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Correspondence

Physician Health Programs

In follow-up to Dr. Huntoon's excellent article about how Physician Health Programs (PHPs) are skirting the Americans with Disabilities Act (ADA),¹ I completely agree with the need to find ADA-knowledgeable attorneys, but unfortunately that is no simple matter. With PHPs, there are at least two different titles of the ADA simultaneously involved and sometimes three: Title II (the licensing boards) and Title III (the PHP). If the referral into the program was made by the employer (you would be surprised how often that does not happen), then Title I of the ADA is also involved. Attorneys tend to specialize in only one of these titles. So, finding an attorney with substantial experience across multiple titles of the ADA is not easy.

The simultaneous involvement of different titles also creates complications from an economics of law practice perspective because the available remedies differ. The economics of taking on such a case can vary depending upon the title involved.

Licensing attorneys, with whom I frequently consult on these matters though I am not a licensing attorney myself, are often not familiar with the ADA at all. In addition, they may resist utilizing the ADA for a variety of reasons, including but not limited to the perception that it might affect other cases they have before the boards. In these situations, it will be up to the client to persuade his attorney of the need to involve ADA expertise in order to fulfill his ethical obligation to the client.

There are several different ABA Model Rules of Professional Conduct that should strongly encourage licensing counsel to get ADA expertise involved when necessary. Those model rules include ABA Model Rule of Professional Conduct 1.1 (Competence); and 1.3 (Diligence), and there may be others either separately or in combination that might apply as well.

Lawyers are expensive. So, it is incredibly important for the appropriately qualified lawyers to get involved immediately. Too often, people come to me after they have spent tens of thousands of dollars dealing with PHPs with the result that they can't afford the attorneys with the necessary expertise. Getting attorneys involved early also allows for the possibility that the doctor's malpractice insurance policy might cover the cost of attorneys, including consultants with ADA expertise. Whether that is possible depends on the contractual provisions of the specific policy.

William D. Goren, Esq., J.D., L.L.M.

Decatur, Ga.

I appreciated Dr. Huntoon's Winter 2025 editorial,¹ which makes an important contribution to our understanding of this serious problem. I have been studying this issue in the context of Lawyer Assistance Programs' involvement in attorney licensing—including their efforts to justify regulatory overreach by labeling lawyers safety-sensitive workers, and have written a recent law review article concerning this problem.² Based on my research, it appears there is substantial overlap between the actions and apparent motives of PHPs and LAPs. Thus, I think it is critical for physicians and lawyers to understand what is happening in both spaces so that we can chart a path forward together.

Paula Schaefer, J.D.

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In the winter issue, Dr. Huntoon advances a compelling thesis: that labeling professional roles as "safety-sensitive" can function as a means of evading the ADA, which prohibits discriminatory action against licensees by employers, licensing boards, and PHPs, or their analogues (such as Lawyers Assistance Programs).¹

I agree and would extend the concern further. The safety-sensitive designation risks becoming a mechanism not only for skirting the ADA but for weaponizing disability itself—using diagnosis or perceived vulnerability as justification for heightened scrutiny, prolonged monitoring, and expansive fitness-for-duty evaluations.

Once an allegation of “unsafe” conduct is raised—whether or not any impairment is demonstrated—two reinforcing processes often follow. First, the licensee may be placed into indefinite monitoring and subjected to repeated, costly evaluations based solely on the allegation. The invocation of “safety” effectively lowers the threshold for imposing ADA-prohibited burdens, even in the absence of objective evidence. Second, PHP-endorsed concepts such as “potential for impairment” implicitly equate diagnosis with risk. “Potential for impairment” is easily reframed as “potential for unsafety,” creating a rationale for exclusion from safety-sensitive roles indefinitely—even when the disability is remote, historical, or never associated with impaired performance.

The danger escalates when entire professions—such as clinical medicine—are designated as safety-sensitive. In that case, the distinction between role and profession collapses. Any clinician with a current or past diagnosis, regardless of capability or performance history, risks being deemed unqualified for the profession itself. This represents a novel and deeply troubling form of disability discrimination.

More alarming still is the treatment of individuals with no history of impairment who are newly “regarded as” impaired. Although PHPs often claim they do not diagnose, referral to PHP-preferred multiday evaluations predictably results in diagnoses, “rule-out” conditions, or speculative differentials. The inability to meaningfully challenge these findings is then treated as evidence of disability, and thus of “potential impairment.”

From there, the conclusion of “risk” or “jeopardized safety” is conveyed to employers and licensing boards as authoritative, triggering exclusion, monitoring, or worse—often without meaningful due process.

Carried to its logical extreme, this framework allows an individual to be

deemed “unsafe,” not qualified for a safety-sensitive profession, and potentially subject to emergency suspension under the ADA’s direct-threat doctrine or state public-endangerment statutes. Defending one’s career against such a process is, in practical terms, nearly impossible.

Two urgent steps are required. First, rigorous multidisciplinary study of the use and abuse of safety-sensitive designations, particularly given the regulatory and cognitive capture of licensing boards by PHPs and similar programs. Second, uncompromising enforcement of due process at every stage of the administrative process—from allegation to evaluation, determination, and appeal.

