

MORAL HAZARD: THE PROS AND CONS OF AVOIDING DATA BANK REPORTS

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INTRODUCTION

Over the years, tort litigation has been the predominant mechanism for patients to seek accountability for the quality of their health care. From time to time, however, legislation has also emerged to address one or another perceived problem in health care quality – sometimes with unexpected consequences. This Article addresses

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one such statute and the adverse consequences it has come to exhibit.

In 1986, on the heels of another “malpractice crisis,” Congress enacted the Health Care Quality Improvement Act (HCQIA)¹ to address, not the affordability or availability of malpractice insurance, but the actual quality of care patients receive. At the time, Congress believed that one of the best ways to improve quality was to increase the prevalence and intensity of peer review. Toward that end, the HCQIA provided physicians and other licensed health care professionals with qualified immunity from liability when they participated or provided information for peer review activities.²

Additionally, the HCQIA set up a National Practitioner Data Bank (NPDB) to collect information on providers so that those undertaking such review would have a broader fund of information on which to base their decisions. Notably, at the time the statute was enacted, it was possible for a physician to commit numerous egregious acts of malpractice—even lose his or her license in one state and then move to another state and begin practice afresh—with local physicians and hospitals none the wiser.

To address this problem, the HCQIA first required that the NPDB collect information of three types: adverse professional review actions (e.g., a hospital’s decision to curtail a physician’s privileges), state medical boards’ license sanctions, and medical malpractice payments. Second, the Act required hospitals to consult the NPDB upon credentialing a provider and every two years thereafter, in hopes that hospitals would be able to intercept poor-quality providers and limit their opportunities to practice.

This Article particularly focuses on the third type of NPDB report—medical malpractice payments—and argues that this requirement can significantly interfere with recent improvements in the management of medical error. As observed in Part I, medical malpractice litigation generally does a poor job of reaching its goals of justice, compensation, and deterrence. Indeed, by impeding communication at many levels, litigation appears to impede the kinds of system-level improvements now recognized as crucial for improving the quality and safety of health care.

As discussed in Part II, a number of hospitals have begun to reverse this untoward result via programs of disclosure, apology, and early resolution where they discern that their errors have caused

1. Health Care Quality Improvement Act, 42 U.S.C. §§ 11101–11152 (2006).

2. *Id.* § 11112.

harm. Although, theoretically, this approach should be equally attractive to physicians, physician participation is, in fact, deterred by the HCQIA's mandate to report medical malpractice payouts to the NPDB. Given that physician defendants usually prevail if they litigate, early resolution with a guaranteed, permanent black mark in the Data Bank often presents an unattractive option.

As Part II also notes, the choice need not be so stark. A number of options permit physicians to join in an early, mediated resolution, yet still avoid reporting to the Data Bank. However, once we see that physicians can dodge the Data Bank, an important question arises, which is the primary focus of this Article.³ If the purpose of the NPDB is to identify poor practitioners, and if physicians can avoid making this kind of otherwise-required report,⁴ we must ask whether it is somehow unseemly to recommend that physicians use every lawful means to avoid reporting medical malpractice payments.

This is the "moral hazard" issue. This Article argues that, although the HCQIA's requirement to report malpractice payments aims to improve the quality of health care, strong evidence indicates that it harms, more than helps, this effort. Part III provides a first response, showing that the malpractice reporting mandate tends to hamper, rather than improve, system-level improvements in health care quality. System-level improvements are now recognized to be far more important than individual errors in improving overall quality and safety. Part IV explains that the data in the malpractice payment portion of the Data Bank is profoundly troubled and, in many cases, more misleading than helpful.

Part V argues that the HCQIA's overarching emphasis on hospital peer review—as informed by NPDB data—has now become largely anachronistic as a mechanism for identifying and restricting poor-quality providers. Finally, Part VI shows that alternative, emerging approaches for delivering and evaluating care are far superior for enhancing the quality and safety of patient care. In the ultimate analysis, then, lawfully avoiding this sort of Data Bank report appears to be a good thing.

3. The discussion in Parts I and II is abbreviated; more detailed discussion can be found in Morreim, *supra* note *.

4. It is important to note that this Article discusses only the NPDB's reports of medical malpractice payments, not its requirements for reporting adverse professional review actions or states' licensure sanctions.

I. HEALTH CARE AND THE GOALS OF MALPRACTICE LITIGATION

When it comes to litigation over injuries allegedly caused by medical malpractice, several points have garnered widespread agreement and empirical support. Although the goals of the medical malpractice litigation system are said to include justice, compensation for those wrongfully injured, and deterrence to prevent similar errors in the future, these goals are generally not well met. While tort liability can sometimes achieve justice—and, indeed, may sometimes be the only way to achieve it—compensation and quality improvement have proven to be far more elusive goals.

Compensation is poorly served because a large proportion of negligently caused injuries never result in a claim and because, reciprocally, a significant proportion of filed claims are not connected with negligent injury.⁵ Even in cases where compensation is rightly directed toward a plaintiff who deserves it, on average the majority of the money covers litigation and attorney expenses.⁶

Similarly, litigation's deterrence function poorly serves quality improvement. The fear of litigation inspires physicians into costly

5. Edward A. Dauer & Leonard J. Marcus, *Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement*, 60 LAW & CONTEMP. PROBS. 185, 190 n.26 (1997) ("Andrews et al. reported serious injuries at a rate of 17.7%, with claims for compensation at only 1.2%. See Lori B. Andrews et al., *An Alternative Strategy for Studying Adverse Events in Medical Care*, 349 LANCET 309, 312 (1997). The Harvard study found that one out of seven patients injured through actionable negligence made claims (assuming that all claims made came from the pool of negligent events), and that one out of five cases where negligence caused death or at least six months of disability resulted in a paid claim."); Troyen A. Brennan et al., *Relation Between Negligent Adverse Events and the Outcomes of Medical Malpractice Litigation*, 335 NEW ENG. J. MED. 1963, 1963 (1996) (showing that "the severity of the patient's disability, not the occurrence of an adverse event, or an adverse event due to negligence, was predictive of payment to the plaintiff."). See also Elisabeth Ryzen, *The National Practitioner Data Bank—Problems and Proposed Reforms*, 13 J. LEGAL MED. 409, 431–32 (1992); William M. Sage et al., *Bridging the Relational-Regulatory Gap: A Pragmatic Information Policy for Patient Safety and Medical Malpractice*, 59 VAND. L. REV. 1263, 1271 (2006); Florence Yee, Note, *Mandatory Mediation: The Extra Dose Needed to Cure the Medical Malpractice Crisis*, 7 CARDOZO J. CONFLICT RESOL. 393, 425 (2006). One study by the American Medical Association found, on the basis of data from the Physician Insurers Association of America, that in 2008, 65% of claims were dropped, dismissed, or withdrawn; 26% were settled; and only 5% were resolved by trial. Of those that went to trial, physician defendants prevailed 90% of the time. CAROL K. KANE, AM. MED. ASS'N, *MEDICAL LIABILITY CLAIM FREQUENCY: A 2007-2008 SNAPSHOT OF PHYSICIANS 1* (2010), <http://www.ama-assn.org/ama1/pub/upload/mm/363/prp-201001-claim-freq.pdf>.

6. One recent study found that "for every dollar spent on compensation, 54 cents went to administrative expenses (including those involving lawyers, experts, and courts)." The study also found that 35% of the claims examined did not involve errors; claims not involving errors accounted for between 13% to 16% of the system's total monetary costs. David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2024, 2027–29 (2006).

and sometimes harmful excessive (“defensive”) interventions.⁷ And physicians who have been named defendants tend, even if only transiently, to make more errors.⁸

Perhaps most importantly, litigation tends to inhibit communication at a time it is most urgently needed—to explore an adverse event in detail, and to determine how it happened and how best to fix the problem. Many, if not most, adverse events result, not so much from an individual provider’s error, but from complex system flaws that collectively contribute to the outcome. And those system-level problems can only be identified if information is available from a multiplicity of sources—from physicians, nurses, allied health workers, hospital administrators, and the patient and/or family.⁹

Unfortunately, litigation tends to deter this much-needed communication. Providers may be advised against talking with patients or families about what happened, even if they are permitted to ex-

7. J. William Thomas et al., *Low Costs of Defensive Medicine, Small Savings from Tort Reform*, 29 HEALTH AFF. 1578, 1578 (2010). See also Richard E. Anderson, *Billions for Defense: The Pervasive Nature of Defensive Medicine*, 159 ARCHIVES INTERNAL MED. 2399, 2399–2402 (1999); Randall R. Bovbjerg et al., *Defensive Medicine and Tort Reform: New Evidence in an Old Bottle*, 21 J. HEALTH POL. POL’Y & L. 267, 267 (1996); Emily R. Carrier et al., *Physicians’ Fears of Malpractice Lawsuits Are Not Assuaged by Tort Reforms*, 29 HEALTH AFF. 1585, 1585 (2010); Dauer & Marcus, *supra* note 5, at 192; Michelle M. Mello et al., *National Costs of the Medical Liability System*, 29 HEALTH AFF. 1569, 1569–77 (2010); David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 JAMA 2609, 2609–17 (2005).

8. Edward A. Dauer, *A Therapeutic Jurisprudence Perspective on Legal Responses to Medical Error*, 24 J. LEGAL MED. 37, 44 (2003).

Sara Charles, a psychiatrist at the University of Illinois, . . . found distinct elevations in what she termed ‘depressive symptom clusters’—increased incidences of, for example, fatigue, insomnia, difficulty in concentrating, headache and other physical illnesses, suicidal ideation, and a sharp (nearly tripled) increase in excessive alcohol use. Other subjective reports showed reduced self-esteem, decreased self-confidence, ‘loss of nerve’ in clinical situations, increased sense of being misunderstood and of being defeated; and marked increases in reports of anger, inner tension, depressed mood, frustration, and irritability.

Id. at 43.

