

Systematic Abuse and Misuse of Psychiatry in the Medical Regulatory-Therapeutic Complex

Robert S. Emmons, M.D.

Kernan Manion, M.D.

Louise B. Andrew, M.D., J.D.

Overview

The possibility of systematic abuse and misuse of psychiatry occurring in the medical regulatory environment has, in our view, escaped notice because of the stigma and powerlessness of those affected, coupled with a lack of governmental oversight or judicial recognition of what is considered to be an intra-professional issue. Traditional definitions of abuse and misuse of psychiatry did not envision its occurrence within a professional regulatory system. Nor was it considered that abusers need not intend to misuse psychiatry to cause harm, but that misuse and resultant harm could ensue from the construct of the system itself.

We therefore propose an expanded version of the American Psychiatric Association (APA) definition of abuse and misuse of psychiatry to better conceptualize and characterize the source and types of harms engendered in this newly described medical regulatory-diagnostic and compulsory rehabilitation nexus, which we term the “medical regulatory-therapeutic complex” (MRTC). While the increasing prevalence of the problem compels solutions, our purpose in this article is to expose the existence of such abuse, to explain its origins, to highlight the unique medical regulatory rehabilitative nexus in which it is occurring, and to begin the dialogue from which solutions may emerge.

Licensing and Credentialing

Licensing and credentialing of physicians is intended to protect the public from incompetent or unethical practice. It is accomplished through a patchwork of statute, regulation, case law, and collegial review, with much of the activity concentrated in medical licensing boards (MLBs) and hospital peer review committees (HPRCs). In recent decades, MLBs and HPRCs have granted a nearly exclusive franchise to state Physician Health Programs (PHPs) to assess or refer for psychological fitness for duty evaluations (PFFDEs) of physicians, either to treat or refer for treatment, and to make decisions about whether and how to return allegedly impaired physicians to the workplace. At present, no uniform enforceable legal, professional, or ethical standards exist for the conduct of PFFDEs of physicians in the context of the medical regulatory environment.

It has become commonplace to make such medical licensing and/or hospital privilege decisions—with the attendant risk of reporting to the National Practitioner Data Bank (NPDB)—contingent upon strict compliance with referrals to, and all resultant treatment recommendations from, the PHP. This contingency requirement, combined with a lack of due process and a therapeutic philosophy of practice that does not conform to generally accepted clinical standards, has created a system in which evaluatees can be harmed, with no recourse or even an

independent review mechanism.

Because this MRTC requires evaluators to serve both forensic and therapeutic functions, we hold that evaluatees should be entitled to due process, in addition to all the protections and ethical requirements attendant to ordinary clinical psychiatric practice. The concept of abuse and misuse of psychiatry provides the best framework for characterizing an emerging form of systemic injustice that transcends incompetent or unethical practice by individuals. A definition of systemic abuse in the MRTC, as proposed below, is needed to provide a foundation for developing ethical standards for PFFDE.

Case Example

Dr. PJ applied for a second medical license in a nearby state, answering “yes” to the question “Have you ever been treated for a mental illness?” because of an episode of depression experienced in medical school 17 years prior. The MLB referred him to its PHP. After a telephone interview including his physician, Dr. PJ was told that he would as a formality need to meet in person so that the PHP could generate a report to the MLB. He was told to bring \$500 in cash to the PHP. There, Dr. PJ was met by a social worker who stated that policy required he first sign forms consenting to full disclosure of all his medical records, and to compliance with all recommendations that might be made by the PHP, or his non-compliance would be reported to the MLB. Asking the nature of such recommendations, he was told that there was a more than 90 percent chance he would need to undergo a multi-day inpatient evaluation, costing \$5,000 cash. And that usually this would be followed by 3 months of inpatient treatment (costing about \$40,000) and then 3–5 years of outpatient treatment and monitoring. But first, he would have to take a drug test.

