REFORMING THE NATIONAL PRACTITIONER DATA BANK TO PROMOTE FAIR MED-MAL OUTCOMES

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In 1990, the federal government created a clearinghouse to track, among other things, all medical malpractice payments made in the United States. Congress created the National Practitioner Data Bank (NPDB) as a repository to hold information about individual doctors’ malpractice and disciplinary histories. Doctors’ NPDB files, while not visible to the public, are available to medical organizations. The availability of doctors’ NPDB files aid medical organizations in making better hiring decisions, as well as preventing incompetent doctors from moving from state to state in the hope of escaping local regulators.

The NPDB’s existence, though, has become a significant barrier to malpractice claims settlement. Many doctors fear being listed in the NPDB and this has significantly diminished the likelihood of payment when a claim is made (a claim made post-NPDB is only 59% as likely to attract a settlement as a pre-NPDB claim). Fear of being listed in the NPDB has resulted in a culture of evasion and exploitation of reporting loopholes that weaken the NPDB’s data collection efforts.

This Article argues that, while the NPDB seeks to protect potential malpractice victims from inept doctors, part of the cost has been borne by actual malpractice victims. These patients are now more likely to go without compensation because payments would create a paper trail of past performance that some doctors are unwilling to allow to exist. This article tells the story of the NPDB – and organized medicine’s response to it – and

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argues for improvements to remove barriers to fair compensation and to improve the NPDB’s ability to track malpractice data.

I. INTRODUCTION

On May 16, 2009, Samuel Sweet, a 62-year-old husband, father, and grandfather, Marine Corps veteran of Vietnam, and Pennsylvanian, died. He went to a Pittsburgh hospital reporting a severe headache that ultimately proved to be a subarachnoid hemorrhage. Though typically a treatable condition, Sweet died at the hospital from what his family alleged was a combination of errors made by the doctors and nurses responsible for his care. The family alleged, among other things, that Mr. Sweet was not properly intubated, which, coupled with a series of errors in judgment regarding the intubation, resulted in his death. The evidence also showed that, after causing Mr. Sweet’s death, hospital staff attempted to falsify his medical records in an effort to cover-up their mistakes. Attempting to cover up what happened by altering Sweet’s record was “a serious claim that, if proven, could result in state sanctions against the staff members beyond any award in the civil case.”

After becoming aware of the circumstances of Samuel’s death, the Sweets filed a lawsuit against the four medical providers whose negligent care allegedly caused it. The suit alleged that while Sweet was in respiratory distress, a nurse improperly administered a tranquilizer that stopped his breathing. Further, Sweet’s family claimed the doctors and nurses wrote notes stating Sweet refused intubation until it was too late, attempting to place the blame on the patient, rather than the caregivers. In 2012, their case resolved with a court-approved settlement.

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3 Id.
4 Id.
5 Id.
6 Id.
7 Id.
The end of the Sweet family’s tragedy is the beginning of this article. After the family agreed to resolve the claim, but before they were compensated, lawyers for the hospital contacted them asking that they remove the names of the four individual defendants from the settlement agreement.9 “UPMC [Presbyterian hospital] asked, and the Sweets didn’t oppose, a request to remove all four doctors as defendants in the case.” Instead, the hospital’s lawyers wanted only the hospital to be listed as the party responsible for making the settlement.10 UPMC’s spokesman, Paul Wood, claimed that the four providers were dismissed because the actions in the case were not due to any one physician, but in effect, this meant that the only defendant officially held responsible was the hospital. Had the hospital admitted that the removal of the individual was done as a condition of settlement, then the report would have been reportable. 

The reason: by strategically manipulating the parties on whose behalf the settlement was made, the individuals involved with Mr. Sweet’s death could exploit a technicality and avoid being reported to the federal entity designated to track all malpractice payments – the National Practitioner Data Bank (“NPDB”).11 While this article focuses on the reporting of medical malpractice payments, the NPDB must also be informed of other actions. For example, state licensing boards must report disciplinary actions; hospitals and other health care facilities must report suspension, restriction or surrender of clinical privileges as a result of investigation; professional societies must report review actions related to professional competence that adversely affected membership; and the Department of Health and Human Services must report exclusions

9 Id.
11 Health Care Quality Improvement Act of 1986, Pub.L. No. 99-660, 100 Stat. 3743 Sec. 425 (1986) (HCQIA) (codified at 42 U.S.C. §§ 11101-11152 (2011)). NPDB Guidebook, supra note 9, at E-13. Although not the focus of this article, peer review reporting is an area in drastic need of reform. According to Public Citizen, peer review reporting is one of the most important and most misunderstood Medical Practice Act requirements. Alan Levine and Sidney Wolfe, MD, Hospitals Drop the Ball on Physician Oversight, May 27, 2009, pp.2, 5, 16-18, 21, available at: http://www.citizen.org/documents/18731.pdf. The scope of the apparent intentional gaming to avoid peer review sanction-reporting is staggering: after 17 years of existence, almost half of all hospitals in the United States have never reported a single privilege sanction. Id. Prior to the opening of the NPDB, the federal government estimated that 5,000 reports would be submitted every year. The health care industry estimated 10,000. Id. The actual number proved to be 650; or one-sixteenth of the industry’s own prediction. Id.
from Medicaid/Medicare and other federal programs. The effect of the scheme was the prevention of the doctors’ and nurses’ future employers from ever knowing of, or investigating, their role in Samuel Sweet’s death.

The specific ploy used by the defendants is called “corporate shielding,” and it is estimated to be used in up to 50% of all malpractice settlements.12 It is not the only trick used to bypass NPDB reporting, and those interested in using these self-serving methods need not search far to get instruction.13 The venerable American Medical Association’s (AMA) own website, for example, once gave advice to readers on “how to evade a report to the NPDB.”14

The Sweets’ may have perceived that they had a Hobson’s choice to agree with this manipulation of the NPDB as a condition for settlement.15 The Sweets’ attorney suggested that if the family refused to agree to remove a doctor’s name from a settlement, he could make resolution more difficult for the family:

"I've had a number of cases where I know the doctor is responsible for a death or injury and the hospital wants to dismiss him or her," Mr. Perry said. But, he said, since plaintiffs such as Mr. Sweet's wife, Janet, often need the settlement money to pay for the lost income of a loved one or ongoing medical care, "how much do I want to fight?"

Simply put, many insurers and doctors refuse to settle a claim if it means having the negligent doctor reported. A 2003 study showed that within six years of the NPDB’s inception, the probability that an injured patient’s claim would receive payment fell to

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12 See Hamill, supra note 7 (highlighting corporate shield issue as “a known problem for a long time”); see also Lawrence E. Smarr, A Comparative Assessment of the PIAA Data Sharing Project and the National Practitioner Data Bank: Policy, Purpose, and Application, 60 L. CONTEMP. PROBS. 59, 67 (1997) (estimating number of malpractice-payment reports affected by corporate shielding).

13 See Section III, infra, discussing various methods of NPDB evasion.


15 See Hamill, supra, note 7.
59% of pre-NPDB levels. In a separate study, a national insurance organization revealed that 97% of insurers were less willing to settle claims after becoming required to report their insured doctors to the NPDB.

Thus, while the NPDB seeks to protect potential malpractice victims from inept doctors, part of the cost has been paid by actual malpractice victims. These victims are now more likely to go without compensation because payments would create a paper trail of past performance that some doctors are unwilling to allow to exist. Yet, when a doctor does successfully avoid reporting claims to the NPDB, the cost is borne by not only future employers (who must make a hiring decision without crucial information), but the patients who will ultimately be treated by the evasive practitioner.

This article argues that it is time to improve the NPDB reporting in a way that protects injured patients by incentivizing settlement, and also takes meaningful steps to improve the NPDB’s data collection. To do so, it traces the genesis of the NPDB, summarizes the NPDB’s difficulties in maintaining compliance, and explains how opponents of the NPDB have pushed it toward failure. Ultimately, this article concludes with a series of proposed reforms to improve the NPDB’s efforts to collect accurate data as well as increase the likelihood of fair compensation for malpractice claims.

II. THE NPDB’S CONTROVERSIAL GENESIS

Before the NPDB was created, each state was responsible for monitoring its own doctors and there were no formal channels for them to communicate with one another. Before the Health Care Quality Improvement Act of 1986, this information was only available pertaining to the physician’s actions within a certain state. Physician recruiters

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16 Teresa M. Waters et al., Impact of the National Practitioner Data Bank on Resolution of Malpractice Claims, 40 INQUIRY 283, 290 (2003).
18 For the sake of brevity, this article refers to the medical professionals subject to NPDB reporting as “doctors” or “physicians.” However, other medical professionals are also subject to NPDB reporting, including dentists and any individual licensed or authorized by a State to provide health care services. See Department of Health and Human Services. “National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners.” Federal Registrar 75, No. 18 (January 28, 2010). (expanding the definition of health care entities required to report).
and hiring entities were unable to find out if the physician being recruited had any problems in other parts of the country unless disclosed fully by the applicant. This proved problematic.

