Editorial

Sham Peer Review: Exposing the Methodology of Evil

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Having run the AAPS Sham Peer Review Hotline for more than 20 years and having served as a court-qualified expert in sham peer review, I have come to the incontrovertible conclusion that those who seek to harm colleagues by conducting a sham peer review are engaging in pure evil. Like the tactics characteristic of sham peer review,[1] the methods of evil employed by evildoers are remarkably similar from case to case. The goal is to inflict maximum harm on the physician victim.

Evildoers are driven by the pursuit of power, control, and money. In pursuit of these goals, they will often do whatever it takes to destroy a good physician whom they portray as "bad" and deserving of exclusion and punishment. By the time a Notice Letter (e.g. summary suspension, Request for Corrective Action) has been sent to the physician, evildoers are committed to finding the physician "guilty" at all costs, and the focus is on administering punishment. When any charges are shown to be false or not supported by evidence, they will quickly shift to other more subjective charges (e.g., disruptive physician or professional misconduct) to save face and avoid being exposed as purveyors of false charges. The secrecy of peer review proceedings helps to protect the evildoers.

Evildoers often demonstrate a willingness, if not eagerness, to lie under oath at peer review hearings and to encourage witnesses against the physician to do the same. They engage in virtue signaling, purporting to serve the greater good and to protect patients against unsafe or poor-quality care. Truth and facts do not impede their intent to obtain a pre-determined outcome.

Sham peer review often involves a collaborative effort with others, including those in hospital administration. In one case, a hospital chief executive officer (CEO) went to a nurse's station and actively solicited complaints against the targeted physician. The nurses, being employees of the hospital, came to understand that their jobs and futures were dependent on coming forward with complaints, even if those complaints were false and/or fabricated.

Like a mob action, an "attack" by a group of physicians and others has the effect of mitigating individual responsibility. Thus, "it was the group that decided to take this action against the physician, not I."

It has also become clear over the years that evildoers fear negative publicity and being exposed much more than they fear litigation. They fear the bright light of public scrutiny, both for their own reputation and the reputation of the hospital.

Actions to Discredit the Targeted Physician Prior to the 'Attack'

In an effort to make the targeted physician more vulnerable to attack, evildoers will often circulate false and damaging rumors about the targeted physician prior to an attack. Like predators who will cut out a weak member from the herd and then attack, damaging rumors act to isolate the physician: "He is not like the rest of the herd." Sometimes evildoers will simultaneously engage in gaslighting in an attempt to cause the targeted physician to lose confidence in himself.

In one case, a physician's home was illegally entered, windows were opened that had previously been shut, and things inside his home were moved from one location to another.[2] The hospital subsequently portrayed the physician as psychiatrically impaired and sought to compel him to obtain a psychiatric evaluation.[2]

False and damaging rumors are used to mislead others in order to encourage them to participate in the attack. This strategy is often successful because physicians who participate in a peer review often will not take the time to independently look at the so-called evidence against the physician and instead will simply take the word of a choreographer (e.g., the vice president of medical affairs or chief medical officer).

In the case in which the hospital CEO actively solicited complaints against the physician, he stacked a large collection of papers on the table at a medical executive committee (MEC) meeting and told the MEC physicians that it was a collection of incident reports attributable to the physician and the MEC needed to do something about that rogue physician.

Working as an expert in that case, I reviewed the entire pile of documents. There were few if any negative incidents attributable to the physician. Rather, the documents included thank-you letters from patients, medication errors made by nurses, and incident reports about patients falling out of bed. The physician, however, did not cause these patients to fall out of bed.

In another case, the vice president of medical affairs (VPMA) told the hearing panel and MEC that the doctor had given the patient a medication that would allegedly cause harm. The hearing panel was poised to take action against the physician based on the VPMA's representation. The hospital called the nurse on duty at the time of the alleged incident to testify at the peer review hearing. The VPMA was utterly shocked when she testified that she never gave the medication in question. The VPMA and compliant hearing panel members quickly pivoted to a more subjective charge. Evidencing that this was a deliberate evil attack, not a pursuit of safe quality care, the VPMA commented to the physician that after they were finished with him his "income would be going down." The physician's privileges were ultimately revoked.

