

# A Perspective on the Emergence of Healthcare Sham Peer Reviews in Australia—Past, Present, and Future

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*“When data is missing, data will be made up.”*  
J. Overton (emergency medicine physician, U.S.)

## ABSTRACT

The phenomenon of sham peer review, first described in the U.S., is spreading internationally. Three case reports at different stages in their proceedings, taken from the files of Health Practitioners Australia Reform Association (HPARA), illustrate similarities to the methods used in the U.S.

Sham peer review contributes to Australia’s current unenviable record of having some of the world’s highest rates of medical litigation. Medical litigation has descended into contests of fact and circumstance, aided by the “expert witness” who may provide sham reviews.

## Introduction

A sham (or bad faith) peer review is one that is false or perverted and dishonest; one that is purposely created to destroy the career of the intended victim, with irreversible damage to professional reputation. Sham peer reviews do not seek to benefit patients, improve practice, or reveal the truth. In fact, it is just the opposite. In many circumstances it is political, sometimes industrial, but may also be personal. In almost all instances the reviewer receives a fee for preparing the report.

The States of Queensland and New South Wales now lead the world rankings for malpractice litigation, well ahead of California. Since 2009, Australia has made it mandatory to report a health practitioner to the regulatory authority if one merely suspects an incident of professional misconduct.

The Health Professionals Australia Reform Association (HPARA) was formed in 2015 to achieve reform of the regulation of health professionals in Australia. In its concerted campaign to check the rapid expansion of sham peer reviews in Australia, it has embraced the wisdom of its mentor organization, the Association of American Physicians and Surgeons (AAPS). Like the AAPS, it supports honest and genuine peer reviews.

The primary objective of HPARA is to secure a federal investigation (e.g. through a Royal Commission) into medical care and its associated corruption in Australia and to trigger legal reform. In the interim, we support our “shammed” members in order to avert self-harm, unnecessary legal processes, and family breakdowns, by advocating the pursuit of transparency. As Dr. John Wright noted,<sup>1</sup> “Some reports suggest that only 20% of victims of ‘sham’ peer review ever return to their usual work.”

In matters that reach the Australian Health Practitioners Regulatory Agency, notification (complaint) bias is often triggered by the possibility of financial gain or compensation

to the notifier. Present law provides that even withdrawal of a complaint may still lead to statutory action. This arms any notifier, who may have a sinister motive or a vested interest, with a pathway of absolute power over a vulnerable clinician. In Australia, this is described as an “unfair go.”

This statutory obligation to report needs to be revised to prevent increasing politicization of medical practice and abuse of practitioners.

The Western world’s first recorded case of sham peer review was the Dr. Bonham case.<sup>2</sup> This was considered the earliest documentation of judicial review of the principles of common law and natural justice, and it concerned medical practice and monies.

In England, this did not mean much to subsequent legal systems or jurists, but in the U.S. it led to development and refining of the American Constitution.<sup>3,4</sup>

To date, the phenomenon of medical sham peer review has been extensively described only in the U.S.,<sup>5,6</sup> where it has reached such plague proportions that in one area 23% of emergency staff were threatened with dismissal if they complained of dangerous hospital practices.<sup>1</sup> It appears that in this last decade, it has spread widely throughout Australia<sup>7</sup> and even the UK<sup>8,9</sup> for reasons of the increasing politicization of medical services.

The features and outcomes of sham reviews are remarkably similar everywhere, to the extent that many believe there is an established modus operandi for their perpetrator network.

An as-yet-unresolved case not considered here, against orthopaedic surgeon Dr. Richard Emery, is discussed by Dr. Don Kane.<sup>10</sup> Higher authorities have yet to act on this alleged malfeasance.

One of us (LN) has reviewed the cases of variously shammed individuals<sup>11</sup> in Australia, which could be found online in the public domain and in other media records.

In our systematic search, we also found what appears to be an early documented Australian case—that of Dr. John Wright, a Sydney-based pediatric surgeon, whose case is well known to American physicians who first supported him in the 1980s. Another case is that of Dr. Z.S. Jemielita<sup>12</sup> in Western Australia, whose spouse, Dr. D. Russell, took her own life during a Health Insurance Commission investigation on their joint practice and report to the regulator (Medical Board of Western Australia) in the 1980s. A third is that of Dr. E. Popovic,<sup>13</sup> who took his own life in 2011. These were all very likely to have been sham peer reviews.

## Case Report 1

The victim was a New Zealand medical graduate. He had moved to Australia and established a general surgical private

practice specializing in innovative, uncomplicated Medicare-funded procedures for more than two decades.

