Organization Science

Publication details, including instructions for authors and subscription information:
http://pubsonline.informs.org

"It Takes More Than a Pill to Kill": Bounded Accountability in Disciplining Professional Misconduct Despite Heightened Transparency

Ece Kaynak, Hatim A. Rahman

To cite this article:
Ece Kaynak, Hatim A. Rahman (2024) "It Takes More Than a Pill to Kill": Bounded Accountability in Disciplining Professional Misconduct Despite Heightened Transparency. Organization Science

Published online in Articles in Advance 20 Jun 2024

. https://doi.org/10.1287/orsc.2023.17932

https://pubsonline.informs.org/journal/orsc

ORGANIZATION SCIENCE
Articles in Advance, pp. 1–31
ISSN 1047-7039 (print), ISSN 1526-5455 (online)

"It Takes More Than a Pill to Kill": Bounded Accountability in Disciplining Professional Misconduct Despite Heightened Transparency

Ece Kaynak,[a,*] **Hatim A. Rahman**[b,*]

[a] Bayes Business School, City, University of London, London EC1Y 8TZ, United Kingdom; [b] Kellogg School of Management, Northwestern University, Evanston, Illinois 60208

*Corresponding authors

Contact: ece.kaynak@city.ac.uk, https://orcid.org/0000-0003-4077-2200 (EK); hatim.rahman@kellogg.northwestern.edu, https://orcid.org/0000-0002-5592-8143 (HAR)

Received: July 9, 2023
Revised: January 23, 2024; May 3, 2024
Accepted: May 6, 2024
Published Online in Articles in Advance: June 20, 2024

https://doi.org/10.1287/orsc.2023.17932

Abstract. Existing theory suggests that professionals are ineffective at regulating the work of their peers, especially when it comes to disciplining misconduct, because of professional norms of collegiality. In response, transparency measures have been put in place over the years to increase accountability toward key external audiences, such as the public, and to ensure that professionals hold guilty peers accountable for misconduct. Few studies, however, have sufficiently investigated how professionals discipline peer misconduct in the face of transparency measures. We gained access to a state medical board's internal deliberations about how to discipline physicians guilty of overprescribing opioids, endangering public health. We found that even in the most egregious cases, the board predominantly refrained from implementing stringent disciplinary action despite extensive transparency measures. Our data allow us to theorize what we call bounded accountability, which refers to individuals charged with holding guilty actors accountable for their misconduct instituting only limited discipline. We found four mechanisms that constrained the exercise of accountability: *information asymmetries* between regulatory bodies, *bureaucratic inefficiencies* of the disciplinary apparatus, *shared professional beliefs* among decision makers, and *interpersonal emotions* between decision makers and the guilty professionals who are put in charge of disciplining. We found that these mechanisms operated at the field, occupational, organizational, and interpersonal levels, respectively. Utilizing a highly consequential study context, our findings suggest that when professional misconduct is disciplined by members of the same occupation, bounded accountability is the most likely outcome, even with extensive transparency measures in place.

Supplemental Material: The online appendix is available at https://doi.org/10.1287/orsc.2023.17932.

Keywords: professionals • accountability • transparency • expertise • occupations • misconduct • opioids • state medical boards

Introduction

The effective governance of professional work is both a practical and a theoretical concern (Kellogg 2011, Anteby et al. 2016). As more work in society is conducted by experts who command esoteric knowledge, governing professional work to protect its beneficiaries has become paramount (Gorman and Sandefur 2011). Existing literature suggests that expert and professional work, ranging from traditional professions (e.g., law, medicine, engineering) to contemporary professions (e.g., finance, information technology), cannot be governed without the active cooperation of the experts themselves (Huising 2014). Because professional work is often difficult to observe and comprehend for lay audiences, professionals have historically enjoyed a high degree of autonomy (Hughes 1958, Larson 1977, Freidson 1986, Abbott 1988), conceptualized as the "occupational community's ability to dictate who will and will not be a member, as well as how the content and conduct of a member's work will be assessed" (Van Maanen and Barley 1984, p. 35).

In the case of traditional professions such as medicine, law, or accounting, this right to self-regulate professional work is formally granted and protected by the

state with the expectation that professionals use their expertise in service of the public interest (Goode 1957, Freidson 1984). In the case of other expert occupations, the esoteric nature of expertise means the underlying quality of work is difficult to judge for clients and lay audiences (Gorman and Sandefur 2011). As a result, there is a high level of trust between professionals and the recipients of their services. For example, lawyers are expected to protect and represent their clients' interests without providing frivolous advice, physicians are entrusted with their patients' health and are expected to uphold standards of care and avoid unnecessary medical procedures, and accountants are expected to represent their clients' finances in a manner that is beneficial to the client and in line with the law. When professionals engage in misconduct that violates this trust and harms clients, it can have life-altering consequences, such as in cases of medical malpractice or financial fraud (Chaney and Philipich 2002). As a result, scholars have highlighted several informal and formal mechanisms that regulate professional work and hold professionals accountable when they engage in misconduct.

Informal mechanisms governing professional work originate from the lengthy training and socialization processes that novices undergo as they join a profession, whereby they learn the norms and expected behaviors of their professional community (Becker et al. 1961). These norms and codes of conduct are then reinforced through peer monitoring and peer assessment throughout one's career. Studies depict, for example, how novices learn how to deal with difficult clients (Van Maanen 1978), become accustomed to a culture of overwork (Michel 2011), and learn how to identify and respond to mistakes at work (Bosk 1979). Such informal mechanisms of professional self-regulation are further complemented with formal self-regulation carried out by state-level professional bodies that are tasked with both licensing professionals and disciplining misconduct. Despite such informal and formal regulation mechanisms, however, toward the late 20th century, scholars studying occupational communities noted that professionals and their disciplinary bodies are often ineffective at sanctioning misconduct among their ranks. Studies showed, for example, that professional bodies were reluctant to challenge their peers or hold them accountable even in cases of clear and egregious misconduct (Freidson and Rhea 1963, Cruess and Cruess 2005, Abel 2012).

To counterbalance professional communities' tendency to show leniency toward their members' mistakes and wrongdoing, more formal and external mechanisms of regulation were introduced. These mechanisms include external rules, laws, and regulations governing professional work (Heimer 1999, Kellogg 2009, Gray and Silbey 2014, Huising 2014, Evans and Silbey 2021), sunshine laws making professional disciplinary bodies' decision-making processes more transparent to external audiences (Horowitz 2012), and the inclusion of public members in professional bodies to represent the public's interest (Haw Allensworth 2017). Expert work today is thus governed through a multipronged process involving greater transparency and public oversight to ensure effective self-regulation (Boyd 1998, Timmermans and Oh 2010, Evans 2021). Yet theoretically and empirically, we have little evidence showing how these field-level changes have affected professional bodies' self-regulation processes (Chiarello 2011, Gorman 2014). Specifically looking at professional bodies' role in disciplining misconduct, we ask, how and when do professional bodies hold their members accountable for misconduct in the face of heightened transparency measures?

The literature on transparency provides insight into this question. This literature's general assumption is that transparency acts as a control mechanism and encourages good behavior, exemplified by Jeremy Bentham's seminal work on the panopticon, where he states, "The more strictly we are watched, the better we behave" (Bentham 2001, p. 277). More specifically, studies show that transparency promotes desired behaviors when those subjected to transparency measures are motivated to align their behaviors with external audience expectations because of normative pressures, legitimacy concerns, and/or reputation management (e.g. Sewell 1998, Espeland and Sauder 2016). As long as transparency is not experienced as threatening or coercive (Bernstein 2012, Anteby and Chan 2018), studies show that the effects of transparency are generally positive (Mitchell et al. 1998, Bloomfield 2001, Klitgaard 2009). Studies have found, for example, that making public officials' records and communications transparent can both increase the detection of misconduct and reduce corruption (e.g., Cordis and Warren 2014). Relatedly, within organizations, studies show how increased transparency into organizational processes decreases biases in managers' decision making, such as when determining worker salaries (e.g., Castilla 2008, 2015).

Extending the transparency literature's insights suggests that when professional bodies' self-regulation processes are made transparent to the public, professionals put in charge of disciplining their peers' misconduct should be more diligent in doing so, especially in cases of clear and documented misconduct, because exercising effective self-regulation helps the profession protect its reputation as a trustworthy profession serving the public good (Sewell and Barker 2006). To date, however, few scholars have empirically examined how the insights of the transparency literature apply to professional bodies' regulation of misconduct, in part because of difficulties in accessing data. It is difficult

for outside audiences to identify cases of professional misconduct, and even when misconduct is identified, the internal deliberations of professionals making disciplinary judgments are rarely accessible to public scrutiny.

In this paper, we use novel data on the internal deliberations of a state-level professional body to study how professional groups discipline peer misconduct in the face of heightened transparency measures. Specifically, we collected data on how physicians serving on a state medical board (henceforward the "Board") disciplined their peers found guilty of overprescribing opioids during the opioid epidemic between 2015 and 2019. During this time, the Board's management of the opioid crisis faced increased external scrutiny from the legislature and media because the state ranked among the top five for opioid-related deaths. The state in question also had one of the most comprehensive sunshine laws in the country such that the Board was required to record and publicly post their internal deliberations about their disciplinary decisions. When the Board disciplined its members for misconduct, it was fulfilling its accountability responsibility to a key external audience, the public, by protecting them from unethical or incompetent physicians; it was also holding guilty professionals accountable for their misconduct by restricting or preventing them from practicing medicine. Heightened transparency into the Board's disciplinary decision-making process should have elevated its sense of responsibility toward the public and thus encouraged stricter disciplining of peer misconduct.

Yet contrary to predictions based on the literature on transparency, in our analysis, we found that the Board overwhelmingly refrained from levying strict disciplinary action on physicians found guilty of misconduct, and instead, it allowed guilty physicians to continue practicing medicine. This limited accountability that guilty physicians faced was not solely because of sympathy between peers or norms of collegiality, however, as the professions literature would predict. We found that mechanisms based on organizational- and field-level factors also played a significant role in the decision-making process, preventing the Board from holding guilty physicians strictly accountable for their misconduct.

Our data, consisting of a relatively rare account of the internal disciplinary decision-making processes of a professional body, represent a strategic research setting (Merton 1987), enabling us to inductively theorize what we call "bounded accountability." Bounded accountability refers to individuals charged with holding guilty actors accountable for their misconduct instituting only limited discipline, even in the face of measures taken to improve accountability. We found that four mechanisms, operating at different levels, constrained the Board's exercise of accountability on guilty professionals: information asymmetries, shared professional beliefs, bureaucratic inefficiencies, and interpersonal emotions. First, at the national or field level, we found that *information asymmetries* existed between professional bodies in different states, which guilty individuals could exploit and which, in turn, constrained a professional body from exercising strict accountability. Second, at the level of the occupation, we found that *shared professional beliefs* contributed to bounded accountability because these beliefs systematically influenced professional bodies' decision making and prevented them from pursuing strict disciplinary measures. A third mechanism we uncovered that contributed to bounded accountability was *bureaucratic inefficiencies*. We found that the bureaucratic apparatus within which a professional body is enmeshed created inefficiencies such that imposing strict discipline could be difficult and time-consuming. Bureaucratic inefficiencies were thus an organizational-level mechanism constraining accountability. Finally, at the interpersonal level, we found that *emotions* such as sympathy and compassion toward a guilty peer could lead to bounded accountability.

Through the concept of bounded accountability, we make several theoretical contributions. First, whereas the professions literature suggests that, absent transparency measures, professional bodies refrain from holding their peers accountable for misconduct primarily because of interpersonal and occupational dynamics (e.g., collegiality and deference to professional judgment) (Barber 1962, Freidson 2001, Lamont 2009), we show that in the face of heightened transparency measures, bounded accountability can also result from field- and organizational-level constraints. Second, our analysis demonstrates how professional bodies can be ineffective at holding their peers accountable even in cases of clear and documented misconduct. The cases we analyzed were all documented cases of egregious misconduct, and the Board's job was only to decide on the nature of discipline. Still, we found that the Board systematically refrained from exercising strict accountability and allowed guilty professionals to continue practicing medicine. Third, our study contributes to the transparency literature by showing that transparency can have a limited impact on accountability when there is a gap in expertise between the observer (e.g., the public) and the observed (e.g., the professional body) because the observer cannot set and impose accountability measures independently of the observed to determine whether appropriate actions are taken. Our study thus responds to calls from transparency scholars to examine factors that might moderate the relationship between transparency and accountability (Bernstein 2017). Finally, our data allow us to theorize the very rare instances when professional bodies

exercised stricter discipline on their guilty peers, such as by revoking a guilty professional's license.

Literature Review

Professional Autonomy and the Regulation of Misconduct

Professional communities' claims to autonomy rest on both their esoteric expertise and their service orientation toward clients (Gorman and Sandefur 2011). Scholars highlight that professionals who possess "scarce and impenetrable knowledge" (Pettigrew 1973, p. 23) and who are successful in convincing external audiences that they possess such knowledge are granted autonomy, including the ability to discipline peer misconduct (Freidson 1986, Anteby et al. 2016). Professionals' unique expertise has allowed them to retain much of their autonomy over the years despite stakeholders' attempts to externally regulate professional work, with the goal of protecting the public from incompetent or unethical professionals.

The professions literature shows that the regulation of professional work and misconduct is exercised through several informal and formal mechanisms. Whereas informal and internally led mechanisms of regulation were common in the first part of the 20th century, more formal and externally imposed regulatory mechanisms were introduced over the years to address concerns regarding lax handling of misconduct and concerns over quality in professional services (Weisz et al. 2007, Gorman and Sandefur 2011). Still, scholars argue, because of the inability of external audiences to fully comprehend and judge professional work, this type of work cannot be governed without the active cooperation of the professionals themselves (Huising 2014, Evans and Silbey 2021).

Informal Mechanisms Regulating Professional Misconduct. Informal control mechanisms, such as socialization and peer monitoring, are most powerful in regulating professional work during the formative years of a novice joining a profession (Van Maanen 1973, Fine 1985, Kaynak 2023). A long and intense period of socialization and professional training encodes the group's shared values and norms into new members, thus controlling how they perceive everyday reality and judge standards of practice both in their own work and in the work of their peers (Schleef 2006, Anteby et al. 2016). Studies of the socialization of army officers, firefighters, and doctors, for example, depict the strict and demanding training they endure as they are initiated into the profession under the watchful eyes of senior professionals (Becker et al. 1961). Bosk (1979), in his famous study of how novice doctors learn to judge and sanction different types of medical errors, notes how this encoding acts as a powerful mode of normative control.

Once thoroughly trained and socialized, professionals carry out their work using considerable autonomy and by applying their professional judgment to individual cases. At this stage, everyday regulation of work is achieved through peer oversight (Barber 1962) and peer assessment processes (Lamont 2009). Afraid of their peers' criticism and potential disbarment from the community, professionals try to meet the expectations of their profession and curb misconduct (Arnold and Kay 1995). Finally, as a community, professionals have an incentive to collectively uphold professional standards to maintain their reputation and standing in society and to continue to enjoy their autonomy (Scott 1982, Abel 2008).

Despite these informal mechanisms governing professional work, observers noted that norms of collegiality, respect for each other's autonomy, and the expectation of giving each other the benefit of the doubt undermined the self-regulation of misconduct among professionals and led them to refrain from speaking up against misconduct (Freidson 1970, Gorman 2014). Abel (2008, p. 499), for example, observed how the "police form a silent blue wall when charged with abuse. Doctors refuse to report or testify against those accused of malpractice. Hospitals ignore whistle-blowers. The military tries combat-related offenses in courts staffed by combat veterans." Accountants working in elite accounting firms silently tolerate their colleagues' misconduct (Morrill 1995). As such, over time scholars and policymakers concluded that informal mechanisms of professional self-regulation were ineffective at curbing misconduct.

Formal Mechanisms Regulating Professional Misconduct. Formal regulation of professional work in the United States is organized at the state level. Examples of state-level professional regulatory bodies are state bar associations for lawyers, state medical boards for physicians, state boards of pharmacy for pharmacists, and boards of accountancy for certified public accountants. These professional boards both hold the power to grant membership to the profession and serve a disciplinary role, making judgments on how to sanction misconduct (Freidson 1984, 2001). According to Chiarello (2011, p. 307), "With few exceptions, boards share key characteristics: They are formed through legislative statutes that structure boards similarly to administrative agencies, including delegation of authority to make, interpret, and enforce rules by board members appointed by the governor and approved by the legislature." Despite their central role in the formal exercise of professional self-regulation, there are few empirical studies of professional boards. The studies that have been conducted criticize these state-level regulatory bodies for being predominantly composed of professionals who are members of the community they are supposed to regulate, thus reproducing the shortcomings

of informal self-regulatory mechanisms (Haw Allensworth 2017). Chiarello (2011, p. 306), who studied the Washington State Board of Pharmacy, for example, notes, "Boards have a duty to protect the public, but because they are mostly comprised of professionals whose common interests may conflict with those of the public, their ability to do so is questionable." Haw Allensworth (2017), who examined the composition of 1,790 state-level licensing boards in the 1980s and 1990s, notes that boards are not only predominantly occupied by members of the profession they are regulating but some have rules against public members having voting rights, chronic vacancies, or absences of public members. As a result, at least prior to the introduction of transparency measures and other external regulatory mechanisms, professional boards were largely found to be slow in responding to consumer complaints, rarely issue serious sanctions, and generally be reluctant to hold guilty professionals accountable for misconduct (Freidson 1984, Abel 2008).