Table of Abbreviations

ADA - Americans with Disabilities Act
APA - American Psychiatric Association
HPRC - Hospital Peer Review Committee
FSPHP - Federation of State Physician Health Programs
MRTC - Medical Regulatory – Therapeutic Complex
MLB - Medical Licensing Board
PHP - Physician Health Program
PFFDE - Psychological Fitness for Duty Evaluation

Thinking this must be a mistake, Dr. PJ asked to speak to someone else. The medical director then appeared and asked why he was refusing to take a drug test. Dr. PJ explained that he was told this visit was a formality because of his depression, that he had never used drugs, and that he didn't feel comfortable signing blanket consents, given what he was told about likely future recommendations. The director stated that from his perspective, because of this refusal, the doctor must have something to hide, so that whatever the reason for the original referral, he was now also under suspicion of having a drug problem. Dr. PJ left to consult with an attorney. The attorney suggested obtaining a drug test privately, but the PHP director said this would have no validity. Several lawyers then opined that in all likelihood Dr. PJ would need to sign the consents, and that representation to resist the process would cost around \$30,000. Dr. PJ decided that licensing in the second state was not worth the expenditure, withdrew his application, and did not return to the PHP. Dr. PJ remained concerned that his withdrawal of the licensure application might generate a harmful report to both his original MLB and the NPDB.¹

Historical Background

PHPs were an outgrowth of Impaired Physician Committees, originally created as a benevolent means to treat physicians with substance use disorders and return them to the workplace, as opposed to ending the careers of physicians suffering from treatable medical conditions. These programs were initially and still often are led by recovering persons with no training in psychiatry, but they have 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.² Prolonged, often inpatient treatment at a small number of "preferred physician treatment programs," employing exclusively an Alcoholics Anonymous-derived 12-step ideology, is usually recommended to physician participants who are found to have any substances, including alcohol, present on random drug testing.³ No justification is offered for length of stay that is three times the normal recommended for addicted persons (90 as opposed to 28 days),⁴ and no allowance is made for physician participants to choose alternative treatments or venues. This "paradigm" is based on a 2008 survey⁵ that was never subjected to rigorous statistical analysis, the data from which has, however, been repeatedly mined for additional publications. The so-called blueprint study is self-proclaimed by the authors to represent the "gold standard" for treatment of physicians in recovery.⁶ PHPs encourage referrals from MLBs, HPRCs, and the general public; physicians are invited to self-refer as well.

Medical regulators, including MLBs and HPRCs, have expanded their scope of referral to PHPs for a variety of indications, one of which, according to leaders of the PHP movement, is to avert the need for the time-consuming due-process considerations required in most medical disciplinary proceedings. Skipper and DuPont, two of the principal proponents of the "PHP Blueprint for Recovery," have written:

Unlike boards, PHPs are not constrained by due process and other legal impediments to action. Regulatory boards, as legal entities, are usually required to conduct an investigation, develop a case, give notices, conduct due process and judicial hearings, and allow appeals.... In contrast, PHPs only need credible symptoms (and not probable cause) to recommend discontinuation of practice and thorough evaluation. PHPs can only recommend because they have no direct authority over licensure. However, in most cases, physicians comply with PHP recommendations to avoid the risk of formal notification of the board.⁷

With exclusive referral relationships in place, MLBs and PHPs often unquestioningly defer to each other's recommendations.

It has become commonplace to make medical licensing and/or hospital privileges and the attendant risk of reporting to the NPDB contingent upon immediate and unwavering compliance with referrals to PHPs as well as their treatment recommendations. This coercive practice essentially nullifies the principle of informed consent for treatment, or indeed any other form of autonomy for evaluatees, leaving them without recourse in the event of incompetent or unethical practice by a PHP's evaluators or its preferred treatment providers.

