purpose other than the furtherance of quality care. It is an insidious and spreading evil which threatens to destroy not only the integrity of the medical profession but quality care for all patients. It is eliminating some of the most competent, ethical and caring physicians from our hospitals. Sham peer review is being used by unethical physicians to attack other physicians so as to eliminate competition. It is a process which is being driven by money. As reimbursements to hospitals and physicians decline, sham peer review increases. Increasingly, hospitals are retaliating against physician whistleblowers to silence them and to end their careers. Sham peer review has become the weapon of choice used by hospitals to eliminate these good, conscientious physicians from the hospital.

Although thousands of patients die every year from preventable errors which occur in hospitals, many physicians today are afraid to come forward to report problems in hospitals out of fear that their careers will be ended by a retaliatory sham peer review. Fewer and fewer physicians are willing to risk their career and livelihood to protect patients in hospitals. It is easier and far safer for physicians to simply look the other way and remain silent” [67]

From Medscape:

“In Austin v. McNamara (9th Cir. 1992), the Court of Appeals for the Ninth Circuit interpreted HCQIA to bestow immunity on a hospital regardless of its "animosity", "hostility" or "bad faith" in revoking a physician's privileges at the hospital. The Court held that "the test [for immunity under §11112(a)] is an objective one." This precedent has been widely followed to exclude evidence of bad faith from lawsuits against hospitals for sham peer review. This precedent was distinguished by Clark v. Columbia/HCA Info. Servs (2001), as follows:

“The presumption of immunity has been interpreted by the federal courts almost exclusively in favor of finding immunity for peer review board members. [citing Austin as an example] ...in only two cases have federal courts reversed an order of summary judgment based on immunity because the physician demonstrated by a preponderance of the evidence that the board failed to give appropriate fair notice and procedures in accordance with § 11112(a)(3) – Islami v. Covenant Medical Center, Inc. and LeMasters v. Christ Hospital. In addition, in Brown v.

Presbyterian Healthcare Services, the Tenth Circuit upheld a district court's finding that the peer review board lacked immunity because the board only investigated two patient charts before deciding to revoke the physician's privileges, which was not a reasonable effort to obtain facts under § 11112(a)(4). Moreover, in Brown the board reported false findings to the National Practitioner Data Bank pursuant to § 11137(c).'

Not only is the peer review process corrupt, it's ineffective, says Ralph M. Bard, a physician turned attorney in Tullahoma, TN. To Err Is Human, the Institute of Medicine's report on patient safety, was released after HCQIA and the NPDB had been in place for many years. Yet the report shows a high rate of medical errors—and that error rate remains high. Rather than being used to weed out bad doctors, peer review as it exists today is used primarily as a weapon against young, vulnerable practitioners. 'Peer review wasn't intended as a means to oust qualified physicians to the benefit of their more economically successful competitors.' says James Lewis Griffith Sr., a malpractice attorney in Philadelphia.

When coupled with mandated reports to the state medical licensing board and the National Practitioner Data Bank, hospital discipline -- even if it is a sham -- can ruin a physician's career and make it virtually impossible for the doctor to relocate and start again.

Compounding the problem of sham peer review is sham due process, in which hospital lawyers - - who usually control sham peer-review proceedings -- afford the targeted physicians little or no meaningful rights to exonerate themselves. Sham peer review and sham due process are made possible by medical staff bylaws which for the most part are written by lawyers selected and paid for by the hospital. Not surprisingly, these hospital lawyers create bylaws that protect the hospital's interests, not the interests of the medical staff or individual physicians. In voting on medical staff bylaws, most physicians are either naive or apathetic, thinking, 'Peer review only happens to bad doctors; it'll never happen to me.' Experience shows, however, that it is often good, strong doctors who are targeted by sham peer review. No physician is immune from attack" [68].

