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Blacklisted: The Constitutionality of the Federal System for Publishing Reports of "Bad" Doctors in the National Practitioner Data Bank

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**BLACKLISTED:
THE CONSTITUTIONALITY OF THE FEDERAL
SYSTEM FOR PUBLISHING REPORTS OF “BAD”
DOCTORS IN THE NATIONAL PRACTITIONER DATA
BANK**

*Katharine A. Van Tassel**

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INTRODUCTION

The United States has a growing number of government-created blacklists,¹ including those for convicted sexual predators, suspected gang members, and suspected terrorists. The latest surprise entry in this trend is the federally created data bank of “bad” physicians called the National Practitioner Data Bank (NPDB).² The NPDB is the first time the federal government has engaged in blacklisting since the McCarthy era. Physicians are blacklisted after being “found” to have provided poor quality of care through a highly subjective, and oft-times summary, peer review process conducted by private hospitals.

Physician blacklisting by the NPDB has become a pressing national issue as it has serious legal and social consequences. First, the physician blacklisting process has a high risk of error as it is both over inclusive, unfairly destroying the careers of many competent physicians, and under inclusive, as it ignores many incompetent physicians. Second, the NPDB reporting system encourages the perpetuation of custom-based practices undermining efforts to improve the quality and cost of healthcare through the practice of evidence-based treatment choices. Third, the NPDB system is being used to silence physician whistleblowers which also negatively impacts quality of care. Finally, last year the NPDB expanded its scope to take on blacklisting of *all* licensed healthcare practitioners in the United States, including dentists, nurses, physicians' assistants, and social workers, extending its reach to over

¹ The term blacklist means “a list of persons who are disapproved of or are to be punished or boycotted.” *Definition of “Blacklist,”* MERRIAM-WEBSTER'S ONLINE DICTIONARY, <http://www.merriam-webster.com/dictionary/blacklist> (last visited Aug. 14, 2011).

² 42 U.S.C. § 11101 (2006); 45 C.F.R. § 60.1 (2010).

six million people.³ This expansion magnifies the NPDB's negative effects exponentially as it begins to affect the practice habits of all healthcare professionals.

In order to highlight the problems with the NPDB, this Article compares physician blacklisting with other forms of blacklisting. For example, both physician and sexual predator blacklisting programs have the same goals: allowing the public to engage in self-protection by preventing "predators" from traveling to new locations to prey on a new group of unsuspecting victims. And both sexual predators and physicians suffer similar stigmatization as the result of the "badge of infamy" that comes with being blacklisted. But this is where the similarities end. Accused sex offenders get all of the trappings of due process to avoid being wrongfully convicted and incorrectly placed on sexual predator blacklists. In contrast, most physicians, who are serving the community, get very few due process protections before being blacklisted. And some physicians are provided no due process rights at all. On the whole, the NPDB fails to fairly protect the liberty and property rights of targeted physicians.

The problems with the NPDB can be resolved by providing physicians, and other healthcare providers, with the same kind of due process protections that are provided to alleged sexual offenders before they are blacklisted. Adding these procedural protections will protect competent physicians from the erroneous destruction of their careers while also increasing the accuracy of the NPDB, which will protect patients from incompetent providers. Overall, the very specific due process protections suggested by this Article will improve healthcare quality, cost, and access.

This Article first provides a brief summary of the history of blacklisting in the United States. Then a comparison is made between physician blacklisting and other forms of blacklisting. This comparison reveals that physicians receive far fewer procedural safeguards than other targeted populations that pose a much greater risk of harm. The next Section explains the NPDB reporting and publishing system in order to then explore its constitutionality by applying the three-part test of *Mathews v. Eldridge*. The *Mathews* test suggests that the NPDB unconstitutionally impacts both the property and liberty rights of the targeted physicians. This exercise also raises startling questions regarding the overall negative impact of the NPDB reporting system on the quality and cost of healthcare, issues of current and pressing national importance. The NPDB reporting system appears to encourage the perpetuation of custom-based practices undermining efforts to improve the

³ BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, CAREER GUIDE TO INDUSTRIES, 2010-11 EDITION (2010), available at <http://www.bls.gov/oco/cg/cgs035.htm> (indicating that the number of healthcare professionals in the United States is 6,283,900).

quality and cost of healthcare through the practice of evidence-based treatment choices. The NPDB system is also being used to silence physician whistleblowers, negatively impacting quality of care. The last Part of the Article suggests that the problems with the NPDB can be resolved by providing physicians, and other healthcare providers, with the same kind of due process protections that are provided to alleged sexual offenders before they are blacklisted. Adding the specific procedural protections suggested by this Article will protect physicians from the erroneous destruction of their careers while also increasing the accuracy of the NPDB and improving healthcare quality, cost, and access.

I. HISTORY OF BLACKLISTING IN THE UNITED STATES

A. *History of Blacklisting:*

General Criminal Registries, McCarthyism, Suspected Gang Members, Suspected Terrorists, and No-Fly Lists

The principal goal of the justice systems of most early civilizations was the achievement of vengeance.⁴ Deterrence was usually a secondary benefit.⁵ In colonial America, the settlers took matters up a notch by making use of shame and shaming in order to both further these goals and to encourage repentance.⁶ The settlers regularly used the simple, but cruel, expedient of physical branding to achieve these goals while also ensuring that members of the community could engage in self-protection.⁷ Branding also meant that potential recidivists could not travel to new communities in order to prey on a new group of unwary victims⁸:

Burglary was punished in all the colonies by branding with a capital B in the right hand for the first offense, in the left hand for the second, "and if either be committed on the Lord's Daye his Brand shall bee sett on his Forehead as a *mark of infamy*."⁹ In Maryland, every county was ordered to have branding irons, with the lettering specifically prescribed: SL stood for seditious libel and could be burned on

⁴ James A. Cox, *Bilboes, Brands, and Branks: Colonial Crimes and Punishments*, COLONIAL WILLIAMSBURG J., Spring 2003, available at <http://www.history.org/foundation/journal/spring03/branks.cfm>.

