THE *D I S R U P T E D* PHYSICIAN

A Case Study in Administrative Abuse of Authority

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This book is dedicated to the memory of those whose voices have been forever silenced by the abuses of power and abject cruelty of the Medical Regulatory Treatment and Rehabilitative Complex (MRTRC).

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Foreword

Preface

In November, 2015, a personal tragedy struck and I was shattered. For three months, I wept. Razor wire spun inside my head. Though I laid in bed night and day, sleep eluded me. Common sense dissolved in a toxic mix of alcohol, antidepressants and sedatives. I was grief-stricken, traumatized, betrayed, paralyzed. It took more than three arduous months and the help of family, friends, and therapists for me to recover my bearings. Longer than that to regain my self-confidence.

But I did recover. Not like the Phoenix rising dramatically from the ashes, but like the broken vase repaired, shard by shard, with gold-imbedded glaze: kintsugi, the Japanese art of turning broken pottery into a thing of beauty. I returned to work, hesitantly at first, then enthusiastically. I was now more forgiving of the failings of others. Because I had failed and been forgiven. Or so I thought.

But a few months later, my medical board called and a new nightmare began. After several grueling interrogations, including one that lasted 72 hours, I was alleged to be "impaired in the ability to practice medicine with reasonable skill and safety" due to substance abuse and mental illness. If I didn't submit to three months of inpatient addiction treatment, it would be assumed that the allegations against me were true and my license would be suspended.

I understood the seriousness of the situation. But I was still fragile. I still needed the support of my therapist and the love of family and friends. If I were wrongfully incarcerated, isolated and indoctrinated, I feared I would succumb to the indignity. Reluctantly, I refused to submit. I chose life over license.

Shortly thereafter, the board made its decision. My medical license was first suspended, then permanently revoked. Later, a distorted version of my traumatic grief was published on their website for anyone to read. I was now in the company of reprobates: physicians who wantonly maimed and killed their patients, committed sexual offenses, ran pill mills or bilked the federal government out of millions in Medicare funds. I felt shame: deep, hot, searing, suffocating shame.

Months later, outwardly healed but inwardly vulnerable, I stumbled across Dr. Michael Langan's blog. I had thought I was alone in my shame but I learned that were others like me, competent and caring physicians who had also been threatened, coerced, violated, shamed and financially wrung dry by the same bureaucracy. Physicians who, like me, had never harmed a patient but upon whom the mantle of shame had been hoisted by bureaucratic fiat, a shame they now carried on their shoulders every single day. Langan called them "The Silenced and Afraid."

But I was no longer afraid and I decided I would not be silenced. I would be embarrassed but not ashamed. So, in March, 2018, I chose to break my silence publicly, candidly and ruthlessly. I knew that some would call me a liar and a drunk because those epithets had been hurled at me by "experts" in forensic and addiction medicine.

Yet I also knew that, if I hid my failings from others, the truth of what I said would not be believed, my word would not be trusted. So I wrote an essay, 850 words, in raw, explicit detail, "They Fell Like Dominos: My License, My Certification, My Profession." It was published as an Op-Ed in the online journal Doximity.

As I expected, the pejoratives came rushing in. I steeled myself against them and responded with all the grace I could muster. But other stories of trauma and abuse also rushed in, as did the shocked response by many more that such a travesty could occur. Over one thousand voices in response to 850 words. I could not ignore their importance.

As a result of that brief essay, I became part of a movement by those who had been similarly abused and by those who recoiled at the abuse, all convinced that the needless loss of health professionals must stop, that the senseless self-slaughter of their colleagues—by alcohol or pills or guns or ropes or razor blades—must cease.

Out of this was born "The Disrupted Physician," the story of Dr. Michael Langan's decades-long struggle to salvage his career and seek justice for the silenced and afraid. Langan's story needs to be told because of the many

health professionals who've also lost their careers due a regulatory system, not just those who've been silenced and afraid, but those whose voices have been forever silenced by the shame and pain they could not bear.

Introduction

This book is about injustices perpetrated against physicians who are alleged to be impaired in their ability to practice medicine by their respective licensing boards and associated Physicians Health Services and their consultants. These programs coerce physicians who are alleged to have mental health or substance use disorders into expensive, years-long monitoring and treatment regimens that are often overly inclusive, lacking in scientific validity and sometimes overtly harmful. These programs often fail to achieve their stated primary goal of "protecting the patient from bad doctors."

The main thread of this book is the experience of Dr. Michael Langan M.D., an accomplished geriatrician who, since 2006, has been in a struggle with the Massachusetts Board of Registration in Medicine (BORIM) and its affiliated Physicians Health Services (PHS). Langan is the curator of the blog "The Disrupted Physician" www.disruptedphysician.blog, from which the title of this book is taken. He posts salient articles, personal opinion pieces and comments from colleagues that help elucidate the extent and severity of the problem.

In 2006, Langan asked Physicians Health Services for assistance in weaning off a pain medication he became habituated to during treatment of post-herpetic neuralgia, a painful complication of shingles (herpes zoster). After a year of random drug testing, he was forced to undergo a three-month long, expensive inpatient addiction treatment program after which he was diagnosed with alcoholism, a condition for which there was no evidence.

Thus began Langan's 16 year long struggle to salvage his career. After discharge from the addiction treatment facility, he was coerced into participating in a five-year long "rehabilitation" program for physicians who are alleged to be "impaired in their ability to practice medicine with reasonable skill and safety due to mental health or substance use disorders." At one point, a spuriously positive test for alcoholism was used as the rationale to extend the length of his program, increase its stipulations and, ultimately, to suspend his license.

I will show how licensed health professionals' real or alleged mental health and substance use disorders are used against them in biased addiction treatment programs and licensing board investigations and how the moral and psychological damage caused by these programs can lead to (or exacerbate) depression, anxiety and suicidality. Pivotal to compliance with these programs is PHPs' influence over medical licensing boards. Based on a PHP's recommendation, With a single keystroke, a board can suspend or revoke a license and annihilate a once productive career.

Included in this book are chapters on ethical, legal and civil rights violations by PHPs, addiction treatment centers and licensing boards. I will describe how the various entities in the medical regulatory system collude to produce fraudulent test results, extort money, commit defamation, and interfere with proper treatment of mental health, substance use disorders and even medical problems. I will also specifically examine violations of the Americans with Disabilities Act [ADA], the Health Insurance Portability and Accountability Act (HIPAA) and the basic principles of medical ethics.

No licensed health professional at any stage of his career is immune from this regulatory apparatus. Students, residents, mid-career professionals and health professionals of retirement age have all been victims. Many have been driven into bankruptcy; most have been deeply traumatized; a few have taken their own lives.

While I often use the pronoun "he" and refer to "physicians," it's often for the sake of economy of words, not substance. I am deeply aware that this issue affects women as well as men, and other licensed health professionals.

The Disrupted Physician is not just a treatise about Langan' unwavering resolve to seek justice but also the portrait of a man of intelligence, perspicacity, and faith in his own agency. Langan's experience is both a cautionary tale to all physicians and other licensed health professionals about the Medical Regulatory Treatment

Complex (MRTC) and an inspiration to those who are determined to prevail against its seemingly overwhelming odds.

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Chapter 1: The Rabbit Hole

Back in 2006, board-certified internist and geriatrician at Massachusetts General Hospital [MGH], Dr. Michael L. Langan, had an outbreak of shingles on the left side of his face. His physician prescribed Vicodin™, a combination of acetaminophen (Tylenol™) and the narcotic hydrocodone, for a painful complication of shingles known as "post-herpetic neuralgia" which he used at night when the pain interfered with sleep. Post-herpetic neuralgia can last for months.

After many weeks, the pain eased up, but each time he tried to discontinue the Vicodin, he would develop an abstinence syndrome: flu-like symptoms such as headache, body aches, and chills. He no longer needed Vicodin for pain; he needed it to stave off withdrawal symptoms from discontinuing its use.

Although it may be a symptom of addiction when it's associated with maladaptive behaviors such as public intoxication, missing work, or driving while impaired, an abstinence syndrome from medicinal use of a controlled substance is not a sign of "substance abuse." And proper use of a prescribed controlled substance is not illicit use. Unfortunately for Langan, medical licensing boards (MLBs) and their associated Physician Health Programs (PHPs) often conflate abstinence symptoms and legitimate use of a controlled substance, as well as moderate alcohol consumption, with substance abuse and addiction.

After dealing with an abstinence syndrome for many months, Langan asked for help from Physician Health Services (PHS), a nonprofit organization founded by the Massachusetts Medical Society. The published mandate of Physician Health Programs (PHPs) in general is to provide ongoing treatment to physicians with substance abuse disorders and other conditions that might interfere with their ability to safely practice medicine while, at the same time, keeping the public safe from possible harm. Not as clearly stated is that, as a condition of keeping their licenses, these physicians must scrupulously follow their PHP's stringent treatment and monitoring plans or be reported to their respective medical licensing board for possible license discipline.

PHS and other Physician Health Programs around the country evolved out of Employee Assistance Programs (EAPs)—voluntary, work-based programs designed to confidentially support employees who are experiencing social or psychological issues that might impair their work performance. They provide free assessment and counseling that is confidential, short-term, narrowly focused, and minimally restrictive. EAPs try to keep employees on the job while they're in treatment; the employer is required to cover treatment costs and make reasonable work accommodations around any temporary or partial disability. Rarely, if ever, do EAPs recommend prolonged absence from work or referral for inpatient services.

Like EAPs, physician health programs assess physicians with potentially work-impairing conditions (primarily substance abuse and mental health disorders) and refer them for evaluation and treatment when indicated. PHPs started out as informal support groups facilitated by physician colleagues, some of whom had also previously struggled with substance abuse. However, under the influence of its umbrella organization, the Federation of State Physician Health Programs (FSPHP), PHP practices were formalized. And when they became entangled in the lucrative drug testing and treatment industries, as will become clear, their resemblance to EAPs evaporated.

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After Langan presented to PHS in 2006, according to the standard protocol for physicians with an alleged substance use disorder, he underwent extensive drug testing. The results were positive for hydrocodone (the narcotic component of Vicodin™) that his personal physician prescribed him but no other controlled or potentially addictive prescription medications, alcohol, or illicit drugs.

All drug tests (other than breath alcohol tests or "breathalyzers") that have legal implications for the client or agency (that orders the test) and the donor (who provides the specimen) must comply with forensic (legal) drug testing standards, These standards apply to all physician health programs. Non-forensic (clinical) drug tests that lack these safeguards are appropriate only for initial screening purposes or for guiding treatment decisions at the point of medical care.

Forensic drug testing usually starts with a kit provided by the testing lab that includes all necessary supplies and paperwork and ends with certification by a specially trained physician known as a Medical Review Officer (MRO). The MRO is responsible for certifying that the results of the tests comply with forensic specifications before being sent to the client.

Forensic testing standards protect the donor from negative repercussions of a controlled substance that is legally prescribed and appropriately used; as well as from a false positive test, one that incorrectly identifies a substance as controlled or illicit. For example, the U.S. Department of Transportation discovered that eating a single poppy seed bagel the morning of a drug test could produce a positive test for morphine at its original cutoff concentration of 500 nanograms/milliliter (ng/ml). As a result, the cut-off concentration was increased to 2000 ng/ml.

Forensic testing protocols also protect the client or agency from liability in case of a legal challenge from the donor. Whether for pre-employment screening, traffic violations, drug courts, police arrests, or physician discipline, if a forensic drug test deviates from these standards, legally, it's literally not worth the paper it's printed on.

After speaking with Langan and reviewing his test results, PHS Associate Medical Director, Dr. J. Wesley Boyd, and Assistant Medical Director, Dr. John Knight, concurred that he was fit to return to work as long as he signed a Letter of Agreement (LOA) to participate in weekly random drug screening for alcohol and illicit drugs for the next 12 months. Believing this to be a fair request, Langan signed the LOA.

Random drug testing required Langan to call a designated number every morning to determine if he had to be tested that day. If so, Langan would take time out of his busy clinical schedule to drive to the collection lab and provide an observed urine specimen, then return to the clinic as quickly as possible to resume patient care.

Langan was scrupulous about avoiding alcohol and recreational drugs but continued to have pain from the nerves damaged by the shingles outbreak. Because he occasionally used Vicodin when the pain interfered with sleep, his drug tests were positive for hydrocodone at a low level from time to time, but he himself never exhibited any behavioral manifestations of drug use or alcohol consumption.

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While state physician health programs have no statutory power over physicians' licenses, they are closely aligned with their respective medical licensing boards which wield virtually absolute control. Medical licensing boards throughout the U.S. and its territories are created by their respective legislatures; the members of their boards of directors are usually appointed by state governors. They have broad discretion to investigate complaints about licensed health professionals and to discipline those whom they believe have violated their state's Medical Practice Act. In many respects, medical licensing boards function as state governmental agencies. However, as will become increasingly apparent, in other respects, they are a power unto themselves.

The Massachusetts Board of Registration in Medicine (BORIM) is structurally and functionally similar to other state licensing boards. It has a close relationship with PHS. If the PHS director believes that a physician under his auspices has violated his Letter of Agreement, he will report that concern to BORIM's Physician Health and Compliance Unit (PHCU).

Lawyers and support staff with PHCU's Complaint Committee will then meet and discuss the circumstances. If they determine that the complaint has merit, they will report it to the full Board of Directors, a group of five physicians and two members of the general public who volunteer to serve for defined three-year terms. The fate of a Massachusetts physician's license is ultimately in the hands of the Board of Directors' chair who signs off on the Board's official decisions.

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In 2007, a year after Langan first consulted PHS, its new director, Dr. Luis Sanchez, noticed an occasional low positive result for hydrocodone. At that time, Dr. Wayne A. Gavryck, a member of the American Society of Addiction Medicine and a board-certified internal medicine specialist, was serving as PHS's Medical Review Officer. It was his responsibility to ensure that Langan's drug tests adhered to forensic standards before reporting them to PHS.

Since Langan was using medication left over from a valid prescription for Vicodin, if the testing had adhered to forensic standards, Sanchez would not have known about his occasional use of Vicodin. But Sanchez was either using the less stringent clinical standards, ignoring the verified negative results, or sidestepping the MRO process altogether.

Because of these positive tests, Sanchez required Langan to undergo additional testing for alcohol and illicit drugs, including fingernail analysis to detect any use of forbidden substances in the previous six months. All of his test results were negative. Nevertheless, Linda Bresnahan, the Director of Program Operations, who was not a physician, remanded him to one of PHS's "preferred" out-of-state addiction evaluation and treatment facilities, The Talbott Center in College Park, Georgia, for a 96-hour inpatient evaluation for substance abuse.

Langan and his colleagues were puzzled by this request. He was board-certified in internal medicine and completed fellowships at both Harvard Medical School and Massachusetts General Hospital (MGH). He also had a "Certificate of Added Qualification" (CAQ) in geriatrics, a subspecialty of internal medicine. He had been on the staff of two different skilled nursing facilities and developed extensive experience teaching and mentoring medical students and residents. For his research in geriatric pharmacology and other topics, he received two prestigious awards.

During his 13 years at Harvard Medical School and 10 years at MGH, Langan's professional conduct was exemplary. He was highly regarded by his peers and patients alike and had never been professionally disciplined or threatened with a malpractice claim. His chosen subspecialty of geriatrics is a branch of medicine that requires compassion, patience, wisdom, and exactitude—attributes he possessed in abundance. Moreover, his geriatrics program at MGH was considered one of the best in the country, having been rated #1 by U.S News and World Report five years in a row.

Although irritated by the inconvenience and cost and the interruption in patient care at MGH, Langan took the order in stride, assuming that, once he completed the evaluation and detoxified from the hydrocodone, he'd be declared "fit for duty" and back at work. He assumed incorrectly.

As advised by PHS, Langan brought a certified check for $4,500 written to the Talbott Center for the cost of the evaluation, a letter from the manufacturer of hydrocodone demonstrating what associated metabolites (breakdown products) might be found in his urine, and the results of his fingernail analysis.

An augur of trouble arose on Langan's first day when he was ushered into the office of an administrator in the finance department. The administrator reviewed his bank accounts, retirement accounts, and credit history to determine his borrowing capacity and the value of his financial assets. He then demanded to know how Langan would come up with $80,000 in cash for long-term drug treatment.

Langan estimated that he would need at most a week to detoxify from the hydrocodone so he wasn't concerned about the cost of long-term treatment. However, he was $500 short for a required physical exam by internal medicine physician Dr. George McNabb. "I was told that I would not be able to be admitted until I paid in full. Neither I, nor anybody I know at MGH, has refused care to a patient based on pre-payment." But Talbott did so routinely. However, the issue was resolved and the evaluation, including repeated urine drug and alcohol testing and hair analysis, proceeded on schedule.

The next day, Dr. Paul Earley, the facility's medical director and addiction medicine specialist, told Dr. Langan bluntly, "Your future is in my hands and you are clearly in denial about your addiction. If you don't accept treatment, you'll be reported to your board and never practice medicine again." When Langan asked for an explanation, Earley responded with what Langan described as "thought-stopping memes and psychobabble" such as, "You need a checkup from the neck up," "You have a swollen head," and, "It was your best thinking that got you here." Puzzled and frustrated by Dr. Earley's bloviating, but fearful of risking his career, he reluctantly agreed to continue the evaluation.

After his encounter with Dr. Earley, Langan was administered two neuropsychiatric tests by licensed psychologist Dr. Steven Snook. One was an IQ (intelligence quotient) test, the Wechsler Adult Intelligence Scale (WAIS). For reference, the mathematical average on an IQ test is 100. "Genius level" is 150 or more.

While Snook reported that Langan's IQ score was in the "high average to superior" range at 122, it was at least 20 points below his previous scores, a significant discrepancy. The WAIS is considered a reliable instrument that produces similar results in the same individual over time absent any intervening cognitive decline. Langan was concerned that the drop in his IQ score could be misinterpreted as such, and, in fact, it was.

If Dr. Langan had any suspicion that Dr. Snook had incorrectly interpreted or falsely reported the results of his WAIS, Snook's interpretation of his Minnesota Multiphasic Personality Inventory (MMPI) reinforced it. The MMPI is an extensive questionnaire used to help evaluate an individual's mental health. Its most recent iteration, the MMPI-2, is used in legal cases, including criminal defense and custody disputes, for employment screening and in treatment programs. When interpreted in conjunction with a comprehensive medical and psychological evaluation, the MMPI-2 aligns nicely with any presumptive psychiatric diagnoses and thus is considered a valid test.

The MMPI-2 is also a very reliable inventory. Like the WAIS, the MMPI-2 generates similar results on the same individual over time unless confounding factors develop that affect his or her psychological well-being. A computer algorithm generates a profile from the raw scores and interprets their results, thereby obviating any interpretive bias by the test administrator.

Most of the questions on the MMPI relate directly to the psychological health of the test-taker. However, woven into the test are questions that assess the test's validity. A high F-scale score suggests that the test-taker is attempting to manipulate the results in his favor and a high K-scale score indicates lack of candor.

The L-scale (the "Lie Scale") was particularly salient to Langan's assessment. It's composed of 15 statements whose answers indicate the extent to which the test-taker is trying to project an unrealistic and idealized image of himself. Langan's score on the L-scale was 65, a significantly elevated result. Snook wrote:

> "An analysis of his response style in this inventory showed that he understood the items, but responded in a rather guarded and cautious manner. His pattern of responding is typical of an individual who may be seen as making a naive and unsophisticated attempt to appear in a positive light. There may be a pattern of minimizing and denying even common human faults. Such a pattern of responding is not unusual in such an assessment but may reflect a person who is not particularly insightful in terms of his own feelings and behavior."

Having formally studied the MMPI in college, Langan knew that "only people bereft of common sense" would consistently disagree with statements like "I do not always tell the truth" or "I do not like everyone I know." Langan was not lacking in common sense and did not disagree with such statements, but Snook none-the-less characterized him as evasive, naive, and in denial about his true nature. Something was amiss. At the end of the four-day evaluation, Langan was led into the conference room where he was met by his assessment team: Snook, Earley, and McNabb, the internist. Langan reported that McNabb "shined a light in my eyes for a nanosecond, listened to two heartbeats and four breaths through his stethoscope and tried to palpate my liver to the tune of $500."

For their part, Snook and Earley were gearing up for what could only be described as an ambush. They alleged that Langan suffered from both cognitive impairment and denial about the severity of his substance abuse, adding that he couldn't possibly practice medicine safely without at least 90 days of residential treatment at Talbott. After hearing this, Langan's initial reaction was that "it was another person's assessment given to me by mistake."

Shocked and confused, Langan replied, "I don't understand. I have negative hair and nail analyses, a legitimate explanation for the (previous) positive opioid tests and have never had any problems at work. I've also given you a list of people to contact who could verify that my work performance was excellent and there was no concern by anyone including nurses, patients, and students." Earley bluntly replied: "Outside evaluators might cover for you so we can't let them weigh in with their opinions."

As Langan pressed for more answers, Earley would loudly interject with more "incomprehensible gibberish." At one point, Earley glanced out the window and informed Langan, "There's a disease doing pushups in the parking lot." It was then that Langan realized he was deep in an addiction treatment rabbit hole, and the only way to dig himself out was by acquiescing to their demands.

Although he successfully detoxed from hydrocodone within seven days and was anxious to get home, Langan took on the role of a repentant drug addict and began methodically digging his way through Talbott's labyrinthine demands. Punctual at meetings. Asking a higher power for help. Completing worksheets describing his progress in conquering drug abuse. Quoting the proper lines from the book Alcoholics Anonymous (also known as the "Big Book" or The Alcoholic's Bible) at the proper time. Acknowledging that he was "powerless" against his addiction. Reciting the Alcoholics Prayer with mock sincerity over and over again.

Langan also attended AA classes and lectures, went to group and individual therapy, and did everything else expected of him. Everything except believing in the false diagnoses of substance abuse and cognitive impairment that had sentenced him to Talbott. He gritted his teeth, and, while inwardly seething, stoically burrowed his way through 90 days of painful cognitive dissonance, confident that, when it was over, life would return to normal.

Chapter 2: The Epitome of Normal

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Dr. Langan was understandably traumatized by his experience at Talbott but nonetheless relieved that he'd survived with his medical license and sanity intact and he knew that the people who mattered believed in him. Once he was discharged from Talbott, he tried to put the experience out of his mind. But Langan was also a man of science and principle who believed in justice and reason. He couldn't dismiss Dr. Snook's errant interpretation of his MMPI-2, the false diagnoses of cognitive impairment and substance abuse, and the potential consequences to his well-being and career.

Langan initially believed that he was a victim of "confirmatory bias," a phenomenon in which the evaluator, in his words, "motivated by the desire to bolster a favored hypothesis, unconsciously engages in selective reporting or skewed interpretations of data thereby producing a distorted picture." Confirmatory bias tends to support the most common and expected diagnoses and gives short shrift to those that are more obscure or complicated. Common advice given to third year medical students is, "When you hear hoof beats, think horses, not zebras." However, the corollary is, "If a zebra is standing on your foot, don't call it a horse."

Langan later learned he was not alone. In May of 1999, Dr. G. Douglas Talbott, a recovering alcoholic and the eponymous founder of Talbott Recovery Systems, was forced to step down as president of the American Society of Addiction Medicine (ASAM) after a jury awarded one of his patients, Dr. Leonard Masters, $1.3 million in actual damages and an undisclosed amount in punitive damages for malpractice, fraud, and false imprisonment.

Masters had been anonymously accused of improperly prescribing controlled substances and was subsequently referred to the Florida Physician Health Program (FPHP) for alleged professional impairment. The FPHP director, a recovering alcoholic, gave him two stark choices: "Either lose your license or be evaluated at one of our preferred assessment centers."

Believing that he would be cleared of the allegation, Masters chose the Talbott Recovery Program. With his medical license suspended, he was coerced into staying there for four months for treatment of alleged alcoholism. Upon discharge, he had to sign a five-year monitoring contract with the FPHP in order to reactivate his suspended medical license.

But according to Masters' attorney, Eric Block, "No one else ever accused him of having a problem with alcohol. Not his friends, not his wife, not his seven children, not his fellow doctors, not his employees, not his employers. No one."

Masters later sued Talbott and the Florida PHP and won. While corrections were made to the false diagnoses on Dr. Masters' medical record and he was compensated monetarily, no changes were made to the system that had defamed and defrauded him. Other than losing his title as president of ASAM, Talbott himself faced no professional repercussions. Langan reported that he "continued to present himself and ASAM as the most qualified advocates for the assessment and treatment of medical professionals for substance abuse and addiction up until his death in 2014."

Concerned about a similar pattern of diagnostic fraud by the Talbott Center, Langan consulted MGH neuropsychologist, Dr. Lauren Pollack, as soon as he returned to Boston. After extensively interviewing and evaluating Langan, she concurred that the MMPI-2 interpretation was likely incorrect and asked Talbott Center to release Langan's medical records to her for review.

After several ignored requests, Pollack finally received the raw data and score sheet from which Langan's psychiatric assessment was made. The data were then run through the MGH Neuropsychology Department's computer; the results confirmed that his MMPI-2 scores were the epitome of normal. He and

Pollack reluctantly concluded that the psychologist hadn't simply misinterpreted Langan's test results; he had deliberately distorted them to fit the hypothesis that Langan was in denial about his addiction. In other words, Langan wasn't a victim of confirmatory bias, an inadvertent misdiagnosis, but of a far more sinister process, diagnosis rigging, in which the misdiagnosis is intentional.

Pollack then wrote a letter to BORIM, stating, "I have since attained a copy of the raw MMPI-2 data from that assessment, due to Dr. Langan's expressed concerns about his response pattern. After reviewing these data, it is unclear to me on what basis [Dr. Snook's] statements were made." Then, in the clearest of terms, Pollack informed BORIM that the MMPI-2 performed at Talbott Center had been interpreted as displaying defensiveness and denial when, in fact, it was completely normal. BORIM never acknowledged receipt of her letter.

Langan was aware of the potential trouble he could cause by lodging an official complaint against one of PHS's colleagues. In fact, when PHS's Linda Bresnahan learned of his intentions, she threatened retribution, stating, "You won't be a doctor in five years. Dead, relapsed, or in jail, I don't care." "Dead?" Langan asked incredulously. "That or you'll wish you were " was her response.

Nevertheless, Langan felt compelled to report Dr. Snook to the Georgia State Board of Examiners of Psychologists, an agency similar to medical licensing boards. He included copies of Snook's original assessment and interpretation, relevant sections of the American Psychological Association's ethics code, Pollack's detailed expert opinion, correspondence from several experts in neuropsychology, and a detailed explanation of how the MMPI-2 should be interpreted.

A psychology student could easily see that Snook's handling of the test violated protocol. However, the "cognizant reviewer" (the supposed expert) at the Board of Examiners deemed Langan's complaint a "difference of opinion" and declined to pursue it. Langan could not understand how a test result generated by a computer algorithm and purposefully altered by a test administrator could be a mere difference of opinion, so he wrote and asked the reviewer on what supporting evidence the alternative opinion could possibly be based. He never received a reply.

Langan eventually sent a letter to the Association of State and Provincial Psychology Boards (ASPPB) whose director then referred the matter to the Georgia Psychological Association (GPA). At the GPA's insistence, in December 2009, Snook finally submitted a letter to the organization acknowledging his error along with a correction: "An analysis of his response style to this inventory showed that he understood the items and responded in a straightforward manner. The validity scales were noted to be within acceptable limits and the resulting profile was judged to have been useful for clinical interpretation."

Snook also offered Langan his "profound apologies for any distress the uncorrected report may have caused you" but he didn't acknowledge any purposeful wrongdoing nor was he formally sanctioned by the GPA. Langan later spoke to several other doctors whose MMPI-2 interpretations by other Physician Health Programs were virtually identical to Snook's, strongly suggesting that his experience wasn't a fluke.

After reviewing all the data he'd collected about testing at PHPs and after much thought and analysis, Langan reluctantly concluded that he wasn't a victim of confirmatory bias or even diagnosis rigging. Like Masters, he had been purposefully misdiagnosed for the direct monetary benefit of Talbott Center. And like Masters, he believed he was a victim of "diagnostic fraud" and false imprisonment.

Yet feeling some sense of empowerment for uncovering the fraud, Langan refocused on what was most important to him: his family, patients, and colleagues. He had demonstrated his sobriety, good character, and competence and, except for the annoying random drug screens that he was becoming accustomed to, had closed the book on his troubles with the Massachusetts Physicians Health Services. Or so he believed.

Chapter 3: Ante Up

During his stay at Talbott Center in 2007, Langan demonstrated conclusively that he was no longer physically dependent on opioids and that he hadn't used, much less abused, alcohol or illicit drugs throughout the entire investigation. Based on his final meeting with the Talbott Center team, he was prepared to be diagnosed with "opioid use disorder" and monitored for relapse for another year or two. He would accept the monitoring with dignity and diligence, certain that the quality of his work would absolve him of any lingering stigma or doubts about his competence.

But a few weeks after he returned home, Langan learned that Talbott Center diagnosed him with "alcohol use disorder" instead, a condition for which Langan had absolutely no historical or laboratory evidence. PHS declared that, as a result of this diagnosis, he was "impaired in his ability to practice medicine according to accepted standards" without five years of invasive monitoring and intensive rehabilitation.

Once practicing physicians are labeled "impaired" due to alleged substance abuse or mental illness by a physician health program, they may be locked into a regimen of treatment and monitoring consistent with guidelines of the Federation of State Physician Health Programs (FSPHP), an umbrella organization of state PHPs. Unlike state medical regulatory boards, which have direct power over physicians' licenses, the FSPHP has no legal authority over state PHPs or their participants. Yet it wields considerable influence.

Inpatient treatment is the last resort for treatment of alcoholism and other addictions for members of the general public. When inpatient treatment is justified, the usual length of stay is seven to thirty days, the cost of which is usually covered by most commercial insurance companies, as well as Medicare and Medicaid. The following are the accepted criteria for inpatient addiction treatment:

1. If the patient failed intensive outpatient (IOP) treatment, a rigorous regimen that includes individual therapy, group therapy, drug testing and participation in Alcoholics Anonymous or Narcotics Anonymous.
2. If the patient has a serious coexisting mental health disorder (dual diagnoses) that also needs intensive treatment or would interfere with outpatient treatment.
3. If the patient has co-occurring health problems (such as a seizure disorder) that require medical attention during detoxification;
4. If the patient was previously hospitalized and subsequently experienced a serious relapse;
5. If the patient is a convicted drug offender and inpatient addiction treatment is approved by a judge or drug court as an alternative to imprisonment.

In contrast, for physicians involved with a PHP, hospitalization for 30-90 days is often the first step in "rehabilitation." The addiction treatment facilities usually require cash up front from physicians because billing an insurance company for unnecessary services could lead to a charge of insurance fraud. And billing Medicare and Medicaid could invite scrutiny by the Center for Medicare and Medicaid Services (CMS) and other federal agencies.

Addiction treatment facilities like Talbott profit more from treating physicians than other patients, not simply because the length of stay is greater, but also because the daily billing rate (up to $1000 a day) is higher. The total cost of hospitalization, including drug testing and ancillary services, can be as high as $96,000. The rehab industry is big business. Physicians are one of its biggest cash cows.

In addition to psychometric tests such as the MMPI and WAIS, some physicians are forced to take polygraph (lie detector) tests which can cost up to $900. The mere threat of polygraph testing has been shown to

elicit additional personal information from physicians. Polygraph tests are so subjective and unreliable that they are not admissible in criminal court unless both the defense and prosecution agree and the judge allows it. Yet their results are entered into the physician-patient's medical record as if they were confirmed facts.

Once they've completed their inpatient requirements, physicians must then enter into a contract known variously as a Consent Decree, Consent Order, or Letter of Agreement (LOA). Regardless of the term used, this contract is neither consensual nor voluntary. These "agreements" are often referred to as "contingent contracts" because restoring and maintaining a medical license is contingent upon rigid adherence to all conditions for the duration of the agreement, usually five years.

If the reader is skeptical that such a program exists and is sanctioned by medical societies and boards of medicine, then perhaps the published words of Robert L. Dupont and Lisa J. Merlo, two leaders of physician health programs, will dispel that skepticism. In their article, PHYSICIAN HEALTH PROGRAMS: A Model for Treating Substance Use Disorders [SUDs]. they write:

> "Unlike the "standard of care" for individuals with SUDs in the general population, physicians and health care professionals with SUDs typically enter a comprehensive system of care management that produces the best long-term outcomes for these chronic, commonly fatal disorders. Although participation in PHP care is 'voluntary,' failure to adhere to the PHP contract obligations typically results in adverse actions by the Board of Medicine, hospital, insurance company, or family member(s) who referred them to the PHP and/or withheld consequences as a result of PHP participation.
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> Following evaluation, physicians are referred to the appropriate level of SUD treatment, typically in a program with expertise in treating health care professionals with SUDs. Indeed, 69 percent of physicians undergo residential care for 30 to 90 days. Following successful completion of their formal treatment, the physician signs a monitoring contract with the PHP.
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> Participants are typically required to participate in the program for a period of five years, with consequences for noncompliance with the PHP's recommendations (ranging from re-evaluation to additional treatment and possible reporting to the state licensing board). Importantly, throughout the five-year contract, physicians are monitored closely for any alcohol and drug use through frequent, random drug and alcohol testing using an extensive drug testing panel.
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> Various levels of "relapse" or noncompliance range from missing appointments to dishonesty to return to drug or alcohol use, all of which result in prompt intervention by the PHPs to re-engage physicians, evaluate the need for more intensive treatment and/or drug testing, and assess the need for reporting to state medical boards. A single missed test or positive test for alcohol or drug use is considered a serious violation and may lead to removal from medical practice for more intensive treatment."

