

NOTE

THE DISTORTIVE EFFECT OF THE NATIONAL PRACTITIONER DATA BANK ON MEDICAL MALPRACTICE LITIGATION AND SETTLEMENT

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I. INTRODUCTION

Congress created the National Practitioner Data Bank ("NPDB") in 1986 to address a concern that medical liability cases were increasing throughout the nation.¹ In order to prevent physicians from moving from state to state in order to escape a poor outcome, the NPDB was supposed to provide a central clearinghouse of information for every physician in the country—regardless of where they practiced.² The idea was quite simple: whenever a physician was involved in a malpractice case or a professional disciplinary action, it would be reported to the NPDB and form a record for that physician.³ New practices considering working with that physician

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¹ U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTH RES. & SERVS. ADMIN., NPDB GUIDEBOOK A-1-2 (2015), <https://www.npdb.hrsa.gov/resources/NPDBGuidebook.pdf> [<https://perma.cc/J9QM-MKUM>] [hereinafter NPDB GUIDEBOOK].

² *Id.*

³ *See id.*

could request the information as part of evaluating him or her for credentialing.⁴

However, the NPDB⁵ distorts medical malpractice litigation and settlement—harming defendant-physicians, plaintiff-patients, and insurers. Hospitals considering credentialing or renewing privileges for a physician effectively must request the NPDB report—they will be penalized in a malpractice action if they do not.⁶ Further, the NPDB plays an important role in determining whether to allow the physician to practice at the institution.⁷ Thus, the fear of an NPDB entry from malpractice litigation or settlement is driving physicians to press their insurers to mount a complete defense and litigate claims to judgment.⁸ In some cases, operating under laws conceived to prevent insurers from leaving their clients with judgments over policy limits, insurers have incentives and the legal right to settle against a physician's wishes and interests. In other cases, physicians and insurers prolong litigation where both sides would be open to settlement with the plaintiff had the NPDB not provided a barrier.⁹

*Webb v. Witt*¹⁰ illustrates this conflict and its harm. Empress Nazirah Ashanti Webb was delivered with an injury to her brachial plexus,¹¹ causing permanent paralysis of her right arm.¹² In the resulting medical malpractice suit against the physicians and hospital,¹³ the insurer recommended settlement.¹⁴ One of the physicians, Dr. Susan Kaufman, D.O., resisted this move

⁴ See *id.* at A-5-7.

⁵ 42 U.S.C. §§ 11101-11152 (2012); 45 C.F.R. §§ 60.1-22 (2016).

⁶ 42 U.S.C. § 11135(a)-(b).

⁷ See generally Teresa M. Waters et al., *The Role of National Practitioner Data Bank in the Credentialing Process*, 21 AM. J. MED. QUALITY 30 (2006).

⁸ Whether a physician can press his or her insurer to litigate depends on their contractual arrangement. Some states require insurers to provide “no consent” to settle insurance policy options. See, e.g., N.Y. COMP. CODES R. & REGS. tit. 11, § 70.2 (2016); see also Waters, *supra* note 7. However, some states require insurers to not give physicians the right to veto a settlement within policy limits. See, e.g., FLA. STAT. § 627.4147(b)(1) (2016).

⁹ Medical malpractice litigation can be quite lengthy already, especially if settlement negotiations break down and a case goes to trial. See NEIL VIDMAR, *MEDICAL MALPRACTICE AND THE AMERICAN JURY: CONFRONTING THE MYTHS ABOUT JURY INCOMPETENCE, DEEP POCKETS, AND OUTRAGEOUS DAMAGE AWARDS* 49-67 (1995).

¹⁰ 876 A.2d 858 (N.J. Super. App. Div. 2005).

¹¹ This complex nerve structure controls the movement of the arm and hands; an injury can cause paralysis of the limb. See Allen T. Bishop, *Brachial Plexus Injuries*, AM. ACAD. OF ORTHOPAEDIC SURGEONS (2015), <http://orthoinfo.aaos.org/topic.cfm?topic=A00678> [<https://perma.cc/BX99-4B6J>] (last visited Nov. 14, 2018).

¹² *Webb*, 876 A.2d at 861-62.

¹³ See *id.*

¹⁴ *Id.* at 862. The role of the hospital as the insurer or acquirer of insurance adds yet another conflict to the picture, but it does not change the fundamental distorting role of the NPDB. It will not be analyzed in depth in this paper. In this case, the hospital was the only named insured on the malpractice policy, but the insurance policy at issue stated that the insurer must make “a reasonable attempt to consult” Kaufman before settling. *Id.* at 861. This wrinkle recapitulates the fact that many malpractice insurance policies do not require the physician-insured to consent to settlement (so-called “pride provisions”). Kent D. Syverud, *The Duty to Settle*, 76 VA. L. REV. 1113, 1175-76 (1990). Another variation, “hammer” clauses, require consent not to be withheld unreasonably. Jonathan L. Schwartz & Seth L. Laver, *The*

to settle on her behalf, arguing that the settlement would reduce her ability to practice medicine by preventing her from entering insurer networks and obtaining hospital privileges.¹⁵ She specifically alleged that reporting a settlement to the NPDB would prevent her from securing future medical liability insurance.¹⁶ The court rejected her claims and allowed the insurer to settle on the hospital and physicians' behalf.¹⁷ Yet, that same court noted "that Kaufman's main concern does not appear to be the settlement itself, but rather how it is reported to the federal and state databanks. Clearly, her interests are served by a settlement of the claims, so long as the reported percentage of her responsibility is zero."¹⁸ Thus, the physician was unable to litigate her claims, the insurer chose to settle a claim against the interest of the insured, and the resulting litigation delayed payment to the plaintiff—a payment that all parties appeared to agree was reasonable.

The NPDB's brooding shadow over medical malpractice has led many litigants and commentators to term it a "blacklist."¹⁹ Part II explores whether this term is appropriate by describing the NPDB in the context of insurer-physician relations. This discussion will connect the well-described model of insurer-insured relations to the present concerns raised about the NPDB's potential distortive effect on litigation and settlement as the data bank was being enacted in the late 1980s. Part III will explore mechanisms to alter reports—and place a physician's "side" into the record kept by the NPDB. Attempts to alter reports have triggered litigation against reporting entities and the NPDB itself, and although they have largely failed, these suits illustrate the unique problems that the NPDB causes physicians. In Part IV, these unsuccessful suits will be contrasted against a body of law surrounding the accuracy of another putative "blacklist"—credit scores.²⁰ Part V will begin to sketch out some basic policy recommendations.

Case of the Missing Insured: A Tricky Variation on the Consent to Settle, 25 WESTLAW J. INS. COVERAGE 3, 4 (2015). The New Jersey court, in fact, qualifies that its holdings apply to an insurance policy without a consent-to-settle clause. See *Webb*, 876 A.2d at 868.

¹⁵ *Id.* at 862–63.

¹⁶ *Webb*, 876 A.2d at 863. Dr. Kaufman also claimed that similar effects would arise from reporting to New Jersey's data bank. See *id.* at 865–66; see also N.J. STAT. ANN. § 45:9–22.22–25 (West 2016).

¹⁷ The court rejected Dr. Kaufman's arguments on procedural and substantive insurance law theories. See *Webb*, 876 A.2d at 863.

¹⁸ *Id.*

¹⁹ See, e.g., *Leal v. Sec'y, U.S. Dep't of Health & Human Servs.*, 620 F.3d 1280, 1283 (11th Cir. 2010) (plaintiff's characterization); Elisabeth Ryzen, *The National Practitioner Data Bank: Problems and Proposed Reforms*, 13 J. LEGAL MED. 409, 444 (1992) (summarizing other views); Gabriel H. Teninbaum, *Reforming the National Practitioner Data Bank to Promote Fair Med-Mal Outcomes*, 5 WM. & MARY POL'Y REV. 83, 104, 115 (2013) (summarizing other views). See generally Katharine A. Van Tassel, *Blacklisted: The Constitutionality of the Federal System for Publishing Reports of "Bad" Doctors in the National Practitioner Data Bank*, 33 CARDOZO L. REV. 2031 (2012).

²⁰ See generally James M. Pérez, Note, *Blacklisted: The Unwarranted Divestment of Access to Bank Accounts*, 80 N.Y.U. L. REV. 1586 (2005).