Although participation in PHPs is alleged to lead to high rates of abstinence, it is not clear that coercion is the decisive therapeutic ingredient,⁸ for several reasons. For one, neither the referring nor admitting diagnosis are independently verified. For another, treatment outcomes for physicians with substance use disorders in coercive environments have never been systematically compared to non-coercive environments. The use of less draconian contingencies has not been studied. Further, the use of therapeutic coercion is extended from the treatment of substance use disorders to a plethora of putative mental disorders based on ideology alone.

The use of professional credentialing for contingency management binds MLBs, HPRCs, PHPs, and "preferred physician treatment programs" together seamlessly into an MRTC. As a result, differences of opinion about diagnosis and treatment cannot be resolved in the ordinary clinical way, which would be to get a second opinion or try an alternate treatment.

State PHPs are typically though not invariably nonprofit public charities operating under an exclusive non-competitive contract with the MLB.⁹ As corporations, they are not licensed or authorized by states to practice medicine in any capacity, and of late some claim that they do not conduct assessments of any sort—neither diagnostic nor peer review, although in the past some argued that what they were conducting was in fact peer review.¹⁰

Due-process protections available in civil proceedings, already weakened in administrative domains, may be entirely absent in the PHP arena, in part because these programs may deny even conducting diagnostic assessments and are licensed as merely educational entities. Statutory and case law, and judicial deference to what on its face undoubtedly appears to the courts to be a well-functioning intra-professional self-regulating administrative system, tends to reinforce the precedent of legal immunity.

Notwithstanding PHPs' benevolent origins, this combination of coercion, virtual legal immunity, lack of independent oversight, and denial of due process creates an environment

in which private reports of abuse of PHP-evaluated physicians abound, as illustrated in the North Carolina state audit¹⁰ and by the case of Dr. PJ.¹ Alleged abuses include: bad-faith referral as an extension of sham peer review; orders for PFFDE based on insufficient evidence; insider referrals to “preferred programs;”^{10,11} false diagnosis and over-diagnosis; inappropriate treatment recommendations that can be made by nonphysicians; reliance on anonymous evidence provided by unreliable reporters; financial exploitation in the form of coerced expensive, overly restrictive, and medically unjustified treatment options; unauthorized disclosure of protected medical information and public dissemination of non-validated and contested diagnoses; and even loss of license in cases where no legitimate evidence of impairment exists¹¹ (personal communication, Jesse O. Cavenar, Jr., M.D., Oct 29, 2018).

Stigma and fear of professional retaliation keep many physicians who feel they have been mistreated from coming forward publicly with complaints, as attested to in many private communications with authors, so systematic data on maltreatment of physicians in the MRTC are unavailable. But the career costs, both direct and indirect, are substantial. Direct cost of participation in a PHP-mandated referral are estimated to average between \$250,000 and \$321,000.⁶ Legal costs to contest the system can equal or exceed these amounts, and lost income is inevitable in either event.

Physicians who are involuntarily referred, or even those who self-refer without fully understanding the process may legitimately feel trapped by the denial of due process, and, consumed with the prospects of losing their livelihoods, may develop new psychopathologies or even take their own lives. Physicians in all specialties are now in short supply. When practice interruption or termination by the MRTC is not ethically or medically justified, time away from work and/or revocation of licenses and hospital privileges can result in temporary delay or even permanent loss of patient access to critical caregivers, as eventuated in the case of Dr. PJ.¹

Rationale for Defining Misuse and Abuse of Psychiatry in the MRTC

Practice in the MRTC takes place in the gray areas between peer review, forensic psychiatric evaluation, and bona fide clinical practice. The Federation of State Physician Health Programs (FSPHP) publishes its own PHP Program Guidelines,⁹ accompanied by the following disclaimer: “The Federation... expressly disclaims any and all responsibility for application of the guidelines to any individual program” and further opines that “optimally Physician Health Programs will have qualified legal immunity for actions taken in good faith.” However, no definition is offered for “good faith,” and there is no recommendation for, nor mechanism entailed, to address grievances by physician participants. The Federation’s Code of Ethical Conduct¹² primarily addresses its members’ duties to each other, including a provision “to serve all members of the Federation with loyalty and fairness.” The only enumerated duty to program participants is to “observe appropriate professional boundaries.” Additionally, this code has no mechanism of enforcement.