An allegation of impairment due to substance use disorder will not only result in five years of intensive "rehabilitation," it generally follows physicians for the rest of their careers. One reason is that PHPs are strongly influenced by the American Society of Addiction Medicine which promulgates the belief that addiction is a "lifelong chronic relapsing brain disorder" that can only be treated by complete and permanent abstinence from all mood-altering substances and "surrendering one's will and life over to the care of God or some other higher power." ASAM contends that recovering alcoholics are never "cured." The best they can achieve is "sustained remission." Their risk of relapse always remains high.

Another reason that the allegation casts such a long shadow is that the physician's license and hospital privileges are often suspended on an emergency basis while he's an inpatient. The suspension will be lifted only

if he starts complying immediately with his five-year contract. A license suspension of any duration is reportable to the National Practitioner's Data Bank (NPDB), a registry of all formal adverse actions taken against physicians, including malpractice awards, loss of hospital privileges, and adverse license actions.

The NPDB is relied upon heavily by healthcare institutions and medical licensing boards when they evaluate the professionalism and other qualifications of their applicants. There is no recognized procedure for removing a report from the NPDB if an adverse action is subsequently determined to be wrongful. It's a permanent stain on the physician's record.

In many states, when renewing a license or applying for a new license, physicians must also reveal past treatment for mental illness or substance abuse—even if these conditions have completely resolved. Thus, the burden of proof is permanently on the physician to provide convincing evidence that he or she is *not* impaired.

Since most consent decrees regarding substance abuse are taken from guidelines issued by the FSPHP, they're fairly uniform across the country. Once the mandatory 30-90-day confinement in an addiction treatment facility is complete, the participant must completely abstain from alcohol and illicit drugs and:

1. Obtain explicit permission to use controlled prescription medications,
2. Participate in AA meetings and social activities two to three times a week,
3. See a substance abuse specialist and psychiatrist regularly,
4. Provide weekly random forensic urine drug screens,
5. Get permission from the PHP to travel out of state, and
6. Meet with the PHP in person every three months.

Medicare, Medicaid, and commercial insurance companies may cover some of the outpatient psychiatric care and visits with substance abuse specialists. Any additional out-of-pocket costs, including drug tests, must be borne by the physician.

As of 2020, a simple urine drug screen costs between $30 and $60. Two very sensitive and non-FDA-approved urine tests for recent alcohol consumption, ethyl glucuronide (EtG) and ethyl sulfate (EtS), cost about $85 each. A test for heavy, long-term alcohol consumption over the previous month or so, phosphatidyl ethanol (PEth), usually costs at least $150. Less frequently used tests such as hair and fingernail analysis, which have a three- to six-month window of detection for substance use, could cost $200 to $600 each.

Recently a company called Vtox started offering a service, DNA-verified Urine Drug Testing, that compares markers on the DNA of the donor obtained from a cheek swab to the markers on the DNA in the urine specimen. Vtox then logs the donor identification and DNA information into their system. Positive matches constitute proof that the specimen came from the donor of record. Unfortunately for Langan, this verification system wasn't available when he was under contract with PHS.

Vtox's selling points are that it obviates the need for an "embarrassing" observed urine collection and saves the collector time. However, Vtox's website doesn't discuss the potential ramifications of relinquishing one's DNA information to a commercial database. Nor does it mention the cost of the test, an indication of incipient sticker shock.

Over the five-year contract period, basic weekly random urine drug testing alone could cost up to $15,000. Weekly EtG, EtS and PEth testing could add another $80,000. Many physicians have difficulty finding work while under the cloud of a PHP contract even if they have an active license. The inability to pay for mandatory treatment, testing and monitoring constitutes non-compliance which the PHP generally reports to its medical licensing board. If the board then suspends the physician's license, the cost of compliance in the hope of

reinstatement combined with the loss of income can push him into a downward financial spiral that can end in impoverishment.[1]

DuPont and Merlo concluded, "Overall the estimated personal cost of participating in the PHP was approximately $250,000. The large majority—85 percent—of participants reported this was 'money well spent.'" That figure doesn't take inflation into account or include those who didn't complete their contracts due to bankruptcy, logistical issues, or intolerable psychological distress.

Dupont's model for treating substance use disorders can cost more than money; it can cost lives. Some physicians have suicided rather than continue participating in a PHP contract. The in-patient treatment is particularly traumatizing. Just as any specific weather event can't be blamed solely on climate change, not every physician suicide that occurs during involvement with a PHP can be blamed solely on the PHP. But the evidence is increasingly clear that the stress, shame and deprivation caused by these so called "health programs" are implicated in suicides. I seriously doubt that the families of those who suicided during the course of their contract would agree that this was "money well spent."

One such physician who has been written widely about was Dr. Gregory Miday. A promising young physician at a prestigious oncology fellowship in Missouri, Miday struggled with alcoholism. After nearly finishing a brutal five-year abstinence-only program with the Missouri PHP, he had some alcoholic beverages while on vacation. Knowing that his "relapse" would be discovered and that he would face further discipline, Miday made a tragic decision.

Rather than continue to suffer at the hands of the PHP, on June 21, 2012, Miday chose to take his own life.

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Chapter 4: The Ozone Layer and a Positive Drug Test

As previously noted, the terms of PHP contracts are strictly enforced. If a physician shows an indication of what the American Society of Addiction Medicine terms "pre-relapse" behavior such as missing an AA meeting or a scheduled drug test, the contract can be extended and new stipulations added. If he has a positive drug or alcohol test, he may be reported to his medical board. If he exhibits behavior consistent with substance abuse (e.g., intoxication) or has a positive drug test (such as a positive Breathalyzer™), he will not only be reported to his medical board, but his license will usually be summarily suspended.

I spoke with a physician working under a consent decree who had dislocated his shoulder. He was given a narcotic in the emergency room prior to the painful procedure of replacing his shoulder back into its socket. His next drug screen was positive for opiates. Even though he submitted the E.R. report to his medical board confirming the circumstances, because he hadn't gotten *advance* permission to use a narcotic, the board treated the positive drug test as a relapse. Although he pleaded for reason and mercy, the board revoked his medical license.

Even a minor infraction can have major consequences. Another physician missed a drug test after three years in a PHP monitoring program because he was out-of-state attending his brother's funeral. Although he notified his PHP in advance, he was deemed "non-compliant" and was forced to choose between restarting the five-year program and losing his license.

Emotionally exhausted and financially destitute after an already lengthy struggle to comply, the physician chose the latter. When I spoke to him, he was out of work, out of hope, and weighed down by delinquent student loan debt. He was being financially supported by his partner at the time, but their relationship was breaking down, and he was on the verge of homelessness.

The Massachusetts PHS wasn't satisfied imposing the typical monitoring contract on Langan. In addition to the usual stipulations of an LOA for substance abuse, he had to:

1) Find a practice monitor, a colleague who would monitor his professional comportment and submit quarterly reports to PHS.
2) Meet with the PHS associate director once a month instead of quarterly.
3) Get random routine urine drug testing twice a week instead of once a week.
4) Include EtG and EtS in his random drug screening.

The use of EtG and EtS testing is controversial in alcohol rehabilitation programs. These tests are so sensitive they can detect recent exposure to alcohol from mouthwash and over-the-counter elixirs and liquids, alcohol-based hand sanitizers, and some allergy and asthma inhalers. They cannot reliably differentiate between incidental environmental exposure and purposeful consumption of alcohol which can lead to false allegations of relapse.

On Talbott Center's recommendation, PHS required Langan's psychiatrist to prescribe him naltrexone, a medication that blocks the euphoric effects of opioids and alcohol and, when taken regularly, can reduce cravings. This was an unusual requirement because, based on their theory that "it's just substituting one drug for another," most physician health programs forbid the use of medication-assisted treatment (MAT) to ease withdrawal symptoms or maintain abstinence. Not only was naltrexone of no direct benefit to Langan since he was no longer opioid dependent and was never an alcoholic, but it would later prove quite problematic.

Langan had a lifelong history of asthma, depending on his inhalers for his very breath, and was required by MGH's strict infection control rules to use an alcohol-based hand sanitizer after each patient encounter. Not

wanting to violate either the terms of his agreement with PHS or MGH's infection protocols or, worse, risk his own health by discontinuing his inhalers, he asked for advice from a colleague familiar with EtG and EtS testing.

Langan's colleague assured him that his current inhaler didn't contain alcohol and that the hand sanitizer wouldn't raise his blood alcohol above the test's limits of detection. "Besides," his colleague added, "neither of those tests is approved by the FDA for alcohol screening in forensic drug testing regimens because of their oversensitivity and lack of proven value."

In spite of the cost and irrationality of his LOA with PHS, so determined was Langan to keep practicing medicine that he assiduously complied with all of its stipulations. Dr. Langan's essential nature was to do his best at whatever task was presented to him, and he was determined to succeed at this one. As a result, for the next two years, he continued practicing his profession with significant inconvenience and expense, but without direct interference.

In January 2008, Dr. Langan was informed by PHS that his recent urine drug screen and hair analysis were positive for opiates and he was ordered to undergo another substance abuse assessment. Langan was perplexed because he had long since stopped using Vicodin, but, with his medical license at risk, he agreed. He chose the McLean Ambulatory Treatment Center in Naukeag, Massachusetts. McLean is a private organization affiliated with the Massachusetts Department of Health. Unlike most PHP-preferred diagnostic and treatment facilities, McLean accepted his insurance.

Langan's evaluation, once again, revealed no evidence of substance use. His repeat drug and alcohol tests were negative and the evaluator admitted that he couldn't explain the singular positive opiate test results reported by the PHS, stating, "If use was so out of control it would seem that Dr. Langan would have some behavioral signs."

But Langan had no "behavioral signs" and on July 16, 2008, he was permitted to return to medical practice. Apparently, the McLean evaluator was unaware that naltrexone can cause false positive opioid tests and apparently PHS's medical review officer was not doing his job either.

In 2009, a year after Langan's evaluation at McLean, Dr. Knight was removed from PHS and, one year after that, so was Dr. Boyd. Both had served as associate directors for over 20 years and had witnessed firsthand the deterioration in PHS's treatment of its physician clients. They both openly objected to use of EtG and EtS in PHS's monitoring program and the practice of automatically equating a diagnosis of a mental health or substance use disorder with actual professional impairment. Such stereotyping was, in their opinion, a clear violation of the Americans with Disabilities Act.

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Due to a fluke in atmospheric physics, Langan's struggle with PHS became significantly more challenging. Back in 1974, a group of research scientists observed a correlation between the use of chlorofluorocarbon (CFC) propellants and refrigerants and an increased incidence of skin cancer, cataracts, and other maladies in humans and animals alike. They concurrently observed an association between use of CFCs and thinning of the ozone layer, a layer of air in the stratosphere that protects life from harmful solar radiation.

Researchers were particularly alarmed by the development of a hole in the ozone layer directly over Antarctica. After a decade of research and observation, scientists finally demonstrated a direct causal relationship between the use of CFCs and thinning of the ozone layer. As a result of unprecedented international cooperation, CFCs were banned worldwide.

Though it contributed a small fraction to atmospheric CFCs, the CFC propellant in Langan's asthma inhalers was banned and replaced by a hydrofluoroalkane (HFA) propellant. HFAs don't degrade the ozone layer, but they are structurally similar enough to ethanol to cross-react with drug tests for alcohol. Because the

lungs have a large surface area for absorption, inhalation of HFAs can cause significantly higher concentrations of EtG and EtS in the urine (often above the cut-off limit) than does use of oral mouthwashes and topical hand sanitizers or occasional doses of OTC liquid medications.

After Langan started using his reformulated inhalers, EtG and EtS were sometimes positive at low concentrations in his urine. In August 2008, Dr. Sanchez conveyed these test results to Attorney Robert Harvey, manager of BORIM's Physician Health and Compliance Unit (PHCU).

Sanchez wrote, "By FDA mandate, the inhaler manufacturers changed to ethyl alcohol propellants in January of this year. PHS will be working with Dr. Langan to determine if there are alternative options. Meanwhile, PHS has advised him to continue to use these medications as needed and as directed by his treatment providers without penalty." That email should have resolved the problem of false positive tests from his inhaler use but it didn't.

Adverse actions against physicians who are alleged to have violated their LOA include adding further conditions to pre-existing LOAs, extending their duration, and, gravest of all, referring the offenders to their respective medical licensing board. Once a physician in a PHP contract is reported to his licensing board, his right to practice medicine is in existential danger. As previously mentioned, a medical licensing board has the authority to suspend, limit or revoke his medical license.

If the medical board decides that the physician's continued practice presents an imminent threat to public safety, it may immediately suspend the physician's license without a prior hearing, an action referred to as an emergency or summary suspension. Emergency suspensions often occur even when there's no evidence of unprofessional behavior. The mere diagnosis of a condition that could theoretically impair his ability to practice safely and competently, or a hint that he's not 100% compliant with his contract, can trigger an emergency suspension.

A summary license suspension, even if temporary, can have both immediate and permanent professional repercussions, including loss of employment, hospital privileges, and positions in residency training, as well as difficulty obtaining licenses in other states and securing opportunities for advancement. If the physician remains non-compliant, the Board can impose an indefinite license suspension which often leads to a permanent revocation.

If the Board decides that a specific aspect of the physician's fitness to practice is irremediable, it can impose limitations on a license rather than revoking it outright. For example, a physician with Parkinson's disease could keep his license but be forbidden to perform surgery. However, license restrictions such as these are rarely implemented.

Physicians who are considered intractably non-compliant with their LOA or irreparably impaired to practice may have their licenses permanently revoked. Alternatively, they may be allowed to "voluntarily" surrender their license. While a voluntary surrender may appear to be a lesser punishment than a permanent revocation, it has the same effect. With either action on his record in one state, a physician can seldom obtain a license in another. Without an active license, a physician cannot practice medicine and cannot earn a living in his chosen career. Foreign medical residents on a work visa cannot even remain in the U.S.

License limitations, suspensions, voluntary surrenders, and revocations are posted on the medical board's public website and reported to national repositories such as the National Practitioner Data Bank, as well as the American Board of Medical Specialties (ABMS) and the Federation of State Medical Boards (FSMB), an umbrella organization of state medical licensing boards.

The FSMB keeps track of all adverse actions against a physician's license and notifies all other medical boards of such events. In contradistinction to what many people assume, a physician who loses a license in one

state will find it difficult, if not impossible, to secure an unrestricted license anywhere else in the United States or any of its territories.

Chapter 5: Like-Minded Docs and Laboratory-Developed Tests

Through June 8, 2011, Langan's routine drug screens were negative for illicit drugs and his EtS and EtG tests were either below the limit of detection (negative) or positive at a low level and he was permitted to practice medicine unimpeded. He continued to follow the stipulations of his contract: avoiding alcohol, attending peer support meetings, getting twice weekly random drug screens, and seeing a therapist and the PHS associate director as required. Also, out of fear of being accused of non-compliance, he continued taking naltrexone.

However, on two separate occasions in June of 2011, Langan's EtG/ EtS tests were reported as positive in extremely high concentrations. Levels greater than 1000 ng/ml[2] for EtG and 200 ng/ml for EtS are considered definitive proof of recent heavy alcohol consumption. On June 20 and June 30, his levels were reported as 11,700/2070 ng/ml and 13,700/2,270 ng/ml respectively. Notably, all of his previous urine collections were logged in as "witnessed" by the collector, but these two were not. Thus, there was no documentation that these were Langan's specimens.

The ratio between EtG and EtS concentrations normally vary when specimens are collected on different days because they are processed by the kidneys and excreted into the urine at different rates. The EtG/EtS ratios of these two specimens, although presumably collected 10 days apart, were both 6:1. This could be a coincidence but it could also be because the same specimen was tested on two different occasions. Also, it's not uncommon for EtG (but not EtS) to gradually rise within the specimen tube over time; this could explain why the second test had a higher concentration of EtG than the first even if both tests were from the same specimen.

EtG and EtS levels that high indicate very heavy drinking within the previous 72 hours, an amount of alcohol consumption that is not compatible with a physician performing professional duties such as doing rounds, taking care of clinic patients, and documenting encounters. At those levels, a regular drinker would be intoxicated; a non-drinker would be stuporous; even a seasoned alcoholic would be dysfunctional. To put it bluntly, it's physiologically impossible for someone to have EtG and EtS concentrations this high without being obviously intoxicated over the previous few days.

The day after the second positive EtG/EtS tests, Sanchez ordered Langan to cancel an important out-of-town business trip involving a patent for an Automatic Medication Injection Device, a novel method of delivery of epinephrine to patients experiencing anaphylactic shock. Instead, he was remanded to Quest Diagnostics' collection site to have his blood drawn for a phosphatidyl ethanol test (PEthStat). This test, Sanchez claimed, would confirm that he had been drinking heavily over the previous few months rather than recently exposed to alcohol from his inhaler.

Unlike EtG and EtS which are direct metabolites of alcohol, PEth is a biomarker (a proxy) for alcohol consumption that's produced from the interaction between red blood cell members and ethanol. PEth accumulates over time in the blood streams of regular drinkers. Like EtG and EtS, PEthStat is a laboratory-developed test (LDT). At the time of Langan's involvement with PHS, it had not been approved by the FDA for identifying relapse in alcohol treatment programs. Currently, it is approved for use only in conjunction with behavioral evidence of intoxication or other definitive signs of substance abuse.

On July 1, 2011 Langan went to Quest Diagnostics collection center to have his blood drawn for PEth. Langan noticed that the technician who drew his blood wasn't using a forensic test collection kit and didn't mix the blood sample with the preservative and anticoagulant in the collection tube. However, he didn't remember having been tested for PEth before and didn't recognize the significance of these lapses at the time.

On July 14, 2011, United States Drug Testing Lab (USDTL), the specialty lab that PHS and many other PHPs use for forensics drug testing, reported to PHS that Langan's PEth concentration was positive at 365.4 ng/ml. To put this in perspective, PEth will usually be negative after occasional light alcohol consumption. A PEth concentration just above the threshold of 20 ng/ml correlates with regular light alcohol consumption or recent moderate alcohol consumption. A concentration greater than 200 ng/ml indicates heavy, long-term alcohol abuse. Langan's PEth concentration was more than 10 times higher than would be expected of a moderate drinker and the second highest concentration USDTL had recorded to date.

From a clinical standpoint, an individual with such a high concentration of PEth would have been drinking heavily on a regular basis, intoxicated or hung over and experiencing wild swings in his mood and behavior. He'd also exhibit maladaptive behaviors such as missing work, getting into arguments with colleagues, bullying or ignoring staff members, getting traffic tickets, and violating social norms, as well as having alcohol on his breath and slurring his speech. But Langan's demeanor, behavior, and professionalism remained exemplary, a scenario that's physiologically impossible to reconcile with a PEth concentration of 365.4 ng/ml and his otherwise negative random tests for alcohol metabolites. Simply impossible.

Even Joseph Jones, Vice-President of Operations for USDTL, concurred. He stated in an email to Sanchez on September 6, 2011 that "In the case of someone [with a PEth concentration] in the 300s, they were either intoxicated at the time of collection or they have a very significant alcohol abuse disorder. A level of 300 is consistent with someone putting away a lot of alcohol on a routine basis."

Based on the inexplicably high levels of EtG, EtS, and PEth, Langan was given two weeks to arrange another expensive, cash-only substance abuse evaluation. Langan was incredulous. He had been following every stipulation of his LOA to the letter, no matter how expensive, time-consuming, or irrational. But suddenly his career was on the sharp edge of a scalpel and, if he didn't react quickly and aggressively, it could bleed out.

Hoping to avoid another biased evaluation, Langan immediately contacted his practice monitor, Dr. Timothy Wilens, the director of the Center for Addiction Medicine at MGH, and Dr. Michael Bierer, a board-certified in addiction medicine specialist, for advice and assistance.

Both consultants collected collateral information from his attending physicians and supervisors at MGH, performed complete physical exams and cognitive evaluations, and ran a battery of tests for the deleterious health effects of heavy drinking such as vitamin deficiencies, liver disease, and anemia. Neither consultant found any evidence of drug or alcohol abuse, behavioral impairment, or health problems. They assured PHS that Langan's professional comportment, patient care, diagnostic acumen, and teaching skills were "superlative."

Wilens also reminded PHS Director Sanchez that EtS, EtG, and PEth should only be used in conjunction with behavioral manifestations to denote relapse. He vouched for Langan's sobriety, professionalism, and clinical competence in the clearest of terms. Wilens concluded, "My clinical impression does not support that Dr. Langan suffers from an alcohol use disorder and I disagree with PHS on the supposition that Dr. Langan has an alcohol problem."

The letter from Wilens must have been dropped into Director Sanchez's physical or virtual trash. He characterized Langan's six-week delay in getting another PHS-approved evaluation as a significant violation of his LOA and, on July 28, 2011, he reported Langan's alleged non-compliance to Attorney Robert Harvey who referred it to the PHCU's Complaint Committee.

After reviewing Langan's contract, the Complaint Committee in turn concluded that, not only was the delay clear evidence of non-compliance but that the positive PEthStat was irrefutable evidence that Langan had consumed significant quantities of alcohol in flagrant violation of his LOA.

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In early August of 2011, Langan was ordered to immediately cease patient care and head to a PHP-approved treatment center for *another* evaluation. While he was given a choice of three different centers, in Langan's mind, it was like deciding which head of a poisonous three-headed snake he'd prefer to be bitten by. All three were headed by members of "Like-Minded Docs" (LMD), a physician organization largely composed of recovering alcoholics who strongly support the chronic disease model of substance abuse and the Alcoholics Anonymous (AA) 12-step model for treating it.

Members of Like-Minded Docs believe strongly that "psychosocial interventions are necessary components of the treatment of all persons with addiction." While LMD members were averse to the use of medication-assisted treatment (MAT) such as methadone and buprenorphine for opioid addiction and had active disagreement about the use of psychoactive (mood-altering) drugs such as antidepressants, they were of one mind about AA and "The Great Power of the Twelve Steps" to treat addiction.

Like-Minded Docs' approach to substance abuse and addiction can be a godsend to those with serious and recalcitrant drug and alcohol use disorders who have been unable to achieve sobriety on their own and would benefit from a convivial, spiritual and holistic approach to treatment. But for the pragmatic person with significant time constraints who doesn't need intensive treatment, it's an expensive and time-consuming quagmire that can suffocate rather than save them. For the individual who's falsely accused of substance abuse, the cognitive dissonance it creates can be an intellectual and spiritual nightmare.

One of Like-Minded Docs' core beliefs is that physicians are "different" from other professionals with substance use disorders in part because of their easy access to addictive medications. They also theorize that physicians are more heavily in denial due to pride, the high stakes involved, and the stigma attached to substance abuse. As such, they believe that physicians need more intense and prolonged treatment for substance abuse than other professionals. Hence, the five-year monitoring contracts and complete abstinence requirement.

Like-Minded Docs also contends that physicians need more frequent and extensive drug testing because, they postulate, physicians can use their specialized knowledge of pharmacology to obfuscate their continuing substance abuse. For example, the drug of choice might be one that's not yet part of standard drug panels (such as a novel street drug or a prescription medication whose abuse potential hasn't yet been recognized) or one that's more potent and/or more quickly eliminated from the body's system than others.

For example, physicians might choose alprazolam (Xanax) over diazepam (Valium) as their drug of choice. While they are both sedatives in the benzodiazepine family, alprazolam is eliminated from the system much more rapidly and can produce the same physiologic effects with only $1/10^{th}$ the dose. As a result, its concentration in blood and urine is much lower and the detection time much shorter than diazepam, making it harder to detect continued use.

Likewise, fentanyl is extremely potent; the therapeutic dose is 1/100th of most other opiates and shows up in the urine in very low concentrations, if at all. Concentrations below 1 ng/ml cannot be detected by current technology. Theoretically, strategic use of a highly potent, quickly metabolized drug along with drinking a lot of water just before the specimen collection could keep the physician's continued substance abuse under the radar.

Like-Minded Docs has close to 300 physician members, most of whom belong to the American Society of Addiction Medicine (ASAM), an organization of self-styled non-residency trained addictionologists. One of those members is Dr. Paul Earley, the physician whose corrupt diagnosis of alcoholism put Langan on the path towards career destruction. Once a drug abuser himself whose license to practice medicine was suspended as a result, Earley subsequently became Talbott Center's medical director. He is past president of both FSPHP and ASAM and current director of the Georgia PHP. He also has a consulting service that heavily promulgates drug testing of licensed healthcare professionals as a way to "keep the public safe."

Addiction medicine wasn't recognized as a specialty by the American Board of Medical Specialties (ABMS) at the time of Langan's involvement with BORIM. To date the only formal requirements for membership seem to be a medical license, some familiarity with addiction—often through personal struggle with substance abuse—passing a written examination, and a pulse.

Langan himself, out of curiosity, took ASAM's certification exam and passed it with great ease and little preparation. As he describes in his blog,

> "The requirements to sit for the exam included so many "practice experience hours" over the past five years and 50 CME [Continuing Medical Education] credits related to addiction. With a year of psychopharmacology research, a half-day per week moonlighting at the Massachusetts Bay Transportation Authority (MBTA) medical clinic giving drug tests to bus drivers and another overnight moonlighting job giving medical clearance to patients at a local psychiatric hospital detox unit, I satisfied the former requirement.
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> For the latter I looked through the last five years of morning reports, noontime lectures and grand rounds I went to and added them up and, falling a little short, supplemented the CME credits with some online modules. And with that I was given a date at Pearson to take the test.
>
> I have absolutely no training or education in the field of addiction medicine. I didn't pick up a book or study anything. I did not prepare at all. I did not even get a good night's sleep the night before and stayed up until 2:30 a.m. Nevertheless, I went to the testing facility the next morning and finished the test within an hour and a half. Passing score was 394 and I got a 459. And the point I am trying to make is I am no expert in Addiction Medicine. Yet the certificate says I am."

Currently, many directors of board-affiliated evaluation and treatment centers are members of Like-Minded Docs and virtually all Physician Health Programs mandate this group's approach for physicians with alleged substance abuse. It includes total abstinence, faithful allegiance to the dictates of Alcoholics Anonymous, and acknowledgement of one's inherent helplessness in the face of drug and alcohol addiction. Because Langan had great faith in his own agency, the latter precept was perhaps the most difficult one for him to even pretend to accept.

Once again, the only way Langan could continue to practice medicine was to acquiesce to PHS's demands.

Chapter 6: The Fraud Revealed

On September 18, 2011, Langan arrived at the Hazelden Addiction Treatment Center in Minnesota for his third mandated substance abuse evaluation. While there, just as at Talbott Center and McLean, he had no withdrawal symptoms or other signs of alcohol or drug dependence. Neither his blood PEthStat, urine EtG and EtS, nor hair and fingernail analyses revealed any evidence of alcohol consumption or drug use in the previous six months.

Emil Jalonen M.S. J.D., the Hazelden evaluator, concluded that Dr. Langan had no past or present alcohol use disorder and could practice medicine "with reasonable skill and safety." However, because he could not explain the positive PEthStat of July 1, 2011—the possibility that it was a fraudulent test never entered his mind—he recommended that Langan increase his attendance at 12-step meetings from once a week to three times a week "just to be safe" and to incorporate PEthStat into his routine drug-testing regimen.

Again, Langan was incredulous. He was the poster child of sobriety. A punctilious and highly motivated professional, he was following every stipulation of his contract to the letter, no matter how unnecessary, time-consuming, or irrational it seemed. Notably, throughout the entire investigation, the only "evidence" of alcohol use or abuse came from the exquisitely sensitive and, in two instances, inexplicably elevated EtG and EtS tests and the incomprehensibly high PEthStat result. He never had alcohol on his breath, never was observed drinking, and never exhibited signs of impairment. Yet now he had to attend more meetings and spend more money on testing.

Strict forensic drug testing protocols were started by the federal government in the 1980s. The original rationale for federal drug testing was to screen commercial truck drivers and other workers in safety-sensitive positions for illicit drugs that might impair their ability to competently perform their jobs. Initially, the DOT didn't screen for controlled prescription medications or alcohol. Breath and blood alcohol tests were done only if a worker was involved in an on-the-job accident or other serious incident and there was "reasonable suspicion" of intoxication.

The interest in routine testing for metabolites of alcohol came from the drug treatment, testing and monitoring industries, not from a government mandate. Because alcohol itself can only be detected in the breath or blood for a few hours, drug testing labs created laboratory developed tests (LDTs) for metabolites of alcohol that stay in the system for several days and they encouraged the use of finger nail and hair specimens and PEth tests which have a three- to six-month window for detecting past use. The alcohol rehabilitation industry provided a lucrative market for such tests.

The current technology of drug testing is remarkable. Not only can dozens of substances be detected but concentrations as low as one nanogram per milliliter of a substance can be identified and quantified. This is akin to identifying one drop of a substance in a bathtub of water and accurately measuring its concentration.

Regardless of how they are interpreted and used, to be considered legally valid, forensic drug tests must conform to an exacting process. The testing facility provides a kit which includes specimen containers, sealing tape, a return mailer, and numbered labels to match the number on the enclosed chain-of-custody (COC) form that accompanies the donor's specimen.

The COC form creates a paper trail that is vital for validating the testing process. Specimen collectors must follow a standard procedure including witnessing or performing the collection, signing and dating the COC form, and placing the ID labels on both the COC and the specimen container(s). The collector must record the appearance, concentration, and temperature of urine specimens on the COC. While it did not do so at the time of Langan's involvement, the collector usually pours the sample into two separate containers, Bottle A and Bottle B, so called "split-specimen" testing.

Blood specimens must be properly mixed with the preservatives and/or anticoagulants in the enclosed sample containers. Once all these steps are completed, the collector seals the container(s) with the enclosed tape and, after the donor has initialed it, places it in the mailer.

After the specimen has been analyzed and reported by the certified lab, the lab report and COC are reviewed by the Medical Review Officer. The MRO examines the COC to ensure that it's accurate and complete. If the test is negative, the results are sent directly to the client. If it's positive for a controlled, illicit, addictive or forbidden substance, the MRO will first contact the donor for an explanation. If the donor doesn't have a legitimate explanation for the positive test or if the test is positive for alcohol or its metabolites in a zero-tolerance treatment program, the MRO will report the positive test results to the client.

On the other hand, if the MRO determines that the result is a false positive (such as poppy seed bagels or an HFA inhaler) or that the donor has a valid prescription, the MRO will report the results to the client as a negative test. It may be difficult to wrap one's head around the concept of a positive being a negative, but this

process was put in place to protect the donor from false accusations of drug abuse. As I previously stated, proper use of a legitimately prescribed medication is not substance abuse.

In the event that a COC is incomplete (or missing!!!) or demonstrates a flaw in the collection, transfer, or analysis of the specimen, the MRO must follow specific protocols. Minor defects such as a missing collector's signature are considered "correctable flaws" and, once they're corrected, reporting can proceed.

If a urine specimen is negative, but diluted, the MRO will report it as such. The client can decide whether to accept the test results or ask the donor to provide another specimen. Negative dilute urine specimens should not be used as evidence against the donor. However, specimens that are contaminated or inconsistent with urine, such as the cupful of Mountain Dew a patient once handed me, are treated as forensically (legally) positive even if no drugs of abuse are detectable.

Other defects such as a mismatch between the ID on the specimen and the ID on the chain-of-custody form are considered "fatal flaws." If the lab documented evidence of tampering of a specimen (such as a broken seal), the MRO can request that the lab run the split specimen (Bottle B) if it's available. If not, the original test will be reported simply as "canceled" and the MRO will recommend to the client that the donor promptly provide another specimen for analysis.

While Langan had to toe the party line with his Letter of Agreement, he was becoming increasingly suspicious of the validity of the PEthStat result. He theorized that the alcohol swab from the first blood draw and the high ambient temperatures in Boston in July during the unusual seven-day delay in processing the specimen may have combined to produce PEth in the test tube. But was that enough to explain the second highest PEthStat ever recorded? Langan was skeptical and decided to request from USDTL a "Litigation Package," a complete set of documents relating to how the specimen was collected, handled, analyzed, and reported.

Langan's initial requests for the litigation package were unsuccessful. He was first told that such requests had to come from the laboratory's client, in this case PHS, so he asked PHS attorney Deb Grossbaum for help securing a copy. She would not cooperate, insisting that it would be too expensive and time-consuming because it would have to involve lawyers. Langan's attorney, Scott Liebert, later described her as becoming increasingly "touchy and defensive" over his repeated requests. She finally wrote to Liebert, "Langan needs to decide if he's working with PHS or against PHS."