He also obtained a law degree, qualifying as an attorney and co-founding the medico-legal section of the Royal Australasian College of Surgeons (RACS).

A retrospective 10-year audit of his surgical outcomes found them to be equivalent to those from two North American Centers of Excellence.

In 2006, his medical board investigated him for alleged professional misconduct over a case treated 3 years previously. An otherwise successfully treated patient had developed septicemia 5 months later while in hospital for a self-inflicted condition she had not disclosed to her family and doctors, and she died while not under the victim-physician's care. A complaint was lodged by the family after being informed by the hospital and treating intensive care specialists that there were "advanced surgical complications" rendering their in-hospital treatment in intensive care impossible.

The medical board failed to include the victim physician in its investigation, yet it unilaterally imposed conditions on his practice. The board alerted the media to allegations when the victim did not agree on restrictive practicing conditions being imposed. The board then prosecuted him before the Medical Tribunal, actively seeking out other complaints from hospital records stretching back two decades. It then added a second case to its prosecution despite a coroner's post-mortem with official findings exonerating him.

The Medical Tribunal concluded in 2009 that he had "contributed to the death of two patients," after a 6-week hearing before what appeared to be an inappropriately constituted and hostile tribunal. The evidence against him was principally from the group of internists responsible for initiating, and then not diagnosing the hospital-acquired sepsis, and opinions from two purported peers. The tribunal was silent on other facts that contributed to the deaths.

An academic surgeon from elsewhere in Australia, who had no experience or expertise in that form of innovative surgery, provided the "expert" testimony needed for a classic sham peer review. His evidence contradicted the coroner's post-mortem findings and added much confusion to the tribunal.

Despite much "factual" and circumstantial evidence in both matters being shown to be false, the tribunal preferred the "expert" opinion evidence to that of coroner's pathologist and the pathologist testifying for the targeted physician.

The full extent of behind-the-scenes scheming was revealed only several years later. The victim had by then "retired permanently" from practice because of the conduct of his defense counsel (provided belatedly by his malpractice insurer), who firstly ensured the victim's absence from the penalty hearing and then, without consultation, accepted on behalf of his client a draconian penalty of permanent retirement without any prospect of future reinstatement.

There were clearly other vested interests involved in this course of events. The professional liability insurer instructed its attorney to emphasize the company's interest in minimizing its potential liabilities. News media were then encouraged to alert the plaintiff litigation industry about any adverse findings.

One way of avoiding future liability for Australian insurers is to force the clinician into permanent retirement. This shifts costs to the Australian government. Thus the "penalty" agreed to by the malpractice attorney made sure that the insurer would not be liable for future costs of claims based on adverse findings presented at the hearing.

The private hospital was also very concerned about its own vulnerability to litigation and had adopted a policy of "cherry picking" the easy and profitable cases, promoting and favoring practitioners who brought business to the hospital, while actively discouraging high-risk procedures. False audits were prepared for future blame shifting—which were secretly supplied to the investigators and revealed when opportune.

This hospital had a high nosocomial infection-related mortality rate in its "flagship" intensive care unit. Its intensive care physicians in particular were very concerned about being blamed for patients' deaths while under their treatment, and understated any of their own possible contributions to the causes of death.

One of the patient's relatives was well connected to a union movement with close ties to the government, and was able to manipulate the daughter of the deceased into participating in the official investigation team and the subsequent preparations to prosecute the victim physician. For example, the daughter was able to object to certain experts and their reports regarding her mother's demise that did not align with the original version of events laid out to her by the intensive care staff and hospital representatives shortly after her mother's death.

The daughter had first complained to the police and coroner, citing the reasons given to her, but the intensive care specialists deflected their official inquiries to hospital administration. Neither the police nor coroner took further interest in what appeared to outsiders as contradicting actions and statements.

From her integral position in the investigation/prosecution team she was also able to act as an activist to the media pressing the carefully narrated version of events supplied to her by the hospital. A national investigative television program commenced advertising for other of the victim's patients to contact them to complement their initial sensational and factually incorrect program.

Appointments to the three-member peer-review tribunal panel were corrupted by the inclusion of a retired geriatrician and a junior emergency medicine specialist. No true peers of the victim were included. The prosecutor was a family court specialist. The tribunal president was a district court judge with a reported track record of never finding against prosecutors in his entire judicial career.

There was clearly no procedural fairness, due process, or natural justice in the proceedings. This was a classic "kangaroo court."