II. LIABILITY INSURERS, PHYSICIANS, AND THE NPDB

Liability insurance overshadows the conduct of malpractice litigation. The terms of agreements between insurers and physicians materially affect the conduct of a given malpractice litigation. And, those same terms can lead to yet more conflict after a malpractice suit has concluded.²¹

This part will focus on the decision to continue to litigate or to settle. As such, this section is divided into three parts: Part A will provide a basic overview of the complex—and sometimes counterintuitive—dynamics that connect a liability insurer, insured, defense counsel, plaintiff, plaintiff’s counsel, and juries in a medical malpractice situation. Part B will explain what the NPDB actually is and briefly outline its operation. This part will omit a lengthy discussion of physician peer review boards and antitrust immunity, though that part of the law has also been criticized recently.²² Part C will bring Parts A and B together, demonstrating how the NPDB distorts medical malpractice litigation and settlement to the detriment of physicians and plaintiffs. Although the subject of this paper is the federal NPDB, state malpractice databases should, presumably, produce similar effects on litigation and settlement within their respective boundaries.²³

A. *The Basics of the Interaction Between the Insured and the Insurance Company*

Medical malpractice is not merely the conflict between a physician and his or her former patient. “Tort litigation and liability insurance are symbiotic institutions”²⁴ Courts and legislatures have imposed obligations on insurers—such as the duty to defend or settle—in order to try to align the incentives of parties.²⁵ Nonetheless, a typical medical malpractice suit in-

²¹ Even the quintessential IL contracts and malpractice case, *Hawkins v. McGee*, 146 A. 641 (N.H. 1929), spawned a conflict between Dr. McGee and his insurer to cover those now-famous damages described in the case. See *McGee v. U.S. Fid. & Guar. Co.*, 53 F.2d 953, 956 (1st Cir. 1931) (holding that the insurance company was under no obligation to cover the judgment against Dr. McGee).

²² See 42 U.S.C. §§ 11111–11115; see also Van Tassel, *supra* note 19, at 2052–57.

²³ See generally Jeffrey P. Donohue, Note and Comment, *Developing Issues Under the Massachusetts ‘Physician Profile’ Act*, 23 AM. J.L. & MED. 115 (1997). Several states have their own malpractice reporting requirements or authorize their state medical boards to obtain such information from courts. See, e.g., ALA. CODE § 34-24-56 (2016); ALASKA STAT. ANN. § 08.64.345 (West 2016); ARK. CODE ANN. § 17-95-103 (West 2016); MASS. GEN. LAWS ANN. ch. 112, § 5C (West 2016); MICH. COMP. LAWS ANN. § 333.16231 (West 2016); NEV. REV. STAT. ANN. § 630.173 (West 2016); OHIO REV. CODE ANN. § 4731.281 (West 2016); P.R. LAWS ANN. tit. 20, § 134a (2013).

²⁴ Syverud, *supra* note 14, at 1114.

²⁵ This paper does not purport to cover all the nuances of this area of law, but a good review can be found at TOM BAKER, *INSURANCE LAW AND POLICY* 524–636 (2d ed. 2008). Further, regardless of whether an insurance company may or may not settle over the objections of its insured, it must inform the insured as to its action. See, e.g., *Rogers v. Robson*, 407 N.E.2d 47, 49 (Ill. 1980).

volves four major players: 1) the plaintiff (often represented by a lawyer working for a contingent fee), 2) the defendant-physician, 3) the medical malpractice liability insurer, and 4) the lawyer for the physician hired by the insurer.²⁶ All four players have distinct interests that may or may not align depending on the posture and merits of the litigation. However, to simplify the analysis for our purposes, this paper concentrates upon the physician and his or her liability insurer.²⁷

Liability insurance law, however, did not develop specifically to meet the concerns of physicians and address medical malpractice—but to protect consumers who could not afford to pay judgments above their liability insurance caps. *Crisci v. Security Insurance Co. of New Haven, Connecticut*²⁸ provides a paradigmatic example. Rosina Crisci owned an apartment building where June DiMare was injured when a step broke.²⁹ The DiMares sued Ms. Crisci for \$400,000. Ms. Crisci had liability insurance for \$10,000, and she triggered the policy provisions obligating Security Insurance to defend her and “make any settlement it deemed expedient.”³⁰ In its investigation, Security Insurance determined that if the jury believed the DiMares’ claims, the verdict would be no less than \$100,000. However, Security Insurance refused to settle the case for \$6500.³¹ (The insurance company would only be on the hook for \$10,000 anyway.) The jury returned a verdict of \$101,000, leaving Ms. Crisci with liability over nine times her policy limit.³² Nonetheless, the court found the insurer liable for the excess over the policy limit.³³

While physicians are protected by the same rule,³⁴ physicians sued for medical malpractice often suffer from a different problem: they frequently want to risk the expense and unpredictability of discovery, depositions, trials, and juries to get a vindicating verdict—with their liability insurance potentially footing the bill.³⁵ The issue for the physician, then, is not only the

²⁶ Tom Baker, *Liability Insurance Conflicts and Defense Lawyers: From Triangles to Tetrahedrons*, 4 CONN. INS. L.J. 101, 113 (1998).

²⁷ Physicians and insurers also conflict with the appointed counsel. See generally Richard H. Underwood, *The Doctor and His Lawyer: Conflicts of Interest*, 30 KAN. L. REV. 385 (1982).

²⁸ 426 P.2d 173 (Cal. 1967).

²⁹ *Id.* at 175.

³⁰ *Id.*

³¹ See *id.* at 175–76. Ms. Crisci was willing to pay \$2,500 of a \$9,000 settlement offer by plaintiff. *Id.*

³² *Id.* at 176.

³³ *Id.* at 178. The *Crisci* or “reasonable offer” rule, with some modifications, is now the majority rule defining the insurer’s duty to settle. “Under the reasonable-offer test, the question is whether an insurer under a policy without limits would have accepted the offer.” KENNETH S. ABRAHAM & DANIEL SCHWARCZ, *INSURANCE LAW AND REGULATION* 615 (6th ed., 2015).

³⁴ See, e.g., *Garner v. Am. Mut. Liab. Ins. Co.*, 107 Cal. Rptr. 604, 608–09 (Ct. App. 1973) (holding that even when physicians’ attorneys testify that they would not expect the jury to return a verdict above the policy limits, an insurance company must come to its own independent judgment as to merits of a physician’s case and cannot delegate that responsibility to a board that does not bear the risk and liability for a jury award above the policy limit).

³⁵ See Scott Stephens Thomas, *An Insurer’s Right to Settle Versus Its Duty to Defend Nonmeritorious Medical Malpractice Claims*, 16 J. LEGAL MED. 545, 572 (1995). Of course, if

money but also the reputational and long-term costs of even a settled medical malpractice suit.³⁶ Beyond tangible costs, medical malpractice can trigger deep emotional turmoil and uncertainty in the physician, patient, and patient's family.³⁷ Magnifying these issues is the fact that the language of many malpractice insurance contracts gives control of settlement to the insurer—who does not have to contend with the reputational and other long-term costs of a lawsuit.³⁸ The next several cases provide examples of courts ignoring these concerns. The issue of whether the physician committed malpractice is less relevant—but the courts' refusal to engage in any more nuanced analysis of the costs of a malpractice lawsuit to a physician is.

For instance, some courts have refused to recognize situations where the duty to settle does not fit the circumstances well. *Harrison v. Long*³⁹ illustrates this problem. Dr. Long was sued for malpractice by the parents of Bradley Harrison.⁴⁰ Accordingly, Dr. Long activated his malpractice liability insurance from St. Paul Fire and Marine Insurance Co.⁴¹ St. Paul found it expedient to settle the case over the policy limits, so the insurer notified the Kansas Health Care Stabilization Fund, *which would cover the settlement amount over the liability cap*.⁴² Dr. Long objected to settlement on due process and property rights grounds as depriving his "right" to defend himself against accusations of malpractice.⁴³ But, the court rejected his arguments as he had contracted with the insurance company to defend him and did not

a physician perceives that a malpractice claim is legitimate, he or she will often push to settle to minimize the publicity and expense of the mistake. *See id.* at 546.

³⁶ *See* West Wake Price & Co v. Ching [1957] 1 W.L.R. 45, 53 (QB) (noting a lawsuit may damage a professional's reputation even if the suit is not successful).

³⁷ *See, e.g.,* Sara C. Charles, *Coping with a Medical Malpractice Suit*, 174 W.J. MEDICINE 55, 55 (2001) (physicians); Tom Delbanco & Signall K. Bell, *GUILTY, AFRAID, AND ALONE — Struggling with Medical Error*, 357 NEW ENG. J. MED. 1682, 1682 (2007) (patients).

³⁸ Medical malpractice policy language is often not public, but it does enter public records in litigation over the meaning of the insurance contract. *See, e.g.,* Mitchum v. Hudgens, 533 So. 2d 194, 196 (Ala. 1988) (emphasis added) ("We'll defend any suit brought against you for damages covered under this agreement. We'll do this even if the suit is groundless or fraudulent. *We have the right to investigate, negotiate and settle any suit or claim if we think that's appropriate.*"); Shuster v. S. Broward Hosp. Dist. Physicians' Prof'l Liab. Ins. Tr., 570 So. 2d 1362, 1364 (Fla. Dist. Ct. App. 1990), *aff'd*, 591 So. 2d 174 (Fla. 1992) (emphasis added) ("The company shall have the right and duty to defend any suit against the named insured seeking such damages, even if any of the allegations of the suit are groundless, false or fraudulent. *The company may make such investigation and such settlement of any claim or suit as it deems expedient.*"). *But see* Aquilina v. O'Connor, 399 N.Y.S.2d 919, 921 (App. Div. 1977) (emphasis added) ("[E]ven if such suit is groundless, false or fraudulent; but the company may make such investigation, negotiation and settlement of any claim or suit as it deems advisable, provided that *no claim or suit shall be settled or compromised* by the company *except with the written consent of the insured.*"); *supra* note 2 and accompanying text.