9. See Lucian L. Leape, *Error in Medicine*, 272 JAMA 1851, 1851 (1994); INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* (Linda T. Kohn et al., eds., 2000); see also David Blumenthal, *Total Quality Management and Physicians’ Clinical Decisions*, 269 JAMA 2775, 2775 (1993); David Blumenthal & Charles M. Kilo, *A Report Card on Continuous Quality Improvement*, 76 MILBANK Q. 625, 625 (1998); Thomas Bodenheimer, *The American Health Care System – The Movement for Improved Quality in Health Care*, 340 NEW ENG. J. MED. 488, 491 (1999); Mark R. Chassin, *Is Health Care Ready for Six Sigma Quality?*, 76 MILBANK Q. 565, 577–78 (1998); Avedis Donabedian, *The Quality of Care: How Can It Be Assessed?*, 260 JAMA 1743, 1747–48 (1988); David M. Eddy, *Clinical Policies and the Quality of Clinical Practice*, 307 NEW ENG. J. MED. 343, 346 (1982); Stephen F. Jencks & Gail R. Wilensky, *The Health Care Quality Improvement Initiative*, 268 JAMA 900, 900 (1992); Glenn Laffel & Donald M. Berwick, *Quality in Health Care*, 268 JAMA 407, 408 (1992); Glenn Laffel & David Blumenthal, *The Case for Using Industrial Quality Management Science in Health Care Organizations*, 262 JAMA 2869, 2870–72 (1989).

press sympathy.¹⁰ And if multiple providers are involved, their mutual finger pointing can further deter sharing information. The discovery process is commonly a game of “hide the ball,” delaying and minimizing each tidbit of information as much as possible, perhaps in an effort to induce the other side to give up the quest or, at the least, to think twice before suing the next time.¹¹

II. EARLY RESOLUTION: BENEFITS WITH A CHALLENGE

In recent years, however, some hospitals have discovered the benefits of broad communication and early resolution. When these hospitals’ investigations reveal they have erred, disclosure, apology, and early resolution can better compensate patients and families, preserve important relationships, save the hospital substantial defense costs, shorten resolution times, reduce outstanding lawsuits, and promote the detailed explorations necessary to improving quality on the system-level.

The University of Michigan Health System (UMHS), for instance, has implemented an active disclosure-with-offer program. By 2001, UMHS

began responding to all open and new malpractice claims by admitting fault and offering compensation when an internal investigation reveals medical error. If an investigation reveals no error, UMHS provides the reasons for its conclusion and vigorously defends a claim, if necessary. In April 2002, UMHS began linking the investigation process with peer review and quality improvement efforts.¹²

Once the program had been fully operational for several years, the results were striking:

10. Andrew D. Feld & Richard E. Moses, *Most Doctors Win: What to Do If Sued for Medical Malpractice*, 104 AM. J. GASTROENTEROLOGY 1346, 1346–47 (2009); see also CAROL B. LIEBMAN & CHRIS STERN HYMAN, MEDICAL ERROR DISCLOSURE, MEDIATION SKILLS, AND MALPRACTICE LITIGATION: A DEMONSTRATION PROJECT IN PENNSYLVANIA 41–42 (2005), available at http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/Medical_liability/LiebmanReport.pdf.

11. William M. Sage, *The Forgotten Third: Liability Insurance and the Medical Malpractice Crisis*, 23 HEALTH AFF. 11, 11–12 (2004) (“Information about the cause of injuries is denied patients and families for prolonged periods, compensation is unavailable when it is most needed, and quality feedback to providers is attenuated to the point of uselessness.”).

12. Allen Kachalia et al., *Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program*, 153 ANNALS INTERNAL MED. 213, 213–14 (2010). See also Richard C. Boothman et al., *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, 2 J. HEALTH & LIFE SCI. L. 125 (2009) (discussing the UMHS approach to medical malpractice claims).

[T]he average monthly rate of new claims decreased from 7.03 to 4.52 per 100,000 patient encounters The average monthly rate of lawsuits decreased from 2.13 to 0.75 per 100,000 patient encounters Median time from claim reporting to resolution decreased from 1.36 to 0.95 years. Average monthly cost rates decreased for total liability . . . , patient compensation . . . , and non-compensation-related legal costs.¹³

A number of other hospitals have instituted comparable programs and have likewise seen marked success.¹⁴ As noted by Boothman et al.,

By interrupting the march to the courthouse, the animosity intrinsic to suing someone is lessened and often avoided, which allows for discussions not impassioned by name-calling, threats of professional ruin, reinforced victimhood, exaggerated claims, and dismissive defenses. If it appears that compensation is owed, the discussion shifts from the typical approach, in which both sides take equally unreasonable financial positions and work towards a middle ground, evidence-based discussions about what is truly owed because of the medical error. With this approach, it is

13. Kachalia et al., *supra* note 12, at 213 (summarizing the results of the study).

14. Other institutions are said to include Children's Healthcare of Atlanta, Kaiser Permanente, Children's Hospitals and Clinics of Minnesota, Johns Hopkins, Catholic Healthcare West, Chicago Rush-Presbyterian-St. Luke's Medical Center, Drexel University College of Medicine, Minnesota Fairview Hospitals, University of Pittsburgh Medical Center, and University of Illinois at Chicago. See Dale C. Hetzler, *Superordinate Claims Management: Resolution Focus from Day One*, 21 GA. ST. U. L. REV. 891, 896 (2005) (discussing Children's Healthcare of Atlanta); Chris Stern Hyman et al., *Interest-Based Mediation of Medical Malpractice Lawsuits: A Route to Improved Patient Safety?*, 35 J. HEALTH POL. POL'Y & L. 797 (2010) (discussing mediation of medical malpractice lawsuits); Stephen Langel, *Averting Medical Malpractice Lawsuits: Effective Medicine—or Inadequate Cure?*, 29 HEALTH AFF. 1565 (2010) (discussing Minnesota Fairview Hospitals); Yee, *supra* note 5, at 439–42 (discussing Chicago St. Luke's Medical Center and Drexel); Max Douglas Brown, *Rush Hospitals' Medical Malpractice Mediation Program: An ADR Success Story*, 86 ILL. B.J. 432, 432 (1998) (discussing Chicago's Rush-Presbyterian-St. Luke's Medical Center); Jonathan R. Cohen, *Apology and Organizations: Exploring an Example from Medical Practice*, 27 FORDHAM URB. L.J. 1447 (2000) (discussing Veterans Affairs Medical Center of Lexington, Kentucky); see also Richard Blatt et al., *Co-Mediation: A Success Story at Chicago's Rush Medical Center*, ADR SYSTEMS, <http://www.adrsystems.com/news/Co-Mediation.pdf> (last visited Dec. 20, 2011); Liebman & Hyman, *supra* note 10, at 53–56; Christopher Guadagnino, *Malpractice Mediation Poised to Expand*, PHYSICIAN'S NEWS DIG. (Apr. 23, 2004), <http://www.physiciansnews.com/2004/04/23/malpractice-mediation-poised-to-expand>; Robert A. Creo et al., *Malpractice Case Alternative Dispute Resolution*, PHYSICIAN'S NEWS DIG. (Nov.13, 2005), <http://www.physiciansnews.com/2005/11/13/malpractice-case-alternative-dispute-resolution>.

not uncommon for a settlement amount to be very close to the original offer and for both sides to agree on the substantive basis for the settlement.¹⁵

In theory, this sort of early dispute resolution should be equally attractive to physicians. After all, they too would benefit by preserving important relationships, reducing the amount of time and money spent defending claims, and enhancing their communication with patients and other providers following an adverse event.

However, the National Practitioner Data Bank poses a major barrier. As noted above, the NPDB requires that reports be made for amounts paid to settle medical malpractice claims. Specifically, the HCQIA requires that "[e]ach 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."¹⁶ A "medical malpractice action or claim," in turn, is defined as "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."¹⁷

These NPDB reports are permanent. Although they are generally kept confidential, each hospital must query the NPDB when initially credentialing, and every two years thereafter, for each physician on its medical staff.¹⁸ Entities such as managed care organizations are permitted to access the information,¹⁹ but hospitals are affirmatively required to make regular checks.

The NPDB thus forces an unhappy choice on physicians considering an early, mediated resolution. If they fight the matter all the way to trial, they enjoy very strong odds of winning.²⁰ But if they settle

15. Boothman et al., *supra* note 12, at 142.

16. 42 U.S.C. § 11131(a) (2006).

17. *Id.* § 11151(7).

18. *Id.* § 11135.

19. *Id.* § 11137(a).

20. Studdert et al., *supra* note 6, at 2026 (finding that of the 15% of claims that were decided by trial verdict, plaintiffs prevailed only 21% of the time); *see also* Kane, *supra* note 5, at 1-2 (finding that on the basis of data from the Physician Insurers Association of America, in 2008, 65% of claims were dropped, dismissed, or withdrawn; 25.7% were settled; only 5% were resolved by trial; and, of those that went to trial, physician defendants prevailed 90% of the time). Even more dramatic figures in Tennessee in 2008 are as follows: of 3154 claims closed in the state in 2008, only 425 were resolved through judgment at trial; of those, defendant pre-

early – even if early settlement is otherwise better for everyone – the consequence will likely be a permanent “black mark” in the NPDB.

On closer inspection, however, perhaps the NPDB need not loom so large. By statute, by regulation, and by case law, a number of avenues are available by which payment can be made in a malpractice case without any requirement to report the physician²¹ to the Data Bank. For example, if the physician simply pays the claim out of pocket rather than having an insurer or other entity pay on his or her behalf, no NPDB report would need to be made.²² Such a result can also occur if the physician waives the patient’s debt or refunds payment.²³

Perhaps more interestingly, a Data Bank report can also be avoided if the plaintiff, or his or her attorney, makes the claim or demand in an unwritten format, as by telephone or direct face-to-face communication. The physician likewise can initiate oral communication upon realizing he or she has made an error, and can thus contact the patient or family to resolve the matter. In both scenarios the physician can forgo reporting because the trigger requiring a report for a medical malpractice payment is “a *written* claim or demand for payment based on a health care provider’s furnishing (or failure to furnish) health care services.”²⁴ No writing, no report.