By way of example, a 1994 Boston Globe investigative report revealed just how easily incompetent doctors could skip from state to state and continue practicing medicine.\(^{20}\) One physician featured in the piece was alleged to have negligently injured five patients in Massachusetts before disappearing from the state, leaving behind a string of pending malpractice cases.\(^{21}\) He left his victims without any chance to recover by choosing not to carry malpractice insurance, and shielded his assets by hiding them in his wife’s name.\(^{22}\) The trail of claims against him in Massachusetts did not prevent him, though, from getting a new job in Georgia.\(^{23}\) Despite the allegations in Massachusetts, he arrived in Georgia with “glowing” references.\(^{24}\) Things eventually soured when the doctor reported to the emergency room while drunk.\(^{25}\) The doctor then left Georgia for Pennsylvania, where he got yet another new job as a doctor and began, once again, to treat patients.\(^{26}\)

By opening a central repository, Congress hoped the NPDB would prevent this sort of skipping around to avoid state regulators.\(^{27}\) The data bank was created as part of the 1986 Health Care Quality Improvement Act (HCQIA).\(^{28}\) It included a bargain: in exchange for requiring the reporting of all malpractice payments and discipline against


\(^{21}\) Id. at 1.

\(^{22}\) Id.

\(^{23}\) Id. at 2.

\(^{24}\) Id.

\(^{25}\) Id.

\(^{26}\) Id.

\(^{27}\) 42 U.S.C. § 11101(2) (1986) (“There is a national need 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.”); Hearings on H.R. 5110: Before the Subcomm. on Health and the Environment of the House Comm. on Energy and Commerce, 99th Cong., 2d Sess. 99-660, 192 (July 15, 1986) [hereinafter Hearings on H.R. 5110] (“[T]he general public will be better protected when incompetent and unprofessional physicians can no longer simply move from one community to another.”).

physicians, it granted partial immunity to health care entities that conduct peer reviews. The coupling of immunity with required reporting was intended to protect hospitals from charges of malfeasance for reporting information about doctors with imperfect records, while discouraging potential employers from unknowingly hiring incompetent doctors. The NPDB would not make hiring decisions, per se, but if it worked correctly, it would assure that employers had applicants’ complete history of paid claims and discipline.

Although it never purported to do anything but collect information, NPDB was turned into a boogey man by the critics from the outset. They claimed its mere existence would do everything from ruin doctors’ careers to destroy their psyches. Insiders admitted many doctors would put self-interest first if forcing litigation was the only way for them to avoid being reported to the NPDB. Scholars warned that if paying a claim

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29 42 U.S.C. § 11101(a)(D). “[A]ny person who participates with or assists the body with respect to the action, shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action.” Id. This set of provisions was implemented to address a perception that increased peer review would also bring an onslaught of lawsuits brought by physicians against peer review groups, essentially “chilling” the peer review policing process of the medical profession. See Health Care Quality Improvement Act of 1986: Hearings Before the Subcomm. on Civil and Constitutional Rights of the House Comm. on the Judiciary, 99th Cong., 2d Sess., at 34 (Oct. 8 and 9, 1986) [hereinafter Hearings on H.R. 5540]. See also 42 U.S.C. § 11131-11137 (setting forth requirements for reporting). “The Health Care Quality Improvement Act of 1986…authorizes the Secretary to establish (either directly or by contract) a National Practitioner Data Bank (NPDB) to collect and release certain information relating to the professional competence and conduct of physicians, dentists, and other health care practitioners.” 45 C.F.R. § 60.1.

30 See Hearings on H.R. 5110, supra note 26, at 193 (“This provision prevents incompetent doctors from moving from State to State and continuing to endanger the lives of patients.”).

31 Susan L. Horner, The Health Care Quality Improvement Act of 1986: Its History, Provisions, Applications and Implications, 16 Am. J.L. Med. 453 (1990). During debate over the bill that ultimately created the NPDB, Representative Waxman noted that “some physician groups are concerned that a central data bank of disciplinary actions and malpractice claims would pose a threat to the medical profession, particularly if that central repository is at the Department of Health and Human Services.” Hearings on H.R. 5110, 99th Cong., 2d Sess., supra note 26, at 366 (1986); see Scott Stephens Thomas, An Insurer’s Right to Settle Versus Its Duty to Defend Nonmeritorious Medical Malpractice Claims, 16 J. LEGAL MED. 545, 546 (1995) (“settlement may severely harm the defendant physician because of a federally mandated reporting … to the National Practitioner Data Bank, and a potential increase in medical professional liability premiums or an inability to secure such liability insurance coverage.”).

32 See Rolph, Kravitz, McGuigan, Malpractice Claims Data as a Quality Improvement Tool II: Is Targeting Effective?, 266 J. AMER. MED. ASSOC. 2093 (1991) (suggesting reporting requirements should be reevaluated). “We already know the data bank has had the unintended effect of making physicians reluctant
meant that others would become aware of it, doctors would fight hard to avoid doing so.\textsuperscript{33} Implicit in these arguments was the refusal of some doctors to settle valid claims, even if that meant patients injured by negligence would never be compensated without the time, expense and pressure of a trial. Congress noted the threat when considering creation of the NPDB:

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 faced with the certainty that they can no longer hide their past records, physicians facing disciplinary action will feel compelled to challenge vigorously any action taken against them.\textsuperscript{34}
\end{quote}

To discourage non-compliance, the NPDB rules imposed a $10,000 fine for any failure to report a malpractice payment.\textsuperscript{35} 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, in the entire history of the NPDB, levied a single fine against any person or entity for failure to report a malpractice claim.\textsuperscript{36}

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\textsuperscript{33} See Ryzen, supra note 27, at 428 (“[p]hysicians may be less willing to settle cases, and evasive settlements may be increasing”). It was predicted that the reporting requirements would have an adverse impact on some physicians, their willingness to pay a claim, and their tendency to utilize defensive medicine practices. See id.

\textsuperscript{34} H.R. REP. NO. 99-903, at 3 (1986), reprinted in 1986 U.S.C.A.N.N. 6384. Physicians often react to malpractice suits in a vigorous way, seeking to gain not only a defense verdict, but also vindication against possible harm to reputation. See Waters, supra note 15, at 283-90 (analyzing influence of NPDB reporting on physician decision to fight rather than settle).

\textsuperscript{35} 42 U.S.C. 11131 (c).

\textsuperscript{36} Letter from Thomas Flavin, Freedom of Information Officer, Health Resources and Services Administration, Department of Health Human Services (September 25, 2012) (on file with author).
HHS has always been on the defensive with respect to the NPDB. During the congressional hearings on its creation, critics proposed most any alternative they could imagine to kill the creation of a central data bank. As alternatives, they proposed strengthening state licensing boards, improving state peer review and risk management programs, and making certain insurance company information available to disciplinary agencies.

Congress did not accept the premise that patients could be protected without the NPDB. As one congressman explained, state licensing boards, hospitals and medical societies had already proven incapable of self-policing involving malpractice. As one congressman pointed out, “even the most diligent hospital [could not] obtain adequate background about physicians applying for privileges at its facility.” The idea that states or medical societies and insurers would magically begin exchanging this sort of information without the NPDB seemed unlikely.

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37 Hearings on H.R. 5110, supra note 26, at 457. An AMA representative stated that the organization “[does not] think it 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, might be subject to Freedom of Information Act, request would be poorly understood, would not be necessarily verifiable, could not be analyzed.” Id. See id. at 74, 87 (providing AMA legislation proposals to include funds for state licensing boards to retain more authority). “[T]hese boards must have adequate resources to fulfill their…investigative and disciplinary…functions.” Id. at 87; see also id. at 111 (listing ABA recommendation for “increased funding to strengthen medical licensing and disciplinary boards at the state level”).

38 See id. at 87-88 (AMA). The AMA encouraged the promulgation of state requirements for risk management systems, as well as physician peer review, as a condition of maintaining insurance. Id. The ABA also endorsed efforts to implement effective risk management programs and peer review. See id. at 92 (“We endorse the American Medical Association’s…efforts to implement effective risk management programs in the delivery of health care services.”).

39 See id. at 71 (AMA) (recommending access to insurance company files).


41 “One of the reasons we favored a central repository was that there was not sufficient exchange of information among state licensing agencies to facilitate timely access to information on practitioners.” Hearings on H.R. 5110 at 422 (statement by Director of HHS, Richard Fogel). “States found it difficult to take quick, appropriate actions against those who move from one State to another.” Id.
Once apparent that the NPDB would be created, opponents changed tactics and sought to weaken it. They urged that the data bank add a “threshold,” which would prevent it from collecting data on small malpractice payments. The most commonly stated argument in favor of thresholds was that small payments are often made to avoid the cost of defending a case as opposed to evidence of an act of malpractice. It would also, of course, keep fewer doctors from being reported.

Threshold proponents did not suggest how they would deal with the reporting of low-value payments that did result from clear malpractice. For example, an HHS official explained that if a $50,000 threshold was to be instituted, it would eliminate virtually all dental claims. Simply stated, because damages tend to be small in some claims—regardless of level of culpability—the threshold would prevent future employers from being aware of those claims.