Time-Pressure Coercion

In a number of cases a physician was pressured to sign a document or agreement (voluntary abeyance or resignation of privileges) at a closed-door meeting, while the physician was forbidden to call his attorney to seek advice prior to signing. The physician is typically told that he must sign this agreement/document prior to leaving the room or the "deal is off," and he will be summarily suspended.

This type of time-pressure coercion generally occurs when the attacking hospital either has a very weak case or no case at all.

Strategic Timing of Attacks

Evildoers will frequently launch an attack at a time designed to cause the physician victim maximum stress and devastation. Attacks may be launched while the physician and his family are on vacation, for instance. This may cause the physician to abruptly cancel his vacation and return home to deal with the attack. This negatively impacts his entire family. The attackers know the precise time of the physician's planned vacation, as the physician often provides written notice of when he will be gone and who will be covering for him while he is away. Similarly, attacks are often launched when the physician is away at an out-of-town medical conference.

Evildoers will sometimes launch an attack when they know the physician's spouse is seriously ill or has recently been hospitalized with a diagnosis of cancer. In one case, the physician notified the hospital in writing that he would be traveling to a distant hospital to be with his wife, and of who would be covering for him in the emergency room (ER) in his absence. While he was sitting at his wife's bedside in the hospital, he received a call notifying him that his failure to go to the hospital when summoned by the ER was professional misconduct.

Likewise, attacks may be launched at a time when evildoers know that the physician's wife is pregnant, perhaps in the hope of causing a miscarriage.

Multi-Pronged Attacks

Attacks coming from different sources at the same time are launched for the purpose of creating a shock-and-awe effect on the targeted physician. These reliably produce maximal harm.

In one case, a physician whistleblower complained about poor-quality care in the hospital, including evidence that some nurses were administering euthanasia. The euthanasia charges were subsequently substantiated, and the nurses involved lost their license. About three days after the physician had voiced his concerns to the hospital administrator about these serious issues, he was labeled "disruptive" and summarily suspended. At the same time, his three foster children were seized from his home by child protective services. This simultaneous attack was coordinated by hospital counsel, who also served as counsel for the Department of Social Services. False charges of child sexual abuse were filed against the physician, and the hospital portrayed him as a pedophile. The hospital reported this false information in a report filed against the physician in the National Practitioner Data Bank (NPDB). Since the county where the physician resided found no support for the charges, the prosecutor "shopped" the charges around from county to county, eventually finding one where the case could be heard. Ultimately, the charges were found to be totally without merit. At that point, having failed to convict the physician, the prosecutor turned his focus to the physician's wife, accusing her of child rape. Although there was no merit to that charge either, the extreme stress it caused his wife ultimately led to her committing suicide. The outcome of this evil multi-pronged attack was that the physician never got his foster children back, he can no longer practice medicine due to the NPDB report, and he no longer has a wife. No criminal charges were ever brought against the nurses who committed euthanasia.

Evildoers will also often look for ways to engage law enforcement to "take down" the physician. In a recent case, an interventional cardiologist who was training a technician during a procedure tapped the technician on the shoulder and quietly asked her to stop advancing the catheter/guidewire as it was placing the artery at risk for perforation. He did this quietly so as not to alarm the patient. The technician was indignant at this corrective instruction, stomped out of the room (leaving someone else to take over for her), went to the authorities, and filed assault charges against the physician. She falsely claimed that he "punched" her, causing her pain. Pictures were taken at the police station, but no evidence of redness, swelling, or bruising could be seen. She subsequently left town, could not be found, and charges against the physician were dropped.

