Peer Review Committees and State Licensing Boards: Responding to Allegations of Physician Misconduct

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Although physicians tend to be more concerned about malpractice actions, adjudication of complaints of alleged physician misconduct by peer review organizations and state licensing authorities can have equally serious consequences. Unlike medical malpractice, no patient injury is necessary to support the claim of alleged misconduct. Unlike malpractice, in which a plaintiff must be the injured party, in administrative peer review, colleagues, family members, and patients may all qualify as potential complainants. Unlike malpractice, where the standard of care is what the average prudent practitioner would be expected to do in similar circumstances, in peer review, the standard of care is the code that the organization has endorsed and to which the individual practitioner has agreed by choosing to join the organization. Forensic psychiatrists who may serve either as experts for a peer review or state board investigation or as peer review committee members must understand the legal foundation of the process and the attendant psychological and sociopolitical forces affecting the different parties.

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The mental state and mental capacity of a physician or other health care provider may be called into question by allegations of misconduct made by a complainant to a state medical board or to any of an array of health care agencies of which the health care provider, the respondent, is a member.[1,2]

Forensic psychiatrists serving as expert witnesses or as part of the administrative committee charged with adjudication of the complaint may find themselves navigating in a medicolegal arena that bears little similarity to the laws and process of traditional medical malpractice. Expert witnesses and adjudicators need an understanding of the legal basis for this administrative legal process and the procedurally important interstices of that process. In addition to that legal and procedural understanding, they will also be well served by an appreciation of the typical adaptive and maladaptive replies of respondents and complainants and the peer reviewers themselves. This knowledge base can better equip all parties to provide peer reviews that are just.

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The Legal Foundation of Peer Review

In 1986 when the Health Care Quality Improvement Act (HCQIA)[3] became federal law, the term peer review changed from a medical expression that was open to a panoply of professional definitions to a legal term of art, with statutory definitions and requirements, immunities, and sanctions. If HCQIA is known to physicians at all, it is more generally known as the law that established the National Practitioner Data Bank (NPDB). That data repository was in part created to make it more difficult for physicians with a substantial history of malpractice in one state to cross the border to another state and set up practice with a clean professional slate.

What is less well known is the finding by the U.S. Congress that "There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review."[3] In light of this conclusion, the HCQIA provided civil immunity to all persons in health care agencies who were engaged in physician peer review, so long as they observed the requisite due process. Examples of health care agencies include hospitals, clinics, inde-

pendent practice associations, group practices, third-party payers, and professional societies.

The promotion of physician peer review by health care agencies and the reporting relationships of these health care agencies to state licensing boards and to the NPDB made the HCQIA a watershed event in the regulation of physicians.

HCQIA defined the requisite due process. At a minimum, peer review must take place "(1) in the reasonable belief that the action was in the furtherance of quality health care, (2) after a reasonable effort to obtain the facts of the matter, (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3)" (Ref. 3, § 11112). Any action taken against a respondent must be in the reasonable belief that the action was warranted based on the facts found during the peer review process. Respondents must be informed of the allegations against them and provided with notice of the stages of the adjudication. Respondents have a right to legal counsel, to know and to cross-examine individuals who have been witnesses against them, and to present information and call witnesses in their own defense. Although not required by HCQIA, some health care agencies have chosen to include the right of appeal. States typically include a right of appeal for state medical board discipline.

The 1986 HCQIA definition of the elements of due process has more recently been restated in the so-called final rule:

> Peer review organization means an organization with the primary purpose of evaluating the quality of patient care practices or services ordered or performed by health care practitioners, physicians, or dentists measured against objective criteria which define acceptable and adequate practice through an evaluation by a sufficient number of health practitioners in such an area to ensure adequate peer review. The organization has due process mechanisms available to health care practitioners, physicians and dentists. This definition excludes utilization and quality control peer review organizations described in Part B of Title XI of the Social Security Act (referred to as QIOs) and other organizations funded by the Centers for Medicare and Medicaid (CMS) to support the QIO program [Ref. 4, p 4676].