Medical Boards

"... I am persuaded that licensure has reduced both the quantity and quality of medical practice...It has reduced the opportunities for people to become physicians, it has forced the public to pay more for less satisfactory service, and it has retarded technological development...I conclude that licensure should be eliminated as a requirement for the practice of medicine" [69][73]

Milton Friedman, Nobel prize-winning economist

"As a rule, regulation is acquired by the industry and is designed and operated primarily for its benefit" [70][73]

George J. Stigler, Nobel Prize-winning economist

"Licensing has served to channel the development of health care services by granting an exclusive privilege and high status to practitioners relying on a particular approach to health care, a disease-oriented intrusive approach rather than a preventive approach....By granting a

monopoly to a particular approach to health care, the licensing laws may serve to assure an ineffective health care system" [71][73]

Lori B. Andrews, Professor of Law at Chicago-Kent College

"Let us allow physicians, hospitals and schools to spring up where they're needed, abolish the restrictive licensure laws, and simply invoke the laws against fraud to insure honesty among all providers of health care...That will make health care affordable for everyone..." [72] [73]

Ron Paul, MD, former Texas Congressman

"America for the first 140 years was fundamentally a free market in health care services. Few licensing laws or other barriers to entry into the healing arts existed [74]. America's founders opposed licensing, a common practice in England. They believed in 1) a right to work, 2) a right to freedom of choice for practitioners and consumers and 3) the government as a neutral party to protect those rights. Many types of healing schools and clinics operated without government interference. Competition kept prices down. The government protected the consumer against fraud and negligence. No healing modality or group of healers had a legal advantage over the others. Whoever helped people the most prospered" [73]

In 2012 the American Medical Association wrote:

"With State and Federal legal immunity protections and no oversight, Medical Boards nationally have increased their staffs and expanded their abilities to investigate and discipline doctors. The result has been more disciplinary actions against doctors. Board actions against physicians increased 6.8%, from 5,652 in 2010 to 6,034 in 2011; prejudicial actions — such as license suspensions, revocations, probations and other restrictions — rose 4.1%, from 4,798 in 2010 to 4,996 in 2011; and non-prejudicial actions, for less serious offenses, jumped 21.5%, from 854 to 1,038 during the same period according to the Federation of State Medical Boards (FSMB). Disciplinary actions nationwide rose 13.4% from 2007 to 2012.

Legislation passed in Washington in 2008 created a five-year pilot project to grant the Washington State Medical Quality Assurance Commission greater control over its staff and budget. Subsequently, there was a **42.1% rise** in the commission's actions since 2007.

The number of disciplinary actions by the Florida Board of Medicine jumped from 215 in 2010 to 332 in 2011. "While the state medical association supports prosecution of physicians who are prescribing illegally, the new laws go too far", Jeff Scott, general counsel with the Florida Medical Assn., said in 2012. He added, "**It's going to make it difficult for a legitimate pain patient to see a doctor,**" he said. "It's going to limit access, and it's going to compound the problem" [75].

Most Medical Boards are composed of physicians that practice and believe in allopathic medicine exclusively. Typically Physician Assistants or other healthcare providers aren't allowed to participate on Medical Boards, even though they typically practice allopathic based medicine and are licensed by the same Board. Medical Boards definitely don't include alternative medicine practitioners, but do routinely investigate, harass and revoke them.

According to Dr. Sydney Wolfe of Public Citizen (see also Medical Boards – Brief History) “There is considerable evidence that most boards are inadequately disciplining physicians. Action must be taken, legislatively and through public pressure on medical boards themselves, to increase the amount of discipline and thus the amount of patient protection.” How Dr. Wolfe makes such a correlation regarding physician discipline and patient protection is unknown. There is no data to support his statement. There is data which shows no change in patient protection with an increase in physician discipline. Dr. Wolfe’s unsubstantiated statements are causing significant harm to physicians, their families and patients.

States vary in how Medical Board’s budgets are financed and determined. Some Boards have, or are seeking, semiautonomous status which gives little, if any, legislative control over their budget and therefore, less control over the Medical Board. These Boards are supposedly financing themselves with licensing fees and fines. This presents an obvious **conflict of interest**, especially related to physician fines. An environment is created which gives these Medical Boards **a financial incentive to discipline physicians**. Boards end up cannibalizing their licensees to survive financially

Sticks and Stones Break My Bones, and Yes Words Hurt Me

“So, Peer Review has changed the basic nature of medical practice. It has selected for a certain kind of personality, the kind that gets along, and is not threatening. It has led to a rejection of other kinds of personalities. Clinic medicine looks more like IBM than rugged pioneer types.”

[76]

Tony Francis, MD

Medical Boards, hospitals and other entities have developed derogatory, demeaning, dehumanizing terms to describe and psychologically attack physicians. These prejudicial expressions are also concocted for public consumption so as to destroy a physician’s practice and name. The primary terms used are **“arrogant”, “disruptive”, “impaired”, and “outlier”**. They are no different than labels used to denigrate race, religion, country of origin, sex, sexuality, style of dress, politics, socioeconomic status, intelligence, etc. The labels given to physicians are frequently used very subjectively and are broadly applied to attack them for various nefarious reasons.