Thus, scholars and policymakers alike have argued that professional self-regulation of misconduct, whether exercised through formal or informal mechanisms, often does not work as well as imagined (Freidson and Rhea 1963, Abbott 1988, Cruess and Cruess 2005). As a result of such observations and "a perceived lack of transparency and unresponsiveness to shortcomings" on the part of professionals (Bertkau et al. 2005), the past few decades have seen greater outside involvement in the regulation of professional work to curtail the "live-and-let-live etiquette" of the past (Gorman and Sandefur 2011). Today, professional work is increasingly governed by external rules and regulations (Hafferty and Light 1995, Boyd 1998, Weisz et al. 2007). To encourage greater accountability in how professionals formally self-regulate misconduct, multiple checks and balances have been introduced to professional bodies. Notably, sunshine laws have been introduced in many states to increase the transparency of disciplinary proceedings (Horowitz 2012). The inclusion of public members in professional bodies and greater state involvement in the disciplinary decision-making process are other measures put in place to ensure due process. Of these changes, Gorman (2014, pp. 491–492) notes that, "An earlier generation of sociologists developed a theoretical model of professional self-regulation during the golden age of the professions in the mid-20th century. Since then, the professional world has changed in significant ways, making it important and timely to take a fresh look at this topic" (Gorman 2014). State-level professional boards, furthermore, have received less attention from scholars of professional and expert work (Chiarello 2011). Our study aims to address this gap by looking at how professional boards discipline misconduct in the face of transparency measures intended to promote effective regulation of misconduct and protect the public. We next turn to the transparency literature for insights on how increased transparency into disciplinary decision-making processes might improve professional bodies' regulation of peer misconduct.

How Enhanced Transparency Affects Accountability

Management scholars have investigated how and under what conditions transparency encourages desired behaviors and improves accountability in organizations (e.g., Bernstein 2012, Castilla 2015, Pierce et al. 2015). Studies identify at least three mechanisms through which transparency can increase accountability. First, transparency can render opaque or hidden information accessible. Once information is transparent, it can help people recognize and correct injustices, biases, or asymmetries they were previously unaware of (Loughry and Tosi 2008). Castilla (2015), for example, found that transparency can increase accountability in managerial decision making because it makes managers more aware of the biased patterns or shortcomings in their decision making. Second, transparency can increase accountability when such transparency is tied to meaningful outcomes. For example, many governments require organizations that receive federal funds, such as public universities, to release information regarding employee pay to ensure recipients of public funds comply with the government's nondiscrimination policies. Failure to adhere to these policies can lead to fines and even lawsuits (Baker et al. 2023). Thus, in such circumstances, transparency can compel an individual, group, or organization to act in line with audience expectations and be more accountable. Third, transparency can increase accountability when those subject to transparency feel the need to align their behaviors with external audience expectations because of normative pressures, legitimacy concerns, and/or reputation management (Espeland and Sauder 2016). Several studies, for example, document how organizations and people align their behavior with third-party evaluations to improve their reputation in the eyes of external audiences (Karunakaran et al. 2022, Rahman 2024).

Relevant to our study, prior work has examined the effects of transparency on professionals who are accountable to the broader public, such as government officials. In such situations, transparency is theorized to improve accountability because those subject to transparency are often also subject to penalties for misconduct and/or they wish to align their behaviors with the expectations of external audiences. Several studies, for example, have observed that when states adopt strong freedom of information laws, corruption decreases[1] (Cordis and Warren 2014). In another study, researchers found that when the Ugandan government began to publish monthly data about how much money

was being transferred to local governments and districts for educational purposes, corruption and the withholding of funds by local governments were reduced, and the total amount of money that reached schools increased by 60% (Brunetti and Weder 2003). Related work shows how actors align their behaviors with public expectations to improve their reputations, even when they are indirectly subject to increased transparency measures (see Sharkey and Bromley 2015). Such studies demonstrate that transparency is considered the gold standard for decreasing the likelihood that professionals in both government and private enterprise engage in undesired behaviors and instead align their behaviors with the expectations of legitimate stakeholders, such as the public or shareholders (Hood and Heald 2006, Hood 2010).

Extending the insights of the transparency literature to the formal regulation of professional misconduct suggests that when professional bodies are asked to make their disciplinary processes more transparent to audiences to whom they feel a professional responsibility but whom they do not deem a threat (Goode 1957), these professional bodies should be incentivized to make decisions in line with audience expectations (Tetlock 1999). When professional bodies whom the public relies on fail to properly regulate peer misconduct, they risk tarnishing the reputation of their profession in the eyes of the public (Chaney and Philipich 2002). A telling example is the declining reputation of the police force in the United States as more cases appear, showing how the profession repeatedly fails to effectively regulate misconduct among its ranks (Dewan and Baker 2020, Umansky 2023, Zhao and Papachristos 2024).

Some scholars, however, suggest that the relationship between transparency and accountability is moderated by a desire or need for privacy. In his review of the transparency literature, Bernstein (2017, p. 237) notes, "While transparency can improve our accurate awareness of others, that relationship is moderated—and can even be turned negative—by the thirst of the observed for privacy." For example, researchers suggest that when there is transparency into both the decision-making process and outcome, people may be hesitant to share unpopular or controversial opinions that deviate from audience expectations (Thakor and Merton 2023). Other studies suggest that transparency experienced as coercive monitoring or surveillance can lead to unproductive behaviors (Harris 2010, Bernstein 2012, Anteby and Chan 2018). Overall, however, the literature suggests that when not experienced as a threat to privacy and as long as there is an alignment of incentives between the observer and the observed, transparency should lead to enhanced accountability. In our research setting, the public's desire for safety in the delivery of healthcare combined with the medical profession's desire to maintain its reputation and legitimacy in the eyes of the public (Goode 1957) should lead the state medical board to exercise stricter regulation of peer misconduct, especially for documented cases of egregious misconduct in our data set.

Research Setting and Methodology

The Opioid Crisis and State Medical Boards

Deaths related to opioid overdoses have skyrocketed since the 1990s in the United States. Since 1999, close to 500,000 deaths have been attributed to opioid overdose, making it one of the leading causes of death in the country (Scholl et al. 2018). The Centers for Disease Control and Prevention (CDC)'s most recent data indicate that 187 people in the United States die every day from opioid overdoses, representing the largest number of deaths since they began tracking these data (Centers for Disease Control and Prevention 2022). Given the ongoing impact of the crisis, scholars across disciplines have examined the factors contributing to deaths linked to opioid use (e.g., Case and Deaton 2015, Venkataramani and Chatterjee 2019, Zhang et al. 2023). To date, however, limited scholarly research has been conducted on the effectiveness of professional disciplinary bodies in curbing overprescription-related misconduct among physicians. In our data, the recognition that more attention is needed on how physician opioid prescription behavior contributed to patient deaths is encapsulated by a state attorney's statement during an overprescription trial where he said, "It takes more than a pill to kill a patient that is suffering from narcotic dependence."

State Medical Board. State medical boards are professional licensing and disciplinary bodies that have the sole right to discipline physicians with regard to their medical licenses. We examined how the medical board of an anonymized U.S. state (henceforth referred to as the "Board" and the "State," respectively) regulated professional misconduct pertaining to peers' overprescription of opioids.[2]

Established in the early 1900s, the Board's stated mission was to protect the health, safety and welfare of people in the State. The Board met six times a year to fulfill its responsibilities. The Board consisted of 12 members: nine licensed physicians who had at least six years of experience and three members of the public who were health care consumers. The members of the Board were appointed by the State's governor and served five-year terms. Board members were not paid and served on the Board as a service to the public and the profession. In addition, the Board had an administrative staff responsible for investigating misconduct cases before they were brought to the attention of the Board.

The main staff in charge of investigating cases were lawyers from the State's office of the general counsel as well as a medical consultant who was a physician who had previously served on the Board. The medical consultant provided medical expertise in the investigation of misconduct cases. When cases went to trial, these trials were further overseen by a judge. Both the state-appointed judge and the general counsel's roles were advisory in nature, and neither had the right to discipline guilty physicians.

Importantly, the State had sunshine laws requiring the Board to make its meetings publicly accessible, including the internal deliberation of cases. The egregiousness of the opioid crisis in the State and the public visibility of the Board's internal deliberations, coupled with state oversight and public participation in the disciplinary process, made this state medical board a strategic setting for studying how professionals hold their peers accountable for misconduct under heightened transparency measures.

Investigating Physician Misconduct. The Board had an established procedure for investigating physician misconduct cases. First, a hard-copy complaint form had to be mailed to the Board. Then, the general counsel made an initial assessment to determine if the complaint constitutes a violation within the scope of the Board's authority. If the assessment revealed that a violation had occurred, the general counsel and medical consultant either determined an early disposition (e.g., no action, letter of warning, or letter of concern) or started a field investigation. If the complaint proceeded to a field investigation, the general counsel collected information on the case, which primarily consisted of medical records, and this information was reviewed to determine disposition or further prosecution for disciplinary action. If further prosecution was warranted, the general counsel and medical consultant tried to reach a settlement with the guilty physician, referred to as an "agreed order." If the guilty physician refused to settle, then the case became a "contested case" and proceeded to an "administrative trial."

Agreed orders (i.e., settlements) were presented to the Board during one of their meetings, when they were discussed and approved based on simple majority vote. If the Board did not approve the order, it could propose a different disciplinary action. If the guilty physician did not agree with the revised disciplinary decision, the physician could request to go to trial. If a case proceeded to trial, the process unfolded like a legal case, albeit with important differences. The general counsel served as the prosecution for the state and presented the Board with their recommended disciplinary action, which they had reached with the medical consultant. The accused physician was the defendant and was often represented by an attorney. An administrative judge was appointed to oversee the trial, regulate the course of the hearing, and rule on any evidentiary or procedural issues. Trials proceeded with opening statements from both parties, followed by witness testimonies, closing statements, and, finally, the Board's deliberation and disciplinary judgment. In a trial, the Board represented a hybrid form of lawyer, judge, and jury. As explained by an Administrative Judge, the Board's responsibility was to act as "the exclusive finders of fact," "exclusive judges of the credibility or believability of the witness," and "exclusive judges of the application of the state's statutes and rules governing the practice of medicine in the State." Three members of the Board (two physicians and one consumer member) were appointed to hear trial cases. The final decision required two of the three members to agree on a disciplinary action.

Disciplinary Outcomes. In both agreed orders and contested cases (i.e., trials), the Board could discipline guilty physicians in several ways, including a reprimand, probation, suspension, or revocation of their medical licenses. Reprimanding a physician's license did not restrict one's practice of medicine but served as a warning to the physician. Placing a physician's license on probation was a more serious form of discipline but still allowed the physician to continue practicing medicine. Suspending a physician's license prevented that physician from practicing medicine for a limited, predetermined time (usually less than a year) until certain conditions were met. In some cases, guilty physicians wishing "to avoid further administrative action" (General Counsel) also chose to voluntarily retire or surrender their medical licenses in the State. Finally, the Board could choose to revoke a physician's license, which removed the physician's ability to practice medicine in the State. All of these disciplinary actions were reported to state and national databases.

It is important to note that cases appearing before the Board represented the most egregious cases of physician misconduct. These cases had passed through a funnel of investigation by the general counsel and medical consultant and had been deemed deserving of disciplinary action. Before a case came before the Board, the general counsel and medical consultant had three opportunities to determine that no action was needed (i.e., when the complaint was received, before deciding whether to launch a field investigation, and after reviewing the information from the field investigation). Because the general counsel and medical consultant were not required to release any information about cases they deemed as not warranting additional action, we would expect leniency to be most salient in this stage of the investigation and that only egregious complaints would be brought before the Board. As a result, the cases that were ultimately reviewed and

disciplined by the Board represented the most severe cases of misconduct, highlighting how we would expect the Board to levy strict disciplinary decisions.

Data Collection

Several features of the State's sunshine laws provided a relatively rare, unvarnished view of the process by which a professional body regulates peer misconduct. First, the State required that "all board discussions and deliberation be in public before all parties," (Administrative Judge) allowing anyone in attendance to observe and hear the cases. This provision included the Board's deliberation of evidence, internal decision-making process, and even the formulation of the final wording that would be included in disciplinary orders. In contrast, other states with sunshine laws often require trials to be public, but the internal deliberation of evidence, the decision-making process, and the conclusions that are drawn take place in private. Hence, our data offer a unique glimpse into the internal deliberations of a professional disciplinary body charged with disciplining misconduct. Second, according to what we observed, beginning in January 2015, the State began to publicly post audio and/or video recordings of all Board meetings, in their entirety, online. These recordings were accompanied by detailed meeting minutes documenting who attended each meeting and information on misconduct cases. Finally, for each disciplinary decision the Board made, the "findings of fact, conclusions of law and the policy reasons for [the] decision" (Administrative Judge) had to be publicly stated during meetings so that they would be on record. These data are described in more detail as follows.

Board Meetings and Minutes. We collected all the Board's publicly available recorded meetings and minutes from between January 2015 and December 2019, which represented 30 meetings in total. Each meeting spanned two days and routinely lasted over eight hours each day. Meetings focused on disciplining misconduct but also included deciding whether to grant medical licenses and updating medical guidelines.

To reiterate, we had two reasons for focusing exclusively on the Board's handling of opioid-related misconduct: first, between 2015 and 2019 states across the country, including the state we studied, enacted several measures to stem the opioid crisis, including stricter sunshine laws and guidelines for prescribing opioids. The state we studied further implemented a task force to review how opioid-related misconduct cases were disciplined and to devise improvements. Given the heightened sensitivity to addressing the opioid crisis in the State, focusing on professional boards' disciplining of opioid-related misconduct represented a strategic setting for studying professional self-regulation insofar as we would expect collegial or arbitrary reasons to play a lesser role in the decision-making process than existing literature suggests. Second, by focusing on one type of misconduct, we minimized potential variations in disciplinary decision making because of other factors, such as the type of misconduct and its consequences for public health (e.g., overbilling, inappropriate relationships with patients).

To determine which misconduct cases dealt with opioids, we read the minutes for each meeting, which described the type of physician misconduct for each case. Next, we hired and trained several research assistants to listen to each recording to identify and save the portion of Board deliberations where opioid-related cases were discussed. This yielded 112 instances where physicians guilty of overprescribing opioids were disciplined. Once we had the relevant audio recordings, we used a third-party service to transcribe these meetings. Afterward, our research assistants listened to every audio file with the transcription to ensure that recordings were accurately transcribed, and the appropriate speakers were identified (e.g., Board member, physician's lawyer, witness). Given how labor intensive this process was, it took over a year to collect and ensure the accuracy of these data.

Final Orders. Board members were required to articulate the "findings of fact, conclusions of law and the policy reasons" (Administrative Judge) for each disciplinary decision. These statements were codified in a document that was signed by the guilty physician and Board members. We collected final orders, which were posted online, for each case in our data to compare this information with the internal deliberations of the cases.

Data Analysis

We analyzed our data using ATLAS.ti qualitative coding software, guided by the principles of inductive theory building (Strauss and Corbin 1998, Glaser and Strauss 2010, Grodal et al. 2021). Although our analysis was iterative, for analytical clarity, we present it in four sequential stages. In the first stage, each author independently read and open coded meeting transcripts to identify salient themes in the data. We also wrote memos about recurrent themes that warranted additional coding and discussion because they presented theoretical or empirical puzzles. We then compared each other's open codes and memos to identify which themes stood out in our open coding. For instance, both authors identified a clear narrative arc to the Board meetings, which involved the general counsel laying out the facts of the case, the guilty physician or the physician's lawyer presenting their side of the story, Board members asking questions, and, finally, internal deliberations in which Board members discussed the case.