⁵ *Id.*

⁶ LAWRENCE M. FRIEDMAN, *A HISTORY OF AMERICAN LAW* 69 (2d ed. 1985).

⁷ *Id.* at 69–70.

⁸ Pieter Spierenburg, *The Body and the State: Early Modern Europe*, in *THE OXFORD HISTORY OF THE PRISON: THE PRACTICE OF PUNISHMENT IN WESTERN SOCIETY* 49, 53 (Norval Morris & David J. Rothman eds., 1995) ("[B]randing was a preindustrial method for identifying recidivists.").

⁹ Cox, *supra* note 4 (emphasis added).

either cheek. M stood for manslaughter, T for thief, R for rogue or vagabond, F for forgery.¹⁰

By the early 1800s, branding was seen as socially unacceptable torture.¹¹ Consequently, American society needed a new method for identifying those who posed the risk of criminal harm to others. Establishing this means fell to the police, which, by the mid-1800s, had become more organized, professional, and proactive in the realm of public safety.¹² As described by Professor Peter Becker, “[s]tigma was no longer directly inscribed on the body of the perpetrator, but was rather administered in collections of data by the police.”¹³ This data was initially used by the police to identify repeat offenders for purposes of sentencing and rehabilitation efforts and later to prevent and detect crimes in the community.¹⁴ To further these efforts, the police embraced new technologies as they were developed to create criminal registries with various degrees of success, from photographic technologies,¹⁵ to anthropometry,¹⁶ and finally to dactyloscopy,¹⁷ known now as fingerprinting.

According to Professor Wayne Logan, “[i]n the United States, registration was only haltingly embraced—targeting particular non-criminal sub-populations: emancipated African Americans in antebellum times, German Americans during World War I, and other select subgroups.”¹⁸ However, the 1920s and 1930s brought public anxiety over a perceived crime wave perpetrated by underworld gangsters and

¹⁰ *Id.*; see also CYNDI BANKS, PUNISHMENT IN AMERICA 11 (2005) (“For example, the laws of colonial New Jersey stipulated that a first offense of burglary would be punished by branding the letter ‘T’ on the hand of the accused, and a second offense by branding an ‘R’ on the accused’s forehead.”).

¹¹ WAYNE A. LOGAN, KNOWLEDGE AS POWER: CRIMINAL REGISTRATION AND COMMUNITY NOTIFICATION LAWS IN AMERICA 4 (2009); see also Spierenburg, *supra* note 8, at 52 (noting that punishment in Europe moved from bodily disfigurement to confinement in prisons). In *Wilkerson v. Utah*, 99 U.S. 130 (1878), the Supreme Court commented that punishments involving torture—for example, drawing and quartering, public dissecting, burning alive, or disembowelling and “others in the same line of unnecessary cruelty”—would constitute cruel and unusual punishment violating the Constitution regardless of the crime. *Id.* at 135–36.

¹² LAWRENCE M. FREIDMAN, CRIME AND PUNISHMENT IN AMERICAN HISTORY 27–30, 66–71 (1993); KERMIT HALL, THE MAGIC MIRROR: LAW IN AMERICAN HISTORY 176–78, 184–85 (1989).

¹³ Peter Becker, *The Standardized Gaze: The Standardization of the Search Warrant in Nineteenth-Century Germany*, in DOCUMENTING INDIVIDUAL IDENTITY 139, 155 (Jane Caplan & John Torpey eds., 2001) (describing a parallel phenomenon in Germany); see also LOGAN, *supra* note 11, at 20.

¹⁴ LOGAN, *supra* note 11, at 20.

¹⁵ *Id.* at 4.

¹⁶ *Id.* at 9–10. Anthropometric, or bodily, identification was created by Alphonse Bertillon—and so was called “Bertillonism”—and involved measuring three data points including the dimensions of the head, finger, and ear, descriptions of facial features, and peculiar marks. *Id.* at 10.

¹⁷ *Id.* at 13.

¹⁸ *Id.* at 20.

hoodlums. With an increased interest in crime prevention came a renewed interest in criminal registration and a small wave of local registration laws were passed.¹⁹ Then, the 1940s changed the public's focus to wartime issues and the brief interest in registration receded until the 1950s with the appearance of a new breed of criminal, the Mafia.²⁰ The public's fear of the Mafia translated into the passage of another, and somewhat larger, wave of mostly local, criminal registration laws.²¹ These early criminal registration laws were controversial, with journalists condemning the stigmatizing effects of registration:

It was the old idea of the brand all over again, though it took the form of this blacklist file instead of the old scarlet letter of New England. There was little thought of doing anything to rehabilitate these people—or even to protect society from them. The emphasis was merely on having them branded and filed, Gestapo style, so that they could be hounded and cracked down upon when the public mood so demanded²²

Justice officials of the times warned that criminal registration laws created alarming precedent, and cautioned that “[b]efore embarking upon this new practice with a particularly offensive group of individuals, we should not overlook the fact that we may be opening the door to similar practices for other groups as time goes on.”²³ History proved these predictions to be correct when the public fear of the Mafia morphed into the fear of Communists and this same time period saw the birth of McCarthyism and blacklisting at the federal level for the first time.²⁴

However, by the end of the mid-1960s the U.S. Supreme Court brought an end to blacklisting of alleged communists,²⁵ and by the end

¹⁹ *Id.* at 22–28.

²⁰ *Id.* at 28; *see also* REPORT BY THE PRESIDENT'S COMM'N ON LAW ENFORCEMENT & ADMIN. OF JUSTICE, THE CHALLENGE OF CRIME IN A FREE SOCIETY 192–98 (1967) (noting that Senate hearings led by Tennessee Senator Ernest Kefauver received national media attention and generated public concern over the Mafia).