Langan didn't accept Grossbaum's excuses. He reasoned that PHS, who had ordered the test, had a right to acquire all documents related to it. Plus, he confided in Liebert, he was neither "for" nor "against" PHS. He was for the truth and against the lab fraud he suspected had taken place.

On December 6, 2011, Dr. Langan received a letter from Sanchez summarizing the reasons for the increased meetings and drug tests. Apparently, Sanchez had forgotten (or ignored) an email he'd previously sent to Attorney Harvey stating "PHS has advised him [Langan] to continue to use these medications [his inhalers] as needed and as directed by his treatment providers without penalty" as well as a letter to Kenneth Minaker, Langan's practice monitor, stating that "given the explanation that Langan provided for the positive EtG result, PHS considers Dr. Langan to be compliant with his PHS Substance Use Monitoring Contract."

However, Sanchez's December 6, 2011 e-mail stated quite the opposite:

> "Although you explained that you have been abstinent throughout your PHS monitoring, PHS has not been able [to] document this abstinence due to your stated use of an asthma inhaler that contains an alcohol-based propellant and your continued use of alcohol-based hand wash, despite being cautioned that use of these products could confound your negative testing.

When PHS received the June 20, 2011 EtG and EtS test results, suggesting a level of alcohol ingestion beyond that expected from incidental exposure, PHS repeated these tests. The subsequent test results from June 30 were comparable to those from June 20. As EtG is known to be a very sensitive test, PHS utilized a different test, PEth, in order to further confirm the presence of alcohol metabolites. This third test was also positive for a biomarker at a level beyond that expected from incidental ethanol exposure. Therefore, PHS recommended that you participate in an independent evaluation at a facility skilled in working with health care professionals.

You participated in the recommended evaluation of September 18, 2011. You were administered your asthma inhaler regularly and again tested for EtG, EtS and PEth at the conclusion of the evaluation, the results of which remained negative. Therefore, PHS remained unable to further address whether the alcohol metabolites detected on June 20, June 30 and July 1 were a result of intentional or incidental ingestion."

Sanchez concluded: "PHS has received assurances from your workplace monitors and treatment providers that they have seen no evidence of impairment. Accordingly, PHS has agreed to continue to monitor you pursuant to your current monitoring contract with the following agreement:

1. You have agreed to avoid exposure to agents that could interfere with testing including alcohol based hand wash, HFA inhalers and other agents that might produce positive EtG, EtS and/or PEth results. If your health requires you to use an HFA inhaler, you will notify PHS in advance so PHS can assess its ability to continue monitoring.
2. You have agreed to increase your participation in PHS-approved support group meetings to three meetings a week for the next three months, at least one of which will be a physician meeting.
3. You have agreed to provide PHS with the name and phone number of a consenting meeting participant willing to confirm your meeting attendance.
4. You have acknowledged that PHS will continue testing for alcohol bio-markers consistent with recommendations of the independent evaluator.
5. You have agreed with PHS to a payment arrangement to address laboratory fees. You acknowledged that if you are unable to meet this agreement, PHS will need to refrain from testing until the laboratory fees can be paid."

At the end of his December 6, 2011 letter, Sanchez acknowledged that Langan was challenging the validity of the PEthStat results but he insisted that USDTL would prove Langan wrong. He signed off with this gratuitous statement: "Meanwhile PHS is hopeful that going forward we will be able to support your recovery program in a way that is most helpful to you."

Langan had an immediate concern: money. He was already in arrears on lab testing fees. Having spent over $60,000 already on testing, "treatment," repeated evaluations and lawyer's fees, he now had to pay $2,000 up front and $600 more a month for the PEth testing. If he couldn't afford the additional tests, he'd be considered "non-compliant," a grossly unfair stipulation in most contracts with physician health programs.

Langan wasn't being singled out. It's PHP policy that can wreak havoc on a physician's financial security. A Missouri physician's license was suspended while in a PHP. After using up his savings, retirement and

proceeds from selling his home, he could no longer afford the cost and his license was revoked. Now in his 70's, he lives in abject poverty in an RV that has no running water.

PHS's new demands were particularly unjust. Even if the PEth test was valid, as previously noted, tests for alcohol should not be used in isolation to denote relapse or non-compliance. The requirement that Langan discontinue his inhalers "to avoid confounding the test" was reckless and dangerous. And the requirement that he provide the names and phone numbers of meeting participants was unethical on its face.

The latter requirement was so concerning to Langan that he questioned Linda Bresnehan about it. Bresnehan claimed that Director Jalonen had recommended it. However, Jalonen later told him in no uncertain terms that he did not, and would not, recommend a measure that violated the anonymity of other meeting participants.

The pressure of the increasingly demanding stipulations, their expense, and the uncertainty of his ability to earn a living weighed heavily on him. After reading Sanchez's letter outlining the new stipulations in his LOA that resulted from the elevated PEth test, Langan was becoming increasingly anxious to review the litigation package. He didn't know that Sanchez had received a copy from USDTL in October of 2011, two months earlier. Sanchez had not informed Langan, Langan's attorney, or any member of the Board of this fact.

The next time Langan submitted a blood sample for PEthStat, he noticed that the lab tech had him sign a chain-of-custody form, used a betadine swab rather than an alcohol prep pad to sterilize the area where the blood was drawn from and then carefully inverted a gray top test tube several times to mix it with the preservative and anticoagulant before sealing it and placing it in the mailer provided.

The repeat PEthStat came back negative. Langan later recalled that in June 2010, a year before the improbable PEth, he was ordered to provide a blood sample for PEthStat but the test was canceled due to "unspecified errors in handling." He never found out what those errors were but they were most likely flaws in the forensic testing procedure that were noticed by an MRO.

Finally, on December 13, 2011, after five months of repeated requests to both USDTL and PHS and, significantly, one week after Sanchez informed him of the new stipulations to his contract, Langan finally received the litigation package he had pressed so hard to secure.

The litigation package included the July 1, 2011 faxed clinical order for PEthStat on PHS's letterhead signed by PHS's secretary. The words "pt. signature" were hand-printed on the bottom of the page followed by an indecipherable donor signature—but not Langan's indecipherable signature. [Figure 1]

On July 8, Quest forwarded the specimen along with the clinical order form to USDTL where it was logged in and underwent testing. It was assigned a laboratory ascension number of 877649. The unique donor ID and chain-of-custody number on the report were listed as **461430.** The date and location of the collection were missing, as was any documentation of how the sample was handled and processed after it was received by USDL. [Figure 2]

A second fax on PHS's letterhead dated July 19, and signed by the same secretary, read, "Please update the lab report to reflect the donor ID number as listed on the order: to **1310"** and a third fax, "Please update the lab report to reflect that chain-of-custody was maintained." Again, there was NO chain-of-custody form associated with this report. FIGURE [Figure 3]

The second lab report from USDTL in response to the secretary's requests included the original PEthStat result of **365.4 ng/ml.** The chain-of-custody number was changed to **1310** as had been requested, but the unique donor ID number remained the same: **461430.** A July 13 batch work order also listed **461430** as the donor ID number. There were several notations in large type at the bottom of the lab report: REVISED REPORT PER CLIENTS [sic] REQUEST, CORRECTED DONOR ID FROM 461430 TO 1310 and CORRECTED

COLLECTION DATE TO 07/01/11. The name and location of the collector were still missing. [Appendix Figure 4]

Jones also faxed her another copy of the test results along with the statement, "I certify that the specimen identified by the laboratory ascension number above has been examined upon receipt, handled and analyzed in accordance with this laboratory's Standard Operating Procedures." [Figure 5]

With every forensic drug test, there should be five copies of the chain-of-custody form. One copy is filed by the collector. One is kept by the donor. One stays at the facility that runs the test. Two are signed by the MRO, one of which is kept in his or her files, and the other is sent to the client, in this case, PHS. [Figure 7.] For Langan's PEthStat test, there were none.

The following flaws in the PEthStat testing process would be obvious to a certified MRO:

1. The original order faxed to Quest from PHS was a clinical test request, not a forensic test request as was required by PHS.
2. The faxed order form was altered after the fact by USDTL to appear as if it were a chain-of-custody form, a clear violation of forensic protocols.
3. While the sample was collected on July 1, it wasn't received by USDTL until July 8, violating industry standards for handling biological materials.
4. Most significantly, an unknown donor's ID # 461430, was on the original lab report, not Langan's unique ID #1310. [Figure 6]

Any one of those omissions or errors should have immediately caused the test to be canceled. Instead, it was used as an excuse to further punish Langan for a substance use disorder he never had.

Sanchez, as Director of Massachusetts Physicians Health Services, knew, or should have known, that all drug tests done on PHS participants must be run as forensic tests. He knew, or should have known, that the original PEth report was on an unknown donor, not Langan. And, given the number of fatal errors, Dr. Gavryk, the in-house medical review officer knew, or should have known, to immediately cancel the test and recommend a repeat collection.

Nonetheless, Sanchez used the PEthStat report as an excuse to require Langan to attend additional support meetings and find participants willing to verify his attendance. Ironically, Sanchez's subsequent actions strongly suggest that he knew all along that what he did was wrong.

Assuming that the Massachusetts Board of Registration in Medicine had no knowledge of the improprieties in testing and reporting, Langan immediately forwarded a copy of the package to PHCU director, Attorney Robert Harvey. The next day, December 15, 2011, Langan's attorney, Scott Liebert, sent a copy to the PHCU's senior board attorneys, Deb Stoller and Tracy Ottina, along with a cover letter requesting that they submit the package to the Board of Directors for consideration at its upcoming meeting on December 22, 2011.

Neither Langan nor Liebert knew that Stoller had already received a copy of the package but had purposely withheld it from the Board of Directors

The contents of the litigation package did have an effect on BORIM, but not an apology, a retraction, or an easing of the requirements of his LOA as he had the right to expect. Instead, Stoller sent Liebert a certified letter claiming that the increased disciplinary measures were a result of his failure to begin his evaluation at the Hazelden Addiction Center in a timely manner.

In her letter, Attorney Stoller warned that, while Langan's license would not be immediately suspended, should he test positive for alcohol or illicit substances at any concentration, he must immediately enter into a Voluntary Agreement Not to Practice (VANP). While a VANP, just like a license suspension, would prevent him

from practicing medicine, it's not reported to the National Practitioners Data Bank and, in theory, is more easily reversed.

Stoller also extended his LOA another two years to March 18, 2015 and affirmed Sanchez's new stipulations. She added that he must meet with an AA sponsor outside of the medical profession once a week and participate in an eight-week program of "mindfulness stress reduction" through the University of Massachusetts Medical Center.

By this time, Langan desperately needed stress reduction, but not from a mindfulness program. Were the new stipulations not challenging enough already, Stoller advised Langan's lawyer that Langan had only seven days to carry out any new stipulations, proclaiming, "should he decline to do so (which includes an attempt to negotiate and/or dispute PHS' recommendations), his license may be immediately suspended." In other words, she made it clear that BORIM would discipline him for exercising his right to speak out against PHS's unjust demands.

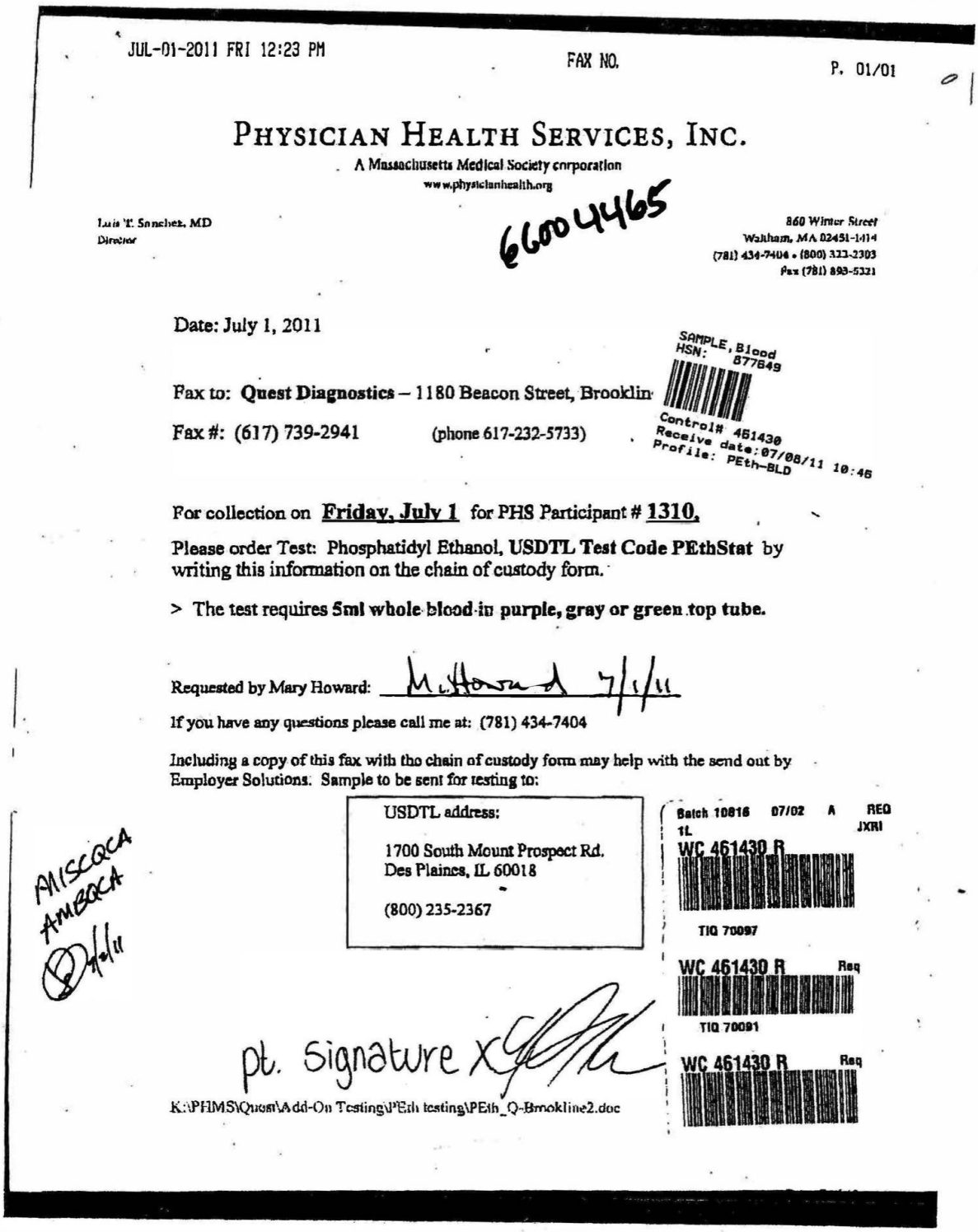
Neither PHS nor BORIM was a licensed healthcare provider. Their insistence that he discontinue his asthma inhaler was tantamount to "practicing medicine without a license," a clear violation of Massachusetts law. Ironically, if PHS or BORIM were legitimately practicing medicine, their decision to endanger his life like that would be considered malpractice.

At its monthly meeting on December 21, 2011, the Board of Directors affirmed Attorney Stoller's disciplinary "recommendations" and directed Langan to provide a copy of its orders to every facility where he practiced medicine, every insurance company he participated with and every state medical board where he was licensed, as well as the Massachusetts Department of Health and the Federal Drug Enforcement Agency (DEA). Dr. Langan's sullied reputation would be broadcast far and wide.

The Merriam Webster dictionary defines "recommendation" as "advice or suggestions that are endorsed as fitting and worthy of acceptance." The "recommendations" given to Langan in his contract with PHS were anything but. As Langan wrote, "These contracts and agreements are not genuine, as they are signed under duress, undue influence and coercion."

On December 29, 2011, Attorney Liebert wrote to Stoller and the Board that Langan agreed to the new stipulations and would follow them to the letter with one exception: he reserved his right to "petition the Board for Reconsideration of the Order" once he proved that the July 1, 2011, PEthStat was invalid.

Liebert then emailed Langan stating, "Unfortunately the terms, as objectionable as they are given that all of this is based on invalid test results, are not negotiable. There is no viable alternative other than signing it, as refusal to do so will lead to imposition of a disciplinary action.



JUL-01-2011 FRI 12:23 PM FAX NO. P. 01/01

PHYSICIAN HEALTH SERVICES, INC.

A Massachusetts Medical Society corporation
www.physicianhealth.org

Luis T. Sanchez, MD
Director

860 Winter Street
Waltham, MA 02451-1414
(781) 434-7404 • (800) 323-2303
Fax (781) 893-5321

66004465

Date: July 1, 2011

SAMPLE, Blood
HSN: 877849
Control# 461430
Receive date: 07/08/11 10:46
Profile: PEth-BLD

Fax to: **Quest Diagnostics** – 1180 Beacon Street, Brooklin

Fax #: (617) 739-2941 (phone 617-232-5733)

For collection on **Friday, July 1** for PHS Participant # **1310,**

Please order Test: Phosphatidyl Ethanol, **USDTL Test Code PEthStat** by writing this information on the chain of custody form.

> The test requires **5ml whole blood in purple, gray or green top tube.**

Requested by Mary Howard: M. Howard 7/1/11

If you have any questions please call me at: (781) 434-7404

Including a copy of this fax with the chain of custody form may help with the send out by Employer Solutions. Sample to be sent for testing to:

USDTL address:

1700 South Mount Prospect Rd.
Des Plaines, IL 60018

(800) 235-2367

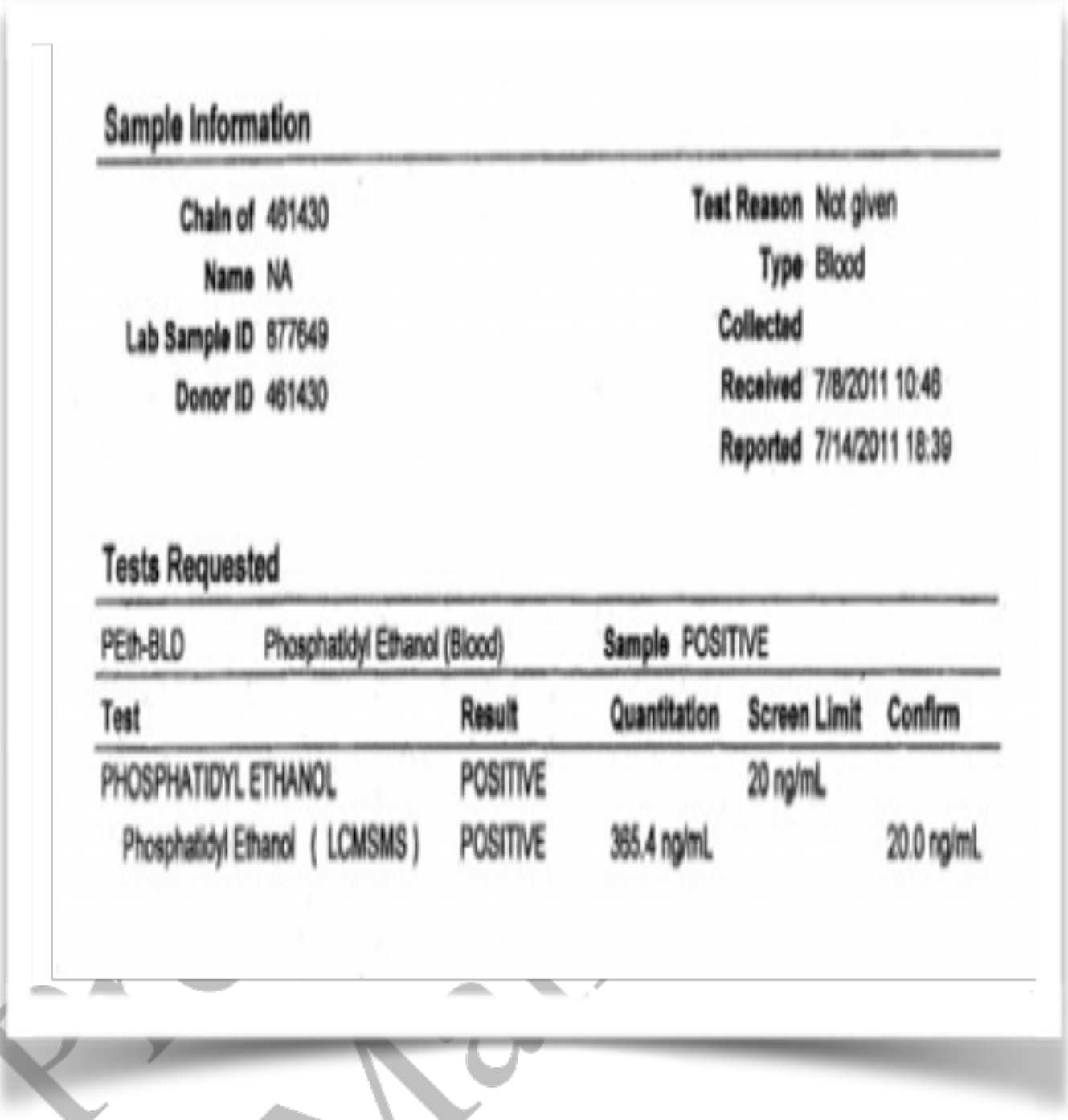
Batch 10816 07/02 A REQ
1L JXRI
WC 461430 R
TIQ 70097
WC 461430 R Req
TIQ 70091
WC 461430 R Req

AMSCQCA
AMBQCA
7/1/11

pt. Signature x

K:\PHMS\Quest\Add-On Testing\PEth testing\PEth_Q-Brookline2.doc

FIGURE 1: ORIGINAL FAXED CLINICAL ORDER TO USDTL FOR PETH TEST WITH FORGED SIGNATURE.



Sample Information

Chain of 461430
Name NA
Lab Sample ID 877649
Donor ID 461430

Test Reason Not given
Type Blood
Collected
Received 7/8/2011 10:46
Reported 7/14/2011 18:39

Tests Requested

PEth-BLD Phosphatidyl Ethanol (Blood) Sample POSITIVE

Test	Result	Quantitation	Screen Limit	Confirm
PHOSPHATIDYL ETHANOL	POSITIVE		20 ng/mL	
Phosphatidyl Ethanol (LCMSMS)	POSITIVE	365.4 ng/mL		20.0 ng/mL

FIGURE 2: PETH TEST REPORT WITH UNKNOWN DONOR ID NUMBER.

JUL-19-2011 TUE 02:19 PM FAX NO. P. 01

PHYSICIAN HEALTH SERVICES, INC.

A Massachusetts Medical Society corporation
www.physicianhealth.org

Luis T. Sanchez, MD
Director

860 Winter Street
Waltham, MA 02451-1414
(781) 434-7404 • (800) 322-2303
Fax (781) 893-5321

Date: July 19, 2011

To: United States Drug Testing Laboratories
Fax: 847-375-0775
Total number of pages: 3

Account Number: PHSWMA for Physician Health Services
attn: Kendyll
RE: Specimen Chain of: **461430**

Donor ID as listed: **461430**
Donor ID: 1310
Collection Date: **7/1/2011**
Received Date: **7/8/11**

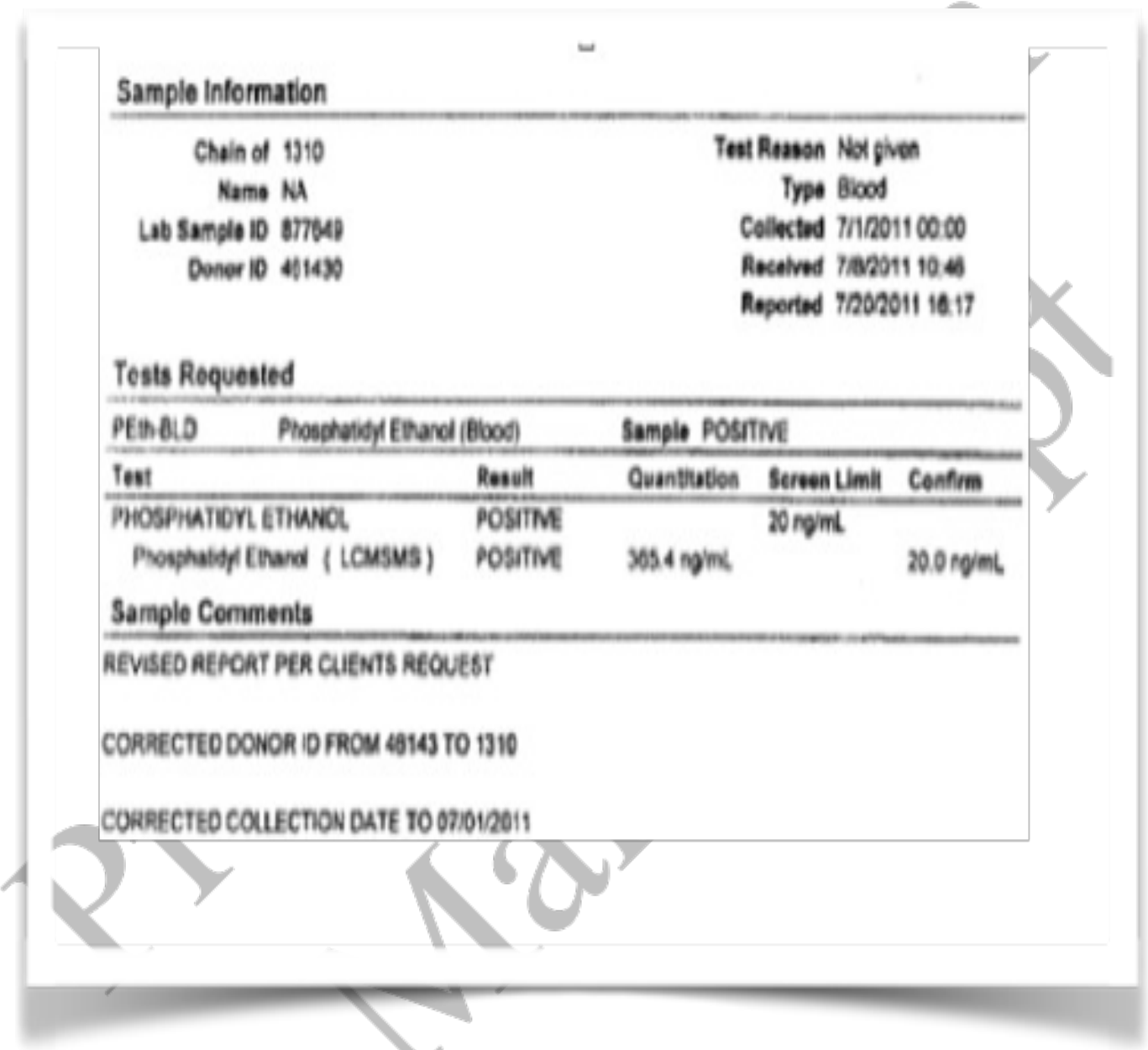
Please update the lab report to reflect the donor ID number as listed on the order: to **1310**

Please update the lab report to reflect that chain of custody was maintained.

Requested by Mary Howard: M. Howard 7/19/11
(signed) (date)

If you have any questions, please call Linda Bresnahan781-434-7404

FIGURE 3: REQUEST FROM MARY HOWARD FOR USDTL TO CHANGE THE DONOR ID FROM 461430 TO 1310.



Sample Information

Chain of 1310
Name NA
Lab Sample ID 877649
Donor ID 401430

Test Reason Not given
Type Blood
Collected 7/1/2011 00:00
Received 7/8/2011 10:46
Reported 7/20/2011 16:17

Tests Requested

PEth-BLD Phosphatidyl Ethanol (Blood) Sample POSITIVE

Test	Result	Quantitation	Screen Limit	Confirm
PHOSPHATIDYL ETHANOL	POSITIVE		20 ng/mL	
Phosphatidyl Ethanol (LCMSMS)	POSITIVE	365.4 ng/mL		20.0 ng/mL

Sample Comments

REVISED REPORT PER CLIENTS REQUEST

CORRECTED DONOR ID FROM 40143 TO 1310

CORRECTED COLLECTION DATE TO 07/01/2011

FIGURE 4: REVISED REPORT FROM USDTL ACKNOWLEDGING REQUEST TO CHANGE BOTH THE UNIQUE DONOR ID NUMBER AND THE COLLECTION DATE.

United States Drug Testing Laboratories
1700 S. Mount Prospect Road Des Plaines, Illinois 60018
847.375.0770 Ph 847.375.0775 Fax
800.235.2367 Ph www.usdtl.com

SUMMARY OF RESULTS

ACCOUNT: Physician Health Services

USDTL NUMBER: 877649
SPECIMEN ID: 1310
461430
MATRIX: Blood

TEST REQUESTED: Phosphatidylethanol - Blood

INITIAL TEST
METHOD: Liquid Chromatography – Tandem Mass Spectrometry

Drug	Cutoff (ng/mL)	Response of Specimen (ng/mL)	Result
Phosphatidylethanol	20	255.4	**POSITIVE**

CONFIRMATION TEST
METHOD: Liquid Chromatography – Tandem Mass Spectrometry

Drug	Cutoff (ng/mL)	Response of Specimen (ng/mL)	Result
Phosphatidylethanol	20	365.4	**POSITIVE**

I certify that the specimen identified by the laboratory accession number above has been examined upon receipt, handled, and analyzed in accordance with this laboratory's Standard Operating Procedure.

Joseph Jones, MS, NRCC-TC
Vice President, Laboratory Operations

Dec 03, 2011
Date

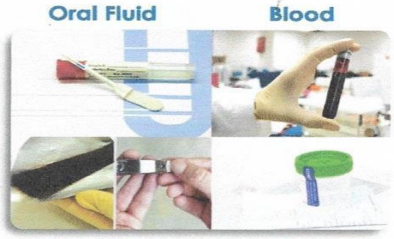
Page 2 of 43

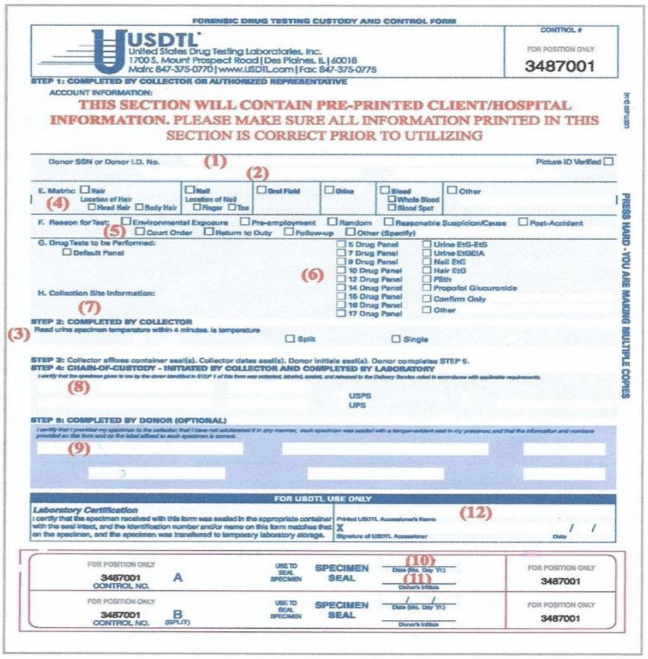
FIGURE 5: FAX FROM JOSEPH JONES ON DECEMBER 3, 2011 ASSERTING THAT STANDARD OPERATING PROCEDURE WAS FOLLOWED.

FIGURE 6: LANGAN'S ID CARD WITH UNIQUE ID NUMBER 1310.

Forensic Custody and Control Form Instructions

1. Annotate the donor's ID number. This may be the Social Security number, Driver's License number, Medical Record number, Employee number or any other number of your facilities choosing.
2. Annotate the donor name, last name first (optional). Verify donor identity with a government-issued photo ID.
3. **For urine sample only, annotate the specimen temperature within four minutes of collection.** Mark whether split or single collection, and annotate remarks regarding collection, if any.
4. Mark the sample matrix and location (if applicable).
5. Check or annotate the appropriate reason for testing.
6. Annotate the panel to be performed.
7. Annotate the collection facility if different from employer/client.
8. Date, sign and print collector's name.
9. Donor may date, sign and print their name (optional).
10. Affix tamper evident (barcoded) container seal(s) from the Custody and Control form. Date the seal(s).
11. Have donor initial seal(s). Be sure to check/match the specimen identification information with the form.
12. This section is for lab use only.





USDTL
Advancing The Gold Standard

Information up-to-date as of: 07.31.2014

1700 South Mount Prospect Road | Des Plaines, IL 60018 | 800.235.2367 | www.USDTL.com

FIGURE 7: USDTL'S CHAIN OF CUSTODY FORM WITH INSTRUCTIONS ON COMPLETION. THIS WAS MISSING FROM LANGAN'S LITIGATION PACKAGE.

