**Journal of American Physicians and Surgeons**
**Mission Statement**
The *Journal of American Physicians and Surgeons*, the official peer-reviewed journal of the Association of American Physicians and Surgeons (AAPS), is committed to publishing scholarly articles related to the practice of medicine and to promoting open debate and scientific integrity.

**Subscriptions and Advertising**
aaps@aapsonline.org

**Subscription Rates:**
AAPS Members (included in annual dues)
Non-members $75 per year
Institutions $125 per year
Students/Residents $15 per year
Foreign $200 per year (US currency only)

AAPS
*Omnia pro aegroto*

**Cover Design**
Rachel Eck

**Typesetting**
Marilyn Kessler

**Website**
www.jpands.org

**Webmaster**
Jeremy Snavely



POSTMASTER:
Send address changes to:

1601 N. Tucson Blvd, Suite 9
Tucson, AZ 85716

*Journal of American Physicians and Surgeons* (ISSN 1543-4826)
is published quarterly.


# Correspondence

**Polygraph Testing**

I read the thorough discussion of polygraph (lie detector) use in physician peer review and evaluation-for-fitness matters in the summer issue.[1] I have been an expert and consultant in peer review matters, endorsed by the Texas Medical and Hospital Associations in the early 1990s, so I appreciate and admire Dr. Huntoon's command of the issues and his lucid writing on peer review matters, his advice to physicians about professional peer review, how it should be done, and the laws and legal principles that apply to peer review affairs.

I would only expand a little on the jurisprudence discussion. The Frye (1923) standard for admissibility of scientific testimony and evidence is "general acceptance in the relevant scientific community." The Daubert Standards (1993), which guide judges in all federal and most state courts, are more rigorous and multi-faceted to ensure that the scientific evidence is relevant, material, and reliable.

Under the Daubert Opinion rules the courts are to consider: (1) whether the theory or technique can be and has been tested, (2) whether it has been subjected to peer review and publication, (3) error rates, (4) the existence of standards governing the operation of the technique, and (5) degree of acceptance in the scientific community, since widespread acceptance is a positive sign and minimal support is a negative sign for a widely known technique.[2]

Dr. Huntoon's essay is important in the extraordinary, authoritative portfolio of articles he has written for the Journal.

An argument could be made that since a minority of the states allow lie-detector evidence and there is a prohibition in employment matters excepting for government jobs, security jobs, or controlled-substance-management jobs, a physician can refuse a polygraph, and a refusal should be without negative consequence. If an entity insists, the physician has a choice: concede and hope for the best, sue if the outcome is negative, or refuse and sue if the entity proposes a finding that includes a penalty for refusal.

**John Dale Dunn, M.D., J.D.**
Brownwood, Texas

Thanks for this comprehensive piece on the colorful history and highly controversial use of polygraphy in legal and medical regulatory-therapeutic, and now apparently also in hospital "peer review" settings.[1]

The "golden lasso" vignette was amusing; would that only Wonder Woman possessed such a device, presumably used only for good.

The Federation of State Physician Health Programs (FSPHP) has held at least three educational sessions at annual meetings on polygraphs, and subsequently reported glowingly on the utility of polygraphy, initially in cases of alleged boundary violations, and more recently in alleged substance-use cases.

"Failing" a polygraph test or question can be considered by a PHP to be an indication of dishonesty, which is one of FSPHP's expanded definitions of "relapse," which is reportable to a licensure board as "noncompliance" with a monitoring agreement. However, as you explained, polygraphy is NOT a test of truth telling.

Two additional facts have been conveyed by PHP clients about the use of this tactic in PHP-mandated "Comprehensive Diagnostic Evaluations" (CDEs) at Preferred Evaluation and Treatment Centers (ETACs), as well as at mandated semi-annual on-site "check-ins" by former residential clients. In at least one particularly ill-reputed ETAC, the equipment was discovered during litigation by a local lawyer to be out of date, and the hired polygrapher not "certified" by his own "professional" association, which would require adherence to ethical codes.

In some cases, the doctor is sent for a polygraph en route to the CDE. This certainly would appear to function as a fear-inducing tactic designed to "soften up" the client prior to the even more invasive examination to be conducted at the ETAC (akin to sleep, rest, food or water deprivation prior to torture).

Further, unless it is conducted as a flat-out "fishing expedition," to conduct a polygraph examination ethically the questions must be developed beforehand and revealed to the examinee. If such questions relate to health issues, the polygrapher would necessarily have received protected health information (PHI) from the referring entity to formulate these questions. Consent to

release of PHI for substance-use-related disorders is strictly governed by 42USCFR Part 2,[3] and any unauthorized dissemination of such information is subject to severe penalties.

No PHP has yet demonstrated convincingly that all consents they extract from participants (under threat of licensure-board reporting) for sharing of PHI are compliant with this law. Therefore, any physician being evaluated for ostensible substance use disorder who is subjected to a polygraph examination without giving specific 42CFR Part 2-compliant consent may have a federal claim with potentially VERY substantial consequences against all the entities sharing the PHI. It wouldn't hurt for physicians to show a copy of this law to the examiner at any polygraph examination to which they are being subjected on the allegation of one of these health conditions, as well as keeping a copy of any consent they were "encouraged" (in order to avoid board reporting) to sign.