Additionally, the “corporate shield” provides a major advantage for physicians who are hospital employees or are in comparable arrangements. Where an entity such as a hospital or clinic makes a payment in a suit that does not identify an individual practitioner,

vailed in 420, with plaintiff taking nothing. TENN. DEP’T OF COMMERCE & INS., 2009 MEDICAL MALPRACTICE CLAIMS REPORT, 4, 6 (2009), available at <http://www.tn.gov/commerce/insurance/documents/2009MedicalMalpracticeClaimsReport.pdf>.

21. Although this Article focuses on physicians, the HCQIA applies to other licensed health care providers as well, including dentists. See 42 U.S.C. §§ 11131, 11151 (2006).

22. *Am. Dental Ass’n v. Shalala*, 3 F.3d 445, 446 (D.C. Cir. 1993).

23. HEALTH RES. & SERVS. ADMIN., U.S. DEP’T OF HEALTH & HUMAN SERVS., PUB. NO. HRSA-95-225, NATIONAL PRACTITIONER DATA BANK GUIDEBOOK E-12 (2001), available at <http://www.npdb-hipdb.hrsa.gov/resources/NPDBGuidebook.pdf> [hereinafter NPDB GUIDEBOOK]; see also 45 C.F.R. § 60.7 (2010) (“For purposes of this section, the waiver of an outstanding debt is not construed as a ‘payment’ and is not required to be reported.”). *But see* NPDB GUIDEBOOK *supra*, at E-12 (“If a refund of a practitioner’s fee is made by an entity (including solo incorporated practitioners), that payment is reportable to the NPDB.”).

24. 42 U.S.C. § 11151(7) (2006) (emphasis added). The NPDB Guidebook clarifies: “For purposes of NPDB reporting, medical malpractice payments are limited to exchanges of money. A refund of a fee is reportable only if it results from a **written** complaint or claim demanding monetary payment for damages.” NPDB GUIDEBOOK, *supra* note 23, at E-12.

no NPDB report is required.²⁵ Likewise, where a practitioner is dismissed from a lawsuit prior to the settlement or judgment, no report needs to be made.²⁶

In essence, “[t]he corporate shield refers to the situation where the medical corporation for which the doctor works is named in the suit, and the doctor is either not originally named or is released specifically for the purpose of avoiding a report to the NPDB.”²⁷ Hospitals on the forefront of early dispute resolution for medical malpractice claims have freely used the corporate shield. The University of Michigan Health System, for instance, avowedly embraces this approach, and its settlements are generally in the institution’s name.²⁸ As a result, “reporting of individual caregivers in medical malpractice claims in the National Practitioner Data Bank is rare. However, full claims histories are maintained and reported for each involved caregiver, as required.”²⁹

Other avenues for avoiding malpractice Data Bank reports are also available.³⁰ For present purposes, the upshot is that although the

25. “A payment made as a result of a suit or claim solely against an entity (for example, a hospital, clinic, or group practice) and that does not identify an individual practitioner is not reportable under the NPDB’s current regulations.” NPDB GUIDEBOOK, *supra* note 23, at E-8.

In order for a particular physician, dentist, or other health care practitioner to be named in an MMPR submitted to the NPDB, the practitioner must be named in both the written complaint or claim demanding monetary payment for damages and the settlement release or final adjudication, if any. Practitioners named in the release, but not in the written demand or as defendants in the lawsuit, are not reportable to the NPDB. A practitioner named in the written complaint or claim who is subsequently dismissed from the lawsuit and not named in the settlement release is not reportable to the NPDB.

Id. at E-11.

26. A payment made to settle a medical malpractice claim or action is not reportable to the NPDB if the defendant health care practitioner is dismissed from the lawsuit **prior** to the settlement or judgment. However, if the dismissal results **from a condition in the settlement or release**, then the payment is reportable. In the first instance, there is no payment for the benefit of the health care practitioner because the individual has been dismissed from the action **independently** of the settlement or release. In the latter instance, if the practitioner is dismissed from the lawsuit **in consideration** of the payment being made in settlement of the lawsuit, the payment can only be construed as a payment for the benefit of the health care practitioner and must be reported to the NPDB.

Id. at E-12.

27. Lawrence E. Smarr, *A Comparative Assessment of the PIAA Data Sharing Project and the National Practitioner Data Bank: Policy, Purpose, and Application*, 60 LAW & CONTEMP. PROBS. 59, 67 (1997).

28. Kachalia et al., *supra* note 12, at 214.

29. *Id.*

30. These include high-low agreements, statutes, and contractual agreements mandating early mediation and, arguably, the pre-suit notification period many states require, during

HCQIA prima facie requires all medical malpractice payments to be reported, the reality is that a number of avenues permit legitimate escape.

III. MORAL HAZARD ISSUES AND QUALITY OF CARE

A. Overview of Moral Hazard Issues

If it is thus possible to avoid reporting medical malpractice payments via a number of avenues, the question arises whether such avoidance is desirable. If the purpose of the NPDB malpractice payment reports is to warn hospitals and state medical boards that a particular physician may be incompetent or otherwise problematic, it might seem inappropriate to recommend avoiding these reports at every lawful opportunity. Is not the purpose of the Data Bank to keep tabs on incompetent practitioners and, in the process, protect the public from harm? Is it really a “victory” to protect such providers from having their mistakes duly recorded and potentially used as a basis on which to limit the damage they can do to the next patient? Indeed, as the Department of Health and Human Services (DHHS) has pondered aloud, does not the “corporate shield” (and by implication, other ways of avoiding these reports) potentially “mask the extent of substandard care and diminish [the] NPDB’s usefulness as a flagging system”?³¹ It is time now to explore that “moral hazard” issue.

As this Article will show, powerful arguments persuade to the contrary. First, and perhaps most importantly, to the extent that the Data Bank deters physicians from entering into early dispute resolution, the result can be far more harmful to quality improvement—after all, the central focus of the HCQIA—than any putative benefits from ensuring malpractice payment reports.

which plaintiffs advise prospective defendants that they intend to file suit but have not yet filed a written claim or demand for payment. See Morreim, *supra* note *, Part III.

31. HEALTH RES. & SERVS. ADMIN., U.S. DEP’T OF HEALTH & HUMAN SERVS., NATIONAL PRACTITIONER DATA BANK 2005 ANNUAL REPORT 30 (2005), available at <http://www.npdb-hipdb.hrsa.gov/resources/reports/2005NPDBAnnualReport.pdf> [hereinafter 2005 NPDB ANNUAL REPORT]; U.S. DEP’T OF HEALTH & HUMAN SERVS., NATIONAL PRACTITIONER DATA BANK 2006 ANNUAL REPORT 34 (2006), available at <http://www.npdb-hipdb.hrsa.gov/resources/reports/2006NPDBAnnualReport.pdf> [hereinafter 2006 NPDB ANNUAL REPORT]. See also HEALTH RES. & SERVS. ADMIN., U.S. DEP’T OF HEALTH & HUMAN SERVS., NATIONAL PRACTITIONER DATA BANK COMBINED ANNUAL REPORT 2007, 2008, AND 2009 30 (2011), available at <http://www.npdb-hipdb.hrsa.gov/resources/reports/2007-08-09NPDBAnnualRep.pdf> [hereinafter 2007-2009 NPDB ANNUAL REPORT].

Additionally, these reports³² are hardly a faithful documentation of poor-quality medical practice. For one thing, as discussed below, there is wide variation in the character of the events being reported. Many malpractice settlements are the product of a simple business decision that it is cheaper to settle than fight. In other cases, physicians such as military doctors are only reported if extensive review reveals genuine malpractice. Additionally, DHHS essentially concedes that the mandate to report is unenforceable. Ultimately, the data are of such mixed and dubious quality that, as the expression goes, "garbage in, garbage out."

Finally, the HCQIA's focus on hospitals' peer review committees as the major locus for monitoring physician performance has become archaic. Fewer and fewer physicians actually practice in hospitals; hence, if the NPDB's goal is to prevent incompetent physicians from moving from state to state, then hospital surveillance is no longer a reliable mechanism. Additionally, although hospital peer review remains an important function for other reasons, it should focus on physicians' actual medical practices, not on odd collections of largely uninterpretable data.

Fortunately, newer and considerably better forms of continuing quality review are emerging, which require considerably more careful monitoring of physician performance than periodic inspection of dubious entries in the NPDB. In the end, as this Article will now argue, lawfully dodging the Data Bank is not merely permissible, it is desirable.

B. Quality of Care

If the discussion in Part I is correct, litigation is often powerfully antithetical to improving the quality and safety of patient care, in large part because it discourages communication that is essential to identifying and exploring underlying problems that need to be fixed. As noted there, adverse medical events stem largely from system-level problems rather than simplistically from individual persons and their mistakes. Far-reaching communication is needed to discern the complex causes of these system failures. Unfortunately, litigation and its twisting, near-endless road of discovery tend to inhibit and delay the very communication that is most urgently needed to make health care safer.

32. As noted, this Article does not focus on, nor criticize the compilation of, the other two types of NPDB reports: adverse peer review actions and state license board sanctions.

Accordingly, to the extent that the NPDB prompts physicians to continue litigating rather than mediate early,³³ it directly threatens important avenues of quality improvement that are well recognized today but were little known back in 1986. Such a result would contravene the very purpose of the law that created the Data Bank. The HCQIA was enacted amidst express congressional findings that “[t]he increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State.”³⁴

Congress chose hospital peer review, fueled by Data Bank information, as its preferred mechanism for improving quality by “restrict[ing] the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician’s previous damaging or incompetent performance.”³⁵ Nevertheless, Congress’ overriding emphasis in the Act was to improve the quality of health care. If hospital peer review was the most effective vehicle at that time—and arguably it was—this is no longer true today. Accordingly, avoiding malpractice Data Bank reports wherever legally permissible appears to be more, rather than less, consistent with Congress’ ultimate intent.