Also opining on due process, the Joint Commission in its Standard and Elements of Performance MS.10.01.01 has required "mechanisms including a fair hearing and appeal process for addressing adverse decisions regarding reappointment, denial, reduction, suspension, or revocation of privileges that may relate to quality of care, treatment and service issues." There is an opportunity for "an unbiased hearing body of the medical staff and an opportunity to appeal the decision of the hearing body to the governing body."[5]

Respondent physicians could vitiate their peer reviewers' civil immunity were they to prove a departure from due process by a preponderance of the evidence. It is notable that the HCQIA provided immunity so long as there was a reasonable belief that the action was in the furtherance of health care. The Act does not require that peer review investigators ultimately be correct in their suspicions. It does require peer reviewers to be free of bias for or against the respondent physician. Typical sources of an allegation of bias may derive from independent knowledge of the events in question; a preexisting unduly positive or negative relationship with the respondent; or a substantial personal, financial, or professional stake in the outcome of the peer review.

A second factor in understanding the legal foundation for peer review derives from physicians' voluntarily joining a health care agency with a peer review process. This includes a physician's choice to be licensed by a state medical board. In joining, the physician is bound in a legally enforceable contract between member and organization governed by charter, bylaws, and procedures.[6]

The organization's code of conduct becomes the basis for an enforceable standard of care and conduct. The processes of enforcement articulated in the bylaws are the due process standards of adjudication and enforcement to which both the organization and the individual physician must adhere. Conformity with the bylaws, due process, and the requirement for absence of bias are the ultimate measures of a just peer review.

Differences Between Medical Malpractice and Adjudication by Peer Review

In medical malpractice, the applicable standard of care is that of the average prudent physician in similar circumstances.[7] Unlike medical malpractice, in the adjudication of administrative complaints, the standard of care to which the member physician is held is the code of conduct adopted by the organization. The trier of fact's determination of the standard

of care that is applicable to specific facts is a complex judgment in both litigation and peer review, usually involving consideration of expert testimony and legal and regulatory guidelines.[7] Sometimes, in an effort to promote an image of being above average, an organization will adopt standards of physician conduct that exceed the ordinary and prudent standards used in civil litigation or the standards proffered by the state board. Member physicians of the organization are required to adhere to these exceptional standards and in peer review may find themselves held to standards of care and conduct that are aspirational rather than reasonable.

There are other significant differences in the administrative adjudication of complaints by peer review. In medical malpractice, a plaintiff files suit to be monetarily compensated (made whole) for damages allegedly incurred by the negligence of the defendant physician.

In peer review, the complainant need not have suffered any damage and, regardless of damage, no financial restitution is offered. Sometimes a plaintiff will file an administrative complaint in the hopes of a peer review sanction against the physician that can later be used as evidence to bolster a civil claim of medical malpractice or to promote a financial settlement in lieu of a civil trial.[8]

In medical malpractice, the defendant's conduct is scrutinized to the extent that it is relevant to proving negligent damage to the plaintiff. In peer review and in state board adjudications, the physician's professional demeanor and conduct are, of themselves, legitimate arenas of inquiry regardless of the question of damage. Physicians are required to be civil and collaborative with other members of the health care team. Departures from appropriate conduct, being adjudicated as being a disruptive physician, can lead to sanctions as serious as malpractice litigation from poor clinical outcomes.[9,10]

Medical malpractice litigation focuses on a patient's treatment that led to the alleged damage. There are rules of evidence about what can and cannot be introduced into the litigation. In contrast, the complaint that initiates peer review may be focused on past events, but the scope of investigation of a physician's conduct can be expanded to include matters that were not part of the original complaint. Rules of evidence are substantially relaxed in administrative as opposed to civil legal proceedings.[3]

Nor is the peer review limited to investigation of past conduct. It also involves prospective judgments about the respondent physician's capacity and motivation to conform his practice of medicine to the applicable standard of care. The outcome of peer review may include not only warnings, probation, suspension, or expulsion for misconduct, but also prospective limitations to a physician's practice privileges, required clinical supervision, educational remediation, and treatment of diagnosed mental illness.

In alleged medical malpractice, a plaintiff and defendant either settle or have their day in court. Typically a plaintiff verdict or settlement must be reported to the state board of licensure and to the NPDB and the information made available to the public. Disciplinary sanctions from a health care agency may include a letter of concern or a warning, probation, limitations of practice, suspension and revocation, or expulsion. Reporting requirements of the heath care agency to the state board may vary by jurisdiction. Often, both the sanctioned respondent and the health care agency must report any disciplinary action to the state board. All three are required to notify the NPDB of suspensions and expulsions. State boards increasingly are choosing to make the fact of a disciplinary sanction available to the public.[11]

In addition, most heath care agencies as a condition of membership require notice from the respondent member of any peer review sanction. The newly notified health care agency, including the state board, may choose to open its own investigation and can add to existing sanctions, privilege restrictions, oversight of the physician's practice, educational remediation, and mental health treatment.