Beyond statements by the FSPHP of its commitment to self-

regulation, a search of PubMed yields only one paper, by Boyd and Knight, on ethics in PFFDEs conducted by PHPs.⁴ They note the same structural problems noted above regarding the MRTC, particularly coercion, and they call for independent ethical review, greater transparency in general, and promulgation of national standards. While non-binding guidelines for forensic psychiatric evaluation in PFFDE of physicians have been published, abundant private reports by physician evaluatees indicate that such guidelines are often not followed (personal communications with authors). As Appelbaum poignantly stated in reference to ethical debate in his own field of forensic psychiatry, “A field that is unable to distinguish the improper from the proper, the ethical from the unethical, must tolerate all behaviors equally since no neutral principle exists for accepting some and condemning others.”¹³ Although the MRTC may contain individual unethical and incompetent actors, we believe that this problem is also a systemic one.

As a preliminary remedy for a system in which no consensus standards for professional practice or ethics exist, we propose that the informed conscience of the individual PFFDE evaluator provides the best starting point for independent ethical review. In each case of alleged maltreatment, the entire enterprise hinges on the action of a medical clinician, operating in an involuntary, coercive environment, in conducting an evaluation and making a diagnosis that will be construed as psychiatric in nature. We believe that the current regulatory environment in which PFFDEs are conducted too easily facilitates the misuse or abuse of psychiatry. Recognition and acknowledgment of this systemic vulnerability, and development of uniform standards of ethical practice by evaluators as well as rigorous oversight of their implementation, will provide some guidance for evaluators, as well as some measure of protection from malfeasance for those evaluated. In this way, the PHP field may move towards the ideals of uniformity, transparency, and accountability.

In general, professionals in any given field establish and publicize their own standards for ethics and clinical competence. Where this has not been done, as Appelbaum opined years ago to be the case in forensic psychiatry, all behaviors will be tolerated equally.¹³ Critiques and attributions of systemic abuse must, of necessity, originate with aggrieved parties and experts with no financial or organizational ties to the flawed system.

Paul Chodoff, in “Misuse and Abuse of Psychiatry: An Overview,” defines misuse of psychiatry as improper use of psychiatric diagnosis or treatment that can inadvertently lead to bad outcomes, and abuse is defined as psychiatry practiced in bad faith with intent to harm or with reckless disregard for potential ill effects on the well-being of affected individuals.¹⁴

Much of the currently available literature has focused on political abuses of psychiatry, not clinical abuses within the medical arena. It is perhaps not surprising that well-meaning participants in the MRTC may exhibit a kind of moral blindness to the harms inflicted on evaluatees by a system from which they themselves have benefited personally, and in which they may also have significant personal, professional, and/or financial investment.

Regrettably, physicians with no prior or personal involvement in the MRTC tend to mistakenly view these programs as ethically delimited and legitimately empowered extensions

of their profession. Presuming adherence to bedrock medical and psychiatric principles and ethics, these professionals may fail to validate, or even to entertain the concerns of their own colleagues who may be grievously harmed by such systemic abuses of psychiatry.

The American Psychiatric Association's Position Statement on Abuse and Misuse of Psychiatry (1994) states that the organization supports "the use of psychiatric knowledge, practice, and institutions only for purposes consistent with ethical evaluation and treatment, research, consultation and education," noting that "abuse and misuse of psychiatry occur when psychiatric knowledge, assessment, or practice is used to *further illegitimate organizational, social or political objectives*" [emphasis added].^{15,16}

While certainly helpful, this definition is inherently limited, as it is not sufficiently inclusive of components of abuse that may emerge in a flawed system. A flawed system can cause harm by misuse or abuse even in the absence of intention. Moreover, a definition of abuse such as this one based on intention can be difficult to enforce, as it inevitably invites speculation, debate, and denial.