The tribunal's eventual findings were inconsistent with the evidence, and its own procedural rulings, in which the cause of death was not allowed to be litigated, were contradicted when the tribunal altered the cause of death to suit the "evidence" of the prosecution—contradicting both death certificates and facts of the coroner's autopsy in the second matter.

## **Lessons from Case 1**

This case illustrates the dangers posed to any practitioner, particularly in the current Australian regulatory climate, by his own colleagues. As vested interests of self-preservation are paramount, these will often pervert the course of justice, particularly if supported by regulations that encourage mandatory reporting—which does not distinguish truth from lies, or societal interests from self-interest.

The case illustrates the strategic abuse of the mandatory reporting now entrenched in Australia and that of sham peer review, which have become the keystones in constructing cases of negligence and/or professional misconduct against practitioners.

This case also illustrates the risks to a foreign graduate practicing in a highly parochial marketplace. Such persons inherently have little or no peer group support network or the “old boys’ club.” They become vulnerable scapegoats for the failings of others that the system might choose to suppress or simply ignore.

Additionally, the low standards of justice, with weak rules of evidence and incompetent tribunals by which the alleged misconduct of Australian medical practitioners are determined, are all demonstrated.

Readers should note that police inaction continues after the Chesterman<sup>14</sup> and Forrester<sup>15</sup> inquiries into the functioning of medical regulatory authorities in Queensland.

In a fair [adversarial system, no one involved in medical misadventure benefits if the causes of an adverse event are not properly discovered or disclosed. Organizations representing medical practitioners and patients should be asking for inquisitorial systems to be introduced so that the truth is not only discovered, but elaborated.

## **Case Report 2**

The victim in this case, the sole breadwinner in his immediate family, was a mid-career specialist with nearly 30 years of untainted international practice. This person was recruited initially to the state of Victoria to rebuild a dysfunctional and depleted department. Success was achieved within 6 months when a newly qualified second locally trained specialist was recruited to assist and support the effort. This second person was ambitious, belligerent, and aggressive. The victim kept silent, not retaliating or answering back, while enduring increased bullying from the new specialist.

The victim had near-perfect peer review reports by the Royal Australasian College of Physicians (RACP), his specialty organization, and was well-liked and respected by many patients. However, in its final report the RACP made the discretionary assessment that the victim physician was deficient in “communication skills” and clinical judgment in a particular treatment field. Concerning this treatment, Level II randomized controlled data remained unavailable for another 10 years. When finally available, data revealed that the experimental protocol the victim had been criticized for opposing was no better than the standard therapy and had more adverse effects.

In another episode, the victim recommended a new treatment from Europe of which the RACP evaluators were unaware. The latter had told the patient to “get his affairs in

order” and await his demise. The patient, however, preferred to follow the counsel of the victim and survived. The patient remains alive and well today, free of disease more than decade later.

The RACP evaluation favored the victim’s new colleague, and the victim, under duress, dissociated from the institution with a confidential exit deed of release that did not allow past circumstances to be fully explained. It is not known whether the institution agreed to the same constraints.

The victim’s colleague removed and falsified information, concocting charges. In turn, the RACP lacked due diligence and participated in “mob bullying” of the victim.

When the victim moved on to another position, the employer obtained, by hearsay stealth, falsely embedded information about the victim, and used this in attacking him in the course of cooperating with Medicare to investigate the alleged fraudulent use of his provider number to make financial claims.

A Freedom of Information inquiry showed that the RACP had planted misinformation with both the medical board and employer.

The matter remains unresolved at this time, more than a decade later, with the state government dismissing requests to have the issue reviewed independently, and with the victim adapting to the situation and gaining recognition in an additional specialty.

Recently, the institution at which the victim first worked independently investigated the matter of a workplace bullying culture over a 2-year period and concluded that it was severe, systemic, entrenched, and tainted with nepotism.<sup>16</sup> The full report remains confidential, but its executive summary is extremely damning. Key senior staff and ex-staff, including the second specialist previously described, have recently resigned or moved to other jurisdictions.

## **Case Report 3**

The victim came to Melbourne in early 2002 to undertake a Ph.D. program in neurosciences at Monash University. He designed a transgenic mouse to model a human condition named ADNFLE (autosomal dominant nocturnal frontal lobe epilepsy).<sup>17</sup> He was able to show that the transgenic mouse did display a pathological phenotype similar to the human condition.<sup>18</sup> These findings were later verified by a similar, independent finding.<sup>19</sup> He also helped another distinguished faculty clinician establish an algorithm for detecting epileptic EEGs. A variant of this algorithm would go on to be implemented in a commercial device proposed by the University of Melbourne.