During its deliberations, the Board was required to articulate the reasons behind its decision-making process. This granular data allowed us to identify the various narratives used by different actors. For example, the general counsel used narratives such as 'doctor did not follow standard of care,' 'doctor has poor character,' and 'doctor violated public trust' to express the egregiousness of a physician's misconduct. Guilty physicians and their attorneys, on the other hand, used narratives that would assist in 'contextualizing and humanizing [the] actions' of doctors, 'pleading ignorance,' and 'claiming to be reformed.' Board members, on the other hand, had their own narrative repertoire for arguing for more or less strict disciplinary decisions. After our initial open coding, we went back to the literature to assess the theoretical novelty of our findings.

In the second stage of our analysis, we iterated between the literature on professional self-regulation of misconduct and our findings to identify theoretical puzzles that existing literature did not sufficiently address. In light of the literature on professions and on transparency, we were surprised by the infrequency with which the Board revoked guilty physicians' licenses, despite agreeing that a physician's actions constituted "unprofessional, dishonorable, or unethical conduct," "gross malpractice or a pattern of continued or repeated malpractice," or "ignorance, negligence, or incompetence in the course of medical practice" (Board Disciplinary Orders). That is, even though the Board routinely agreed that physicians had violated standards and norms—and sometimes even the law—with serious consequences to public health, and even though the Board often explicitly discussed how it could revoke a guilty physician's license, we observed surprisingly few cases in which the Board ultimately decided on revocation. As a result, we categorized revocation as a 'strict' or 'stringent' disciplinary outcome. Revocation was the only disciplinary outcome that involuntarily removed a physician's ability to practice medicine in the state, and, based on our data, it was the only outcome that Board members considered to send a "strong signal" to external audiences that the misconduct was "really egregious" such that the physician "should [not] be licensed again" (Board Deliberations). According to the emic understandings of our informants, all other disciplinary options at the Board's disposal—reprimand, probation, or suspension—implied that the doctor deserved a second chance and should be allowed to reform and continue practicing medicine. We also categorized voluntary retirement or surrender of medical licenses as a case of comparative leniency by the Board because guilty physicians entered into these agreed orders to "avoid further administrative action" (General Counsel). Thus, when the Board refrained from levying a revocation, we categorized the Board's decision as comparatively lenient. Importantly, we found the cases in which the Board revoked a physician's license proceeded in a relatively straightforward manner. In contrast, we found the Board employed more elaborate justifications for why physicians guilty of overprescribing opioids should be allowed to retain their medical licenses despite the egregiousness of their offenses.

Neither the professions nor the transparency literatures examine the internal discussions of professionals in charge of disciplining their peers, and we thus focused our third round of coding on these data that provide a window into the everyday exercise of professional self-regulation. We honed in on our data on the Board's internal deliberations, paying particular attention to how Board members interpreted the evidence presented in each case and how they explained whether they believed a physician should keep their medical license. For example, in our data, we observed multiple instances where the Board initially considered revoking the license of a guilty physician, but after being reminded that pursuing a revocation would result in the Board expending more time and resources during which time the guilty physician would continue practicing without any restrictions, the Board eventually settled on a less strict discipline (e.g., reprimand, probation, or suspension) to "get the doctor off the streets" (Board Deliberations) quicker. We categorized these instances in which the Board invoked resource constraints (i.e., time or money) to justify its disciplinary decisions as being motivated by 'bureaucratic inefficiencies' and by the Board's accommodation of these inefficiencies. We also observed several instances in which guilty doctors were able to evade strict discipline by relocating to a different state and obtaining a license to practice there while they were under investigation in their home state. In their discussions, Board members referred to information asymmetries between different state medical boards that guilty physicians could exploit in this manner and that allowed guilty physicians to evade strict discipline. We labeled these cases as arising from 'information asymmetries' between different regulatory bodies.

We found that, in most cases, the Board explored "continuing [professional] education" and "peer monitoring" as tools to reform guilty physicians, address their professional shortcomings, and help them become "safe physicians" (Board Deliberations) rather than trying to punish physicians for their misconduct. We grouped these cases of lenient disciplinary decision making as being motivated by 'shared professional beliefs'—in this case, a belief in rehabilitation over punishment. Finally, in a subset of our data, we found that the Board's decision-making process was influenced by 'interpersonal emotions' of compassion and sympathy

toward guilty peers. These cases were marked by codes such as Board members arguing that 'doctor is not a bad person' and considering the 'impact on physician employability' that a given discipline could have, usually in response to the guilty physician 'making emotional pleas to the Board' and expressing 'financial hardship endured as a result of previous Board orders.'

Together, through a process of comparison and contrast (Grodal et al. 2021), our analysis pointed to four overarching mechanisms contributing to bounded accountability: bureaucratic inefficiencies, information asymmetries, shared professional beliefs, and interpersonal emotions. Collectively, we labeled these four mechanisms as contributing to bounded accountability because, in all these cases, the Board imposed limited discipline upon guilty physicians, even though enhanced transparency measures had been put in place to encourage the disciplinary body to hold guilty professionals more strictly accountable for their actions. Our findings illustrate how these mechanisms contributing to bounded accountability unfolded during Board deliberations. In our analysis of 112 opioid-related misconduct cases over a five-year period, the Board reached a revocation decision only six times. Our coding of these rare cases points to two mechanisms that led the Board to revoke a physician's license. These are described in the last section of our findings.

In the final stage of our analysis, we compared Board members' deliberations with the final, publicly posted disciplinary orders. These final orders had to be formulated during the Board's deliberations, and they were thus helpful in triangulating the facts of each case and the codified justifications for disciplinary decisions.

Online Appendix A provides a supplementary analysis showing the frequency with which mechanisms leading to bounded accountability appeared in our data. This table shows that 'shared professional beliefs' was the most widely observed mechanism, present in 73 cases in our data set, followed by 'bureaucratic inefficiencies' (21 cases), 'information asymmetries' (10 cases), and 'interpersonal emotions' (6 cases). We did not observe bounded accountability in 18 cases either because of strict discipline being levied, an ongoing misconduct case in which the Board had yet to reach a disciplinary decision, or other miscellaneous reasons. It is important to note that the frequency of these mechanisms appearing in any disciplinary setting is likely influenced by various factors such as the type of misconduct, the guilty physician's history of misconduct, resources at the Board's disposal, and/or Board composition. Ultimately, our analysis helped us theorize how professional bodies hold their peers accountable for their wrongdoings and enabled us to uncover mechanisms that constrained the exercise of accountability despite enhanced transparency measures in place.

Findings

Our findings allow us to conceptualize how professional self-regulation of misconduct often results in bounded accountability, even in cases of documented egregious misconduct and despite transparency measures put in place to promote strict accountability for guilty physicians (see Online Appendix B for data highlighting the Board's commitment to sunshine laws governing their disciplinary process). The physicians appearing before the state medical board had already been investigated and found guilty of misconduct, and the Board's task was to decide how to discipline these guilty physicians. Members of the Board expressed that their decisions should be made in service of their mission to "protect the health, safety, and welfare of the people of the State." We found multiple references to the opioid crisis in the Board's deliberation of cases, particularly with reference to its gravity in the State and the impact that the Board's disciplinary decisions had on the crisis. For example, a Board member emphasized that the Board's decisions sent a signal to external audiences that could affect the ongoing nature of the crisis:

> I think that we need to send the message out [to the public]. We are essentially in a disaster. There is an opioid problem nationally and our State is in the forefront and famous for that. And I think that unless we tackle the issue in a certain manner, I think it will continue to advance. (Board Member K)

Our data show that even though our setting had unique features that should have led the Board to more strictly regulate peer misconduct, four mechanisms contributed to bounded accountability for guilty physicians: inefficiencies of the bureaucratic apparatus that surrounded the Board's decision-making process, information asymmetries between professional bodies operating in different states, the shared professional beliefs of Board members, and finally, interpersonal emotions. After explaining how these mechanisms contribute to bounded accountability, in the final part of our findings, we present data on the very rare instances where professional self-regulation resulted in strict accountability.

Bounded Accountability: Bureaucratic Inefficiencies

In its investigation of misconduct and disciplining of guilty physicians, the Board operated within a state-supported bureaucracy with finite resources. We found that the inefficiencies of the Board's bureaucratic apparatus could prevent it from levying strict disciplinary decisions, even when Board members expressed that a physician's misconduct warranted strict discipline. We observed multiple instances when, during their internal deliberations, the Board members discussed the

need to revoke a guilty physician's license yet ultimately settled on a less strict discipline after being reminded of bureaucratic inefficiencies that could prevent strict discipline from being implemented in a timely manner. These bureaucratic inefficiencies reflect an organizational-level mechanism constricting accountability.

Our data indicate several bureaucratic constraints that prevented the exercise of strict discipline. First, pursuing strict discipline usually meant going to trial, and the Board had limited investigative resources to take cases to trial. Moreover, pretrial evidence collection could take a considerable amount of time. Because the Board we studied met just six times a year, collecting sufficient evidence and then setting a trial date could take months or years, and guilty physicians could continue practicing medicine without any discipline on their license while awaiting trial. The most efficient way to reach a disciplinary decision was therefore through a settlement, or plea deal, with the guilty physician. Settlements required the Board to expend less time and resources and could not be appealed later. The general counsel explained the rationale for settling cases with guilty physicians:

> It does take years to try those cases if we only have six trial days a year. So, the Office of General Counsel … we try to settle cases. We try to do that because it is more expedient … It is less likely to be appealed and take years to drag on.

Our data show that Board members largely accepted and adhered to these bureaucratic constraints, even when they expressed that a guilty physician deserved a stricter discipline because of the severity of their misconduct.

The general counsel, together with the medical consultant, negotiated settlements with guilty physicians on behalf of the Board. Because a settlement meant that the guilty physician had to agree to one's own discipline, the accountability that could be exercised via settlements was generally less severe than a disciplinary decision reached through trial. Still, as much as possible, the general counsel and medical consultant brought cases before the Board for discipline in the form of a settlement that the Board could approve or amend. Bureaucratic inefficiencies incentivized the Board to approve these agreed orders or suggest small amendments that the guilty physician would agree to. In the words of several Board members, agreed orders were often approved to keep physicians "off the street" (Board Member F) instead of allowing them to practice with an unencumbered license while awaiting stricter discipline.

Dr. N's case exemplifies how the Board's ability to regulate misconduct was bounded by bureaucratic inefficiencies. Dr. N owned a pain management clinic as well as a pharmacy to fulfill prescriptions he wrote for patients. The Board investigated Dr. N's opioid-prescribing behavior from 2012 to 2015. The statement of facts (which Dr. N agreed was accurate) included:

> Respondent prescribed narcotics and/or other controlled substances to patients when the quantity, duration, and method were such that the patients could become addicted to the habit of taking said controlled substances, yet failed to properly or consistently monitor for or seek out and respond to signs of substance abuse on the part of patients and make a bona fide effort to cure the habit of such patients or failed to document any such effort. (Online Appendix C provides a fuller description of Dr. N's misconduct.)

The case came before the Board in the form of an agreed order, which noted that these actions violated several statutes indicative of "unprofessional, dishonorable or unethical conduct … Gross malpractice or a pattern of continued or repeated malpractice, ignorance, negligence, or incompetence in the course of medical practice." After their investigation, the general counsel and medical consultant's recommendation was to suspend the physician's license for 30 days, after which time the physician could continue practicing medicine with certain restrictions. The agreed order stated that after the suspension, the physician would be on probation for three years. He would still be allowed to practice and prescribe opioids, but he had to "decrease the volume of prescribed opioids" (Agreed Order) to conform with current guidelines.

During their deliberations, Board members raised the possibility of revoking the physician's medical license given the severity of his misconduct. Board Member K argued,

> I think the 30-day suspension and then three-year probation is lighter than warranted here. Personally, I can't vote for this one. I think it's a slap on the wrist … I do not think that this order is adequate for the facts that have been presented to us. I think it's very light.

Board Member F stated, "I think the only thing more severe [than the proposed discipline] would be complete revocation." Another Board member questioned why the physician, according to the agreed order, should be allowed to retain his Drug Enforcement Administration (DEA) license, which gave him the ability to prescribe controlled substances even while on probation.

> Board Member M: Why does he get to keep his DEA license? … The offenses that he has committed would warrant a DEA license sanction.
>
> Medical Consultant: I think your points are quite valid. I think this was a compromise to get him off the streets.

Board Member K acknowledged that the Board often makes compromises for the sake of efficiency to "get doctors off the street" but argued that the severity of offenses did not warrant such an approach:

> We do negotiate in order to get them off the street. And I honestly appreciate that, and I understand it. But I don't think that we should send the signal out that we will just level your wrist.

Although several Board members acknowledged these points, during their internal deliberations, others highlighted that accepting the current agreed order, although not ideal given the severity of the misconduct, was a more efficient way to hold the guilty physician accountable considering the bureaucratic limitations of the Board's administrative apparatus. The medical consultant who investigated and negotiated the agreed order acknowledged the bureaucratic realities of attempting to reject an agreed order in hopes of obtaining a more stringent disciplinary outcome through a trial. He commented,

> I guess the question we have when we face these decisions, you know, you have 100 cases like this, and if you don't come to an agreed order, then you go to a contested case two to three years from now. And he's practicing just like he is [i.e., without any restrictions] for two to three more years. The wheels of injustice move rapidly, and the wheels of justice move slowly.—Board Member F

Board Member D, when evaluating whether to revoke Dr. N's license, supported this concern:

> I just think that, just as a guesstimate, when we reject one of these orders [in favor of pursuing revocation] … we [are] talking next month it'll come back as a contested case, or it's going to be six months before we hear that case again because I do think that needs to weigh into the decision.

Board Member D further noted that second-guessing the investigative team's decision making could result in months of delay with an uncertain outcome. Board Member M similarly noted that although stricter discipline was preferable, he also would vote for the agreed order because it was a more efficient, immediate way to hold the guilty physician accountable: "Although it pains me to allow Dr. N to walk away with what I think is a light discipline, in the sake of expediency it may not be an unreasonable thing to do." Ultimately, the Board voted to approve the order, allowing Dr. N to retain his medical license. Table 1 provides additional representative data highlighting how bureaucratic inefficiencies, operating as an organizational-level constraint, contributed to bounded accountability for guilty physicians.

Bounded Accountability: Information Asymmetries

Our data indicate that, despite the transparency imposed on professional self-regulation processes, there could arise significant information asymmetries between professional bodies in different states, which guilty physicians could exploit to evade strict accountability for their actions. For example, state medical boards reported their disciplinary decisions to a national database only after cases were finalized. As a result, when guilty physicians were under investigation in their home state but had not received a disciplinary action on their license, they could apply for a new medical license in a different state, and because their license in their home state showed no disciplinary decision (nor did it show physicians were pending investigation), the new state's board would have no way of knowing physicians were under investigation. Moreover, our data indicate that if a disciplinary decision was made about guilty physicians in their home state, any new states in which they received licensing were not automatically informed. Thus, guilty physicians who were either awaiting discipline or had been disciplined by their home states could potentially exploit these information asymmetries and obtain unrestricted licenses to practice in other states. We not only observed that physicians resorted to this strategy, but we also found that the Board expressed concern that state medical boards did not meticulously check the national databases for reporting professional misconduct, and when they did, the available data could be interpreted in different ways. Finally, we observed that when physicians took advantage of such information asymmetries and started practicing in a new state, the home state's subsequent decision-making process could be impacted.

Dr. R's case demonstrates how information asymmetries between different regulatory bodies at the field level contributed to bounded accountability for guilty physicians. The Board investigated Dr. R's opioid-prescribing behavior between 2008 and 2016 and found over 30 patient records "to be below the standard of care" because the "respondent provided treatment that included prescribing narcotics and other medications and controlled substances in amounts and/or durations not medically necessary, advisable, or justified for a diagnosed condition." More troubling, the state found that in a recent 11-month period, five patients died of overdoses shortly after Dr. R improperly prescribed opioids to them. The state's findings noted, "Respondent's prescribing resulted in *adverse outcomes for several of the Respondent's patients, including overdoses and overdose deaths*" (emphasis added) (Online Appendix D provides a fuller description of Dr. R's misconduct).