In a similar case, an ER physician encountered a patient brought into the ER one night who was high on drugs and extremely combative. The patient was being appropriately restrained on a gurney to prevent harm to herself and others. She had apparently been hitting, kicking, and trying to bite ER personnel. The ER physician held her head so she could not bite the people trying to help her. When the patient sobered up and left the hospital, she went immediately to the police and filed charges of assault and battery against the physician for restraining her head. Fortunately, the police chose not to arrest the physician based on these spurious charges.

In another case, a hospital CEO who had a grudge against a physician paid $10,000 to a man who reportedly was either a Mafia member or affiliated with the Mafia to frame the doctor. The anonymous caller called 911 and told police that a man wearing black gloves and a white lab coat was out of his car waving around a gun in what was portrayed as a road-rage incident. The anonymous caller provided a description of the physician's car and license plate number, and told police they could find the car in a hospital parking lot. While the car was in the hospital parking lot, someone planted a gun and black gloves in it. The physician was taken by police from the hospital cafeteria, and after searching his car with permission, police arrested the physician for possession of a loaded weapon, carrying a concealed gun, and brandishing a

firearm. They transported the physician to the police station, where he was booked, strip-searched, and placed in a cell for approximately five hours. Further investigation revealed that the physician's fingerprints were not on the gun, DNA found inside the gloves was not a match to the physician's, and no reliable witness could be found. The district attorney ultimately declined to press charges.[3]

Multipronged attacks sometimes involve actual physical attacks against the physician. To date, there have been six cases of tire "box cutter insertions." These involve inserting a box-cutter blade into a tire and breaking it off. When this is done correctly, the tire does not immediately go flat. But, when the car is traveling at high speed on an interstate or freeway, the tire catastrophically fails, causing the driver to lose control and crash. This could cause injury or death of the doctor from what appears to be a mere car accident.

In the case discussed above involving a Mafia-affiliated henchman, a box-cutter blade was inserted and broken off in one of the tires on the doctor's car. His daughter was driving his car with two foreign exchange student passengers at the time that the tire catastrophically failed, causing a roll-over crash. Fortunately, everyone in the car was wearing a seatbelt, and there were no serious injuries.[3]

In the case discussed above involving a gaslighting incident, the physician's tires had a box cutter blade inserted and broken off on three separate occasions.[2] Fortunately, no injuries occurred.

In yet another case from another country, the use of a box-cutter blade failed to produce the desired result because the doctor had run-flat tires. Someone subsequently drilled a small hole in a fuel line next to the engine. The intended result was that when the engine got hot the leaking fuel would ignite and either cause an explosion or massive fire. The doctor's brand-new car was engulfed in flames and totaled. Fortunately, the doctor was able to escape without suffering burns or other injuries.

In another case, a neurosurgeon who was employed by the hospital was embroiled in a sham peer review. The underlying motive was a turf battle between the neurosurgeon and interventional radiologists over two procedures they had in common. The economic competitors brought spurious charges against him. While the hospital searched diligently without success to find a clinical deficiency to successfully prosecute the neurosurgeon, they consistently criticized him for drinking "too many" fruit smoothies while on duty in the hospital.

The surgeon subsequently developed a serious neurological condition, which caused him to need a special harness to hold him up while performing long surgeries. Eventually, as a result of this severe disability, the physician could no longer perform surgeries. The hospital, which provided disability insurance to the physician as part of his contract, claimed that he had no disability in an effort to deprive him of disability benefits. Additionally, it underreported his hours worked, so it would pay him less if ultimately forced to pay disability benefits. The physician had to hire an attorney and sue the hospital to obtain the disability benefits to which he was rightfully entitled. This ordeal caused extreme stress to himself and his family, and the physician subsequently died at a relatively young age.