As a consequence of allegations of misconduct proven by an administrative heath care agency, third-party payers may choose to remove a physician from their panels. The legal costs to a respondent physician to defend these various exposures can be burdensome, and unlike the insurance for medical malpractice, which is substantial, the insurance for defense of state board and peer review adjudications is often specifically capped by the terms of the insurance contract and is paltry compared with the funds available for a defense in civil litigation.[12]

Civility in Health Care

For over a decade, health care has prioritized professional conduct as a key element of effective clinical

care and a substantial contributing factor to fostering quality and to diminishing medical errors. In June of 2000, the American Medical Association (AMA) defined disruptive physician behavior as, "Conduct whether verbal or physical, that negatively affects or that potentially may negatively affect patient care. This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team."[13]

In January 2001, the Joint Commission on Accreditation of Healthcare Organizations (now The Joint Commission) issued requirements of hospitals for a nondisciplinary and a disciplinary path to identify and manage physicians who were impaired or potentially impaired by illness, including psychiatric illness and substance abuse.

State medical boards have recognized disruptive conduct, psychiatric illness, and substance abuse as bases for peer review and board intervention. Boards also expect appropriate notice by health care agencies who sanctioned their members for these and other concerns.

In 2000, the Institute of Medicine published *To Err Is Human: Building a Safer Health System*. In this publication, the Committee on the Quality of Health Care in America concluded "tens of thousands of Americans die each year from errors in their care and hundreds of thousands suffer or barely escape from nonfatal injuries."[14] In 2001, the Committee published their second and final report, *Crossing the Quality Chasm: A New Health System for the 21st Century*,[15] in which they articulated principles to remedy the likelihood of medical errors.

Medical errors and quality improvement have continued as key concerns in medicine during the past decade. Quality improvement has also been linked to hoped-for cost containment by eliminating iatrogenic problems. Disruptive conduct has been repeatedly cited as an enemy of quality improvement and a cause of medical errors.

ECRI, an independent agency that assesses health care, wrote in its March 2006 report summarizing data on disruptive physician behavior:

> It is an unfortunate truth that disruptive practitioner behavior is resulting in compromised patient care in hospitals throughout the country, despite federal and state laws and accrediting agency standards that require facilities to address such behavior. Numerous surveys of health care providers have found that a majority of respondents perceive a strong link between poor patient outcomes and disruptive behavior. Disciplining a disruptive practitioner, especially a physician, can be a difficult task for facilities for a variety of reasons, including their desire to retain revenue generated by a physician or fear of litigation. All health care staff must be held accountable for their behaviors [Ref. 16, p 1].

In July 2008, The Joint Commission stated, in "Behaviors that Undermine a Culture of Safety":

> Intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team [Ref. 17, p 3].

Physicians who in decades past practiced as individual sovereigns of health care and who, to a large degree, had immunity from behavioral oversight are now mandated to be civil collaborators in a large interprofessional team.

Frequency

Unlike the prevalence of alleged and adjudicated medical malpractice, there are no data on the frequency of complaints to all health care agencies and which clinicians have required peer review investigation and adjudication. However, statistics on allegations, investigations, and adjudications are available from the different state boards.[18]

In keeping with the mission of protecting the public, boards have been sensitive to the rates of recidivism of physicians when considering the severity of sanctions and the intensity of monitoring requirements. Grant and Alford[19] examined the Federation of State Medical Board data concerning sanctions for 1994 to 1998 (Period A) and 1999 to 2002 (Period B) to assess the rates of recidivism. They demonstrated that less than one percent of physicians who had not been sanctioned during the earlier period subsequently received any type of sanction in the later period.

However, 9.7 percent of physicians who received only a mild sanction in Period A were sanctioned during Period B. Even more troubling, Grant and Alfred noted that a full 20 percent of physicians who had received either a medium or severe sanction during Period A were subsequently sanctioned during Period B. The relative risk of the group receiving a mild sanction in Period B was over 10; the relative risk of the group receiving a medium or severe sanction exceeded 30, compared with that of the no-

sanction group. The authors concluded that the data suggest a need for more vigilance in the monitoring of disciplined physicians or less reliance on rehabilitative sanctions, given these high recidivism rates.