While the Board was investigating Dr. R's case, he moved to a new state, obtained a new medical license, and began practicing there. When the Board convened to try the case, Dr. R admitted that his prescribing practices fell "below the standard of care" and stated that he was no longer treating chronic pain patients and had no intention of coming back to practice in the State. Given the gravity of this case, the general counsel

Table 1. Additional Examples of Bureaucratic Inefficiencies Contributing to Bounded Accountability

Case facts	Board deliberation data
"Dr. S provided treatment for chronic pain to numerous patients, which included prescribing doses of narcotics and other controlled substances without documenting sufficient justification for such prescribing in the patients' charts … Respondent was among the top fifty (50) prescribers of controlled substances in the State in 2014 and 2015" (General Counsel).	Board Member N (consumer member): From a consumer perspective, I find this egregious. And I would prefer a revocation. Board Member F: Well, we found it egregious too, that's why we recommended probation, which is equivalent to revocation because he will not be on any insurance panel. Board Member D: Probation is not equivalent to revocation in this case because I'm sure there are plenty of people willing to pay cash and lots of it [for controlled substances]. Board Member G: It greatly pains me that [Board Member F] just said that this person could practice for two more years before this comes [back] before the board [in a contested trial] Board Member P: If I could, **the reason I voted yes for this order is for really one reason, that we need some sort of measure on him right now. And to do a revocation is an expensive ordeal and takes years.**
"Respondent (Dr. BL) prescribed Suboxone for patients after multiple inconsistently positive and negative urine drug screens and respondent failed to document the findings as they were discussed with the patients. On numerous occasions, respondent prescribed Suboxone for patients who had urine drug screens that were positive for benzodiazepines. And ultimately, he ended up opening up his own clinic in January of 2016, where medical records obtained did not show that he did any urine drug screens. **The allegations of fact constitute a violation of … dispensing, prescribing, or otherwise distributing any controlled substance, controlled substance analogue, or other drug to any person in violation of any law of the state or of the United States" (General Counsel).**	General Counsel: **I'm just asking you to think about when you're looking at these settlement orders, and then you're thinking you want it to go to trial, to try to be as realistic as you can about the rest of your board members in what any particular panel of your board might do in an actual situation when it comes to trial. We've certainly seen cases where we've seen [agreed] orders refused, and the indication is, no, there needs to be more discipline. And then we go through a trial and we end up, right, as either less or it's the exact same. It's certainly not more.** And so and that's fine. We can go forward with the trial. But what's happened in some cases is, well, now we have to go and file charges and it might take us two years to get for—in trial. We had some individuals. It was in a halfway house and the case was continued multiple times. **Two years later, we end up at the same place. So I'm just asking you to think realistically on this case.**
Dr. O's records were reviewed by the department and "demonstrated insufficient documentation of evaluations, treatment options discussed, treatment objectives, and other modalities of treatment that would justify prescribing controlled substances to these patients … The facts stipulated authorizes disciplinary action against a Respondent who prescribes, orders, administers, or dispenses dangerous drugs or controlled substances without observing Board guidelines." (Final Order)	Board Member C: This is fine, but I'm very chary of these things that just get popped on us without the opportunity to review in advance. **I realize the terror of the calendar that we all live under. But I've had exactly three minutes to read through this**, and I can't see anything wrong with it. But I think slower than that. So just as a comment, once again, we keep sort of having things crop up real fast, and I don't care for that. General Counsel: I can assure you that the Office of General Counsel puts a great deal of pressure on respondents if we're near settling a case to do so well in advance of the meeting. However, it is also our policy that **if we get a signed consent order the morning of a board meeting, we're not going to leave that person undisciplined for two more months and not bring it to your attention. So if you don't feel comfortable making a decision on a case that morning and waiting a couple of months for that person to be undisciplined, that's perfectly acceptable to this office.** But we are going to continue to bring this before the Board.

Note. Bold represents emphasis.

recommended revoking Dr. R's medical license. The general counsel explained,

> This kind of practice is unacceptable … This isn't medicine. This is something else. It is lazy … It's dangerous in the community and wherever this man is going to practice. The State asks that you assess Dr. R a penalty of one thousand dollars for each of the patient charts we examined here and that you revoke his license to practice medicine. Nothing else, nothing else would protect the people of [our State] or the people of [the new state where Dr. R resides] or wherever else this man goes.

Dr. R did not agree to his license being revoked in the State, so the case went to trial. In their internal deliberations during trial, Board Member B acknowledged,

"There's not any disagreement that the care fell below the standard of care. Both the expert [witness] and the respondent [i.e., the physician] said it did." Board Member H added, "We saw not just an occasional substandard care, but a pattern and trend of substandard care … Your first rule is first do no harm, and what I have seen in these charts was a disregard for that rule and for that law, which is the first law of medicine … I can't condone this type of practice with anything less than revocation, in my opinion." However, as the deliberations went on, the Board started discussing alternative ways of holding the physician accountable. Board Member B proposed, "If we decide to revoke, it's moot, but if we decide that we don't want to revoke and we don't want him practicing in our State, we can suspend his license indefinitely, and then when it expires and he agrees not to reapply, then he doesn't practice in our State again … We would protect the citizens of our State without revoking his license. I'm not saying I agree with it, I'm just giving options, so we consider all options." One of the consumer members on the Board, Board Member A, asked how the new state where the physician was practicing would interpret the difference between a revocation and the suggested suspension of the physician's license:

> Board Member A: What's the difference between suspension, with him never coming back to [our State], and revocation?
>
> Board Member B: I would guess the way it's perceived by other states and other credentialing organizations, hospitals. I mean, a revocation is to me—and from what I understand in my experience on the Board—is not good on your record. And it's for really egregious activities that we don't think you need to be licensed and we're not sure that you ever should be licensed again … Suspension is for giving somebody a chance to change their ways and be a good physician.

Here, a Board member directly states that a revocation not only ensures that the offending physician does not practice in their state but also sends a strong signal to other state medical boards and the public that their assessment of the physician's misconduct reached a level such that the physician should never "be licensed again."

The following exchange demonstrates the information asymmetries between professional boards that allowed guilty physicians to evade accountability for their actions. Outside of a national database housed by the United States Department of Health and Human Services,[3] there was no established mechanism or oversight governing how state medical boards communicate with each other, especially information on how disciplinary decisions were reached. The Board was aware of such information asymmetries that guilty physicians could exploit:

> Board Member A (consumer member): [If we suspend Dr. R's license] can he still practice medicine in [new State]?
>
> Board Member B: That would be [the new State's] decision … We don't know exactly what's going to happen, if [the new State] would know about it.

As the discussion around how to discipline Dr. R continued, one Board member suggested, "We could put in the order that he's required to notify [new State] of this disciplinary action" (Board Member B). The Board considered this additional requirement given the severity of the misconduct involved. Upon further discussion, the Board steered away from a revocation and decided to suspend Dr. R's license with the caveat that he would be prohibited from ever applying for licensure in their state and that the new state would be notified of this decision:

> The State medical license of Dr. R, M.D., license number [redacted], is hereby SUSPENDED until May 31, 2019, at which time his license will expire. Dr. R will be prohibited from renewing this license, reinstating this license, or applying for a new license. The Board will notify the [new State] Medical Board of this action.

The Board unanimously approved the order. Upon further investigation, we found that following this decision, Dr. R continued to practice medicine in the new state until he eventually pleaded guilty to a federal investigation into the same misconduct the Board had reviewed. His guilty plea and subsequent incarceration triggered the revocation of his license in both states. This case demonstrates how information asymmetries operating at the field level between professional bodies in the United States contributed to bounded accountability for guilty physicians, allowing them to evade strict discipline. Importantly, Dr. R's license was eventually revoked in both states, not because of new evidence or because the Board(s) altered its disciplinary decisions but because the physician was incarcerated by a higher-order disciplinary apparatus, the criminal justice system. Table 2 provides additional representative data highlighting how information asymmetries contributed to bounded accountability for guilty physicians even in the face of heightened transparency into the Board's decision-making process.

Bounded Accountability: Shared Professional Beliefs

We found that a shared professional belief in rehabilitation, as opposed to punishment, constituted the most prominent mechanism contributing to bounded accountability for guilty physicians in our data. This mechanism operated at the occupational level and undergirded Board members' disciplinary decision-making process more generally. Even for the most egregious cases of

Table 2. Additional Examples of Information Asymmetries Contributing to Bounded Accountability

Case facts	Board deliberation data
"Respondent (Dr. LS) is a board-certified radiologist, and back in 2010, he prescribed some controlled substances to two women with whom he had sexual relationships. Those prescriptions, including controlled substances such as oxycodone and hydrocodone, he didn't create or maintain medical records relating to those, and he consumed at least some of those prescribed substances himself … The facts stipulated constitute a violation of … dispensing, prescribing, or otherwise distributing any controlled substance, controlled substance analogue, or other drug to any person in violation of any law of the state or of the United States." (General Counsel)	Board Member O: **The only thing that I think gives me any reservation is … We have to trust that the other states are going to look at it [this Board's order] and take it seriously and take that action.** Board Member N (consumer member): I agree with Board Member O because he could actually do telemedicine. I mean, at some point … But some other state, and like you say, **you would hope that they [another state's medical board] would look at this order, but I'm a little bit concerned about that.** Board Member O: **My fear is that they will look at it and say this is just a reprimand … They don't really get into the details of it.**
Dr. BO appeared before the Board applying for a license to practice in State. His license in New Jersey was revoked, and his license in New York was suspended. The Respondent came with a witness testifying to his character and arguing that Dr. BO would be working in neurology in State. Dr. BO also stated that he was appealing the revocation decision in New Jersey. The Board was persuaded as to his reasons for appealing. The Board decided to grant Dr. BO license to practice in State. However, they could not understand why his DEA license was also surrendered along with his medical license and whether this indicated any opioid-related misconduct. After much discussion, the Board was unable to agree on why the physician had to surrender his DEA license in New Jersey. The Board decided to grant the physician a license conditional upon one year of monitoring his recordkeeping and billing practice. They put an additional restriction preventing the physician from working in a pain management clinic.	Board Member K: Do you currently have a license in New Jersey? Dr. BO: No, sir. It was actually a voluntary surrender of my license instead of going through the investigation … My lawyer said it's a straightforward settlement … . Board Member P: Do you still have a registration with the Drug Enforcement Agency? DEA? Dr. BO: I don't have a registration because I gave up my license, but I never had a problem with the DEA … . Board Member G: I'm still at a loss for the connection with the DEA [about why it was surrendered in New Jersey]. Is anyone else? Board Member K: The order says the respondent shall surrender each of his controlled dangerous substances registrations. Board Member M: That sounds like a pro forma to me … If you give up your license to practice medicine, you shouldn't keep your DEA license. Board Member N (consumer member): **I would just question why they felt like they [i.e. the New Jersey Board] needed to put it in the order.** I agree that if you don't have a license, you probably can't hold a DEA. The fact that they put it in order, it's kind of curious … . **Board Member P: Well, if he lost his DEA for reasons that you don't understand, you need to understand the reasons before you restrict his license … My position is that I do not see any behavior that the applicant has demonstrated that would warrant limiting his ability to practice pain management**. If you could demonstrate that to me, I'd subscribe to it.

Note. Bold represents emphasis.

professional misconduct involving patient deaths and even for physicians who were repeat offenders, we found that rather than pursuing stricter disciplinary actions, the Board predominantly opted for disciplinary measures designed to rehabilitate guilty physicians. As Board Member H expressed, "I think we're all interested in giving everybody a chance … I would like to see a physician learn from their mistakes and change." Thus, disciplinary outcomes across our data predominantly took the form of a reportable restriction on the physician's license (such as a reprimand, probation, or suspension) that still allowed the physician to return to medical practice, coupled with rehabilitative measures. These rehabilitative measures included various continuing education courses, sometimes coupled with a requirement that the guilty physician's practice be subjected to peer monitoring to ensure compliance with professional standards.

Several independent third-party institutions were entrusted with rehabilitating guilty physicians. For example, during the Board's internal deliberations, if it was suggested that the guilty physician had engaged in misconduct because of lacking in proper knowledge of standards of practice (e.g., the physician "did not know any better"), the guilty physician was ordered to attend continuing education courses at nearby universities. Guilty physicians in our sample were frequently ordered to attend courses on the proper practices for prescribing, documenting, and keeping records about controlled substances and on maintaining appropriate

boundaries with patients. If guilty physicians demonstrated a pattern of gross misconduct, they were usually also ordered to enter a three- or five-year peer-monitoring program overseen by the state medical foundation (SMF).[4] The mission of this third-party institution was to rehabilitate physicians and provide them with advocacy and support. The guilty physician would be assigned an official peer monitor, who was charged with overseeing the physician's patient records and intervening when coming across behavior that did not meet standards of practice. Importantly, while undergoing peer supervision and/or continuing education, guilty physicians were usually able to continue practicing medicine.

All the disciplinary decision options at the Board's disposal, except for revocation, were designed to rehabilitate guilty physicians. This included suspension, which was the strictest discipline the Board could levy short of revocation. Board Member B explained the rehabilitative logic behind suspension. He said, "Suspension is for giving somebody a chance to change their ways and be a good physician, and they do that by going to courses and getting monitors, and while they're doing that, they're not seeing patients," usually for up to six months.

The Board's handling of Dr. S's case illustrates how a professional belief in rehabilitation, one that extended even to repeat offenders, undergirded the Board's decision making and contributed to bounded accountability for guilty physicians. For context, before the new case was brought to the Board's attention, Dr. S had already been disciplined for previous misconduct. Several years ago, he had pleaded guilty in criminal court to prescription fraud for self-prescribing opioids. At that time, the Board put his medical license on probation, and Dr. S lost his DEA license, which allowed him to prescribe controlled substances. Dr. S appeared before the Board in 2019 in light of newly discovered misconduct. Federal authorities had discovered an illegal scheme that Dr. S had set up with Dr. M, another physician on probation. Dr. S and Dr. M had met in a continuing education program that they both were attending on Board orders. The two doctors decided to launch their own clinic to treat patients addicted to opioids. The General Counsel explained,

> [Both doctors] were on probation. And they decided that they were going to go out on their own and open their own clinic and that they were going to see addicted patients and prescribe controlled substances to them.[5] When they started it together, they didn't have an office. So the patients—some of them—were being seen at Dr. S's house. Some of the patients were seen at their own residences. Some of the patients were seen at businesses like McDonald's, and sometimes Dr. M and Dr. S would see the patients together [at these locations]. Later on, they would commonly prescribe Suboxone and benzodiazepines in combination and they would prescribe phentermine to patients.

Because insurers often do not want to work with physicians on probation, Dr. M and Dr. S took cash payments from patients in exchange for prescriptions. Additionally, because the physicians were not meeting patients in an office, both physicians admitted that before prescribing opioids, they did not have patients undergo screening, did not formally document their prescriptions in medical charts, and did not have a written protocol for determining prescriptions to patients. Moreover, because Dr. S no longer had a DEA license, he illegally prescribed controlled substances using Dr. M's prescription pad. According to the general counsel, state and federal authorities found that,

> Dr. M had pre-signed prescriptions so that Dr. S could write in what was going to be prescribed to the patients, even though Dr. S was not authorized to write controlled substance prescriptions. He was not authorized to write prescriptions for benzodiazepines, for Lyrica that he wrote, or for Suboxone buprenorphine products. And in fact, sometimes Dr. S didn't have pre-signed prescriptions from Dr. M and so he would sign Dr. M's name on the prescriptions … Dr. S was writing prescriptions without authority.

Dr. S had pleaded guilty to the charges brought against him in federal court and was awaiting sentencing when he appeared before the Board. The general counsel and medical consultant originally reached a settlement with the guilty physician, involving a six-month suspension followed by a five-year probation with peer-monitoring and continuing education requirements. The suspension of the physician's license was already in effect because he had pled guilty in federal court. The general counsel expressed that she and the medical consultant negotiated this relatively lenient settlement because Dr. S had been forthcoming about his misconduct, pleaded guilty, showed remorse, and cooperated with the State by providing testimony during the Board's trial of his business partner. The Board, however, rejected the settlement, arguing it was too lenient. One Board member expressed that it was too "light" (Board Member P), even given his cooperative behavior. Board Member H expressed, "I can't in good conscience approve this. I'm sorry." Consumer Board Member A argued, "This man is not safe to be out in public," and Consumer Board Member T suggested, "We could revoke his license." Desiring stricter discipline for the guilty physician, the Board rejected the settlement, and the case went to trial.

Unlike the Board meeting when his settlement case was discussed, during the Board's trial of his case, Dr. S was given the opportunity to provide testimony and express remorse. He did not dispute any of the charges brought against him and pleaded ignorance.

He expressed that he was not aware of the illegality of his actions. In the trial's closing arguments, Dr. S's attorney emphasized these points:

> He was so ignorant! And ignorance is not an excuse for violation of law, that's a well-established legal principle. But he was so ignorant of the wrongfulness of his actions that when a federal search warrant was served on him, he … sits and talks with the feds in their car for hours, telling them everything that he'd been doing because he thought it was all OK. He thought it was legit.

The general counsel reminded the Board of their duty to protect the citizens of the State, but, at the same time, that their mission was not to "put people in jail." He said,

> The question is, what's the appropriate discipline? This board doesn't put people in jail. That's not the purpose of this board. The purpose is to protect the health, safety, and welfare of patients. And so, what are the appropriate disciplines that can do that?