We propose to broaden the definition of abuse and misuse of psychiatry in the PFFDE arena beyond a criterion of furthering "illegitimate objectives" to include considerations of system, process, and outcome within a context that may itself bear legitimacy: to wit, existing to further legitimate objectives.

The Global Initiative on Psychiatry offers a definition of psychiatric abuse that is based on the denial of human rights.¹⁷ A process-oriented definition like this can encompass the current denial of due process for physicians facing allegations of impairment. Chodoff offers a broader definition of psychiatric abuse, which is the use of psychiatry to enforce social codes against the best interests of the individual.¹⁴ This system-focused definition usefully broadens the scope beyond individual bad actors, to encompass a structurally unethical and unjust system in which some or most agents can be motivated by good, even noble, intentions to treat impaired physicians and protect the public.

Medical regulators and PHPs do not make any attempt to track the prevalence of physician client suicides that occur after their referrals, or the development of new mental disorders that are created as side effects of their interventions.³ We believe it is important to consider these harms, and we therefore propose that bad clinical outcomes for evaluatees should be incorporated into a working definition of psychiatric misuse and abuse.

It is worth noting that the coercion inherent in current practices by regulators in referrals to PHPs is inconsistent with Principle 15 of the Madrid Declaration on Ethical Standards for Psychiatric Practice, approved by the General Assembly of the World Psychiatric Association:

It is the duty of a psychiatrist confronted with dual obligations and responsibilities at assessment time to disclose to the person being assessed the nature of the triangular relationship and the absence of a therapeutic doctor-patient relationship, besides the obligation to report to a third party even if the findings are damaging to the interests of the person under assessment. Under these circumstances, *the person may choose not to proceed with the assessment* [emphasis added].¹⁸

However, the use of contingency management, currently standard in the MRTC, means that a physician choosing not to proceed will likely be confronted with an outcome even more dire than might have occurred as a result of the treatment.

General Principles of Ethical PFFDE in the MRTC

The following principles and definition are intended as benchmarks for physicians who face allegations of potential impairment, and their attorneys, to use before consenting to any variant of PFFDE; as an articulation of fundamental principles of conduct for ethical evaluators; and as a framework within which to retrospectively evaluate and collect data on allegations of abuse. Physicians who are referred for PFFDE should make every effort to avoid evaluators and programs that do not accept these principles.

It is well recognized that the fundamental purposes of medicine are to understand, to heal, to provide comfort, and to relieve suffering. Because the results of a PFFDE—even one conducted honoring all medical ethical principles—may entail profound or even grave career and livelihood consequences, such assessments conducted in the context of medical regulation must be conducted with utmost integrity and delicacy. The initial coerced referral for a PFFDE in the MRTC as well as subsequent coerced referrals by this evaluator for additional PFFDE or any of its variants are often analogous to an involuntary or civil commitment, and the evaluatee must be afforded many if not all of the same well-established legal, clinical, and ethical protections required in a commitment case. As a paramount matter of medical professionalism, the PFFDE evaluator must understand the gravity of the examination to the individual, and respect the fundamental rights and dignity of the colleague being evaluated.

Appelbaum, in his effort to develop a new code of ethics for his field, argued that forensic psychiatrists should openly acknowledge that they only serve justice, and therefore are not bound by the standards of ordinary clinical ethics, particularly, the duty to do no harm.¹³ Because the MRTC uniquely hybridizes the forensic psychiatry and the PFFDE assessment framework with its primary goal of protecting the public from incompetent or unethical medical practice, blending it with the therapeutically oriented diagnostic and rehabilitation function of assessing and treating allegedly impaired physicians, we believe that physicians subjected to a PFFDE are entitled to the provision of the highest standards of due process, along with all of the ethical, clinical, and scientific requirements of ordinary clinical psychiatric practice. If PFFDE evaluators and affiliated treatment programs specializing in these services are allowed to operate without even requisite adherence to basic clinical psychiatry standards, then they, in our opinion, might as well abandon all claims of therapeutic intent, and fully acknowledge that they serve instead as agents of retributive justice.