Sample Information

Chain of Custody	1310	**Test Reason**	Not given
Name	NA	**Type**	Blood
Lab Sample ID	577649	**Collected**	7/1/2011 00:00
Donor ID	461430	**Received**	7/8/2011 10:46
		Reported	10/4/2012 12:50

Tests Requested

PETH-BLD Phosphatidyl Ethanol (Blood) **Sample** POSITIVE

Test	Result	Quantitation	Screen Limit	Confirm
PHOSPHATIDYL ETHANOL	POSITIVE		20 ng/mL	
Phosphatidyl Ethanol (LCMSMS)	POSITIVE	365.4 ng/mL		20.0 ng/mL

Sample Comments

REVISED REPORT PER CLIENTS REQUEST

CORRECTED DONOR ID FROM 46143 TO 1310

CORRECTED COLLECTION DATE TO 07/01/2011

APPENDED REPORT: EXTERNAL CHAIN OF CUSTODY PROTOCOL WAS NOT FOLLOWED PER STANDARD PROTOCOL

Certification

Data approved by Joseph Joines on 10/4/2012

FIGURE 8: ACKNOWLEDGEMENT BY USDTL THAT SOP WASN'T FOLLOWED.

Chapter 7: Secrets and Lies

Logistically, the most problematic mandate of Langan's revised LOA was that another attendee must document his presence at support meetings and provide their first name and phone number. AA is called "Alcoholics Anonymous" for one very obvious reason: the meetings are supposed to be anonymous. Because it compelled him to commit an unethical act, such a contract stipulation would be unenforceable in a court of law. But Langan was not in a court of law; he was in a contract with an unregulated regulatory board that had given itself permission to ignore the law.

This mandate presented such a serious impediment to compliance that Langan spent several months finding individuals who were willing to provide their first names and phone numbers and attest to his presence at each of his meetings. Meanwhile, Harvey and Sanchez erupted with a flurry of unsubstantiated accusations: that Langan hadn't attended all of his meetings; that he falsely claimed he had attended meetings he hadn't actually attended; that his records of attendance were incomplete; and even that he'd confessed in an email that he'd missed some meetings.

Harvey and Sanchez later demanded that the attendees also submit written affidavits confirming Langan's presence at those meetings and provide Dr. Gary Chinman, an employee of PHS, additional verbal confirmation. A female contact told Langan that Chinman's attempts to get more information were so intense and relentless that she felt like Chinman was "stalking" her.

Another attendee complained in a letter dated December 28, 2012, that Dr. Chinman phoned her on three separate occasions. She wrote that the first two conversations went well but described the third call as "an attack." "Chinman," she wrote, "demanded to know where the meetings were, the times, what professionals were in these meetings, the duration, who held the group and many more questions I felt to be debrading [sic]. Dr. Chinman would raise his voice at times and repeat questions several times as if my answer did not suffice."

Langan's contact from a physician support group sent a letter to BORIM soon thereafter stating, "Chinman called and started asking about other people in the group and [I] was aghast at the breeches of anonymity Dr. Chinman was making." Feeling threatened, the contact revoked his permission for further release of information. Langan's career was still balancing on a knife's edge.

In January 2012, Langan enlisted the help of Amy Daniels, manager of the investigational division of the College of American Pathologists (CAP), a national organization of board-certified pathologists that sets standards of practice in laboratory medicine. He forwarded the USDTL litigation package to her along with a letter pointing out that the PEthStat was improperly collected and sent to the lab without a chain-of-custody form, collector signature, or date. By reporting it as a forensic test, USDTL, Langan asserted, acted "with willful disregard for the consequences" including "multiple violations of standards of care, industry regulations, medical and laboratory ethics, and fundamental moral integrity."

Langan postulated that, because PHS's drug testing regimens generate significant revenue for USDTL, USDTL might have been willing to break forensic testing protocol to curry favor with PHS. He mentioned two other cases in the Boston area in which neither physician had evidence of alcohol use other than a positive PEthStat but both were accused of being alcoholics. "One," he stated emphatically, "lost his license and the other may very well lose his life. This is not laboratory error but laboratory fraud."

Langan also brought to Ms. Daniels's attention a February 2010 PEthStat that was later rejected due to "unspecified errors in handling." "The second sample" (the improbable PEth), he observed, "was collected on July 1, 2011 by a technician unfamiliar with forensic drug testing who later informed me that she thought it was a clinical specimen."

Ironically, the technician was doing what was expected of her. PHS tried to evade forensic protocols by ordering the PEthStat as a clinical test then tried to reverse engineer it back into a forensic test. Langan also conveyed to Daniels his theory about fermentation of alcohol in the test tube. A far more nefarious (and accurate) explanation didn't occur to him until later.

Ms. Daniels readily agreed to investigate both Quest Diagnostics, the lab that received the specimen in error, and USDTL, the lab that ran the test without following forensic protocol. After completing her investigation in May 2012, Daniels confirmed Langan's suspicions and advised USDTL to formally retract the results of the original test.

Prior to Ms. Daniels' admonition to USDTL, on March 22, 2012, Linda Bresnahan, the associate director of PHS, received a letter from Quest Diagnostics' compliance officer, Nina Hobin. Hobin confirmed that Quest had received the notorious PEthStat specimen on July 2, 2011 without an accompanying chain-of-custody form.

Hobin explained that the technician who drew Langan's blood at Quest Diagnostics Patient Services Center in Brookline was unfamiliar with PHS's procedures for drug testing and logged in the specimen, using the faxed letter from PHS as a clinical order. Hobin further explained that Quest Diagnostics did not conduct PEthStat tests because they weren't FDA-approved, so the collector placed a tracking label on the test tube and forwarded the specimen to USDTL, whose name and address were on the faxed test request.

While Ms. Hobin's letter explained the week's gap between the collection of the specimen and the processing of the test, as well as the lack of a chain-of-custody form, it didn't explain the extraordinarily high concentration of PEth in the lab report.

In response to Ms. Daniel's request that the fraudulent PEthStat be invalidated, five months later, on October 4, 2012, USDTL's Dr. Jones finally issued an amended report to Sanchez recommending that the test result be voided, stating only that "external chain-of-custody was not followed per standard protocol." He made no mention of the numerous fatal flaws in the chain-of-custody and the absence of MRO review, implying that this had been an innocent error rather than a purposeful violation of protocol.

Instead of immediately disclosing the fact that USDTL had invalidated the PEthStat and ending the onerous requirement of attending and documenting multiple meetings, Sanchez changed tack. He set aside the positive PEthStat results and boldly asserted in an email to Attorney Harvey on October 23, 2012 that "Dr. Michael Langan was non-compliant with his Physician Health Services monitoring contract in that he repeatedly affirmed participation in peer support group meetings that [he] did not, in fact, attend." In other words, Dr. Langan was now being disciplined for allegedly failing to document his attendance at AA support meetings that were required solely because of an invalid test result.

In spite of the logistical nightmare, Langan did attend and did document his attendance, at every required AA support meeting. And he definitely did not confess in an email that he'd failed to do so. After reading the email that Sanchez wrote to Harvey, it occurred to Langan that one page of the documentation he'd originally sent Sanchez was missing or that his handwriting was illegible. Or, possibly, he mused charitably, because he was attending two different types of meetings (one for the general public and one for medical professionals) at two separate locations (Brookline and Bournewood), Sanchez was simply "confused."

Recognizing the dire consequences of what could be a simple miscommunication, Langan immediately recopied all the documents, painstakingly hand-printing the attendance logs. On October 23, 2012, he sent the documentation to Sanchez and Harvey along with the first names, phone numbers, and copies of the affidavits of two of the attendees who vouched for his attendance. Nevertheless, three days later, on October 26, 2012, Attorney Harvey initiated formal board proceedings against Langan on the basis of non-compliance with support meetings.

Langan had previously sought expert opinion about the spurious PEthStat test from Dr. James Flood, Chief of Toxicology at MGH's Chemistry and Toxicology Laboratory. Flood had both a clinical and academic interest in testing for drugs of abuse, and was more than willing to review Langan's case. On November 5, 2012, Flood submitted a letter to Jacob Hafter J.D., Langan's new attorney, stating, "I was astonished at the large number of errors (including so-called 'fatal' flaws and 'out of standard operation procedure events') that occurred during the blood collection, processing and transportation" of the specimen in question."

Flood then listed the multiple specific flaws including the lack of chain-of-custody and the eight-day delay in testing. He also averred that natural fermentation of alcohol from an alcohol prep pad could not possibly have caused the stratospherically high PEth concentration. Instead, he postulated, "Langan's unique ID number may have been added to a known positive specimen from a different donor." He theorized that the paperwork was later clumsily altered to make it appear that the specimen was Langan's.

Flood was also highly critical of the actions and inactions of the MROs at both USDTL and PHS who ignored the fatal flaws and missed the opportunity to retest Langan's blood in a timely manner. Since PEth is detectable for up to four weeks after consumption of large quantities of alcohol, if Langan was given a chance to provide a second specimen within a few days of the first test, it would be clear evidence that the initial PEthStat was invalid. Whether the course of events that befell Langan would have been avoided is a matter of conjecture. Nevertheless, it was the MRO's responsibility to offer a retest and Langan's right to insist on one if only he'd known.

Flood concluded with certainty that these were all "purposeful and intentional acts by PHS to show [Langan's] July 1, 2011 test as valid when in reality this test was invalid and involved both fatal laboratory errors and lack of adequate MRO review of results." He then insisted, "Anything based on his July 1, 2011 test as a confirmatory positive should be reversed, rectified and remediated."

Attorney Hafter immediately forwarded Flood's letter to Attorney Harvey, but not only did Harvey fail to take remedial action, he didn't acknowledge its receipt. In fact, Flood's letter wasn't date-stamped and entered into Langan's file until August 15, 2014, almost two years later.

On November 8, 2012, two days after receiving Dr. Flood's letter, Harvey forwarded Sanchez's allegation of non-compliance with required meetings directly to the PCHU's Complaint Committee. In response, without independently reviewing Langan's case, the Complaint Committee "confirmed" that Langan had violated the terms of his LOA and referred the matter to the full Board of Directors for its consideration.

In an email on December 3, 2012, Sanchez castigated Langan for the actions he took to protect himself from the false accusations, writing:

> "Your actions severely compromise PHS's ability to provide meaningful support and monitoring services. You have repeatedly agreed to accommodations by PHS to suit your needs, with which you have then been non-compliant. In addition, you have expressed contempt for these agreed-upon accommodations to other monitors and recruited others to misrepresent the facts to PHS. You have made representations to PHS that you later acknowledged to be untrue, and you have made representations to third parties that are inconsistent with the representations you have made to PHS."

In a touch of irony, Langan's problem was not that he made representations that were untrue but that he was constitutionally incapable of making false representations even when the truth alienated and angered those who had power over him.

Finally, on December 11, 2012, more than two months after receiving the amended report from USDTL noting that PEthStat protocol wasn't followed, Sanchez forwarded the litigation package to Harvey, claiming that he had just received it "yesterday" and that "PHS did not make a determination of relapse following that positive test, nor is PHS aware of any action taken by the Massachusetts Board of Registration in Medicine as a result of the July 28, 2012 report."

Sanchez made no mention of the expensive and inconvenient evaluation at Hazelden, the increased frequency of meeting attendance, and the added burden of documenting his attendance that absolutely were a result of the July 28, 2011 report. Nor did he acknowledge that, because he was coerced into discontinuing his asthma inhalers, Langan experienced two asthma attacks so severe that they almost cost him his life.

Knowing full well that BORIM had indeed taken action against him as a result of the July 28, 2011 report, on December 12, 2012, Langan reached out directly to Joseph Jones at USDTL once more. In a strongly worded letter he reminded Jones that two experts in forensic drug testing had concluded that, not only had USDTL breached its own protocols, but that Langan suffered significant harm as a result. In Langan's mind, it was Jones's professional and moral duty to declare in writing to PHS that the PEthStat of July 1, 2011 was unequivocally invalid and that a timely repeated PEth test using forensic standards would have vindicated him.

In the 10 years that followed, Jones never acknowledged his role in producing the invalid PEthStat. And rather than suffer any adverse professional consequences of his participation in lab fraud, he earned an online PhD from Walden University, was promoted by USDTL, and is now Executive Vice President of the company.

Meanwhile, the friction between Langan, Director Sanchez, and other PHS staff over Langan's efforts to invalidate the PEthStat became so heated that, the following week, Sanchez asked PHCU Attorney Harvey to assign Dr. Langan a practice monitor who was unaffiliated with PHS and BORIM. Although Massachusetts General Hospital was willing to provide even stricter monitoring of compliance with his LOA and greater supervision over his medical care, the Board of Directors denied Sanchez's petition.

Although his lawyer was out of town at the time, based on an imminent threat of formal disciplinary action while the compliance issues were being reviewed by the Board, on December 18, 2012, Dr. Langan reluctantly signed a Voluntary Agreement Not to Practice (VANP) as a "gesture of goodwill."

Being one of only six physicians in a nationally recognized geriatrics department, he knew that his sudden absence from practice would cause considerable disruption to his colleagues, one of whom was seriously ill, and to his patients, many of whom depended on his specialized care. But at the time, he thought that his VANP would be reversed once the compliance issues were sorted out. He would be proven wrong once again.

Ten days later, on December 28, 2012, after considerable thought and discussion with his lawyer about the consequences of his absence from practice, Langan requested that his VANP be withdrawn. But the Board of Directors wouldn't even acknowledge his request. As will become increasingly clear, when someone is caught up in a medical board investigatory and disciplinary process, nothing is truly voluntary.

Chapter 8: That Ship Has Sailed

On January 10, 2013, while Langan's license was teetering on the brink of formal suspension, he finally accepted that BORIM wasn't going to revoke his VANP. When Attorney Hafter returned to Boston, Langan asked him to submit to Attorney Harvey a formal "Emergency Petition to Allow Dr. Langan to Return to Practice."

In the petition, Hafter contended that the Board was disciplining Langan on the basis of the single accusation by Director Sanchez that Langan "repeatedly affirmed participation in peer support group meetings that [he] did not, in fact, attend" without presenting any evidence of which meetings he allegedly missed. Hafter argued that Langan had presented sworn testimony that he attended all required meetings and had provided signed letters and affidavits from various people verifying his attendance.

Hafter explained to Harvey: "Dr. Langan entered into the 'voluntary' agreement not to practice in good faith as an attempt to gain goodwill with the Board but under no circumstances would his participation in this 'voluntary' agreement extend past January 9, 2013. Its [the Board's] refusal to even consider allowing him to practice. . . will cause Dr. Langan severe economic hardship . . . and further reputational harm."

Haftner continued, "At this point we view such actions . . . as a suspension. The problem, however, is that the Board cannot meet its burden to demonstrate that Dr. Langan is a danger to the public to justify its suspension. . . One sentence in one report is not sufficient evidence upon which the Board can prevent a physician from exercising his constitutional property rights."

Hafter then reminded Harvey of the multiple letters from Langan's highly regarded colleagues who attested to his sobriety, professionalism, and competence. He ended with a passionate plea to Harvey and the Board:

"Dr. Langan has overcome great adversity, including proven falsified lab reports by PHS and their affiliates, and remains sober to this day. To punish him and his family by taking away his property right—his license to practice medicine—without the proper due process rights, is unconstitutional and punitive. It would be unfortunate if the Board's refusal to be fair to Dr. Langan would be the straw that broke the camel's back."

It wasn't that straw—perhaps PHS and BORIM were hoping it would be—but the wheels of bureaucracy continued to grind painfully against Langan. On January 23, 2013, the Chair of the Board of Directors, Dr. Candace Lapidus Sloane, submitted an order to BORIM stating, "The Emergency Petition to Allow Dr. Langan to return to Practice is hereby DENIED."

On February 6, 2013, the full Board of Directors met formally to consider the status of Langan's license. Attorney Harvey withheld from the Board the corrected PEthStat report, Langan's completed record of attendance at support meetings, and the letter from Dr. Flood concluding that the test was invalid.

Worse, Harvey testified that Langan had "confessed" in an email that he had not attended all of the required support meetings, without producing an email that supported the allegation. Even after years of requests by Langan and his lawyers, this email hasn't surfaced for one simple reason: it doesn't exist.

Based on the incriminating evidence Attorney Harvey presented, as well as the exculpatory evidence he withheld, Chairwoman Sloane issued a formal suspension of Langan's license to practice medicine that same day, concluding that:

1. Langan violated his LOA by refusing to enter into an evaluation program at the request of PHS. (He hadn't refused.)
2. Langan falsely reported that he participated in required peer group meetings that he didn't attend. (He didn't falsely report attendance.)

3. Langan had not submitted any documentation that he attended all of the required meetings. (He did submit it, twice)
4. Langan confessed that he falsely reported participation in meetings that he didn't attend. (He most certainly did not.)

Sloane reaffirmed the additional terms of Langan's already burdensome LOA and warned that "any stay [removal] of suspension will be contingent upon continued monitoring of the Licensee's practice of medicine subject to terms and conditions deemed warranted by the Board."

Although he knew that Langan needed it before he could file a formal appeal, Harvey withheld Sloane's formal statement of reasons from Langan until after the Board's 14-day appeals deadline. When Hafter asked that the deadline be extended, Harvey replied tersely, "That ship has sailed."

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Over the next year, even though his attempts to prove that forensic fraud was itself a technical violation of his latest LOA, Langan persisted in trying to reveal the truth. Otherwise, he continued to comply assiduously with its other terms. Drug tests. AA meetings. Counseling sessions. Peer support groups. Monthly status reports. Mindfulness practice. Even eschewing his asthma inhalers. All this in his unshakable belief that justice would prevail.

During this time, Langan had become increasingly uncomfortable with AA's faith-based abstinence programs which he was now required to attend three times a week. Their tenets—particularly the belief that alcoholics are powerless over their addiction and must surrender to a higher power—were antithetical to his personal belief system. Contending that his First Amendment right to freedom in matters of religion was being violated, in the spring of 2013, Langan consulted the Appignani Humanist Legal Center, a civil rights organization, for advice.

A member of the Appignani Center, William J. Burgess Esquire, interviewed Langan extensively and studied his case. On April 3, 2013, Burgess sent a letter to Attorney Harvey and Director Sanchez regarding what he considered "a serious separation of church and state concern" because they failed to offer Langan secular alternatives to AA.

Burgess quoted an order by BORIM that Langan must "participate in a minimum of three 12-step meetings per week and develop an active 12-step sponsor relationship" or lose his medical license. Burgess argued that "for the government to coerce someone to participate in religious activity strikes at the core of the Establishment Clause of the First Amendment." He provided multiple examples of precedents that reinforced his argument.

Burgess concluded that both BORIM and PHS must explicitly offer secular alternatives, not just in Langan's case, but in all of its disciplinary contracts. Toward that end, he recommended the "SMART Recovery" group, a non-denominational recovery program recommended by multiple prestigious organizations.

Harvey and Sanchez responded by claiming that they had never interfered with Langan's right to participate in a secular program and that PHS's policy was to require participants merely "to attend Alcoholics Anonymous, Narcotics Anonymous, or other support groups throughout the terms of this contract." However, PHS didn't provide any documentation that it had given Langan any such offer and, clearly, while he was institutionalized at Talbott Center, Langan had no choice in the matter.

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Stranded without an active medical license, Langan struggled to comply with his LOA and care for his family. He drained his savings account, raided his retirement funds, and took out a second mortgage on his house. Later he and his family moved into a modest apartment and, at one point, they were nearly evicted because of his difficulty paying the rent.

Langan also lost his health insurance, one consequence of which was that he couldn't afford his daughter's EpiPen. One day she experienced an episode of anaphylactic shock, a potentially life-threatening allergic reaction during which the blood pressure and heart rate drop precipitously and the airway swells to a critical degree. Without an EpiPen, Langan couldn't initiate immediate treatment and he watched helplessly as she struggled to breathe on the way to the emergency department.

Although his daughter recovered fully, the near miss rattled Langan to the core. He became even more determined to outwit and outlast Sanchez, Harvey, Sloane, and others who were denying him the ability to earn a living and care for his family.

During this time, Langan repeatedly petitioned BORIM'S Physician Health and Compliance Unit for reinstatement of his license. But PHCU's attorneys repeatedly responded that, before they would consider his request, he would have to be deemed "fit for duty" by one of its preferred evaluators. Langan knew from experience to avoid any consultant who had a cozy relationship with BORIM and PHS but, for months, that's all they would offer.

Finally, in November 2013, BORIM approved a fitness for duty evaluation by Dr. Patricia Recupero M.D., J.D., a highly respected clinical and consultative forensic psychiatrist who Langan believed could provide an unbiased assessment.

Dr. Recupero conducted a comprehensive, multi-day neuropsychiatric evaluation. She extensively interviewed Langan and carefully reviewed his personal medical records, drug tests, and records from both PHS and BORIM. She also interviewed his wife, something no evaluator had previously done. After she completed her evaluation, Recupero issued a comprehensive 87-page report. Her conclusions are summarized below.

(1) Dr. Langan is safe to return to medical practice without the need for supervision.
Dr. Langan has never posed a danger to patients. Rather, to the contrary, the opinions of his supervisor at Mass General Hospital have consistently been that he has provided exemplary care to his patients and behaved as a respected colleague.

(2) Dr. Langan has an excellent prognosis overall and a low risk of relapse.
Dr. Langan demonstrates insight into his opioid problem and how it developed and the maladaptive response to his inability to taper the medication. This insight supports his continued commitment to sobriety.

(3) Dr. Langan had never had an alcohol use, abuse or dependency problem.
It is critical to understand the parameters and the inadequacy of EtG testing for forensic use and purposes such as the monitoring of a physician for purposes of relapse. Looking at the totality of the tests and the evidence provided by Dr. Langan's supervisors and his wife, Dr. Langan had not engaged in alcohol use and abuse during the course of his work with PHS.

(4) It was inappropriate to require Dr. Langan to collect the names and phone numbers of other attendees at AA meetings. Identifying people by use of their telephone numbers is a violation of the traditions and norms of Alcoholics Anonymous.

(5) Even if the Board of Registration in Medicine decides that Dr. Langan requires additional treatment and supervision, PHS should not be involved in such supervision. There is an extreme conflict of

interest between PHS and Dr. Langan. During the course of that year [2012-2013] they have found multiple reasons to report Dr. Langan's behavior as noncompliant.

(6) The standard "Physician Substance Use Monitoring Contract" failed to demonstrate the requisite individualized treatment plan for a physician in Langan's condition and likely violates the Americans with Disabilities Act. The timing of the acknowledgement of the inaccuracy of the PEth test and the report of Langan as noncompliant suggests that the report to the Board was in retaliation for Dr. Langan's persistence in identifying the inaccuracy of the PEth test.

(7) I do not believe that Dr. Langan requires further supervision and is safe to return to the practice of medicine. Making such treatment voluntary would be my recommendation, to a reasonable degree of medical certainty.

Recupero also iterated her concerns about the emotional stress, coercion, and intimidation that had been inflicted on Langan by PHS, BORIM and its lawyers, and the Board of Directors over the previous several years.

While BORIM finally agreed to transfer Langan's monitoring from PHS to Dr. Timothy Wilens at Massachusetts General Hospital, they were otherwise unmoved. Rather than considering Recupero's findings a vindication for Dr. Langan, BORIM lamely claimed that it was "not obligated to comply with the recommendations of its experts."

That begs the questions: if it was not obliged to comply with the recommendations of its experts; if it was not obligated to comply with the Americans with Disabilities Act; if it wasn't required to honor his property rights or his freedom of speech and religion; if it wasn't supposed to immediately invalidate fraudulent drug test results or adhere to acceptable evidentiary standards in suspending a physician's license; if it wasn't obligated to follow basic tenets of contract law, then what exactly was it obligated to do?

Chapter 9: The First Amendment Pleads the Fifth

In June 2013, Dr. Langan started www.disrupted physician.blog, a blog that, in his words, focuses on "the systemic and unchecked fraud and abuse reported by physicians referred to state physician health programs (PHPs) and acts as a resource for physicians who may find themselves experiencing PHP fraud and abuse."

On his blog, Langan also posted commentary about fraud in the drug testing industry, focusing on the misuse of laboratory-developed tests such as PEthStat, EtG and EtS. He was well aware that PHS and BORIM would not look kindly on such public commentary (and they didn't) but he believed he needed to make the information public and doing so wouldn't make his plight any worse.

Albeit with some trepidation, Langan posted details about his personal experiences with PHS and its directors, BORIM and its attorneys, and the Board of Directors and its Chair. He also wrote and curated articles about malfeasance by other physician health programs and medical boards across the country and posted letters from other healthcare professionals who'd had adverse experiences with their respective medical boards and physician health programs.

Since 2013, more than 1,200 physicians, residents, medical students, and nurses and a dozen or so airline pilots have contacted Langan asking for advice and support. He stated in one post, "I've had many [individuals] call in crisis, some suicidal. Many have told me the website saved their lives and in two cases literally. Two called to tell me the website had just stopped them from ending their lives and said thank you. Finding out they were not alone was enough to instill hope."

One writer captured the relief and validation, as well as heartache and horror, that many of his colleagues conveyed:

> "Today I stumbled upon your website. And today, for the first time, I have learned that my case is not rare. I suspect the other physician victims in this matter have occasionally allowed themselves to dream wistfully of justice. Justice which they have seen thwarted at every turn. Perhaps they, like me, have dreamily imagined the relief and joy and LIFE they would experience if the truth were simply presented and the perpetrators held accountable.
>
> I have imagined standing up in court and triumphantly affecting justice for myself as well as all of the other current and future victims. I deliver a powerful defense of justice. My 'dream speech'. I have imagined that I might still live. And then I wake up. And so today, imagine my shock, when I found my 'dream speech' here. My speech. Reasonable. Honest. Consistent. And based firmly in truth, justice and defense of the powerless against the powerful. My speech, it seemed, but authored by another.
>
> Thank you, Dr. Langan. You have given a voice to my struggles. Please never stop speaking for me, and people like me, many of whom, I fear, will not survive to see justice.

Langan later reflected, "The Disrupted Physician may have started as an informational website, discussion forum and blog but as it has evolved into a makeshift crisis management/suicide hotline niche service for physicians, medical students and others who may find themselves coerced into the so-called medical-regulatory-therapeutic complex (MRTC)."

The MRTC moniker is an outgrowth of the concept of "regulatory capture," an economic theory that Investopedia describes as a process by which "regulatory agencies may come to be dominated by the industries

or interests they are charged with regulating. The result is that the aforementioned agencies act in ways that benefit incumbent firms in the industry it is supposed to be regulating" instead of acting in the public interest.

On September 10, 2013, PHS Assistant Director Bresnahan received an email from USDTL's Director Jones with the subject: "inciting incedent [sic] @WarrenMulleney." Jones wrote, "Hi Linda, This came across our desk today from our Twitter feeds. We do not intend on making any comment or reply but thought that you should be made aware."

The Twitter messages were in response to Langan's recent post, "Docs [documents] showing forensic fraud in drug testing labs not isolated to rogue techs." Twitter user @WarrenMullaney responded, "Cutoff levels exist for a reason. Drug testing requires protocols dictated by science not $. Egregious ad by USDTL. Need to expose coercion, abuse and fraud. Incompetence and indoctrination."

Langan and Mullaney's posts were in response to an ad put out by USDTL's president, Douglas Lewis, advising its clients (e.g., PHS) of one way to challenge a "negative" drug test result by a donor. As previously mentioned, in formal forensic drug testing, a urine specimen may be split into two separate containers, Bottle A and Bottle B. Bottle A is routinely tested. Typically, Bottle B can be run by another lab if the donor contests the initial test results or if Bottle A is damaged or its contents are processed incorrectly.

But Lewis offered a unique service to clients who believed the donor's test results were negative only because they were below the standard cut-off value. At the client's request, the lab would retest the specimen from Bottle B using a cut-off value that's 40% lower than the standard cut-off.

The application of this new offering relates specifically to incidental or environmental exposure to alcohol-containing handwashes, mouthwashes and OTC medications. The federal standard cut-off for EtG is 100 ng/ml. Any concentration below that is reported as a negative test. If the lab retests the specimen with Bottle B using the lower cut-off value of 40 ng/ml, false positives, the very problem the cut-off value was designed to prevent, can occur.

Unless the results of Bottle B are reviewed by a meticulous MRO who catches a duplication error (same donor and same specimen collection date but two different test results) or a change in the usual cut-off value, the donor may be credibly accused of violating the terms of their contract. Langan's experience demonstrates the difficulty of challenging and rectifying false positive test results once they become part of the licensee's record.

There's no way of knowing why Lewis would jeopardize his company's reputation by openly advertising a service that violates federal standards in drug testing. But this is not the only example of questionable practices by USDTL. Recall that it willfully ran tests that SAMHSA recommended against using in drug treatment programs or weren't FDA-approved. We also know beyond a shadow of a doubt that it cooperated in producing at least one fraudulent PEthStat result.

USDTL was also running drug tests on newborns' umbilical cord tissue without the mother's knowledge or permission. Umbilical cord analysis accurately reflects drug use by the mother going back 20 weeks and is, in effect, testing *her* for drug abuse. If the results were used only as a guide for treating the mother and baby, umbilical cord testing would be justified based on her general consent for medical treatment. But that would obviate the need for forensic protocols.

According to USDTL's website, "Like meconium, the umbilical cord tissue belongs to the baby, so there are no issues testing it and *no need for the mom's permission.* [emphasis mine] It's available immediately for 100% of births and needs only 1 collection by 1 collector. This saves time and money, but it also gets the specimen to the lab quicker, so the turnaround time is much shorter. The look back is 20 weeks with extensive panel options and alcohol and heroin detection that is superior to any other newborn specimen on the market."

As it stands, these results could be used as evidence by Child Protective Services and law enforcement agencies to impugn the mother without her being aware she had been tested by proxy. An MRO can't review a positive test with a baby. If a pregnant woman is properly prescribed methadone or buprenorphine (both are opioids) to help keep her off of street drugs during her pregnancy, she could be falsely accused of child endangerment and risk a protracted battle for custody of her newborn.

When Langan's blood was tested for PEth, USDTL used a specimen from whole blood. Later, however, it started using a technique known as dried blood spot (DBS) testing, a technique the drug testing industry had little experience with at the time. DBS involves collecting a blood specimen from a finger stick then carefully applying it to a dry matrix affixed to a test card. For the test result to be valid, the collection must be in a single layer and air dried before it's put in the collection bag.

But USDTL wasn't training collectors how to properly handle DBS specimens. In one case, an airline pilot was accused of relapse in his alcohol rehabilitation program because of an improperly performed DBS. It wasn't until the pilot sued USDTL that Jones, the chief witness against the pilot, inadvertently exposed another aspect of its relaxed relationship to proper forensic procedures.

I digress, but it's important to demonstrate that USDTL has shown a pattern of ignoring forensic protocols, using non-FDA approved drug tests, and evading informed consent rules in its zeal to attract business and improve its bottom line.

In May 2014, Langan changed tack in his effort to prove laboratory fraud. Hoping he could flush out the truth by suing USDTL for damages, he hired lawyer Inga Bernstein with Zalkind Duncan & Bernstein LLP to apply the Consumer Protection Act to his case. In her statement to USDTL, Bernstein alleged that, "as a direct and proximate cause of USDTL's malfeasance, Langan suffered severe economic losses—including salary, bonuses, benefits, retirement, consulting fees—and incurred legal fees in his heretofore vain attempt to challenge the actions of Physicians Health Services and the Board of Registration in Medicine."

USDTL had a great deal at stake should its fraudulent testing and reporting come to light, so it retained an experienced and aggressive lawyer, William F. Burke Esquire, to defend against Langan's charges. Like any good attorney at a large corporation with deep pockets, Burke rebutted Bernstein's claim immediately and decisively. He responded that Langan's PEthStat was a simple clinical test ordered as part of his treatment for substance abuse—not a forensic test that required a chain-of-custody—and that the results were accurate and valid.

Burke added emphatically that "USDTL in-house data has shown the PEthStat test to be stable for three weeks at room temperature . . . Therefore, the time between the collection of the blood sample and the test date had no detrimental impact on the positive test results."

Ironically, by denying Langan's theory that fermentation in the test tube during a hot spell in Boston could create PEth in a test tube and declaring that the PEthStat was a clinical test, Burke inadvertently impugned the integrity of the lab he was representing. No longer could anyone countenance the possibility that the PEthStat report was the result of an "innocent" procedural error.

Langan was now convinced, just as Dr. Flood was in 2012, that either his own specimen or the lab report had been replaced by one from a known alcoholic. The switch would explain both the reason the original unique patient ID number **461430** didn't match up with Langan's ID number **1310** and the phenomenally high concentration of PEth of 365.4 ng/ml. Ironically, if USDTL had chosen a specimen from someone whose PEth concentration was more believable in the context of monitoring a practicing physician, Langan might not have questioned its authenticity.

Whether this was a substituted specimen or a switched lab report, the Litigation Package demonstrated that the fraud must have happened on USDTL's premises, most likely under the direction of Dr. Jones at the prompting of Dr. Sanchez in cooperation with MRO Gavryk. Langan's lawyer would have jumped on Burke's pronouncement and followed it to its inevitable conclusion if Langan had been able to afford a protracted legal battle. But he couldn't. The fraud remained concealed.

On August 15, 2014, more than a year after Langan's license was suspended, Dr. Recupero's report of December 2013 clearing Dr. Langan to return to practice and Dr. Flood's letter of November 2012 warning about the invalid PEthStat of July 1, 2011 were finally time-stamped and entered into Dr. Langan's official file with BORIM. These documents weren't presented to the Board of Directors.