Psychological and Sociopolitical Forces on the Parties in Peer Review

In medical malpractice litigation, there are five to six parties: the defendant doctor, the plaintiff patient or patient surrogate, attorneys for each, a judge, and possibly a jury. In a state board or peer review adjudication, the parties are a complainant; a respondent physician; a trier of fact who, depending on the health care agency, may or may not have legal training; an attorney for the respondent; and an attorney for the trier of fact.

Although the organization's membership does not have any direct standing in the process of peer review or the public in state board adjudication, the membership of health care organizations and the public at large may attempt to exert undue influence in peer review by pressuring the adjudicating peer review committee, a possibility that has no parallel in the adjudication of medical malpractice.

Complainants

There is no direct monetary incentive for a complainant to participate in peer review. Filing complaints requires filling out a form at no cost. The complainant's conscious motivation typically derives from wanting to right or avenge what that individual perceives as an injustice or an offense. Complainants in peer review are not limited to patients. Colleagues and coworkers, including organizational coworkers who are not health care providers, may allege misconduct. Family members of patients may actively participate as witnesses.

Complainants may be very angry. They may perceive or portray themselves on the side of right and as protecting innocent persons from the alleged mistreatment that the complainants have received. Although they typically frame their efforts as seeking the greater good for all, complainants may also want to see the peer review board exact retribution on their behalf.

In the authors' experience, complainants typically view themselves as less powerful than the respondent physician and perceive themselves as taking on a stronger adversary. They usually are apprehensive that their complaints will be bureaucratically disregarded. The slow pace of adjudication may heighten those concerns and foster the belief that the peer review is in fact a *de facto* shield for the physician.

In a peer review investigation of a complaint, the reviewers could find deficiencies including malpractice, poor practice, misconduct, harassment, fraud, frank monetary or sexual exploitation, substance abuse, or dementia. Yet, in the absence of bad feelings, these findings alone often do not result in a complaint against a physician.[20–22] Rightly or wrongly, complainants may feel that they have been ignored, abandoned, blamed, cheated, shown disrespect, or subjected to private or public humiliation and, as a result, have been dishonored or have lost face.

Peer reviewers should use a respectful tone in communicating to complainants that these feelings are taken seriously, if not literally, and, at the same time, reviewers must not depart in any way from the procedures of their institution or from the applicable standards of care and conduct in their effort to discern the facts of the matter in question.

Physician Respondents

While most physicians are intellectually aware of their exposure to allegations of medical malpractice, few have that same level of awareness of their exposure to organizational peer review or to state board investigations and to the gravity of the potential consequences. From the best practitioners to the worst, surprise may become outrage.

The quality of an individual physician's work notwithstanding, physicians view themselves as attempting to do good in an increasingly complicated world. They may regard substantial elements of the complaint as uninformed and misguided at best. Although the complainants see themselves as the party without power in this process, respondent physicians often have the same view of themselves. The perception of being helpless may be fostered by the right of the organization to demand that the respondent undergo an independent forensic psychiatric examination or drug and alcohol testing.

In an effort to reassert their stature, physicians may mistakenly disregard their rights to remain silent and to the assistance of counsel. A respondent may comment verbally or in writing that the complaint and the investigation are baseless: whether factually correct or not, the assertion may be, in process, misguided. Even among very capable physicians, the in-

ternal experience of anger is often so profound that it unwittingly leaks into a variety of communications as contempt.

In the authors' experience, respondent physicians often feel a profound sense of betrayal, both by the complainant and by the investigators. Investigators who are following procedures may be thought of as partisans against the doctor, merely because they objectively proceeded with the investigation rather than dismissing it out of hand.

In addition to the sense of betrayal, respondent physicians often feel a loss of status and public face, even though the investigation is confidential. One respondent, who was exonerated on all counts by a state board investigation, commented on how "dirty" he felt during the whole process, even though his professional actions were well within the standard of care. Because the investigatory process may activate unconscious guilt, some respondents are prone to overconfessing or taking responsibility for something for which, on balance, they should not.

In the adversarial partisan climate, perspective taking (that is, being able to consider another's point of view even if one thinks that it is incorrect) may be the first casualty. It is often replaced by pathological certainty and by myopic and binary thinking.

In our experience, the high moral tone of complainants may be greeted with a dismissive, high-handed tone from the responding physician. In this emotionally charged climate of injury and anger, it is easy for the facts to be mistakenly relegated to the backseat in lieu of arguments over principle and honor. Some respondents may simply refuse to cooperate with the investigation.