³⁹ 734 P.2d 1155 (Kan. 1987).

⁴⁰ *Id.* at 1157.

⁴¹ *Id.*

⁴² *Id.* Kansas had enacted the Fund to cover such damages "as a partial response to the increasing pressure of what was termed a national medical malpractice crisis." *Id.*; *see also* KAN. STAT. ANN. § 40-3403 (2016). Physicians paid a premium for the additional protection by the state. *Harrison*, 734 P.2d at 1157.

⁴³ *Harrison*, 734 P.2d at 1158-60.

have an overriding constitutional right to litigate.⁴⁴ So, even though the liability insurer could still go to the Stabilization Fund after trial, St. Paul chose to settle the case over a physician objection.⁴⁵

Further, courts do not compute the devastating reputational effects that a *settlement* can inflict on physicians. *Feliberty v. Damon*⁴⁶ provides one example of this type of conflict. Thomas Michaels, an iron worker, visited Dr. Feliberty, a Buffalo physician, complaining of “recurring throat pain and lumps in his neck.”⁴⁷ After a brief exam, Dr. Feliberty recommended Michaels get an x-ray of his chest.⁴⁸ Michaels did not return to see the physician.⁴⁹ Two-and-a-half years later, Michaels sued Dr. Feliberty for failure to diagnose lymphoma.⁵⁰ A medical malpractice panel unanimously found negligence, and the case proceeded to trial.⁵¹ The final judgment against Dr. Feliberty was \$743,000.⁵² Although the physician wished to appeal, the insurer settled for \$700,000—within Dr. Feliberty’s liability limits.⁵³ Despite the physician alleging that his medical practice had been ruined and that he had been forced to leave his practice location, the court found no problem with the insurer’s conduct because the insurance contract had given the insurer an exclusive right to settle.⁵⁴ The physician could have purchased more expensive insurance if he wished to have a “consent to settle” clause.⁵⁵

Even though a physician’s loss in court heightens the conflict between an insurer who wishes to settle and a physician who wishes to appeal, an outcome favorable to a physician presents a similar conflict. In *Aquilina v. O’Connor*,⁵⁶ Dr. Aquilina, a neurosurgeon, was sued by the estate of a deceased patient.⁵⁷ Dr. Aquilina “moved for summary judgment upon the grounds that he had not been the treating physician, only an emergency con-

⁴⁴ *Id.* at 1160–61. Dr. Long’s required contribution to the Stabilization Fund increased 400 percent. *Id.* at 1158.

⁴⁵ Presumably, the insurer was attempting to save money on lawyers’ fees and litigation costs, for the Stabilization Fund did cover both judgments and settlements over liability insurance limits, see KAN. STAT. ANN. § 40-3403(c)(1) (“Any amount due from a judgment or settlement which is in excess of the basic coverage liability of all liable resident health care providers or resident self-insurers for any personal injury or death arising out of the rendering of or the failure to render professional services within or without this state . . .”).

⁴⁶ 527 N.E.2d 261 (N.Y. 1988).

⁴⁷ *Id.* at 261.

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *Id.* at 261–62.

⁵¹ *Feliberty*, 527 N.E.2d at 262; see also N.Y. JUD. LAW § 148-a (McKinney 1983) (repealed 1991). New York no longer uses mandatory medical malpractice panels.

⁵² *Feliberty*, 527 N.E.2d at 262.

⁵³ *Id.*

⁵⁴ *Id.* (“While the settlement was within policy limits and plaintiff therefore technically suffered no out-of-pocket loss, he is understandably concerned about . . . a different interest—his professional reputation. This . . . contract, however, specifies that the ‘company may make such investigation and such settlement of any claim or suit as it deems expedient.’”).

⁵⁵ *Id.*

⁵⁶ 399 N.Y.S.2d 919 (App. Div. 1977).

⁵⁷ *Id.* at 920.

sultant, and that his diagnosis had been correct and proper.”⁵⁸ Plaintiff wished to discontinue the action and Aquilina’s insurance-retained attorney negotiated a settlement dismissing the action with prejudice. However, Dr. Aquilina desired to sue plaintiff and her attorney for malicious prosecution and abuse of process—but was unable due to the settlement.⁵⁹ Despite a “consent to settle” clause in the insurance policy, the court held that dismissal of a suit negotiated between the two parties *does not qualify as a settlement* and that Dr. Aquilina had no cause of action.⁶⁰

Thus, even before the NPDB was enacted, physicians and insurers suffered a potentially severe conflict of interest.⁶¹ However, the NPDB would provide an even stronger incentive to physicians not to settle, worsening the conflicts illustrated above. Before turning to the NPDB’s effect on litigation, this Article turns to the question of what the NPDB is and its basic operation.

B. An Overview of the NPDB

The NPDB arose out of a well-founded concern about physicians escaping liability for malpractice. Congress found that “[t]he increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems . . .” and that “[t]here is a . . . need to restrict the ability of incompetent physicians to move from State to State”⁶² As part of a program to fix this problem, Congress mandated that any insurer making a settlement on a malpractice claim report it to the NPDB.⁶³ Other reportable incidents to the NPDB include sanctions by state medical boards,⁶⁴ disciplinary actions (and some investigations) by hospital peer-review boards,⁶⁵ and criminal convictions or exclusion from government healthcare programs.⁶⁶ NPDB reports should include basic demographic information, the amount of a settlement, a description of settlement or judgment terms, and a “description of the acts or omissions and injuries

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ *Id.* at 921.

⁶¹ *See, e.g.,* Shuster v. S. Broward Hosp. Dist. Physicians’ Prof’l Liab. Ins. Tr., 591 So. 2d 174, 175–76 (Fla. 1992) (An insurer may settle a malpractice claim against a physician within the policy limits of the insurance contract even if the physician is exposed to other damages by settlement.); Teague v. St. Paul Fire & Marine Ins. Co., 10 So.3d 806, 842–44 (La. Ct. App. 2009) (A physician cannot recover reputation damages in a legal malpractice action against a firm and insurer who represented him in a medical malpractice action).

⁶² 42 U.S.C. §§ 11101(1)–(2) (2012).

⁶³ *Id.* § 11131(a) (“Each entity (including an insurance company) which makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report . . . information respecting the payment and circumstances thereof.”); *see also* 45 C.F.R. §§ 60.7, .14, .16 (2016).

⁶⁴ 42 U.S.C. § 11132; *see also* 45 C.F.R. §§ 60.8–10.

⁶⁵ 42 U.S.C. § 11133; *see also* 45 C.F.R. §§ 60.11–12.

⁶⁶ 45 C.F.R. §§ 60.13–14.

or illness upon which the action or claim was based”⁶⁷ The narrative portion of the report—the critical description of the acts or omissions—is capped at 4000 characters, including punctuation and spaces.⁶⁸

The law also imposes obligations on hospitals and health care systems. Hospitals are required to request information from the NPDB whenever they are considering whether to grant privileges to a physician and every two years thereafter.⁶⁹ Although the law presumes that “a payment in settlement of a medical malpractice action or claim *shall not* be construed as creating a presumption that medical malpractice has occurred,”⁷⁰ some courts have found that the NPDB reports are discoverable in corporate liability litigation, such as negligent credentialing cases.⁷¹ Further, the law provides some modest penalties for not reporting,⁷² though there is little evidence that the penalties are being enforced.⁷³

Although the NPDB embodies laudable goals, Congress was made aware of potential issues with collecting and reporting medical malpractice settlements. First, settlements, especially low-value settlements, reflect mere nuisance value and not the merits of a case,⁷⁴ for “a malpractice suit in and of itself . . . may have nothing whatsoever to do with quality of care is-

⁶⁷ *Id.* § 60.7; *see also* 42 U.S.C. § 11131(b).

⁶⁸ NPDB GUIDEBOOK, *supra* note 1, at E-11.

⁶⁹ 45 C.F.R. § 60.17; *see* 42 U.S.C. § 11135(a).

⁷⁰ 42 U.S.C. § 11137(d) (emphasis added).

⁷¹ *See, e.g.,* Klaine v. S. Ill. Hosp. Servs., 47 N.E.3d 966, 975 (Ill. 2016) (“[W]e believe it is clear that information reported to the NPDB, though confidential, is not privileged from discovery in instances where, as here, a lawsuit has been filed against the hospital and the hospital’s knowledge of information regarding the physician’s competence is at issue.”).

⁷² *See* 42 U.S.C. § 11131(c).

⁷³ Teninbaum, *supra* note 19, at 90 (“History reveals that the NPDB has been unable or unwilling to enforce the rules: in response to a Freedom of Information Act request made during the drafting of this article, HHS has never . . . levied a single fine against any person or entity for failure to report a malpractice claim.”).