Indeed, further evidence of this evolution emerges in the Patient Protection and Affordable Care Act of 2010.³⁶ This Act authorized the DHHS Secretary to award grants “for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations.”³⁷ Applicants for these grants were asked to show how their proposal would, *inter alia*,

- (A) make[] the medical liability system more reliable by increasing the availability of prompt and fair resolution of disputes;
- (B) encourage[] the efficient resolution of disputes;

33. Physicians became less willing to settle cases shortly after the NPDB became fully operational, expressly because of NPDB concerns. See Teresa M. Waters et al., *Impact of the National Practitioner Data Bank on Resolution of Malpractice Claims*, 40 INQUIRY 283, 290 (2003); Smarr, *supra* note 27, at 71; see also Michelle M. Mello & Thomas H. Gallagher, *Malpractice Reform – Opportunities for Leadership by Health Care Institutions and Liability Insurers*, 362 NEW ENG. J. MED. 1353, 1355 (2010).

34. Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101(1) (2006).

35. *Id.* § 11101(2).

36. Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered sections of 42 U.S.C.).

37. 42 U.S.C.A. § 280g-15(a) (West 2010).

- (C) encourage[] the disclosure of health care errors; [and]
- (D) enhance[] patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events.³⁸

To the extent that the NPDB chills physicians' willingness to participate in such activities, it appears to be in direct conflict with Congress' current intent.

IV. DEGRADATION OF NPDB DATA: GARBAGE IN, GARBAGE OUT

For a variety of reasons, information in the NPDB's malpractice payment reports should not be deemed a reliable indication of whether or how often a practitioner has committed malpractice—i.e., whether he is an “incompetent physician” as contemplated by the statute.³⁹ DHHS expressly recognizes that a Data Bank report does not necessarily betoken malpractice.⁴⁰ Unfortunately, the limits of NPDB integrity and completeness are considerably worse than DHHS may envision. Arguably, its medical malpractice entries are no longer very useful, even as a flagging system.

A. Medical Malpractice Reports Do Not Capture Malpractice Well

As discussed in Part I, empirical studies have revealed that there is very little connection between negligent iatrogenesis and a filed medical malpractice claim: most negligence does not result in a claim, and most claims are not linked with negligence.⁴¹ In some cases physicians may wish to compensate patients for adverse outcomes even in the absence of any hint of negligence.

For example, it is not uncommon for anesthesiologists or certified registered nurse anesthetists to dislodge a tooth or

38. *Id.* § 280g-15(c)(2).

39. *See id.*

40. “The NPDB acts primarily as a flagging system; its principal purpose is to facilitate a comprehensive review of professional credentials. Information on medical malpractice payments, certain adverse licensure actions, adverse clinical privilege actions, adverse professional society membership actions, and Medicare/Medicaid exclusions is collected from and disseminated to eligible entities.” NPDB GUIDEBOOK, *supra* note 23, at E-1. “The Secretary of HHS understands that some medical malpractice claims (particularly those referred to as nuisance claims) may be settled for convenience, not as a reflection on the professional competence or conduct of a practitioner.” *Id.* at E-9; 45 C.F.R. § 60.7(d) (2010) (“A payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred.”).

41. *See supra* note 5 and accompanying text; Leape, *supra* note 9; A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Practice Study III*, 325 NEW ENG. J. MED. 245, 246-49 (1991).

filling during intubation or extubation. This is often caused by the poor condition of the patient's dentition, and can result in a small settlement to compensate the patient for damage or replacement, which must be reported to the NPDB.⁴²

B. Medical Malpractice Reports Appear Significantly Late

Whereas an early settlement will appear virtually immediately in the Data Bank, a litigated medical malpractice resolution takes far longer to be reflected. According to DHHS's annual NPDB reports, the average duration from the time the incident occurred to the time a payment is made is over four and a half years, and in some states is nearly eight years.⁴³ By the time a payment appears in the Data Bank, it is seriously out of date. Even if a report were indicative of malpractice at the time of the incident, it does not follow that the physician is still "incompetent" five years later. Its value as an alert to peer reviewers is thus considerably attenuated.

A second problem is that, as noted, physicians are encouraged to litigate. The longer they hang on, the longer it takes for a resolution and, thereafter, for a Data Bank report to appear. Furthermore, since physicians predominantly prevail when they litigate instead of mediate, the odds go down that any report will be made at all—even if the physician's care was negligent.

C. Underreporting, Unenforceability

In theory, entities such as medical malpractice insurers have a significant incentive to report to the NPDB each time they pay a settlement or judgment on behalf of a practitioner. After all, failure to report means a potential penalty of \$11,000 per instance.

In reality, however, evidence indicates that significant underreporting is probably occurring. In 2000, the U.S. General Accounting

42. Smarr, *supra* note 27, at 69.

43. Per the NPDB 2005 Annual Report, the average duration was 4.66 years, up eighteen days from 2004. 2005 NPDB ANNUAL REPORT, *supra* note 31, at 8. The delay varied among states, from 3.20 years in Oregon to 6.16 years in Massachusetts. *Id.* And per the 2006 report, "Payments were made most quickly in South Dakota (a mean payment delay of 3.26 years) and California (3.30 years). Payments were slowest in Alaska (7.83 years) and Massachusetts (6.60 years)." 2006 NPDB ANNUAL REPORT, *supra* note 31, at 33. The most recent NPDB Annual Report did not update these figures. See 2007-2009 NPDB ANNUAL REPORT, *supra* note 31. See also Smarr, *supra* note 27, at 71-72 (noting that because of its nearly five-year lag, the NPDB fails to provide timely information).

Office (GAO) found high levels of errors among all three kinds of reports (malpractice, peer review, and licensure actions).⁴⁴ Specifically regarding the NPDB's medical malpractice portion, the GAO observed that, although the Health Services Resource Administration (HRSA)

has been concerned that malpractice payments are underreported, it has not been able to determine the magnitude of the problem despite many years of effort. Medical malpractice payments can be underreported in two ways, neither of which has been successfully quantified. First, agency officials believe that some insurers may be using a technicality in NPDB's reporting requirements to avoid reporting some practitioners. Second, agency officials believe that some insurers and self-insured organizations such as HMOs and other health plans should report to NPDB but do not.⁴⁵

The report then makes a crucial point: "HRSA has not yet identified or fined any organizations for failing to report the required information. Agency officials told us that they are reluctant to impose fines because they believe that the cost of levying and collecting civil penalties often exceeds the \$11,000 maximum amount that can be assessed."⁴⁶

A large part of the problem is that there appears to be no reliable way for HRSA to track whether and when insurers actually make malpractice payments in the first place, so as to be able to match those with Data Bank reports. In one effort to track down discrepancies between payments and reports, HRSA used malpractice claims data that insurance companies voluntarily reported to an umbrella organization, the National Association of Insurance Commissioners (NAIC).⁴⁷ The problem with that approach is that any Data Bank re-

44. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-01-130, NATIONAL PRACTITIONER DATA BANK: MAJOR IMPROVEMENTS ARE NEEDED TO ENHANCE DATA BANK'S RELIABILITY 5, 10-13 (2000), available at <http://www.gao.gov/new.items/d01130.pdf>.

45. *Id.* at 10.

46. *Id.* at 10-11.

47. [HRSA] identified 41 insurers that reported payments to NAIC but not to NPDB. HRSA contacted these companies seeking explanations regarding the differences in the reported payments. As of September 2000, 17 of the 41 companies have adequately explained the discrepancies to HRSA. For instance, NAIC data, for some companies, reflect total payments made by their corporations—combining payments made on behalf of individual practitioners with payments made on behalf of organizations. NPDB data only represent payments made on behalf of individual practitioners. Of the remaining 24 companies, 18 recognized their omissions and agreed to file the delinquent reports. The other six companies have not responded to HRSA's inquiries

port verification done via comparisons with the NAIC database is of limited value since reports to that organization are completely voluntary. Insurers who wish to avoid being caught for failure to make NPDB reports need only refrain from making voluntary reports to the NAIC, and there will be no discrepancy for HRSA to observe.

Of interest, the most recent NPDB Annual Report does little to address this issue. Although the report states that the NPDB enhanced compliance activities for 2007, 2008, and 2009, these activities were directed toward such entities as “the DEA, Medicaid Fraud Control Units (MFCU), the National Council of State Boards of Nursing, the Federation of Chiropractic Licensing Boards, and the National Association of Boards of Pharmacy.”⁴⁸ The report asserts that the NPDB monitored compliance and that the Division of Practitioner Data Bank “ensured that medical malpractice and adverse actions were being reported to the NPDB.”⁴⁹ However, no specifics are provided regarding *how* the agency ensured such compliance. The closest information on point indicates that, under the requirement for hospitals to report adverse actions regarding practitioners’ privileges, many hospitals have never reported anything to the Data Bank.⁵⁰

In sum, it appears that there is little way for HRSA to determine whether insurers are actually reporting as required. Even if it were possible to detect discrepancies, HRSA acknowledges that the cost of enforcement exceeds the value of the penalty assessed against the insurer. Hence, there is limited incentive for HRSA to enforce the mandate even where violations are detected. The NPDB mandate to report malpractice payments thus appears unenforceable.

This essentially inevitable underreporting presents obvious problems. First, if the goal of the Data Bank is to alert hospital peer review entities of physicians who may be poor practitioners, this obviously cannot happen where a report is never made. Second, significant underreporting will inappropriately stigmatize those physicians who actually land in the Data Bank if, in fact, a significant number of other physicians with comparable medical malpractice records are never reported.

and have been warned by the agency that they will be reported to HHS/OIG for possible enforcement action.

Id. at 12.

48. See 2007-2009 NPDB ANNUAL REPORT, *supra* note 31, at 19, 24, 29, 35.

49. *Id.* at 20.

50. *Id.* at 72-73.

It might be replied that the HCQIA requires that any malpractice report made to the NPDB must also be forwarded to state licensing boards,⁵¹ and that many states require malpractice payments to be directly reported to state licensure boards.⁵² Hence, even if there is a relative dearth of comprehensive NPDB data, the mandate to report may still do some good.