**Louise B. Andrew, M.D., J.D.**
Victoria, BC, Canada

Dr. Huntoon's article on polygraph testing identifies a practice that should alarm the medical community.[1] While he focuses chiefly on PHPs and their affiliated secondary multiday evaluation centers, his concern properly extends to hospitals as well, particularly where the practice is being widely applied to fitness-for-duty determinations, credentialing, and peer review processes. The central problem is not simply that polygraphs are unreliable, as the National Research Council concluded in its comprehensive National Academies report.[4] It is that a coercive nonmedical credibility interrogation technique is being inserted into a medical evaluation process—manifestly for rehabilitation purposes but pre-forensic in nature—where refusal, anxiety, or an "inconclusive" result may be converted into evidence of noncompliance, denial, or impairment requiring treatment before resuming practice.

Polygraphy is not a legitimate diagnostic instrument for substance use, psychiatric disorder, or fitness to practice. It measures physiological arousal, not truthfulness. In the PHP environment, the examinee is often already under existential threat: loss of license, privileges, training status, reputation, income, and professional identity, and perhaps even faces deportation. In that context, autonomic arousal may reflect fear, trauma, humiliation, sleep deprivation, medication effects, medical illness, or the terror of (perhaps yet again) being disbelieved. Thus, it may serve to generate the very suspicion that then justifies diagnosis, compulsory treatment, aggressive monitoring, or adverse board reporting. To treat that response as clinically meaningful is not evidence-based medicine. It is psychologically coercive and potentially traumatizing. And it is antithetical to the very principle of professionalism in medicine that the ordering entity purports to uphold.

Physicians and counsel must abandon the prevalent mythology that unquestioning submission will be rewarded as evidence of upstanding character. Counsel often fears that procedural objections will anger the PHP, prolong non-practice, increase legal expenses, and jeopardize reinstatement. But that fear can become the system's leverage. In a coercive FFDE/PHP (fitness-for-duty evaluation/physician health program) process, compliance itself may be weaponized: participation may validate the process, expand the inquiry, justify intrusive recommendations, and later be portrayed as voluntary consent, leaving the physician in an inextricable bind, and at that point, unable to afford counsel.

Physicians must recognize that, when confronted with such a demand, they are not merely permitted to ask questions; they have a professional and career-protective duty to do so. Before submitting to a polygraph examination, a physician should request written clarification of the legal authority for the demand, the clinical rationale, the accepted medical standard supporting its use, the scope of questioning, the intended use of the results, the consequences of refusal or inconclusive findings, and, perhaps most importantly, whether the policy has been reviewed and approved by the organization's legal counsel. Non-response itself becomes part of the evidentiary record.

The act of asking these questions should not be characterized as evasion, defiance, denial, or noncompliance. Physicians undergoing a legitimate, evidence-based fitness evaluation should not be punished for requesting the legal and clinical basis for a non-validated interrogation device that could be weaponized against them. If such questioning is converted into an adverse inference or retaliatory report, that itself exposes the coercive nature of the process.

No physician should automatically consent to a polygraph exam ordered by a medical board, PHP, preferred evaluation center, hospital, or training program. The appropriate response need not be belligerence, but disciplined insistence on written authority, written rationale, defined scope, preserved objections, and legal accountability. Respectful assertion of rights is not defiance; it is essential self-protection.

**Kernan Manion, M.D.**
Gloucester, Mass.

**REFERENCES**

1. Huntoon LR. Physician Health Programs: polygraph testing. *J Am Phys Surg* 31:46-49. Available at: https://jpands.org/vol31no2/huntoon.pdf . Accessed Jul 26, 2026.
2. Mueller CB, Kirkpatrick LC, Richter L. §7.7 Reliability Standard (Daubert, Frye). GWU Law School Public Law Research Paper No. 2018-71. SSRN. Available at: https://ssrn.com/abstract=3277067 . Accessed Jul 27, 2026.
3. Code of Federal Regulations. Title 42. Part 2—Confidentiality of Substance Use Disorder Patient Records. Available at: https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-2 . Accessed Jul 10, 2026.
4. Executive summary. In: *The Polygraph and Lie Detection*. National Research Council, National Academies; 2003. Available at: https://www.nationalacademies.org/read/10420/chapter/2#2 . Accessed Jul 13, 2026.

## Vaccines and Rheumatic Disease

Thank you for your article on the musculoskeletal and rheumatological effects of vaccination.[1] There has been a local wave of severe rheumatological disease following COVID-19. A family member (unvaccinated) has been diagnosed with a clotting disorder that has affected her pregnancies, and I have several friends with similar severe conditions diagnosed over the past several years who had been otherwise healthy. I agree with Dr. Peter McCullough regarding the likelihood of spike-protein-mediated disease, which explains why the "vaccinated" and the not "vaccinated" are both susceptible, yet the "vaccinated" are at so much higher risk because of aggressive unnaturally stimulated immune activation, higher and longer spike protein burden, and other as yet not fully elucidated causes.

A vaccine not discussed in your article would be GlaxoSmithKline's old Lyme vaccine, which was withdrawn by the company itself in the early 2000s after usage voluntarily plummeted due the widespread experience of Lyme-like arthritis. It is a relatively recent example of vaccination as a potential trigger of debilitating musculoskeletal autoimmune-mediated disease. The health authorities went through the usual circle-the-wagons routine at that time too, but it was not enough to save the vaccine from the market choices of a free-thinking and informed public. Now vaccine manufacturers are dependent/reliant on unlawful government mandates to keep their products in demand, and on fake-news media to suppress and censor any adverse reports.

**Stephen Hughes, M.D.**
Greenville, SC

**REFERENCE**

1. Orient JM. Negative evidence: musculoskeletal manifestations and the safety profile of COVID-19 mRNA vaccines. *J Am Phys Surg* 2023;31:34-45. Available at: https://jpands.org/vol31no2/orient.pdf . Accessed Aug 3, 2026.