⁷⁴ *Medical Malpractice: Hearing on H.R. 5110 Before the Subcomm. on Health & the Env’t of the H. Comm. on Energy and Commerce*, 99th Cong. 305 (1986) [hereinafter *Medical Malpractice Hearing*] (statement of John Harty, President, National Council of Community Hospitals) (“Cases often are settled merely for their nuisance value, and it would be misleading to include such a settlement in the reporting mechanism. In theory the persons evaluating the information reported to the Secretary will be professionals and will be able to evaluate the significance of settlements. Nevertheless, we do not think it is in anyone’s interest that information about small settlements be maintained and circulated, however much they be confidential in theory.”); *id.* at 328–29 (statement of Dr. Harry S. Jonas, President, American College of Obstetrics & Gynecology) (“Malpractice settlements frequently reflect economic considerations on the part of the insurer and the practitioner involved. It is often cheaper and less traumatic to settle a claim rather than go to court and fight the case on its merits. These decisions are totally outside the scope of any peer review process and may or may not reflect upon a physician’s competence. Likewise, claims filed against a physician represent mere allegations not conclusive proof of malpractice.”); *id.* at 442 (statement of Dr. Raymond Scalettar, Member of Board of Trustees, American Medical Association) (“Such data will include an extremely large amount of complex and possibly misleading information that will necessitate careful interpretation to be meaningful. . . . Other suits may be settled for small, and even relatively substantial amounts. These amounts may reflect the nuisance value, costs of litigation and the possibility — particularly in severe injury cases — that juries will find for the plaintiff more out of sympathy than a conviction that true negligence occurred.”); *id.* at 465

sues.”⁷⁵ Settlements, in fact, “are very often notoriously misleading guides to anything that happened and it is not clear . . . that the probative value of a settlement would be the same as that of the other information to be reported.”⁷⁶ This concern led to a proposal to provide a minimum threshold for reporting, around \$10,000 to \$25,000.⁷⁷ Critically, one witness (a member of a hospital association) testified that physicians may well choose to fight a nuisance claim rather than settle, be reported to the NPDB, and face a record when he or she chooses to apply for future hospital privileges.⁷⁸ The American Medical Association agreed.⁷⁹

A second problem was that medical malpractice is not uniform across medical specialties and practice settings. Some physicians can expect multiple lawsuits against them, others not so much.⁸⁰ This is not to say that the number of filed, settled, or otherwise resolved suits is irrelevant, but the number and value of claims must be understood in the context of the physician’s specialty, practice, and location. For instance, surgical specialists are sued more, while pediatricians are sued less often but tend to have larger

(statement of Dr. William E. Allen, Director, Washington Office, American Dental Association) (similar sentiments to the AMA).

⁷⁵ *Id.* at 350 (statement of Dr. Harry L. Metcalf, Chairman, Board of Directors, American Academy of Family Physicians). He continued: “Because this legislation appears to require reporting of . . . every payment under an insurance policy resulting from a malpractice judgment or settlement we question whether the reporting requirement will have the desired result.” *Id.*

⁷⁶ *Health Care Quality Improvement Act of 1986: Hearings on H.R. 5540 Before the Subcomm. on Civil & Constitutional Rights of the H. Comm. on the Judiciary*, 99th Cong. 90 (1986) (statement of attorney Victor M. Glasberg) (testifying on general physician peer review processes).

⁷⁷ *See, e.g., Medical Malpractice Hearing, supra* note 74, at 305, 313–14 (statement of John Harty, President, National Council of Community Hospitals); *id.* at 316 (statement of Richard P. Kusserow, Inspector General, United States Department of Health and Human Services) (“A lot of different States have been wrestling with this problem. I will mention Georgia set it at \$10,000; New Jersey, \$25,000; and California is at \$30,000.”).

⁷⁸ *See id.* at 313–14 (statement of John Harty, President, National Council of Community Hospitals) (“I guess my concern is that a lot of nuisance claims are filed, a lot of nuisance claims are settled rather than being fought when perhaps they should be fought, and you end up with people having a certain record that might get into other hands when it got into the hospitals and have an effect on the physician.”). It is important to note Mr. Harty was not representing the medical profession, but a hospital association, when he broached the concern.

⁷⁹ *See id.* at 442 (statement of Dr. Raymond Scalettar, Member of Board of Trustees, American Medical Association) (“The number of cases going to litigation also would increase as the reporting requirements would make defendants less willing to settle cases.”).

⁸⁰ *Id.* at 29 (statement of Dr. Harry S. Jonas, President, American College of Obstetrics & Gynecology) (“The significance of a certain number of claims depends on a number of factors, including the number of patients seen or procedures performed by the physician, the type of subspecialty practice in which the physician is engaged, and even the fact that the physician is chairman of a department and thus, likely to be named automatically in a great number of suits. As the Dean of a medical school, and as a former head of the obstetrics-gynecology department, I have been named to a number of suits for which I had no direct involvement.”); *id.* at 442 (statement of Dr. Raymond Scalettar, Member of Board of Trustees, American Medical Association) (“An average neurosurgeon, for example, has been sued four times. Some of the suits may involve errors of judgement or mistakes under the extraordinary circumstances of their practice, which says nothing about the physician’s competence.”).

damages since children can need a lifetime of care.⁸¹ Third, even by the early 1980s, many physicians had ceded control of the litigation strategy to their medical malpractice liability carriers, which could make decisions “without regard to the merit of the claim.”⁸²

In the end, Congress valued disclosure of all malpractice settlements over these concerns expressed by physicians, attorneys, and hospital administrators. There is no indication that the courts perceived or Congress intended the NPDB to be such a high-stakes endeavor for physicians. Indeed, Congress’s findings of fact indicate that the law is supposed to “restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician’s previous damaging or incompetent performance.”⁸³ The courts continue to downplay the results of a report to the NPDB. One described the NPDB “by itself” as not quite a rebuke but merely an informational disclosure, stressing that “[t]he official purpose of the report is to disclose information, not to reprimand.”⁸⁴ Another minimized its role: “Information in the [NPDB] is intended ‘only to alert . . . health care entities that *there may be a problem* with a particular practitioner’s professional competence or conduct’ because the practitioner has been the subject of a disciplinary action.”⁸⁵

However, the NPDB’s actual results on litigation and settlement are different.

C. *The Pernicious Influence of the NPDB on Physician Behavior in Medical Malpractice Litigation*

The NPDB weighted the scales further against physicians settling cases. As discussed in Part I.A., physicians were already less likely than a typical

⁸¹ See *id.* at 365 (statement of Dr. Harry S. Jonas, President, American College of Obstetrics & Gynecology) (“It is sometimes a long time before settlements or final judgments come down. It could be a matter of years. If there is a physician who has 26 suits filed against him or her, that information should alert entities to inquire further. That physician should not be unduly judged because of the point I made about malpractice suits not necessarily meaning incompetence. Nevertheless, the suits filed could be relevant to the medical staff considering privileges for that individual.”). See generally Anupam B. Jena et al., *Malpractice Risk According to Physician Specialty*, 365 NEW ENG. J. MED. 629 (2011).

⁸² *Medical Malpractice Hearing*, *supra* note 74, at 286 (statement of Jack Owen, Executive Vice-President, American Hospital Association) (emphasis added) (“It is well known that the majority of small malpractice payments represent the disposition of ‘nuisance’ claims—actions in which the costs of defense would exceed the settlement payment. *Most decisions in this regard are made by a provider’s insurance carrier or fund, without regard to the merit of the claim.* It is also recognized that the vast majority of these claims are in fact meritless and often are made in the anticipation that a ‘nuisance’ settlement will be offered.”).

⁸³ 42 U.S.C. § 11101(2); see also H.R. REP. NO. 99-903, at 2 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6384 (“The purpose of this legislation is to improve the quality of medical care by encouraging physicians to identify and discipline other physicians who are incompetent or who engage in unprofessional behavior.”).

⁸⁴ *Rochling v. Dep’t of Veterans Affairs*, 725 F.3d 927, 932 (8th Cir. 2013).

⁸⁵ *Leal v. Sec’y, U.S. Dep’t of Health & Human Servs.*, 620 F.3d 1280, 1283 (11th Cir. 2010) (emphasis added) (citing NPDB GUIDEBOOK, *supra* note 1, at A-3).

defendant to settle, but the NPDB enhanced that penchant further. A 2003 study of the claims processed by several medical malpractice carriers showed that the number of malpractice suits resulting in payment has fallen and defense costs have risen.⁸⁶ While these changes are concentrated in small-claim medical malpractice—where suits are less likely to be meritorious anyway—increased defense costs often translate to higher malpractice premiums.⁸⁷

Although plaintiff's lawyers may screen claims more effectively in order to try to prevent protracted litigation with a physician attempting to avoid reporting,⁸⁸ NPDB obligations are also driving a spate of litigation between physicians and insurance companies on whether to settle and how precisely to apportion blame.⁸⁹ The issue in these cases is not the amount of the settlement. Rather, it is whether the physicians involved will be reported or whether a hospital insurance plan or defendant will take the entire blame and not report to the NPDB. For instance, in *Melendez v. Hospital for Joint Diseases Orthopedic Institute*,⁹⁰ an orthopedic resident was apportioned a quarter of the blame for an incident that the hospital insurance plan had decided to settle.⁹¹ The resident challenged the apportionment to prevent reporting to the NPDB at such an early stage of his career.⁹² Although the court decided against the resident on procedural grounds,⁹³ it failed to consider that residents are supposed to operate under the supervision of an attending physician.⁹⁴

Another case illustrates how the NPDB can punish physicians for performing emergency care and correcting others' mistakes. In *Doe v. South Carolina Medical Malpractice Liability Joint Underwriting Association*,⁹⁵ Dr. Doe was on duty in an emergency room when he responded to a "may-

⁸⁶ Teresa M. Waters et al., *Impact of the National Practitioner Data Bank on Resolution of Malpractice Claims*, 40 INQUIRY 283, 290–91 (2003).