²¹ LOGAN, *supra* note 11, at 28. By 1969, fifty-two localities had passed criminal registration laws and eight states had criminal registration laws. By 1989, twelve states had criminal registration laws. *Id.*

²² *Id.* at 38 (quoting HOWARD JAY WHITMAN, TERROR IN THE STREETS 383–84 (1951)).

²³ *Id.* at 38–39 (quoting Memorandum from Richard McGhee, Cal. Dir. of Corr., to Earl Warren, Governor of Cal. (July 2, 1947)).

²⁴ The McCarran Internal Security Act, also known as the Subversive Activities Control Act of 1950, was part of a legislative package that was designated as the Internal Security Act of 1950. *See* 50 U.S.C. §§ 788–795 (2006) (repealed 1993). This Act created a blacklist of Communist organizations maintained by the U.S. Attorney General. The Act also established the Subversive Activities Control Board to investigate alleged Communist action and suspected Communist front organizations in order to populate the blacklist. *Id.*

²⁵ In *Yates v. United States*, 354 U.S. 298 (1957), the Court focused on the difference between “advocacy of abstract doctrine and advocacy directed at promoting unlawful action.” *Id.* at 316. According to the Court, “the advocacy and teaching of forcible overthrow as an abstract

of the 1980s, public interest in the creation of criminal registries had almost completely waned.²⁶ Instead, in response to the social pressures to deal with the two crises of the times, legislative efforts were redirected to two different types of blacklisting. First, police databases of alleged gang members sprang up across the country in the mid-1980s at the state level in response to the very real problems with rising crime rates associated with the growth of gangs.²⁷ In the same timeframe, public attention was captured by the perceived medical malpractice insurance crisis and a series of sensationalized cases of known negligent practitioners who were allowed to continue harming patients.²⁸ Public fear led to the second time that a blacklist was created on the federal level—one of “bad” doctors. As more fully described in the next Sections, from 1986 to 1992, federal legislative blacklisting efforts yielded laws and regulations that created the NPDB with a focus on cleansing the healthcare system of these “bad” doctors.

Coming hard on the heels of physician blacklisting, in the early 1990s, a series of highly publicized kidnapping, rape, and murders of child victims by repeat offenders dramatically reanimated public interest in the use of criminal blacklists for sex offenders and the legislative blacklisting focus switched yet again:

In July [of 1993], 10-year-old Zachary Snider of Indiana was molested and murdered by a neighbor who, unbeknownst to community members, was a convicted sex offender. In September, 7-year-old Ashley Estell was abducted from a Texas playground and killed, resulting in the arrest of a previously convicted child molester. A month later, 12-year-old Polly Klaas was kidnapped at knife point from a slumber party in her California home, while her mother slept in an adjacent room. Her body was found two months later and Richard Allen Davis, who had a history of kidnapping and other offenses, was arrested, convicted, and eventually executed for the crime.²⁹

principle” was not punishable as long as it was “divorced from any effort to instigate action to that end.” *Id.* In *Albertson v. SACB*, 382 U.S. 70 (1965), the Court held that the registration portion of the McCarran Act infringed upon the members’ Fifth Amendment right against self-incrimination, essentially marking the end to attempts to register members of the Communist Party.

²⁶ LOGAN, *supra* note 11, at 48. Reservations over fairness and the impact on civil liberties, along with serious doubts about both the completeness and the accuracy of the registries, appeared to relegate criminal blacklists to the archives. *Id.*

²⁷ Gang databases began being used by law enforcement in the mid-1980s. OFFICE OF JUVENILE JUSTICE & DELINQUENCY PREVENTION, OJJDP COMPREHENSIVE GANG MODEL: A GUIDE TO ASSESSING YOUR COMMUNITY’S YOUTH GANG PROBLEM 38 (2009), available at <http://www.nationalgangcenter.gov/Content/Documents/Assessment-Guide/Assessment-Guide.pdf>.

²⁸ See *infra* Part II.A.

²⁹ LOGAN, *supra* note 11, at 54.

By 1995, every state had registration laws and the new phrase “sexual predator” became part of the nation’s vocabulary.³⁰ This second generation of laws greatly expanded the scope of the registration requirement to include community notification.³¹ As Professor Wayne Logan explains, this expansion was driven by a desire by communities to engage in self-protection and was premised on the public’s “right to know.”³²

Frustrated with the continued lack of uniformity in the strength of state programs, Congress passed the Adam Walsh Child Protection and Safety Act of 2006 (AWA), which substantially overhauled federal registration and community notification by establishing a uniform national system.³³ Under the AWA, all sexual offenders, including juveniles, must register, and information on each registrant must be provided to the community by state-created and -maintained websites.³⁴ Registrants are also placed in the Federal Dru Sjodin National Sex Offender Public Website.³⁵ To ensure state compliance, the Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking (SMART) Office within the U.S. Department of Justice was created.³⁶

Of course, since September 11, 2001, the U.S. government’s Terrorist Screening Center maintains a No-Fly List of people who are not

³⁰ *Id.* at 95 (noting that prior to the 1990s, victimizers were portrayed in clinical terms, such as “sexual psychopath” or “sexually dangerous person”).

³¹ *Id.* at 49.