As the Board deliberated the appropriate discipline for Dr. S, they surprisingly did not consider revocation or refer to the call for stricter discipline made at the previous meeting, which was the basis for the trial. Instead, they discussed disciplinary measures that were rehabilitative in nature, designed to assist Dr. S in returning to practice:

> Board Member L: The physician's license is suspended at this point … So we need to discuss what we think needs to be done going forward as far as what you can do to get back in good standing, get your license back … My thought would be—I'll go first on that—personally, I would say let's lift the suspension but go to probation for a period of no less than five years. Just as a starting point.
>
> Board Member T (consumer member): I was thinking the same thing, or have the suspension go for a year and then start the probationary period of five years. But I would be willing to defer to you all. …
>
> Board Member S: I look at the State Medical Foundation as being the dad I wished I always had … I think there's good, solid guidance from there. So as a baseline going forward, maintaining advocacy of the SMF from here on out is a must … lifetime advocacy of the SMF … .
>
> Board Member L: I think a couple of other things that we've done in other cases is require the proper prescribing course that is available and then maybe some sort of review … study of the chronic pain [treatment] guidelines from the state, which you may very well have already done, but we probably need to put it in writing. Those would be my two thoughts … As far as protecting the citizens of the State, we've got to look at [whether] these other things that we're requiring are enough for us to be assured that he's going to be safe to practice.

After a lengthy discussion, Board members decided to lift the suspension on Dr. S's license and put him on a five-year probation, after which time he would be required to maintain lifetime advocacy with the SMF, meaning he would need to be monitored by an assigned peer, with some frequency, for the remainder of his career. The guilty physician would furthermore be required to take several continuing education courses while on probation. Finally, the Board decided that his probation would not be automatically lifted, but the physician would be required to appear before the Board again, thus giving the Board another chance to monitor Dr. S's progress. As the Board members dictated their final order, they rationalized adopting a rehabilitative disciplinary decision:

> Board Member L: Our policy decision will be that the state medical board takes this action because of the history of inappropriate prescribing by Dr. S, and his own personal addiction [to opioids] … His willingness to accept responsibility for his actions and his willingness to proceed along the path of rehabilitation.
>
> Board Member L: His willingness to accept responsibility for his actions and his willingness to engage in a rehabilitative process allows us to … provide a path for him to regain full licensure.

Even in an egregious case involving a physician who was a repeat offender and who pleaded guilty in federal court, a professional belief in rehabilitation over punishment shared by most Board members led to bounded accountability for the guilty physician.[6] Only two years later, Dr. S was sentenced to 18 months in prison on the same charges that were considered by the Board, once again demonstrating the extreme rehabilitative bias with which the Board handled misconduct cases. To facilitate Dr. S's rehabilitation, the Board placed a heavy expectation on the SMF. We found that this was not uncommon, and the Board consistently relied on the SMF to oversee guilty physicians' rehabilitation. Whereas Dr. S's case is a particularly telling example of how shared professional beliefs operating as an occupational-level mechanism could contribute to bounded accountability, we observed this belief in rehabilitation throughout the Board's decision-making process in both agreed orders and contested trial cases.[6] Table 3 provides additional representative data on this mechanism contributing to bounded accountability.

Bounded Accountability: Interpersonal Emotions

We observed a fourth mechanism in our data that contributed to bounded accountability: interpersonal emotions. Guilty physicians sometimes made emotional appeals that resonated with Board members and caused them to develop feelings of sympathy and compassion toward guilty physicians. These emotions led Board

Table 3. Additional Examples of Shared Professional Beliefs Contributing to Bounded Accountability

Case facts	Board deliberation data
"The Respondent (Dr. KL) prescribed multiple combinations of controlled substances without documenting a clear objective finding of chronic pain to justify the ongoing increased prescribing … Respondent prescribed substances without accurately documenting a treatment plan. And the prescribing was greater than necessary and not for therapeutic purpose and not attributable to any diagnosis as charted. The respondent prescribed narcotics and other substances when the quality and duration and method, the way it was prescribed was likely to lead to addiction and failed to adequately counsel his patients about the risk of those addictions and where to document that." (General Counsel)	General Counsel: Respondent's license will be placed on probation for no less than five years … The respondent agrees to surrender his DEA license … until he's completed the requirements … let's skip ahead just a bit. In order to get his DEA license back, **respondent has to take the three-day prescribing course from [University] … And then within 30 days report to the disciplinary coordinator. And that's in addition to any continuing medical education required normally or another course fitting the medical director's approval. Also the respondent must obtain practice monitoring through [Monitoring Program] or another practice monitoring program approved by the board director.** This is to last for two years unless the respondent retires, in which case it will expire at the end of his license … **When the respondent gets his DEA license back, he will have no fewer than ten of his patient records seen within each ninety-day period. And the practice monitor shall determine if any of those require additional changes to the respondent's practice** … At the end of the five-year probationary period and upon completion of the other requirements I just stated … the respondent may petition the Board to have his probation lifted … I submit to any questions. Board Member B: I have one question. The option for DEA reinstatement, is it there for him at any time, correct? General Counsel: It is, yes. Board Member B: Thank you … . Board Member R: **I like the monitoring of this.** Board Member E: **Yes, I think this was a really good order … a lot of monitoring**
The Respondent (Dr. D) was brought to the Board for disciplinary action as a result of prescribing controlled substances "in amounts and/or for durations not medically necessary, advisable, or justified … such that the patients would likely become addicted to the controlled substances. One of his patients died of overdose shortly after the doctor prescribed him four different controlled substances on two different occasions without checking the Controlled Substance Monitoring Database for the patient … The doctor "did not discuss or counsel patients on the risks and potential for addiction when prescribing controlled substances and also failed to employ safeguards, such as pill counts, frequent urine drug screens, and regular CSMD checks to ensure patients were not abusing other substances or diverting controlled substances prescribed." (Final Order)	The general counsel explains that along with the reprimand, several restrictions will be put on his license. General Counsel: First of all, the doctor is required to cap his controlled substance prescriptions to 120 morphine milligram equivalents. He will also limit his prescriptions to one controlled substance per patient. **He will also enroll in a two-day medical course on intensive medical documentation and a three-day course on prescribing controlled substances**. Board Member C: You do understand the stipulations in this order and you agree to adhere to them? Respondent: Yes, sir. Board Member C: I mean, I will tell you that **given the current temperature of the public on the matter of overprescribing controlled substance, especially opioids, and misprescribing, I would say this order is demonstrative of a considerable amount of mercy. Even though there's some difficult things you have to deal with. So we would certainly hope that you take this to heart and change the way you've done things and don't come back.** Respondent: Thank you.
"Respondent (Dr. BT) wrote 29 prescriptions for 30 tabs of phentermine to a friend without establishing a doctor/patient relationship, without performing a physical examination, without making a diagnosis and formulating a therapeutic plan, and without creating and maintaining a medical record … Respondent failed to check the Controlled Substance Monitoring Database before prescribing to the friend who was "doctor shopping" and also received 40 prescriptions for 30 tabs of phentermine from another practitioner during the same time period. Respondent also wrote 10 prescriptions for 30 tabs of phentermine to a coworker without establishing a doctor/patient relationship, without performing a physical examination, without making a diagnosis and formulating a therapeutic plan, and without creating and maintaining a medical record." (General Counsel)	General Counsel: **Dr. BT has agreed to a reprimand and to enroll and complete within one year a two-day medical course entitled Medical Documentation: Clinical, Legal and Economic Implications for Health Care Providers. He also agreed to complete a course on prescribing controlled drugs.**

Note. Bold represents emphasis.

members to refrain from stringent disciplinary measures. Board member emotions constituted an interpersonal-level mechanism constraining the exercise of accountability for guilty physicians. We coded for instances of compassion and sympathy in our data: when in response to emotional appeals, Board members expressed a belief that guilty physicians appeared to learn from their mistakes and that a stricter discipline would create unnecessarily severe financial and/or professional hardship for them. Most of the time, Board members showed no sympathy for how their disciplinary measures would impact the finances or employability of a guilty physician. Occasionally, however, when the emotional appeals of guilty physicians resonated with Board members, they expressed sympathetic sentiments and argued for avoiding stringent disciplinary outcomes.

The case of Dr. A was one such instance in which Board members expressed compassion and sympathy toward the guilty physician upon deciding that he had learned his lesson, was remorseful, and had been experiencing severe professional setbacks since his initial disciplining in his home state. The physician came before the Board with an initial medical license application in which he had not been truthful about the information he presented to the State. Dr. A was originally licensed in another state; however, he had been reprimanded there for self-prescribing opioids and forging an opioid prescription on another doctor's prescription pad. He had also been made to surrender his DEA registration. In his licensure application to the State, Dr. A was not forthcoming regarding his previous misconduct, omitting information about a pending class-action malpractice lawsuit in which his name appeared, a previous class-action lawsuit that had been settled, and the circumstances under which he had to surrender his DEA registration. As a result of this incomplete disclosure in his licensure application, Dr. A's case was discussed at length during the Board meeting to elucidate the facts.

Regarding illegally self-prescribing opioids, Dr. A said that he never denied the charges brought against him and that he had acted in a "foolish" manner and had learned from his mistakes. He explained his regret about self-prescribing opioids:

> The Board called me, I totally confessed to it, and I told them that it was a foolish decision on my part. They decided to reprimand me and I was required to take the [continuing education] course in addition to community service—believe me, this is something I've had to explain with every job application I have had. And it's not a mistake I want to repeat ever. I've more than learned my lesson from this.

During the Board's first meeting to discuss the case, after a lengthy discussion, there was a motion to deny Dr. A's application "based on inaccurate information," and the motion was seconded. The chair of the Board, Board Member K, at this point, suggested the doctor might want to withdraw his application so that he could later reapply and not have a denial of license on his record. He said,

> Doctor, you do have the right to withdraw your application. There is a motion on the floor to deny your application. This is the time usually that we ask you if you would like to withdraw your application or let the board continue with a motion.

The doctor decided to withdraw his application after confirming that he could reapply and that his new application could be reviewed within two to three months. Before withdrawing, however, he made the following emotional plea and expressed his remorse once again:

> Over the last two years, I've been—it has been hard for me to obtain a decent employment. And this [job I found in the State] has been the first chance. Whatever I need to do to be forthcoming and to be completely transparent, I'm willing to do. This is my lifeline I am talking about—for instance, for the last year, I've had to live on borrowed loans and money from family and friends, and I am at my wit's end. I am not here in any way to try to deceive or be nontransparent. I just—believe me, I have learned—more than just learned my lesson. Whatever it takes for me to at least even get a contingent licensure or to be able to start working. I have a job that's waiting for me and I have so much debt.

Dr. A returned before the Board two months after this testimony. The medical consultant who reviewed his previous and recent licensure applications recommended that the Board either deny the doctor's application to practice in the State or license him with a peer-monitoring requirement. She said,

> Medical Consultant A: I think, given the issue of the self-prescribing of controlled substances and prescription fraud, if you required peer monitoring, that could … - make sure that it wasn't repeated.
>
> Dr. A: I'm willing to accept that.
>
> Board Member L: If we granted a license with monitoring, how would that happen?
>
> Medical Consultant A: If you granted him a license and required peer monitoring, he would need to contact one of the monitoring services in order to set that up. And then he would be responsible for paying for it. And you all would need to specify how often you need his practice to be monitored and what exactly you want monitored … .
>
> Board Member K: Any other questions? Is there a motion from the board?

At this point, several members of the Board expressed sympathy for Dr. A, given his professional and

financial troubles, and wanted to refrain from levying a stricter disciplinary decision involving peer monitoring or rejecting his license application. These Board members argued that the guilty physician had already been punished through a reprimand by the state he had previously been practicing in, and he had completed the continuing education courses he was required to take by their medical board. The physician, they argued, expressed remorse and appeared to have learned from his mistakes. At this point, against the recommendation of the medical consultant and general counsel, the Board motioned to grant Dr. A an unrestricted license:

> Board Member M: Given that Dr. A made a mistake and has paid heavily for that mistake, and I do not see a pattern of abuse, and he has fulfilled the remedies that we normally as a board would prescribe for such an action, I would recommend that we give him a full and unrestricted license.
>
> Board Member D: I will second that motion. This seems to have three components to it: the malpractice component, the forgery component, and the DEA component … those are the three issues that we would have expected to see in the initial application. And with the explanation … just to look at what you outline there, that helps us tremendously as a board. We didn't feel comfortable without that clarification at the last meeting. So I second your motion, doctor.

Thus, the motion passed, and Dr. A received an unrestricted license in the State.

We also found instances of sympathy and compassion in which Board members showed receptiveness toward a guilty physician's expressions of remorse and further asked probing questions to facilitate these expressions. Such questions included, "Do you think you did anything wrong?" (General Counsel) or "You said that you were deeply sorry. What would you be deeply sorry about?" (Medical Consultant A). In other cases, we found instances of sympathy when Board members proactively voiced concerns about how a proposed discipline would impact a guilty physician's future employability or create unnecessary financial hardship. For example, continuing with Dr. A's case, the Board briefly discussed limiting his DEA licensure as the general counsel had recommended, seeing as he had been made to surrender his DEA license in another state. However, this discussion led to a consideration of how the doctor could take up employment in the State with a restricted license. One Board member commented, "So that's pretty hard, to work without a DEA"—that is, to practice medicine without being able to prescribe controlled substances. Other Board members agreed, and the idea of restricting Dr. A's DEA license was dropped. After Dr. A was granted an unrestricted license, a Board member extended his "congratulations" to Dr. A, showing full sympathy with his situation. We observed additional expressions of outright sympathy in our data despite Board members being fully cognizant that their deliberations were being recorded and made available to public scrutiny. Table 4 provides further representative data on how Board member emotions contributed to bounded accountability for guilty professionals.

Strict Accountability

We identified only six cases in our data (out of 112) where the Board revoked a guilty physician's license, thus exercising strict accountability. We found that strict accountability was exercised only when doing so preserved the Board's authority with respect to the guilty physician or preserved the profession's legitimacy in the eyes of the public. These two mechanisms thus arose from occupational-level concerns. To preserve the Board's authority, the Board revoked a guilty physician's medical license when the physician made no attempt to comply with the Board's orders. To preserve the profession's legitimacy more broadly, the Board revoked a guilty physician's license when the physician pleaded guilty or was found guilty by the federal government for professional misconduct and sentenced to prison. In comparison with cases in which the Board exercised bounded accountability, these cases generated little internal discussion from the Board and proceeded in a straightforward manner.