On May 7, 2015, despite numerous experts who cleared Dr. Langan of allegations of alcoholism, attested to his unassailable professionalism, and/or provided irrefutable evidence of laboratory malfeasance, the Board of Directors officially denied his petition for a stay of suspension and reaffirmed its February 2013 decision to suspend his license indefinitely.

Remarkably undeterred, in August of 2015, Langan petitioned the Supreme Judicial Court (SJC) of Suffolk County, Massachusetts, to grant him a writ of certiorari, a judicial review designed to detect and correct substantive due process errors in a court proceeding. However, a writ doesn't rule on the facts of a case, only the legality of the processes involved. The justice who reviewed it relied on the Board's records and summarily dismissed his petition on procedural grounds, writing that it was "untimely, having been filed [to the SJC] more than 60 days after the board's decision."

Langan was discouraged but undaunted, He subsequently submitted a motion, *Michael L. Langan M.D. Plaintiff-Petitioner vs Massachusetts Board of Registration in Medicine, Defendant-Respondent,* for "Immediate Relief" of his license suspension to Maura Healy, Attorney General of Commonwealth of Massachusetts and Clerk of the Supreme Judicial Court.

In his written motion to vacate the suspension, Langan posited that the statement of reasons in his case—that he violated the terms of his LOA by not attending all of his required support meetings and not properly documenting those that he did —was simply false. He pointed out that Massachusetts law provides that "a person whose license to practice medicine has been suspended or revoked may directly petition the court to set aside the action. [G.L.c.30A, Sect. 14 (7)]

Langan further posited that he was the victim of "fraud on the court," a malfeasance that occurs when an officer of the court tampers with the *process* of administering justice, in contradistinction to misrepresenting the *underlying facts* of a case. There's usually an element of collusion in fraud on the court. For example, a judge would be committing fraud on the court if he or she accepts a bribe to render a certain judgment or sentence even if the ultimate outcome is unaffected. Fraud on the court, he posited, voids the statute of limitations of 60 days because "a decision produced by fraud on the court is not in essence a decision at all, and never becomes final." [Drobny v C.I.R., 113 F.3d 670,677 (7th Cir. 1997)].

Unfortunately, because of his dire financial situation, Langan had to present his case pro se, that is, he had to act as his own lawyer, either a foolish or desperate decision depending on the circumstances. Langan's was the latter. By contrast, BORIM was represented by the assistant State's Attorney General, Bryan Bertram, who not only had the gravitas and legal acumen that Langan lacked, but also the resources of BORIM and the State of Massachusetts, as well as access to the same false and defamatory information used to justify suspending his license in the first place.

Bertram responded to Langan's petition in great detail. [In the Matter of Michael L. Langan, M.D., SJ-2015-0267.] He argued that another hearing would be "needlessly duplicative" and that Langan and his

counsel "refused to work within the Board's statutory and regulatory scheme," declaring that "the Board—and only the Board—has final approval authority." While he acknowledged that "the Board is aware of the chain of custody issue with the July 2011 PEth test," he claimed, like Sanchez, that "the Board disregarded it as a part of its decision-making." And he vehemently denied suppressing any exculpatory evidence.

The Massachusetts SJC took more than a year to complete its review and issue a decision. In the interim, on June 7, 2016, Langan took his complaints about BORIM's PHCU lawyers and their unholy alliance with Physician Health Services to Helen Rush-Lloyd, Director of Constituent Services at the Massachusetts Department of Public Health. He summarized his case as follows:

> "PHS is analogous to employee assistance programs in other occupations. Like other EAPs, PHS originally had a primarily beneficent relationship with individuals struggling with substance use and other mental health issues. However, as PHS became entangled in the multi-billion dollar drug and alcohol assessment, treatment and testing industry, it became increasingly punitive and riddled with conflicts of interest.
>
> By referring practitioners to facilities or consultants that shared its views on substance use disorders, PHS would be more likely to get confirmation of its allegations, enhancing its reputation with the public. The preferred facilities and consultants are, in turn, rewarded with repeat referrals.
>
> PHS's relationship with BORIM's PHC Unit is crucial in coercing physicians to stick with the program because any perceived non-compliance reported to the Board's PHC Unit can result in a summary license suspension and increasingly punitive contract stipulations."

Langan's appeal to the Department of Health was a pebble dropped in an interminably deep well. It caused nary a ripple.

In June, 2017, the Massachusetts SJC magistrate finally issued her opinion. She agreed that Langan had the right to a judicial review under the certiorari statute but came to a different conclusion. Recall that Langan's medical records confirm that, in 2008, in spite of a wide range of testing, he was positive for only one controlled substance, hydrocodone, a metabolite of the Vicodin™ that had been properly prescribed to him.

However, as a harbinger of how her opinion would unfold, the magistrate started her opinion by stating, "In 2008, after he had tested positive for *various controlled substances*, he and the board entered into a letter of agreement under which he agreed to certain conditions in order to continue practicing medicine." The rest of her writ was riddled with the same false information and unfounded accusations that had dogged Langan throughout his arduous battle with the Board.

Attorney Bertram didn't share USDTL's litigation package or the completed documents of Langan's attendance with the magistrate, a clear violation of the discovery process. As a result, the magistrate was unaware that the switch from allegations of alcohol use to allegations of non-compliance with meetings was a diversionary tactic in response to proof that the PEth test was invalid. She also wasn't aware that the fraudulent PEth test itself had in fact set into motion decisions and actions by the Board that ultimately laid waste to Langan's reputation and career, endangered his own and his family's health, and set him on a course towards financial ruin.

On the basis of the propagated disinformation, the judge ruled, "Because the Board committed no error in denying Langan's petition to stay his suspension, the single justice [of Suffolk County] properly denied relief in

the nature of certiorari." She also affirmed that there was "sufficient evidence supporting the Board's denial of the Respondent's Motion to reconsider the suspension of his medical license."

The Massachusetts Supreme Judicial Court's full text of SJC-12242, "Langan v. Board of Registration in Medicine," is available online. It includes a reference to a statement made by William Burke, the attorney who had previously defended USDTL in Langan's suit for damages, that the PEthStat was a clinical test ordered as part of his treatment for drug abuse. As soon as her opinion was posted to the internet, that false and defamatory statement, which violated Langan's medical privacy rights, could be read by anyone with a browser

Chapter 10: Four False Statements Walk Into a Bar

On January 9, 2017, Massachusetts Public Records Law was updated. The new law, HB 4333, requires that "All evidence, including any records, investigation reports, and documents in the possession of the agency of which it desires to avail itself as evidence in making a decision, shall be offered and made a part of the records in the proceedings." This law applies to the Board of Registration in Medicine.

Over the previous eight months, Langan had repeatedly entreated Attorney Bertram to provide him his file but Bertram stonewalled. In July 2016, he submitted another motion to the Supreme Judicial Court of Suffolk County, this time for BORIM simply to produce the documents. But Bertram claimed in his legal response that he had already sent them, concluding, "Dr. Langan's repeated attempts to create ancillary issues where none exist should stop. The Court should deny Dr. Langan's motion and proceed to an order and judgment on the merits of this case." The magistrate agreed with Bertram.

In March 2017, Langan wrote to Rebecca Murray, Supervisor of the Department of Public Records, asking for her assistance in obtaining complete, legible copies of his records, particularly those that were never submitted to the Board for its consideration. At that point, all he could do was wait.

Finally, in July 2017, through the combined efforts of Attorney Murray and other lawyers with the Department of Public Records, as well as his own sheer doggedness, Langan received the documents that refuted PHS's and BORIM's rationale for suspending his license and proved he complied with support group requirements. On August 31, Murray wrote to Records Access Officer Attorney Gerard Dolan, acknowledging that she had reviewed Langan's records, forwarded them to him and Langan and considered her responsibility in the matter fulfilled.

On November 18, 2017, Langan contacted Dolan, asking him to forward his updated file to the Board of Medicine. He reminded Dolan, "Public Records Law has revealed Mr. Harvey made four false statements[3] in two intentional fraudulent misrepresentations [of Langan's records of attendance] and this is 100% material to three Board and two SJC decisions. This is a serious matter and you have a legal (and ethical) duty to report the fabrications to the appropriate entities."

As a reminder to the reader, the four false statements were:

1. Langan violated his LOA by refusing to enter into an evaluation program at the request of PHS.
2. Langan falsely reported that he participated in required peer group meetings that he didn't attend.
3. Langan had not submitted any documentation that he attended all of the required meetings.
4. Langan confessed that he falsely reported he had participated in meetings that he didn't actually attend.

In Langan's mind the evidence was "so obvious you have to close your eyes not to see it." Apparently, Dolan's eyes were shut. He claimed, like Bertram, that the Board of Registration in Medicine had already sent the Board of Directors all pertinent records and, in any case, Langan hadn't "properly articulated" his request for records. Langan wrote back that he would "be happy to specify the records (including the four false statements) to Mr. Dolan—sentence by sentence and word for word if need be" but Dolan considered the case closed.

3

According to Langan, Dolan chastised the Supervisor of the Department of Public Records and its lawyers for having reviewed the requested records before releasing them, declaring that their job was simply to provide them. Dolan apparently was concerned that the contents of those records might become public knowledge. Finally, after multiple appeals to Dolan, the unlawfully concealed exculpatory evidence was apparently revealed to the Board. Langan hoped the arc of the universe would finally start bending in his direction. But it showed no signs of doing so.

In May 2018, Langan took his concerns to Assistant State Auditor William T. Keefe who was with the Bureau of Special Investigations, the division of the auditor's office that investigates "white collar" crime. He pointed out to Keefe that "Judicial review is not set up to detect intentional fraud such as this as the administrative Supreme Judicial Courts defer to the Board's judgment of facts and only look at issues of law."

Langan also reminded Keefe of the State Auditor's revised statute, specifically the statement that "The department of the state auditor shall audit the accounts, programs, activities and functions" related to "all departments, offices, commissions, institutions and activities of the Commonwealth." He emphasized that "shall" means "must" not "may."

Langan presented documents to Keefe showing that Attorney Harvey fabricated evidence as a pretext to suspending his license and that Assistant Attorney General Bertram concealed legitimate evidence of forensic fraud to uphold the suspension. He appealed to Keefe's conscience by reminding him that BORIM made decisions and took actions that had contributed to the suicides of numerous physicians.

Much to Langan's relief, Keefe expressed interest in his predicament and agreed to review the documents that proved his compliance with his LOA. He also agreed to confer with Fred Whitehurst, a well-respected attorney in North Carolina and expert in laboratory misconduct and fraud regarding the fraudulent PEth test.

Langan was enthusiastic about Keefe's advocacy and found him to be "a genuinely nice guy." When it later became apparent that Keefe lacked the authority to follow through on his agreement, Langan was frustrated and deeply disappointed. Shortly thereafter, Keefe was transferred to the Massachusetts Public Employee Retirement Administration Commission, ending his involvement in Langan's case. Langan wasn't convinced that the timing of the transfer was coincidental.

Langan then petitioned Keefe's superior, State Auditor Suzanne Bump, for a formal audit of BORIM's Physicians Health and Compliance Unit and its relationship to PHS and the Massachusetts Medical Society (MMS). He reiterated details about the fraudulent PEthStat and the false accusations about missing his support meetings, then asserted, "Attorney Harvey and the PHCU Board Counsel omitted and kept to themselves all of the evidence and argument related to the fabricated tests as well as other misconduct."

Langan also described the cozy relationships among all the players in the system—PHPs, medical licensing boards, the American Society of Addiction Medicine and its consultants, the drug testing labs and the "board-preferred" substance abuse evaluation and treatment centers—all of whom profited directly or indirectly from a steady stream of physicians under investigation or in long-term contract with PHPs for alleged substance use disorders. PHS, for example, typically has on average 30 physicians under contract and only one or two complete their contracts in any given year. And addiction treatment centers like Talbott profit immensely from the cash infusions by the physicians that PHPs refer to them.

Langan emphasized that it was unlikely that he was the only physician affected by USDTL's client-friendly practices, adding that USDTL had demonstrated its willingness to bypass basic laboratory protocols and produce fraudulent test results that were professionally and personally detrimental to licensed physicians throughout the country.

Towards the end of his letter to Ms. Bump, Langan alleged that a number of his colleagues had lost their licenses, their livelihood, and even their lives over false accusations of impairment, incompetence, and substandard care. "The Massachusetts PHS and BORIM," he concluded, "were perpetrating and covering up diagnosis rigging, lab fraud and deceit in the name of 'protecting the public.'" Langan and his colleagues were members of the public. Who was protecting them?

In a blog post on June 28, 2019, "The Need to Put a Spotlight on Medical Board Attorney Professional Misconduct," Langan described the pivotal role of BORIM's PHCU lawyers in carrying out the injustice.

> "It appears that it is their responsibility to craft and calibrate a statement of reasons for the decision [to take action against a licensee] that complies with all legal, regulatory and professional standards. An audit will not detect the fraud. Corruption by definition is covert and hidden. The decision-making is fragmented. Accountability firewalls and the diffusion of responsibilities make it difficult to detect individual wrongdoing."

To her credit, Bump did audit BORIM and issued a report on April 7, 2020. According to a press release from www.mass.gov , she called on BORIM to "enter into a formal contract with PHS that establishes the services it will deliver, processes for delivering them, quality standards it must meet, and periodic reviews of its performance." The audit also noted that BORIM had "not effectively monitored compliance reporting by PHS for some of the 27 physicians that had probation agreements. As a result, BORIM could not ensure these physicians did *not* [emphasis mine] return to active practice before their cases are resolved."

Bump didn't mention BORIM's equally egregious practice of preventing capable and competent medical professionals from practicing while they were being investigated or disciplined for issues unrelated to the quality of their medical care. Nor was she aware that there were no time limits on how long PHS could keep a physician under contract or how long BORIM could take to investigate and render a decision on a case brought before it.

Unfortunately, because PHS was a private nonprofit organization, Bump's audit couldn't examine any malfeasance by PHS and was thus inherently limited in examining its potentially conspiratorial relationship with BORIM's PHCU and its attorneys. Finally, Ms. Bump herself had a potential financial conflict of interest that could prevent her from objectively evaluating PHS. She owned Modern Assistance Program (MAP), another employee assistance program that provides health services to clients with alleged drug and alcohol problems.

* * *

In 2019, Dr. Langan's plight got the attention of Attorney Zena Crenshaw-Logal, executive director of The National Judicial Conduct and Disability Law Project (The Law Project). In November 2019, she started an advocacy campaign on his behalf which she entitled "PHP Abuse: How to Get Board Certified in Indentured Servitude." She chose the term "indentured servitude" mindfully.

Wikipedia defines the term as "a form of labor in which a person is contracted to work without salary for a specific number of years. The contract, called an 'indenture,' may be entered voluntarily or it may be imposed as a judicial punishment." Laboring under a letter of agreement while being deprived of the means of earning a living and paying the costs of that agreement certainly fits that definition.

An Oklahoma attorney posted an account on Crenshaw-Logal's Facebook page of a physician-client whose Board commenced its reign of terror against a physician after discovering that he occasionally wrote

prescriptions for individuals who weren't his patients. These were certainly ill-advised acts, but nothing that would rise to the level of "a clear and present danger to the public." He was forced to immediately surrender his license and was remanded to an out-of-state addiction treatment center where he endured two months of institutionalization for a substance abuse disorder he didn't have.

On December 10, 2019, Crenshaw-Logal and Langan shared their concerns with the legislative director of Massachusetts Congressman Joseph Kennedy III. He agreed to get their concerns considered by Congressman Kennedy but never got back with them. I suspect that Kennedy was either skeptical that a state agency could violate a citizen's civil rights with such impunity or thought that supporting physicians rights was a politically dangerous stance.

Crenshaw-Logal never had the opportunity to complete her pursuit of licensing board "indentured servitude" programs. She died suddenly, unexpectedly, and tragically in 2022. Her colleagues and members of the medical profession continue her fight for justice but physicians may never have the same fiery advocacy that she once uniquely provided.

Many other attempts have been made over the past decade or more to draw the attention of courts, the public, and, vitally, state legislatures—the only governmental body that can reform state regulatory boards—of the unwarranted deprivation of physicians' licenses and livelihood and to hold to account those responsible for the injustices they have individually and collectively perpetrated. So far, if anything, the problem is getting incrementally worse.

In 2012, several years after they left PHS, Drs. Boyd and Knight co-authored an article for the Journal of the American Society of Addiction Medicine (ASAM) entitled "Ethical and Managerial Considerations Regarding State Physician Health Programs." In it, they wrote that they still supported the concept of PHPs as a safe harbor and monitoring program for physicians with mental health or substance abuse.

But, based on their personal observations, Boyd and Knight postulated, "If a PHP highlights a physician as particularly problematic, the evaluation center might—whether consciously or not—tailor its diagnosis and recommendations in a way that will support the PHP's impression of that physician." In very diplomatic language, they were describing "diagnosis rigging."

Boyd and Knight expressed a number of other concerns. First, the length of stay for physicians in drug rehab facilities was generally three times longer than that for other professionals. Second, evaluation and treatment at PHP-preferred treatment centers were not covered by insurance and some physicians couldn't afford the price tag for a 90-day stay, especially since they had no income while they were institutionalized.

Third, the stigma around license suspensions was such that physicians often had trouble finding employment once their license was restored. Finally, many of the centers that specialized in evaluations of physicians also provided the costly treatment. Because of their self-selected specialization, all depended on PHP referrals for their financial viability, rendering these relationships rife with potential financial conflicts of interest.

A 2014 audit of the North Carolina Physician Health Program (NCPHP) was prompted by concerns raised by Dr. Jesse Cavenar, a former Duke University professor and Chief Medical Review Officer for the U.S. Army, that dozens of physicians were victimized by the NCPHP process. The audit reviewed 110 cases of physicians under contract with the PHP over a 10-year period.

While the audit didn't uncover specific evidence of abuse or improper treatment, the auditors acknowledged that abuses could occur and not be detected because the NCPHP "did not have objective, impartial due process procedures for physicians who disputed the Program's evaluations and directives or reasonable assurance that physicians received objective and quality evaluations." The team of auditors

recommended that the North Carolina Medical Board and Medical Society increase their oversight of NCPHP to ensure that participants have access to independent and objective evaluations and that conflicts of interest between NCPHP and treatment centers don't arise.

A follow-up audit of NCPHP in 2018 lauded the NCPHP's progress. However, participants weren't interviewed and the medical records of their personal physicians weren't reviewed. Only the information that the NCPHP chose to provide the auditors was examined.

In June of 2016, Jeanne Lenzer, associate editor of the highly regarded British Journal of Medicine (BMJ) authored a thoughtful and well-evidenced article, "Physician Health Programs under Fire." She wrote:

> "Critics charge that some programs are punitive, unmonitored, and deprive doctors of due process rights, preventing them from challenging diagnoses they disagree with. Some doctors say their medical license was suspended or revoked without evidence of professional impairment, tarnishing their reputation and ending their career. Simply answering "yes" to an employment or licensing question about past treatment for depression can be enough to trigger what one doctor described as a "Kafkaesque nightmare."

Lenzer added, paraphrasing Dr. Kernan Manion, "If [the physician] challenges a program determination that they are alcoholic, addicted, or mentally ill, they are assumed to be 'in denial' and told their license will be revoked since they are failing to cooperate with the assessment. However, if they agree, they are generally forced to sign five-year contracts that commit them to highly burdensome and expensive treatment and monitoring programs."

Lenzer concluded, after an interview with Beth Wood, who audited North Carolina's Physician Health Program, "The lack of transparency and failure to honor due process provide fertile grounds for abuse in which anonymous accusers can retaliate against whistleblowers or make accusations based on personal animosities."

In July 2017, Gabrielle Glazer updated an article from 2015 for The Daily Beast entitled "Doctors Are Killing Themselves and No One Is Talking About It." She discussed at length the path that led Dr. Gregory Miday to take his own life and the commonalities he shared with many other physicians. "They face the pressures of 'assembly-line medicine, merciless scheduling demands, fights with insurance companies, growing regulations, and an explosion in scientific literature with which their knowledge must remain current. Their debt burdens often total hundreds of thousands of dollars, and they work in constant fear of malpractice suits."

However, Glazer notes, physicians are reluctant to seek psychiatric care for the anxiety, depression and substance abuse that often arises from these pressures. In addition to the shame and stigma attached to mental illness, physicians worry about being forced by PHPs into years' long faith-and-abstinence based rehabilitation programs, having their medical confidentiality breached, or being reported to their licensing boards as unfit to practice medicine.

According to Glazer, "with their backs against the wall, far too many physicians (and even medical students) see suicide as a rational way out of their dilemma." According to Dr. Pamela Wible, a nationally recognized expert on physician suicide and host of <www.idealmedicalcare.org>, society loses at least 400 physicians a year (the size of an average medical school) to suicide. And, according to Bradley Hall, an addiction medicine physician, "Unfortunately, suicide is one thing physicians are pretty good at" given their access to potentially lethal drugs and knowledge of anatomy. As Wible reflected wryly, "Doctors calculate doses for a living."

Glazer struck an optimistic tone when noting that an article about physician suicide that Wible wrote for Medscape in 2014 garnered more than 100,000 readers and elicited 800 comments. But it is now 2024 and physicians, including those participating in physician "health" programs, continue to take their own lives. To date, Wible has documented 25 individuals who suicided while engaged with a physician health program. Clearly, if physicians are suiciding while being treated or monitored in a PHP, whether there's a direct causal relationship or not, their mental health isn't being properly attended to.

In Michigan in 2018, Attorney Ronald Chapman of Chapman Law Group filed a class-action suit on behalf of three licensed health professions against Health Professionals Recovery Program (HPRP), Michigan's version of a PHP. The suit alleged that, in concert with the Michigan Department of Licensing and Regulatory Affairs (Michigan's medical board), it was abusing its authority by demanding medically unnecessary treatment and using the threat of license suspension to force compliance.

Federal District Judge Arthur Tarnow ruled that HPRP had civil immunity against allegations of abuse of authority, but the suit could proceed on the basis of violation of the Americans with Disabilities Act. However, another judge later dismissed the case on the basis that the plaintiffs' individual circumstances were too disparate to qualify for class action status.

The abuses in North Carolina continued. In 2019, journalist Jonah Kaplan reported that the NCPHP received an anonymous and unsubstantiated accusation that a physician was an alcoholic and that her patients were in imminent danger. She was ordered to attend a four-day evaluation at an out-of-state addiction treatment center at which she was diagnosed with a substance use disorder and told that, as a condition of keeping her license, she must be admitted for 28 days then spend five years in a monitoring program.

Kaplan wrote, "The physician, who is rejecting the diagnosis and has not completed the 28-day treatment, says she is being 'strongly advised' by the NCPHP and NC Medical Board not to practice medicine until further notice." In her defense, one of her patients attested, "She's irreplaceable. She's a good doctor. Never once was there an indication that she wasn't really sharp." However, the N.C. Medical Board refused to let her case proceed unless or until she agreed to participate in NCPHP's treatment program.

That same year, on August 19, 2015, Medscape published an article by Pauline Anderson entitled " Physician Health Programs: More Harm than Good?" In her article, Ms. Anderson wrote,

> "Detractors of the PHP system claim physicians who voluntarily disclose they have mental health or drug problems can be forced into treatment without recourse, face expensive contracts, and are frequently sent out of their home state to receive the prescribed therapy. Some physicians allege that during their interaction with the treatment centers, large amounts of money were demanded up front before any assessment was even conducted."

In 2019, Florida state senator John Milkovich sponsored the state's "Physicians Bill of Rights" to ensure that physicians' civil rights were respected during medical board investigations and related civil matters. It's telling that it would take legislative action to ensure the same basic civil rights for physicians that every other U.S. citizen and legal resident automatically enjoys. But apparently the concept was incongruous with the legislators' and their constituents' sentiments about justice for physicians. The bill was tabled indefinitely.

Louise B. Andrew, M.D., J.D., founder of <www.MDMentor.com> and <www.Physiciansuicide.com> provides support services for physicians experiencing stress from malpractice suits or dealing with depression. She learned from many clients that physicians are also experiencing significant stress from medical board investigations and Professional Health Programs. Once a staunch advocate of PHPs, Andrew is now an active

critic who is particularly alarmed by the failure of these agencies and their delegates to comply with requirements of the ADA and the alarming incidents of PHP-related suicides.

The Center for Physician Rights (CPR) <www.physicianrights.net>, founded by Dr. Kernan Manion, provides logistic advice and emotional support to physicians who've been caught in the vortex of physicians' health programs. Manion himself was ensnared in North Carolina's PHP system after complaining about substandard treatment of US marines with combat related post-traumatic stress disorders in Camp Lejeune's program for reintegrating veterans back into civilian life.

Langan and his colleagues with CPR have pressed for reform of the PHP system for more than a decade; he's currently focused on violations of the Americans with Disabilities Act (ADA) by PHPs and their respective medical licensing boards. The ADA is a civil rights law that prohibits discrimination on the basis of a disability as long as the individual can perform the essential functions of the job with or without reasonable accommodation.

The Healthcare Alliance for Regulatory Reform (HARB-R) <www.harbr-usa.org>, founded by Christian Wolff, a formerly licensed psychotherapist, advocates for nurses, therapists, and other licensed healthcare professionals who are experiencing similar abuses by their respective licensing boards and professional health programs. To date, HARB-R has not succeeded in creating regulatory reform. But it does provide much needed collegial support to victims of these abuses.

The organization Doctors of Courage <www.doctorsofcourage.org>, founded by Dr. Linda Cheek, works with physicians who've been accused by the DEA and other governmental entities of improperly prescribing opiates to their legitimate pain patients. These physicians have been harassed and even imprisoned even though—unlike physicians who run "pill mills"—they were regularly evaluating their patients, prescribing appropriate quantities of narcotics, keeping adequate records and recommending adjunctive treatment such as physical therapy.

In February 2023, United States Senators Ron Wyden, Cory Booker, and Jeff Merkley sent a letter to the U.S. Department of Justice, asking it to investigate possible violations of the ADA www.ada.gov by medical licensing boards. The senators contended that asking questions about mental health—such as "Have you ever been diagnosed with, or treated for a mental health or substance abuse disorder?"—on their licensing applications not only violates the ADA, but discourages physicians from seeking needed mental health care.

Inspired by the senators' expressions of concern, Dr. Wible and Dr. Manion are orchestrating a letter-writing campaign by healthcare professionals who believe their rights under the ADA have been violated and, as a result, have been personally and professionally harmed. Apparently no one is being spared: medical students, residents, established practitioners and those of retirement age have all been targeted by both PHPs and licensing boards.

While the battle has been going on for more than a decade, to this day, little progress toward substantive regulatory reform has been achieved. Although some states have amended or removed certain questions about past mental illness on license applications in response to complaints about ADA violations, their actual treatment of physicians with purported mental health issues, by any objective measure, has not improved. In fact, the agenda of FSPHP's April 17-21 2024 conference <www.fsphp.org>, "Enhancing the Effectiveness of Professional Health Programs Through Collaboration: Improving Health and Wellbeing" suggests that they are expanding both the types of healthcare professionals they're focusing on and the scope of their invasive treatment protocols.

The reluctance to seek care has become more salient in the past few years due to rising levels of burnout, compassion fatigue and suicides among licensed healthcare professionals in all sectors of the medical field,

including those who were emotionally traumatized on the frontlines of the Covid pandemic. These dedicated professionals risk their reputations, their licenses, and their freedom should they seek treatment for the anxiety, depression, substance abuse, PTSD, or suicidality engendered by their common experiential trauma.

Yet we know they also risk their lives if they don't.

Chapter 11: The Hypocritic Oath

The Federation of State Medical Boards (FSMB) is a 501(c)(6) trade association of which all medical boards in the U.S. and its territories are members. According to the IRS, a 501(c)(6) is "an association of persons having a common business interest, whose purpose is to the common business interest and not to engage in a regular business of a kind ordinarily carried on for profit." The FSMB's website states that it "serves as a national voice for state medical boards, supporting them through education, assessment, data, research and advocacy while providing services and initiatives that promote patient safety, quality health care, and regulatory best practices."

The FSMB creates policy via committees and a House of Delegates; archives and distributes information about serious disciplinary actions taken against physicians; and publishes reports about its own and member activities. Like the FSPHP, the FSMB has no direct authority over licensing boards, but it exerts a profound influence. It hosts conferences, seminars, and annual meetings promulgating FSMB policies, defends licensing board actions in the press, and lobbies on their behalf in Congress.

For years, FSMB had been publishing a summary of the number of serious medical board license disciplinary actions (probations, suspensions, revocations, surrenders, and limitations) taken by each state and ranked them according to the rate at which licensees are disciplined (defined as the number of licensees disciplined per 1,000 actively-licensed doctors). The greater the rate of physician discipline, the higher they rank on FSMB's list of state medical boards.

In 1990, this publication caught the attention of Public Citizen, a consumer safety watch group founded by consumer activist Ralph Nader. Without any research or hard data to back it up, Public Citizen declared that there was a direct relationship between the rate of serious disciplinary actions and a medical board's effectiveness in protecting the public from dangerous doctors.

In other words, Public Citizen concluded that more patients were being injured or killed by physicians in states with low disciplinary rates than in states with high disciplinary rates. It further concluded that most states weren't living up to their obligation to remove dangerous doctors from medical practice and demanded that action be taken by both state legislatures and the medical boards themselves to (in their words) "increase the amount of discipline and, thus, the amount of patient protection."

In a 2010 article in Medscape entitled "Ranking State Medical Boards: Are the Worst Really the Best?" attorney Steven Kern wrote a scathing rebuttal to Public Citizen's conclusions, stating bluntly, "Public Citizen has it all wrong. Boards should not be judged by the number of licenses suspended or revoked, but by how well they protect the citizens of their state. Its simplistic analysis is akin to judging a city's police department on the basis of the number of prisoners in its jails rather than the number of crimes committed."

He added presciently, "Given the enormous investment society makes in training physicians, the impending physician shortage, and the need for more physicians in underserved areas, removing physicians from practice is most often shortsighted and counterproductive. Boards must be encouraged, in all but the most egregious cases, to resolve cases in a manner that will allow physicians to use their education and training to improve healthcare. Rarely is that accomplished by removing a physician from practice."

In spite of the pushback by Kern and others, since Public Citizen's first report was published 30 years ago, license discipline has become as much a competitive numbers game as a mechanism to promote patient safety. The more licenses a medical board limits, suspends, or revokes (regardless of the reason) the better its reputation with the FSMB, medical societies, healthcare institutions, and the general public.

Granted, many regulations that medical boards have enacted and/or enforced can improve patient safety. For example, controlled prescription drug databases that many states have implemented can alert physicians to patients who are getting multiple narcotic prescriptions from multiple providers.

However, when a medical board suspends a physician's license because she delegated the task of checking the database to her nurse, patient safety is not jeopardized. Furthermore, the loss of competent physicians from the healthcare system reduces both the supply of healthcare providers (access to care) and the amount of time and energy those who remain can devote to each individual patient (quality of care).

When the Public Citizen report first came out, Massachusetts was rated 38th out of 50 in its disciplinary rate. In her tenure as Chair of BORIM's Board of Directors (2011-2020), Dr. Candace Lapidus Sloane made it her mission to improve that statistic. She supported the imposition of numerous new (and often controversial) regulations on practicing physicians, more barriers to first-time and renewing applicants and increasingly harsh and frequent discipline against so-called "impaired physicians." Massachusetts is now rated 25th in the nation.

In 2017, BORIM scheduled a public hearing on several new proposed medical regulations, some quite restrictive, others quite onerous, and a few, both. One was a measure prohibiting physicians from delegating any medical services, even blood pressure measurements, to healthcare workers who weren't licensed in Massachusetts.

Another was a byzantine process for obtaining and documenting patient consent for medical procedures that the Massachusetts Medical Society was highly critical of. The new patient consent process was approved but is still mired in controversy and making adjustments in response to criticism.

Attendees at the hearing expressed varying opinions about most of its proposals, but they seemed to be of one voice about Sloane's new stance on what she referred to as "good moral character." From the inception of state medical boards in the 1800s, "good moral character" has always been a requisite. While training and continuing medical education requirements have evolved over the past two centuries, these requirements are generally accepted as reflective of the contemporary state of the medical profession. However, what constitutes "good moral character" continues to be subjective and controversial.

At the hearing, Dr. Sloane proposed that "licensure as a qualified physician be granted only to those who shall furnish the board with satisfactory proof that he or she is of good moral character." The new statute would allow Board members to extensively interrogate applicants whose moral character might be judged in doubt based on information on their applications and then require extensive documentation from them about specific, potentially adverse, events in their professional and personal lives.

One physician attending the hearing pointed out that this regulation would grant board members "unilateral authority to decide whose moral character is sufficient and whose is not and shift the burden to the applicant, now implying a presumption of bad moral character upon applicants unless they can provide evidence otherwise" The unsettling question arose, "How much evidence is needed to prove that an applicant is *not* morally deficient?"

Another concern was that, if the application was denied for whatever reason, the Board of Directors would, in Sloane's words, "report the denial to a national database to ensure applicants cannot venue shop and gain admittance to another state." Thus, five physicians and two members of the general public in Massachusetts would be endowed with the power to unilaterally and possibly capriciously make or break the career of someone who is otherwise trained and qualified to provide a vital public service anywhere in the U.S. and its territories.