³² *Id.* at 101–03. The remarkable increase in sexual offender registration laws was the result of the Federal Jacob Wetterling Crimes Against Children and Sexually Violent Offender Registration Act, Pub. L. No. 103-322, 108 Stat. 2038 (1994) (codified as amended at 42 U.S.C. § 14071 (2006) (repealed 2006)). The Wetterling Act relied upon Congress’s spending power to “encourage” states to pass registration and permissive community notification laws to avoid losing ten percent of their Federal Byrne Formula Grant Program funds. 42 U.S.C. § 14071(g)(2) (2006) (repealed 2006). The reliance by state criminal justice programs on the funds afforded them by the Byrne Program meant that every state quickly adopted registration laws. LOGAN, *supra* note 11, at 65. The Wetterling Act subjected sexually violent predators to lifetime registration. *Id.* at 59. However, as the implementation of community-notification programs was not mandatory, only some states created community-notification programs. *Id.* at 60. In 1996, Congress reacted to the states’ reluctance to engage in community notification by making it mandatory with the passage of Megan’s Law. *See* Megan’s Law, Pub. L. No. 104-145, 110 Stat. 1345 (1996) (amending 42 U.S.C. § 14071(d) (1994)). Once again, all of the states quickly fell into line with the federal mandate in order to avoid losing federal funding. *See* LOGAN, *supra* note 11, at 65. The registration and community-notification programs required by the Wetterling Act and Megan’s Law included the requirement that “[i]nformation must be released to members of the public as necessary to protect the public from registered offenders.” Final Guidelines for Megan’s Law and Jacob Wetterling Crimes Against Children and Sexually Violent Offender Registration Act, 62 Fed. Reg. 39009, 39019 (July 21, 1997). States retained discretion with regard to which registrants would be part of the community notification and what information would be provided leading to a wide variation in the range and quality of state programs. LOGAN, *supra* note 11, at 60–62. A series of federal laws that added on additional layers or requirements ensued in order to improve the quality of state programs. *Id.* at 62.

³³ Pub. L. No. 109-248, 120 Stat. 587 (2006) (codified at 42 U.S.C. § 16901 (2006)).

³⁴ LOGAN, *supra* note 11, at 62–64.

³⁵ *Id.* at 64.

³⁶ *Id.* at 65.

allowed to fly on commercial flights for travel into, within, or out of the United States.³⁷ On September 11, 2001, the Federal Bureau of Investigation (FBI) had a list of sixteen people who were on a list they kept of people they deemed to present a risk to aviation.³⁸ By November 2001, the FBI list grew to 400 names.³⁹ At that point, responsibility for the list was transferred to the Federal Aviation Administration.⁴⁰ In mid-December, the list was split to create a list of those not allowed to fly and a list of those who were to be more carefully searched at airports.⁴¹

The news program *60 Minutes* obtained a copy of the list and reported that the no-fly list contained 44,000 names, and that the list of those who must be more carefully searched at airports contained 75,000 names.⁴² With regard to the Terrorist Watch List, the Transportation Security Center's website entitled "Myth Busters" states that "[a]ccording to the Terrorist Screening Center, there are less than 400,000 individuals on the consolidated terrorist watch list."⁴³ The only way for someone to find out if they are on the No-Fly List or the Terrorist Watch List is to be stopped at the airport when they are trying to fly—information that thousands of harmless citizens are learning in this highly disruptive and emotionally upsetting way.⁴⁴

What should stand out in this very general overview of the history of blacklisting in the United States is that most blacklisting efforts are focused on individuals who are targeted because of some characteristic that makes them much more likely to engage in very dangerous criminal activity that carries with it a serious risk of physical harm. The blacklisting of physicians, whose mission is to serve the community, does not seem to fit this pattern. As such, it is easier to understand a decision to neglect due process protections for suspected terrorists in light of the nature and degree of the threat of harm, than this same decision when applied to physicians.

³⁷ *Frequently Asked Questions*, FED. BUREAU OF INVESTIGATION TERRORIST SCREENING CENTER, http://www.fbi.gov/about-us/nsb/tsc/tsc_faqs (last visited Aug. 6, 2011).

³⁸ See Attachment A, Part 1 of Public Record at 2, *Gordon v. FBI*, 390 F. Supp. 2d 897 (N.D. Cal. 2004) (No. C 03-01779), available at http://www.aclunc.org/cases/landmark_cases/asset_upload_file371_3549.pdf (including a PowerPoint presentation created by the U.S. Department of Transportation's Transportation Security Intelligence Service in December of 2002 regarding the TSA Watch List, which was introduced into the public record during the case of *Gordon v. FBI* in 2003).

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ *Id.* at 3.

⁴² *Unlikely Terrorists on No Fly List*, CBSNEWS.COM (Oct. 8, 2009, 1:00 PM), <http://www.cbsnews.com/stories/2006/10/05/60minutes/main2066624.shtml>. According to this *60 Minutes* report, the government will not release the criteria it relies upon to create the list. *Id.*

⁴³ *Myth Buster: TSA's Watch List is More Than One Million People Strong*, TRANSP. SECURITY ADMIN., http://www.tsa.gov/approach/mythbusters/tsa_watch_list.shtm (last visited Aug. 6, 2011).

⁴⁴ See *Unlikely Terrorists on No Fly List*, *supra* note 42.

B. *Procedural Protections:*
Comparing Blacklisting of Sexual Predators, Suspected Gang Members,
Suspected Terrorists, and No-Fly Lists with the Blacklisting of
Physicians

In *Connecticut Department of Public Safety v. Doe (CDPS)*,⁴⁵ the U.S. Supreme Court found that a prior conviction is both a *necessary* and sufficient condition for registration and community notification of sexual offenders to be constitutional. In *CDPS*, the Court held that “the law’s requirements turn on an offender’s conviction alone—a fact that a convicted offender has already had a procedurally safeguarded opportunity to contest.”⁴⁶ The Court explained:

In cases such as *Wisconsin v. Constantineau* and *Goss v. Lopez* we held that due process required the government to accord the plaintiff a hearing to prove or disprove a particular fact or set of facts. But in each of these cases, the fact in question was concededly relevant to the inquiry at hand. Here, however, the fact that respondent seeks to prove—that he is not currently dangerous—is of no consequence under Connecticut’s Megan’s Law. As the DPS Website explains, the law’s requirements turn on an offender’s conviction alone—a fact that a convicted offender has already had a procedurally safeguarded opportunity to contest. . . . No other fact is relevant to the disclosure of registrants’ information.⁴⁷

