Sham peer review is a "corrective action" proceeding commenced by a hospital medical staff against a physician to discipline the physician motivated by other concerns than the quality of patient concerns – such as hospital politics, competitive advantage or retaliation. There are twelve telltale signs that individually and collectively may indicate a situation of malicious peer review.

1. A doctor with a good history and reputation suddenly deemed to have questionable performance indicators. Absent intervening external causes such as recent substance abuse, or mental illness and unusual stress of some kind, physicians usually do not suddenly turn south in terms of professional judgment and performance.

2. The presence of gunny sacking issues. Gunny sacking is the dredging up of old issues long since resolved to demonstrate present problems. While history can be important if it demonstrates a consistent pattern of misbehavior or uneven performance, old anecdotal grievances newly retrieved reminds one of a spouse who raises old grievances in new disagreements.

3. The existence of an "insider" clique of physicians who fiercely maintain control of peer review and credentials positions and pass key medical staff positions back and forth among themselves – while excluding "outsiders."

4. The lack of clear, definitive standards in medical staff bylaws for "disruptive conduct," denial or non-renewal of privileges or other discipline. This permits each physician participating in the process to bring his or her own "standards" no matter how subjective to the process. See *Kiester v. Humana Hospital Alaska, Inc.*, 843 P.2d 1219 (Alaska, 1992) (basic principles of due process of law require that criteria established for granting or denying of hospital privileges to physicians not be vague and ambiguous, and that as established, they be applied objectively.)

5. Medical staff acting in excess of authority or violation of the medical staff bylaws. Failure to follow the letter of the procedures set forth in the investigative or hearing process frequently underscores a separate agenda.

6. The existence of personal animus on the part of those participating in the investigative or hearing process is a clear marker of retaliatory intent.

7. The existence of a conflict of interest on the part of those measuring or participating in the peer review proceedings can violate fundamental conflict of interest principles – casting doubt on the genuineness of espoused quality of care concerns.

8. Minor issues of quality of care magnified beyond a reasonable expectation. Every professional makes mistakes and many of us are lucky when they do not precipitate major problems for our patients and clients. When a reviewing committee loses its perspective and elevates otherwise minor infractions into major violations, judgment becomes flawed and impaired.

9. The "piling on" of complaints. Rather than discrete, illuminating case issues the medical staff appears to throw every thinkable transgression, real and imagined, on the part of the physician against the wall in the apparent hope that something will stick.

10. Disparate, discriminatory treatment. When a physician on the "outside" is treated substantially different with respect to the intensity of scrutiny than a physician on the "inside," where it is clear that the insiders are not demanding from themselves and other insiders the same degree of practice performance as the physician under review. This can sometimes be seen most dramatically in the differential review treatment of two physicians involved in the same case.

11. In the failure to seek all relevant information concerning an issue before a rush to judgment – key physicians or nursing staff members not interviewed and the charts not carefully reviewed. The sample of cases reviewed in order to reach a judgment on competence is unduly narrow. See *Brown v. Presbyterian Healthcare Services*, 101 F.3d 1324 (10th Cir. 1996).

12. The existence of only a faint nod in the proceedings to a sincere concern for the concern about quality or safety of patient care. The lack of consistency in concern about quality of patient care can be a tip-off of a separate agenda or ulterior motive in the proceedings.

While true good faith peer review is an important function of medical staff physicians, the temptation to exploit its protections under the Health Care Quality Improvement Act of 1996 can sometimes be overwhelming, particularly in small, closed communities of providers. Vigilance for sham peer review should be maintained to protect against the erosion of basic constitutional rights.