A nascent career could be smothered in its crib over a youthful indiscretion; an established career could be upended over a single conviction of misdemeanor "Driving Under the Influence" (DUI).

Prior to the formal adoption of the updated good moral character standard and other proposals, Harvard Law School's journal, The Practice, published an article in its March/April 2018 edition titled "Character without Borders: Lessons from Outside the Legal Profession." Written by the Massachusetts Center for the Legal Profession, it explored the legal profession's character and fitness debate by examining how the medical profession handles it.

Dr. Sloane was extensively interviewed for this article. She asserted that being a good doctor and having strong moral character are inextricably linked, stating, "There's a level of competency that every physician must have . . . Doctors are human . . . they're not going to always get it right . . . But we have to know that they have the integrity and the moral character to tell the truth—and to always tell the truth." She explained:

> "For instance, applicants must report being arrested, arraigned, indicted or convicted even if the charges against [them] were dropped, filed, dismissed or otherwise discharged. For each criminal issue, the applicant must provide certified copies of the complaint, judgment or other disposition and a copy of the police report must be sent to you [the applicant] in sealed envelopes from your lawyer, the court or other appropriate agency . . . You must also provide a detailed explanation of the incident, including date, time, place, the court action and final disposition."

The article mentions that, unlike the Massachusetts attorneys' Board of Bar Examiners (BBE), applicants for a medical license in Massachusetts must submit to a Criminal Offender Record Information (CORI) check which makes some of Sloane's additional requirements, not just redundant, but iniquitous.

Sloane was also quoted as saying something that completely contradicts how PHS and BORIM actually treat licensees with allegations of substance abuse:

> "Let's say somebody has a substance abuse problem and they come to us about it. If it does not affect their work, if they have not crossed the threshold of the hospital, if it never comes to that, then that's something that appropriately may not come to our attention. When it becomes our responsibility is when it comes into the workplace. If we see that, we need to stop the practice at that point, we need to assess the total picture, we need to help the person get treatment, and we need to see about a probation agreement to monitor them after they achieve a certain period of sobriety. Every situation is different. Our goal is to help a physician practice safely."

Based on that statement, whether Langan's diagnosis of alcohol use disorder was true or not and whether he ever had alcohol in his system or not, that information should never have come to the attention of the Board. As his peers and colleagues attested over and over again, his professional conduct was exemplary.

Just as confounding is professional health programs' zero tolerance policy on alcohol consumption in combination with use of ultra-sensitive alcohol tests. This invites false positive tests and false accusations of impairment and non-compliance. Asthmatics don't show up to work impaired from using their alcohol-based asthma inhalers—which could cause a positive test for alcohol—but they certainly could show up to work impaired if they don't use them. Yet, Langan's occasional positive EtG and EtS tests led to accusations of impairment, non-compliance and a life-threatening prohibition on their use.

On May 29, 2017, then Governor Charles Baker reappointed Sloane to a third term as Chair that would expire January 1, 2020. Sloane's acceptance of this appointment would later reveal certain aspects of her moral character.

The upgraded "good moral character" standards, along with several other new regulations, were enacted by BORIM in 2019. The Massachusetts Medical Society (MMS) subsequently issued a formal letter of concern that the "moral standard" regulation would require applicants "to report all malpractice claims and criminal proceedings in which they were named as a defendant, irrespective of the ultimate disposition of the case . . ." Furthermore, the MMS complained, the Board didn't clearly define "good moral character" or designate who was ultimately responsible for judging an applicant's moral character.

In June 2019, Boston Magazine published an article entitled "The Secret Truth about Massachusetts' Bad Doctors." The article described Sloane as "an uncompromising patient-safety crusader." Boston Magazine endorsed Sloane's continuous tenure on the Board of Directors, asserting that it was vital for the safety of patients in Massachusetts.

Not everyone was as enthusiastic. The Massachusetts Medical Society, two new members of the board of directors, and an ad hoc group of physician defense attorneys accused BORIM, under Sloane's tenure, of disciplining competent physicians with medical problems overzealously while giving short shrift to those with documented histories of malfeasance and malpractice.

In response, Sloane's critics were decried as outliers motivated by self-interest and indifference to patient safety. Boston Magazine declared, "With Sloane's term on the board ending next year [2020], time is of the essence." On that point, Boston Magazine was correct. Although state law limited board members to a maximum of two three-year contiguous terms, Sloane had already been on the Board and served as its Chair continuously for eight years.

Chapter 12: Theater of the Absurd and a Game of Ping Pong

On July 24, 2019, Langan created a bit of theater by flagrantly posing as a licensed physician in an attempt to generate a criminal complaint of practicing medicine without a license. Such a charge, he reasoned, might get his evidence of fraud by BORIM in a criminal court and guarantee him the assistance of legal counsel, something he sorely needed given his dire financial situation and track record of bitter disappointment when appearing in court pro se.

Langan enlisted the help of a physician friend in South Boston Health Center's concierge hotel house-calling service, "Inn House Doctors," to be the "casting director" in his theatrics. His friend agreed to contact him when he got a non-emergency call from a demanding concierge patient with a trivial medical complaint.

After getting the phone number of a client who fit the profile who was complaining vociferously about a sore throat, Langan contacted her and disclosed his full name, spelling it out and purposely adding or dropping his "Rs" in a feigned Boston accent. He told her it might be from a "bacterier" and that he would see her in a couple of hours at her lodging at the Seaport Hotel in Boston.

Four hours later the patient called him back, irate about the delay, and he responded in a deliberately blasé and cavalier manner, "I'm running late and will be there in a few hours." He finally showed up at her hotel at 9:30 p.m. "with taped glasses, two different colored socks and sweating profusely because I parked ten blocks away and ran to the hotel where she is waiting with a security guard." He handed her a pre-written prescription of Zithromax for her sore throat and then literally hoped for the worst.

Langan stated that he was "prepared to be arrested by the police so that there would be a very public trial." While he didn't get the criminal complaint he'd hoped for, he did get BORIM's attention. On August 8, 2019, Sloane, still acting in the capacity of Board Chair, publicly issued a formal two-count complaint against Langan.

In her "Statement of Allegations" as Petitioner (Plaintiff), Sloane contended that Langan, as Respondent (Defendant), had practiced medicine "while his registration was lapsed, suspended or revoked and practiced medicine deceitfully or engaged in conduct which has the capacity to deceive or defraud." She challenged Langan to show cause why he shouldn't be further disciplined.

Representing Sloane and BORIM was Massachusetts attorney Lisa Fuccione, counsel for the PHCU's Complaint Committee. Once again, Langan had no choice but to appear pro se. His main advisor and supporter was Dr. Bharani Padmanabhan, a neurologist who had also run afoul of BORIM for equally unfounded reasons.

On August 29, 2019, Langan responded to the charges and submitted two motions to the Massachusetts Division of Administrative Law Appeals (DALA), an independent agency that conducts due process adjudicatory hearings for state administrative agencies. A highly regarded magistrate, Judge Judith Burke was overseeing the case. One motion Langan submitted to her was a *Motion To Dismiss* [the charges] and the other was a *Motion To Dismiss For Failure To State A Claim*.

In his motions, Langan denied both complaints as false as a matter of law, contending that his license suspension was predicated upon fraudulent evidence and false allegations. When the formal complaint was issued, he asserted, "Sloane was present on the Board illegally and her signature on the statement of allegations was unauthorized." "Ergo," he concluded, "all documents signed by Dr. Sloane after her second term expired in January 2017 are legally void." He elaborated:

> "Dr. Sloane's eight (8) continuous years as Board Chair have caused utter misery to untold good caring physicians in Massachusetts, many of whom have been driven to suicide as a direct result of Dr. Sloane's unjustified marauding destruction of their professional existence. Respondent still

> grieves for his friend Dr. James Fen, who was unable to countenance [her] contempt for and total lack of respect for practicing physicians and was driven to kill himself as a result."

Langan then summarized his efforts over the years to bring the corruption to light, hoping that the publicity would "prompt an examination by District Attorneys, the courts, a jury and the public at large. . . and steps be taken to prevent the driving of learned doctors to suicide in the prime of their life."

On September 25, 2019, Langan submitted another petition to Magistrate Burke, *Motion To Compel Production By The Petitioner,* of documents to further refute Sloane's claim that he was practicing medicine without a license. He pointed out that she hadn't specified whether his license was lapsed, suspended, or revoked and that there was a vast difference among these options.

Langan explained that a license can lapse simply from inaction, but a suspension or revocation is an official disciplinary action against the licensee. In his words, "This cavalier approach to serious constitutional liberty issues is an established practice at BORIM . . . and represents an ongoing pattern of contempt towards physicians' liberty, rights, and public reputation."

Langan asserted that such an allegation necessitated further examination of BORIM's disciplinary actions against him. He cataloged the multiple attempts by PHCU Attorney Robert Harvey, with the assistance of Records Access Officer Attorney Gerard Dolan, to withhold and conceal records pertinent to his appeal. He further asserted that these documents would reveal obvious fraud.

During a formal serious and detailed investigation into his case, Langan contended, several questions would naturally arise. Did Attorney Harvey intentionally provide false incriminating evidence to the Board and withhold truthful exculpatory evidence? Were Sloane and the rest of the Board of Directors aware of Harvey's intentional misrepresentation at the time? If so, were they actively complicit? If not, why didn't they take action when they eventually found out?

Langan concluded that DALA had the duty and the power to compel the production of documents crucial to his claim that his license was unlawfully suspended and pleaded for the following:

1. Proof that a Certified Letter was sent to him containing the statement of reasons why his license was suspended on February 6, 2013;
2. A certified copy of his "confession" of non-compliance with required meeting attendance; and,
3. A certified copy of the entire evidentiary record that formed the basis of his suspension.

On September 30, 2019, Langan filed another petition to DALA, *Respondent's Motion For Referral To Bar Counsel,* in which he requested that Attorney Harvey be referred to the Massachusetts Law Bar Counsel for "egregious, conscious, willful violations of numerous paragraphs of the SJC's Rules of Professional Conduct." In his motion, Langan recounted the numerous violations of process perpetrated by Harvey in collusion with PHS Director Sanchez over the previous seven years.

Langan also enumerated the multiple injuries that arose from Harvey's misconduct: his two brushes with death due to asthma attacks after use of his inhalers were barred; the loss of his position on the faculty of Harvard Medical School; the resulting financial harm including loss of the family home and of his three daughters' prospects of attending university; and, finally, the loss to the people of Massachusetts of the services of a superbly-trained and competent, caring physician.

By this point, Harvey had many reasons to despise and fear this unlikely adversary. A "win" by Langan would be a loss for Harvey, his reputation, and possibly his career. It would reflect poorly on the Board of

Directors who might scapegoat Harvey by accusing him of withholding pertinent information from them. Perhaps he was infuriated with Langan for standing up to him. But why he had such a vehement personal vendetta against Langan is as much of a mystery as why Langan was diagnosed with alcoholism in the first place.

Magistrate Burke scheduled a pre-hearing conference for October 4, 2019, on Langan's motion to dismiss the charges against him based on Sloane having exceeded her lawful term as Board Chair. But she would not weigh in on Langan's charges against Harvey, ruling that they were not relevant to the specific issues at hand.

Earlier that week, Attorney Dolan submitted a crucial document to Magistrate Burke delineating the parameters of Sloane's tenure at BORIM, asserting that she was legally serving as Board Chair at the time of the allegations and, thus, had the authority to level charges against him. While Attorney Fuccione had a copy of the document, she didn't share it with Langan. Failure to share discovery with the opposing counsel is known as a "Brady Violation," a lapse that a second-year law student would know to avoid.

Dr. Padmanabhan was assisting Langan at the October 4 pre-hearing conference. At one point, he asked the Judge to clarify why she was denying Langan's motion to dismiss the charges against him. "So, from July 2011 to January 2020 [Sloane's tenure as Board Chair] is okay, according to the law?" he asked. Magistrate Burke responded, "Well, that's what would be the Board's position and I am accepting that argument and denying the Motion to Dismiss."

Burke then scheduled an adjudicatory hearing for January 8, 2020, at which time she could review both parties' respective motions and issue her final rulings. Langan later wrote, "Fuccione did not either fax or email me that document. Fuccione asserted that the Board was correct and then sat through an entire meeting literally across a conference table from me without once revealing the existence of that document. I found out about this ex parte document only after the meeting ended. I vigorously protested this exclusive reliance on an intentionally ex parte document that was used to ambush me at my due process hearing."

"Ex parte" refers to substantive contact or communication occurring between one party in a case and either a judge or an outside party that sidesteps the requirement to simultaneously notify the opposing party. In spite of Langan's vigorous protestation of Fuccione's improper maneuvers, a long road lay ahead of Langan to prove that Sloane's presence as Board Chair was unlawful after January 2017, much less that she and the Board had unjustly wrested his medical license from him back on February 6, 2013.

On October 8, 2019, Langan submitted two petitions to Magistrate Burke. The first was *Respondent's Objection and Motion to Reconsider Denial of The Motion to Dismiss,* which pointed out that Dolan was "not an attorney of record in this hearing and who did not send a copy [of the document] to the respondent at all. Langan also laid out, point by point, the laws Sloane violated for staying on the Board of Directors continuously for eight years while simultaneously serving as Board Chair. He alleged that "the ALJ (Administrative Law Judge) erred by denying the motion to dismiss without ruling on Sloane's illegal status as Board Chair," further contending, "This case must proceed no further."

This second motion was an *Objection and Motion to Strike the Deliberately Ex Parte Dolan Improper Order,* claiming that Burke erred in denying Langan's motion to dismiss after "allowing an improper, sneaky, ex parte pleading sent by Gerald Dolan" which caused Langan to be "ambushed, sandbagged and his due process rights undeniably violated."

When Magistrate Burke confronted her about the ex parte document, Fuccione lamely claimed that she mailed a copy of the document to Langan via untracked first-class mail, an impermissible means of serving legal papers even had she done so. Burke would later comment, "I cannot understand why the Petitioner

[Fuccione] has not responded to this motion and supplied the return of service to dispel the Respondent's characterization of the communication as 'ex parte.'"

Burke also admonished Dolan that "Late filings from an attorney who has not filed an appearance in the case are highly improper." However, she continued to rely on Dolan's document concerning Sloane's rightful status on the Board of Directors in her subsequent rulings.

Fuccione was determined that Magistrate Burke should stick with her initial narrow ruling. Practicing medicine without a license in Massachusetts is a misdemeanor, not a felony, but it could result in imprisonment for up to a year. After establishing Sloane's legitimacy as Board Chair in the eyes of the Magistrate, she needed only to prove by a preponderance of evidence that Langan did, in fact, practice medicine on the day in question. First, Fuccione needed testimony from "Patient A," the woman Langan treated at the Seaport Hotel. But Patient A lived in Great Britain and could not be forced to return to the U.S. to testify in person.

On November 26, 2019, Fuccione filed a torrent of motions and evidence to Magistrate Burke, including *Petitioner's Motion in Limine to Introduce Patient A's Hearsay Statements.* A motion *in limine* is a request to either include or exclude specific evidence at the start of a trial. She requested that the following be introduced into evidence:

1. An email from Patient A summarizing the care she received from Langan;
2. A photo of the Zithromax dose pack he prescribed her;
3. Inn House Doctors' receipt for Patient A's care;
4. Photographs of the texts Patient A exchanged with Langan on the day in question;
5. Video surveillance footage from the Seaport Hotel showing Langan entering the premises on the night in question;
6. A statutory report from Board Investigator John Landers who interviewed Patient A via telephone; and, finally,
7. A statement from nurse practitioner Deanne Wimsatt regarding Langan's treatment of Patient A.

Fuccione then asserted that laws governing adjudicatory agencies such as medical licensing boards "need not observe the rules of evidence observed by courts." Then, referring to the email from Patient A, she added, "Courts have routinely upheld agency decisions that relied upon hearsay statements similar to the kind at issue in this case."

In his rebuttal, *Respondent's Motion To Compel Petitioner To Produce Patient A,* Langan argued that Fuccione had "multiple opportunities to obtain a sworn affidavit from Patient A, a sworn deposition conducted at a solicitor's office in London or video deposition conducted via Skype at the Petitioner's offices in Wakefield." "Instead," he asserted, "the Petitioner seeks an end run around a clear state law and numerous explicit rules from the SJC and Appeals Court. This is unacceptable."

In a later ruling, Burke would concur with Langan, stating that "certain hearsay from state agencies lacks the indicia of reliability required by due process hearings." She also agreed that Fuccione had "several months and multiple opportunities" to elicit sworn testimony from Patient A and that these means were "preferable options to the BRM's expectation that Patient A's statement will be automatically admitted as evidence by the Administrative Magistrate."

Burke further explained that, as Presiding Officer, not Fuccione, had the discretion to determine what evidence to admit as well as how to resolve questions of procedure. "In determining whether to admit evidence, particularly of a complaining witness/victim, the rights of the accused and the related ramifications of the BRM

action must be weighed. It would be contrary to the administration of due process to allow Petitioner's Motion in Limine."

As determined as Fuccione was to prove that Langan was practicing medicine without a license, she was more determined that the truth about his 2015 license suspension never see the light of day. Accordingly, on November 26, 2019, she submitted another motion: *Motion In Limine To Exclude The Admission Of Evidence Regarding Extraneous Matters.* However, despite Burke's admonishment to Fuccione regarding ex parte evidence, she omitted this Motion from a packet of documents that she sent to Langan.

As soon as Langan realized that the packet he received was incomplete, he promptly notified Fuccione. She responded in an email, "While I appreciate that email is a faster form of communication, any information you wish to provide me, or any requests that you have, needs to be submitted by U.S. Mail."

On December 31, Fuccione wrote to Langan (ironically in another email): "I have intentionally elected to limit my communications with you to formal proceedings where a stenographer is present and/or filings submitted and verified by U.S. Postal Service. My decision is based on the litany of personal attacks and unfair accusations of fraud and/or misconduct that you have made against me and the Board during the pendency of this matter."

After finally receiving Fuccione's Motion in Limine on December 7, 2019, Langan submitted another petition to Magistrate Burke, Respondent's Opposition to Petitioner's Motion to Exclude Extraneous Matters, alleging, "The sole reason for the Petitioner to wish to exclude evidence vital to the Respondent's affirmative defense is to conceal intentional factual misrepresentation, fabrication of a false narrative and forensic fraud by salaried employees with the board . . . and a rush, by Candace Sloane, to issue a public statement of allegations on behalf of the South Boston Health Center before the Respondent [Langan] or Patient A [the "victim"] were interviewed and without a Complaint Committee meeting."

Langan added that, based on the concept that a defendant is presumed innocent until proven guilty by a court of law, the burden of proof that his assertions of forensic and documentary fraud were "wholly unsupported" rested upon the Petitioner, not himself as the Respondent. He asserted that "deliberately withholding exculpatory evidence prior to the framing of charges is another example of 'fraud against the court,'" in this case, when a judge or other officer of a court renders a decision that he knew, or should have known, was based on false, misleading, or incomplete information.

Langan further explained that the DALA hearing was a quasi-judicial process and thus the Magistrate functions in almost all respects as a judge who should not tamper with justice. "Such fraud," he averred "involves more than an injury to a single litigant. It is wrong against the institutions set up to protect and safeguard the public." Langan concluded, "As a matter of law, in compliance with 100 years of binding and on SJC and US Supreme Court precedent, the Petitioner's Motion to Exclude Extraneous Matters must be denied."

However well-reasoned Langan's appeal to Magistrate Burke was, she would not stray from the immediate allegation that he practiced medicine without a license on the night in question. Even though the suspension may have been wrongful, unjust, or even a violation of his civil rights, she contended, his license was, without doubt, known by him, Sloane, Fuccione, and BORIM to be suspended when he treated Patient A.

Burke also pointed out that the previous SJC decision already concluded that there was sufficient evidence to support BORIM's indefinite suspension of Langan's license. "Ergo," she stated with finality, "it is beyond the scope of this Administrative Magistrate's authority to re-litigate and re-determine the Respondent's previous appeal." In keeping with her ruling, she prohibited Langan from presenting testimony from other witnesses or introducing exhibits that she said had no bearing on the ultimate question of whether he practiced medicine on July 24, 2019.

Eager to expose and memorialize BORIM's misconduct in any manner possible, on December 2, 2019, Langan submitted a *Motion to Authorize Video Recordings.* Fuccione responded with a motion opposing the video recording, stating that Langan had "a documented history of making unsupported accusations against Board staff members" and that "allowing the respondent to make a video recording that he could edit to support his own narrative and post on his website would not serve the public interest or further the principles espoused by Justice Louis Brandeis."

"Furthermore," she wrote, "the presence of a videographer . . . will likely encourage the Respondent to use the trial as a forum in which to air his views on the Board and Physicians Health Services generally." On that account Fuccione was correct. Langan chose to openly practice medicine without a license to get arrested precisely so he could air his grievances in a public venue.

Burke agreed with Fuccione but had her own reasons for disallowing a video recording, explaining that "a videographer would not be an independent and sworn record-keeper" and that "any future disbursement of the contents of the video are unknown." Henceforth, she also ordered all parties to power off their cell phones and keep cameras out of the hearing room. Burke was proving herself to be a strict, but consistent, administrator of justice.

On December 28, 2019, Langan submitted a *Motion To Compel Sworn Testimony From Lisa Fuccione*, explicitly to elicit her reasons for escalating her allegations to the full Board without first taking them to the Complaint Committee and her reason for publicly alleging that Langan had practiced medicine without a license before interviewing either Patient A or himself.

Langan pointed out that the Supreme Court "has long held that investigative functions are distinct from prosecutorial functions and therefore even court prosecutors are not covered by quasi-judicial immunity." He concluded, "Fuccione is not immune from having to testify about her own actions during the investigative phase."

In response, Fuccione averred that "There is nothing preventing the Respondent from obtaining answers to his questions about the board's investigation from a witness other than Complaint Counsel." Nothing, I presume, other than that he was representing himself and had a long history of asking questions for which he got further discipline rather than answers.

Magistrate Burke concurred with Fuccione, opining, "It is a well-known, understood and long-time historical practice that an attorney may not be a witness in a proceeding in which he/she appears as counsel, as there would be a blatant and inherent conflict of interest." She then set aside the matter of Fuccione's pre-hearing conduct and allowed no more mention of it.

Late in December 2019, Magistrate Burke issued a summary of her opinions on the multiple back-and-forth motions filed by Fuccione and Langan, including a number that were not included in this narrative. Both Complaint Counsel Attorney Fuccione and Records Access Officer Attorney Dolan were admonished that "filings from an attorney who has not filed an appearance in the case are highly improper" and that "Complaint Counsel will be the attorney of record who will represent the BORIM throughout the hearing process. The respondent's [Langan's] concerns are duly noted but none of these concerns or admonishments render the document from Attorney Dolan pertaining to the service of Board Chair Candace Sloane an 'ex parte' communication."

Burke also explained that the parameters of Langan's appeal were set at the pre-hearing conference on October 4, 2019, and concerned only the August 8, 2019 Statement of Allegations. "Ergo," she stated, "it is beyond the scope of this Administrative Magistrate's authority to re-litigate and re-determine the Respondent's previous appeal. Accordingly, the Respondent is prohibited from introducing exhibits and eliciting testimony

concerning extraneous matters that have no bearing on the ultimate question of whether he practiced medicine on July 24, 2019 after his certificate of registration was suspended."

On December 31, 2019, Burke once again admonished Complaint Counsel Fuccione that "when emailing or scanning any document to the Magistrate, an electronic copy or scan must also be sent to the Respondent at the same time notwithstanding your service via USPS. 'Ex parte' communications have already been a major issue in this case." Acknowledging that ex parte communications may have had undue influence over her decisions in this case, Magistrate Burke subsequently recused herself from the case.

On February 3, 2021, DALA magistrate Burke handed the adjudication of outstanding issues in the case of BORIM v. Langan over to another DALA magistrate, Kristin M. Palace. Palace reviewed the entire case file and came to the following conclusions:

1. Prior rulings: All Prior Rulings made by ALJ Burke remain in effect.
2. Respondent's motion to compel testimony: Respondent's motion to compel Attorney Lisa Fuccione's testimony is denied.
3. Issues for adjudication: The only two issues relevant to this case are whether respondent practiced medicine on July 24, 2019, and whether respondent's license was suspended on the date in question.
4. Witnesses and Exhibitions: Respondent has not filed the February 6, 2013 order suspending his license, the 2014 Order by BORIM as related to Respondent, or relevant email correspondence.
5. Further Proceedings: This hearing will be scheduled for adjudication at a time and place and in a manner that is acceptable to the health professionals and the requirements of the Commonwealth of Massachusetts.

As of 2024, further proceedings have not been scheduled and a final judgment has not been rendered.

On March 17, 2021 Langan submitted a formal complaint to the Board of Bar Overseers (BBO), Massachusetts's law board, about Lisa Fuccione's conduct while the charges that he practiced medicine without a license were being adjudicated. He specifically brought to the Bar's attention her purposely *ex parte* communications with Magistrate Burke and her support of fraud by Harvey and BORIM. He concluded that "Bar Counsel must docket this complaint and bring disciplinary charges against Fuccione soon."

As of 2024, the complaint has not been docketed and disciplinary charges have not been filed.

Chapter 13: Candace Gets her Come-uppance

In another attempt to garner the attention of the public about what they considered the truth of Sloane's tenure as Chair of the Board of Directions, on August 10, 2019, Langan, Padmanabhan, and three of their colleagues filed a complaint in the Suffolk Superior Judicial Court (SJC) of The Commonwealth of Massachusetts against BORIM, Sloane, and incumbent Governor Charles Baker. Sloane and her husband were major financial contributors to the governor's political campaigns which created a potential conflict of interest which, he posited, may have prompted Baker to appoint her to an illegal third term.

Massachusetts State Law Ch. 13 § 10 is crystal clear: "Each member of the board shall serve for a term of three years. No member shall be appointed to more than two consecutive full terms. . . . a former member shall again be eligible for appointment after a lapse of one or more years. The board shall elect from its members a chairman, vice-chairman and secretary who shall serve for one year and until their successors are appointed and qualified."

Sloane, by her own admission, served on the Board of Directors as Chair continuously throughout her nine-year tenure at BORIM. Minutes, transcripts, and other documents demonstrated that she had signed official documents, presided over board hearings, and performed all other duties of Chair between her official terms and after her allowable second full term had lapsed.

Clearly, Sloane could not have performed the duties of Chair if she weren't simultaneously a member of the Board of Directors. Ipso facto, there is no way to describe her eight-year tenure as anything other than "continuous."

Petitioners Langan et al affirmed their standing with the SJC by stating that they "come under the jurisdiction of the state agency and have each been harmed by the illegal conduct of the Governor, Candace Sloane MD, and the state agency." They further averred, "As the illegal conduct is ongoing and would assuredly impact other victims in the future . . . they have standing to restrain future illegal conduct."

The petitioners beseeched the court to terminate Sloane's appointment to a third consecutive term, carefully laying out a sequence of events showing that Governor Baker reappointed Sloane "in egregious, defiant, conscious, willful, violation of state law on behalf of a major donor." They also alleged that the third appointment letter was initially concealed from the public in conscious violation of state public records laws. The petitioners asserted that it was in the public interest that the SJC:

"promote the rule of law and ensure that appointments to positions of great authority that impact due process rights, and the right of physicians to earn a living through their learned profession, are legal. It is in the public interest to ensure that appointments made by the Governor in exchange for campaign donations do not violate explicit state law."

The petitioners beseeched the court to require BORIM, not just to immediately terminate Sloane, but also to vacate as legally void ab initio (from the beginning) all documents pertaining to these five petitioners that Sloane signed after her second consecutive term on the Board expired in May 2017. If the court agreed, the ruling would render null and void all decisions she made after May 2017 and require that any harm caused by those decisions be rectified, specifically, by restoring their active licenses. It would be a major victory for Langan and his colleagues.

It has been more than six years since Langan et al. submitted their petition to the SJC. Sloane stayed on the Board of Directors until 2020. None of the damage she caused physicians and their patients in the Commonwealth of Massachusetts during her tenure on the Board has been rectified, compensated or even acknowledged by BORIM.

On the contrary, throughout most of her tenure as Chair of the Board of Directors at BORIM, Sloane was remarkably impervious to the consequences of her malign actions. This was not a result of great legal counsel or her uncanny ability to justify her decisions in front of an adjudicatory board; it was a flaw in the design of the system within which she operated.

Medical boards were created by state legislatures; the members of their Board of Directors are "volunteers" appointed by state governors who receive a small stipend for their service; the lawyers who work for the boards are civil servants for the state. Thus, licensing boards are quasi-judicial state agencies.

Like elected officials and other civil servants, licensing board members have immunity against suit or criminal charges if their actions occur in the performance of their official actions and within the confines of agency policies. Even if there's overwhelming evidence of malfeasance by a board member, he or she usually cannot be held to account under these circumstances. Likewise, police officers have qualified immunity against harm they might cause when arresting or subduing a suspect. As long as they are acting "in the line of duty" and adhering to department policy, a police officer can literally "get away with murder."

Langan is not the only physician against whom members of BORIM and its Board of Directors have presented falsified evidence in order to bolster their case. In one case against Sloane and a member of BORIM's PHCU [Eddison Ramsaran, M.D., Petitioner, V. Candace Lapidus Sloane, M.D. And Joseph P. Carrozza, Jr., M.D., Respondents], Dr. Ramsaran took his complaint of falsified evidence and conflicts of interest all the way to the Supreme Court of the United States.

Even though there was clear evidence of malfeasance by Sloane and Carrozza, because of the doctrine of absolute quasi-judicial immunity, they weren't given so much as a slap on the wrist. On the other hand, Carrozza walked away without a medical license or compensation for his financial losses.

In July of 2020, Kris Olson of Massachusetts Lawyers Weekly wrote an article entitled, "Decisions show overreach pattern by M.D. [physician] licensing board." In it, he referenced the 2015 ruling by Supreme Judicial Court Justice Robert Cordy that Massachusetts DALA [Division of Administrative Law Appeals] could uphold a summary suspension of a doctor's license "only if it was supported by a preponderance of the evidence."

The judge further elaborated, "While the due process requirement may be lessened in the context of a temporary suspension . . . such a suspension still must be based on the preponderance of the evidence actually considered."

Since that ruling, Olson noted, DALA has vacated multiple summary suspensions by BORIM's Board of Directors including nine of eleven cases reviewed by Lawyers Weekly. One was the case of Dr. Sheldon Randall, whose medical license was summarily suspended after he made two errors in medical judgment which, in the magistrate's considered opinion, "taken together, do not amount to a serious threat to public health, safety or welfare."

Another was Dr. John C. Nadolny, whose license was summarily suspended "because he allowed his nurse practitioners to log into the state's online medical marijuana certification system." Attorney Scott Liebert, who had impassively defended Dr. Langan in 2012 and 2013, became increasingly concerned over the ensuing years that physicians' basic rights were being repeatedly violated by BORIM.

Liebert commented on Olson's article, stating that, "Doctors often lack the resources—both in terms of time and money—to challenge summary suspensions, and instead . . . end up signing agreements not to practice [while] under duress." Liebert added that the state's patients lost out on the services of "countless talented medical professionals" as a result.

Another issue that put pressure on physicians to "settle quickly" was their concern that their license might lapse during the investigation. If that were to happen, the Board could later reject their license renewal

application even if the prior investigation was resolved in the licensee's favor. A rejected initial medical license application or renewal can have far-reaching ramifications. As proposed by Sloane, just like a suspension, a rejection can be considered an adverse action that must be reported to the National Practitioner's Data Bank and thus can impede a physician's ability to get licensed in another state.

In his ruling, Judge Cordy concluded that emergency suspensions are appropriate only when the preponderance of evidence supports the presumption that the physician's continued practice presents an immediate danger to public health and safety, not an alleged impairment that may (or may not) affect his ability to practice "with reasonable skill and safety."

When supporting evidence doesn't reach that threshold (or, as is often the case, when there is no evidence whatsoever), the physician is not the only one to suffer needlessly. In addition to the obvious impact on the physician and his family when the breadwinner is suddenly unable to win bread, there's an impact on the physician's colleagues, who suddenly have additional patient care responsibilities, and on the patients, who have suddenly lost their trusted healthcare provider.

Most medical regulatory boards require that patients be provided with adequate written notice (usually 30 days) before a physician leaves a practice, as well as assistance transferring medical care and medical records to another provider. Under most circumstances, failure to do so is considered "patient abandonment," a clear violation of medical ethics.

A sudden interruption in care, regardless of the cause, can have dire consequences for patients' health and well-being. In one tragic case, a psychiatrist's emergency license suspension played a role in the suicide of an unstable and profoundly depressed patient. Thus, emergency suspensions by boards create the very situation that their medical practice acts consider unethical.