A physician is typically labeled “arrogant” if they stand up for themselves, demand due process, question the entity or expect legal protections, accountability and integrity from those in control of the physician’s livelihood. All physicians are “arrogant” to at least a mild degree. If they aren’t “confident” (a preferred term), patients will notice and retreat from them. Patients like “confident” physicians. Physicians are expected to be in control. They make life or death decisions while carrying an enormous weight of responsibility. Therefore a physician’s underlying personality trait must be one of “healthy” confidence. This invariably makes it much easier for entities such as a Medical Board to label a physician “arrogant”.

Michael J. Schoppmann, Esq. sums it up:

“Physicians, as their medical license is a privilege and not a right under the law, hold a set of dramatically compromised rights under the law and are routinely, and increasingly, wrongfully

labeled as “Disruptive”, “Impaired” and/or an “Outlier”. Any one of these “Scarlet Letter” labels is a virtually permanent and potentially career ending accusation.

In the new investigatory, regulatory and competitive climate of healthcare, it is critical for physicians to avoid even the inference of being “disruptive.” In order to do so, every physician must acquire an understanding of the new healthcare risk landscape and know how to maintain a risk-prevention state.

Disgruntled patients can complain to health plans/managed care companies, leading to investigations that can result in the termination of the physician’s contract and dramatic losses of income. Action can be taken against a physician’s hospital privileges for intimidating, uncooperative or insensitive behavior.

Moreover, these types of behaviors are reportable to the National Practitioner Data Bank and thereby may trigger cross investigations and/or actions as the physician seeks credentialing or re-credentialing.

The critical first step in avoiding the label of “disruptive” is to immediately obtain any and all rules, regulations, policies or protocols (most commonly referred to as a code of conduct) under which the physician currently practices” [59].

Medical schools, Residencies and Primary Care

Medical schools and residencies are indoctrination centers for the Medical-Industrial Complex. They teach one discipline of medicine, the allopathic branch. They gloatingly teach young physicians to be prejudiced against non-allopathic medical modalities. This is where young physicians are introduced to the pharmaceutical industry, the sole keeper of medications.

College has become quite expensive. Total student debt presently exceeds \$1 trillion dollars in the U.S. When a student finishes Medical school they have typically studied for at least 8 years. Many of them will have an enormous amount of debt to repay. These costs are pushing medical students towards specialty residencies and fellowships that typically result in higher pay. Primary care is seen as a poor option to repay loans over the typical 10 year repayment plan, yet primary care physicians, the backbone of medicine, are what this country needs more of.

According to Marsha Mercer writing for the AARP Bulletin, March 2013:

“Today [2012], the United States is short about 16,000 primary care doctors — the very doctors (family practitioners, internists and pediatricians) who offer the treatments and preventive screenings that save lives and head off expensive emergency room visits and hospitalizations.

Why the shortage? It starts with huge medical school debts and ends with a doctor who is often overworked and underpaid. While students may enter medical school wanting to practice primary care medicine, they graduate saddled with heavy debt — \$250,000 is not unusual — which prompts them to switch to a more lucrative specialty. Only one in five graduating internal medicine residents plans to go into primary care medicine, the Journal of the American Medical Association reports.

‘The doctor shortage is worse than most people think.,’ says Steven Berk, M.D., dean of the School of Medicine at Texas Tech University. ‘The population is getting older, so there's a greater need for primary care physicians. At the same time, physicians are getting older too, and they're retiring earlier," Berk says. And graying doctors — nearly half the nation's 830,000 physicians are over age 50 — are seeing fewer patients than they did four years ago” [77].

Stephen C. Schimpff, MD., professor of medicine and public policy, author and former CEO of the University of Maryland Medical Center wrote: “Less prestige, high debt loads and a knowledge that PCPs work in a non-sustainable business model forcing them to see an excessive number of patients per day in order to meet overhead and still garner an income about one half that of the specialist is, combined, enough to discourage medical school graduates from selecting primary care as a career” [78].