In contrast to blacklisting sexual predators, when physicians are blacklisted by the federal government, they have not been provided with a procedurally safeguarded opportunity to contest the accuracy of the facts included in the reports that are filed with, and then disseminated by, the NPDB.⁴⁸ Moreover, alleged sexual predators are provided with the additional safeguard of having the highest burden of proof placed on the government to prove the allegations against them. Hospitals in peer review only have to establish the allegations against physicians by a preponderance of the evidence.⁴⁹ Finally, there is no requirement that anyone check the blacklists of sexual predators. In juxtaposition, hospitals face stiff sanctions for failing to query the NPDB blacklist for negative reports on every physician who applies for staff privileges and for

⁴⁵ 538 U.S. 1 (2003).

⁴⁶ *Id.* at 7.

⁴⁷ *Id.* (citations omitted).

⁴⁸ See *infra* notes 146–76, 268–343 and accompanying text.

⁴⁹ See CREDENTIALING AND PEER REVIEW PRACTICE GRP. OF THE AM. HEALTH LAW ASS’N, PEER REVIEW GUIDEBOOK 75 (3d ed. 2003) [hereinafter PEER REVIEW GUIDEBOOK].

negative reports every two years for all physicians who already have staff privileges.⁵⁰

The same comparison can be made with regard to suspected gang members and terrorists as well as to no-fly lists. While these types of blacklists contain a high risk of error that makes them constitutionally suspect,⁵¹ at least if a person is arrested and a prosecutor attempts to use gang membership to either obtain a conviction or enhance a sentence, that person is provided with a procedurally safeguarded opportunity to contest the accuracy of the alleged membership.⁵² And if a person discovers that they are falsely placed on one of these lists, that person has a right to access to the courts to obtain injunctive relief to get their name removed.⁵³ As discussed *infra*, physicians who are blacklisted, in the vast majority of cases, do not have access to the judicial system at all.⁵⁴

II. THE NATIONAL PRACTITIONER DATA BANK

A. History

The history and motivation behind the creation of the NPDB is similar in some interesting ways to that of Megan's Laws and other blacklisting efforts. Each of these blacklists resulted from a legislative response to public fears caused by an exaggerated perception of the risk of harm. Professor Wayne Logan, in his excellent book *Knowledge as Power: Criminal Registration and Community Notification Laws in America*, writes:

Much as the nation's first registration laws were prompted by an "emergency" over the perceived threat of an influx of "gangsters," modern laws have been motivated by a sustained sense of exigency

⁵⁰ See *infra* note 141 and accompanying text.

⁵¹ See generally Joshua D. Wright, *The Constitutional Failure of Gang Databases*, 2 STAN. J. C.R. & C.L. 115 (2005) (explaining the high risk of error associated with gang databases and persuasively arguing that they are unconstitutional).

⁵² CHARLES M. KATZ & VINCENT J. WEBB, *POLICING GANGS IN AMERICA* 241 (2006).

⁵³ Wright, *supra* note 51, at 124. Wright points to two illustrative cases:

[T]wo teenage Vietnamese-American girls in California were fortunate enough to have their names removed and photographs purged as a result of a settlement after the ACLU filed a class action lawsuit on their behalf. A more recent case involved a Union City Police Department sweep of James Logan High School in Union City, California. School administrators detained approximately sixty Hispanic and Asian students who were taken from the school cafeteria to vacant classrooms for questioning. Photos of the students were taken and put in the Union City Police gang database and have not been removed to this date. The ACLU has filed a class action lawsuit on behalf of three of the students.

Id. (citations omitted).

⁵⁴ See *infra* notes 172, 343–52 and accompanying text.

concerning sex offenders. Alarming statistics adduced by political leaders have, in turn, been absorbed by the media and the public, leading to a self-perpetuating legislative process resulting in today's nationwide network of registration and notification laws. And, much as in the early 1930s, when the nation was convinced that it was in the grip of a "crime wave," compelling immediate action, the statistical record belied this perception: child and adult sexual abuse has actually declined since the 1990s.⁵⁵

Much of the same can be said of the social and political catalysts for physician blacklisting. In the mid-1980s, at the time of the passage of the Health Care Quality Improvement Act of 1986 (HCQIA) and the creation of the NPDB, the United States was in the middle of a perceived medical malpractice insurance crisis. Insurance companies were pulling out of markets and insurance costs were increasing at rates that were causing some physicians to leave the practice. As pointed out by Professor David Nye:

When the President of the American College of Obstetricians and Gynecologists reported in February 1986 on the state of his profession, he chose Charles Dickens' opening words in *A Tale of Two Cities*. "It was the best of times, it was the worst of times," recited Dr. William Mixson. On one hand, Mixson noted the significant advances in medical care for obstetrical patients and the reduced risks of infant mortality. On the other hand, reported Mixson, the professional liability of members of his profession had reached "crisis proportions."⁵⁶

Stories from the press about this perceived crisis flooded the American consciousness.⁵⁷ Lawyers and the tort system were routinely blamed, with then-President Ronald Regan and Attorney General Edwin Meese joining in the fingerpointing. For this group, tort reform was touted as the solution to the problem.⁵⁸ Others blamed "bad" doctors for the malpractice insurance crisis and advocated getting rid of incompetent physicians.⁵⁹ Acting on this second viewpoint, in the early to mid-1980s:

[S]tates and health care accrediting bodies stepped up their promotion of peer review—the process by which physicians judge the competence of their fellow professionals and recommend disciplinary action for those found dangerously incompetent. As this process

⁵⁵ LOGAN, *supra* note 11, at 97.