Congress ultimately chose not to incorporate a threshold, recognizing that a significant number of small settlements result from authentic negligence with modest damages suffered by the patient. As a consolation to critics, HHS wrote into the NPDB’s regulations that “a payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has

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43 See Hearings on H.R. 5110, supra note 26, at 373 (statement of Jerome Bettman, Chairman, Ethics Committee of the American Academy of Ophthalmologists) (“We are trying to eliminate all the small claims simply because they represent just simply settlement, the nuisance value of defending a case, trying to get some common ground where you could eliminate the majority of those type of settlements.”); id. at 313 (statement of Jack W. Owen, Executive Vice President, American Hospital Association) (proffering claims up until $10,000 “nuisance kind of claims”); id. at 313 (statement of Mr. Horty, President, National Council of Community Hospitals) (suggesting claims under $25,000 be excluded).


45 See Hearings on H.R. 5110, supra note 26, at 14 (“...a significant number of small payments may, notwithstanding the sums involved, represent truly meritorious claims.”). “Implementing reporting thresholds based on an assumption that ‘small’ payments represent settlements for convenience may have unexpected and unfortunate results.” See Josef E. Fischer, National Practitioner Data Bank: The NPDB and Surgical Residents (Letters to the Editor), 82 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS 1 (Jan. 1997), available at http://facs.org/ahp/proliab/0197art.html.
occurred." This caveat, though, has proven virtually meaningless; even high ranking HHS officials associate a report in the data bank with stigma for any doctor named in it.

III. THE BASICS OF THE NPDB’S OPERATION

For all of the concern it has raised, the NPDB's authority is very narrow. It does only two things: it collects information about medical providers, and it disseminates that information to a limited community authorized to view it. It does not sanction any doctor, nor does it draw any conclusions about the significance of the data it collects. This section summarizes the nitty-gritty of the NPDB’s functions.

A. QUERYING THE NPDB

Information from the NPDB about individual doctors is visible only to a closed-universe of users and is completely hidden from and inaccessible to the public.
Individuals allowed to view reports are subject to a $10,000 fine if they fail to keep the information confidential.\(^{49}\)

Only hospitals - and no other person or entity - must query the data bank.\(^{50}\) They are to do so when they are (1) considering hiring or granting clinical privileges to a health care practitioner and (2) as a follow-up for those practitioners every two years after they have been hired.\(^{51}\) Other health care entities (including HMOs and group medical practices, as well as professional medical societies and state licensing boards) are authorized to query the data bank, but not required to do so.\(^{52}\) Individual providers are also, of course, entitled to self-query.\(^{53}\) Other than the entities listed above, the only other group that can ever query a provider’s name is plaintiffs’ attorneys.\(^{54}\) However, they are rarely allowed the opportunity and do so under tightly-controlled circumstances.\(^{55}\)

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Kramer, HHS Spokesman). This move caused a firestorm of criticism. Id. The Public Use file was restored after a few months, with a new requirement that anyone downloading the file not use it to try to identify practitioners. See http://www.npdb-hipdb.hrsa.gov/resources/publicData.jsp (providing new requirements for use of Public Use file); see also E-mail from Robert Oshel, Ph.D., former Associate Director for Research and Disputes for the NPDB, to the author (June 1, 2013, at 6:15 pm) (on file with author) [hereinafter “Oshel e-mail”].

\(^{49}\) 42 U.S.C. § 11137(b)(2).

\(^{50}\) See 45 C.F.R. §60.12 (2010) (listing information that hospitals must request from NPDB); see also, supra note 9, at D-4.

\(^{51}\) NPDB GUIDEBOOK, supra note 9, at D-2

\(^{52}\) See NPDB GUIDEBOOK, supra note 49, at D-3 (listing health care entities that may, but are not required to, query the NPDB).

\(^{53}\) See id. (stating physicians, dentists, and other health care practitioners may query their own files).

\(^{54}\) See NPDB GUIDEBOOK, supra note 9, at D-4 (“Plaintiff’s attorney or plaintiff representing himself or herself who has filed a medical malpractice action or claim in a State or Federal court or other adjudicative body against a hospital [may query] when evidence is submitted to HHS which reveals that the hospital failed to make a required query of the NPDB on the practitioner(s) also named in the action or claim”).

\(^{55}\) See 45 C.F.R. §60.13 (a)(1)(ii); NPDB GUIDEBOOK, supra note 9, at D-4. Defense attorneys are not, however, permitted access to the NPDB because the defendant doctor is permitted to self-query. NPDB GUIDEBOOK, supra note 9, at D-6. A plaintiff, through his or her attorney, can obtain NPDB information in a case in which both an individual provider and a hospital are defendants. NPDB GUIDEBOOK, supra note 9, at D-5. If the plaintiff has evidence that the hospital failed to query the NPDB regarding the provider involved in the allegedly substandard care, the plaintiff may request a query of the NPDB to see that provider’s record. NPDB GUIDEBOOK, supra note 9, at D-6. The absence of a hospital query to the NPDB would, presumably, evidence the hospital’s failure to perform due diligence. NPDB GUIDEBOOK, supra note 9, at D-6 (“[I]nformation...can only be used with respect to a legal action or claim against the hospital, not against the subject.”). Any misuse of the information by the attorney is subject to a fine. Id.
B. REPORTING TO THE NPDB

Any time an insurer, hospital, or other entity makes a payment on behalf of a doctor as a result of a written claim, or in satisfaction of judgment, that paying entity must report it to the NPDB.\(^{56}\) There is no minimum threshold that triggers reporting - even a settlement of one cent, if paid as a result of a written claim, must be reported.\(^{57}\)

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\(^{56}\) 42 U.S.C. § 11131(a) provides:

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, in accordance with section 11134 of this title, information respecting the payment and circumstances thereof.

Though the triggering event for NPDB reporting is when a report is made on behalf of a doctor, some doctors have direct authority to determine if their insurer settles a claim on their behalf, regardless of fault. Those whose insurance contracts include “consent to settle” clauses can prevent case resolution even when a settlement is within an insured’s policy limit and the insurer wishes to settle (thus, preventing them from suffering any personal financial loss). See generally Thomas, supra note 30 (surveying consent-to-settle law and impact of NPDB); cf. 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, 1288 (2006) (‘…disclosing settlements is particularly contentious because many malpractice insurance policies allow the insurer to settle without the physician’s permission. On the other hand, excluding settlements … allows physicians to evade reporting by settling suits confidentially.’). Typically, unless a physician has a specific consent-to-settle clause, the insurer may settle a claim as it deems expedient and in its self-interest, so long as it acted in good faith. Id. Insurers are not required to take reputational harm into consideration when considering a settlement; it is a purely business-based decision. Id. In light of public policy concerns, some states have prohibited the use of consent-to-settle clauses, seeking to reduce the number of cases reaching trial and rationalizing that it is best to settle medical malpractice claims outside the courthouse. See, e.g., Fla. Stat. § 627.4147; Md. Code Ins. § 19-104 (2013). Florida, for example, codified the prohibition against such clauses in the interest of protecting an insurers’ ability to limit liability through settlements that are within policy limits. Freeman v. Cohen, 969 So.2d 1150, 1156 (Fla 4th Dist. Ct. App. 2007) (Klein, J. concurring). If physicians are able to bring claims against insurers for settling a claim that is within their policy based on reputational arguments, insurers would find that potential liability on a given claim may far in excess of policy limits, due to the risk of suit against them by their insured for settling a claim without consent. Id.;Florida’s statute forbids these clauses, stating “[i]t 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 arbitration made pursuant to s. 766.106, settlement offer, or offer of judgment, when such offer is within the policy limits. See Fl. Stat. § 627.4147(b). Similarly, Maryland passed a law prohibiting the inclusion of consent-to-settle clauses to incentivize arbitration of claims, rather than litigation. Kevin G. Quinn, The Health Care Malpractice Claims Statute: Maryland’s Response to the Medical Malpractice Crisis, 10 U. Balt. L. Rev. 74, 78-79 (1980) (discussing reasoning behind
The report must be made whether or not the doctor on whose behalf a payment is made, or the actual payer, believes the act was one of malpractice (as opposed to, for example, being paid out of convenience). The report must include a detailed narrative explaining a description of patient, the patient’s medical condition, the acts or omissions that triggered the complaint, the allegations, and legal outcome. Though it has never been enforced, a penalty of up to $11,000 can be assessed for a failure to report.

Once in the system, NPDB reports are not permanent unless there has been a determination that the report should not have been filed. If there is an error, a doctor can legislation). Maryland also considered such concerns as jury inadequacy, emotionalism, and long delays in resolution in passing the prohibition. Kevin G. Quinn, The Health Care Malpractice Claims Statute: Maryland’s Response to the Medical Malpractice Crisis, 10 U. Balt. L. Rev. 74, 78-79 (1980). Maryland’s statute requires a health care provider’s insurance policy to include a provision that “authorizes the insurer, without restriction, to negotiate and effect a compromise claims within the limits of the insurer’s liability, if the entire amount settled on is to be paid by the insurer.” MD. CODE INS. § 19-104 (2013).