In yet another tragic case, a young neurosurgery resident complained of unsafe patient care, patient-care violations, fraudulent billing, deficiencies in resident training education, abusive treatment of residents, and directed falsification of neurosurgery case numbers to make it appear to the American College of Graduate Medical Education (ACGME) that they were performing more cases than actually performed. Thus, he chose to be a physician whistleblower, an unwise choice particularly for a resident physician. When no changes were made, the physician complained to outside agencies including the ACGME. This put the university's neurosurgical program in jeopardy and angered the university. They set out to retaliate against the physician in the harshest manner possible.

The neurosurgery program director immediately suspended him and referred him for psychiatric evaluation. This evil method comes right from the former Soviet Union playbook in which those who opposed the regime were considered to be "crazy" (sluggish schizophrenia) and sent to a distant psychiatric gulag because no rational sane person would oppose the regime.

The initial psychiatric evaluation was conducted by the university's in-house psychiatrist. The psychiatrist did not establish any diagnosis and did not identify any problem that would impede the resident's ability to safely practice medicine. At the request of the neurosurgery program director, the psychiatrist was coerced to revise his written report, so that the resident would be found unfit for duty. In his revised report, and without further examining the resident, the psychiatrist diagnosed narcissistic personality disorder and stated that disorder could impair the resident's ability to care for patients. In the newly revised report, the psychiatrist also recommended intensive psychiatric treatment. The prognosis was said to be guarded.

In yet another revised report, the psychiatrist stated clearly that the resident was unfit for duty. The program director advised the resident that he could either resign or be labeled psychiatrically unstable with a continued indefinite suspension, an action which would negatively impact the rest of his career. The neurosurgery program director also told the resident that psychiatric treatment may require electroshock therapy (reminiscent of *One Flew Over the Cuckoo's Nest*).

The in-house psychiatrist later admitted to the resident that he had succumbed to political pressure from the program director, something he regretted doing, and he told the resident that the reason the university was harassing him was because of his whistleblowing. The psychiatrist recommended that the resident retain an attorney.

To further pursue a multi-pronged attack, the program director held the resident's Sallie Mae medical school loan paperwork hostage by refusing to sign the required documents. If one is dependent in any way on an evildoer intent on inflicting harm, rest assured that the evildoer will wait and watch for any opportunity to inflict additional harm.

The resident physician had multiple other psychiatric evaluations, none of which found any evidence of any psychiatric impairment that would impair his ability to work with reasonable skill and safety.

The program director subsequently referred the resident to a Physician Health Program (PHP) with a promise that if he complied with the PHP's recommendations the matter would be resolved. The resident subsequently met with the PHP's intake physician, who after reviewing abundant evidence indicative of retaliation by the university, recommended that the resident retain an attorney.

It was later learned that this university neurosurgery program had previously sent five other neurosurgery residents to the same PHP program. All had complained about deficiencies in the neurosurgery program. This abuse of psychiatry was being used as a weapon to ensure the residents would recognize who was in charge and that they needed to be totally submissive to the program director and, of course, keep silent about any deficiencies.

The program director and university legal counsel subsequently concocted a false narrative that the resident was a threat to himself and others, and they directed campus police to go out into the city and bring him back to the university. As directed, the campus police went into the city, off campus, and held the resident and his sister at gunpoint in their car on a public street. The resident was brought back to the university where he was under attack.

The resident obtained an independent psychiatric assessment, which found that he was not impaired and could practice medicine safely. The evildoers at the university did not like the report and referred the resident to yet another "approved" facility for additional psychiatric evaluation and treatment.

Upon learning that a physician consultant for the U.S. Office of Inspector General (OIG) had referred the university's actions against the resident to the U.S. Attorney's Office, the evildoers at the university further retaliated by sending a complaint to the state medical board. The university provided the extremely negative "revised" psychiatric report to the medical board.

In total defiance of prohibition of conflicts of interest, the state medical board and the university were represented by the same law firm. In addition, the lead investigator at the medical board was engaged to an attorney at this same law firm.