Dr. Huntoon cites Dr. Chris Bundy of the Federation of State Medical Boards (FSMB) and former president of the Federation of State Physician Health Programs (FSPHP) as stating, “A monitored physician is a safe doctor.” Given the elastic language and profound due-process failures embedded in the current system, a more accurate formulation may be this: “A monitored PHP is a safe PHP.”

Kernan Manion, M.D.

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Citing 2024 Department of Justice findings against the Tennessee Lawyer Assistance Program in the winter 2025 issue,¹ Dr. Huntoon writes that “[Analogous to lepers in biblical times], [p]rofessionals, who are in recovery from addiction, receiving appropriate treatment, and functioning well, are... subjected to costly, burdensome, and unnecessary (e.g. prolonged inpatient) treatments based on past behavior [dating from] when the addiction was not being treated. Even when treatment has been successful, they are often forever labeled ‘unclean.’”

How can this be? The trade group of PHPs, the FSPHP, composed largely if not exclusively of “recoverings,” have reinvented themselves as expert in EVERY illness that MIGHT result in impairment, often without further qualification or training. And most of them profess that any physician with any illness also has a substance use disorder (SUD) until proven otherwise.

Proof of sobriety is nearly impossible to come by, due to the use of non-FDA-approved, laboratory-derived

tests for metabolites of alcohol and other substances, several of which were developed by these same self-branded recoverings/addictions specialists. If even these overly sensitive tests—that are NOT to be used for forensic purposes according to federal Substance Abuse and Mental Health Services Administration (SAMSHA) guidelines—are negative, physician victims are routinely subjected to polygraphs, and even less reputable physiologic tests for “veracity.”³

PHPs have long been empowered by the FSMB to credibly threaten long-arm licensure action against any “noncompliant” health professional (all conveniently and meretriciously deemed to be “safety sensitive”⁴ workers). This legally unsupportable (but sensible-sounding) meme, according to the American Society of Addictions Medicine,⁵ which is inextricably intertwined with the FSPHP, is poised to be applied through its widely cited Criteria to essentially anyone with a license, most recently including lawyers, even if they are judges or politicians.

A complaint of almost any kind, even brought anonymously by a vindictive patient/ex-spouse/disgruntled colleague/hospital administrator/training program director can result in mandatory interrogation by the PHP, leading to the tentative label of “potential impairment.” This leads to a mandatory, exorbitantly expensive, multiday off-site evaluation in an ostensibly specialized Professionals’ Evaluation and Treatment Center run by “recoverings” (some of them criminally convicted PHP directors) reinvented as addictions specialists.

A recent “refinement” is that at least one of these Centers is mandating physicians to return every 6 months for a multiday “check-in” that includes polygraph evaluation. PHPs claim to be required to follow the dictates of these Centers; but in fact the FSPHP is actively foisting their own heavily skewed diagnostic and treatment criteria on the Centers, using “certification” as an inducement.⁶

The newest mantra of FSPHP is “A monitored physician is a ‘safe’ physician.” These “like-minded docs,” who personally benefited from and zealously promote faith-based abstinence, believe that their own illness quali-

fies them to pass judgment and foist similar treatment on all those whom they believe to be similarly “afflicted.”⁷ Required inpatient “check-ins,” attendance at daily Alcoholics Anonymous/Narcotics Anonymous meetings, and years of monitoring (intensified or prolonged for any allegation of “non-compliance”) are routine components of the PHP racket that are not only tolerated but actively promoted by state medical associations and AMA. Once in the maw of this operation, physicians of ordinary means have practically no means of escape.

This extreme regulatory takeover/overreach is spurred on by AA zealotry and incentives provided by the incredibly lucrative drug treatment and monitoring industry, in which many present and former PHP Directors as well as FSPHP, FSMB and other self-interested entities have direct financial ties.

Thank you, Dr. Huntoon, for bringing this scheme to readers’ attention, by so carefully describing this particularly pernicious emerging form of sham peer review. It amounts to a self-serving and self-perpetuating mechanism to bring all licensed professionals under the control of a group of “recoverings,” most of whom have previously experienced licensure discipline (if not deprivation) or even criminal convictions because of substance use disorders. It is particularly galling that this is all being done in the name of “patient safety,” often to individuals who have NO record of patient complaints or legal claims, on the mere allegation of “potential for impairment.”

Like laws requiring lepers to shout “unclean!,” the medical regulatory-therapeutic complex is foisting its own form of discrimination against physicians, who are typically poorly informed or poorly represented legally, or are already depleted financially by the scheme before they realize that they needed legal representation.

Now that the same pernicious schemes are being applied to lawyers (by some of the same operatives and institutions), it is to be hoped that there will be less complacency and more litigation to expose the scheme for what it really is: extortion by license.