58 See 42 U.S.C. § 11131 (requiring any medical malpractice payment to be reported).

59 See id. (mandating reporting of all settlements or judgments, indistinguishable of reason why payment was made). A disclaimer is included for this reason, stating that “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 professional conduct of a practitioner.” See NPDB GUIDEBOOK, supra note 9 at E-9. Additionally, reporting entities must provide a detailed narrative describing the events, which includes associated legal issues outcomes. Id.

60 NPDB GUIDEBOOK, supra note 9, at E-9. Descriptions cannot include patient names or names of other practitioners, plaintiffs, witnesses, or any other individuals involved in the case. Id.

61 45 C.F.R. § 60.14(b)(c) (1991) (stating Secretary of HHS makes final determination for permanent reports); see also Ryzen, supra note 27, at 420-421 (“The Secretary will [after a report dispute is filed] either change the entry or, if the entry is deemed accurate, insert it into the physician’s permanent file along with the physician’s statement of dispute”).

Though typically permanent, reporters can "void" a report they filed at any time and remove it from the NPDB. E-mail from Robert Oshel, Ph.D., former Associate Director for Research and Disputes for the NPDB, to the author (June 17, 2013, at 1:58 pm) (on file with author). To do so, they must conclude that the report should not have been filed. Id. This sometimes happens as a result of pointed questions raised by the Division of Practitioner Data Banks during the Secretarial Review process. Id. Also, the Division can and does remove ("void") reports found through the Secretarial Review process if the reporting entity does not void them. Id. When a report is voided, any entity which has received a copy of the report is notified
contact the reporting entity to request a correction; if the entity declines, the physician can petition the NPDB to append a personal statement clarifying the report.\textsuperscript{62}

IV. THE MISUSES AND ABUSES OF THE NPDB

Although the law creating the NPDB was passed in 1986, the Data Bank did not actually begin collecting reports until 1990 and implementation of its computer system was completed.\textsuperscript{63} When it finally started operating, many of the predictions of gaming proved true. A 1992 report found that many doctors had already adopted a “scorched earth” approach to the NPDB, refusing to settle any claims and insisting on all cases going to trial.\textsuperscript{64}

By then, it was apparent that loopholes in the regulations had been identified and exploited to avoid reporting.\textsuperscript{65} Defense attorneys were reportedly insisting on verbal demands, instead of written ones, to escape reporting because only written demands resulting in a payment required a report.\textsuperscript{66} By 1992, medical facilities were already using corporate shielding tactics by dropping doctors before any settlement was paid so it that the report has been voided and removed from the NPDB. Id. They are instructed to remove any copies of the now-voided report from their files. Id.

\textsuperscript{62} See 45 C.F.R. § 60.16 (setting forth NPDB dispute process); see also NPDB Guidebook, supra note 9, at F-1 (describing NPDB report dispute process). The subject of a report may not submit changes to the report; instead, he or she must request that the reporting entity file a correction. See NPDB GUIDEBOOK, supra note 9, at F-1. If the entity declines to change it, the subject can then initiate a dispute with the Secretary, add a statement to the report, or both. See NPDB GUIDEBOOK, supra note 9, at F-1. Subjects cannot use the dispute process to protest a payment or appeal the underlying reasons of an adverse action. See NPDB GUIDEBOOK, supra note 9, at F-1. (“Neither the merits of a medical malpractice claim nor the appropriateness of, of basis for, an adverse action may be disputed.”).

\textsuperscript{63} Ryzen, supra note 27, at 421. The long delay was caused primarily by disputes over the proposed rules to govern it. Ryzen, supra note 27, at 421. Things did not get any easier after the delayed opening. On the eve of its operations commencing, the non-partisan General Accounting Office (GAO) released a blistering report, entitled the “National Health Practitioner Data Bank Has Not Been Well Managed.” See generally U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-90-68, NATIONAL PRACTITIONER DATA BANK HAS NOT BEEN WELL MANAGED (1990) (outlining poor development and management of NPDB). The report chronicled the NPDB’s leadership failures, with accusations ranging from contract mismanagement to maintaining insufficient security. Id.

\textsuperscript{64} Ryzen, supra note 27, at 435.

\textsuperscript{65} Ryzen, supra note 27, at 436-438.

\textsuperscript{66} Ryzen, supra note 27, at 436.
appeared that only their hospital-employer was liable. As one attorney put it, “it’s not hard to find settled suits around the nation that have been structured to bypass the reporting requirements.” The situation did not improve in the following years.

With unrelenting gaming of the system, HHS decided by 1998 to reform the reporting requirements to eliminate the corporate shield loophole. They proposed requiring reporting of payments made on behalf of practitioners who provided the care that was the subject of the claim or action, regardless of whether the individual was “named” as a defendant in a settlement. This, HHS theorized, would limit corporate liability.

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67 Ryzen, supra note 27, at 437. The GAO even noted in its 2003 report that “[w]hen physicians are not specifically named in a malpractice judgment or settlement, the related claims are not reported to the data bank, and certain self-insured and managed care plans may be underreported as well.” See U.S. Gov’t ACCOUNTABILITY OFFICE, GAO-03-836, IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE (2003), at 56, available at http://www.gao.gov/new.items/d03836.pdf. It further admitted that “the extent to which this underreporting occurs is not known.” Id.

68 Ryzen, supra note 27, at 437.

69 Shortly after Dr. Ryzen’s article, in 1993, the GAO once again released a report that savaged NPDB management. The report was prompted by “continuing concerns about management of the data bank.” The bluntly-named follow-up report, “National Practitioner Data Bank Continues to Experience Problems,” See generally U.S. Gov’t Accountability Office, GAO-93-1, Health Information Systems: National Health Practitioner Data Bank Continues to Experience Problems (1990), available at http://www.gao.gov/assets/160/152939.pdf. In summary, the report stated:

HHS’ management of the data bank has allowed weaknesses that undermine achievement of a timely, secure, and cost-efficient operation. The data bank usually does not provide users with responses to their queries for several weeks, which in turn delays the granting of privileges to health care practitioners. Further, due to insufficient internal controls, user organizations have, on occasion, received sensitive practitioner data to which they were not entitled. In addition, HHS has inadequately monitored the data bank contractor, which has allowed known automated system problems to persist. Finally, while HHS plans to redesign the data bank, its plans have not incorporated a sound system development approach and are based on funding uncertainties. As a result, HHS may acquire a system that does not address users’ needs. Id. at 2-3.


The proposed regulations would amend the existing reporting requirements regarding payments on medical malpractice claims or actions in order to include reports on payments made on behalf of those practitioners who provided the medical care that is the subject of the claim or action, whether or not they were named as defendants in the claim or action.

shielding, which the agency described as a situation in which parties agreed “to dismiss a defendant health care practitioner from a proceeding, leaving or substituting a hospital or other corporate entity as defendant.”  

As part of this proposal, HHS conceded that their loosely drafted rules were part of the problem and the motivation within the medical industry was “at least in part for the purpose of allowing the practitioner to avoid having a report on a malpractice payment made on his or her behalf submitted to the Data Bank.”

HHS recognized the necessity of this change, explaining that corporate shielding subverts Congress’s intent because it “…makes it possible for practitioners whose negligent or substandard care has resulted in compensable injury to patients to evade having that fact appear in the Data Bank….”

HHS proposed this change with the hope of closing the loophole created by the corporate shielding. The updated advice was added to the guidebook stating “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.”

However, the regulation was toothless because hospitals simply will not admit the doctors were removed as a condition of the settlement. Plaintiffs’ lawyers say that regulation is toothless because hospitals simply will not admit the doctors were removed as a condition of the settlement. See Sean D. Hamill, Removing Doctors in Settlements Can Deflect Oversight, Pitt. Post-Gazette, at A1 (May 20, 2012).