Although many state medical boards do mandate some sort of report regarding a filing or resolution of a medical malpractice claim, the actual consequences of these reports appear to be not nearly as significant as they are for reports in the Data Bank. Rarely do state medical boards impose sanctions simply because a physician has paid for a purported act of malpractice. Rather, license restrictions on the whole are relatively uncommon and tend to follow offenses such as unprofessional conduct, sexual misconduct, misprescribing of controlled substances, and similarly salient problems.⁵³ In 2002, negligence accounted for less than 15% of state boards' disciplinary actions. The most common resolution, in two-thirds of cases, was a private agreement in which the physician was not found guilty of the alleged offense.⁵⁴ Moreover, in some cases these state board re-

51. 42 U.S.C. § 11134(c)(1)-(2) (2010).

52. See, e.g., ARK. CODE ANN. § 17-95-103 (2011) (physicians must notify the medical board of each medical malpractice claim); COLO. REV. STAT. § 10-1-120 (2010) (requiring each medical malpractice insurer to send information to the state medical board regarding each medical malpractice claim for which a settlement or judgment has been paid); FLA. STAT. § 456.041(4) (2010) (requiring reports to the Department of Health of payments for claims exceeding \$100,000); FLA. STAT. § 456.049 (2010) (requiring practitioners to report claims or actions for damages to the Office of Insurance Regulation); KAN. STAT. ANN. § 65-2836(x) (2010) (permitting license revocation for any physician or other licensee who has "failed to report to the board any adverse judgment, settlement, or award against the licensee resulting from a medical malpractice liability claim"); KY. REV. STAT. ANN. § 304.40-310(1)-(2) (West 2011) (requiring reports of malpractice claims settled or finally adjudicated to be made to the commissioner of insurance, who must forward the information to the appropriate licensing board); OHIO REV. CODE ANN. § 4731.224(D) (West 2011) (requiring that any professional liability insurer notify the state medical board of any settlement or payment exceeding \$25,000).

53. See, e.g., Lena H. Sun, *State Boards Don't Always Discipline Doctors Sanctioned by Hospitals*, WASH. POST, Mar. 16, 2011, available at <http://www.washingtonpost.com/wp-dyn/content/article/2011/03/16/AR2011031605966.html>; Alan Levine et al., *State Medical Boards Fail to Discipline Doctors with Hospital Actions Against Them*, PUB. CITIZEN (Mar. 15, 2011), <http://www.citizen.org/documents/1937.pdf> (noting that at least half of physicians disciplined by hospitals had escaped any licensure action, and that the most common categories of failure to take licensure action included physicians who posed an immediate threat to health or safety, were incompetent or negligent, provided substandard care, or who engaged in sexual misconduct, fraud or narcotics violations).

54. Darren Grant & Kelly C. Alfred, *Sanctions and Recidivism: An Evaluation of Physician Discipline by State Medical Boards*, 32 J. HEALTH POL. POL'Y & L. 867, 874 (2007); see also Sidney M. Wolfe et al., *Public Citizen's Health Research Group Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions, 2007-2009*, PUB. CITIZEN (Apr. 5, 2010), <http://www.citizen.org>

ports are purely for informational purposes—for instance, to track trends in malpractice litigation.⁵⁵ More importantly, if state boards' reporting requirements would deter physicians from early resolution in the same way as the NPDB, they should perhaps be reconsidered for the same reasons discussed here.⁵⁶

D. Imbalanced Reporting: Consent-to-Settle Clauses

A key assumption behind the NPDB is that a payment made to settle a malpractice claim implies that the physician must have erred in some way, at least in most cases. This assumption arises partly from the fact that many physicians' insurance contracts feature a "consent-to-settle" clause—that is, a clause permitting the physician to veto any effort to settle the case without her permission. If the physician believes she has not erred, she can defend herself as long as the courts permit, and most times will eventually win the case.

However, this assumption is inapplicable for the many physicians whose policies lack such a clause. In these cases, a settlement may not actually reflect any evaluation that the physician erred, but may simply be premised on a business judgment that it is less costly to settle than fight.⁵⁷ Indeed, the State of Florida directly forbids such clauses:

It is against public policy for any insurance or self-insurance policy to contain a clause giving the insured the exclusive right to veto any offer for admission of liability and for arbi-

/documents/1905.pdf; Sidney M. Wolfe & Kate Resnevic, *Public Citizen's Health Research Group Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions: 2006–2008*, PUB. CITIZEN (Apr. 20, 2009), <http://www.citizen.org/documents/HRG1868.pdf>.

55. See FLA. STAT. § 456.041(4) (2010) (requiring reports of payments exceeding \$100,000 to the Department of Health). "Such claims information shall be reported in the context of comparing an individual practitioner's claims to the experience of other practitioners within the same specialty, or profession if the practitioner is not a specialist." *Id.*

56. Some states also place malpractice information in public view:

According to a recent review, thirty-two states post physician profiles on the Internet for use by consumers. While most sites contain discipline and license data, many states also include physician-specific information on medical malpractice judgments, with a handful disclosing malpractice settlements as well. Rhode Island and Florida have online report card systems that exclude liability suit information. Massachusetts and New York have systems that include a summary of doctors' liability histories, including selected information on malpractice settlements. California recently approved the creation of a system that would disclose settlement information for repeat offenders.

Sage et al., *supra* note 5, at 1288 (citations omitted).

57. *Id.*; see also Smarr, *supra* note 27, at 69–70.

tration made pursuant to s. 766.106, settlement offer, or offer of judgment, when such offer is within the policy limits. However, any offer of admission of liability, settlement offer, or offer of judgment made by an insurer or self-insurer shall be made in good faith and in the best interests of the insured.⁵⁸

Of note, Florida courts have been reluctant to agree that the physician's professional reputation, including the potentially adverse implications an NPDB report might carry for that reputation, will count as "the best interests of the insured" under this statute. In *Rogers v. Chicago Insurance Co.*, the court interpreted the statutory requirement that all settlements be in the "best interests of the insured" as meaning "the interests of the insured's rights under the [malpractice] policy, not some collateral effect unconnected with the claim."⁵⁹ In *Freeman v. Cohen*,⁶⁰ the appellate court agreed with the insurer that "[t]he policy's purpose was indemnification and a defense of covered claims, not to protect the insured from increases in insurance premiums or damage to his reputation from a paid claim."⁶¹

Nationwide, a number of medical malpractice policies lack a consent-to-settle clause, thereby permitting purely business-based settlement decisions.⁶² As it is unclear how many physicians actually have such a clause in their contracts, we have no way of knowing what proportion of malpractice reports in the NPDB are the product of business expediency decisions in response to mere allegations, and what proportion reflect genuine malpractice. The federal government's simple caveat that "[a] payment in settlement of a medi-

58. FLA. STAT. ANN. § 627.4147(b)1 (2010). *But see* CAL. HEALTH & SAFETY CODE § 1306 (West 2011) (forbidding insurers from entering into settlement exceeding \$3000 without the written consent of the insured).

59. 964 So. 2d 280, 284 (Fla. Dist. Ct. App. 2007). In *Rogers*, the insurer had ninety days to investigate the claim, but it did not begin to do so until the deadline was nearly expired. *Id.* at 281. The insurer opted to settle the case instead of fight. *Id.* The District Court of Appeal of Florida upheld the insurer's right to settle, denying the physician's claim that settling exhibited bad faith. *Id.* at 284; *see also* Robert I. Rubin, *Legal, Practical, and Ethical Considerations of Medical Malpractice Settlements*, 83 FLA. B. J. 47, 48 (2009).

60. 969 So. 2d 1150, 1155 (Fla. Dist. Ct. App. 2007).

61. *Id.*; *see also* Thomas E. Dukes, III & Helen V. Owens, *Settlements and Releases in Malpractice Claims*, in FLORIDA MEDICAL MALPRACTICE HANDBOOK (2006), available at Westlaw MALP FL-CLE 16-1.

62. *See, e.g.*, *Teague v. St. Paul Fire & Marine Ins. Co.*, 974 So. 2d 1266 (La. 2008); Brief for Appellant, *Shega v. Lewis*, No. D 029700, 1999 WL 33895195 (Cal. Ct. App. Jan. 13, 1999); Brief for Appellant, *Rohart v. Melsar Risk Mgmt. Servs., Inc.*, No. 4 D09-3396, 2010 WL 4923909 (Fla. Dist. Ct. App. Dec. 1, 2010), 2009 WL 5068585.

cal malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred"⁶³ is not particularly helpful.

E. Imbalanced Reporting: Government Physicians

The problem of wide variation in the quality of Data Bank information is exacerbated when government-employed physicians are also factored into the analysis. When someone is allegedly injured by the acts of federal employees, the Federal Tort Claims Act⁶⁴ is implicated rather than state law, and the plaintiff generally sues the federal government rather than the particular government employees involved. Accordingly, the HCQIA required that the DHHS Secretary explore how the statute would apply to government-employed healthcare practitioners, and then enter into memoranda of understanding (MOU) with the Secretary of Defense, the Administrator of Veterans' Affairs, and the Administrator of the Drug Enforcement Administration.⁶⁵

The MOUs that emerged created a peer review process to function as an intermediary between a medical malpractice payment and an NPDB report.⁶⁶ They thereby created very different standards for reporting government physicians than for ordinary physicians.⁶⁷ Thus, military physicians can only be reported for medical malpractice payments if several layers of senior evaluation, including the respective military branch's surgeon general, determine that the physician actually committed malpractice and that the malpractice caused the injury. The military review system therefore can decline to report, even when a court has found the physician at fault for malpractice.⁶⁸ This standard is significantly different from that to

63. 45 C.F.R. § 60.7(d) (2010).

64. 28 U.S.C. §§ 1346(b), 2671-80 (2006).

65. 42 U.S.C. § 11152(b)-(c) (2006); *see also* 2007-2009 NPDB ANNUAL REPORT, *supra* note 31, at 10.