The Board interpreted unresponsive physicians or physicians who disregarded Board orders as "thumbing [their] nose at the board and the profession and the standards that [the Board] set" (General Counsel). For example, Dr. P was found to overprescribe opioids to himself such that it "adversely affect(ed) his ability to practice medicine." The general counsel originally negotiated an agreed order with Dr. P that included taking "three continuing medical education courses." The general counsel, however, noted that, "[The physician] has not attended any of those continuing medical education courses." Subsequently, the general counsel noted that she repeatedly tried to get in contact with Dr. P, explaining to the Board that their office "sent over ten emails, mailings, and physically spoke with the Respondent." The general counsel, however, received "no response from [Dr. P]" and consequently advocated that the Board "revoke Dr. P's medical license for not being able to safely practice and also failure to comply with the conditions to which she previously agreed." The Board did not hold any internal deliberation about the case and proceeded to unanimously revoke the physician's license. Importantly, we found that in the two cases in which an unresponsive physician's license was quickly and unanimously revoked, the physicians in question had not even appeared before the Board to represent

Table 4. Additional Examples of Interpersonal Emotions Contributing to Bounded Accountability

Case facts	Board deliberation data
Dr. H was an ob-gyn specialist who had prescribed 70 opioid prescriptions to a single patient, "prescribed controlled substances to about nineteen other individuals without creating or maintaining any medical records whatsoever," and engaged in sexual relationships with 10 other women before enlisting them as patients. The general counsel explained, "The vast majority of those prescriptions were not documented in the patient's medical records, and the Respondent believed that the patient was selling at least some of the controlled substances for money, but he continued to prescribe for her. In addition, on at least one occasion, he consumed some of the controlled substances he prescribed for her."	Dr. H: I like to state that, you know, during this process, I've been deeply humbled … I'm truly sorry, and I like to show that I could be a better physician than I was the last time I practiced here in [the State] and that I could practice good, safe medicine with good boundaries and follow the statutes and guidelines of [the State]. Board Member H: Dr. H, the man you were before and the man you are today: What's the difference? Dr. H: A great degree of humility done away with the character traits, the narcissistic character traits that I had previously. I don't, I don't feel that sense of entitlement that I previously felt. That sense of where rules may not particularly apply to me the way they may have to other people. Board Member G: This was egregious … we are considering giving somebody who had multiple affairs with patients, sexual misconduct for over many, many years … I think that people can be helped, but I don't think I'm misspeaking … He's got a poker face … I just feel really uncomfortable about this. … Board Member B: **What I see different is, in the past, when we've had people that have had these egregious violations, they were caught, so to speak. This doctor is self-reported and he has been very desirous, or at least it appears he's been very desirous, to make amends. And I think that's different than someone who gets caught and maybe wishes he didn't** … he's gone to four different programs and he's been very compliant and he wishes to remain compliant. **I think that these types of physicians need to be looked at in a different light than the ones who get caught … So he's a doctor that realized he made a mistake, admitted he made a mistake, and he went for help on his own. And he's done everything he's been asked to do. And I think that means something.** We have someone who did some egregious things but has certainly made attempts and is making attempts to rectify thyself, which is something that is worthwhile. The Board proceeded to grant Dr. H. a conditional license with a lifetime peer-supervision requirement, along with the requirement that all of his future patients sign a form documenting that they would have a chaperone present.
"The treatment Respondent (Dr. P) provided to some patients included prescribing buprenorphine and benzodiazepines, a combination that is contraindicated when treating addiction with opioids … Respondent's charts reflected little documentation appropriate for the prescribing of benzodiazepines. Respondent allows his patients to fail many urine drug screens before he determines that discharge is appropriate … The facts described constitute … dispensing, prescribing, or otherwise distributing any controlled substance, controlled substance analogue, or other drug to any person in violation of any law of the state or of the United States." (General Counsel)	General Counsel: In looking at a reprimand we're looking at the fact that he was very compliant. He was very eager to get advice from the board and try to work with us. He was already improving on some of these issues. He was understanding that he needed to maybe be more strict on the drug screen policy as far as who he was discharging. And he is dealing with a very difficult patient population, individuals who had been addicted maybe to benzodiazepines as well as an opioid, and he didn't want them to go into withdrawal from that. So I think he's dealing with a difficult patient population and we wanted to take that into consideration when we developed the discipline … . Board Member O: **I'm wrestling with this … because looking at the guidelines, one of the bullet points for risk of immediate harm is inappropriate prescribing of controlled substances, which obviously, to me, has happened in this case. But I also think that when you have a chance to help a physician get through an issue and continue to be able to practice, and the appropriate discipline, and there's the question of which way you should go, I tend to lean that way. I would rather give the physician a chance. And it sounds like this physician was making and is making some improvements in their area and trying to practice appropriately.**

Table 4. (Continued)

Case facts	Board deliberation data
Dr. S was found guilty of running an illegal operation with Dr. M (whose case was discussed previously in the paper) while they were both on probation. Their clinic was identified as a pill mill, where the doctors wrote opioid prescriptions for cash without any documentation, without treatment plans, without any screening. Both doctors' cases went to trial. During the trial for Dr. S, several Board members developed sympathy toward Dr. S, who himself suffered from narcotic dependence at a point in his career … Two years later, the doctor was sentenced to 18 months in prison for the same offenses considered by the Board.	Board Member S: **I'm the newest member of this board, and I was told that my charge was to protect the health, safety, and welfare of the citizens of the State. And do I believe that taking the Respondent's license does that? I actually don't. I don't believe it does that. From what I saw today—and you know, hopefully, I'm a decent judge of somebody's heart—I saw somebody that cares about taking good care of a population that struggles to find help. That's what I saw** … And as I look back through the Respondent's history, it seems that … that you struggled for … for a good time with some things … I'm in recovery myself, and I've had many slips, never chemical, but plenty of emotional slips and judgmental slips … **Simply being in compliance with a [peer monitoring] contract is different than behavioral change and recovery going forward. And I think that we need to help you with that. I mean that. Not punishment … to help you going forward** … The opioid crisis kills about five people a day. And even in our own talks here about how, in our private lives, we all have friends and family that don't have any idea where to turn. So we need people in this field …

Note. Bold represents emphasis.

themselves. Thus, our data illustrate that physicians who recognized the Board's authority, were responsive to the Board, and made an effort to represent themselves before the Board benefited from bounded accountability, whereas physicians who were unresponsive to the Board's authority were subjected to stricter discipline.

In the case of physicians found guilty of misconduct in criminal court and sentenced to prison, we found the Board also did not hesitate to revoke their medical license. For example, in the case of Dr. W, the general counsel commented, "He pled guilty in US District Court to 14 counts of knowing and intentionally dispensing or causing to be dispensed controlled substances which were outside the scope of his professional practice nor were they for legitimate medical purposes. He was sentenced to 36 months in federal prison … The discipline that's proposed to you today after review is that his license be revoked." Board Member O proceeded to say, "I would make a motion that we accept." The Board unanimously accepted revoking the physician's license without any discussion or questions.

These data reveal that the Board revoked a physician's license primarily when the physician refused to engage or comply with the Board's authority or when a higher-order court found the physician guilty. The former situation reveals how a profession can be willing to castigate one of its members when that member's behavior indicates the member no longer respects the profession's authority and thus no longer exhibits appropriate membership behaviors. The latter reveals how a profession, even one with such high status as medicine, will defer to judicial decisions regarding their members' misconduct because showing misalignment with the criminal justice system would cast doubt on the reputation and legitimacy of the profession and its ability to self-regulate.

Discussion

In this study, we used our strategic case involving physicians found guilty of overprescribing opioids to develop a new theory about how professional bodies hold their peers accountable for misconduct in the face of heightened transparency measures. Our study context had many of the conditions in place that, according to the literature, should encourage professionals to impose strict discipline upon peers found guilty of misconduct: there was transparency into both the decision-making process and the output, those being observed were both high status and shielded by their esoteric expertise such that they did not experience transparency as a threat to privacy (Sewell 1998, Frink et al. 2008), reaching stringent disciplinary decisions aligned with external audience expectations, and holding guilty peers strictly accountable for their misconduct would help professionals protect their reputation as a trustworthy occupation serving the public good. Yet even under such conditions, our findings show that transparency did not produce strict disciplinary outcomes. We call this phenomenon "bounded accountability." Our longitudinal data spanning 112 cases of opioid-related misconduct disciplined by the Board over the course of five years enabled us to observe how the Board systematically refrained from exercising strict discipline on guilty physicians. The most startling evidence of bounded accountability was

several instances where guilty physicians who received only rehabilitative disciplinary decisions from the Board were later found guilty in court and incarcerated for the same offenses. We found that the mechanisms contributing to bounded accountability operated despite enhanced transparency measures in place and, many times, despite decision makers' stated preference for imposing strict discipline.

Bounded Accountability Model

Synthesizing our findings enables us to theorize multiple mechanisms contributing to bounded accountability for guilty professionals, as illustrated in Figure 1. These mechanisms include (1) *information asymmetries* between various regulatory bodies that guilty professionals can exploit to avoid strict accountability for their actions, (2) *bureaucratic inefficiencies*, reflecting professionals' tendency to accommodate the inefficiencies of the bureaucratic apparatus within which a professional regulatory body operates, (3) *shared professional beliefs*, reflecting professionals' shared norms and beliefs constraining disciplinary decision making, and finally, (4) *interpersonal emotions*, such as sympathy, that members of a professional body can feel toward guilty peers. Importantly, we found that these mechanisms originated from field-, organizational-, occupational-, and interpersonal-level considerations and constraints. We further unpack each mechanism contributing to bounded accountability as follows.

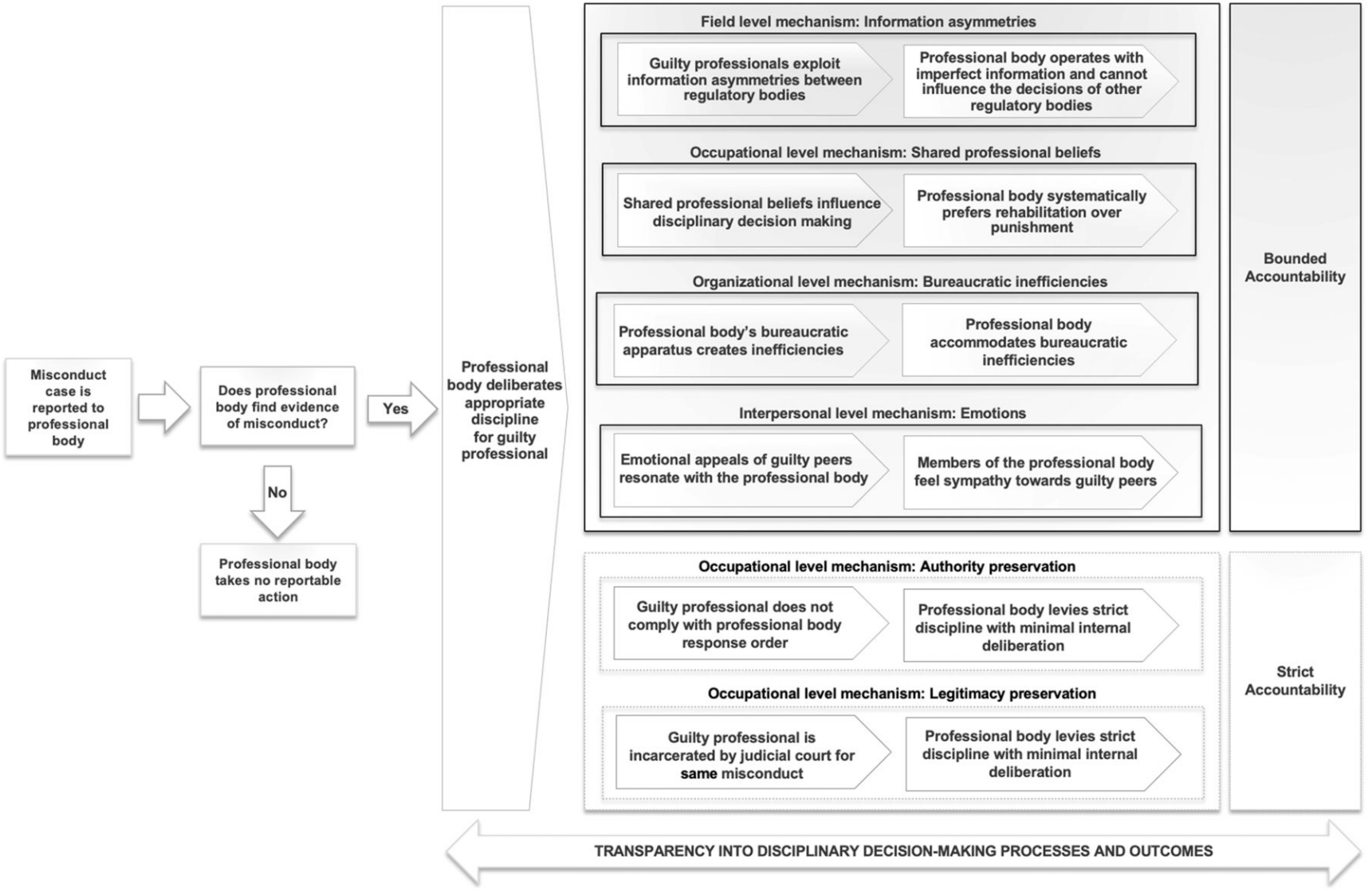
Bureaucratic inefficiencies originate from organizational-level constraints, such as inefficiencies involved in conducting disciplinary investigations and the administrative procedures of a professional body, which often have limited resources. Even when a professional body agrees that a given misconduct is severe and warrants strict discipline, the decision-making process can be bounded by efficiency constraints that professionals accommodate. In our data, we saw that if pursuing strict discipline would take an extended period of time, professionals were willing to opt for a comparatively lenient discipline that could be levied more easily and quickly. Moreover, professionals argued that pursuing strict discipline did not guarantee a stringent outcome and that after years of investigation, a guilty professional could walk away with a light discipline at the end of a trial. Our data show how the professional body accommodated bureaucratic inefficiencies by taking disciplinary actions intended to quickly get a guilty physician "off the streets," as in the case of Dr. N.

We see evidence of bureaucratic inefficiencies contributing to bounded accountability in other professional settings as well. When police officers and professors, for example, are found guilty of serious professional misconduct, they are often placed on administrative leave rather than having their professional credentials revoked, in part because such discipline can be imposed immediately and without the lengthy, contentious process of an administrative trial (e.g., Yang 2022). Our study thus extends previous research (Emerson 1983) to show how accommodating bureaucratic inefficiencies can lead to less strict disciplinary outcomes, or bounded accountability, for guilty actors.

Information asymmetries between different regulatory bodies constituted a field-level constraint on the exercise of accountability. Our data reveal several sources of information asymmetries between state medical boards that guilty professionals could exploit. It was possible, for example, for professionals undergoing disciplinary procedures in one state to move and get fully licensed in another state because there was no established process for systematically sharing information about ongoing misconduct investigations. Even after disciplinary decisions were reported in the national database, there was no guarantee that different state medical boards would be informed immediately or that they would accurately ascertain the reasons behind disciplinary decisions, especially the compromises made to reach them. This could lead a state medical board to underestimate the seriousness of underlying offenses disciplined by another board. We further observed that a professional getting licensed in a new state could alter the course of disciplinary proceedings in the home state (e.g., Dr. R's case). Few studies, to our knowledge, acknowledge and discuss how the (in)effectiveness of information-sharing systems between regulatory bodies and organizations across the United States impacts the regulation of professional misconduct. Anecdotal evidence, however, suggests that guilty professionals can easily exploit information asymmetries between state-level professional bodies, to the detriment of public safety (e.g., Rabin 2021).

Shared professional beliefs as a mechanism contributing to bounded accountability originate at the level of the occupational community. For the medical profession, this took the form of a preference for rehabilitation over punishment and undergirded the Board's decision-making process. Importantly, guilty physicians were mostly allowed to keep their medical licenses and continue practicing medicine as they pursued rehabilitation. The predominance of rehabilitative disciplinary outcomes for physicians found guilty of egregious misconduct shows how influential shared beliefs can be when members of an occupation are put in charge of holding their peers accountable. This was the case, even though the Board's disciplinary processes were made transparent to a key stakeholder (i.e. the public) and a quarter of the Board was composed of nonphysicians. Furthermore, a belief in rehabilitation applied even to physicians whose overprescribing behavior was linked to patient deaths, physicians who were repeat offenders, and physicians who pleaded guilty in federal court. Whereas other studies show that a belief in rehabilitation is widespread across professions as a mechanism

Figure 1. Mechanisms Contributing to Bounded and Strict Accountability



Notes. The solid bracketed portion of this figure depicts the main empirical findings of the study. The portion of the figure bracketed with dashed lines depicts the rare cases where strict accountability was observed in our data (only six out of 112 misconduct cases). Future research should further explore different mechanisms facilitating the exercise of strict accountability.

for disciplining misconduct (e.g., McPherson and Sauder 2013), our data suggest that not only is such a preference widespread but it also does not necessarily deter subsequent misconduct.

Finally, we propose that emotions such as sympathy and compassion, arising at the interpersonal level, can act as a mechanism contributing to bounded accountability for guilty professionals. Although the literature treats collegiality and sympathy toward peers as a key reason for leniency in professional self-regulation processes (e.g., Freidson and Rhea 1963, Abel 2008), we found that personal feelings of sympathy and compassion were infrequently expressed during Board meetings. We observed this mechanism at work when a guilty physician expressed remorse and made emotional appeals to the Board that resonated with Board members. Board members expressed their sympathy by showing concern for any professional or financial difficulties a guilty physician could undergo if a more stringent disciplinary outcome was imposed. This finding resonates with what we know about the U.S. judicial system wherein defendants and their lawyers make emotional appeals to jury members and judges in an attempt to win lenient disciplinary outcomes.

Relationship Between Mechanisms. Our findings suggest that these mechanisms could independently or jointly contribute to bounded accountability for guilty actors. We found that the most frequently observed stand-alone mechanism contributing to bounded accountability was shared professional beliefs, observed in two-thirds of the cases in our data. This mechanism was also the most likely mechanism to co-occur with another mechanism. For example, if the Board decided to allow a guilty physician to keep one's license because of bureaucratic inefficiencies or information asymmetries, the final disciplinary order often involved rehabilitative elements. We also observed that as Board deliberations were converging on a rehabilitative disciplinary outcome, this leniency could be amplified by feelings of sympathy and compassion toward a guilty physician (interpersonal emotions co-occurring with shared professional beliefs). Interpersonal emotions rarely operated as a stand-alone mechanism. When Board members started feeling sympathy toward a guilty peer, they incorporated rehabilitative elements in their final disciplinary order.