Many saw the proposed change as a threat to due process, in effect turning the insurance companies into the judge and jury. See id. Lawrence Smarr, President of the Physician Insurers Association of America, noted that “[t]he data bank
that requiring reporting of all paid claims would eliminate the unsavory practice of corporate shielding and improve data integrity.\footnote{See 63 Fed. Reg. 71255 (Dec. 24, 1998); see also Joyce Price, Doctors Dispute Complaint Data Bank, THE WASHINGTON TIMES, at A3 (Dec. 26, 1991) available at 1991 WLNR 148602. Thomas Croft, the director of the Division of Quality Assurance for the federal Bureau of Health Professions, stated that the problem with a reporting plan based on malpractice settlements is that, on average, "a payment comes seven years after a claim is filed." Id. Fewer than 20 percent of claims result in lawsuits, and Mr. Croft stated “[o]ne option under consideration is to require reporting all malpractice claims.” Id.}

To avoid unfair results, HHS identified in the proposal an escape valve for the rare situations in which system error, rather than a practitioner, was responsible for injury to a patient. As part of the proposal, to avoid unfair results, HHS even identified an escape valve for the rare situations in which a system error resulted in an injury to a patient, as opposed to an injury caused directly by a practitioner.\footnote{63 Fed. Reg. at 71256: [HHS] does recognize that there are legitimate situations when it is impossible to identify a practitioner(s) for whose benefit the payment was made. For example, a situation could occur wherein a power failure causes a heart monitor to cease functioning leading to an injury or death, which ultimately leads to a malpractice payment. In these very limited circumstances, the Secretary proposes to require that the reporter state the sequence of events that led to the payment, why the practitioner could not be identified, and the amount of the payment. The Department will use this information to identify medical malpractice reporters that appear to make a practice of not identifying specific practitioners.} In the event of an authentic system failure, the reporter of the payment would simply explain the sequence of events and explain why no negligent individual could be identified.\footnote{Id.}

With a proposed rule ready for implementation after a normally-perfunctory comment period, the mess that followed is difficult to fathom. After receiving comments to the proposed rule, HHS decided against immediately finalizing it.\footnote{Id.} As a reason, they explained that “[m]ore than 120 comments on the proposed rule were received…” and “[g]iven the large number of thoughtful comments and the high level of concern that was voiced about the potential impact of the proposal as published, HRSA believes it is has a valid concern that entities are avoiding reporting on practitioners. But they’ve reached the wrong conclusion on how to deal with it.” Id. Additionally, Executive Vice President of the AMA, E. Ratcliffe Anderson Jr., rejected the idea that the loophole even existed, claiming the government had no right to second-guess who a plaintiff decides to sue. Id.

\footnote{Id. Additional, Executive Vice President of the AMA, E. Ratcliffe Anderson Jr., rejected the idea that the loophole even existed, claiming the government had no right to second-guess who a plaintiff decides to sue. Id.}
imperative to gather additional data and conduct further analyses before proceeding.”

Yet there is no evidence that further data was gathered, nor any suggestion that there was further analysis of the issue.

The withdrawal of the rule marked the beginning of a confusing tangle of regulatory process, delay, and, ultimately, failure. On April 17, 2000, HHS announced that a new proposal - a “second notice of proposed rulemaking” - would be issued on May 14, 2001. However, the date passed and none was issued. HHS then announced the new proposal would be issued July 2001. It was not. On December 9, 2002, HHS announced a new rule would instead be proposed in November 2002 (despite November 2002 already having passed). It did not issue. On May 27, 2003, HHS announced the new proposal would issue May 2003. It did not. On June 28, 2004, HHS changed the date to April 2004 (meaning that at the time the announcement was published in the Federal Register, the deadline had elapsed two months prior). No notice was forthcoming. Next, on December 13, 2004, HHS stated that the proposed rule would issue July 2005. On May 16, 2005, HHS reiterated that the new proposal would issue July 2005. For the seventh time, it was not issued as promised.

Without explanation, and with no new proposal released for comment, HHS ceased to list the supposedly revised rule as an “anticipated proposed rule.” Instead, they changed the agenda statement for the rule to a “long-term action.” On October 31, 2005, HHS issued a statement saying that the second notice announcing the proposed rule had “to be determined.” They repeated the claim that the rule was “to be determined.”

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80 Id. The U.S. Gov't Accountability Office’s November 2000 report noted that “[a]lthough HRSA has long been concerned that underreporting weakens NPDB’s reliability, steps for addressing such issues are not part of the agency’s strategic plan. As a result, HRSA’s efforts to quantify or minimize underreporting have been unsuccessful.” U.S. Gov’t Accountability Office, GAO-01-130, Nat’l Practitioner Data Bank: Major Improvements Are Needed to Enhance Data Bank's Reliability 4 (2000), available at http://www.gao.gov/new.items/d01130.pdf.
82 67 Fed. Reg. 74519 (December 9, 2002).
more times on April 24, 2006, December 11, 2006, and April 20, 2007. No new proposal was forthcoming, nor was there ever any information to suggest why it was not. Instead, the proposal has vanished.

During this long odyssey, watchdog organizations were highly critical of the NPDB’s operations. GAO published a November 2000 report entitled “National Practitioner Data Bank: Major Improvements Are Needed to Enhance Data Bank’s Reliability.” The GAO concluded that HHS had long been aware of widespread underreporting of medical malpractice payments, but “the agency has not included steps for addressing underreporting in its strategic plan, nor has it taken a systematic approach to the problem.” The report also chronicled the ill-fated (and at that time, ongoing) attempt to create a new regulation to close the corporate shield loophole. The GAO attributed the failure to bring about this change to “the health care industry,” which “overwhelmingly opposed the proposal….” This report did not provide insights into why the health care industry was able to defeat this rule, nor did it explain why HHS would choose not to pursue needed regulatory reform when the affected industry objected.

NPDB opponents jumped on the GAO report to argue that, instead of being reformed, the data bank should be shuttered. Thomas R. Reardon, MD., a past president of the AMA, called it “seriously flawed.” A past president of the AMA called it “seriously flawed.” In response, defenders of the NPDB recognized the AMA’s criticism as hollow. One medical journal editorial said the AMA’s attitude toward the

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92 Id. at 10.
93 Id.
94 Id. at 11.
96 Id.
97 Id.
NPDB was “a little like the Corleone family complaining about inept police work.” The editorial posited that the real reason for the criticism emanating from the AMA was that:

> [m]any AMA members simply hate the idea that malpractice suits and disciplinary actions against them are recorded somewhere, especially in a national repository. They would much rather toss a stick of dynamite at the databank than take out a wrench and fix it. These doctors have an accomplice in the hospitals that alter the way they discipline their staffs to avoid having to report negative information.

The widespread acceptance of the AMA’s oppose-at-any-cost attitude toward the NPDB was, in part, confirmed by data that revealed dramatic rates of errors and noncompliance with reporting procedures. In addition to widespread underreporting, a study auditing NPDB malpractice reports found that nearly all reports that actually were submitted were incomplete. Of a 250-report sample, only one met the NPDB’s requirements for disclosing the circumstances associated with payments. More than 19 of every 20 reports ignored the required evaluation of whether the doctor being reported met the standard of care.

More than ninety-five percent of the reports in the sample failed to mention whether the standard of care had been considered when the claim was settled or adjudicated, and of the reports that did, only one such noted the actual determination. HHS actually acknowledged that the reports were often incomplete, explaining they are not manually screened before accepted into the data bank. Additionally, 71 of the 250 reports included patient and practitioner names, information that is not supposed to be included in the report.

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99 Id.
100 Id. at 20.
101 Id. at 22-23. (declaring licensure reports inaccurate, inconsistent, and submitted in duplicate).
102 Id at 20.
103 95.6% of the reports failed to include this information. Id. at 20 (”only 1 met NPDB requirements for disclosing the circumstances associated with payments”). Id. at 20-22
104 Id.
Embarrassingly, in addition to private practitioners evading the NPDB reporting requirements, it has become apparent that HHS has failed to maintain NPDB compliance even among doctors employed by HHS itself. HHS oversees hundreds of healthcare providers, including doctors employed by the Indian Health Service and National Institutes of Health. 105 While HHS agencies are not technically subject to report to the NPDB, they have done so since the outset as a result of a policy directive requiring it. 106 A 2005 report investigating these HHS doctors found that over a 15-year period, barely one-third of the NPDB reports that should have been filed actually were. 107

V. INDUSTRY RESPONSE TO THE NPDB’S PROBLEMS

Over the course of its existence, the NPDB has proven ineffective at collecting the information that it is empowered to gather. Worse than that, these failures have made it harder for patients to receive compensation for injuries. It is not simply bureaucratic bumbling behind the NPDB’s problems, though. The next section explains how the medical industry has encouraged this result.

Opponents use impassioned rhetoric to delegitimize the NPDB, calling it a “blacklist,” an “Orwellian nightmare,” “Medical McCarthyism,” “Big Brother,” “Frankenstein,” “scarlet letter,” and akin to “Nazi Germany.” 108 An industry representative used scare tactics when he published a piece thundering that the NPDB was enacted to ruin medical careers, not protect the public. 109 In 2008, Medical Economics ran an article called “Who’s Afraid of the NPDB?” with a subheading stating: “If you’re not, perhaps you should be. A National Practitioner Data Bank listing can wreak havoc on your career.” 110

If these attitudes are truly as prevalent as these headlines suggest, it explains why the creation of the NPDB has led to reduced payment rates for injured patients. It also

106 Id.
107 Id. at 4. HHS doctors reported 257 medical malpractice cases to the NPDB. However, the HHS report determined that as many as 457 additional cases that should have been reported were not.
108 Ryzen, supra note 27, at 444 (1992) (listing negative labels applied to NPDB).
helps to explain why a program enacted to protect patients has proven to be a stumbling block to fair compensation.

Opposition to the NPDB is not just empty rhetoric. Instead, NPDB opponents have mobilized and taught one another loopholes and tricks to beat the system. This section develops a paradigm of the creative, evasive ways identified to bypass reporting requirements and effectively subvert the NPDB’s statutory purpose.