Patients who are acting irrationally are, in the final analysis, acting within the realm of being patients, albeit difficult ones. Respondents sometimes wrongly feel free to retaliate because the complaint is perceived, rightly or wrongly, as unreasonable.

Respondents who are able to prevail over their negative emotions will martial evidence early in the process, evidence that will be presented with a low level of emotion. In this quasi legal, adversarial environment, unfamiliar to physician respondents, counsel is often invaluable and in our experience, is always to be recommended. Complaints are easier to resolve early in the investigatory process, before the scope of inquiry has widened. Questions can be answered directly, with parsimony and relevance. A good defense does not include being defensive.

If the investigation proceeds to a hearing, the process increasingly mirrors the adversarial process of malpractice litigation. Although respondents have the legal right to represent themselves, in our view, assistance of counsel at a hearing is essential. A strong defense may include vigorous attacks on the peer reviewers and the organization itself. Allegations of noncompetitive practices, bias, malice, and departures from due process are common.

Any of those allegations, if proven, may vitiate the immunity conferred by the HCQIA and expose the organization and the individual participants to civil suit. Allegations in such counterlitigation have included defamation, intentional infliction of emotional distress, tortious interference with a business relationship, conspiracy through abuse of economic power, violation of the Racketeer Influenced and Corrupt Organizations (RICO) Act, and demands for compensatory and punitive damages.[6,9,23]

Peer Investigators and Peer Reviewers

It is a historically new obligation for health care organizations to oversee member physicians, physicians who may be independent providers of health care and not employees of the heath care agency. Health care agency investigators and reviewers are often *ad hoc* volunteers for a newly formed committee or individuals for whom peer review is a very small part of their overall job description. They often lack experience with adversarial adjudications.[20]

Both judging and its decisions have political ramifications within the organization. Longstanding intrainstitutional conflicts may contaminate what should be a process that aspires to objectivity and justice. Members may lobby or attack an organization's officers, investigators, or adjudicators in an effort to influence the review process. Organization members may become involved as witnesses in counterallegations of bias, malice, and noncompetitive practices.

In health care organizations, the persons involved with peer investigation and peer finders of fact may have little familiarity with such matters as due process and confidentiality, as they arise in a legal context. They typically are not accustomed to being lobbied or threatened in the way that may happen in peer review.

In addition to vulnerabilities from political forces within the organization, peer reviewers and investigators are vulnerable to thinking that they are supe-

rior and fundamentally different from the peers whom they review. The experience of sitting in judgment of others is narcissistically appealing. It may lead adjudicators to apply standards of practice and conduct that are unrealistic or sanctimonious and that lack compassion and humility. Alternatively, unwitting identification with a respondent may lead a peer review to support practices that are unduly lax because it is the group's standard of practice.

Peer review requires strict confidentiality to protect members' privacy. These standards may be violated by others in the organization on whom the reviewers are used to relying. Alleged disclosure of confidential information can be a basis for counter-allegations of defamation and malice against the adjudicating body.

Peer reviewers and investigators may also have a legal advisory imbalance. Often a health care organization has access to in-house counsel who is responsible for a range of organizational health care legal matters. However, respondent physicians have the incentive to retain litigators who specialize in this area of law and may have substantially more expertise than in-house counsel to whom the peer reviewers have access. Peer reviewers who feel legally outgunned and underprotected may have increasing difficulty in adhering to making the balanced judgments and assessments with which they are charged.

Peer reviewers and investigators are also vulnerable to acting out longstanding tensions between the institution and outliers and whistleblowers. It is well for reviewers to be reminded of the Athenian Senate's death sentence for Socrates, a man whose primary infraction was the public intellectual humiliation of persons in power. Clinicians have been punished or fired for taking a stand against institutional policies or a person whom they have correctly judged as clinically deficient.[24]

State Boards

State boards of medical licensure vary greatly in composition from one state to another.[25] They operate with extensive investigatory and legal latitude granted by the state government. Their fundamental mission is the protection of the public. Some of that mission is performed by credentialing and licensing health care providers and promulgating regulations and policies to foster the safety of health care practice. Another facet of protecting the public is the investigation, enforcement, and discipline of licensees.[26] More than one doctor complaining that his individual rights were being violated has been told that a license to practice medicine is a privilege, not a right, and that these were the terms for that privilege.