Importantly, bureaucratic inefficiencies or information asymmetries as mechanisms leading to bounded accountability came into play only later during Board deliberations after Board members had coalesced around an intention to strictly discipline a guilty physician. At this point, if Board members were reminded of either inefficiencies leading to potential disciplinary delays or complications arising from the guilty doctor relocating to another regulatory body's jurisdiction, these considerations altered the Board's disciplinary decision-making process. Once bureaucratic inefficiencies or information asymmetries were invoked, these mechanisms could independently or jointly with other mechanisms constrain the exercise of accountability. Most commonly, if the Board decided not to exercise strict accountability because of bureaucratic inefficiencies or information asymmetries, the disciplinary decision involved rehabilitative measures, as noted earlier, to reform guilty physicians while allowing them to retain their medical license. Online Appendix E presents a subset of cases to demonstrate how more than one mechanism could come into play in the course of the Board's deliberations and contribute to bounded accountability.

Finally, it is important to note that the manner in which the mechanisms unfolded or interacted in our data is just one instantiation of how these mechanisms can contribute to bounded accountability. For example, it is possible that in an even more resource-constrained professional body, bureaucratic inefficiencies could be the prevailing mechanism contributing to bounded accountability. Ultimately, more studies are needed to uncover the repertoire of possible mechanisms that can constrain the exercise of strict accountability on guilty professionals.

Mechanisms Contributing to Strict Accountability. The rare instances in which the Board revoked a physician's license (six out of 112 cases of misconduct) reveal the mechanisms contributing to a professional body enforcing strict accountability on peers guilty of misconduct. As illustrated in Figure 1, our data suggest that when guilty professionals fail to recognize and show deference to the Board's authority and the profession, the professional body does not hesitate to exercise strict accountability. Failing to appear before the Board or failing to comply with a disciplinary order's requirements resulted in license revocation in our data, irrespective of the underlying offenses. We theorize that such actions render a guilty professional undeserving of sympathy or rehabilitative efforts. This insight contributes to the professions literature, which, thus far, has not considered the possibility of how professionals might discipline guilty peers when they show a lack of deference toward the profession and its disciplinary bodies.

The second mechanism contributing to guilty physicians receiving strict discipline from the Board was when guilty physicians were incarcerated in the criminal justice system for the same offenses considered by the Board. We observed that the Board did not hesitate to revoke the licenses of guilty physicians who had

previously received limited disciplinary action from the Board if they were later found guilty in court and incarcerated. We found that strict discipline in these situations once again unfolded with minimal discussion. Although the lack of deliberation limits our ability to theorize the Board's exact decision-making process, drawing from existing literature (Chaney and Philipich 2002, Chambers 2005), our analysis suggests that dissociating incarcerated physicians from the profession was intended to preserve the medical community's reputation by showing alignment with the criminal justice system, which is arguably a higher-order disciplinary body. Allowing peers incarcerated for professional misconduct to keep their license to practice would reflect poorly on the profession's self-regulatory abilities and judgment. Thus, we argue that strict discipline will be levied when a profession believes that doing so will protect its reputation and legitimacy as a professional group.

The Role of Transparency in Bounded Accountability

Our study shows that bounded accountability mechanisms operate *despite* extensive transparency measures put in place to improve the accountability that professional bodies feel toward their external audiences, namely the public, and the accountability that they, in turn, levy on guilty professionals. Whereas our data cannot directly answer how transparency might have impacted the particular ways in which mechanisms contributing to bounded accountability unfolded, previous work suggests that the mechanisms we uncover likely exist independently of transparency measures. For example, regardless of transparency measures, professional bodies that are enmeshed in extensive bureaucratic procedures may find themselves exercising bounded accountability as a result of these inefficiencies. Likewise, information asymmetries between different regulatory bodies can exist in the absence of transparency measures, leading to bounded accountability. Finally, prior literature—which is largely based on studies conducted when professional regulatory systems were opaque to the public and other audiences—shows that interpersonal feelings of sympathy or norms such as collegiality can hinder the effective disciplining of peer misconduct in the absence of transparency (Barber 1962, Freidson 1984, Gorman and Sandefur 2011).

However, the extensiveness of transparency measures imposed on a disciplinary decision-making process likely affects the frequency with which professionals invoke the various mechanisms contributing to or used to rationalize bounded accountability. For example, prior literature suggests that sympathy and norms of collegiality are the dominant mechanism that produces in-group protectionism and lenience in professional regulation. However, in the face of extensive transparency measures in place, we found that interpersonal emotions rarely contributed to bounded accountability. Insights from political science and related literature suggest that without transparency measures in place (Chambers 2005, Thakor and Merton 2023), if the Board could deliberate in private, for example, they could feel more comfortable voicing sympathy or compassion toward guilty peers or invoking other rationales for exercising bounded accountability. Our study thus illustrates the persistence of bounded accountability even in the face of transparency measures put in place to render professional regulatory systems more effective. Ultimately, more research across different settings is needed to identify how different mechanisms contributing to bounded accountability may unfold and interact with each other and how different levels and types of transparency affect these mechanisms.

Contributions to the Literature on Professional and Expert Work

This study makes several contributions to studies of professional and expert work and specifically to our understanding of professional self-regulation. Prior literature suggests that the informal and formal mechanisms undergirding the regulation of professional work are often ineffective at holding guilty professionals accountable. Whereas the professions literature primarily points to occupational-level and interpersonal mechanisms, such as collegiality and sympathy between members of an occupation, as prohibiting the exercise of strict accountability (Freidson 1970, 1984; Abel 2008), we show that organizational- and field-level mechanisms also play a key role in rendering self-regulatory systems less effective. Taken as a whole, our study suggests that when professional misconduct is regulated by members of a profession, bounded accountability is the most likely outcome, even under egregious circumstances and even in the face of heightened transparency measures.

Implications for the Regulation of Professional and Expert Work. Our findings provide insights into understanding potential challenges in regulating a broader range of contemporary expert work, such as computer and data science professionals who design the digital technologies that permeate every aspect of our lives (Zuboff 2019) or finance professionals whose decisions have consequences for domestic and international financial markets (MacKenzie 2011, MacKenzie and Spears 2014, Pernell et al. 2017). Perhaps most pertinent to our discussion is the way in which governments, think tanks, universities, and firms today are struggling with the challenge of regulating the work of artificial intelligence (AI) experts (Burrell and Fourcade 2021). Emerging insights suggest that information technology professionals themselves are concerned by the rapid

and unregulated development of AI. The dominant logic of these professions is encapsulated in now popular phrases such as "move fast, break things," "ask for forgiveness, don't ask for permission," and "fail forward" (Taplin 2018). The shared professional belief to pursue innovation with limited consideration for its social effects is evident in the recent emergence of generative AI technologies, which professionals train in part by using copyrighted data without soliciting creators' permission or compensating them for their intellectual property (Brittain 2023). The decision to use copyrighted data without the creators' permission or compensation was at the heart of the 2023 Hollywood writers and actors' strike, and it has sparked numerous class-action lawsuits against the companies responsible for training and deploying these generative AI systems (Grynbaum and Mac 2023). Although policymakers, including those in the White House and European Union, recognize that these professions' informal self-regulatory mechanisms are insufficient to protect the public and are therefore attempting to devise formal mechanisms to regulate how professionals develop and deploy emerging AI technologies, once again, policymakers and the broader public's lack of expertise necessitates the involvement of AI experts in regulating AI (Huising 2014, Evans and Silbey 2021).

To ensure such initiatives are not unduly dominated by professionals' shared beliefs and interests, our study suggests three recommendations for more effective regulation of professional work and misconduct that go beyond providing transparency into decision-making processes and outcomes. First, regulation is needed at the national level, even perhaps through an international consortium of countries, so that AI companies do not exploit loopholes arising from patchwork regulation and potential information asymmetries between regulatory bodies (Rahman et al. 2024). Second, oversight bodies must have the necessary resources (e.g., time and money) to adequately investigate and levy their decisions, which is even more essential given the complexity of generative AI and new technologies and the resources it takes to audit such systems (Costanza-Chock et al. 2022). This recommendation reduces the likelihood that bureaucratic inefficiencies will contribute to bounded accountability in the regulation of professional work. Finally, it is important that the disciplinary body that is set up at the national (and local) level not be dominated by the professional beliefs and assumptions of the profession it is intended to regulate. This is arguably the most difficult intervention, as deference to expertise tends to allow professional beliefs to dominate disciplinary proceedings concerning expert work. However, if the goal of professional regulation is to protect the public good, then the dominant paradigm undergirding regulatory and disciplinary decision making should not reflect experts' narrow interests. Without such changes, our paper suggests that even with increased transparency measures, the four mechanisms we uncovered, as well as others, can lead to bounded accountability in the regulation of professional work and misconduct.

Contributions to the Literature on Transparency

Our study also contributes to the literature on transparency, which has not adequately considered how professional dynamics affect the relationship between transparency and accountability. Transparency is widely viewed as a means for achieving accountability in organizations (Frink and Klimoski 2004; Castilla 2008, 2015; Cordis and Warren 2014), especially when it is not viewed as a threat to privacy (Bernstein 2017). Further, for actors accountable to external audiences, such as public officials, transparency can promote accountability through normative pressures, legitimacy concerns, or reputation management (Loughry and Tosi 2008, Espeland and Sauder 2016). In our study context, accountability operated at two layers: when the Board disciplined guilty peers, they were both fulfilling their accountability responsibility to the public, and they were holding guilty professionals accountable for misconduct. Heightened transparency into Board deliberations should have elevated the Board's sense of accountability to the public and encouraged stricter disciplining of peer misconduct. Our study shows, however, that transparency alone cannot promote strict accountability when there is a significant gap in expertise between the observer (e.g., the public) and the observed (e.g., a professional body). That is, it is difficult for audiences who lack expertise in an area to assess and judge the quality of decisions made by experts. This expertise gap undermines accountability by diminishing the benefits of transparency identified in prior studies.

In our study, transparency was partly achieved through public access to the Board's deliberations and final orders and partly through the involvement of nonphysician members (i.e., "healthcare consumers") in the disciplinary process. Prior literature suggests that including nonprofessionals or beneficiaries of professional services in a professional self-regulation process should increase oversight and reduce professionals' tendency to be lenient toward each other, thus promoting accountability (Horowitz 2012, Haw Allensworth 2017). We found that even though nonphysician Board members and state-appointed attorneys at times advocated for more stringent (and occasionally less stringent) disciplinary measures against guilty physicians, they ultimately deferred to the physician members of the Board whom they considered to have unique expertise to judge the severity of cases and determine appropriate discipline. The language of "deferring" to the expertise of physician members of the Board or expert

witnesses was frequently used in our setting. Thus, our study suggests that increased transparency has limited effects on accountability when there is a gap in expertise between decision makers, or between the observer and the observed, because nonexperts involved in the system cannot set and impose performance metrics independently of those being observed. Specifically in our setting, neither the public nor their representatives who were involved in the disciplinary decision-making process had medical expertise allowing them to assess misconduct cases, let alone decisively advocate for more stringent disciplinary outcomes in opposition to physician members.

More broadly, these findings demonstrate that even with a robust system of checks and balances, the state and public still defer to the judgment of professionals because they alone possess the expertise needed to assess and discipline misconduct in professional work (see also the U.S. Supreme Court's unanimous decision in *Ruan v. United States*; Liptak 2022). Our findings thus bring to light a key insight of the professions literature discussed earlier—that discrepancy in expertise between professionals and their audiences undermines the external control of professional work—to explain how transparency may not produce strict accountability.

Our study also contributes to the transparency literature by illustrating how transparency, when it does not subject the observed to tangible, concrete accountability enforcement, can have limited effects. As highlighted earlier, prior studies suggest transparency increases accountability, even when there is not a direct principal-agent relationship between the observer and observed, as a result of normative pressures, legitimacy concerns, or reputation management. For example, organizations adopt sustainability practices, even when they are not required to, in an effort to increase their legitimacy and reputation in the eyes of the public and investors (Sharkey and Bromley 2015). Although the Board frequently made reference to its responsibility to protect the public and its professional mandate to protect the citizens of the State, and although, on multiple occasions, Board members criticized disciplinary decisions as being too lenient, we did not observe any tangible consequences experienced by Board members when a particular decision proved to have been blatantly ineffective, such as when a physician who had received a rehabilitative discipline was later sentenced to prison in criminal court.

Our study thus emphasizes the importance of transparency being coupled with either a tangible enforcement mechanism or with stronger incentives to align behavior with audience expectations and/or with normative pressures for legitimacy. Without such repercussions for decision makers, heightened transparency is unlikely to lead to better regulation of misconduct. This unfortunate outcome is observed in the case of police body cameras, for example. Although body cameras are widely adopted, they often fail to promote accountability in part because police departments retain control over the camera footage and refuse to stringently discipline police officers even in cases of civilian deaths. Without any repercussions for police departments that fail to share camera footage or strictly discipline rogue officers, the transparency afforded by body cameras often does not produce improved accountability (Umansky 2023). Thus, an important implication of our study is that calls for enhanced transparency—through new technology, more human oversight, or other mechanisms—are unlikely to promote stricter accountability because they do not directly ameliorate the mechanisms we uncovered.

Limitations and Boundary Conditions

Recent quantitative analysis suggests that state medical boards in other states also rarely enact strict accountability in cases involving physicians guilty of overprescribing opioids, providing evidence that the lack of strict accountability we observed was not particular to the state we studied (Davis and Carr 2017). Nevertheless, our study has several limitations and boundary conditions that suggest opportunities for future research. We observed downstream decision making such that by the time guilty professionals appeared before the Board, their misconduct had been documented, and the Board's only task was to decide on the nature of discipline. We can imagine more leniency occurring upstream in the disciplinary decision-making process, such as professionals declining to investigate certain allegations of misconduct or overlooking misconduct in the first place. In our setting, the misconduct cases that came to the Board represented an incomplete picture of how many physicians in the State were overprescribing opioids because we have no records of how many complaints were not acted upon or received only a warning.[7] Future research should examine upstream decision making and whether additional mechanisms operate when professionals are dealing with more routine cases of professional misconduct, such as overbilling or failure to abide by professional standards of practice with less severe consequences.

Another boundary condition of our study is that we observed self-regulation within a relatively high-status, powerful profession. Thus, it can be argued that the regulation of misconduct was more insulated and transparency measures were less effective in promoting accountability. That said, irrespective of professional status, we know that contemporary experts enjoy considerable insularity from oversight because of the esoteric nature of their expertise. Still, the extent to which an occupation gains professional status and power in society is a boundary condition that influences how pervasive bounded accountability for professional misconduct can be.

Finally, the composition of the professional disciplinary body, in terms of how many members of a profession versus nonmembers are included, can influence the effectiveness of professional self-regulation processes. In our setting, the Board included nine physician members and three members of the public. Other states have different board compositions, including an even number of physician members and members of the public. These distributions can influence the dominance of shared professional beliefs and susceptibility to interpersonal emotions in disciplinary decision making. Future research should examine how board composition affects the disciplinary decision-making process.

Acknowledgments

Both authors contributed equally to this work. The authors are grateful for the excellent feedback and editorial guidance we received from Associate Editor Andrew Nelson and three anonymous reviewers. The authors would like to thank Michel Anteby, Steve Barley, Curtis Chan, Daisy Chung, Joelle Evans, and Siobhan O'Mahony for their helpful comments. Seminar participants at Boston College, Boston University, University of California Davis, as well as participants at the Academy of Management Conference, Junior Faculty Organizational Theory Conference, and EGOS also provided valuable feedback for this paper. Finally, the authors would like to thank Pablo Schnelle, Annika Le, Hope McKnight, and Michael Righi, who provided excellent research assistance, and Sarah O'Brien, who provided insightful editing expertise. All errors are our own.

Endnotes

[1] This was measured by criminal convictions of public employees engaging in official misconduct or misuse of office.

[2] We anonymized the state medical board and the people in this study to encourage readers to relate the theoretical insights we uncover to other field-level dynamics occurring within other professions rather than focusing on the State, Board members, or guilty physicians involved in the data.

[3] See https://www.npdb.hrsa.gov/index.jsp.

[4] The SMF is a 501(c)3 nonprofit organization independent of the Board that helps physicians "in treatment, return to practice, and ongoing recovery" for issues such as burnout and stress, alcohol and drug dependency, disruptive behavior, boundary issues, and other behavioral or cognitive illnesses.

[5] Opioid addiction treatment involves the prescription of controlled substances.

[6] Some guilty physicians in our data admitted to being addicted to opioids themselves. This condition also contributed to the Board wishing to "rehabilitate" a guilty physician, as physicians in this condition were deemed to be patients themselves, which triggered rehabilitative responses from Board members. However, we did not observe this factor to be a dominant mechanism in our data leading to bounded accountability. Regardless of a guilty physician's relationship to opioids, most guilty physicians were given the chance to rehabilitate themselves and become "safe physicians" as a result of the shared professional belief among Board members favoring rehabilitation over strict punishment.