A. CORPORATE SHIELDING

As referenced above, the reporting rules apply to payments made on behalf of an individual for malpractice. However, a payment made solely as a result of a claim against an entity (such as a hospital or group practice) is not reportable. In fact, for a particular provider to be reported for a malpractice claim, 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.” A provider identified in a release, but not in the initial written demand (or as a defendant in a lawsuit), is not to be reported. A practitioner named in the initial claim, but subsequently dismissed and not named in the settlement release, is, likewise, not subject to the reporting requirements. NPDB officials have acknowledged that this ‘corporate shield’ effect may have affected the number of malpractice-payment reports.

This bypass strategy is common where physicians work for an entity that is willing to be held liable for them, such as university hospitals or HMOs. Arguably, the plaintiff is still afforded a fair settlement amount—but the tactic hides a possibly-incompetent physician’s record and subverts the purpose of the NPDB in collecting data on doctors for whom claims are paid.

For some medical facilities, using the corporate shield is a publicized strategy to minimize reporting. The University of Michigan Health System (UMHS), for example, “avowedly uses the corporate shield, and its settlements are generally in the institution's

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112 NPDB Guidebook, supra note 9, at E-8 and E-30, Question 9.
113 NPDB Guidebook, supra note 9, at E-8.
114 NPDB Guidebook, supra note 9, at E-11.
116 Id.
UMHS physicians are employees rather than independent contractors and "reporting of individual caregivers in medical malpractice claims in the National Practitioner Data Bank is rare." UMHS takes advantage of being a self-insured employer and will pay the claim in the entity’s name, even when a doctor is solely responsible. Incompetent physicians are shielded from reporting by virtue of being employed by a willing corporate shill. By so doing, they prevent the NPDB from ever becoming aware of a payment paid as a result of a claim against an individual.

1. Preventing A Written Claim From Arising

To be considered a reportable claim under the NPDB, a claim must be written. Verbal requests for compensation for malpractice are, thus, not covered. Though this loophole seems inconsistent with the NPDB’s goal of identifying doctors making payments for malpractice, it is well-known and broadly exploited. As the NPDB requirements deal explicitly with written complaints filed with an adjudicative body, doctors have been able to circumvent NPDB regulations by negotiating with a plaintiff’s attorney and settling on the basis of an oral complaint. The NPDB even seems to tacitly recommend this technique, stating in its guidebook that “[o]nly payments resulting from written demands are reportable to the NPDB. Even if the practitioner transmits the demand in writing to the medical malpractice payer, the payment is not reportable if the patient’s only demand was oral.”

Some businesses in the insurance industry have constructed entire sets of procedures for exploiting the verbal claims loophole. For example, in Colorado, COPIC Insurance is the state’s largest malpractice insurer and operates an early disclosure and compensation program that allows physicians to escape NPDB reporting because

120 See 45 C.F.R. § 60.3; see also Ryzen, supra note 27, at 436 (discussing practice of defense attorneys to encourage plaintiffs’ counsel to first call to discuss settlement before making written claim).
121 Id.
122 NPDB Guidebook, supra note 9, at E-31.
payment is offered voluntarily before a lawyer is engaged or a claim is filed. If a patient asks that a lawyer write to COPIC to make a demand, they are immediately eliminated from participating in the program.

2. Provider Pays Out-of-Pocket

As originally written, the NPDB’s authorizing statute required each “entity” making a medical malpractice payment to report it. The U.S. Court of Appeals for the D.C. Circuit has read the requirement narrowly to require the reporting of only payments made on behalf of a physician. As a result, a payment made by a doctor him or herself is not considered a payment requiring NPDB reporting. This is true even if that payment is made for a clear act of negligence harming a patient. While not binding precedent outside of the D.C. Circuit, anti-NPDB advocates have broadcasted the advice that doctors who have paid for insurance policies can pay claims out-of-pocket to avoid NPDB reporting.

3. Refunding Money

To be reportable, a money payment must be made and a doctor can avoid the requirement to report a payment by waiving the patient’s debt or refunding payment. For example, the NPDB Guidebook advises that “if a patient has an adverse reaction to an injection and is willing to accept a waiver of fee as settlement, that waiver is not reportable to the NPDB.” However, the authors of the official NPDB Guidebook

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124 In fact, if COPIC becomes aware that the patient hired a lawyer, they are eliminated from eligibility. See Sage, supra note 55, at 1300.
125 42 U.S.C. 11131(a).
127 See Morreim, supra note 116, at 132-33 (detailing mechanism of paying out of pocket to avoid NPDB report); id. at 156 (medical malpractice insurers and other entities should refrain from reporting payments…when a practitioner pays out of pocket).
128 Id. at 296, NPDB Guidebook, supra note 9, at E-12 (2001); 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 note 9, 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.”).
129 NPDB Guidebook, supra note 9, at E-12.
seemingly ignore the subtle implication that a patient’s acceptance of a refund or debt forgiveness somehow makes it less likely that a provider committed an act of negligence.130

4. Pre-Suit Mediation

In theory, a doctor can use a mediation agreement to avoid reporting a payment should the patient be subsequently compensated for malpractice.131 Some facilities have patients sign a mediation agreement before treatment that says that if there is an allegation of malpractice, the parties will mediate.132 Separately, some states require mediation prior to the filing of malpractice claims in court.133

For patients subject to pre-suit mediation, it has been argued that the claim that begins the process is not a “written demand” asking for money for the alleged malpractice, “but simply [a request] for a voluntary conversation whose usual purpose is to avoid litigation.”134 As a result, “the plain language of the statute or contract suggests that an NPDB report is not required. That is, a written demand to discuss does not constitute a written demand for payment. If a settlement ensues, the argument goes that plain language further would imply that the money was not paid in response to a written claim or demand for payment.”135

5. End-Running the NPDB with State Legislation

At least one state, Oregon, has crafted special legislation to avoid practitioners who believe they are liable for malpractice to offer to enter into negotiations for a payment.136 Any resulting payment, by definition in the law, is explicitly not made in response to a written demand.137 The legislative history shows that this was plainly

130 Id.
132 Id.
133 Morreim, Mediating Med-Mal Without the Data Bank Reports at [no page on URL], citing S.C. CODE ANN. § 15-79-125(C); see, e.g., W. VA. CODE, § 55-7B-6(f).
134 Id.
135 Id.
136 2013 OREG. SESS. LAWS Ch. 5 (S.B. 483); see Oshel e-mail, supra note 47.
137 2013 OREG. SESS. LAWS Ch. 5 (S.B. 483); see Oshel e-mail, supra note 47.
The effect is that practitioners can repeatedly negotiate payments stemming from malpractice without ever having to report to the NPDB. The law goes one step further and prevents licensing boards and hospital peer reviewers from using information about these payments to take disciplinary action. Ultimately, the Oregon law facilitates malpractice payments, but does nothing to inform future employers about— or protect the public from— further malpractice by the practitioner.

While those who decry the NPDB will celebrate the identification of these evasion techniques, the overarching issue is how HHS, the agency charged with maintaining the integrity of the data bank and protecting the public, polices such brazen reporting. At times, the HHS has been explicit in their recognition that the NPDB is routinely circumvented and yet, the agency has not reformed NPDB to capture accurate information about malpractice payments. Instead, their response has been to equivocate repeatedly, with the only clear reason being the objections of those the NPDB exists to regulate.

VI. REFORMING THE NPDB

In addition to having problems with data integrity and serving as a barrier to claims settlement, the NPDB has few supporters. It has become one of those rare legal creations that is unpopular both with the medical-insurance community and the plaintiffs’ bar. Its long-term problems and widespread unpopularity forces one to ask a bigger

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138 See Oshel e-mail, supra note 47.
139 2013 OREG. SESS. LAWS Ch. 5 (S.B. 483); see Oshel e-mail, supra note 47.
140 2013 OREG. SESS. LAWS Ch. 5 (S.B. 483); see Oshel e-mail, supra note 47.
141 For example, Seattle’s Pivotal Law Group, published a piece describing its experience as plaintiffs’ lawyers and stating how commonly the NPDB serves as a settlement barrier:

    Based on personal experience in a number of cases, it is not uncommon to encounter a situation where the malpractice carrier and/or defense counsel recommends settlement, but the physician, who may have the right to preclude settlement under the terms of his or her insurance policy and is concerned about the effects of reporting to the NPDB (on obtaining subsequent hospital privileges, licensure issues, and increased malpractice premiums, etc.), refuses to authorize settlement.

question: if the NPDB harms malpractice victims, as well as individual medical providers who refuse to settle a claim due to concern about harm to their reputation, why have the data bank at all? This section asks what should be done to reform the NPDB, or if it should be kept at all.

A. KEEP THE NPDB, OR CLOSE IT DOWN?

There is evidence that the NPDB is meeting its purpose of helping medical employers make better hiring decisions. For example, a 2003 study found that 21% of applicants’ NPDB reports included information that was previously unknown to the querying institution.\textsuperscript{142} This was true “[e]ven when practitioners knew the information they provided would be verified.”\textsuperscript{143} Indeed, the 2003 study’s authors found that although some incompleteness could be attributed to innocent causes, a significant portion of doctors applying for jobs may have been “willfully withholding negative information.”\textsuperscript{144} Put differently, some doctors with a bad history are applying for jobs and misrepresenting their discipline history. The NPDB has helped to make potential employers aware of this information gap in more than one of every five cases. It follows that more complete information has allowed medical employers to make better hiring decisions.