The medical board, likely at the urging of the university, suspended the physician's medical license based on alleged psychiatric impairment and a newly developed charge of substance abuse disorder. Later it was discovered that the order suspending his license was unsigned, unauthorized, and not approved by any member of the medical board. The president of the medical board was not even aware that the suspension had been ordered. To compound the injury, another state subsequently suspended the physician's license based on the suspension that occurred in the first state.

The resident physician was never allowed to complete his residency and never practiced medicine again. After enduring the stress of years of unsuccessful litigation against the university and its evildoers, he tragically died at a young age.

Efforts to Humiliate and Break the Victim

At peer review hearings and at MEC meetings where the physician is asked to explain his care or conduct, evildoers will often do the equivalent of administering a swirly (shoving the victim's head in the toilet and flushing). This is done for the purpose of humiliating and breaking the physician victim.

Evildoers frequently seek to extract a false confession from the physician victim. They will attempt to coerce the victim to "show remorse" and "take ownership" for something that was not the physician's fault or in which he did nothing wrong.

If the victim goes along with this coercion with the belief that if he confesses and shows remorse the hearing panel or MEC will show mercy and not harm him, it causes irreparable moral injury. Moreover, if he falsely confesses to wrongdoing, more often than not the MEC and hearing panel will harm him anyway.

Under these circumstances, the physician must find some way to "play the game" without losing his core self. He must hold fast to doing what is right and keeping his core beliefs.

Maliciously Entangling a Physician in a Physician Health Program (PHP)

Physician Health Programs (PHPs) can be beneficial when used appropriately. These programs have helped physicians who had a drug or alcohol problem to rehabilitate and return to active practice.

But an inappropriate referral of a physician can also be used as a weapon to harm him. Once entangled in the PHP, the physician is trapped in a "gulag" where conflicts, corruption, and abuse of psychiatry are rampant.

In one case, a physician, who was employed by a hospital, went to the hospital administrator and told him he was feeling somewhat depressed. Two of the physician's siblings had died unexpectedly during the COVID era, and the physician was striving to cope with this loss. The administrator told the physician he needed to go to the PHP. Following the administrator's instruction, he self-referred to the PHP. At the PHP they did drug and alcohol testing and forced him to take a lie detector test. No alcohol or drugs were found in his system. However, alcohol metabolites (e.g. acetaldehyde, acetate, ethyl glucuronide, ethyl sulfate) were detected. The doctor explained that he often had a glass of wine with dinner. Alcohol metabolites can be detected for a number of days after a person has consumed alcohol. Based on this spurious "evidence," the PHP determined that he had an alcohol problem, recommended that he not be allowed to work, and recommended eight weeks of in-patient treatment at a distant specialized treatment center at a cost of approximately $80,000. The physician subsequently obtained a second opinion from an independent addiction specialist, who determined that the physician did not have any alcohol problem. When the physician asked what would happen if he did not enroll in treatment at the specialized treatment center he was told that would be a problem as far as his being able to return to work in the hospital. The physician was subsequently told that he must provide the independent physician's report to the hospital by a certain date or they would impose a summary suspension. The physician timely supplied the requested report to

the hospital, but the hospital implemented a summary suspension anyway. The physician ended up going to the specialized treatment center for six weeks of in-patient treatment. In addition to drug and alcohol testing, they performed neuropsychological testing and reported some cognitive issues (likely secondary to his depression). They also filled out an "alcohol history form" for him without his input. Following his discharge from the treatment center, he is now subject to one year of weekly drug and alcohol testing. The one thing that was never addressed or treated was his depression. He has been unable to get a job due to the summary suspension report in the NPDB. Thus, he is no longer able to earn a living practicing medicine.