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Vaccines and Autism

According to Dr. Tamzin Rosenwasser’s laudatory review of *Vaccines: Mythology, Ideology and Reality*, its authors recommend that the cause of autism be investigated.¹

There is no reason to research that which has already been apparent for years. It should be obvious to health professionals with pediatric experience that most autism or autism spectrum cases are caused by encephalitic brain damage from the live vaccine measles virus in the MMR vaccine that is injected at age one year, and that some severe autism cases result from DTP vaccination. The most profound case of autism I have ever seen followed infantile Haemophilis influenzae type B (Hib) vaccination.

When I was in medical school, childhood vaccination was very infrequent. I was taught that the prevalence of autism in the U.S. population was 1 in 300,000–400,000 (0.00033%–0.00025%). Now, enforced early childhood vaccination is ubiquitous, and the prevalence of autism spectrum disorder in children is supposedly about 4%. If to this statistic are added vaccinated children who are abnormally nervous or

hyperactive, vaccine-generated autism spectrum disorder affects 10% of the pediatric population.

The pediatric medical business earns profits from injecting medically unneeded vaccines, and from treating young children for consequent adverse effects, such as food allergies, autism spectrum disorder, chronic eczema, and chronic asthma, as well as the frequent upper respiratory infections and ear infections resulting from a vaccine-weakened immune system. Currently, the healthiest children are the unvaccinated ones.

Irene Nasaduke, M.D.
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Mao's Great Famine

In Craig Cantoni’s review of Frank Dikotter’s book,¹ the statement that “Stalin...had starved tens of millions of kulaks while punishing party members who told him the truth” merits clarification.

Kulak means fist in Ukrainian and Russian. In Russian slang, kulak signified “tight-fisted person,” a term applied by Soviet Communists to peasants owning a cow and enough land to eke out a living.

No ethnic Russians were starved. Only Ukrainians were targeted by artificial, genocidal famines. Forcibly removing from Ukrainian farmers all grain, including seed grain for next year’s sowing, the Soviets starved to death approximately the following numbers of Ukrainians: 3 million in 1921-1922, 7 to 10 million in 1932-1933, and 3 million in 1945-1946.

In 1931, the Soviets took away from Ukrainian farmers all their livestock and enclosed them in open fields surrounded by barbed wire. The animals’ owners were forbidden to approach, touch, feed, or water them on pain of being shot dead for interfering with what was now government property. All the cows and horses died slowly and inhumanely.

During World War II, the Germans followed Soviet precedents. Lacking Stalin’s order to fight back, 3 million Red Army soldiers in the two Ukrainian

and one Belarusian armies lined up on the Soviet Union's western border surrendered en masse to invading Germans, then were starved to death in open-field prisoner-of-war camps surrounded by barbed wire during the winter of 1941-1942.

After the two Ukrainian armies were lost, Germans occupied all of Ukraine from 1941 to 1943 and seized all the Ukrainian collective farms' grain for their own needs. German soldiers set fire to Ukrainian village houses as they advanced, leaving the inhabitants without shelter or food for the approaching winter, and deliberately starved to death Ukrainian city dwellers. About 5 million Ukrainian civilians died of German-caused artificial starvation in 1941-1943.

About a million GULAG prisoners (mostly Ukrainians) starved to death during World War II. Ukrainian artificial starvation deaths from 1921 to 1946 totaled up to 24 million.

If Mr. Cantoni alludes to Ukrainian starvation deaths, Stalin rewarded rather than punished "party members who told him the truth." For example, Nikita Khrushchev advanced his career by doubling assigned quotas of thousands

of Ukrainians shot to death in the 1930s.

As Red Army soldiers advanced in 1943, they massacred all inhabitants of reconquered easternmost Ukrainian villages. The Soviet regime later blamed retreating German soldiers, as though the latter had time, energy, and bullets to waste killing peaceful Ukrainian civilians instead of saving their resources to repel attacking Soviet troops.

The Soviets repopulated emptied eastern Ukrainian lands with ethnic Russians, forming an initial pretext for the war of Russia against Ukraine ongoing since 2014.

The Soviets had similarly murdered thousands of Polish officers at Katyn in 1940, and blamed the Germans. In 1943, the Germans proved Soviet guilt by digging up the corpses.

Deception was Soviet policy. In the Russian Civil War, fought mostly on Ukrainian-settled land, and during World War II as fought on Ukrainian soil, false-flag operations by Soviet armed forces and partisans against ethnic groups and Germans were blamed on Ukrainians. Much worse lethal reprisals against innocent Ukrainians by affected minorities and German troops

ensued. Resultant false, anti-Ukrainian propaganda is still being proliferated and acted upon.

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1. Cantoni CJ. Review of: *Mao's Great Famine: The History of China's Most Devastating Catastrophe, 1958-1962*, by Frank Dikotter. *J Am Phys Surg* 2025;30:127.

Erratum

In the review of *The Disrupted Physician* by Anne Phelan, M.D.,¹ it is erroneously stated that Dr. Michael Langan is the author's husband. Dr. Phelan has no relation to Dr. Langan except that both had their careers derailed by the Medical Regulatory Therapeutic Rehabilitation Complex. She learned about Dr. Langan through her efforts to unravel the fraudulent and abusive system that has harmed them and many others so seriously.

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