Doctors Insurance Company did a survey of their clients in 2012 and wrote an article titled “Nine out of 10 Physicians Unwilling to Recommend Health Care As a Profession, Exacerbating Anticipated Physician Shortage” [79]

Lynnette Khalfani-Cox wrote in Daily Finance in 2010:

“...with enormous student loans, [and you] can't wipe out college debt in bankruptcy court. Under the law, professionals with any kind of state license – doctors, lawyers, accountants and so on – can all have their professional licenses revoked if they default on federal student loans.

Such defaults are particularly troublesome for health-care workers because borrowers in default also get excluded from the Medicare and Medicaid programs by the U.S. Department of Health and Human Services. For existing doctors and health-care providers, they'd be unable to accept Medicare payments, which is critical for hospitals, clinics, physicians and others.

Moreover, for medical professionals, a federal student loan default ‘effectively eliminates 98% of your employment opportunities,’ says Michael Smith, an attorney with The Health Law Firm, an Altamonte Springs, Fla.-based company that provides legal services to the health-care industry” [80].

Many State Medical Boards determine whether their state’s Medical School(s) and Residency programs meet their “standards”. They also determine whether out of state or internationally trained physicians who apply for licensure meet their standards. In many states, especially smaller ones, there is a very closely linked relationship between Medical Boards, Medical Schools and the State Medical Association. It’s cronyism. They feed off of and into each other, with a small pool of physicians who lead these entities. The physicians chosen have a specific personality type and the same belief in how medicine should be practiced in their state. These physicians are then used interchangeably in the hierarchal positions of these organizations. These incestuous relationships result in not just an allopathic approach to patients, but a singular allopathic approach. For students and physicians who choose not to follow this specific allopathic approach, there will be definite negative sequelae.

Medical Societies

There are a number of medical societies. They may be local, state, national or international in scope. They may focus on a singular or diverse group of medical issues. The biggest such society in the U.S. is the American Medical Association (AMA) which was organized in 1847. The AMA's supposed mission was to protect the public from 'quacks; however their actual objective was to increase the income of its members, allopathic physicians. A report submitted at the AMA convention in 1847 was unusually candid in stating "... The very large number of physicians in the United States has frequently been the subject of remark ... No wonder that the merest pittance in the way of remuneration is scantily doled out even to the most industrious in our ranks ..." [81]

An excellent article written by Lawrence Wilson, MD states, "The method adopted by the AMA to increase their members' incomes was to eliminate the competition by passing licensing laws. Virtually every law restricting the practice of medicine in America has been enacted not on the crest of public demand, but due to intense pressure from the political representatives of physicians" [73]

State Medical Society hierarchy is a common source of State Medical Board members, but varies with each state. In Oregon, only 54% of physicians belong to the Oregon Medical Association (OMA), yet the Oregon Medical Practice Act commands that every M.D. or D.O. that's considered for the Oregon Medical Board (OMB) **must only** come from a list of potential candidates provided by the OMA to the Governor's office.[82] Mississippi, with a participation rate of 70%, has the same system for placing physician Medical Board members as Oregon. This should immediately trigger conflict of interest concerns, especially for those who aren't members of the State's Medical Society.

Physician participation rates in State Medical Societies differ significantly. In Colorado and Nebraska participation is as low as 25%, whereas in Kansas and Vermont it is 70-75% and in South Dakota it is upwards of 90%. Most states don't require that physician recommendations for Medical Board positions come directly from State Medical Societies. Frequently though, physicians on Medical Boards are also State Medical Society members. There are exceptions such as Washington where 40% of physicians are members of the State Medical Society and presently none of them are on the State's Medical Board.

The same physicians on Medical Boards have also typically been on hospital, medical society and medical school boards and peer review committees. A specific personality seems drawn to, and then retained within, these administrative physician positions. With this level of collusion between organizations such as Medical Boards, Medical Societies, hospitals, medical schools and residency programs, it certainly raises concerns for abuse and retaliation against physicians and healthcare providers. Unfortunately, that's exactly what we are seeing across the U.S. Therefore, it's of no surprise that State Medical Societies are silent on Medical Board and PHP abuses and on legislation that affects physician due process rights.