This highly successful Ph.D. student then made a decision to pursue medicine at Melbourne University. Unfortunately, when he tried soliciting simple advice about this, he met with startling prejudice. He had always suffered from a mild stammer, but that never stopped him from pursuing his goals and succeeding.

When he approached a clinical professor for advice on pursuing medicine, that professor (who seemed to have no problem with his speech when he was making contributions to the knowledge of ADNFLE) told him very bluntly that he “had no business pursuing a medical degree” in Australia

because of his stutter, and that “senior clinical faculty would not tolerate anyone with a stammer.”

The victim ignored the faculty member’s advice and enrolled in medicine at Melbourne University as a full-fee international student.

About a year into the course, this clinical professor requested that he come over to his house to show him some laboratory data that he had generated. When he found out the victim did indeed enroll in medical school, he immediately told him that there was “no way he would be able to complete the course without redressing his stammer completely and immediately.”

While the victim did acknowledge his stammer, he was privately wondering why, for the first time in his life, someone was trying to falsely convince him that it was such a detriment. When going through the basic sciences portion of the course, the victim was never once harassed by any faculty member about his stammer. That all changed once he commenced clinical school in Melbourne, Victoria. The clinical dean of this school began to request one-on-one meetings with him on almost a daily basis. He was berated about his stammer and why it “did not belong in Australian medicine.” The language the dean used was almost identical to that of the earlier clinical professor. In all fairness to the hospital, this was the only person in the hospital who had treated him like this. All other clinical staff at the hospital treated him with utmost respect.

On the day of the examinations, the victim’s worst nightmare began to come true. Before examinations he was specifically instructed to speak as slowly as possible as to avoid stammering at all costs, and he would be provided with some extra time. Much to his surprise, no extra time was given as he was cut off by the examiner halfway through reporting his findings of clinical examination. When he protested about being instructed to talk slowly while not being given the allotted extra time, his pleas were instantly dismissed. He was then given a failing grade for the case.

The Objective Structured Clinical Examination (OSCE) portion of the examination was also irregular. He was not provided with proper Vacutainer tubes for the venipuncture station. He was denied key endoscopy pictures and was not given credit for saying that a barium swallow may be a correct examination for dysphagia, although this was the accepted teaching. His OSCE marking sheets, which he later obtained through the freedom of information laws, contained inconsistencies.

Extraordinarily, while he was given full credit for correctly diagnosing a diabetic patient with foot neuropathy, he was given no credit for actually conducting the examination, thereby failing that OSCE station.

The medical faculty failed him and ordered a repeat of the entire clinical year, commencing immediately. This would effectively mean that he would have to come up with an extra \$100,000 over the next 15 days or have his student visa revoked. It became obvious at this point that he was being actively and maliciously driven out of the course.

He then began getting threatening phone calls from other clinical deans to either pay the fees immediately or leave the country. He met with the school’s deputy dean, secretly recording the conversation to prove that the faculty was acting in a malicious manner.

When he brought up the point of why Vacutainer tubes

were not provided at a key OSCE station, the deputy dean responded that, “the tubes” were always an issue and that he actually “passed that station.” This was untrue, as the examiner failed him for not using the Vacutainers, which were nowhere to be found at the time.

When this evidence was presented to university administrators he thought he would get some kind of just hearing to address the matter. Unfortunately, what he got instead was a threat of a two-year “incarceration term” if he exposed any of this evidence in public. He was forced to immediately leave Australia, with a crushing financial debt.

In a civil society, people who overcome great odds to succeed are rewarded. But in this case it appears that a graduate medical student was sacrificed to oblige a politically powerful clinician.

## Discussion

The existence of sham peer reviews in Australia is real and proven. Many more varied cases are now being reported. The regulatory environment has transformed from “guiding” and supportive into a “robust” adversarial one in which a culture of “name, blame, and shame” has evolved.

The worldwide similarity of sham peer reviews is remarkable. They may have recently come to prominence in the U.S. but have been noted in 17th-century England and began appearing in Australia in the 1980s. A recent editorial suggested that the practice may also occur in developing countries such as India and Pakistan.<sup>20</sup>

Sham peer reviews occur across the health professions, but because medical practitioners have the resources to battle the system, they appear to be the most represented. While Dr. Bonham was falsely imprisoned physically, we suggest that most of today’s victims have been subject to psychological false imprisonment.<sup>21</sup> In addition to physicians, other victims include patients and their caregivers and close associates of the victims, particularly their immediate families.