With the size of the medical industry in the United States, the number of medical hiring decisions that the NPDB has protected has been enormous: estimates are that NPDB querying alters 5% of hiring decisions.\textsuperscript{145} Given the size of medical field, this

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\textsuperscript{142} Pivotal Law Group’s recommended course was for plaintiffs to participate in the defendants’ evasion of the NPDB:

Given the disincentives to settlement created by the NPDB reporting requirements, in the authors’ experience it is advisable, where appropriate and supported by the facts and law, to include as defendants hospitals, clinics and other organizations that may have culpability in a medical negligence action – as these parties do not face the same reporting requirements imposed on physicians by the NPDB.

\textsuperscript{143} Id.

\textsuperscript{144} Id.

\textsuperscript{145} Id. “Based on a conservative estimate of 3.2 million credentialing decisions made in the United States [this is the number of queries to the NPDB in 2001], this translates into 160,000 decisions that may have been changed.” Id.
means that 160,000 hiring or retention decisions for medical professionals in the United States are affected annually as a result of NPDB querying. It would be absurd to say the NPDB is not useful in at least some respects with this figure in mind.

Its utility has been directly acknowledged by those making hiring decisions. While some doctors and medical associations howl against the NPDB, hospitals and managed care organizations (MCOs) tend to support it: “[Eighty-three] percent of hospital officials and [ninety-six] percent of MCO officials we surveyed regarded the Data Bank reports they received on practitioners to be useful to them….” Two-thirds of all queries are submitted by voluntary queriers, especially MCOs. It should speak to the perceived usefulness of NPDB reports that voluntary queriers spend millions a year to obtain these reports.

Ultimately, then, the NPDB appears to have some level of effectiveness in helping hospitals make hiring decisions. This important benefit makes protection and improvement of the NPDB worthwhile. However, important changes are needed to improve the ability of those injured by malpractice, for whom the NPDB’s very existence has become a barrier to recovery.

B. HOW TO REFORM THE NPDB

To resolve the problem, there are two types of changes that could potentially impact settlement behavior: changing the way those subject to the NPDB behave, and changing the way the NPDB conducts itself. These changes should be made with an eye toward incentivizing behaviors that treat injured patients fairly while not unduly harming medical professionals, their potential employers, or others with an interest in the NPDB. This section proposes a series of possibilities to do so.

1. Eliminating Corporate Shielding by Switching to an “All Paid Claims” or “All Claims” Reporting System

If the NPDB is to exist, then improving data integrity must be an important priority. If done properly, improving data integrity might ultimately also improve patients’ abilities to receive compensation.

146 Id.
148 See Oshel e-mail, supra note 47.
149 See Oshel e-mail, supra note 47.
The HHS has already proposed one loophole closure: the elimination of the corporate shield.150 By requiring the naming of doctors on whose behalf payments are made, the corporate shield will effectively be destroyed.151 For reasons that are unexplained and, perhaps, inexplicable, HHS never finalized the rule that would have done just this.152 At first glance, closing this loophole seems like a good solution.

The downside of closing the corporate shield loophole is that, while it would help with data integrity, it may further damage injured patients’ ability to receive compensation: If the corporate shield loophole is the nod-and-wink method insurers are using to pay claims without reporting insured doctors to the NPDB, it follow that closing it will have a negative impact on claims payment.

Another option, which resolves the corporate shield problem and would promote fair compensation, would be to require the reporting of all claims made against an individual doctor, whether paid or not. Under this approach, any claim made against a doctor would require a report, even if not ultimately resulting in a payment. This would both reduce gaming and promote resolution of viable claims. Simply put, doctors would not be able to avoid an NPDB report because the decision to make a claim would be solely in the hands of the patients (as opposed to a settlement, which only occurs with the agreement of the insurer and potentially the individual provider; or a verdict, which requires a jury’s approval).

The “all claims” reporting requirement has even received support from some within the medical field as a more honest way to handle reporting.153 It seems likely, though, that the AMA and others would oppose a rule requiring the reporting of all claims. However, it should be understood that requiring reporting of all claims is not a dramatic departure from current practices. First, many state databanks (or regulatory agencies) already require reporting of all claims, and have carried on this practice without

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151 Id.
152 See notes 69-88 and accompanying text.
153 At the NPDB hearings, for example, the President of the American College of Obstetricians and Gynecologists, recommended that “the number of malpractice actions filed be included as reportable events as well, not just the settlements and judgments.” Hearings on H.R. 5110 at 365.
serious issues or challenges for many years. Malpractice carriers and medical employment applications frequently ask about all claims – paid or not - as well.

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154 Any argument that the reporting of all claims, as opposed to only requiring the reporting of paid claims, is novel or radical is simply incorrect. A number of state-level databases have required these measures for decades. See, e.g.:  

**ARK. CODE. ANN. § 17-95-103(a)** (West 2013) (Effective December 31, 2005):  
“Every physician licensed to practice medicine and surgery in the State of Arkansas, within ten (10) days after the receipt or notification of a claim or filing of a lawsuit against him or her with medical malpractice, shall notify the Arkansas State Medical Board of the claim or lawsuit.”

**N.Y. Ins. Law § 315(b)(1)** (McKinney 2013) (Effective October 6, 2000):  
“Each insurance company engaged in issuing professional medical malpractice insurance in this state the medical malpractice insurance association shall file with the superintendent and with the commissioner of health quarterly reports on all claims for medical malpractice made against any of its insureds and received by it during the preceding three month period…”

**N.D. CENT. CODE § 26.1-01-05(1)** (West 2013):  
“A health care provider or the insurer of a health care provider, if any, shall report all claims, settlements of claims, or final judgments against the health care provider to the commissioner.”

**OKLA. STAT. ANN. tit. 76, § 17** (West 2013):  
“Whenever a claim of personal injury is made against any practitioner of the healing arts or a licensed hospital, a report shall be made to the appropriate licensing board or agency by the liability insurer of such practitioner or hospital within sixty (60) days after receipt of information that a claim is being made. In the event that such claim is made against a party not insured, the report shall be made by the party.”

**OR. REV. STAT. ANN. § 742.400(2)** (West 2013):  
“Within 30 days after receiving notice of a claim, a reporter shall report the claim to the appropriate board.”

**40 PA. CONS. STAT. ANN. § 1303.903(1)** (West 2013) (Effective May 20, 2002):  
“A physician shall report to the State Board of Medicine or the State Board of Osteopathic Medicine, as appropriate, within 60 days of the occurrence of any of the following: (1) Notice of a complaint in a medical professional liability action that is filed against the physician.”

**R.I. GEN. LAWS ANN. § 5-37-9(2)(i)** (West 2013):  
“Every insurer providing professional liability insurance to a physician licensed under the provisions of this chapter shall send a complete
Given that doctors already report (or, are at least, are supposed to report) this data to those who would ultimately discover it through an NPDB query, moving to a requirement of reporting “all claims” is not a significant departure from current procedures. It would serve the NPDB’s interests by improving data collection, and it would serve the public’s interest by removing the barrier to settling of viable claims created by the current NPDB reporting rules.

2. Re-Draft Rules to Close Other Loopholes

Section IV of this article describes various loopholes exploited by anti-NPDB people and organizations. The idea that a doctor could pay a malpractice payment out of pocket, or avoiding a written request for money from an attorney, is simply antithetical to the purposes of the NPDB. To improve in this area, HHS should create new regulations that specifically address each “dodge” that has been identified and expressly forbid its practice.

3. Punish Noncompliance with the Law

As it stands, avoidance and evasion of reporting for malpractice payments is so rampant that the NPDB cannot be said to have fully accomplished its purported primary

report to the board presenting any notice of any civil action filed, settlement of any claim or cause of action, or final judgment rendered in any cause of action for damages for death or personal injury caused by the physician’s negligence, error, or omission in practice, or his or her rendering of unauthorized professional services...within thirty (30) days after notice of any civil action filed, settlement, judgment or arbitration.”

“For claims closed or open and pending on or after January 1, 2008...[e]very insuring entity or self-insurer that provides health care liability insurance to any facility or provider in this state must report each health care liability claim to the commissioner...”

“Any insurer writing coverage for health care malpractice in this state, by March 1 of each year, shall file with the commissioner a report of all claims against a health care provider and a report of all awards or settlements given in cases against health care providers.”

155 See supra note 12, Section IV (identifying various dodges use to avoid NPDB reporting)
goal of identifying doctors that commit malpractice. This is made possible, in part, by loose reporting requirements, but also potentially by the government’s inability to police its own data bank as the law requires. For the entire period of its existence, HHS has never levied a single fine against a noncompliant entity. It stands to reason that a more proactive investigative strategy would help to ferret out evaders, as well as to set a tone reflecting that the government takes enforcement of its own regulations seriously.

4. Change Attitudes about NPDB Reporting

The NPDB regulations specifically state 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.” It appears, though, that few who are subject to the NPDB actually believe that. A significant problem arises when this attitude is prevalent and serves as a disincentive to settle colorable claims.