66. U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 44, at 12.

67. The 2006 NPDB Annual Report states:

The Secretary signed an MOU with the U.S. Department of Defense (DOD) September 21, 1987, with the DEA on November 4, 1988 (revised on June 19, 2003), and with the U.S. Department of Veterans Affairs (VA) November 19, 1990. In addition, MOUs with the U.S. Department of Transportation, U.S. Coast Guard and with the U.S. Department of Justice, Bureau of Prisons were signed June 6, 1994 and August 21, 1994, respectively. Policies under which the Public Health Service participates in the NPDB were implemented November 9, 1989 and October 15, 1990.

2006 NPDB ANNUAL REPORT, *supra* note 31, at 17.

68. The process is elaborate:

which ordinary physicians are held. For an ordinary physician, an insurer's simple business decision is sufficient to leave a black mark in the Data Bank, as is a court verdict that reflects not scientific evidence, but only jury emotion.

Matters are only marginally different in the case of physicians employed by DHHS, such as those working for the National Institutes of Health (NIH) or the Indian Health Service. In principle, "all settled or adjudicated HHS medical malpractice cases must be reported to the NPDB. This policy applies to all cases regardless of whether the standard of care has been met."⁶⁹

However, DHHS can abstain from reporting "for those cases in which the adverse event was caused by system error."⁷⁰ This exception appears eminently sensible if the NPDB's goal is to identify incompetent practitioners. After all, if the individual's error was mainly the product of far broader system-level errors, then it seems un-

The U.S. Department of Defense's (DOD) policy requires malpractice payments to be reported to the NPDB only if the practitioner was responsible for an act or omission that was the cause (or a major contributing cause) of the harm that gave rise to the payment. Also, it is reported only if at least one of the following circumstances exists about the act or omission: (1) The Surgeon General of the affected military department (Air Force, Army, or Navy) determines that the practitioner deviated from the standard of care; (2) The payment was the result of a judicial determination of negligence and the Surgeon General finds that the court's determination was clearly based on the act or omission; and (3) The payment was the result of an administrative or litigation settlement and the Surgeon General finds that based on the case's record as whole, the purpose of the NPDB requires that a report be made. The U.S. Department of Veterans Affairs (VA) uses a similar process when deciding whether to report malpractice payments.

Id. at 34; see also VETERAN'S HEALTH ADMIN., DEP'T OF VETERANS AFFAIRS, VHA HANDBOOK 1100.17: NATIONAL PRACTITIONER DATA BANK (NPDB) REPORTS 6-11 (2009), available at http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2135.

Reporting to the NPDB is based on the finding by a Review Panel that there was substandard care, professional incompetence, or professional misconduct during an episode of care. . . . For each involved practitioner, the Medical Center Director's notification must state that the request for a statement does not imply blame or fault, but, rather, is the practitioner's opportunity to submit information for consideration by the Review Panel. . . . Payment will be considered to have been made for the benefit of a physician, dentist, or other licensed health care practitioner when the Director, Office of Medical-Legal Affairs, notifies, per subparagraph 8h(1), the Medical Center Director that the conclusion (of at least a majority) of the Review Panel is that payment was related to substandard care, professional incompetence, or professional misconduct on the part of the physician, dentist, or other licensed health care practitioner. In any case where professional incompetence or professional misconduct is involved, coordination with other relevant processes should occur (e.g., Professional Standards Board, Disciplinary Appeals Board, or administrative investigations).

Id.; 38 C.F.R. § 46.3(b) (2010) (reporting of malpractice payments).

69. 2006 NPDB ANNUAL REPORT, *supra* note 31, at 17-18.

70. *Id.* at 18.

fair to tag the individual physician as though that physician was primarily responsible for the outcome.

By implication, however, this caveat will effectively exclude a substantial portion of Data Bank reports that would be required for non-DHHS physicians. As observed above in Part I, two decades of research into systems-level aspects of adverse medical outcomes have made it clear that rarely is an adverse outcome simply the product of a single practitioner's carelessness.⁷¹ Thus, where an NIH physician can show that system-level flaws either caused or significantly contributed to the adverse outcome, he or she need not be reported. Under otherwise identical circumstances, nongovernment physicians would of course be reported because no such exception applies to them.

Perhaps not surprisingly, DHHS rarely reports its physicians to the Data Bank. In the first fifteen years of NPDB operation, DHHS agencies reported a total of only 257 medical malpractice cases.⁷² By 2006, after a concerted effort to increase reporting, the sixteen-year total rose to 574, 30% of which were reported in 2006.⁷³

F. Imbalanced Reporting: Sovereign Immunity and Charity Care

Somewhat analogously, many states permit physicians who provide charity care or who work for the state to be shielded from malpractice liability via charitable or sovereign immunity.⁷⁴ The state of

71. See *supra* Part I. See generally Judy Smetzer et al., *Shaping Systems for Better Behavioral Choices: Lessons Learned from a Fatal Medication Error*, 36 JOINT COMMISSION J. ON QUALITY & PATIENT SAFETY 152 (2010) (discussing how a medical error initially thought to have been caused by simple carelessness, upon closer analysis, may actually stem from multiple layers of system-level problems); see also Sidney W.A. Dekker, *We Have Newton on a Retainer: Reductionism When We Need Systems Thinking*, 36 JOINT COMMISSION J. ON QUALITY & PATIENT SAFETY 147, 147-49 (2010); Charles R. Denham, *The Missing Safe Practice*, 36 JOINT COMMISSION J. ON QUALITY & PATIENT SAFETY 149, 149-50 (2010); Lucian L. Leape, *Who's to Blame?*, 36 JOINT COMMISSION J. ON QUALITY & PATIENT SAFETY 150, 150-51 (2010).

72. 2005 NPDB ANNUAL REPORT, *supra* note 31, at 15.

73. 2006 NPDB ANNUAL REPORT, *supra* note 31, at 18. These numbers were not updated in the most recent report. See 2007-2009 NPDB ANNUAL REPORT, *supra* note 31.

74. See, e.g., GA. CODE ANN. § 51-1-29.1(a)(1) (West, Westlaw through the 2011 Reg. Sess.); LA. REV. STAT. ANN. § 40:1299.39 (West, Westlaw through the 2011 1st Extraordinary Sess.); OKLA. STAT. ANN. tit. 51 §§ 152, 152.1-.2 (West, Westlaw through current chapters of the 1st Reg. Sess. of the 53d Legis. (2011)); TEX. CIV. PRAC. & REM. CODE ANN. § 74.003 (West, Westlaw through the end of the 2011 Reg. Sess. and 1st Called Sess. of the 82d Legis.); UTAH CODE ANN. § 58-13-3; 51 (West, Westlaw through 2011 2d Spec. Sess.). See generally Carol A. Crocca, *Annotation, Validity, Construction, and Application of State Statutory Provisions Limiting Amount of Recovery in Medical Malpractice Claims*, 26 A.L.R. 5th 245 (1995) (discussing statutory limits in medical malpractice context).

Arkansas, for instance, provides that physicians who are retired but still licensed, and who render uncompensated or low-cost medical services at designated clinics, “shall not be liable for any civil damages for any act or omission resulting from the rendering of such medical services, unless the act or omission was the result of such licensee’s gross negligence or willful misconduct.”⁷⁵ Clearly, a physician who has this immunity will not incur a Data Bank report under circumstances in which another physician, not similarly immunized, would be susceptible to a suit and a report.

V. HOSPITAL PEER REVIEW: EVOLUTION AND ANACHRONISM

Finally, the HCQIA itself has become at least partly anachronistic. The anachronism emerges from several assumptions implicit in the statute. First, in 1986, Congress, through the HCQIA, seemed to presume that adverse outcomes are largely the product of individual persons and their carelessness and that reducing individuals’ poor practice will markedly improve healthcare safety and quality. A second, corollary assumption was that identifying poor practitioners and disciplining them or restricting their practice will lead to significantly fewer adverse events. Third, the HCQIA assumed that the best strategy for identifying such errant individuals is the hospital and its peer review system.

75. ARK. CODE ANN. § 17-95-106(a) (West, Westlaw through 2010 2d Reg. Sess. of 26th Legis.). See also ALASKA STAT. § 09.65.300 (West, Westlaw through the 1st Reg. Sess. and 3d Spec. Sess. of the 15th Legis. (2011)); ARIZ. REV. STAT. ANN. § 12-571 (West, Westlaw through 1st Reg. Sess. and 3d Spec. Sess. of the 50th Legis.); DEL. CODE ANN. tit. 10, § 8135 (West, Westlaw through 78 Laws 2011, chs. 1-72, 75, 79-92); D.C. CODE § 7-402 (1995) (specific to obstetrics and gynecology); GA. CODE ANN. § 31-8-195.1 (West, Westlaw through the 2011 Reg. Sess.); IDAHO CODE ANN. § 39-7703 (West, Westlaw through 2011, chs. 1-335 that were effective on or before July 1, 2011); 225 ILL. COMP. STAT. 60/31 (West, Westlaw through P.A. 97-191, with the exception of P.A. 57-81 and P.A. 97-168, of the 2011 Reg. Sess.); IND. CODE § 34-30-13-1 (West, Westlaw through end of 2011 1st Reg. Sess.); MICH. COMP. LAWS § 333.16277 (West, Westlaw through P.A. 2011, No. 233, of the 2011 Reg. Sess., 96th Legis.); MISS. CODE ANN. § 11-1-71 (West, Westlaw through 2010 Reg. and 1st and 2d Extraordinary Sess.) (immunity for volunteer service rendered at schools or under special volunteer medical license); NEB. REV. STAT. § 25-21,188.02 (West, Westlaw through 101st Legis. 2d Reg. Sess.); N.C. GEN. STAT. § 90-21.16 (West, Westlaw through Chapter 18); N.D. CENT. CODE § 32-03.1-02.2 (West, Westlaw through 2009 Reg. Sess.); OHIO REV. CODE ANN. § 2305.234 (West, Westlaw through 2011 Files 1 to 47, 49 and 52 of the 12th GA (2011-2012), apv. by 7/15/2011, and filed with the Secretary of SSR by 7/18/2011); OKLA. ST. tit. 76, § 32 (West, Westlaw through 1st Reg. Sess. of the 23d Legis. (2011) effective Aug. 26, 2011); TENN. CODE ANN. § 63-6-708 (West, Westlaw through the 2011 2d Spec. Sess.); UTAH CODE ANN. § 58-13-3 (West, Westlaw through 2011 2d Spec. Sess.); WASH. REV. CODE § 4.24.300 (West, Westlaw through 2011 Legis.); W. VA. CODE § 30-3-10a (West, Westlaw through 2011 Reg. Sess.); WYO. STAT. § 1-1-129 (West, Westlaw through 2011 General Sess.).