⁵⁶ David J. Nye et al., *The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances*, 76 GEO. L.J. 1495, 1495 (1988).

⁵⁷ *See id.* at 1496–98.

⁵⁸ *Id.*

⁵⁹ H.R. REP. NO. 99-903, at 1 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6384, 6384 ("This bill is needed to deal with one important aspect of the medical malpractice problem in this country— incompetent and unprofessional physicians.").

gathered force, physicians aggrieved by the results of peer review increasingly appeared in federal court claiming that the actions of their peers were anti-competitive and violated federal antitrust laws. Although hospitals and peer review participants generally prevailed in these lawsuits, the victories entailed costly and time-consuming litigation.⁶⁰

Stepping into this volatile scene was the U.S. Supreme Court case of *Patrick v. Burget*.⁶¹ In *Patrick*, the plaintiff, Dr. Timothy Patrick, worked at the Astoria Medical Clinic (the Astoria Clinic) for one year in a small Oregon town of 10,000.⁶² Two of the defendants in the case were partners in the Astoria Clinic, Dr. Gary Boelling and Dr. Franklin Russell.⁶³ Another defendant was a surgeon working at the Astoria Clinic, Dr. Richard Harris.⁶⁴

After his one year at the Astoria Clinic, Dr. Patrick decided not to join the Astoria Clinic as a partner, instead leaving to start his own practice.⁶⁵ Dr. Patrick's new practice reflected both his specialty as a vascular surgeon and his practice as a general surgeon.⁶⁶ Dr. Patrick's new general surgery practice was in competition with the Astoria Clinic.⁶⁷ In light of this competition, the partner's in the Astoria Clinic refused to enter into cross-coverage agreements with Dr. Patrick.⁶⁸ In addition, instead of referring their patients who needed vascular surgery to the local office of Dr. Patrick, they sent these patients fifty miles away to other doctors.⁶⁹

In the meantime, the doctors who worked at the competing Astoria Clinic began to criticize Dr. Patrick for failing to obtain adequate back-up coverage and outside consultations.⁷⁰ Then, in 1979, Dr. Boelling, a partner in the Astoria Clinic, made a complaint against Dr. Patrick to the executive committee of the Columbia Memorial Hospital's (CMH) medical staff. Dr. Boelling claimed that Dr. Patrick left a patient in the care of a recently hired associate, who then left the patient unattended.⁷¹ CMH was the only hospital in Astoria, Oregon at that time.⁷² And dur-

⁶⁰ *Manion v. Evans*, 986 F.2d 1036, 1037 (6th Cir. 1993).

⁶¹ 486 U.S. 94 (1988).

⁶² *Id.* at 95–96.

⁶³ *Id.* at 96–97.

⁶⁴ *Id.* at 97.

⁶⁵ *Id.* at 96.

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ *Id.* at 96–97.

⁷² *Id.* at 96.

ing the relevant time period, a majority of the physicians at the CMH were either employees or partners of the Astoria Clinic.⁷³

The person who chaired the investigation of this complaint was none other than Dr. Russell, a partner in the Astoria Clinic and a competitor of Dr. Patrick's.⁷⁴ Based on this investigation, the executive committee referred this complaint, along with information about other cases handled by Dr. Patrick, to the State Board of Medical Examiners (BOME).⁷⁵ The members of the BOME committee criticized Dr. Patrick's medical practices to the full BOME, which then issued a letter of reprimand that had been drafted by the same Dr. Russell who performed the hospital investigation and who was a competitor of Dr. Patrick.⁷⁶ Once Dr. Patrick began to pursue judicial review of the BOME, the BOME completely retracted the reprimand letter.⁷⁷

Then, only two years later, defendant Richard Harris, an Astoria Clinic surgeon, requested that CMH review Dr. Patrick's clinical privileges at the CMH.⁷⁸ The executive committee of the CMH's medical staff performed this review and decided to terminate Dr. Patrick's privileges on the ground that his care of his patients was below the extraordinarily vague "standards of the hospital."⁷⁹ Dr. Patrick demanded a hearing, as provided by hospital bylaws.⁸⁰ And, not much of a surprise, the same Dr. Boelling appears in the story again as the chair of the five member ad hoc committee that heard the charges and the defense.⁸¹

After the members of the committee refused to testify about their personal bias against him, Dr. Patrick resigned his staff privileges before the committee reached its decision rather than risk termination.⁸² He then filed an antitrust lawsuit alleging that the clinic's physicians violated antitrust laws by bringing a sham hospital peer review proceeding in order to eliminate him as a competitor by destroying his practice.⁸³ Dr. Patrick won \$650,000 in antitrust damages in the jury trial. The court trebled the damages to \$2.2 million under the antitrust laws and awarded \$228,600 in attorney's fees.⁸⁴ On appeal, the Ninth Circuit

⁷³ *Id.*

⁷⁴ *Id.* at 97.

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ *Id.* The validity of this type of vague standard and the perils that are associated with its use are explained *infra* notes 276-99 and accompanying text.

⁸⁰ *Patrick*, 486 U.S. at 97.

⁸¹ *Id.*

⁸² *Id.*

⁸³ *Id.* at 97-98.