Physician burnout

American medicine is undergoing vast changes, placing the status of physicians in the medical industrial complex at great risk. Most physicians feel overwhelmed by increasing bureaucratic mandates from insurers, hospitals, and government. At the same time, physicians are the front line employees of healthcare and assume the majority of the risk for patient care. This has left many in the profession with increasing disillusionment [83]

Samantha Meltzer-Brody a psychiatrist and director of, Taking Care of Our Own, University of North Carolina, Chapel Hill, NC states it best:

“Daily, I am contacted by good doctors who are struggling with symptoms of burnout syndrome and who have become overwhelmed by the challenges of attempting to practice medicine in today’s health care environment. As a psychiatrist who runs a program to address and treat these distressed doctors, I am troubled by the ever-growing number of calls I receive.

The burned-out physician is exhausted — mentally and physically — and often no longer able to find empathy or connection with patients. The question of how to escape from what has become a highly unpleasant situation becomes a frequent one. Given the high demands of the profession and serious consequences of mistakes, the burned-out doctor is a potentially impaired one. And the impaired physician is not able to maintain the unflappable, perpetually cool under fire, always objective, professional and yet compassionate demeanor that is expected by society. Worst of all, the impaired physician is at great risk for developing depression, suicidal ideation, or a serious addiction.

The doctors who contact me report feeling beaten down by an increasingly hostile work environment. They say that they don’t have time to take care of patients the way they envisioned when they decided to apply to medical school. Many describe feeling betrayed by a system that they say seems focused on achieving the bottom line with little regard for the impact on both doctors and patients.

Most of these doctors report spending a significant amount of their time dealing with the electronic medical record and documentation. The ratio of time spent on doctor-patient interactions compared to physician-computer ones appears so horribly skewed that it has reached the point of complete dysmorphia. These good physicians call me when they feel like they can’t continue any longer in the profession. They want to quit medicine. They report a loss of joy and meaning in their work. They describe the toll that the profession has had on their mental health, physical health, and personal lives. And most wrenchingly, they don’t see an end.

What can we do? There are no easy answers to the complex issues that threaten our profession. **The Taking Care of Our Own Program...has had an over 200% rate of growth in the first year, reflecting the enormous need...** [84]

Burned out physicians will eventually be labeled as disruptive, impaired, an outlier or arrogant. There’s a reason it’s difficult and extremely expensive for physicians to find disability insurance; psychiatric claims. Burnout leads to depression, anxiety, PTSD, suicide, divorce, drug abuse, surly behaviors and interactions, etc. It’s nothing new; it’s been occurring for a long time. Go without routine sleep, eat erratically, work long hours, operate under constantly stressful

situations and have no time for your family or self and most individuals will decompensate physically and psychologically within weeks. Physicians operate within these parameters year after year. How are they to remain healthy, functional humans? They can't. Even a superhero couldn't, yet physicians are expected to endure and thrive under such conditions. If a physician makes a single mistake, or snaps just one day, their entire career is on the line.



ASSESSMENT

Physicians should protect themselves from all professional risks and perils; legally and financially now. Prior to practicing in any state physicians should thoroughly educate themselves regarding:

- State Medical Practice laws
- State Medical Board discipline rates
- State Medical Board process for complaints, investigation and discipline
- How Medical Board hearings are held
- How are appeals handled
- What percent of appeals result in a reversal of Medical Board decisions
- Hospital bylaws, procedures and other associated legal materials
- Clinic bylaws, procedures and other associated legal materials
- All financial contracts

- Legal documents associated with contracting entities like Medicare, private insurance, etc.

CONCLUSION

Being a physician has never been easy, but the task has become so onerous and dangerous that physicians are either leaving the profession or thinking about it daily. Medical schools may be full, but those idealistic and naive students cannot imagine the system they are about to encounter. They are only aware of a romanticized notion of practicing medicine and caring for patients. This is reinforced in medical school, internship and residency. These physicians in training focus only on studying allopathic medicine and caring for patients. Nothing of merit is taught about the business of medicine or what residents will encounter once in the real world. Many physicians remain ignorant of the financial, legal and political ramifications of their chosen profession.

It is time for physicians to move away from just a steady diet of medical training. We must become better educated financially, legally and from a risk management perspective regarding all aspects of the medical milieu in which we operate.