A former HHS executive pointed out that “there’s nothing in a data bank report that a hospital clinical privileges application doesn’t already ask for.” Not only do job applications and applications for medical privileges regularly require information about all claims against the provider, but many state boards also require it. Why should that information being kept more centrally be of concern? Still, doctors make no secret of their discomfort with the idea of being "blacklisted" as a result of a report to the NPDB. This intense fear is misplaced. As a group of patient safety advocates recently stated:

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156 See Sage, supra note 55, at 1299 (“Many providers simply refuse to participate [with NPDB reporting], highlighting the voluntary nature of even mandatory systems.”
157 Letter from Thomas Flavin, Freedom of Information Officer, Health Resources and Services Administration, Department of Health Human Services (September 25, 2012) (on file with author).
158 45 C.F.R. § 60.7(d) (1991). It was not without debate, however: the original draft of the bill introducing the HCQIA did not contain such a provision, but rather was added subsequently to deal with physician’s concerns that payments would be construed as always being synonymous with malpractice. Ryzen, supra note 27, at 429 (1992).
159 See note 152 (listing states that require all claims made—not just paid—be reported).
160 Sandra Tunajek, Dealing with Litigation Stress Syndrome, 61 AANA J. 7 (July 2007) (noting more than 95% of lawsuit defendants acknowledge some physical and/or emotional reaction). “A study concerning the emotional repercussions of litigation reported symptoms of isolation, negative self-image (in particular feeling misunderstood, defeated, or ashamed) … depression, a sense of not being in control, and the
It is important to emphasize that the NPDB takes no disciplinary actions; it merely reports on actions and payments that physicians are already required to disclose in their applications. If a physician with a bad record has problems securing a license or clinical privileges, it is because of the underlying malpractice, privileges, or licensing actions, not because of the NPDB. The NPDB is only a messenger—and it is a messenger who provides new information only when a physician fails to make a required disclosure. In practice this has been shown to be both necessary and very valuable to those querying the databank, who, in one study, told university-based surveyors that nine percent of the time NPDB reports provided new decision-affecting information not disclosed as required in physicians’ applications.  

Doctors should simply reject the idea that a report will harm their career trajectory unless clear evidence is presented that careers are harmed by NPDB reporting. Instead, hyperbole and shocking headline have been simply accepted as being true. That fear would replace reliable evidence is unsurprising given the research showing that many subject to it have a very poor understanding of the NPDB. A 1995 study found that 58% of practicing physicians surveyed did not know the general public does not have associated feeling of helplessness. Id. “Accusations of professional negligence or incompetence are very personal and frightening. The unknown, the anticipated financial consequences, potential loss of one’s career, and guilt and self-doubt have a major impact on the individual’s ability to tolerate the stress of litigation. Id.


163 This is evidenced by the finding that a significant number of doctors misstate or misrepresent their claims history when applying for a job - information that, can, and will, easily be confirmed when an employer queries the NPDB. Teresa M. Waters, et. al, How Useful is the Information Provided by the National Practitioner Data Bank, 29 JOINT COMM. J. ON QUAL. SAFETY 416, 423 (2003) (reporting study results finding 21% of hospitals received “new” information from NPDB queries).

access to the NPDB information. Only 13% knew how to obtain their files. More than 20% of respondents "thought NPDB was an FBI registry of physicians with felony convictions." Though this information is relatively dated, it should be incumbent upon HHS to determine if awareness of the NPDB has changed within organized medicine and, if not, to work to educate doctors.

An attorney for the American Hospital Association believes doctors should not be so fearful of the NPDB: "Do they check the data bank? Yes… Do they make a decision based solely on the data bank? No. It's just another source of information." This message should be repeated, loud and often, by the NPDB, medical associations, hospital administrators, and doctors themselves.

5. Ignore the “Threshold” Red Herring

A 2000 editorial in Modern Healthcare described the medical industry’s view of the NPDB as follows:

Many…simply hate the idea that malpractice suits and disciplinary actions against them are recorded somewhere, especially in a national repository. They would much rather toss a stick of dynamite at the databank then take out a wrench and fix it.

This attitude is emblematic of the approach of threshold proponents. The argument goes that, rather than potentially be asked to explain why a small payment is made on their behalf, doctors should be able to keep those payments secret. In exchange, patients that have suffered modest damages will no longer have their claims held hostage. The stated justification is that some small claims are made “for convenience.”

165 Id. at 202.
166 Id.
167 Id.
170 In 1990, the HHS Office of Inspector General released a report that discussed the viability of imposing reporting floors. Office of the Inspector General, OEl-01-90-00521, National Practitioner Data Bank: Malpractice Reporting Requirements, Department of Health and Human Services: National Practitioner Data Bank: Malpractice Reporting Requirements (1990), available at https://oig.hhs.gov/oei/reports/oei-01-90-00521.pdf. Thirty six of thirty seven insurers (97.3%) who were surveyed were in favor of a reporting threshold. Id. at B-3  The report found that "several insurers believe that a floor would make practitioners
through no proponent of thresholds has ever identified why it is justifiable not to report small claims that result from authentic carelessness.\textsuperscript{171}

Whether employing thresholds would truly have the effect of promoting payment of small claims is unknown. What is certain, though, is that adding a threshold would have negative effects on the databank’s integrity. Doing so would further delegitimize it by making it harder to flag doctors who are incompetent. With thresholds, it is impossible to tell if a small claim was made for negligence if unreported and not subject to investigation by potential employers.

Thresholds would lead to a new set of strategies to avoid the new reporting requirements. This can be surmised from the experiences of states that have added thresholds to their databases. For example, New Jersey has a $25,000 floor in its state malpractice database and found that “many doctors were settling claims for $24,999.”\textsuperscript{172} With this gaming repugnant to the goals of flagging potential negligent doctors, New Jersey repealed its threshold.\textsuperscript{173} Ohio has a similar threshold and has found that "payments under $25,000 often represented settlements designed to avoid litigation costs."\textsuperscript{174} California, which has a $30,000 reporting floor, had 6.8\% of its claims settled for $29,999 and many other claims settled for between $29,000 and $29,990.\textsuperscript{175} The experience in these states give no reason for the belief that institution of a reporting threshold would do anything but lead to further distortions in the information reported to the NPDB, the information that Congress believes is necessary to track. The curious figures also, of course, reflect that the thresholds are leading to distorted payments to injured plaintiffs themselves.

In addition to current methods to dodge reporting, new tricks to game the system would also likely arise, should thresholds be included. One option would be to allocate payments among multiple defendants to keep each of their payment amounts under the threshold.\textsuperscript{176} If, for example, a surgeon, anesthesiologist, and nurse were all named in a

\textsuperscript{171} See Josef E. Fischer, “National Practitioner Data Bank: The NPDB and Surgical Residents” (Letters to the Editor), 82 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS 1 (Jan. 1997), supra note 44.

\textsuperscript{172} Id. at 6.

\textsuperscript{173} Id.

\textsuperscript{174} Id. at 7.

\textsuperscript{175} Id.

surgical malpractice case and the NPDB began using a $50,000 threshold, each defendant could agree to pay $49,999 (therefore a total of $149,997 to the plaintiff) and avoid being reported.

Even among experts, there is no agreement on whether creating a threshold would cause more harm than good. This is true even within HHS. For example, former HHS General Counsel Michael J. Astrue, while serving the agency, favored creating specialty-based thresholds. However, the director of quality assurance at Health Resources and Services Administration (the HHS entity which runs the data bank) said attempting a threshold is an “incredibly complex venture,” that would potentially result in unfair line drawing, as well as an administrative nightmare.

6. Be Open to Changes that Promote Data Bank Integrity

Methods to further reform the data bank should incorporate evidence-based analysis. Researchers should continue to investigate methods to enhance the integrity of the databank as a flagging tool, while improving patients’ ability to recover compensation when entitled by law. Simultaneously, efforts should be made to prevent doctors from being listed if the reporting has no link to proof of their competence to provide future medical care.

To accomplish this goal, the NPDB should be proactive in encouraging researchers to come together to discuss ways to improve the NPDB itself in ways that would benefit the public, individuals harm by malpractice, and medical providers subject to NPDB reporting. However, before such steps should be considered, the NPDB must work to improve the system’s integrity so that it can be certain that it captures the appropriate information while incentivizing the settlement of colorable claims.

VII. CONCLUSION

Reforming the NPDB has proven to be an upside-down process: patient rights and public safety have been relegated to the whims of an industry that would rather that the federal government not regulate it. The effect has been that not only is the NPDB’s data collection suspect, but patients harmed by malpractice are less likely to receive compensation for their injuries.

177 Id. Astrue’s idea was to make the threshold $75,000-$100,000 for neurosurgeons, obstetricians and perhaps other "high-risk" groups; $50,000 for other, physicians; and $20,000-$30,000 for dentists.
178 Id.
Reversing this course should be seen by the federal government as necessary. By changing the NPDB’s reporting rules, as well as working to change the culture around them, the data bank can operate in a way that authentically protects patients, both to prevent malpractice and to promote fair outcomes when it occurs.

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