⁸⁴ *Id.* at 98. The Ninth Circuit later reversed, finding that the trial court did not properly instruct the jury on the state action of antitrust immunity to peer review activities. Ultimately, the U.S. Court reversed the Ninth Circuit, holding that Oregon's peer review statute did not provide

Court of Appeals specifically found that “there was substantial evidence that respondents had acted in bad faith in the peer-review process.”⁸⁵

Rather than focus on the sham peer review aspects of the case,⁸⁶ the press spin on the case that caught national attention was that an incompetent physician terminated a peer review proceeding in order to avoid a verdict on his competence.⁸⁷ Then, that same incompetent physician turned around and sued the members of the peer review committee and won millions.⁸⁸ This mischaracterization of the case allegedly caused alarm among those in the medical profession as it raised the specter of possible retaliatory litigation for good faith participation in peer review.⁸⁹ Members of Congress speculated that this undocumented fear discouraged physicians from participating in peer review to avoid the risk of being sued for millions.⁹⁰ To alleviate these speculative fears, a bill was introduced by Congressman Ron Wyden of Oregon to provide immunity from retaliatory lawsuits for those engaging in “good faith” peer review.⁹¹

While the *Patrick* case was playing out in the press, another series of well-publicized cases⁹² caught the attention of the nation through the effective use of the same narrative technique or storytelling that was used later to trigger Megan’s Laws. For example, the *Boston Globe*’s 1986 story on the infamous Dr. Frederick Huffnagle was akin to reading

for active supervision as necessary to establish antitrust immunity under the state-action doctrine. *Id.* at 98–99.

⁸⁵ *Id.* at 98.

⁸⁶ The Court of Appeals specifically found:

[T]here was substantial evidence that respondents had acted in bad faith in the peer-review process. The [Court of Appeals] held, however, that even if respondents had used the peer-review process to disadvantage a competitor rather than to improve patient care, their conduct in the peer-review proceedings was immune from antitrust scrutiny. The court reasoned that the peer-review activities of physicians in Oregon fall within the state-action exemption from antitrust liability because Oregon has articulated a policy in favor of peer review and actively supervises the peer-review process.

Id. at 98.

⁸⁷ See Nicholas Kadar, *How Courts Are Protecting Unjustified Peer Review Actions Against Physicians by Hospitals*, 16 J. AM. PHYSICIANS & SURGEONS 17, 20 (2011).

⁸⁸ *Id.*

⁸⁹ *Id.*; see also H.R. REP. NO. 99-903, at 3 (1986), reprinted in 1986 U.S.C.C.A.N. 6384, 6385–86.

⁹⁰ Kadar, *supra* note 87, at 20; H.R. REP. NO. 99-903, at 2–3.

⁹¹ Kadar, *supra* note 87, at 20; H.R. REP. NO. 99-903.

⁹² Charlotte L. Rosenberg, *How Bad Doctors Dodge Discipline*, 62 MED. ECON. 241 (1985) (reporting on thirty-three physicians who engaged in state hopping after negative state licensure proceedings); U.S. GEN. ACCOUNTING OFFICE, GAO-84-53, EXPANDED FEDERAL AUTHORITY NEEDED TO PROTECT MEDICARE AND MEDICAID PATIENTS FROM HEALTH PRACTITIONERS WHO LOSE THEIR LICENSES, at iii, 7–8 (1984), available at <http://www.gao.gov/assets/150/141458.pdf> (identifying thirty-nine doctors who relocated to new states after losing their license in another state and pointing out that far less than one percent of physicians have problems that lead to licensure sanctions which translates into less than one per 1000 physicians).

a spine-tingling horror story.⁹³ Within two years of obtaining staff privileges at Beverly Hospital in Danvers, Connecticut, Dr. Huffnagle was placed on probation in 1970 for performing experimental hip replacement surgery without conducting a prior consultation or obtaining the proper equipment.⁹⁴ Dr. Huffnagle had never performed the surgery before, nor had anyone else at the hospital where the surgery was performed. Due to this incident, among “other serious continuing difficulties,” Beverly Hospital declined to renew his staff privileges.⁹⁵

No problem for Dr. Huffnagle, who also had staff privileges at nearby Hunt Memorial.⁹⁶ In spite of the problems at Beverly Hospital, Dr. Huffnagle continued to perform surgeries at Hunt Memorial, including several surgeries on Beatrice Higgins.⁹⁷ Although she had osteoarthritis, Beatrice could still walk to the grocery store to get her groceries when she first met Dr. Huffnagle.⁹⁸ The good doctor implanted an artificial knee in Beatrice that was the wrong size.⁹⁹ When he removed it, he fractured a bone and ruptured a tendon. Five year later, Beatrice was still confined to a nursing home and could only leave in a wheelchair.¹⁰⁰

In 1981, Dr. Huffnagle moved to California, leaving behind five malpractice suits in which patients were compensated for injuries.¹⁰¹ Dr. Huffnagle obtained staff privileges at Westminster Hospital in California by claiming that his staff privileges had never failed to be renewed and that no settlements had been paid pursuant to any malpractice claims against him.¹⁰² Dr. Huffnagle only lasted one year at Westminster; however, in that one year, he had four more malpractice lawsuits filed against him.¹⁰³ Twenty-nine-year-old Roger Lucas was a bindery supervisor who pulled a muscle in his back when stacking crates.¹⁰⁴ Four years after a botched surgery by Dr. Huffnagle, Roger Lucas was left seriously disabled and in constant pain. He was unable to ever work again.¹⁰⁵ After his year in California, Dr. Huffnagle moved to Massachusetts and was easily hired by Massachusetts Osteopathic.¹⁰⁶

⁹³ *Small Percentage of Doctors Responsible for Surge in Malpractice Suits, Rates*, BOS. GLOBE, June 15, 1986, at 1.

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

Stories like those of Dr. Huffnagle and Dr. Patrick enflamed public passions and legislators were pressured to act. As described in HCQIA's legislative history:

[G]roups such as state licensing boards, hospitals and medical societies that should be weeding out incompetent or unprofessional doctors often do not do so. Even when such bodies do act against bad physicians, these physicians find it all to [sic] easy to move to different hospitals or states and continue their practices in these new locations.