⁸⁷ *Id.* at 291.

⁸⁸ *See id.*

⁸⁹ *See, e.g.,* *Babic v. Physicians Protective Tr. Fund*, 738 So. 2d 442, 444–45 (Fla. Dist. Ct. App. 1999) ("By making misrepresentations . . . to . . . the National Practitioners Data Bank regarding the terms and conditions of the *Jacobson* case, including without limitation, that the \$500,000 settlement was against *Babic*, only, when in fact, the *Jacobson* case settlement was expressly made against all Defendants, with no apportionment of payment . . ."); *Bleday v. OUM Grp.*, 645 A.2d 1358, 1360 (Pa. Super. Ct. 1994) ("Appellants assert that they will be subjected to increased insurance premiums, loss of earnings, and harm to reputation since Dr. Bleday's name will be placed on the National Physician Data Bank . . .").

⁹⁰ 575 N.Y.S.2d 636 (Sup. Ct. 1991), *aff'd*, 579 N.Y.S.2d 74 (App. Div. 1992); *see also* Thomas, *supra* note 35, at 567–68.

⁹¹ *Melendez*, 575 N.Y.S.2d at 637.

⁹² *Id.*

⁹³ *Id.* at 637–38.

⁹⁴ *Cf. Mozingo v. Pitt Cty. Mem'l Hosp., Inc.*, 415 S.E.2d 341, 346 (N.C. 1992) ("In the present case, the defendant Dr. Kazior stipulated that he assumed the responsibility for the on-call supervision of the obstetrics residents at the Hospital. As a result, we have concluded that the defendant owed Mazingo, Jr., a duty of reasonable care in supervising the residents who actually cared for him.")

⁹⁵ 557 S.E.2d 670 (S.C. 2001).

day” in the hospital’s intensive care unit.⁹⁶ After some delay in reestablishing airway access, the patient was found to be brain dead.⁹⁷ The same carrier insured all the physicians that had responded, but Dr. Doe received separate counsel.⁹⁸ The insurer decided to settle with the patient’s estate, prompting Dr. Doe to request that the settlement not be made in his name. Based upon the insurer’s attorney’s opinion that South Carolina’s Good Samaritan statute⁹⁹ would not apply—and not on an examination of Dr. Doe’s medical judgement—the insurer made the settlement in Dr. Doe’s name and reported him to the NPDB—along with six other defendants.¹⁰⁰ The court found no breach of a duty of good faith in the insurer’s apportionment of the blame.¹⁰¹

Accordingly, physicians and their counsel have searched for ways to “dodge” reporting, defeating the disclosure-driven focus of the NPDB and damaging other dispute-resolution systems in medicine. Several techniques to escape reporting to the NPDB have been developed and reported in the literature, including 1) corporate shielding;¹⁰² 2) paying verbal demands for malpractice injury;¹⁰³ 3) paying out-of-pocket without liability insurance;¹⁰⁴ 4) refunding money paid for medical care;¹⁰⁵ 5) pre-complaint mediation;¹⁰⁶ and 6) some other statutory schemes.¹⁰⁷ It is hard to determine how widespread these practices are since they escape public reporting and litigation systems. Nonetheless, when faced with a potential report to the NPDB, a physician and his or her counsel may resort to these methods to avoid reporting. Further, requiring reporting appears to interfere with health-system and

⁹⁶ *Id.* at 672.

⁹⁷ *Id.* at 672–73.

⁹⁸ *Id.* at 673.

⁹⁹ S.C. CODE ANN. § 15-1-310 (2016) (“Any person, who in good faith gratuitously renders emergency care at the scene of an accident or emergency to the victim thereof, shall not be liable for any civil damages for any personal injury as a result of any act or omission by such person in rendering the emergency care or as a result of any act or failure to act to provide or arrange for further medical treatment or care for the injured person, except acts or omissions amounting to gross negligence or wilful [sic] or wanton misconduct.”).

¹⁰⁰ *Id.* at 672, 673 n.4.

¹⁰¹ *Id.* at 676.

¹⁰² Teninbaum, *supra* note 19, at 105–06 (corporate entities do not report their corporate liability to the NPDB).

¹⁰³ *Id.* at 106–07; *see also* 42 U.S.C. § 11151(7) (2012) (“The term ‘medical malpractice action or claim’ means a written claim or demand for payment based on a health care provider’s furnishing (or failure to furnish) health care services, and includes the filing of a cause of action, based on the law of tort, brought in any court of any State or the United States seeking monetary damages.”).

¹⁰⁴ Teninbaum, *supra* note 19, at 107; *see also* Am. Dental Ass’n v. Shalala, 3 F.3d 445, 446 (D.C. Cir. 1993) (“Although the Act does not define the term ‘entity,’ its language and structure indicate clearly that Congress did not intend the statutory term ‘entity’ to include individual practitioners.”).

¹⁰⁵ Teninbaum, *supra* note 19, at 107–08; *see also* 45 C.F.R. § 60.7 (2016) (“For purposes of this section, the waiver of an outstanding debt is not construed as a ‘payment’ and is not required to be reported.”).

¹⁰⁶ Teninbaum, *supra* note 19, at 108.

¹⁰⁷ *Id.* at 108–09; *see also* OR. REV. STAT. § 31.250 (2016) (requiring that parties in a medical malpractice suit enter into “dispute resolution” after commencing litigation).

hospital programs to encourage physician apology, since such disclosures can end up in the NPDB—while a corporate apology does not.¹⁰⁸

These developments defeat the purpose of the NPDB. However, the difficulties that physicians have faced in trying to change or “put their side of the story” into often legitimate reports makes the dodging techniques more appealing. This paper now turns to physicians’ attempts to place their own statements into the NPDB record.

III. PHYSICIANS’ FAILED ATTEMPTS TO CHALLENGE AN INACCURATE OR MISLEADING NPDB REPORT

Current NPDB procedures to challenge reports are inadequate for many medical malpractice claims, especially those that do not reach formal adjudication. As discussed above, the mere existence of the NPDB disincentivizes settlement and heightens conflicts between physicians and insurers. However, compounding this issue are the poor safeguards against inaccurate or misleading reports. A poorly drafted or potentially disputed report can ripple through the duration of a physician’s career. All else being equal, NPDB reports that better reflect the reality of a situation and that afford more protections to physicians would lessen these incentives to prolong medical malpractice litigation. The next several cases illustrate the difficulties providers face when they attempt to change or dispute a report. They will then provide examples of NPDB report language (the NPDB does not provide sample reports for physicians or lawyers to review).

As a preliminary matter, there are two major mechanisms to change a report: 1) a “subject statement” and 2) dispute resolution. The first—the subject statement—is essentially a 4000-character response to the entity’s 4000-character narrative report.¹⁰⁹ It does not obligate a reporting entity to change their description of the event.¹¹⁰ To change an entity report, a physician must enter the dispute process.¹¹¹ This process notifies the filer of the report as well as anyone who has queried the NPDB for the last three years that a report is disputed.¹¹² At that point, the filing entity has an opportunity to alter the report on its own.¹¹³ If the physician is satisfied, the dispute ends. If not, providers may request that the NPDB “review the report for accu-

¹⁰⁸ See generally Haavi Morreim, *Moral Hazard: The Pros and Cons of Avoiding Data Bank Reports*, 4 DREXEL L. REV. 265 (2011); Julie Barker Pape, Note, *Physician Data Banks: The Public’s Right to Know Versus the Physician’s Right to Privacy*, 66 FORDHAM L. REV. 975 (1997).

¹⁰⁹ See *How to Submit a Statement*, NPDB, <https://www.npdb.hrsa.gov/pract/howToSubmitAStatement.jsp> [<https://perma.cc/YTV7-8TQ8>] (last visited Nov. 14, 2018).

¹¹⁰ See NPDB GUIDEBOOK, *supra* note 1, at F-2–3.

¹¹¹ There is actually “dispute status,” whereby the report is described as in “dispute,” and “dispute resolution,” where the NPDB can take action in certain limited circumstances described below. See *id.* at F-3.