Sloane, who was off the Board by then, reacted strongly to Olson's article. In a Letter to the Editor (LTE) on August 13, 2020, she called it "factually incorrect, unbalanced, and without any patient safety perspective." She further claimed that, before she arrived in 2011, a Boston Globe Spotlight Series had chronicled "gaps and dereliction of the board's members and staff that had resulted in a pattern of grievous patient harm." She also asserted that "hundreds of disciplinary cases before the board were greatly influenced by a small specialty defense bar that utilized its knowledge of the rules and staff to outwit the actions of well-intentioned enforcement professionals."

Sloane proceeded to describe Liebert as "one of the worst of the 'revolving door' of former regulators known for often representing the worst offenders who posed the greatest risks to patients' life and health" then exclaimed, "He is the one without a moral compass!" She boasted that, as a result of her singular efforts in protecting patient safety, in 2020, the Federation of State Medical Boards awarded her the "Clark Leadership Medal" for service to the public's health and safety, an apparent fitting end to her self-described "decades of volunteer service to the Board, nine years as its chair, as elected by my fellow commissioners."

Math must not be Sloane's strong suit. Because Board Chairs can only serve for one year at a time, after which a successor is chosen, I calculated that she would have to serve on the Board for 16 years to legally serve as Chair for a total of nine.

Liebert did not take kindly to Sloane impugning his motives, modus operandi, or moral character. In response to her LTE, he rebutted a number of her contentions and accusations, reminding readers of the nine out of eleven summary suspensions vacated by DALA and the frequent doubts about whether physicians coming before the Board of Directors were afforded due process, including the right to a timely and fair hearing.

Liebert also countered, "There was no Boston Globe Spotlight series critical of the board in the months prior to Dr. Sloane's appointment and there was no article . . . suggesting that incompetence or dereliction by

board members and staff had caused patient harm." Furthermore, he stressed, even the FSMB acknowledged that the ranking of state medical boards by Public Citizen was based solely on the number of physicians disciplined per capita, not on the overall quality of care physicians provided. In fact, he asserted, "Those rankings only served to put pressure on state medical boards to take more disciplinary actions without regard for any correlation between that number and any improvement in patient safety."

Liebert then reflected, "What I find most disturbing is Dr. Sloane's allegation that the incompetence of prior board staff and board members caused 'grievous patient harm' and that defense attorneys for physician clients "used their knowledge of the rules and staff to outwit the actions of the well-intentioned enforcement professionals." He acknowledged that, under most circumstances, lawyers would be pleased to know that they had "outwitted" their adversaries, but, in this context, it served "only as a slap in the face to the very capable and very hard-working board members and staff."

Lawyers Weekly published a final Letter to the Editor on the subject from a cadre of attorneys who took issue with Sloane's accusations, asserting that "Some of our clients have been exonerated, and some have not, but all have the right to due process protections . . . to the principles of fundamental fairness . . . and to a defense that puts the board to its proof." The letter concluded, "Questioning the morals of lawyers for defending the accused should be anathema to any governmental body, and it is therefore incumbent on the present board members to publicly disavow that approach to their adjudicatory responsibilities."

The letter was signed by twenty-five Massachusetts lawyers.

Chapter 14: The Slings and Arrows of Langan's Misfortunes

In 2006, Massachusetts Physicians Health Services properly diagnosed Langan with physical dependence on prescription Vicodin™ and required him to participate in weekly random drug testing for one year. Because these tests weren't properly verified by a Medical Review Officer, which would have prevented disclosure, PHS learned that he was still using Vicodin on occasion. However, without evidence of alcohol consumption, illicit drug use, or any hint of impairment in his ability to practice medicine, in 2007, PHS's new director, Dr. Luis Sanchez, referred him to The Talbott Center for a four-day inpatient substance abuse evaluation.

Talbott Center then coerced him into paying $45,000 for a 90-day inpatient program based on the dictates of Alcohol Anonymous (AA) and the American Society of Addiction Medicine (ASAM). He was told that, if he failed to complete Talbott's "recommended" stay, his non-compliance would be reported to Physicians Health Services (PHS) who would then report it to the Board of Registration in Medicine (BORIM) which would, in turn, almost certainly suspend his medical license.

Without an iota of evidence from laboratory tests, signs of withdrawal, or a history of substance abuse, The Talbott Center inexplicably diagnosed Langan with alcohol use disorder. PHS immediately imposed on him an expensive, arbitrary and stringent five-year letter of agreement (LOA) in violation of the Americans with Disabilities Act[4], evidence-based medicine, and the principles of medical ethics.

PHS also coerced Langan into participating in a faith-based Alcoholics Anonymous program in violation of The Establishment Clause of the First Amendment. Additionally, it ordered Langan to be regularly screened for alcohol using tests that were either contraindicated by SAMHSA in drug treatment programs or not yet approved by the FDA.

In July 2011, in collusion with the Director of Operations of the United States Drug Testing Lab Inc. (USDTL) and PHS's medical review officer, PHS Director Sanchez used a fraudulent phosphatidyl ethanol (PEth) test report as "evidence" that he had been drinking heavily over the previous two months. Sanchez then

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notified BORIM attorney Robert Harvey of the positive test, asserting that it was proof that Langan was non-compliant with his LOA.

After learning of Langan's purported non-compliance, Harvey's associate, lawyer Deb Stoller extended his LOA for another two years and added several new stipulations. The most logistically challenging stipulation was that his now thrice-weekly attendance at support meetings must be confirmed by other attendees in violation of their anonymity. Regardless, Stoller warned Langan that failure to get confirmation would result in immediate license suspension.

In December 2011, after multiple failed attempts, Langan finally secured a copy of the litigation package from USDTL that proved the PEth test attributed to him was fraudulent. But Sanchez (who had received the litigation package two months earlier) and Harvey withheld that crucial information from the Board of Directors and, on December 21, 2011, the Board affirmed the additional stipulations.

Throughout 2012, Langan rigorously followed every stipulation of his LOA, including support meeting requirements, and continued to practice medicine without outside interference. In the interim, he consulted Amy Daniels at the College of American Pathologists and James Flood, an expert in forensic drug testing at MGH, both of whom confirmed that the PEthStat was invalid and informed Sanchez and the Board of their conclusions.

When Sanchez and Harvey received the experts' conclusions and recommendations in December 2012, they claimed that they "disregarded" the spurious PEthStat results and, instead, accused Langan of non-compliance with support meeting requirements. Facing an imminent formal license suspension, Langan signed a Voluntary Agreement not to Practice (VANP).

Attorney Harvey then withheld the evidence of laboratory fraud, as well as the proof of Langan's compliance with support meeting requirements, at a crucial February 2013 Board meeting. The Board refused to withdraw Langan's VANP and instead formally suspended his license in total disregard for his property rights. Harvey then withheld the Board's statement of reasons for the suspension from Langan past the fourteen-day deadline to formally contest it.

In 2015, after two years of rigorously complying with his LOA in spite of losing his primary source of income, Langan petitioned the Board to reinstate his license. The Board refused. In 2016, he appealed to the Suffolk (County) Supreme Judicial Court (SJC) and, in 2017, to the Massachusetts SJC but, both times, his suspension was upheld.

In 2017, Langan petitioned the Massachusetts Division of Administrative Law Appeals (DALA) and the Massachusetts Department of Health for relief, but his petitions were either denied or ignored. After multiple requests to BORIM's attorney, Bryan Bertram, he at last secured the documents that proved he complied with his support meetings. But Attorney Gerard Dolan refused to forward those documents to the Board for its consideration.

Langan then spearheaded an effort to discredit Candace Lapidus Sloane, the Chair of the Board of Directors, who, he asserted, had suspended the licenses of "multiple honest, law-abiding and competent Massachusetts physicians" after false allegations of addiction and impairment. He intentionally provoked a charge of "practicing medicine without a license" in a risky (and perhaps ill-advised) attempt to draw attention to Sloane's misdeeds.

In response to Sloane's charge that he had practiced medicine without a license, Langan again petitioned DALA, this time to get the charges dismissed on the basis that the original license suspension was unlawful. But both Magistrates who adjudicated his case refused to hear his case against Sloane and BORIM's attorneys, and

instead affirmed that, on the day in question, Langan had, without question, practiced medicine without a license.

Over the years, PHS and BORIM, brush stroke by brush stroke, transmuted the image of a skilled and idealistic young physician into the portrait of an incompetent, defiant, and dishonorable doctor who was deemed a danger to his patients. Langan's persistence in proving that the PEth test was fraudulent was portrayed as delusional fanaticism. His blog postings and complaints to his colleagues about his mistreatment were portrayed, not as an exercise of free speech and attempts to blow the whistle on their unethical and illegal actions, but as the fractious rants of a disaffected doctor who needed to be silenced.

Langan's delay in going to Hazelden for a third addiction evaluation was characterized as deliberate defiance by a physician in denial about his alcoholism. Ironically, Hazelden's inability to explain the positive PEthStat morphed into presumptive proof of its validity. His struggle to comply with the increasingly burdensome and unethical requirements of his LOA was portrayed as blatant obstructionism. And the multiple experts who vouched for Langan's sobriety and professional competence were written off as biased enablers.

The Oxford Dictionary defines "defamation" as "a public statement about individuals, products, groups or organizations which is untrue and may cause them harm." It is termed "libel" when written and "slander" when spoken. Surely, such mischaracterizations, which are now public record, qualify as defamation, if not absolute assassination, of the character of an honest, honorable, dependable and highly educated professional.

Langan's story illustrates the immense unchecked power that physician health programs have when working in concert with their respective medical licensing boards, drug testing labs and addiction treatment centers, especially when their practices are sanctioned by their umbrella organizations, the Federation of State Physicians Health Programs (FSPHP) and the Federation of State Medical Boards (FSMB).

Langan's odyssey began when he naively requested help for an abstinence syndrome, as a result of which he lost his savings, his home and his career and almost lost his life. After almost two decades of struggle, Langan's medical license remains suspended. Even if it were miraculously restored today, because of practice re-entry requirements, he would still face a long road to resuming his clinical career.

Langan has shown remarkable resilience and determination in the face of unjustified removal from the profession into which he invested so much time, energy and money and to which he still had much to contribute. When it became apparent that his license suspension wouldn't be stayed any time soon, he supported his family as a professional landscaper. He wasn't demeaned by the change in his financial and social status; instead, he observed cheerfully that he had become quite "buff" as a result.

Most PHPs require that physicians under contract get explicit permission from them or their associated medical board to travel out of state. Back in the 2010's, Langan was thwarted in his efforts to secure funding for his novel delivery device for epinephrine because he was refused permission to leave Massachusetts to negotiate with an investor. But he still holds two potentially valuable patents on this device.

While the DALA case is on appeal, Langan continues to host the Disrupted Physician blog <www.disruptedphysician.blog>which remains an important repository for information about the Medical Regulatory Treatment Complex and an emotional lifeline for licensed professionals who are experiencing existential despair over the torment inflicted by their PHP and ASAM colleagues who view the world through reductionist lenses.

Langan is also an active member of Dr. Manion's organization, the Center for Physicians Rights <www.physicianrights.net> and has engaged in multiple conversations with this author and provided her with hundreds of pages of documentation that support his case against PHS and BORIM.

Determined to put his knowledge, skills, analytic ability, and intelligence to good use, for the past three years, Langan has been serving as the medical information liaison to BioNADrx Holdings, a pharmaceutical start-up that specializes in developing pharmacologic treatment of addicts who are undergoing the often excruciating and sometimes dangerous process of withdrawal from addictive drugs such as opiates, xylazine, and alcohol.

I wish that Langan's experience with his medical licensing board and physician health program were a rare, even singular, event. But it isn't. I realized that when I first stumbled across his blog in 2017 and read the numerous "Letters From Those Abused and Afraid" posted on his website. It's cold comfort knowing you aren't alone when so many of your colleagues are suffering at the hands of programs that claim to be concerned about physicians' health and regulatory agencies that ignore state and federal regulations.

For every courageous person I've talked to or heard about, there may be dozens who have been shamed into silence, despair or even suicide by some aspect of the Medical Regulatory Treatment Complex, a regulatory scheme characterized by coercion, extortion, defamation, collusion and fraud, all in the name of "physician health" and "patient safety." I wish that more of those who've survived their experience would feel free to speak out. Until then, staunch critics of the MRTC, such as those I've mentioned in this narrative, will have to be their voices.

Chapter 15: The Mystery Solved

When I first started writing "The Disrupted Physician," I was perplexed by why Talbott Center discharged Langan with a diagnosis of alcoholism and why PHS took Talbott at its word. Langan's problem was caused by medicinal use of an opiate. His diagnosis should have been "opioid use disorder (OUD)." PHS might have been justified in continuing weekly random drug testing for another year, but, since there was NO evidence of impairment or current substance use, no other intervention was warranted.

Allegations of "impairment in the ability to practice medicine with reasonable skill and safety" have increased substantially over the past 20 years or more; professional impairment due to alleged substance abuse currently accounts for more than 30% of disciplinary actions taken against physicians in the U.S. There are several reasons for the increase. For example, Dr. Paul Earley, who first diagnosed Langan with alcoholism, has recently claimed publicly that " all physicians with mental health disorders also have a substance use disorder unless proven otherwise." And we know how difficult it is to prove the negative.

Some of the increase in diagnosis of substance use disorders (SUDs) in physicians is attributable to changes in the Diagnostic and Statistical Manual of Mental Disorders (the DSM), the psychiatrist's guide to mental health diagnoses. The DSM-IV divided substance use disorders into two categories: substance abuse and substance dependence. An individual could meet the criteria for substance dependence without necessarily meeting the criteria for substance abuse. The DSM-V, which came out in 2013, combines the two diagnoses into a single category. The revised criteria are:

1. Escalating use
2. Repeated failed attempts to discontinue use.
3. Inability to regulate consumption.
4. Inordinate time spent around alcohol consumption or drug use.
5. Cravings for use.
6. Continued use in spite of social, occupational, and recreation problems.
7. Giving up on social, occupational or recreational activities because of use.
8. Risky behavior related to use.
9. Health problems related to use.
10. Tolerance to use.
11. Withdrawal symptoms following discontinuation.

Meeting *only two* criteria in the previous 12 months constitutes a diagnosis of substance use disorder; dependence is automatically considered a criterion. An individual is more than 10% likely to be diagnosed with SUD under DSM-V criteria than under DSM-IV criteria. And because of their concern for potential future impairment and/or relapse, proponents of the PHP / ASAM system posit that any degree or duration of substance abuse requires active intervention of indeterminate (e.g., lifelong) duration.

Furthermore, based on the observations that practicing medicine is inherently stressful and that chronic stress increases the risk of substance use disorders, PHP and ASAM proponents have been able to mandate proactive intervention for individuals who have no history of substance use disorders whatsoever but are perceived to be "at risk" for future abuse. In at least one case I'm aware of, a physician was remanded to

addiction treatment solely because the evaluator felt he could "benefit from learning more about the disease of addiction."

The increase in highly profitable addiction treatment centers and drug testing labs has also contributed to the rise in SUD diagnoses and impairment-related license discipline. These industries profit, not from the prevalence of SUDs per se, but from the prevalence of the detection, diagnosis and treatment of SUDs. The more liberally the condition is defined, the more frequently a SUD will be diagnosed. The more varied and sensitive the drug tests are, the more easily "evidence" of substance abuse can be found. At the same time, the more addiction treatment centers there are, the more pressure exists to fill those beds and the more incentive exists for drug testing labs to ply their services.

When organizations like the American Society of Addiction Medicine (ASAM), the Federation of State Physician Health Programs (FSPHP) and their state PHPs align themselves with these multi-billion dollar industries, the sheer sums of money involved invite conflicts of interest and unethical behavior. But this doesn't explain why Talbott Center diagnosed Langan with alcohol use disorder instead of opioid use disorder and why PHS accepted the diagnosis without question. As I continued my research, I discovered that Langan's case was not exceptional. Many physicians who weren't problem drinkers (or didn't drink at all) were nonetheless being diagnosed with alcoholism.

I'm aware of two cases in which physicians were diagnosed with alcoholism based on an anonymous complaint of alcohol on their breath or intoxication when no contemporaneous test for alcohol in their systems was done and no evidence of alcohol abuse, even after extensive investigation, was uncovered. In a third case, an addiction treatment center recommended "prophylactic" inpatient treatment for a physician ostensibly to prevent his moderate consumption of wine with dinner from becoming alcoholism.

The AA / ASAM model of addiction considers alcoholism to be a chronic, progressive and inevitably fatal brain disorder (!) that leads to impairment in all areas of life. Presumably, death is the ultimate impairment. Physician Health Programs and their proponents postulate that, without early intervention, professional impairment and patient harm are inevitable.

This is a spurious assumption considering that it's not scientifically validated. Most people who drink regularly don't become problem drinkers and most cases of problematic drinking resolve on their own. Take, for example, the individual who drinks to self-treat an underlying anxiety disorder or to cope with situational stress. When the mental health issue is addressed or when the situational stress is alleviated, the problem drinking usually resolves spontaneously. As another example, most college students who drink too much as undergraduates go on to lead sober, productive lives after matriculation.

So what is it about the diagnosis of alcoholism that sets it apart from the diagnosis of other substance use disorders? For one thing, alcohol is a legal drug that doesn't require a prescription. It's also ubiquitous. It's found in various products from hand sanitizers to cold and asthma medications; it's consumed in a variety of socially-acceptable venues; and it's part of many religious rites and cherished celebrations. Also, "Drinking and Driving" is the most common cause of a DUI / DWI charge. Because of its ubiquity compared to other controlled or illicit substances, it's relatively easy to find evidence of excessive alcohol consumption or an innuendo of alcohol intoxication.

Because alcohol consumption is part of the fabric of our society, PHPs have even been known to presumptively apply the faux diagnosis of "occult alcoholism" to individuals who don't meet any of the DSM-V criteria for past or current alcohol abuse. ASAM specialists who use this diagnosis consider "occult alcoholism" particularly problematic because, they postulate, an alcoholic in denial—particularly one who's "enabled" by friends, family and colleagues—won't seek treatment. In fact, "denial" has become a diagnosis of its own in AA

culture. Unfortunately for those so labeled, there's no clear way to distinguish the problem drinker in denial from the presumed "occult" drinker who, understandably, denies he's an alcoholic. A true Catch-22.

It's easier to find forensic evidence of alcohol consumption than forensic evidence of other substances with abuse potential. If the donor has a legitimate prescription for a controlled prescription medication, a competent MRO will report a *chemically* positive test as a forensically *negative* test. But a chemically positive test for alcohol in an abstinence-only treatment program can be reported directly to the client without a determination of the source of the exposure.

Also, despite SAMHSA's proscription against the practice, tests for alcohol exposure are routinely used by PHPs to "confirm" the diagnosis of alcoholism or "prove" non-compliance with treatment protocols even when there are no behavioral correlates of use or abuse. Zero-tolerance policies combined with ultrasensitive testing without reasonable suspicion potentially violate the 4th Amendment's prohibition against unwarranted search and seizure and, I believe, should be prohibited without exception.

These features—the ubiquity of alcohol products and alcohol treatment programs, the social acceptance of alcohol, the availability of ultra-sensitive tests for alcohol exposure, the concept of "occult alcoholism" and the ease of forensically "confirming" alcohol use, abuse and relapse—favor the diagnosis of alcohol use disorder over other substance use disorders. After much research and analysis, I have concluded that Talbott Center diagnosed Langan with alcohol use disorder precisely because that's the singular diagnosis PHS expected and would reward with further referrals.

Chapter 15: A Critical Retrospective

Langan's case cogently illustrates a number of deficiencies in the complex and evolving approach to allegedly impaired healthcare professionals that includes unwarranted surveillance, treatment, and license discipline, along with public dissemination of their personal medical records. It is axiomatic that systemic injustice is more likely to occur when regulatory agencies write their own rules and lack transparency and independent oversight by an informed, neutral, and authoritative third party, especially when large sums of money are involved.

A physician or other healthcare professional can become entangled in a professional health program or licensing board investigation for multiple reasons that are unrelated to their clinical acumen or professional comportment: a trivial complaint about poor customer service; an unsubstantiated accusation of intoxication; an ill-defined allegation of disruptive behavior; a single incident of driving while impaired.

Even a request for accommodation of a recognized disability such as attention deficit-hyperactivity disorder (ADHD) or bipolar illness or a voluntary medical leave of absence can trigger a referral to a PHP. Like Langan, a physician could also naively seek care from a PHP of his own volition, asking for assistance with a substance use problem but finding only career destruction and emotional despair.

I've noticed another disturbing practice involving both PHPs and medical boards: "whistleblower retaliation" against licensed healthcare providers who complain about working conditions, substandard medical care or fraudulent activities. Clearly, some of PHS's and BORIM's adverse actions against Langan were in retaliation for him having publicized their wrongdoings on www.disruptedphysician.blog or complaining to his colleagues about their unjustified actions against him. Sanchez said as much when he castigated Langan for expressing "contempt for these agreed-upon accommodations to other monitors and recruited others to misrepresent the facts to PHS." Dr. Floyd, MGH's forensic drug testing expert, pointed out that the fraudulent PEth test Sanchez devised was most likely in retaliation against Langan for speaking out against PHS.

I've discovered other equally egregious examples of retaliation. A physician with a pre-existing ADA-recognized disability reported fraudulent billing by the company he worked for to the Centers for Medicare and Medicaid Services (CMS). The federal government promised him whistleblower protection in exchange for his testimony but didn't follow through. His company then initiated a specious complaint of "illegible handwriting" to his medical board and altered several patients' electronic medical records to embellish their contention that he was impaired. After several years of struggle, he is only now on the verge of recovering his right to practice medicine.

In another instance, a pharmacist lost her job and ultimately her career after complaining to the management of a large pharmaceutical chain that understaffing and the short turnaround times they demanded for filling prescriptions were endangering patient safety. While the issue was in contention, her computer was hacked and the files she'd saved on her interactions with the company were erased. In spite of her intelligence, expertise and dedication to patient care, because she spoke out, she has never again been able to work in her profession.

Simply checking **YES** on a license application about past treatment for a substance use or mental health disorder or taking a medical leave of absence can trigger a cascade of recrimination that can ultimately cost licensed healthcare professionals their careers. It matters not how well they're currently faring; licensing boards respect no "statute of limitations" on human fallibility or personal exigencies.

By claiming that they don't practice medicine, but merely provide screening, referral, and monitoring services, PHPs and their consultants indemnify themselves against medical liability for the harm their coercive tactics, wrongful diagnoses and unscientific rehabilitation programs cause. However, this distinction is illusory. It is the PHP that does the initial screening and decides that the practitioner must be referred for further evaluation and treatment. It is the PHP that approves treatment protocols, orders and oversees drug testing, and refers participants to their affiliated consultants addiction treatment centers.

The American Society of Addiction Medicine (ASAM) consultants also claim that they aren't practicing medicine, but merely doing evaluations and following PHPs' subsequent orders for treatment. As a consequence, they are seldom held to account for false imprisonment, fraudulent diagnoses or even simple medical malpractice.

Even when a bone fide patient-physician relationship exists, there are barriers to recompense. In one particularly egregious case, a psychiatrist was called to consult on a hospitalized physician who was experiencing a post-surgical delirium. He surreptitiously withdrew a urine specimen from her foley catheter (urine collection) bag, submitted it as a clinical specimen, and then reported the results to her medical board. Her test was positive only for the controlled substances her surgeon administered in the hospital, but, incomprehensibly, the board immediately suspended her license and ordered an extensive evaluation at an out-of-state addiction treatment center.

Ultimately, even though the evaluation uncovered no evidence of impairment and her license was restored, the beleaguered physician lost her job, her reputation and her financial security as a result of the psychiatrist's violation of medical ethics. Because she had an indisputable physician-patient relationship with the psychiatrist, she had the right to sue him for damages. But her complaint didn't get past her state's malpractice review board. Her only alternative—to submit a complaint about him to her medical board—would have been an exercise in futility. Again, I digress. But it's important to understand the lengths some boards will go to in their zeal to enhance their reputation as being hard on "bad" doctors.

More insidiously, PHPs and their ASAM counterparts are practicing medicine when they interrupt the licensee's vital mental health care during the coerced 90-day inpatient addiction treatment. PHPs may also countermand the licensee's legitimate prescriptions for insomnia, ADHD, anxiety, bipolar illness and, yes, even asthma. Ergo, for all intents and purposes, PHPs and their consultants ARE practicing medicine and their clients ARE their patients.

As such, the medical care of licensed health professionals should conform to the same rigorous standards of medical ethics that apply to any other patient. These are:

1. Autonomy: Patients have the right to participate in their own healthcare decisions, including choosing their own healthcare providers and refusing treatment that they deem inappropriate, harmful or superfluous.
2. Beneficence. Patients have the right to healthcare that serves their own best interests rather than those of an outside entity. Exceptions should only be granted by judges or courts of law.
3. Justice. Patients have a right to healthcare that is shaped by their individual needs and beliefs, not by their social or financial status, occupation or other external circumstances.
4. Nonmaleficence. Patients have a right to healthcare that doesn't cause unnecessary suffering, harm or expense or deprive them of personal liberty without due process.

If I may be so bold, I would like to add one other basic principle of medical ethics: confidentiality. The relationship between a physician and patient is sacrosanct. Absent specific permission by the patient, the information contained in the medical record should be shared only as required by law and only to the extent necessary to accomplish a legitimate goal, such as payment for services, continuity of medical care, public health and safety, and public record of licensure status. A medical board need only list the proximate reason for license discipline (e.g., "impairment" or "criminal conviction") and should be prohibited from publishing intimate medical details on its website.

The Health Insurance Portability and Accountability Act (HIPAA) was enacted in 1996 to ensure confidentiality of the medical record. Originally designed to protect electronic medical records while in transit, facilitate billing and coding, and guarantee patients' access to their own records, HIPAA is now synonymous with patient privacy even though the word "privacy" is not in its title. HIPAA regulations and other privacy laws protect, not just the medical record per se, but also the sanctity of the physician-patient relationship. Violations of privacy erode the trust between patients and their provider, especially where psychiatric records are involved.

Physicians and other licensed healthcare professionals as patients should have all these rights. But they don't. Once they present to a PHP, they're under control of the PHP. Their professional license and personal medical records become the cudgels that coerce their full cooperation. The PHP will share their complete medical records with its consultants without express permission and, if the licensee isn't cooperative, it will also share them with their affiliated medical board. Not only is this a clear violation of confidentiality, it sets up the opportunity for biased evaluations (rigged diagnoses) and counterproductive treatment protocols that violate other principles of medical ethics.

The addiction treatment center's ASAM medical director is supposedly an "expert" in addictionology but, in many cases, he or she doesn't distinguish mental illness from substance abuse or mild substance abuse from serious addiction. Instead, the director will almost invariably conclude that the practitioner requires intensive and prolonged inpatient rehabilitation. Coercing carceral (inpatient or institutional) care on an individual when a less restrictive environment such as intensive outpatient therapy is just as effective is also a violation of medical ethics.

Once these allegedly impaired practitioners are discharged from inpatient care, PHPs will then impose an onerous five-year rehabilitation contract on them, one that bears little resemblance to evidence-based medicine and, not only fails to take their medical needs and best interests into account, but often causes unnecessary suffering. In any other healthcare context, this would be considered medical malfeasance and malpractice. The drug testing industry facilitates the PHP's unethical conduct by offering a panoply of oversensitive laboratory-developed drug tests that they can use as evidence of ongoing substance abuse and/or relapse.

Even though temporary or minor relapses can be expected in the course of treatment for addiction, PHPs may *punish* participants for relapses by extending the duration of the contract, adding new stipulations or referring them to their respective licensing board for disciplinary action. As previously mentioned, PHPs may even intervene if they observe "pre-relapse behavior" such as a missed random drug test or AA meeting. Such punitive actions are counter-therapeutic, if not overtly abusive. Again, a violation of medical ethics.

As described in the chapter "Ante Up," physicians participating in professional health programs may be forced to pay up to $250,000 over their five-year contract period in order to keep or restore their medical licenses. The inability to pay can result in referral to the medical board and subsequent license suspension. The Oxford Dictionary defines extortion as "the practice of obtaining something, especially money, through force or threats." This is not simply a violation of medical ethics; this is criminal activity.

To compound the potential for mistreatment and injustice, PHP directors not only have complete autonomy over the terms of the contract, but also which infractions warrant a report to their respective licensing boards. The licensing board attorneys who review PHP compliance issues, in turn, have total discretion over what evidence they provide to—and what evidence they withhold from—their Board of Directors.

The Board of Directors, in turn, has unquestioned authority over what discipline to impose. Unquestioned authority and complete discretion and autonomy create multiple opportunities for abuse of power in any organization. PHPs, addiction treatment centers and medical licensing boards are no exception.

The Federation of State Physicians Health Programs (FSPHP) facilitates the violation of patient rights under the ADA by exhorting PHPs to adhere to standardized protocols and discouraging individualized care. Medical boards, in turn, have the sole and undisputed authority to revoke the license of a "non-compliant" practitioner and can publish detailed information about his medical condition that would otherwise be protected by both HIPAA and state medical privacy laws.

Cooperating with one another, these organizations, institutions and agencies have created a complex, unregulated and coercive conglomerate that some critics refer to as the "Medical Regulatory Therapeutic and Rehabilitation Complex" (MRTRC), satirically referred to as "Mr. Trick."

Every major player in this system of "punishment disguised as treatment" benefits at the expense of competent physicians, their patients, and, ironically, the public at large. The ASAM specialists have well-remunerated positions as directors of addiction treatment centers that often both evaluate *and* treat allegedly impaired physicians. The treatment facilities profit financially from the large infusions of cash by PHP-mandated participants.

The medical directors, lawyers and other officers at PHPs have lucrative, long term careers provided by a steady stream of physicians accused of impairment. The FSPHP, a trade group that wields strong influence over PHP policies, receives significant funding from grants, donations and state and federal lobbying efforts. As a tax-exempt organization, they are indirectly funded by ordinary taxpayers. State medical boards enjoy enhanced reputations when they increase their disciplinary rates. The entire system is rife with financial and professional conflicts of interest.

I will go out on a limb here and posit that organizations and agencies in the MRTC are actively engaging in a loose conspiracy to produce false evidence and rigged diagnoses, extract money using threats of harm, engage in medical kidnapping and false imprisonment, commit defamation, ignore federal laws and trample on the civil rights of health professionals. Unethical and illegal conspiratorial activities such as these violate the federal Racketeer Influenced and Corrupt Organizations (RICO) statute.

The statute of limitations for filing criminal charges or bringing suit for RICO violations is four years. Usually the clock doesn't start ticking until the victim realizes he's been harmed. In the case of medical licensees, the harm is usually obvious and immediate. However, it could be argued that the time should be tolled until the licensee realizes that he or she wasn't merely the subject of a legitimate rehabilitative or disciplinary process, but, instead, was a victim of racketeering. It remains to be seen whether participants in the MRTC conspiracy have absolute quasi-judicial immunity from RICO statute violations.

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An individual should be considered qualified to practice his profession if he meets the essential eligibility requirements for licensure: education, training and the ability to practice with reasonable skill and safety. He should not have to be in perfect physical or mental health or provide material proof of his good character. Furthermore, according to the Americans with Disabilities Act, public entities, including licensing boards, may not discriminate against an otherwise qualified individual unless his conduct poses a direct threat to others.

An assessment of "direct threat" must be based on valid evidence of professional misconduct, maliciousness or incompetence such as multiple and/or serious malpractice judgments, eye-witness accounts of misconduct or workplace intoxication, conviction for a felony or sex offense, or repeated and/or serious complaints to the medical board or other authority. The rules of evidence that apply in a courtroom should also apply in a regulatory board hearing or investigation.

Over the last two decades or so, medical licensing boards have displayed a disturbing trend towards disciplining health professionals for specific mental health diagnoses and related stereotypes about how these conditions might affect their competence rather than for demonstrable evidence of incompetence or unprofessional behavior. For example, discrimination against alleged alcoholics persists long *after* they have achieved a reasonable period of sobriety, a clear violation of the ADA.

Medical licensing boards, professional health programs and their respective umbrella organizations, FSMB and FSPHP, as well as the American Society of Addiction Mendicine (ASAM), seem oblivious to these legal requirements. In clear violation of civil, state and federal laws, these organizations repeatedly follow, encourage and/or enforce legally impermissible procedures to investigate and discipline physicians who *allegedly* suffer from *potentially* disabling disorders.

Although medical licensing boards typically justify their actions as necessary to safeguard the public's health and safety, the underlying reason they often summarily suspend the licenses of allegedly "impaired physicians" is to avoid potential legal liability and bad publicity.

As the current clinical director of the Ohio Professional Health Program (Ohio PHP), explained to me in 2016, "The board would rather suspend the licenses of ten competent physicians than risk a headline in the Columbus [Ohio] Dispatch of one physician who caused harm to a patient." Actions like these violate the fundamental legal principles of presumed innocence, equal application of the law, and respect for the rules of evidence.

Unfortunately, for every primary care physician whose license is suspended based on a false allegation of impairment and associated incompetence, more than 2,000 patients may lose their doctor unnecessarily. Some specialists have 7000 patients on their panels; even the temporary loss of one unjustly sidelined physician can have a major impact on the health of a community. A dearth of practicing physicians *does not* translate into enhanced patient safety.