COLLABORATE

Discuss this chapter online with others at: www.MedicalExecutivePost.com

ACKNOWLEDGEMENTS

To Kernan T. Manion MD, Work / Life Design, Wrightsville Beach, NC and Michael Lawrence Langan; MD Boston, MA

REFERENCES

- [1] Pamela Wible, M.D. December 12, 2012 – TED speaker
<http://www.idealmedicalcare.org/blog/why-physicians-commit-suicide/>
- [2] <https://s1.fsmb.org/Docinfo/History.aspx>.
- [3] http://en.wikipedia.org/wiki/Federation_of_State_Medical_Boards
- [4] http://medtech1.com/new_tech/newtechnologyfeature.cfm/212/61.
- [5] http://blog.oregonlive.com/oregonianextra/2009/02/australia_ready_to_charge.html#2.
- [6] <https://www.themedicalbag.com/despicabledoctor/this-surgeon-spent-his-entire-career-as-a-defendant-in-court>
- [7] <http://www.citizen.org/hrg1937>.
- [8] <http://www.citizen.org/Page.aspx?pid=1248>
- [9] <http://www.citizen.org/documents/2034.pdf>
- [10] <http://www.fsmb.org/policy/what-is-a-smb-faq>.
- [11] <http://www.okmedicalboard.org/>.
- [12] <http://www.nmmb.state.nm.us/>
- [13] <http://www.in.gov/pla/3638.htm>

- [14] <http://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Medicine/Pages/default.aspx#.VOO-ZfZ0zIU>
- [15] <http://dpr.delaware.gov/boards/medicalpractice/members.shtml>
- [16] <http://www.oregon.gov/OMB/Pages/index.aspx>
- [17] <http://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Medicine/Pages/default.aspx#.VOO-ZfZ0zIU>
- [18] <http://www.mbc.ca.gov/>
- [19] <https://www.ndbomex.org/>
- [20] <http://dpr.delaware.gov/boards/medicalpractice/members.shtml>
- [21] http://www.aapsonline.org/index.php/site/article/high_noon_in_aaps_vs_tmb_-_be_there_feb_19/
- [22] <http://healthimpactnews.com/2014/texas-medical-board-tries-to-eliminate-alternative-health/>
- [23] <http://articles.mercola.com/sites/articles/archive/2013/01/19/cancer-doctor-burzynski.aspx>
- [24] <http://www.reddirtreport.com/red-dirt-news/state-medical-board-spent-more-700000-investigate-spine-surgeon>
- [25] <http://www.reddirtreport.com/red-dirt-news/supreme-court-justices-admonish-state-medical-board-due-process-concerns>
- [26] <https://www.ndbomex.org/>
- [27] State of Oregon Auditors Division, Board of Medical Examiners, Special Review, November 19, 1996
- [28] <http://dpr.delaware.gov/index.shtml>
- [29] <http://mn.gov/health-licensing-boards/medical-practice/>
- [30] <http://nahmodlaw.com/?s=substantive+due+process>
- [31] Webster's Online Dictionary
- [32] Black's Law Dictionary (8th Ed. 1990)
- [33] [http://en.wikipedia.org/wiki/State_court_\(United_States\)](http://en.wikipedia.org/wiki/State_court_(United_States))
- [34] <http://www.oregon.gov/omb/board/Documents/performance-measures/2013-annual-report.pdf>
- [35] <http://www.drlaw.com/Articles/White-Paper---The-Targeting-of-Physicians---Insigh.aspx>
- [36] <http://law.justia.com/cases/federal/appellate-courts/ca9/12-35705/12-35705-2014-05-29.html>
- [37] Fourteenth Amendment U.S. Constitution
- [38] Eleventh Amendment U.S. Constitution
- [39] <http://www.britannica.com/EBchecked/topic/184510/Eleventh-Amendment>
- [40] http://www.aapsonline.org/index.php/article/another_victory_againstbr_texas_medical_board
- [41] <http://healthimpactnews.com/2014/texas-medical-board-tries-to-eliminate-alternative-health/>
- [42] <https://www.facebook.com/video.php?v=678202715563198>
- [43] <http://www.anh-usa.org/milestone-victory-texas-state-medical-board-attack-on-leading-integrative-doctor-beaten-back/>
- [44] <http://www.salem-news.com/articles/december092013/david-allen-es.php>
- [45] <http://www.cnn.com/2015/02/05/health/anti-vaccine-doctor-jack-wolfson/>
- [46] <http://www.forbes.com/sites/peterlipson/2015/01/30/anti-vaccine-doctors-should-lose-their-licenses/>