¹¹² *Id.*

¹¹³ *Id.*

racy,”¹¹⁴ but the NPDB “will only review the accuracy of the reported information, and will not consider the merits . . . of the action”¹¹⁵ In listing examples of pertinent documentation for a malpractice settlement, the NPDB lists merely the written claim or settlement and explicitly labels as “unrelated” any items relating to the facts and merits of the underlying malpractice case.¹¹⁶

This system means that sometimes the NPDB becomes a repository of resolved or transient concerns about a physician, turning relatively minor incidents into life-changing events. For instance, in *Doe v. Thompson*,¹¹⁷ a physician struggled to erase a temporary suspension in which the physician was completely cleared. A St. Louis hospital filed a report with NPDB “regarding its summary suspension of [Dr. Doe] for an indefinite period.”¹¹⁸ After lifting its suspension, the hospital filed the following report: “This report revises the adverse action report filed 2/17/94, which informed the [NPDB] of the summary suspension of Dr. Doe *pending psychiatric evaluation*. Based on the receipt of a *positive evaluation*, the summary suspension of Dr. Doe has been revoked, effective April 25, 1994.”¹¹⁹ Dr. Doe “objected to describing the psychiatric evaluation as ‘positive’”—or any mention of the evaluation at all—claiming that the inclusion was preventing him from seeking new privileges at any hospital.¹²⁰ The NPDB partially agreed and amended the report:

This report revises the adverse action report filed February 17, 1994, which informed the [NPDB] of the summary suspension of Dr. Doe pending an appropriate evaluation. Based on the receipt of an evaluation that found that Dr. Doe was *not suffering from any type of psychiatric disorder*, the summary suspension of Dr. Doe has been revoked effective April 25, 1994.¹²¹

While the court found that he had a right to change his report using statutory authority outside the NPDB, it took Dr. Doe two years to reach that point.¹²² Ultimately, he was barred by the statute of limitations.¹²³

In fact, the NPDB goes out of its way to stay out of disputes between a physician, hospital, or insurer, which means that the NPDB can hold records

¹¹⁴ 45 C.F.R. § 60.21(c)(1) (2016); *see also* 42 U.S.C. § 11136 (2012).

¹¹⁵ 45 C.F.R. § 60.21(c)(1).

¹¹⁶ *See* NPDB GUIDEBOOK, *supra* note 1, at F-6 tbl.1.

¹¹⁷ 332 F. Supp. 2d 124 (D.D.C. 2004).

¹¹⁸ *Id.* at 126.

¹¹⁹ *Id.* (alteration in original) (emphasis added).

¹²⁰ *Id.* at 126–27.

¹²¹ *Id.* at 127 (alteration in original) (emphasis added).

¹²² The court concluded that the heightened review standards of the Privacy Act applied. *See id.* at 129–33; *see also* 5 U.S.C. § 552a (2012).

¹²³ *Thompson*, 332 F. Supp. 2d at 134. The statute of limitations under the Privacy Act is two years, except where there is material and willful misrepresentation. *See* 5 U.S.C. § 552a(g)(5).

that do not tell the whole story of a particular episode.¹²⁴ The data bank has often reaffirmed its stay-out-of-the-merits position in litigation against physicians and other health practitioners seeking to mitigate damage from a potentially inaccurate report.¹²⁵ This position is reasonable when the NPDB serves as a clearinghouse for criminal convictions or other situations that have strong due process protections. For instance, few would dispute the accuracy of the following partially reproduced NPDB report for a physician who pleaded guilty to a count of mail fraud for developing a fraudulent medical claim based on a fictitious car accident¹²⁶:

DATE OF ACTION:	02/13/92
ADVERSE ACTION CODE:	406.00 REPRIMAND
LENGTH OF ACTION:	PERMANENT
EFFECTIVE DATE OF ACTION:	02/13/92
ACT/OMISSIONS DESCRIPTION:	CIVIL PENALTY \$1,000.00 RESPONDENT PLED GUILTY TO ONE COUNT OF MAIL FRAUD ¹²⁷

However, when the NPDB records some of the details of a complex medical malpractice case—one that may not ever reach a final disposition—the record can simply be incomplete. For instance, the 4000-character entity narrative and subject response cannot cover the complexity of a case like *Doe v. Rogers*.¹²⁸ Although there is no information whether the incident matured into a medical malpractice claim, the limited record indicates that it well could. Dr. Doe performed a late-night, emergency laparoscopic appendectomy on a fourteen-year old girl suffering from acute appendicitis. During the procedure, Dr. Doe removed tissue—described by him as an “inflamed band” but characterized by the anesthesiologist as the patient’s

¹²⁴ See NPDB GUIDEBOOK, *supra* note 1, at F-16.

¹²⁵ See, e.g., *Leal v. Sec’y, U.S. Dep’t of Health & Human Servs.*, 620 F.3d 1280, 1284 (11th Cir. 2010) (“Dr. Leal’s affidavits disputed to some extent the Hospital’s version of his conduct. That dispute is outside the scope of the Secretary’s review.”); *Doe v. Rogers*, 139 F. Supp. 3d 120, 148–49 (D.D.C. 2015) (agreeing with *Leal*); *Simpkins v. Shalala*, 999 F. Supp. 106, 111 (D.D.C. 1998) (“Moreover, this court is convinced that regardless of what HHS’s obligations may or may not be to review whether a reporting entity acted correctly in a peer review action or an entity’s investigation of a doctor, it has a duty to determine whether the events that transpired should have resulted in a Data Bank Report Surely there is a difference between requiring HHS to review whether the health care entity acted correctly in suspending the doctor and requiring HHS to review whether the entity in fact suspended the doctor. In this case, HHS had a duty to review whether Dr. Simpkins’ resignation and D.C. General’s actions with regard to Dr. Simpkins triggered D.C. General’s reporting responsibilities under the HCQI Act.”).

¹²⁶ See *Doe v. U.S. Dep’t of Health & Human Servs.*, 871 F. Supp. 808, 810 (E.D. Pa. 1994), *aff’d*, 66 F.3d 310 (3d Cir. 1995) (table case).

¹²⁷ *Id.* at 814.

¹²⁸ 139 F. Supp. 3d 120 (D.D.C. 2015).

fallopian tube.¹²⁹ Pathology confirmed that the removed tissue was indeed the patient's inflamed fallopian tube, and Dr. Doe did not dispute that he failed to recognize the anatomy properly.¹³⁰ However, the resulting NPDB report failed to include any indication of the elements of a medical malpractice claim, especially a deviation from the standard of care (i.e., what steps the physician should have taken):

In June 2009, the physician commenced practice at the Hospital in thoracic and general surgery. On Friday, October 2, 2009, the physician performed a laparoscopic appendectomy on a 14-year-old female. In the course of performing the procedure, the physician inadvertently removed part of one of the patient's fallopian tubes.¹³¹

Although the case concentrates on the propriety of reporting after Dr. Doe voluntarily suspended his practice at the hospital,¹³² the NPDB's description of the potential malpractice event that triggered the remainder of the case is paltry at best. It provides little context and prevents healthcare institutions from assessing whether a physician is likely to repeat a mistake of such magnitude again.

While one may respond that the example was taken from a case more about suspension of privileges than about medical malpractice, poor practice can be the predicate for a suspension of privileges or medical malpractice.¹³³ Further, the NPDB challenges—whatever their specific facts—indicate the frustration and anxiety physicians feel towards a listing.¹³⁴ Of course, there are incompetent physicians that the system must detect and potentially remediate, and many of the cases may well involve those “bad apples” in the profession. Indeed, the NPDB “is not designed to provide protection to phy-

¹²⁹ See *id.* at 129. The fallopian tube transmits eggs from the ovaries to the uterus for potential implantation and pregnancy. See Robert W. Rebar, *Problems with the Fallopian Tubes and Abnormalities in the Pelvis*, MERCK MANUAL (2018), <https://www.merckmanuals.com/home/women-s-health-issues/infertility/problems-with-the-fallopian-tubes-and-abnormalities-in-the-pelvis> [https://perma.cc/EL3B-WDX4].

¹³⁰ See *Rogers*, 139 F. Supp. 3d at 129–30.

¹³¹ *Id.* at 131. The remainder of the report describes the disciplinary action taken by the hospital and not the actual care of the patient herself.

¹³² *Id.* at 131–32.

¹³³ See, e.g., *Elam v. College Park Hosp.*, 183 Cal. Rptr. 156, 165–66 (Ct. App. 1982) (“In light of our conclusion Hospital owes generally a duty to insure the competency of its medical staff and to evaluate the quality of medical treatment rendered on its premises, the filed papers pertaining to the motion for summary judgment are replete with triable issues of fact. For example, whether Hospital should have conducted an investigation through its peer review committee upon notice of the *Bailey* case? Whether the committee had conducted its periodic reviews of Schur in a nonnegligent manner? Assuming a review was made after notice of the *Bailey* case, was it performed in a nonnegligent manner? If it had been made in a careful and proper manner, would the committee have recommended revocation or suspension of Schur's staff privileges?”).

¹³⁴ Unfortunately, these reported cases do not reproduce the exact language used in the NPDB reports, and the reports are otherwise confidential to the public.

sicians at all costs”¹³⁵ But, the dramatic consequences of one mistake—especially when the factual circumstances appear less than crystal clear—indicate that the NPDB skews too far the other way and captures good physicians who make mistakes.