The evaluating medical professional working within this hybrid system is duty bound to act with beneficence, to honor and protect the confidentiality of personal medical information, and, above all, to do no harm, directly or indirectly.

Conflicts of interest cannot always be avoided, but in the setting of a physician PFFDE, it must be emphasized that continuing financial relationships between referring organizations and evaluators inevitably create a very high risk

of abuse. Therefore, any such potential conflicts of interest as ownership or direction or employment, by an entity that provides treatment to physicians deemed to be in need of treatment, should usually be completely avoided; but in any event must always be disclosed. PFFDE evaluators must make their diagnostic findings and treatment plan recommendations openly available, transparent, and intelligible to the evaluated physician. They must also offer a means of prompt correction or notation of disagreement upon contest by the evaluatee. Such recourse must be made explicitly clear in the event of disputed findings.

The principle that it is unethical for psychiatrists to participate in systems that are inherently unethical and unjust is well established for circumstances such as torture or legal execution,^{18,19} and the same principle should obtain for participation in PFFDE. The case of Dr. PJ illustrates potential misuse of psychiatry in several of its elements, starting with a licensing question that violates the provisions of the Americans with Disabilities Act (ADA). Given the potential for misuse and abuse of psychiatry in the current MRTC, we strongly recommend that physicians referred for evaluation for alleged impairment seek private evaluators with experience in the field of PFFDE of physicians who maintain independence from MLBs, HPRCs, and PHPs. We further call on all evaluators and employees within PHPs to report to appropriate authorities, and to withhold referrals from, colleagues who practice incompetently or unethically, including those who may have actual or potential conflicts of interest.

An Expanded Definition of Abuse and Misuse of Psychiatry Applicable to the MRTC

Searching PubMed using the key words “abuse of psychiatry,” “physician health programs,” and “physician fitness for duty” yields no results. We propose the following statement and working definition of abuse and misuse of psychiatry in the context of physician psychological fitness for duty evaluation:

Physicians facing allegations of any mental disorder are entitled to ethical, compassionate, and confidential PFFDE and delineation of proposed treatment in an environment that is free of coercion. No scientific evidence for the efficacy of any therapeutic program has been presented that is conclusive enough to justify the treatment of physicians as a special class of citizens with limited rights to autonomy in choice, duration, or location of assessment and treatment. No legal or scientific basis exists outside of the protections afforded by the ADA and civil commitment laws for the restriction of due process and other rights to physician citizens.

Abuse and misuse of psychiatry occur in PFFDE when referrals or orders for evaluation, treatment, or monitoring are made to support illegitimate organizational, social, or political objectives. Abuse and misuse of psychiatry also occur in PFFDE when the evaluatee is denied full due process and/or is wrongfully harmed by the limitation of due process by denial of knowledge of or timely access to available administrative remedies in referral, evaluation, treatment, or monitoring. Due process in the PFFDE context is defined as the right to know the basis for referral, the right to contest the referral at any stage of the process, knowledge of the outcome of any referral, and

recourse to a fair mechanism, independent of referral sources, to adjudicate disputes. Potential harms to an evaluatee resulting from lack of a full and fair process include: creation of new psychopathology, loss of liberty, false attribution of mental illness, loss of confidentiality, loss of professional reputation, and deprivation of wealth, livelihood, and well-being.

Robert S. Emmons, M.D., practices psychiatry in Burlington, Vt. Contact: robertsemmons@comcast.net. **Kernan Manion, M.D.**, practiced psychiatry in Massachusetts and North Carolina for 30 years and is a founder of the Center for Physician Rights, www.physicianrights.net. **Louise B. Andrew, M.D., J.D.**, practices internal and regenerative medicine and counseling via MDmentor.com from Victoria, BC.

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