- [47] <http://www.ncsl.org/research/human-services/license-restrictions-for-failure-to-pay-child-support.aspx>
- [48] <http://forums.studentdoctor.net/threads/doctor-doesnt-pay-student-loans-medical-license-suspended.734666/>
- [49] <http://www.dailyfinance.com/2010/08/20/student-loan-horror-stories-whats-the-worst-than-can-happen/>
- [50] <http://www.uvm.edu/~vlrs/Education/studentloansprofessionallicenses.pdf>
- [51] <http://scholarship.law.wm.edu/cgi/viewcontent.cgi?article=1692&context=wmborj>
- [52] <http://www.reddirtreport.com/red-dirt-news/lawmaker-demands-resignation-medical-board-executive>
- [53] http://www.michaeleglasscockiii.com/28/The_Medical_Industrial_Complex_And_Health_Care_Reform.htm
- [54] <http://lowninstitute.org/news/barriers-to-de-innovation-diane-meier-on-the-medical-industrial-complex-how-regional-variation-affects-patients/>
- [55] <http://www.forbes.com/sites/danmunro/2014/02/02/annual-u-s-healthcare-spending-hits-3-8-trillion/>
- [56] http://www.usgovernmentspending.com/defense_budget_2012_3.html
- [57] <http://www.providencejournal.com/article/20140905/Opinion/309059914>
- [58] <http://www.kevinmd.com/blog/2014/05/health-care-industrial-complex-stronger-ever.html>
- [59] <http://www.drlaw.com/Articles/White-Paper---The-Targeting-of-Physicians---Insigh.aspx>
- [60] <http://www.ncauditor.net/EPSSWeb/Reports/Performance/PER-2013-8141.pdf>
- [61] <http://www.peerreview.org/patrick.htm>
- [62] http://en.wikipedia.org/wiki/Healthcare_Quality_Improvement_Act
- [63] <http://www.hcqia.net/>
- [64] http://www.aapsonline.org/index.php/article/sham_peer_review_resources_physicians/
- [65] <http://www.npdb.hrsa.gov/>
- [66] http://www.peerreview.org/hospital/what_every_physician_should_know.htm
- [67] http://www.aapsonline.org/index.php/article/sham_peer_review_resources_physicians/
- [68] <http://boards.medscape.com/forums/?128@@.2a349bb6!comment=1>
- [69] Friedman, M., "Medical Licensure" in the *Dangers of Socialize Medicine*, ed. by Hornberger and Ebeling, Future Freedom Foundation, Fairfax, Va. 1994, .68.
- [70] Andrews, Lori B., *Deregulating Doctoring: Do Medical Licensing Laws Meet Today's Health Care Needs?*, People's Medical Society, 1983, 1986.
- [71] Andrews, L., *ibid.* See also: *The Shadow Health Care System: Regulation of Alternative Health Care Providers* by Lori Andrews, *Houston Law Review*, Vol. 332, #5, 1996.
- [72] Paul, R., "Health Care", *Health Freedom News*, Monrovia, CA, Feb. 1989, P18-19.
- [73] <http://drlwilson.com/Articles/licensing.htm>
- [74] Goodman, J. and Musgrave, G., *Patient Power*, Cato Institute, 1992, p.140.
- [75] <http://www.amednews.com/article/20120604/profession/306049944/1/>
- [76] <http://boards.medscape.com/forums/?128@@.2a349bb6!comment=1>
- [77] <http://www.aarp.org/health/medicare-insurance/info-03-2013/how-to-beat-doctor-shortage.html>
- [78] <http://www.kevinmd.com/blog/2014/02/shortage-primary-care-physicians.html>
- [79] http://www.thedoctors.com/TDC/PressRoom/PressContent/CON_ID_004671

[80] <http://www.dailyfinance.com/2010/08/20/student-loan-horror-stories-whats-the-worst-than-can-happen/>

[81] "[Proceeding of the National Medical Convention](#)", *NY J of Med.*, 9 (July 1847):115.

[82] <http://www.theoma.org/>

[83] Jauhar S. Why Doctors are Sick of Their Profession. *The Wall Street Journal*
Aug 29, 2014

[84] <http://www.kevinmd.com/blog/2014/08/epidemic-physician-burnout-heartbreaking.html>

READINGS

- Biggs, Errol: *Healthcare Governance: A Guide for Effective Boards* (American College of Healthcare Executives Management). Healthcare Administration Press, Boca Raton, FL 2011
- Johnson, D and Chaudhry, H: *Medical Licensing and Discipline in America: A History of the Federation of State Medical Boards*. Lexington Books, 2012.

THE END