On the basis of these assumptions, the Act then inferred that if hospital peer review committees are protected by qualified immunity, and if they are provided with plentiful information via the Data Bank, they will be able to reduce adverse events (1) by restricting or removing physicians' opportunities to practice in the hospital setting and (2) by reducing poorly-performing physicians' opportunities to start anew in another location and perpetuate their errant practices.

This picture has become seriously anachronistic in several ways. First, we now understand that adverse outcomes are largely the product of systems-level flaws and are not usually reducible to incompetent individuals' slip-ups.⁷⁶ Individuals do, of course, err. They become fatigued, distracted, harried, and/or hurried. But patient safety systems need to recognize and encompass those inevitable human failings, rather than simply punish people and admonish greater attentiveness.

A classic example concerns an anesthesiologist who, during surgery, reached into a drawer for the agent to reverse a sedated patient's chemical paralysis. Instead of grabbing the reversal agent, he grabbed the paralytic agent—clearly an error. The broader problem, however, was that both vials were side by side in the same drawer, both had yellow labels, both had yellow caps, and both were the same size and shape. No harm came to the patient in this instance. When the anesthesiologist related the incident to his colleagues, he learned that many of them had also made the same error.⁷⁷ Contemporary systems analysis would predict a high probability for such incidents in a busy surgical setting. Recognizing such, it makes far more sense to reorganize the drawer and to change the colors of labels and caps than to punish anesthesiologists for being human.

In addition to its outdated assumption that errant individuals should be the primary target for improving safety and quality, a second anachronism is the HCQIA's reliance on hospital peer review as the central mechanism for catching such errant individuals. In 1986, nearly all physicians practiced in a hospital setting at least some of the time. Surgeons, anesthesiologists, and other invasive specialists needed hospital-furnished operating rooms, catheterization labs, and the like. Even primary care physicians who spent

76. See *supra*, Part I.

77. Cheryl Gay Stolberg, *Do No Harm: Breaking Down Medicine's Culture of Silence*, N.Y. TIMES, Dec. 5, 1999, at D1.

much of their day in an office nevertheless had to make hospital rounds to visit any patients who were hospitalized.

As a result, nearly all physicians needed to hold credentials and privileges at one or more hospitals, and Congress correctly discerned that, at that time, hospitals held considerable leverage over physicians. Congress further inferred that hospitals' medical staffs might be more likely to aggressively weed out poorly performing physicians if they felt safe from antitrust and similar litigation, and if they had comprehensive information about physicians who were showing poor performance—specifically, information about medical malpractice payouts, licensure restrictions, and adverse credentialing actions. Hence Congress provided strong, albeit qualified, immunity for participating in peer review;⁷⁸ created the NPDB to ensure a broad database;⁷⁹ and required hospitals—but only hospitals—to check the Data Bank upon initial credentialing, and every two years thereafter.⁸⁰

Well into the twenty-first century, however, physicians' relationships with hospitals have changed dramatically. Many primary care physicians no longer find it efficient to round on their hospitalized patients, and instead delegate such duties to hospitalists.⁸¹ At the same time, many specialists have created free-standing ambulatory centers for surgery, invasive cardiology, interventionalist radiology, diagnostic and imaging evaluations of varying types, and numerous other services formerly provided only in a hospital. For these physicians, hospital credentials may also have limited importance. The

78. 42 U.S.C. §§ 11111–11112 (2006).

79. *See id.* §§ 11131–11133.

80. *Id.* § 11135. Other entities, such as state licensing boards and managed care organizations, are *permitted* to view the NPDB, but only hospitals are *required* to view the NPDB. *Id.* §§ 11135, 11137(a).

81. The term *hospitalist* was first coined in 1996, ten years after the HCQIA was enacted. Hospitalists oversee the care of patients for the duration of an inpatient stay. They become intimately familiar not just with serious illness, but also with the mechanics of how to get tests and procedures completed efficiently and with optimal planning for safe and efficient discharge. Hospitalists aid in reducing lengths of stays, morbidity, and mortality. *See* Robert M. Wachter & Lee Goldman, *The Emerging Role of "Hospitalists" in the American Health Care System*, 335 *NEW ENG. J. MED.* 514, 514 (1996); *see also* Mary Beth Hamel et al., *The Growth of Hospitalists and the Changing Face of Primary Care*, 360 *NEW ENG. J. MED.* 1141, 1141–43 (2009); Yong-Fang Kuo et al., *Growth in the Care of Older Patients by Hospitalists in the United States*, 360 *NEW ENG. J. MED.* 1102, 1110–11 (2009). *But see* Editorial, *Frustrations with Hospitalist Care: Need to Improve Transitions and Communication*, 152 *ANNALS INTERNAL MED.* 469, 469 (2010) (noting this evidence is still deficient about how to deliver care optimally in complex cases where seriously ill patients transition between multiple providers); William N. Southern et al., *Hospitalist Care and Length of Stay in Patients Requiring Complex Discharge Planning and Close Clinical Monitoring*, 167 *ARCHIVES INTERNAL MED.* 1869, 1869 (2007).

net result of this evolution is that physicians' histories of adverse professional evaluations, as recorded in the NPDB, are less likely to come to the attention of anyone likely to see or use that information.

VI. SUPERIOR APPROACHES TO ENSURING PRACTITIONER COMPETENCE, ENHANCING PATIENT SAFETY

All of this is not to suggest that there is no such thing as an incompetent physician, that incompetent physicians cannot do harm, or that incompetent physicians should not be identified and either retrained or restricted. It is to say, however, that we now need to identify far more effective ways of improving the safety and quality of care, and of monitoring not just practitioners' individual errors, but more broadly, their ability to provide high-quality care.

In the current economic climate, new structures are emerging that purport to do both—approaches that are far better than just a crude tally of the frequency with which an entity has paid money on behalf of a physician. As early as the 1990s, major corporations and business groups began turning to *value-based purchasing* in the belief that the enormous sums spent on health care should produce high-quality results. They began using their purchasing power to select providers using various outcome measures.⁸² More recently, the Center for Medicare & Medicaid Services (CMS) announced its own value-based purchasing initiative. It will incorporate clinical process-of-care measures in five health categories, such as heart failure and pneumonia, to influence its payments to providers.⁸³ As CMS notes:

Medicare's current payment systems reward quantity, rather than quality of care, and provide neither incentive nor support to improve quality of care. Value-based purchasing (VBP), which links payment more directly to the quality of care provided, is a strategy that can help to transform the current payment system by rewarding providers for delivering high quality, efficient clinical care. Through a number of public reporting programs, demonstration projects, pilot programs, and voluntary efforts, CMS has launched VBP in-

82. JACK MEYER ET AL., AGENCY FOR HEALTHCARE RESEARCH & QUALITY, THEORY AND REALITY OF VALUE-BASED PURCHASING: LESSONS FROM THE PIONEERS ¶39 (1997), available at <http://www.ahrq.gov/qual/meyerrpt.htm>.

83. Cheryl Clark, *CMS Releases Value-Based Purchasing Incentive Plan*, HEALTHLEADERS MEDIA (Jan. 11, 2011), <http://www.healthleadersmedia.com/content/HEP-261211/CMS-Releases-ValueBased-Purchasing-Incentive-Plan>.

itiatives in hospitals, physician offices, nursing homes, home health services, and dialysis facilities.⁸⁴

In a similar vein, Accountable Care Organizations (ACOs) promise to be a significant feature in the landscape of health care. They will feature partnerships or networks of hospitals, primary care providers, and others whose members will share savings achieved if they can reduce costs while maintaining or improving quality of care for their patient population—initially a Medicare population, but likely to be replicated by private health plans.⁸⁵ These ACOs, in turn, will emphasize that patients should have a *medical home*, defined as care provided by a personal physician who can coordinate and integrate services with an eye toward helping the whole person. The medical home must use evidence-based medicine and continuous quality improvement and will be financially rewarded for providing added value via these sorts of services.⁸⁶

In variations on the theme, bundled payments for major units of service, such as a surgical procedure or even the care of patients with a chronic illness like diabetes, provide incentives for physicians, hospitals, and other providers to work together in ways that demand quality and accountability from all.⁸⁷ Likewise, hospitals are increasingly purchasing physician practices, both primary care and specialty.⁸⁸ Here, the hospital investigates the physicians' practice quality as part of its own due diligence and will customarily require data of far better quality than clumsy NPDB reports. These in-

84. U.S. DEP'T OF HEALTH & HUMAN SERVS., MEDICARE HOSPITAL VALUE-BASED PURCHASING PLAN DEVELOPMENT: ISSUES PAPER (Jan. 17, 2007), http://www.cms.gov/AcuteInpatientPPS/downloads/hospital_VBP_plan_issues_paper.pdf; see also Press Release, Hall Render, CMS Proposes Rule to Implement Value-Based Purchasing Program for IPPS Hospitals (Jan. 21, 2011) (on file with author). See generally VALUE BASED PURCHASING AND HEALTH CARE REFORM, <http://www.valuebasedpurchasing.com> (last visited Dec. 9, 2011) (providing general information and updates relevant to value-based purchasing and general health care reform).

85. See Thomas L. Greaney, *Accountable Care Organizations – The Fork in the Road*, 364 NEW ENG. J. MED. e1(1) (2011); Mark C. Shields et al., *A Model for Integrating Independent Physicians into Accountable Care Organizations*, 30 HEALTH AFF. 161 (2011); Anna D. Sinaiko & Meredith B. Rosenthal, *Patients' Role in Accountable Care Organizations*, 363 NEW ENG. J. MED. 2583 (2010); NAT'L COMM. FOR QUALITY ASSURANCE, NCQA PATIENT-CENTERED MEDICAL HOME 2011 (2011), available at http://www.ncqa.org/Portals/0/Programs/Recognition/2011PCMHbrochure_web.pdf.