Indeed, sometimes the NPDB can simply record misleading information. *Rochling v. Department of Veterans Affairs*¹³⁶ demonstrates how potentially competent physicians can be subsumed by the NPDB—or at least do not have the opportunity to present their case. In *Rochling*, a patient with liver disease was treated at an Oklahoma VA hospital, where he underwent a laparoscopic cholecystectomy¹³⁷ and liver biopsy.¹³⁸ A gastroenterologist attempted to perform an endoscopic retrograde cholangiopancreatogram (“ERCP”)¹³⁹ but was unable to do so, prompting a transfer to a VA Hospital in Little Rock, Arkansas with a recommendation to attempt the ERCP again.¹⁴⁰ Dr. Rochling assumed care of the patient at this point.¹⁴¹ He judged that an ERCP was unnecessary based on the patient’s clinical condition.¹⁴² The patient subsequently died.¹⁴³

In the resulting malpractice suit against the VA, the patient’s family placed the blame on the VA surgeon, not Dr. Rochling:

*The VA surgeon placed clips on the patient’s common bile duct and left them there when the surgery was completed, which was below applicable standards of care. Following the surgery the patient began sufferings [sic], signs a[nd] findings indicative of biliary obstruction. Nevertheless, the VA staff failed to timely recognize these signs symptoms and findings [sic] and failed to follow-up with the appropriate imaging studies and corrective surgery. As a proximate result of the foregoing the patient died.*¹⁴⁴

The VA settled, but assessed the *entire settlement against Dr. Rochling, not the surgeon who failed to remove the clips*, and reported accordingly to the NPDB.¹⁴⁵ Dr. Rochling exhausted his administrative remedies against the VA, and the NPDB indicated “that the arguments [Dr.] Rochling made were beyond the scope of proper HHS review.”¹⁴⁶ The reviewing court failed to

¹³⁵ *Leal v. Sec’y, U.S. Dep’t of Health & Human Servs.*, 620 F.3d 1280, 1285 (11th Cir. 2010).

¹³⁶ 725 F.3d 927 (8th Cir. 2013).

¹³⁷ This is a surgical removal of the gallbladder. See THOMAS LATHROP STEDMAN, *STEDMAN’S MEDICAL DICTIONARY* 365 (28th ed. 2006).

¹³⁸ See *Rochling*, 725 F.3d at 929.

¹³⁹ This is a method of visualizing pancreatic, hepatic, and common bile ducts. See STEDMAN, *supra* note 137, at 364.

¹⁴⁰ See *Rochling*, 725 F.3d at 929.

¹⁴¹ See *id.*

¹⁴² See *id.*

¹⁴³ See *id.*

¹⁴⁴ *Id.* (alteration in original) (emphasis added).

¹⁴⁵ See *id.* at 930.

¹⁴⁶ *Id.*

recognize Dr. Rochling's due process claims, leaving him with a mark on his record for the remainder of his career—based on the actions of another physician.¹⁴⁷

These various cases highlight a critical shortcoming of NPDB: by staying out of assessing the accuracy of its data bank, NPDB perpetuates inaccuracies and disputed episodes over a physician's career. Its limited space prevents the development of context and nuance, and its restrictive dispute process leaves providers with few avenues to correct a damaging report. Further, the courts have not been able to provide much relief from this scheme.¹⁴⁸ This system, though, is not the only way to administer a putative "blacklist." Congress and the courts have provided other examples of—not perfect—but better systems in the form of credit reporting.

IV. ANOTHER PARADIGM OF A GOVERNMENT-SUPERVISED "BLACKLIST": CREDIT REPORTING

The NPDB is not alone in the ranks of lists that purport to collect data but can dramatically impact careers and livelihood.¹⁴⁹ Credit scores and reports represent a similar make-or-break type of institution for everyone requiring credit. One legislator has even noted that a "poor credit history is the 'Scarlet Letter' of 20th century America."¹⁵⁰ One key difference between the NPDB and credit reports, however, is that a federal agency compiles the former while private entities develop the latter. This difference has led Congress to increasingly regulate private credit rating agencies, providing consumers with some opportunities to challenge the factual content of their credit scores—namely through the Fair Credit Reporting Act ("FCRA").¹⁵¹

The FCRA provides consumers the right to request a "reasonable reinvestigation" of a particular entry on a credit report.¹⁵² "If . . . an item of the information is found to be inaccurate or incomplete or cannot be verified," the reporting agency will "promptly delete that item of informa-

¹⁴⁷ *Id.* at 932–33.

¹⁴⁸ An additional note: In one case, a physician filed a claim of libel in an action in regards to a NPDB report. *See Sobel v. United States*, 571 F. Supp. 2d 1222, 1226 (D. Kan. 2008). However, the libel claim failed in *Sobel*, as it will every time, for two technical reasons: First, a defamation claim is not available under the Federal Tort Claims Act. *See id.*; *see also* 28 U.S.C. § 2680(h) (2012). Second, libel requires public disclosure, and the NPDB is a confidential database. *Cf. RESTATEMENT (SECOND) OF TORTS* § 558 (AM. LAW INST. 1965) (emphasis added) ("To create liability for defamation there must be . . . an *unprivileged* publication to a third party . . .").

¹⁴⁹ Elizabeth Doyle O'Brien, Comment, *Minimizing the Risk of the Undeserved Scarlet Letter: An Urgent Call to Amend § 1681e(b) of the Fair Credit Reporting Act*, 57 CATH. U.L. REV. 1217, 1220–22 (2008).

¹⁵⁰ 136 CONG. REC. 18766 (1990) (statement of Rep. Annunzio (D-Ill.)).

¹⁵¹ Pub. L. No. 91-508, 84 Stat. 1114 (1970) (codified at 15 U.S.C. §§ 1681–81x (2012)). The FCRA was written as an amendment to the Consumer Credit Protection Act passed two years earlier. *See* Pub. L. No. 90-321, 82 Stat. 146 (1968) (codified at 15 U.S.C. § 1601).

¹⁵² 15 U.S.C. § 1681i.

tion”¹⁵³ If a deletion is made, previous requestors of the credit report can be notified.¹⁵⁴ Like with the NPDB, there have been disputes as to whether the system is working.¹⁵⁵ However, at the very least, “the consumer may file a brief statement setting forth the nature of the dispute” if no resolution is found.¹⁵⁶ Furthermore, unlike with the NPDB, furnishers of credit information (banks, credit card companies, etc.) are obligated to investigate consumer complaints.¹⁵⁷ Unlike the NPDB’s stay-out-of-factual-disputes attitude, the FCRA does give consumers—the subjects of the collected information—the opportunity to dispute the content of reports and insert their side of the story and use the resources of the reporting agency to investigate issues.

Some courts have been willing to provide teeth to these statutory commands.¹⁵⁸ Accordingly, the failure of a credit reporting agency to investigate a consumer’s dispute of an entry on the report has led to successful claims against the reporting agencies.¹⁵⁹ Likewise, creditors themselves can be held responsible for failing to report to a credit agency that a particular debt is in dispute.¹⁶⁰ However, courts have been more hesitant to penalize credit agencies and credit information furnishers when an inaccuracy is not apparent on

¹⁵³ *Id.* § 1681i(a)(5)(A).

¹⁵⁴ *See id.* § 1681i(d).

¹⁵⁵ *See* O’Brien, *supra* note 149, at 1224 n.41.

¹⁵⁶ 15 U.S.C. § 1681i(b). Similar to the NPDB, the FCRA further provides that “[t]he consumer reporting agency may limit such statements to not more than one hundred words if it provides the consumer with assistance in writing a clear summary of the dispute.” *Id.*

¹⁵⁷ *See* 15 U.S.C. § 1681s-2 (2012).

¹⁵⁸ However, the Supreme Court has recently emphasized that the traditional standing requirements must be met, even with a specific statutory scheme. *See Spokeo, Inc. v. Robins*, 136 S. Ct. 1540, 1550 (2016) (“On the one hand, Congress plainly sought to curb the dissemination of false information by adopting procedures designed to decrease that risk. On the other hand, Robins cannot satisfy the demands of Article III by alleging a bare procedural violation. A violation of one of the FCRA’s procedural requirements may result in no harm.”).

¹⁵⁹ *See, e.g., Dennis v. BEH-1, LLC*, 520 F.3d 1066, 1070 (9th Cir. 2008) (holding a credit agency liable for failing to properly investigate a consumer dispute when the agency reported that consumer had a judgment entered against him, when a simple check of a civil register would show the opposite is true); *Morris v. Equifax Info. Servs.*, 457 F.3d 460, 467–68 (5th Cir. 2006) (holding a credit agency liable for failing to investigate consumer dispute even though the agency did not own consumer’s record); *Lazarre v. JPMorgan Chase Bank, N.A.*, 780 F. Supp. 2d 1330, 1335 (S.D. Fla. 2011) (holding a boilerplate response by an “early warning” credit fraud detection system could indicate to a reasonable jury that the credit agency was not providing the consumer a reasonable investigation).