We have many allied health professionals in our database who have been similarly sham reviewed and who could only afford to walk away without a fight. Print space limitations prevent their being mentioned here.

This system in health regulation and evaluation has stimulated a vibrant litigation industry with a culture of blame.

We suggest three hypotheses to explain the existence of sham peer review.

The first hypothesis is that there is a well-informed, secretly entrenched network of individuals involved in this activity, for example, as suggested in the book *The Red Back Web* by Dr. Helen Tsigounis.<sup>22</sup> This may be easily dismissed as conspiracy theory, but some writers claim that other, secretly linked activities are passed on through the generations across the world by secret fellowships or private organizations, etc. However, there is at present no high-quality evidence for this.

A second hypothesis is that individuals who perpetrate sham peer review are psychologically disturbed and are well-equipped to select their own kind to run the organizations they represent. Their personalities may be “borderline” and this pre-selects and recruits them for such tasks in these various organizations that embrace and perpetrate a culture of bullying and oppression. This was essentially how Australia was founded.

The manifestation of their alleged narcissistic personalities can be found in the persons employed in the regulatory machinery of many fields worldwide. Some may argue that the public interest requires their existence, and that politicians feed on the “success” of their allegedly flawed activities in “governance.”

A third hypothesis is that “local standards” are set by private corporations (all specialist colleges and societies), unlike those in the accounting and civil aviation industries—which follow international standards. This allows lawful monopolistic discretionary variation of “standards.” David Dahm<sup>25</sup> discusses the move toward international standards in Australian medicine.<sup>23</sup>

One seriously flawed and oppressive legal example we can learn from the U.S. is the Healthcare Quality Improvement Act (HCQIA) of 1986, the adverse consequences of which have been repeatedly expounded by Dr. Lawrence Huntoon.<sup>24,25</sup>

One major difficulty in Australia is that misinformation generated by “authorities” and their delegates is difficult to counter.<sup>26</sup>

Any equivalent of the HCQIA in Australia should never be passed in its present form because, in addition to basic rule-of-law breaches, it will also breach two existing commonwealth (federal) acts: the Privacy Act 1988 and the Australian Human Rights Commission Act. In our view, multiple current laws are already being breached in Australia by sham peer reviews, including the federal competition laws and international human rights conventions, in addition to various state criminal codes and crimes acts.

Victoria’s Independent Broad-based Anti-corruption Commission (IBAC) published a recent warning<sup>27</sup> to public service employees that organized white-collar crime activities do take place subtly. In Victoria for example, elements of the Crimes Amendment (Bullying) Act 2011<sup>28</sup> apply. All delegates of the medical board, including the specialist colleges, are subject to the Act.

By this definition, workplace “mobbing” or organized bullying, by college authorities, abusive regulatory, or other institutions, may now be technically considered as forms of white-collar “organized crime.”

Colleagues who observe sham peer review and do nothing are in effect complicit participants and not merely “innocent bystanders.”<sup>7</sup> As Joanna Flynn writes in an editorial, “Those who are perpetrators, whether their behaviour is deliberate or unconscious, need to know that their peers do not accept and will not tolerate it.”<sup>29</sup> Unfortunately, the sham peer reviewers are likely the very group that the medical boards listen to and “believe,” and whose mendacious actions they ignore. Instead of enforcing rules against bullying, the doctors in positions of authority are likely to support the perpetrators.

### Preventative Measures—the Future

Dr. Huntoon wrote about preventative and other support measures using the S.I.C.K.L.E. approach: Support, Information, Conduct, Knowledge, Lifestyle, Education.<sup>24</sup> While he likens the format of sham reviews to workplace bullying—and this analogy appears accurate—we do not believe that it will avert a well-planned sham.

For example, sometimes Australian medical practitioners are bonded to places of practice and visa requirements (if

relevant) that make it extremely difficult for a practitioner to simply “walk away.” This bondage readily invites abuse toward the victim placed in a working environment with few or no rights. An entrenched bullying culture is able to set the scene for a prolonged period without being acted upon as depicted in Case 2.<sup>16</sup>

A regulator-driven proactive “buddy system” as in New Zealand has its advantages for confidential non-adversarial support and re-validation.

One thought for the immediate future is this: with a culture of no blame and candor-seeking,<sup>24</sup> as opposed to a litigious and blame-shifting culture, long-term, practical reforms through legislation and education may ensue.

The examples of New Zealand and Norway could be examined.

**Potential Conflicts of Interest:** We all have been victims of Australian sham peer reviews.

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