86. See Carol Carden & Mark Dietrich, *A Valuation Model for the Formation of ACOs*, HEALTH L. WKLY, VOL. 9, Feb. 4, 2011.

87. See Jeroen N. Struijs & Caroline A. Baan, *Integrating Care Through Bundled Payments – Lessons from the Netherlands*, 364 NEW ENG. J. MED. 990, 990 (2011).

88. Robert Kocher & Nikhil R. Sahni, *Hospitals' Race to Employ Physicians – The Logic Behind a Money-Losing Proposition*, 364 NEW ENG. J. MED. 1790, 1791 (2011).

stitutions will continue their peer review processes and must, as always, report adverse actions to the NPDB.⁸⁹ Hospitals and ACOs are much freer to engage in early dispute resolution and use the corporate shield to ensure that their physician employees are not penalized for participating actively in the process.⁹⁰

The highlight of these economic developments is that value-seeking healthcare payors, such as employers, health insurers, and government healthcare programs, provide a substantial incentive to physician groups, ACOs, and other entities to provide high-quality care. Although ACOs and kindred organizations must monitor their providers carefully, this is not accomplished simply by consulting odd malpractice data from a Data Bank that offers at best a mish-mash of largely uninterpretable events. Likewise, hospital peer review continues to be important, but it should no longer be seen predominantly as a traditional hospital committee keeping tabs on medical staff. Rather, the new organizational entities must review physicians' day-to-day performance, including primary care physicians who may never admit patients to the hospital and surgeons who may practice exclusively in ambulatory facilities.

Just as the NPDB's medical malpractice reports are not particularly informative, evidence suggests that they may also be superfluous. The federal government and at least one federal court acknowledge that even if a physician's malpractice payment is not listed in the NPDB, a genuinely problematic physician is nonetheless likely to show up elsewhere in the Data Bank (e.g., with adverse credentialing actions or license restrictions). DHHS has observed that "[p]hysicians with high numbers of Malpractice Payment Reports tended to have at least some Adverse Action Reports and Medicare/Medicaid Exclusion Reports, and vice versa."⁹¹ Indeed, per a report by the GAO to a congressional subcommittee on National

89. 42 U.S.C. § 11133 (2006).

90. See *supra* Part II.

91. 2005 NPDB ANNUAL REPORT, *supra* note 31, at 37; see also 2006 NPDB ANNUAL REPORT, *supra* note 31, at 41 ("[O]nly 65.7 percent of the 525 physicians with 10 or more Malpractice Payment Reports [in the NPDB] had no Adverse Action Reports."). Adverse Action Reports are used by healthcare organizations and state agencies to report an adverse action taken against a physician, dentist, or other healthcare practitioner. See U.S. DEP'T OF HEALTH & HUMAN SERVS., NATIONAL PRACTITIONER DATA BANK GLOSSARY, <http://www.npdb-hipdb.hrsa.gov/resources/glossary.jsp> (last visited Dec. 9, 2011). They may document the (1) suspension, withdrawal, expiration, non-renewal or revocation of the practitioner's license; (2) any adverse action with respect to a practitioner's clinical privileges; (3) professional society membership disciplinary actions; (4) actions taken by the DEA concerning authorization to prescribe controlled substances; and (5) revisions to such actions. See 2005 NPDB ANNUAL REPORT, *supra* note 31, at 6.

Economic Growth, “[i]ndustry experts . . . point[] out that disciplinary actions taken by health care providers and states are better indicators of professional competence than medical malpractice.”⁹²

Similarly, in *American Dental Ass’n v. Shalala*, the D.C. Circuit expressly acknowledged that, even when a malpractice payment does not appear in the Data Bank because the practitioner pays out-of-pocket, “those claims . . . will be reported if they come to the attention of an entity such as a peer review board.”⁹³ Accordingly, permitting self-paying practitioners to avoid a malpractice report to the NPDB “does not fundamentally undermine the Act.”⁹⁴

CONCLUSION

In the final analysis, the foregoing discussion suggests that the HCQIA’s requirement to report medical malpractice payments to the NPDB has worked out rather poorly. Indeed, Sage and colleagues recommend that malpractice reporting provisions be eliminated entirely⁹⁵—a conclusion with which this author agrees.⁹⁶ “[T]he malpractice reporting portion of the NPDB should be repealed. As currently constituted, NPDB reporting discourages set-

92. U.S. GOV’T ACCOUNTABILITY OFFICE, *supra* note 44, at 4.

93. 3 F.3d 445, 448 (D.C. Cir. 1993).

94. *Id.* at 448. Of note, once the *Shalala* court thus circumscribed the requirement to report malpractice payments in this way, Congress could have chosen to amend the statute to require that any payment by an “entity or person” must be reported. Congress chose not to do so, and that decision cannot be construed to be accidental.

95. Sage et al., *supra* note 5, at 1307. “Overall, however, it is likely that patients would be better off if the malpractice reporting provisions of the NPDB were repealed, not least because NPDB information appears to be of limited utility for purposes of rating physician quality.” *Id.* at 1300 (citations omitted).

96. Indeed, as Congress contemplated whether to include malpractice reports in the NPDB, it recognized the limited quality of such data:

With all of its faults, the malpractice system has been the primary approach that aggrieved patients have taken to deal with inadequate medical care. Accordingly, malpractice data can provide important clues for evaluating the credentials of health care practitioners. . . . [T]he Committee is well aware that malpractice data provide only clues, not conclusions. Any number of considerations other than the merits of a claim can affect the size and frequency of malpractice payments. The sympathy generated by the severity of an injury, the attractiveness of a claimant, the skill of a claimant’s attorney, the demands of a busy medical practice and the unpredictability of juries can all lead health care practitioners to settle cases or lose verdicts with respect to medical services that meet or exceed accepted standards of medical care. Furthermore, even a legitimate malpractice claim does not automatically mean that a practitioner deserves disciplinary action. Any practitioner—even the most skilled and careful—can make an occasional mistake. . . .

H.R. REP. NO. 99-903 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6384, 1986 WL 31972.

tlements of claims, impairs openness, prompts defensive medicine, and tempts hospitals to help physicians evade reporting—all without providing useful aggregate data that furthers performance improvement.⁹⁷

The NPDB's problems are myriad. First, the malpractice reporting requirement may actively thwart the HCQIA's goal of promoting quality improvement. It encourages physicians to prolong litigation and thereby discourages the multi-faceted communication that is essential to understand and remedy the root causes of an adverse outcome. Indeed, a breakdown in doctor-patient communication is what prompts many patients to sue in the first place. Moreover, physicians' NPDB-based reluctance to enter into early resolution can impair the ability of hospitals to create broad, problem-solving settlements—an approach that has been shown to arrive at fairer results for patients and families, save considerable expense, and redirect litigation defense funds toward quality improvement efforts.

Second, the NPDB's medical malpractice reports suffer from a host of distortions and inaccuracies that render them, at best, difficult to interpret and, at worst, effectively meaningless. Those problems include the following:

- Most filed claims are not related to negligent iatrogenesis, and most negligent iatrogenesis does not result in a filed claim.⁹⁸
- The reporting requirement is essentially unenforceable.⁹⁹
- While some reports reflect payments for malpractice, others reflect exclusively an insurer's decision to avert a costly trial by settling a claim, and there is no way to discern from the reports whether the patients' claims were meritorious.¹⁰⁰
- Although every medical malpractice payment must be reported for private practice physicians, government-employed physicians are reported under completely different standards, while sovereign and charitable immunities introduce further imbalance.¹⁰¹

97. Sage et al., *supra* note 5, at 1307.

98. *See supra* Part IV.A.

99. *See supra* Part IV.C. HRSA acknowledges that enforcement is prohibitively costly when compared with the \$11,000 penalty that would be garnered from a success, and more importantly, there is no way to ascertain whether or when a medical malpractice payment has been made, other than to compare it with a completely voluntary and therefore unreliable outside database. *See supra* Part IV.C.

100. *See supra* Part IV.D.

101. *See supra* Part IV.E.

Third, the very purpose of collecting medical malpractice data—to inform hospital peer review committees in their credentialing and peer review decisions—has become largely anachronistic. Although hospital peer review remains an essential element of quality and safety improvement, hospitals are no longer a key locus that can be counted on to monitor virtually every physician. In current health care, broader consortia of providers, such as ACOs and integrated networks, have significant and growing financial incentives to ensure that their practitioners provide high-quality care. It is a redirection of energy, from emphasizing the errors of individual practitioners to using adverse events as a fulcrum for improving the quality of care as a whole.

From these observations, we may conclude that the optimal course would simply be to delete medical malpractice payments from the Data Bank altogether. They appear to do distinctly more harm than good. This would take an act of Congress, however, which may or may not happen in the near term. Short of congressional action, it is appropriate for practitioners and their insurers to take advantage of every lawful opportunity to avoid reporting malpractice payments to the Data Bank—that is, to welcome efforts by plaintiffs and attorneys to make their claims orally, to work with hospitals and other institutions who can invoke the corporate shield as part of a global resolution to a case, and to refrain from needlessly reporting payments made during a pre-suit notification period. Plaintiff attorneys should be encouraged to use oral communication whenever possible, and when they file a pre-suit notice, to do so using the language of “potential” or “possible” claim, not of “claim” simpliciter. Physicians likewise should be encouraged, under appropriate circumstances, to approach their patients with disclosure and offers of resolution, an act that in many instances will obviate any need for the patient to make a “written claim or demand for payment.”¹⁰²

With conscientious use of the HCQIA’s available flexibility, physicians can participate far more actively and with considerably greater ease than they do at present in early dispute resolutions that promote fairer settlements for patients and families, save on defense costs by avoiding needless litigation, and redirect energies toward systematic quality improvement. Dodging the NPDB can indeed be virtuous.

102. 42 U.S.C. § 11151(7) (2006).