¹⁶⁰ *See, e.g., Drew v. Equifax Info. Servs., LLC*, 690 F.3d 1100, 1106–07 (9th Cir. 2012) (holding a “fraud block” letter from a credit reporting agency is sufficient to trigger a reinvestigation by the information furnisher, even though the entity expected a different type of notification); *Saunders v. Branch Banking & Tr. Co. of Va.*, 526 F.3d 142, 150–51 (4th Cir. 2008) (holding a jury could conclude that a bank’s failure to disclose to a credit agency the disputed nature of a debt could trigger liability); *Stroman v. Bank of Am. Corp.*, 852 F. Supp. 2d 1366, 1374–75 (N.D. Ga. 2012) (holding once a credit reporting agency notifies a creditor of a dispute, that creditor is obligated to undertake a reasonable investigation); *Mazza v. Verizon Washington DC, Inc.*, 852 F. Supp. 2d 28, 35 (D.D.C. 2012) (holding consumer had pleaded sufficiently to proceed against a credit information furnisher on an alleged failure to investigate a dispute).

the face of a legal instrument¹⁶¹ or when a consumer disputes the legal status of an obligation.¹⁶²

Nonetheless, some courts have interpreted the FCRA to provide extensive and substantive protections to consumers—especially after they have exhausted reexamination procedures. For instance, in *Henson v. CSC Credit Services*,¹⁶³ a state court clerk erroneously listed the Hensons as having a judgment entered against them.¹⁶⁴ After noting that “a consumer reporting agency is required to follow ‘reasonable procedures to assure maximum possible accuracy’ of the information contained in a consumer’s credit report,”¹⁶⁵ the court reasoned that the agency—absent any notification—could not be held liable as a matter of law for relying on a judgment docket.¹⁶⁶ However, once the Hensons notified the credit agency that there was a problem, the duty of reinvestigation required the credit agency to go beyond mere reliance on the docket.¹⁶⁷ With notice, an agency could better direct its resources and more individually investigate the nature and accuracy of the complaint.¹⁶⁸ “Accordingly, a credit reporting agency may be required, in certain circumstances, to verify the accuracy of its initial source of information, in this case the Judgment Docket.”¹⁶⁹

Although by no means perfect, the high-stakes “credit data bank” might provide some basis for reform from the NPDB.

¹⁶¹ See, e.g., *Wright v. Experian Info. Sols., Inc.*, 805 F.3d 1232, 1241 (10th Cir. 2015) (holding a credit agency need not employ a tax lawyer to verify lien documents and may rely on a LexisNexis report, even if inaccurate); *Childress v. Experian Info. Sols., Inc.*, 790 F.3d 745, 747 (7th Cir. 2015) (“What the plaintiff wants would thus require a live human being, with at least a little legal training, to review every bankruptcy dismissal and classify it as either voluntary or involuntary. That’s a lot to ask—too much when one considers the alternative, which is for the agency to act only upon receiving information from the bankruptcy petitioner indicating that the petition has indeed been voluntarily dismissed.”); *Stroud v. Bank of Am.*, 886 F. Supp. 2d 1308, 1314 (S.D. Fla. 2012) (holding a bank had discharged its obligation by verifying personal information on purchase information and bank records).

¹⁶² See, e.g., *DeAndrade v. Trans Union LLC*, 523 F.3d 61, 68 (1st Cir. 2008) (holding when a consumer is currently in litigation with a bank on the status of a loan, a credit agency is not obligated to report such a dispute when the loan appears valid on its face).

¹⁶³ 29 F.3d 280 (7th Cir. 1994).

¹⁶⁴ *Id.* at 282–83. The confusion is perhaps understandable. Jeff Henson (the brother of the party in the case) purchased a car from his brother Greg Henson (the party of the case) and financed his purchase with a loan. *Id.* at 282. The car was stolen, and Jeff stopped making payments. *Id.* The creditor sued both Jeff and Greg, though the suit did note that Greg had no interest in the car any longer. *Id.* Accordingly, judgment was rendered against Jeff alone. *Id.* at 282–83.

¹⁶⁵ *Id.* at 284 (quoting 15 U.S.C. § 1681e (1994)).

¹⁶⁶ *Id.* at 285.

¹⁶⁷ *Id.* at 286–87.

¹⁶⁸ *Id.*

¹⁶⁹ *Id.* at 287. “On remand, the Hensons will have the burden of showing that they brought the alleged error in Greg’s credit report to Trans Union’s attention. If they meet their burden, the trier of fact must weigh the above-mentioned factors in deciding whether Trans Union violated the provisions of section 1681i.” *Id.*

V. RECOMMENDATIONS

The NPDB embodies a good objective—disclosure of malpractice data—that has not been implemented well over the last three decades. There is certainly a need to prevent physicians from moving between hospitals, health systems, or jurisdictions to avoid the consequences or disclosure of their professional performance. However, the registry cannot simply become an unfair and undeserved way to raise malpractice premiums and prevent physicians from gaining privileges at hospitals. Likewise, the registry cannot be yet another incentive for physicians to fight malpractice lawsuits that they or their insurance companies would be willing to settle otherwise. Yet, continuing under the present system promises to perpetuate the conflicts between defendant-physicians and plaintiff-patients, physicians and their liability insurers, and physicians and the NPDB itself.

Some of this litigation arises from the dreaded report to the NPDB. A core issue driving physicians is that every medical malpractice settlement—or even judgment—does not represent a systemic reflection on a physician's ability and competence. This proposition is trivial outside of medical malpractice: Every judgment against a pharmaceutical company, manufacturer, or other type of defendant does not mean that the defendant is not fit to participate in the market. Further complicating this issue is a general reluctance to have mistakes discussed in a public forum.¹⁷⁰

As such, a preliminary proposal for reform would be to separate reporting and disclosure. Although issues of confidentiality would have to be resolved,¹⁷¹ if the NPDB did not report all the data it received, some of the pressure on the medical malpractice tort system would be relieved. Assuming that there is not a systemic pattern of underreporting in a particular specialty, locality, or practice-type, the now-thirty years of data in the NPDB provides a glimpse into the “typical” malpractice profile of physicians in the country across specialty, practice type, and geographic location.¹⁷² Physicians who deviate from that “typical” profile—whether by number of reports, dollar amount of settlements, time between suits, or some other

¹⁷⁰ See generally Amy G. Lehman, *Medical Culture and Error Disclosure*, 10 AM. MED. ASS'N J. ETHICS 282 (2008); Justin J. Waring, *Beyond Blame: Cultural Barriers to Medical Incident Reporting*, 60 SOC. SCI. & MED. 1927 (2005); Pauline W. Chen, *Learning to Keep Patients Safe in a Culture of Fear*, N.Y. TIMES (Mar. 11, 2010), <https://www.nytimes.com/2010/03/11/health/11chen.html> [<https://perma.cc/XM88-RN7K>].

¹⁷¹ Cf. *Medical Malpractice Hearing*, *supra* note 74, at 457 (testimony of Dr. Raymond Scalettar, Member Board of Trustees, American Medical Association) (“We don’t think [the data] should be collected on a Federal level. We think that the information that would be placed in a Federal repository might not have all the necessary privacy features, . . . would not be necessarily verifiable, [and] could not be analyzed.”).

¹⁷² Cf. Michelle M. Mello & David M. Studdert, *Building a National Surveillance System for Malpractice Claims*, 51 HEALTH SERVS. RES. 2642, 2645 (2016) (“Consideration should be given to whether the NPDB might be restructured to serve as a more robust malpractice claims surveillance system, offering researchers a wider range of variables and data linkage opportunities.”).

“trigger”—will have their reports disclosed to hospitals when they apply for privileges.

Further, the NPDB—in a public or private form—could take a more active role in investigating disputed reports. Like credit agencies and creditors in the context of the FCRA, the NPDB can look into disputed cases, especially those that have not had the benefit of full discovery and adjudication. The government has already developed competency in investigating medical injuries in the process of defending federally employed physicians in Federal Tort Claims Act malpractice cases as well as assessing compensation for vaccine¹⁷³ and radiation-testing¹⁷⁴ injuries. Lessons from these institutions can be translated over to assessing the circumstances and context of malpractice reports.

VI. CONCLUSION

However the NPDB is reformed—if it is reformed—the Data Bank must shed the legalistic formalism that it is purely informational. From the beginning, many recognized that the NPDB drives the players in the medical malpractice system. And, how it decides to collect, verify, and report data has tangible effects throughout medical malpractice. Although by no means a silver bullet, reforming the NPDB so that it functions as a true information warehouse will help align the incentives of physicians, insurers, and patients as well as provide vital data on the quality of physicians and other providers.

¹⁷³ See 42 U.S.C. § 300aa-1-34 (2012). Incidentally, the vaccine compensation program was enacted in the same law as the NPDB. Compare Act of November 14, 1986, Pub. L. No. 99-660, tit. III, 100 Stat. 3743, 3755 (enacting the National Childhood Vaccine Injury Act of 1986), with Act of November 14, 1986, Pub. L. No. 99-660, tit. IV, 100 Stat. 3743, 3784 (enacting the Health Care Quality Improvement Act of 1986 and the NPDB).

¹⁷⁴ See 42 U.S.C. § 2210.