Driving a Physician to Commit Suicide

An older surgeon was practicing at a hospital and providing excellent care to his patients. The hospital wanted to bring in a younger physician, to be employed by the hospital, to replace him. So, the hospital sought some pretext on which to eliminate the older physician from the hospital. Not having sufficient reason to question his care, the hospital made one up. The hospital claimed that he had a tremor and that it would be dangerous for him to continue to operate with that condition. The hospital required him to obtain an independent neurological evaluation to determine his fitness to continue to work as a surgeon. The physician chose an independent, third-party-free physician in another state, who has a strong background in movement disorders including tremor. Following a thorough and comprehensive neurologic evaluation, it was determined that the physician had no tremor—not even physiologic tremor. While the physician was in the neurologist's office, the hospital called the neurologist to confirm that he was undergoing an independent neurological assessment. With the surgeon's consent, the independent neurologist provided a written report to the hospital indicating that the surgeon had no tremor at all and that he was fit to continue performing surgeries. When the surgeon returned home, the hospital administration reportedly told him that while he did not currently have a tremor, they were going to watch him very closely to see whether he developed one. At that point, the surgeon saw that the hospital administration was going to continue looking for any opportunity or pretext to force him out using the peer review process. So, he traveled to another state and interviewed at a hospital that did not have his specialty on its medical staff and that very much wanted him to practice there. He and his wife were looking forward to this new opportunity at a hospital that valued what he had to offer. However, after the new hospital contacted the former hospital, the offer from the new hospital was rescinded.

The surgeon's career and life were ruined. He could see that "blackballing" by evildoers in the hospital administration would forever prevent him from obtaining another position. A short time after this offer was rescinded, his wife found him dead on their patio. He had shot himself. The life of a good physician was ended, his wife was devastated, and his patients were deprived of the services of an excellent surgeon.

Unwitting Participants in Sham Peer Review

Just as all peer review is not sham peer review, not everyone involved in a sham peer review is necessarily an evildoer. Some physicians who serve on an MEC or hearing panel may simply be lazy and fail to perform due diligence by independently evaluating the evidence. They unknowingly participate in the sham peer review by taking the word of a choreographer (e.g., vice president of medical affairs or chief medical officer) about what the evidence shows. Hospital-employed physicians who serve on an MEC or hearing panel likewise may ignore or dismiss exculpatory evidence that is not consistent with what the choreographer is telling them. They essentially absolve themselves of any wrongdoing by rationalizing that the choreographer would not lie or mislead them. They choose not to look at the evidence independently or too closely because what they find may not serve the outcome desired by their employer. The fact that they are willing to risk destroying the life of a good physician who has done nothing wrong, as opposed to seeking the truth and doing what is right, speaks volumes about their lack of integrity and places them squarely on the path to becoming full-fledged evildoers.

Protecting Yourself and Fighting Back

Based on the horrendous true stories reviewed here, at some point it becomes blatantly clear that our struggle is not simply against earthly flesh and blood but against the dark influence of powers and principalities (Ephesians 6:12)—i.e., spiritual warfare. The ability to withstand, with the hope of ultimately prevailing against, the attacks of evildoers requires spiritual "weapons." The precise nature of these spiritual "weapons" is fully detailed in Ephesians 6:13-17.

Physicians need to be fully prepared, as a sham peer review "attack" can occur when one least expects it. Specific recommendations for disaster preparedness and defense have been fully discussed in this journal previously.[4] If one identifies one or more of the early warning signs of sham peer review,[5] the physician should carry a high quality audio recording device with him at all times, where it is legal to do so. Physicians should seek the advice of their attorney regarding the legality of covert recordings in their state.

Once a sham peer review attack has been launched, the physician needs to implement an aggressive public relations (PR) campaign. The initial target of this PR campaign should be ethical physicians in the community who are unaware of what is going on. The success of evildoers depends heavily on secrecy. Although evildoers at hospitals often claim that the secrecy of peer review protects the accused physician, the reality is that secrecy protects the identities and deeds of the evildoers. Sometimes when ethical physicians in the community learn what is going on, political pressure is brought to bear which may change the course and outcome of the sham peer review. Informing the public likewise may have a similar effect. The physician should seek the advice of his attorney in pursuing a PR campaign. Although much of the PR work may be accomplished by the physician on his own, in certain circumstances hiring a professional PR

person may be helpful.