[7] Investigative journalists in the state we studied, for example, have highlighted that federal prosecutors are pursuing significantly more cases of physicians' overprescribing opioids compared with the Board.

References

Abbott A (1988) *The System of Professions: An Essay on the Division of Expert Labor* (University of Chicago Press, Chicago).

Abel RL (2008) *Lawyers in the Dock: Learning from Attorney Disciplinary Proceedings* (Oxford University Press, New York).

Abel RL (2012) Comparative studies of lawyer deviance and discipline. *Legal Ethics* 15(2):187–195.

Anteby M, Chan CK (2018) A self-fulfilling cycle of coercive surveillance: Workers' invisibility practices and managerial justification. *Organ. Sci.* 29(2):247–263.

Anteby M, Chan CK, DiBenigno J (2016) Three lenses on occupations and professions in organizations: Becoming, doing, and relating. *Acad. Management Ann.* 10(1):183–244.

Arnold BL, Kay FM (1995) Social capital, violations of trust and the vulnerability of isolates: The social organization of law practice and professional self-regulation. *Internat. J. Sociol. Law* 23:321–346.

Baker M, Halberstam Y, Kroft K, Mas A, Messacar D (2023) Pay transparency and the gender gap. *Amer. Econom. J. Appl. Econom.* 15(2): 157–183.

Barber B (1962) *Science and the Social Order* (Collier Books, New York).

Becker H, Geer B, Hughes EC, Strauss AL (1961) *Boys in White: Student Culture in Medical School* (University of Chicago Press, Chicago).

Bentham J (2001) *The Collected Works of Jeremy Bentham: Writings on the Poor Laws*, vol. I (Oxford University Press, Oxford, UK).

Bernstein ES (2012) The transparency paradox: A role for privacy in organizational learning and operational control. *Admin. Sci. Quart.* 57(2):181–216.

Bernstein ES (2017) Making transparency transparent: The evolution of observation in management theory. *Acad. Management Ann.* 11(1):217–266.

Bertkau A, Halpern J, Yadla S (2005) The privileges and demands of professional self-regulation. *AMA J. Ethics* 7(4):267–269.

Bloomfield B (2001) In the right place at the right time: Electronic tagging and problems of social order/disorder. *Sociol. Rev.* 49(2):174–201.

Bosk CL (1979) *Forgive and Remember: Managing Medical Failure* (University of Chicago Press, Chicago).

Boyd EA (1998) Bureaucratic authority in the "company of equals": The interactional management of medical peer review. *Amer. Sociol. Rev.* 63(2):200–224.

Brittain B (2023) Lawsuit says OpenAI violated US authors' copyrights to train AI chatbot. *Reuters* (June 29), https://www.reuters.com/legal/lawsuit-says-openai-violated-us-authors-copyrights-train-ai-chatbot-2023-06-29/.

Brunetti A, Weder B (2003) A free press is bad news for corruption. *J. Public Econom.* 87(7):1801–1824.

Burrell J, Fourcade M (2021) The society of algorithms. *Annual Rev. Sociol.* 47(1):213–237.

Case A, Deaton A (2015) Rising morbidity and mortality in midlife among White non-Hispanic Americans in the 21st century. *Proc. Natl. Acad. Sci. USA* 112(49):15078–15083.

Castilla EJ (2008) Gender, race, and meritocracy in organizational careers. *Amer. J. Sociol.* 113(6):1479–1526.

Castilla EJ (2015) Accounting for the gap: A firm study manipulating organizational accountability and transparency in pay decisions. *Organ. Sci.* 26(2):311–333.

Centers for Disease Control and Prevention (2022) Understanding the opioid overdose epidemic. Accessed July 21, 2022, https://www.cdc.gov/overdose-prevention/about/understanding-the-opioid-overdose-epidemic.html.

Chambers S (2005) Measuring publicity's effect: Reconciling empirical research and normative theory. *Acta Politica* 40(2):255–266.

Chaney PK, Philipich KL (2002) Shredded reputation: The cost of audit failure. *J. Accounting. Res.* 40(4):1221–1245.

Chiarello E (2011) Challenging professional self-regulation: Social movement influence on pharmacy rulemaking in Washington State. *Work Occupations* 38(3):303–339.

Cordis AS, Warren PL (2014) Sunshine as disinfectant: The effect of state freedom of information act laws on public corruption. *J. Public Econom.* 115:18–36.

Costanza-Chock S, Raji ID, Buolamwini J (2022) Who audits the auditors? Recommendations from a field scan of the algorithmic auditing ecosystem. *Proc. 2022 ACM Conf. Fairness Accountability Transparency* (Association for Computing Machinery, New York), 1571–1583.

Cruess SR, Cruess RL (2005) The medical profession and self-regulation: A current challenge. *AMA J. Ethics* 7(4):320–324.

Davis CS, Carr DH (2017) Self-regulating profession? Administrative discipline of "pill mill" physicians in Florida. *Substance Abuse* 38(3):265–268.

Dewan S, Baker M (2020) Facing protests over use of force, police respond with more force. *New York Times* (May 31), https://www.nytimes.com/2020/05/31/us/police-tactics-floyd-protests.html.

Emerson RM (1983) Holistic effects in social control decision-making. *Law Soc. Rev.* 17(3):425–455.

Espeland WN, Sauder M (2016) *Engines of Anxiety: Academic Rankings, Reputation, and Accountability* (Russell Sage Foundation, New York).

Evans J (2021) How professionals construct moral authority: Expanding boundaries of expert authority in stem cell science. *Admin. Sci. Quart.* 66(4):989–1036.

Evans J, Silbey SS (2021) Co-opting regulation: Professional control through discretionary mobilization of legal prescriptions and expert knowledge. *Organ. Sci.* 33(5):2041–2064.

Fine GA (1985) Occupational aesthetics: How trade school students learn to cook. *J. Contemporary Ethnography* 14:3–32.

Freidson E (1970) *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (University of Chicago Press, Chicago).

Freidson E (1984) The changing nature of professional control. *Annual Rev. Sociol.* 10(1):1–20.

Freidson E (1986) *Professional Powers: A Study of the Institutionalization of Formal Knowledge* (University of Chicago Press, Chicago).

Freidson E (2001) *Professionalism: The Third Logic* (Polity Press, Cambridge, UK).

Freidson E, Rhea B (1963) Processes of control in a company of equals. *Soc. Problems* 11(2):119–131.

Frink DD, Klimoski RJ (2004) Advancing accountability theory and practice: Introduction to the human resource management review special edition. *Human Resource Management Rev.* 14(1):1–17.

Frink DD, Hall AT, Perryman AA, Ranft AL, Hochwarter WA, Ferris GR, Royle MT (2008) Meso-level theory of accountability in organizations. Martocchio JJ, ed. *Research in Personnel and Human Resources Management* (Emerald Group Publishing/MCB University Press, Bingley, UK), 177–245.

Glaser BG, Strauss AL (2010) *The Discovery of Grounded Theory: Strategies for Qualitative Research 5* (Aldine Transaction, New Brunswick, NJ).

Goode WJ (1957) Community within a community: The professions. *Amer. Sociol. Rev.* 22(2):194–200.

Gorman EH (2014) Professional self-regulation in North America: The cases of law and accounting. *Sociol. Compass* 8(5):491–508.

Gorman EH, Sandefur RL (2011) "Golden age," quiescence, and revival: How the sociology of professions became the study of knowledge-based work. *Work Occupations* 38(3):275–302.

Gray GC, Silbey SS (2014) Governing inside the organization: Interpreting regulation and compliance. *Amer. J. Sociol.* 120(1): 96–145.

Grodal S, Anteby M, Holm AL (2021) Achieving rigor in qualitative analysis: The role of active categorization in theory building. *Acad. Management Rev.* 46(3):591–612.

Grynbaum MM, Mac R (2023) The *Times* sues OpenAI and Microsoft over A.I. use of copyrighted work. *New York Times* (December 27), https://www.nytimes.com/2023/12/27/business/media/new-york-times-open-ai-microsoft-lawsuit.html.

Hafferty FW, Light DW (1995) Professional dynamics and the changing nature of medical work. *J. Health Soc. Behav.* 35:132–153.

Harris DA (2010) Picture this: Body worn video devices ('head cams') as tools for ensuring Fourth Amendment compliance by police. *Texas Tech Law Rev.* 43:357–371.

Haw Allensworth R (2017) Foxes at the henhouse: Occupational licensing boards up close. *California Law Rev.* 105:1567–1610.

Heimer CA (1999) Competing institutions: Law, medicine, and family in neonatal intensive care. *Law Soc. Rev.* 33(1):17–66.

Hood C (2010) Accountability and transparency: Siamese twins, matching parts, awkward couple? *West Eur. Politics* 33(5):989–1009.

Hood C, Heald D, eds. (2006) *Transparency: The Key to Better Governance?* (Oxford University Press, Oxford, UK).

Horowitz R (2012) *In the Public Interest: Medical Licensing and the Disciplinary Process* (Rutgers University Press, New Brunswick, NJ).

Hughes EC (1958) *Men and their Work* (Free Press, Glencoe, IL).

Huising R (2014) The erosion of expert control through censure episodes. *Organ. Sci.* 25(6):1633–1661.

Karunakaran A, Orlikowski WJ, Scott SV (2022) Crowd-based accountability: Examining how social media commentary reconfigures organizational accountability. *Organ. Sci.* 33(1):170–193.

Kaynak E (2023) Leveraging learning collectives: How novice outsiders break into an occupation. *Organ. Sci.*, ePub ahead of print July 18, https://doi.org/10.1287/orsc.2020.14214.

Kellogg KC (2009) Operating room: Relational spaces and microinstitutional change in surgery. *Amer. J. Sociol.* 115(3):657–711.

Kellogg KC (2011) *Challenging Operations: Medical Reform and Resistance in Surgery* (University of Chicago Press, Chicago).

Klitgaard R (2009) *Controlling Corruption* (University of California Press, Berkeley, CA).

Lamont M (2009) *How Professors Think: Inside the Curious World of Academic Judgment* (Harvard University Press, Cambridge, MA).

Larson MS (1977) *The Rise of Professionalism: A Sociological Analysis* (Transaction Publishers, New Brunswick, NJ).

Liptak A (2022) Supreme Court sides with doctors accused of running pill mills. New York Times (June 27), https://www.nytimes.com/2022/06/27/us/politics/supreme-court-controlled-substance-act.html.

Loughry ML, Tosi HL (2008) Performance implications of peer monitoring. *Organ. Sci.* 19(6):876–890.

MacKenzie D (2011) The credit crisis as a problem in the sociology of knowledge. *Amer. J. Sociol.* 116(6):1778–1841.

MacKenzie D, Spears T (2014) 'The formula that killed Wall Street': The Gaussian copula and modelling practices in investment banking. *Soc. Stud. Sci.* 44(3):393–417.

McPherson CM, Sauder M (2013) Logics in action: Managing institutional complexity in a drug court. *Admin. Sci. Quart.* 58(2): 165–196.

Merton RK (1987) Three fragments from a sociologist's notebooks: Establishing the phenomenon, specified ignorance, and strategic research materials. *Annual Rev. Sociol.* 13(1):1–29.

Michel A (2011) Transcending socialization: A nine-year ethnography of the body's role in organizational control and knowledge workers' transformation. *Admin. Sci. Quart.* 56(3):325–368.

Mitchell TR, Hopper H, Daniels D, George-Falvy J, Ferris GR (1998) Power, accountability, and inappropriate actions. *Appl. Psych.* 47(4):497–517.

Morrill C (1995) *The Executive Way: Conflict Management in Corporations* (University of Chicago Press, Chicago).

Pierce L, Snow DC, McAfee A (2015) Cleaning house: The impact of information technology monitoring on employee theft and productivity. *Management Sci.* 61(10):2299–2319.

Pernell K, Jung J, Dobbin F (2017) The hazards of expert control: Chief risk officers and risky derivatives. *Amer. Sociol. Rev.* 82(3):511–541.

Pettigrew AM (1973) *The Politics of Organizational Decision-Making* (Routledge, Abingdon, UK)

Rabin RC (2021) After years of sexual abuse allegations, how did this doctor keep working? *New York Times* (October 11), https://www.nytimes.com/2021/10/11/health/ricardo-cruciani-sexual-abuse.html.

Rahman HA (2024) *Inside the Invisible Cage: How Algorithms Control Workers* (University of California Press, Oakland, CA).

Rahman HA, Karunakaran A, Cameron LD (2024) Taming platform power: Taking accountability into account in the management of platforms. *Acad. Management Ann.* 18(1):251–294.

Schleef DJ (2006) *Managing Elites: Socialization in Law and Business Schools* (Rowman & Littlefield Publishers, Lanham, MD).

Scholl L, Seth P, Kariisa M, Wilson N, Baldwin G (2018) Drug and opioid-involved overdose deaths—United States, 2013–2017. *MMWR Morbidity Mortality Weekly Rep.* 67(51–52):1419–1427.

Scott WR (1982) Managing professional work: Three models of control for health organizations. *Health Service Res.* 17(3):213–240.

Sewell G (1998) The discipline of teams: The control of team-based industrial work through electronic and peer surveillance. *Admin. Sci. Quart.* 43(2):397–428.

Sewell G, Barker JR (2006) Coercion vs. care: Using irony to make sense of organizational surveillance. *Acad. Management Rev.* 31(4):934–961.

Sharkey AJ, Bromley P (2015) Can ratings have indirect effects? Evidence from the organizational response to peers' environmental ratings. *Amer. Sociol. Rev.* 80(1):63–91.

Strauss A, Corbin J (1998) *Basics of Qualitative Research Techniques* (Sage, Los Angeles).

Taplin J (2018) *Move Fast and Break Things: How Facebook, Google, and Amazon Cornered Culture and Undermined Democracy* (Back Bay Books, New York).

Tetlock PE (1999) Accountability theory: Mixing properties of human agents with properties of social systems. Levine JM, Messick DM, Thompson LL, eds. *Shared Cognition in Organizations* (Psychology Press, London), 117–138.

Thakor RT, Merton RC (2023) Trust, transparency, and complexity. *Rev. Financial Stud.* 36(8):3213–3256.

Timmermans S, Oh H (2010) The continued social transformation of the medical profession. *J. Health Soc. Behav.* 51(1, suppl)S94–S106.

Umansky E (2023) The failed promise of police body cameras. *New York Times* (December 12), https://www.nytimes.com/2023/12/13/magazine/police-body-cameras-miguel-richards.html.

Van Maanen J (1973) Observations on the making of policemen. *Human Organ.* 32(4):407–418.

Van Maanen J (1978) The asshole. Manning PK, Van Maanen J, eds. *Policing: A View from the Street* (Goodyear Press, Los Angeles), 221–238.

Van Maanen J, Barley SR (1984) *Occupational Communities: Culture and Control in Organizations.* Research in Organizational Behavior (JAI Press, Greenwich, CT), 287–365.

Venkataramani AS, Chatterjee P (2019) Early Medicaid expansions and drug overdose mortality in the USA: A quasi-experimental analysis. *J. General Internal Medicine* 34(1):23–25.

Weisz G, Cambrosio A, Keating P, Knaapen L, Schlich T, Tournay VJ (2007) The emergence of clinical practice guidelines. *Milbank Quart.* 85(4):691–727.

Yang M (2022) Harvard students sue, claiming school ignored professor's sexual harassment. *The Guardian* (February 9), https://www.theguardian.com/education/2022/feb/09/harvard-students-file-lawsuit-claiming-school-ignored-professor-sexual-harassment-for-years.

Zhang VS, Mohliver AC, King M (2023) Where is all the deviance? Liminal prescribing and the social networks underlying the prescription drug crisis. *Admin. Sci. Quart.* 68(1):228–269.

Zhao L, Papachristos AV (2024) Threats to blue networks: The effect of partner injuries on police misconduct. *Amer. Sociol. Rev.* 89(1):159–195.

Zuboff S (2019) *The Age of Surveillance Capitalism: The Fight for a Human Future at the New Frontier of Power* (PublicAffairs, New York).

Ece Kaynak is an assistant professor of organizational behavior at Bayes Business School, City, University of London. She received her PhD from Stanford University's Department of Management Science and Engineering. She studies the changing nature of work, employment relations, and careers, with an emphasis on occupational dynamics.

Hatim A. Rahman is an assistant professor of management and organizations at Northwestern University's Kellogg School of Management. His research focuses on the intersection of new technology, work, labor markets, platforms, and organizations. He earned his PhD from the Center of Work, Technology, and Organization at Stanford's Department of Management Science and Engineering.