Boards vary in the composition of their membership, level of autonomy, available financial and staff resources, and the standard of proof that is used in adjudication. Those that have more staff and are organizationally independent from state government have higher rates of disciplinary action against physicians.[19]

As a governmental oversight agency, a state board's client is the public and the administration then in power, not the physician licensees. State boards that are perceived as being lax with negligent practitioners can face considerable political pressure from both the administration and the public. Media coverage is usually not supportive.[27] The state board's public exposure is analogous to that of a parole board.

The individuals who investigate complaints against licensees are usually not health care providers. They may be trained for legal investigations and, in some cases, are former prosecutors. The agency in general tends, appropriately, to attract individuals who are identified more with the policing of health care and with public safety than with the practice of health care and its practitioners. They in general are incensed by being treated with a lack of respect and especially with less than total honesty. They have seen the very worst of the medical community more than they have seen its better side.

Concluding Caveats

We live in an era in which there has been a public loss of confidence and security in the people and institutions that are designated to protect us. In the wake of that perceived vulnerability and anxiety, there is an increased tendency to rely on testing, investigating, discipline, and enforcement. The effects on public policy of the public's anxiety are evident in health care.

No health care practitioner is immune from being the object of a complaint. Knowledge of the process and the effects on respondents can foster an adaptive response. Counsel with expertise in this arena of law should be sought early. Keeping the investigation focal is to a respondent's benefit. The longer the process takes and the more data that are reviewed, the more likely the investigation will widen.

Physician respondents should on no account continue as the heath care provider for a complainant patient. The physician has become a source of irritation to the patient, and the doctor-patient relationship should be considered irreparably damaged. A good-faith effort should be made to find an alternate provider.

A respondent who did nothing wrong should be mindful not to act as if he did. Acting in a defensive, counteraccusatory, narcissistic, or imperious manner will convey to the investigator a lack of understanding, an inability to have a well-rounded perspective, and the possibility of a guilty mind.

Some individuals, rather than being defensive, risk acting out unconscious guilt by being unduly submissive and then overconfessing. A group investigating an alleged problem is a group in search of an answer. Out of unconscious, displaced guilt, an individual may unwittingly and wrongly volunteer to take the blame and be the explanation for what in fact is an unidentified multilevel organizational problem with several actors.

Respondents should have an overall narrative of the events in question that includes a response to the central allegations of the complaint and considers in advance the foreseeable questions of the investigators. In so doing, respondents can influence the framework and the direction of the investigation. Respondents who are taken off guard by a line of questions usually can ask for time to reflect. "I need to think about that," is an underutilized statement.

Respondents can offer context that can place the events in question in a more favorable light. A complainant's personal limitations can be discussed without being defamatory. A display of humility by a respondent is not tantamount to confession. Admission of regret at someone's distress is not the equivalent of agreeing with the substance of an allegation. Written responses, whether e-mails or letters, should be edited carefully for tone and factual accuracy. Corroboratable, supportive data should be provided early in the investigation.

Respondents who believe that the allegations against them are largely correct should work closely with counsel to consider the available choices and avenues of negotiation, if any. A longer fight in which the respondent ultimately does not prevail will usually and reasonably result in stronger sanctions.

Peer investigators and peer reviewers ideally will enter their task with the understanding that both complainants and respondents have good reasons for having negative emotions, anger being one of the most prominent. This is a task that more often loses than makes friends in an organization. In the event of some instability within the organization, the peer review board may be rejected and its members turned against by the very organization that had asked for its service.

Peer reviewers may have to remind the administration that the review must be truly independent. The administration of an organization in conflict or in transition may be more focused on an expedient punishment than on verifiable due process. The risks to reviewers and the organization for departure from due process are many.

Peer reviewers can best serve themselves and their fellows with repeated reminders that not only is every clinician vulnerable to being wrongly accused, but all have some vulnerability to engaging in behavior that they may later deeply regret.

In some cases, complaints can be quickly resolved, but others proceed to a full hearing. Peer reviewers should assure themselves that they are adequately indemnified by the parent organization so that financial anxieties do not affect their judgments.

In a hearing, the only thing over which the reviewers can have true authority is adherence to the due process that should be afforded the respondent. The measure of their job performance is that the hearing is without bias or malice, adheres to the rules of the organization, and produces judgments that are narrowly constructed and based on a factual foundation.

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