Physicians who serve on an MEC or hearing panel must insist that due process and fundamental fairness be provided to the accused physician. It is imperative that the MEC and hearing panel members read and study the medical staff bylaws. Evidence needs to be independently verified by all MEC and hearing panel members. They should not defer to what the choreographer tells them the evidence shows.

Despite the Health Care Quality Improvement Act's (HCQIA) *presumption* of "guilt" of the accused physician and similar mirror provisions of the medical staff bylaws, MEC and hearing panel members need to insist that charges against the physician be proven before declaring him "guilty." MEC and hearing panel members should not accept the proposition that the accused physician has the burden to prove his innocence. As with jury nullification in a criminal case, MECs and hearing panels can vote to do what is fair and just despite what the administration or hospital attorney tells them they can or cannot do. Ethical physicians have an obligation and responsibility to uphold due process and fundamental fairness and do what is right and just.

Having learned of the tactics characteristic of sham peer review[1] and the methodology of evildoers, it is up to ethical physicians to identify them when they are being used to harm a physician colleague and to speak out against them.

Colleagues who scheme to deprive an accused physician of due process and fundamental fairness and who knowingly and willfully conduct a sham peer review against a physician who has done nothing wrong are inherently evil. Ethical physicians should refuse to associate with or refer patients to such unethical evil physicians.

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AAPS Principles of Medical Policy

Medical care is a professional service, not a right. Rights (as to life, liberty, and property) may be defended by force, if necessary. Professional services are subject to economic laws, such as supply and demand, and are not properly procured by force.

Physicians are professionals. Professionals are agents of their patients or clients, not of corporations, government, insurers, or other entities. Professionals act according to their own best judgment, not government "guidelines," which soon become mandates. Physicians' decisions and procedures cannot be dictated by overseers without destroying their professionalism.

Third-party payment introduces conflicts of interest. Physicians are best paid directly by the recipients of their services. The insurer's contract should be only with subscribers, not with physicians. Patients should pay their physician a mutually agreed-upon fee; the insurer should reimburse the subscriber according to the terms of the contract.

Government regulations reduce access to care. Barriers to market entry, and regulations that impose costs and burdens on the provision of care need to be greatly reduced. Examples include insurance mandates, certificate of need, translation requirements, CLIA regulation of physician office laboratories, HIPAA requirements, FDA restrictions on freedom of speech and physicians' judgment, etc.

Honest, publicly accessible pricing and accounting ("transparency") is essential to controlling costs and optimizing access. Government and other third-party payment or price-fixing obscures the true value of a service, which can only be determined by a buyer's willingness to pay. The resulting misallocation of resources creates both waste and unavailability of services.

Confidentiality is essential to good medical care. Trust is the foundation of the patient-physician relationship. Patient confidences should be preserved; information should be released only upon patient informed consent, with rare exceptions determined by law and related to credible immediate threats to the safety or health of others.

Physicians should be treated fairly in licensure, peer review, and other proceedings. Physicians should not fear loss of their livelihood or burdensome legal expenses because of baseless accusations, competitors' malice, hospitals' attempts to silence dissent, or refusal to violate their consciences. They should be accorded both procedural and substantive due process. They do not lose the basic rights enjoyed by Americans simply because of their vocation.

Medical insurance should be voluntary. While everyone has the responsibility to pay for goods and services he uses, insurance is not the only or best way to finance medical care. It greatly increases costs and expenditures. The right to decline to buy a product is the ultimate and necessary protection against low quality, overpriced offerings by monopolistic providers.

Coverage is not care. Health plans deny payment and ration care. Their promises are often broken. The only reliable protection against serious shortages and deterioration of quality is the right of patients to use their own money to buy the care of their choice.