There's no meaningful avenue for physicians to challenge these career-altering or career-ending decisions before considerable damage has been done. As previously described, even temporary emergency suspensions can trigger a cascade of lifetime career losses. The hearings are adversarial rather than mediational; they occur *after* licenses are suspended; the power is tilted heavily towards the Board; its conclusions are often foregone. In some states, the attorney general is the hearing's judge and the assistant attorney general represents the board which creates a serious imbalance of power whereas the physician is often representing himself.

Challenging PHP and licensing board decisions after the fact requires lawyers and medical experts, an indefinite time horizon, and money that a physician whose earning capacity is threatened or truncated cannot afford. Overcoming the hurdle of absolute quasi-judicial immunity enjoyed by PHP and medical board members is a daunting task that few have accomplished. To add insult to injury, non-disclosure agreements (NDAs) may prevent physicians who've succeeded against these odds from sharing their tactics and strategies with their colleagues.

Licensing boards are a necessary part of the regulation of many professionals—lawyers, professional engineers, healthcare providers, certified public accountants, and the like—to ensure professionalism and competence. Boards have the legal right to set standards for practice qualifications, conduct, and continuing

education. However, their power over professional licenses should not be used as a cudgel by professional health programs to coerce licensees into specific medical treatment protocols. Furthermore, I question whether the threat of license discipline is *ever* an appropriate response to an individual who suffers from a *medical* condition.

In contradistinction to the exhortation in medicine, "Primum Non Nocera" (first of all, do no harm), these so-called health programs have caused serious emotional harm to previously psychiatrically healthy individuals. Those who have a history of psychological trauma or a pre-existing mental health disorder fare even worse. Particularly during carceral treatment, mental health is given short shrift and may deteriorate dramatically. The significant number of suicides that occur among physicians and other health professionals during contracts with their PHPs is a stark testament to the inadequacy, even danger, of coerced treatment.

Healthcare professionals are fully capable of obtaining appropriate medical care through the networks of resources in their own communities. Most have good health insurance and adequate access to healthcare services. What deters licensed health professionals from availing themselves of community resources is not the lack of access to appropriate healthcare, but rather, the fear of exposure to their employers, colleagues and peer review committees or, worse, to a medical regulatory system that has unchecked power to enforce its brand of "rehabilitation" on them, publicly disclose their personal medical information, and punish them for having a disability.

Discrimination against individuals with a legitimate medical diagnosis that doesn't affect their work performance or can be easily accommodated is a flagrant violation of the Americans with Disabilities Act. Singling out a group of individuals for "special" treatment simply because of their chosen profession is also a violation of the 14th Amendment's equal protection clause. The role (if any) of professional health programs should be limited to *monitoring* the conduct and performance of professionals with an identified disability and *assuring* that their disability is reasonably accommodated by the organizations and institutions with which they are affiliated.

Not only is there no evidence-based need for specialized professional's health programs or de facto networks of "preferred" treatment providers to address physical and mental disorders among licensed healthcare professionals, there's NO justification for coerced treatment of ANY condition of ANY individual by a system that respects neither medical ethics nor civil rights and isn't held accountable for its malfeasance and malpractice. Coerced treatment is a violation, not just of medical ethics, but of basic human rights.

Chapter 16: Mission Creep

Physician Health Programs began as informal groups of physicians—many of whom were recovering alcoholics or addicts—who volunteered their time to provide confidential support and advocacy to physicians struggling with similar issues. They also provided unobtrusive monitoring of their colleagues' clinical competence during their recovery through chart reviews and check-ins, and encouraged them to take advantage of therapeutic resources in their own communities.

However, over the past two to three decades, substance abuse specialists and paid PHP directors and staff have replaced volunteers. Standardized legal contracts *recommended* by the FSPHP— rather than individualized programs *required* by the ADA—have replaced trust, flexibility and collegiality. Specialized addiction treatment centers and "preferred" treatment providers have supplanted community resources for treatment and support.

Lucrative and sensitive drug tests have replaced common sense guidelines about the potential effects of alcohol and prescription drugs on professional performance. As PHPs became legitimized and sanctified by medical boards and the FSPHP, they developed the prolonged, expensive and invasive contracts referred to variously as Letters of Agreement, Consent Decrees and Consent Orders. This is not the language of healthcare; this is the language of law.

Referral to a PHP has become commonplace for any health professional identified as disruptive, underperforming or psychologically distressed by their employer, residency program director, peer review committee, colleague or fellow citizen. PHPs routinely fail to distinguish between an illness (which is a medical disorder) and impairment (which is a functional capacity classification). Their subsequent willingness to report even minor infractions of their "recommendations" to their respective medical boards belies any notion that they are "confidential safe harbors."

In the 1980s, the federal government started identifying certain federal employees—including airline pilots, commercial truck drivers, air traffic controllers, nuclear plant employees and law enforcement officials— as occupying "safety-sensitive" occupations. These are defined as positions in which incompetence or misconduct would pose an immediate and proximate threat to public safety if not urgently addressed. Concurrently, positing that substance abuse magnifies the risk, the government instituted routine drug testing of workers in these positions. Private industries, state agencies and non-governmental organizations soon followed suit.

PHPs and their proponents claim that physicians also occupy "safety-sensitive" positions and that a "fail-first" policy of intervention—where there must first be direct evidence of misconduct or incompetence—poses a substantial and immediate risk to public safety. Based on this unfounded assumption, they justify preemptive screening and intervention of physicians whom they deem at risk for potential impairment in their ability to practice medicine with reasonable skill and safety based on a prediction rather than actual evidence.

PHPs' approach is similar to the law enforcement paradigm portrayed in the film "Minority Report" in which an individual deemed at risk of offending is incarcerated before actually committing a crime. "Minority Report, of course, is science fiction. But PHPs' practice of preemptive intervention is a documented fact. Not only is this approach non-intuitive and counterproductive, it's a violation of medical ethics and federal law.

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PHPs are no longer focusing their efforts solely on substance abuse disorders. As Robert Emmons, Kernan Manion and Louse B. Andrew state in their article, "Systemic Misuse and Abuse of Psychiatry in the Medical Regulatory Treatment Complex,"

> "[PHPs] systematically expanded their scope of practice to claim expertise in non-chemical issues including: non-substance addictions; other mental health conditions; cognitive impairment in aging physicians; and conditions which do not appear in the DSM, including workplace conflicts in which the label "disruptive physician" is used (sometimes as a discrediting tactic); and toxic workplace environments that manifest as individual physician burnout."

Additionally, PHPs are expanding their reach into treatment of other healthcare professionals and other medical conditions. For example, the FSPHP announced in its brochure for its 2024 Annual Conference and Business meeting, "Now, more than ever before, our Professional Health Program (PHP) members serve other health professionals in addition to physicians. We will be discussing how PHPs can expand their reach to target populations, broaden their program's resources and services, and address quality/performance to improve effectiveness."

Perhaps even more concerning, the FSPHP, with the support of the American Medical Association, is currently promoting legislation to do just that. Entitled "The AMA Model Bill: Physician Health Programs Act," this legislation would

> "enhance the protection of the public by providing for a successful means of confidential and professional support of physicians *and other health care professionals* who have a potentially impairing substance use disorder, mental health condition, *or other medical disease* that may adversely affect the physician's or other health care professional's ability to safely and effectively treat patients." [Italics mine.]

This proposed bill uses terms such as "a confidential process," "voluntary participation" and "non-disclosure" while, at the same time, it includes an explicit provision "to refer non-compliant physicians and other healthcare professionals to the Board." If passed, this legislation would essentially guarantee that more healthcare professionals with suspected impairment are funneled into coercive and inappropriate, but lucrative), PHP consent decrees and carceral addiction treatment programs

The FSPHP's efforts to expand its members' mission appear to be working. The Commission on Lawyer Assistance Programs (CoLAP), The American Bar Association's equivalent of PHPs, is considering expanding its activities to include routine cognitive evaluation of aging attorneys. Nursing board actions against allegedly impaired nurses more than doubled from 2001 to 2011.

One of the most recent and rapid expansions in physician health program authority that I'm aware of is occurring at the State Medical Board of Ohio (SMBO). The SMBO already has the second highest disciplinary rate in the country, behind only Michigan's Board of Medicine. Through state legislation, in October 2023, SMBO's associated physician health program was expanded to include all Ohio-licensed health professionals. Reflecting that expansion, the Ohio PHP changed its name from the Ohio Physician Health Program to the Ohio Professional Health Program while misleadingly keeping the same acronym.

Using OSMB's claim that they are in "safety-sensitive" occupations, all licensed healthcare practitioners—nurses, respiratory therapists, dieticians, genetic counselors, massage therapists and

acupuncturists—either are now, or may become, under the watchful eye of the Ohio PHP. Even medical students, who don't have licenses yet and are closely supervised, are included in the category of safety-sensitive workers and can be coerced into participating in its new "Confidential Monitoring Program (CMP)."

The Ohio PHP's domain has also expanded beyond substance use and mental health disorders. The SMBO now requires that applicants and registrants be in compliance with the Ohio PHP for treatment of *any* potentially impairing medical condition— for example, Type II diabetes and coronary artery disease—that could conceivably affect their clinical performance.

Providing false information and omitting relevant information on a medical license application is a serious offense that could preclude licensing. But the way the SMBO asks its health-related questions, applicants or licensees who are currently in treatment can confirm they are "in compliance" only by first divulging their protected health information to the Ohio PHP, thus risking getting drawn into its Confidential Monitoring Program.

The Ohio PHP has also established a "Treatment Provider Network" (TPN) through whom all assessment, treatment and readiness to return to work evaluations are provided, which, if mandatory, will limit the right of licensees to choose independent healthcare providers such as occupational health specialists. The Ohio PHP also "offers" well-being screenings both online and in person. If this "offer" becomes an "obligation" or the information gets disseminated, it will be a frank violation of ADA's prohibition against intrusive and unwarranted medical evaluations. Particularly concerning is that, in spite of the expansion of its authority, neither the SMBO nor the Ohio PHP has created an avenue for disputing an approved provider's recommendations.

I'm always cautious about using the "slippery slope" argument, but in this case, it is *not* fallacious. Using the precedent that Ohio has set and the model bill that FSPHP is proposing, PHPs throughout the U.S. and its territories could justify mandating that obese doctors and smokers routinely participate in their program. They could declare that healthcare be a "drug-and alcohol-free" profession and require random drug testing of all their licensees or they could mandate that every clinician over age 70 undergo a 72-hour cognitive evaluation. They could even force pregnant people into special surveillance programs and require formal postpartum return-to-duty evaluations.

Through state legislation, PHPs and their ilk could become the ultimate arbiter of appropriate medical care for virtually any medical condition affecting any licensed healthcare professional in any state. The potential ramifications of this precedent are limited only by the imagination. "Professional health programs" could be established (if they haven't been already) in the legal profession, the educational field, the airline industry, and any other profession that requires a license. This is a frightening prospect for anyone who believes in civil rights, the rule of law and evidence-based medicine.

Corporate-style medicine, malpractice litigation, burdensome electronic medical records, and, ironically, fears about medical board investigations, contribute to stress, burnout, compassion fatigue, moral injury and suicide among health professionals. High levels of responsibility and low levels of control over a long period of time almost guarantee such problems will occur. If we are to have healthy patients cared for by healthy practitioners, fundamental change in that equation needs to occur: primarily, a healthcare system that prioritizes health professionals and their patient over profits and power. But change is slow. Meanwhile, our health professionals need compassion, not coercion; respect, not restraints. Most of all they need the same science-based, ethical medical care that all of us have the right to expect.

Epilogue

I wrote "The Disrupted Physician" partly as an homage to Dr. Langan and partly as a warning to my colleagues about the existence of the Medical Regulatory Treatment Complex, the cadre of agencies and organizations that, in the guise of treatment and discipline, robs vulnerable healthcare professionals of their money, their careers and their sense of self-worth.

Knowledge is power. Knowing that the MRTC exists is the first step in protecting ourselves from it. Otherwise, who would believe that a professional *health* program could purposefully (and legally) harm us in the pursuit of money, prestige and power? Who would believe that our colleagues could turn against us with such malign intent? Who would believe that we would need a lawyer to defend us in matters of personal health?

Most of us choose healthcare as a career because we want to put our talents, knowledge and skills towards the greater good of others. We assume our colleagues are honest, altruistic and trustworthy because we ourselves are honest, altruistic and trustworthy. Most are; sadly, not all.

As a profession, we are well-informed about medical malpractice and how to defend against it. In a malpractice claim, legal representation is provided to us, the rules of evidence are respected, and our civil rights are honored. In medical licensing board investigations or professional health programs, we have none of these protections.

As the saying goes, "Chance favors the prepared mind." Here is some practical advice regarding professional health program evaluations and medical board investigations.

1. Never present to a PHP of your own accord. If you need help, seek out a colleague who will respect your privacy or a local AA/NA chapter that protects your anonymity. On the other hand, don't refer or recommend referral of a colleague to a PHP for an impairment issue. Encourage them to seek out care on their own. If you've witnessed potentially dangerous behavior firsthand, document it and send your concern up the chain of command. Only as a last resort should you report it to your board.

2. Don't self-treat or self-prescribe. A prescription from your treating physician is your best (and possibly only) defense against an unwarranted accusation of prescription medication abuse or self-prescribing, both of which are violations of most state medical practice acts.

3. Understand that licensing board investigations are adversarial. Get a lawyer before you speak to a licensing board staff member. Find out if your malpractice insurer covers any of the costs of defending against a medical board allegation. Consider the upfront costs of an attorney's services an investment in your future, just like the cost of medical school.

4. Don't volunteer information. While you won't get a Miranda warning, anything you say may be held against you. Keep your answers succinct. Provide as little information as possible. "I don't know," "I don't recall," "I need to consult my advisor before providing any more information" and "I don't understand why you're asking this question" are all acceptable answers.

5. Memorialize everything. Keep all correspondence from your PHP or medical board and make copies of all correspondence to them. Backup your documents to an external drive. Take contemporaneous notes with dates, times, with whom you spoke and whoever else was present. Record all

conversations with your PHP, medical board members, and referred consultants even if you're in a two-party consent state. Think carefully about the consequences before notifying your board of a medical leave of absence or treatment for a mental health or substance abuse issue. If you believe that your fundamental rights will be violated, you aren't wrong to consider civil disobedience.

6. Don't sign away your right to medical privacy. Don't provide the names and contact information of your healthcare providers or sign a release of medical records unless absolutely necessary and until you've spoken with a legal representative or an experienced advisor. Your personal medical records (particularly psychotherapy notes) are a font of information that PHPs and medical boards can use against you in an investigation into your fitness to practice.

7. Get advice and support from others. Don't try to do this on your own. There are a number of individuals and organizations that are knowledgeable about medical board investigations and PHP evaluations who can help you navigate the process. See the References section for contact URLs. While the American Medical Association supports the FSPHP's model legislation, some state medical societies offer counseling and peer support that is unaffiliated with a PHP, medical board or state health department.

8. Slow walk the process. While you need to appear cooperative, you must take time to make the right decisions. Never agree to an informal meeting with a board investigator especially if they want to meet you as soon as possible. Your PHP or board will present a false sense of urgency. It's a trap.

9. Be proactive. Get expanded forensic drug testing and an evaluation from a competent and independent healthcare advisor or occupational health physician before you're interviewed by your board or evaluated by a PHP. Again, consider the cost an investment in your career.

10. Project strength and self-control. Show yourself to be a force to be reckoned with even if you're shaking in your shoes. You've done it during patient emergencies. You can do it now. Remember, wolves prey on the weak. Don't be prey.

11. Insist that any specimen you submit for drug testing conforms to forensic standards. Be well-hydrated prior to testing. Make sure that your urine collection is witnessed. Sign and date the chain-of-custody form. Don't volunteer the names of medications you're taking. You're not obliged to provide this information. Even if you're taking a controlled substance, your test could be chemically or forensically negative.

12. Avoid drinking alcohol or taking controlled substances prior to or during your evaluation or investigation. Wash your hands with soap and water, not hand sanitizer. Avoid liquid OTC medications and mouthwash. Assume that anything detected on a drug test can and will be held against you even if you have a valid prescription or are certain it's an environmental exposure.

13. If you believe in the power of prayer, pray. Faith and prayer can help protect you from hopelessness, despair and a sense of isolation. So can faith in humanity.

14. Believe in yourself. This is the most important advice I can give. Your PHP, employer or licensing board will try to strip you of your dignity and sense of self-worth. You are not the sum of your weaknesses and shortcomings. You are a worthwhile human being and consummate healer who deserves to be treated with respect, confidentiality, and evidence-based medical care. Don't succumb to vicarious shame.

Michael Langan's belief in himself as a competent and caring professional and a decent human being helped give him the determination and courage to endure. Believing in yourself, the person you know you are, and the person your family, friends, patients and colleagues know you to be—will help you survive your own Kafkaesque nightmare should it ever come to that. Thank you for reading The Disrupted Physician. Please endure. And please share!

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Glossary of Terms and Acronyms

Ab initio: A legal term meaning "from the outset" or "from the beginning." *Ab initio* implies, but doesn't require, that a legal record be expunged, consequences be rectified or damages be compensated.
Abstinence syndrome: Flu-like symptoms such as headache, body aches, and chills that can occur after discontinuing use of an opiate or other potentially addictive drug.
Absolute Quasi-Judicial Immunity: Immunity of public officials from liability as long as they are acting in good faith within the scope of their official duties.
Administrative Law Judge (ALJ): A judge who presides at hearings where documents and sworn testimony or affidavits are submitted as evidence.
Affidavit: A written statement confirmed by oath or affirmation to be used in legal proceedings.
Alcoholics Anonymous (AA). A private, non-profit organization that helps alcoholics attain and maintain sobriety through fellowship, emotional support, peer counseling and beseeching a "higher power" for strength.
American Board of Medical Specialties (ABMS): The organization that certifies physicians' competency in their medical or surgical subspecialties.
Americans with Disabilities Act (ADA): According to Wikipedia, the ADA is "a civil rights law that prohibits discrimination based on disability. It affords similar protections against discrimination to Americans with disabilities to the Civil Rights Act of 1964. In addition, the ADA also requires covered employers to provide reasonable accommodations to employees with disabilities."
American Society of Addiction Medicine (ASAM): an organization of self-styled non-residency trained addictionologists that has only recently been recognized by the American Board of Medical Specialties.
Association of State and Provincial Psychology Boards (ASPPB): The national specialty board that certifies the qualifications of clinical psychologists and allied professionals.
Biomarker: In the context of drug testing, a biomarker such as PEth is a proxy or substitute for exposure to a specific chemical rather than a direct measure of a chemical or its metabolites. For example, elevated liver enzymes may be considered a "proxy" for alcoholism since alcoholics often have liver disease. However, biomarkers must be interpreted contextually since they can represent multiple medical conditions.
Brady Violation: Failure of a prosecutor to provide evidence to a defendant or his attorney that might be helpful to the defendant's case but is improperly withheld.
Board of Bar Overseers (BBO): The Massachusetts attorney licensing and oversight organization.
Board of Registration in Medicine (BORIM): Massachusetts' medical licensing board.
Breathalyzers™ (BATS): Breath alcohol tests that are used to confirm contemporaneous alcohol use. Breathalyzer tests are waived from forensic requirements.
Carceral: Of or about programs that include incarceration of an individual or the taking of an individual's personal freedom. Coerced extralegal incarceration is referred to as "false imprisonment."
Certiorari: The review by a higher court of a lower court's decision-making process. Certiorari does not include findings of fact.
Center for Medicare and Medicaid Services (CMS). The overseer of federal insurance programs for the elderly, disabled and poor.
The Center for Physician Rights (CPR): www.physicianrights.net A non-profit organization founded by Dr. Kernan Manion. CPR is dedicated to helping physicians who may have been wrongfully subjected to an unfair medical board disciplinary process, physician health program (PHP) fitness-for-duty evaluation and treatment or "peer review" process, and have been deprived of due process or other legal rights.

Certificate of Added Qualifications (CAQ): An extra qualification within a medical specialty or subspecialty for which a physician is already certified. For example, orthopedic surgeons often have a CAQ in sports medicine.

Chain of Custody (COC): The process by which the collection, movement, processing and reporting of evidence is protected from contamination, improper handling or tampering as it moves through a system of collection, transport, analysis and reporting.

Chain-of-Custody Form (COC) or **(CCF):** A document that records the process described above.

College of American Pathologists (CAP): A national organization of board-certified pathologists that sets standards of practice in laboratory medicine. However, CAP has no power of enforcement over laboratories that might violate its standards.

Confirmatory bias: A phenomenon in which the evaluator, motivated by the desire to bolster a favored hypothesis, unconsciously engages in selective reporting or skewed interpretations of data thereby producing a distorted picture.

Constitutional Property Rights: These rights refer to the Fifth Amendment's provision that "no person shall be deprived of life, liberty or property without due process of Law." In this context, a medical license is generally considered "property".

Criminal Offender Record Information (CORI): A repository of criminal convictions that the Massachusetts BORIM uses to vet license applicants.

Cut-off values or levels: The concentration of a drug in the system that is chemically detectable but below the level to be considered positive for legal (forensic) purposes.

Defamation: A public statement about individuals, products, groups or organizations which is untrue and may cause them harm. It is termed "libel" when written and "slander" when spoken.

The Diagnostic and Statistical Manual of Mental Disorders (DSM): A catalog of criteria for over 500 psychiatric diagnoses put out by the American Psychiatric Association. It's widely used by mental health professionals to both assist with diagnosis and submit to health insurance companies for reimbursement. However, there's controversy regarding both its validity and reliability.

Dr. Lorna Breen Heroes' Foundation: An organization founded by the survivors of Dr. Breen, an emergency physician who took her own life after suffering from Covid and the overwhelming stress of caring for Covid patients. The Foundation's first precept is that seeking mental health care is a sign of strength, not weakness, and shouldn't be stigmatized. Worrisomely, the FSPHP is attempting to align itself with the Breen foundation which would be a major setback for physician health and wellbeing.

Doctors of Courage: An organization founded by Dr. Linda Cheek M.D. www.doctorsofcourage.org that supports and defends physicians who have been unjustly accused and/ or convicted of (and sometimes imprisoned for) drug diversion and other drug-related crimes.

Due Process Rights: The 14th Amendment's guarantee that the government can't take a person's right to "life, liberty or property without due process of Law."

Dried Blood Spot (DBS): a blood collection method in which a small sample of blood is collected on a special matrix embedded in a card for detection of certain drugs of abuse (specifically PEth).

Employee Assistance Programs (EAPs): Free confidential workplace programs that help employees cope with a stressful, non-work related illness or injury that might affect their job performance. Work-related stress, illness or injury are dealt with through the Bureau of Worker's Compensation (BWC).

Ethyl Glucuronide (EtG) and Ethyl Sulfate (EtS): Two extremely sensitive drug tests for alcohol consumed within the past 72 hours.

Ex parte: Communication to or from one side only in civil or criminal court or to an outside party; withholding of information from the opposing side.
Fail-first Policy: The administrative and legal doctrine that there must be evidence of incompetence, impairment, breach of duty or misconduct before formal censure or discipline of an individual is permitted.
Fatal flaws (in forensic testing): Uncorrectable errors in the collection, transfer, chain-of-custody, processing or reporting of a laboratory specimen that require a drug test to be canceled.
Federal Drug Enforcement Agency (DEA): The federal agency responsible for upholding U.S. controlled substance regulations.
Federation of State Medical Boards (FSMB) www.fsmb.org: A 501(c)(6) trade association of which almost all medical boards in the U.S. and its territories are members that oversees state licensing board policy. The FSMB's website states that it "serves as a national voice for state medical boards, supporting them through education, assessment, data, research and advocacy while providing services and initiatives that promote patient safety, quality health care, and regulatory best practices." The FSMB has no statutory authority over medical licensing boards.
Federation of State Physician Health Programs (FSPHP) www.fsphp.org: A 501(c)(6) trade association which acts as an umbrella organization of state physician health programs and services. According to its website, the FSPHP provides its members with "exclusive **networking, resources, collaboration** opportunities and **education** tailored to the needs of Physician Health Program staff and initiatives." The FSPHP has no statutory authority over medical licensing boards.
Forensic Drug Tests: Drug tests that have legal implications for the client or agency that orders the test and the donor who provides the specimen. These tests must conform to strict forensic protocols.
Fraud on the Court: A malfeasance that occurs when an officer of the court tampers with the process of administering justice, in contradistinction to misrepresenting the underlying facts of a case.
Georgia Psychological Association (GPA): Georgia's clinical psychotherapy licensing board.
The Healthcare Alliance for Regulatory Reform (HARB-R) www.harbr-usa.**org:** An organization founded by Christian Wolff that supports colleagues in allied health professions who are improperly involved with their license regulatory agencies and pushes for reform of their objectionable practices.
Health Insurance Portability and Accountability Act (HIPAA): According to Health and Human Services (HHS) www.hhs.gov, HIPAA is the agency that sets standards governing "the use and disclosure of individuals' health information—called 'protected health information' by organizations subject to the Privacy Rule—called 'covered entities.'" HIPAA also sets standards for individuals' privacy rights to help them understand and control how their health information is used. Reflecting its fundamental importance, the Office for Civil Rights is responsible for implementing and enforcing HIPAA privacy regulations.
Health Professionals Recovery Program (HPRP): Michigan's version of a physician health program.
Ideal Medical Care www.idealmedicalcare.org: Organization founded by Dr. Pamela Wible, an internationally recognized expert in physician suicide.
Illicit drugs: Drugs that are illegal and have no legitimate purpose in the practice of medicine.
Illicit use: The use of illicit drugs or the use of legitimate drugs for illegal purposes such as diversion or in quantities above those recommended.
Letter of Agreement (LOA): A signed contract between two parties which lays out the stipulations that each party must agree to abide by.
Letter to the Editor (LTE): An opinion piece published in a print or online journal, magazine or newspaper.

Laboratory Developed Tests (LTDs): Tests developed by independent drug testing labs that have not necessarily been evaluated by a federal agency such as the FDA.
Like-Minded Docs (LMD): A physician organization largely composed of recovering alcoholics who strongly support the chronic disease model of substance abuse and the Alcoholics Anonymous (AA) 12-step model for treating it.
Litigation Package: A complete set of documents relating to how a laboratory specimen was collected, handled, analyzed, and reported.
Moral Injury: Psychological, social and spiritual harm caused by events involving the betrayal of own's own deeply held moral beliefs and values. While the causes of moral harm overlap with the causes of PTSD, they are distinctly different conditions.
Medical Licensing Boards (MLBs): State agencies that regulate the practice of medicine. These agencies are created by their respective state legislatures; their board of directors is usually appointed by the state's governor. Medical licensing boards are not required to follow the dictates of the Constitution or its amendments because they are considered professional regulatory boards, not government agencies.
Massachusetts Division of Administrative Law Appeals (DALA): A neutral forum for appealing a decision of another state agency in the State of Massachusetts..
Massachusetts General Hospital (MGH). One of the most renowned clinical and educational hospitals in the United States and whose geriatrics program was voted number one five years in a row by U.S. News and World Report.
Massachusetts Medical Society (MMS). A private, non-profit organization that represents the interests of Massachusetts physicians.
Massachusetts Supreme Judicial Court (SJC): Massachusetts highest appellate court that hears appeals on both criminal and civil cases.
MD Mentor: An organization created by Dr. Louise B. Andrew to support physicians undergoing malpractice stress, medical board investigations or who are involved in PHP programs.
www.MDMentor.com and www.Physiciansuicide.com
Medication Assisted Treatment (MAT): Pharmacologic treatment designed to help ease withdrawal symptoms, control cravings or prevent relapse.
Medical Review Officers (MROs): Specially trained physicians who are responsible for assuring and certifying that the results of drug tests comply with forensic requirements.
Medical Regulatory Treatment Complex (MRTC): Multiple agencies that act in coordination with one another to discipline licensed healthcare professionals often without due process of law. The MRTC moniker is an outgrowth of the concept of "regulatory capture," an economic theory that Investopedia describes as a process by which "regulatory agencies may come to be dominated by the industries or interests they are charged with regulating." The result is that these agencies may end up benefiting the industry they're supposed to be regulating rather than pursuing the public interest.
Medical Regulatory Treatment and Rehabilitation Complex (MRTRC) (Mr. Trick): A collective of medical boards, physician health services, ASAM physicians and directors of addiction treatment centers whose purpose is to "discipline" healthcare professionals for presumed impairment in their ability to practice with reasonable skill and safety by reason of mental illness, substance abuse and other disabilities but who violate multiple state and federal laws and individual civil rights in the process.
Minnesota Multiphasic Personality Inventory (MMPI): An extensive questionnaire used in conjunction with psychiatric evaluation to help evaluate an individual's mental health.

Modern Assistance Program (MAP): A Massachusetts employee assistance program that provides health services to clients with alleged drug and alcohol problems.
***Motion in Limine*:** A motion made by a lawyer at the beginning of a trial requesting that certain evidence either be introduced or excluded at trial.
Nanogram (ng): 1/1000 of a microgram which is 1/1000 of a milligram.
Nanogram per milliliter (ng/ml): In the case of forensic drug testing, the standard unit for describing the concentration of a substance in a bodily fluid or a cellular matrix such as hair.
National Practitioner's Data Bank (NPDB): A registry of all formal adverse actions taken against physicians and other licensed healthcare professionals, including malpractice awards, loss of hospital privileges, and adverse license actions.
Non-Disclosure Agreements (NDAs): Legal agreements that prevent either party in a resolved dispute from publicly disclosing relevant facts in the case to unauthorized third parties. Not all states permit NDAs.
Pro se: Representing oneself in a civil or criminal court case (i.e., without representation by an attorney.)
Ohio Professionals Health Program (OHPHP): Previously Ohio Physician Health Program. Ohio's version of a physician health program.
Opioid Use Disorder (OUD): A medical condition characterized by dependence on heroin, morphine, codeine or other opium derivatives including synthetic drugs such as fentanyl.
Petitioner (Plaintiff): The prosecutor or instigator of a civil or criminal cause of action.
Phosphatidyl Ethanol Test (PEth test/ PEthStat): A test for heavy, long-term alcohol consumption with a window of detection of six to eight weeks.
Physician Health Program(s) (PHP, PHPs). Physician Health Services (PHS, PHSs). Programs specifically targeting physicians with potentially impairing medical conditions. PHPs and PHSs originally focused on substance use disorders (primarily alcoholism) but have expanded to include mental health disorders. Some PHPs are also targeting physicians (and other licensed healthcare professionals) who have physical ailments.
Physician Health and Compliance Unit (PHCU): Massachusetts licensing board unit that, through its Complaint Committee, addresses compliance of licensed physicians' with their Letters of Agreement with their Physician Health Services or probationary terms with the Massachusetts Board of Registration in Medicine.
Public Citizen: A consumer safety watch group founded by consumer activist Ralph Nader that first espoused the notion that greater discipline of physicians equates to greater safety of the general public..
Quest Diagnostics (Quest): A nationally recognized general medical chemistry laboratory.
Reliability: A quality of a medical test or scientific experiment. A test has reliability if its results are reproducible upon repeat testing under the same conditions.
Respondent (Defendant): The recipient or object in a cause or action in a civil or criminal matter.
Shingles: A painful rash caused by reactivation of the chicken pox virus (varicella) in peripheral nerves. It can lead to a painful condition known as "post-herpetic neuralgia."
"Safety-Sensitive" Positions: Occupations or positions within an agency or organization in which incompetence or misconduct would pose an immediate, direct and proximate threat to public safety if not urgently addressed.
Split specimen testing: A technique in forensic testing in which a single biological sample is split into two separate containers usually referred to as Bottle A and Bottle B.
State Medical Board of Ohio (SMBO): Ohio's medical licensing board.
Stay (legal): A (temporary) halting of a decision or action previously issued by a court or judge.

Tolling: A legal doctrine that allows for pausing the statute of limitations on charging a crime or filing a lawsuit such as when the victim of a crime was a minor or the defendant has filed bankruptcy.
Substance Use Disorder (SUD): A medical disorder characterized by excessive or illicit use of a substance with addictive potential, difficulty refraining from its use and interference with activities of daily living.
United States Substance Abuse and Mental Health Services Agency (SAMHSA): A federal agency that develops policies, programs, and services to prevent illegal drug use and abuse of prescription drugs and alcohol, to promote effective substance abuse treatment, develop preventive measures, and protect the privacy of treatment participants.
United States Drug Testing Lab (USDTL): The specialty lab that PHS (and many other PHPs) uses for forensics drug testing.
Validity: A quality of a test or scientific experiment. A test has validity if its results correlate well with what it's designed to measure.
Voluntary Agreement Not to Practice (VANP). A Massachusetts option for forestalling a medical board suspension or revocation. Like a license suspension, a VAMP would prevent a licensee from practicing medicine, but it's not reported to the National Practitioners Data Bank.
WAIS Wechsler Adult Intelligence Scale (WAIS: an "intelligence test" or IQ test.
Whistle-blower: A person who informs on a person or organization engaged in an illicit activity.
Writ: A legal document that orders an individual or entity to perform (or cease performing) a specific action.