The result has been a series of highly visible situations in which physicians with a long history of incompetence or unprofessional conduct have continued to cause needless deaths and injury for years after their damaging behavior was noticed.¹⁰⁷

As is apparent from this passage, the public perception was that physicians and hospitals were reluctant to report their peers and were thereby increasing the overall legal liability for their profession. This reluctance to report was seen as contributing to the overall medical malpractice insurance crisis. After the *Patrick* case, this reluctance to report incompetent physicians was blamed on the alleged fear of retaliatory lawsuits.¹⁰⁸

Together, the perceived medical malpractice insurance crisis, the *Patrick* case and the series of cases in which known incompetent physicians, like Dr. Huffnagle, were allowed to continue to injure patients, came together in 1986 through the all-pervasive media to incite the same kind of public fear that triggered other forms of blacklisting, such as lists of criminals, alleged communists and gang members, and, later, Megan's Laws for sexual predators.

Thus, in 1986, Congress diagnosed an "increasing occurrence of medical malpractice" throughout the nation that warranted the intervention of the federal government and the bill that Congressman Ron Wyden of Oregon introduced was adopted as the HCQIA.¹⁰⁹ In the Act itself, Congress explained the purposes behind the legislation:

(1) The 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.

¹⁰⁷ H.R. REP. NO. 99-903, at 2 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6384, 6385.

¹⁰⁸ A more likely cause was a culture prevalent in most hospitals characterized by a reluctance on the part of physicians to report their colleagues to the hospital administration. *See* U.S. GEN. ACCOUNTING OFFICE, GAO-01-130, NATIONAL PRACTITIONER DATA BANK: MAJOR IMPROVEMENTS ARE NEEDED TO ENHANCE DATA BANK'S RELIABILITY 10-11 (2000), *available at* <http://www.gao.gov/new.items/d01130.pdf>.

¹⁰⁹ 42 U.S.C. §§ 11101-11152 (2006).

(2) 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.

(3) This nationwide problem can be remedied through effective professional peer review.

(4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.

(5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.¹¹⁰

In order to prevent physicians from challenging the results of peer review in court and winning damages, like the case of Dr. Patrick, HCQIA created a form of protection from liability in damages for hospitals and peer review participants.¹¹¹ The point was not to make it impossible for physicians to challenge a sham peer review and thereby to obtain injunctive relief from sanctions unrelated to quality of care, but to insulate the participants from having to pay out money damages if the challenging physician prevailed. For this reason, the Act does not actually use the term "immunity." Instead, it provides that if a "professional review action" meets the Act's standards, the peer reviewers "shall not be liable in damages under any law of the United States or of any State . . . with respect to the [professional review] action."¹¹² HCQIA also established the NPDB in order to prevent physicians like Dr. Huffnagle from "mov[ing] from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance."¹¹³

As Professor Tom Baker points out in his popular and highly regarded book *The Medical Malpractice Myth*,¹¹⁴ the reality is that there was not a crisis in medical malpractice insurance during the 1980s; however, there is no doubt that there was, and still is,¹¹⁵ a crisis in the

¹¹⁰ *Id.* § 11101. For a more complete discussion of HCQIA, see Katharine A. Van Tassel, *Hospital Peer Review Standards and Due Process: Moving from Tort Doctrine Toward Contract Principles Based on Clinical Practice Guidelines*, 36 SETON HALL L. REV. 1179, 1194-97 (2006).

¹¹¹ This immunity does not extend to civil rights claims or government antitrust prosecutions. See 42 U.S.C. § 11111 (2006); Robert J. Enders, *Federal Antitrust Issues Involved in the Denial of Medical Staff Privileges*, 17 LOY. U. CHI. L.J. 331 (1986).

¹¹² 42 U.S.C. § 11111(a)(1).

¹¹³ 42 U.S.C. § 11101(2).

¹¹⁴ See generally TOM BAKER, *THE MEDICAL MALPRACTICE MYTH* (2005).

¹¹⁵ Christopher P. Landrigan et al., *Temporal Trends in Rates of Patient Harm Resulting from Medical Care*, 363 NEW ENG. J. MED. 2124, 2130 (2010) ("In a statewide study of 10 North Carolina hospitals, we found that harm resulting from medical care was common, with little

amount of medical malpractice committed. Professor Baker does a masterful job of deconstructing and debunking “the beliefs that undergird the call for tort ‘reform’ and impede the ability of the polity to focus on, and respond constructively to, the real problems of healthcare in twenty-first century America.”¹¹⁶ So, just as was the case with the disconnect between the reality of the level of the threat from sexual predators that triggered Megan’s Law, Professor Baker persuasively argues that the real cause of the rise in insurance rates in the 1980s was the insurance cycle and that there was no real relationship between “bad” doctors and the perceived insurance crisis.¹¹⁷ Similarly, it is more likely that the reluctance of physicians to report a colleague is related to a long-standing cultural aversion to turning in a peer for poor performance than to a fear of retaliatory lawsuits like that of Dr. Patrick.¹¹⁸

Importantly, Professor Baker points out what many, until recently, have ignored—there is an astonishing amount of malpractice that occurs in the United States:

[T]here really is not any question about the epidemic of medical malpractice. Report after report stretching back into the 1970s makes that fact very clear. The reports also make clear that there really are very few medical malpractice lawsuits, especially compared to the amount of medical malpractice. Depending on how we count, there are between seven and twenty-five serious medical malpractice injuries for every one medical malpractice lawsuit. By comparison, almost everyone who gets injured by a negligent driver files an auto lawsuit or claim.¹¹⁹

The California Medical Insurance Feasibility Study¹²⁰ was the first major study of medical errors that came out in the mid-1970s. This study discovered that one out of every twenty patients was injured by physicians and one out of every ten of these patients died as a result. Of these injuries, one out of every six was the result of malpractice. This translated into physicians injuring 140,000 patients and killing 14,000 patients in California in 1974.¹²¹ Interestingly, this data suggests that a conversion to a no-fault system would be far more expensive than the

evidence that rate of harm had decreased substantially over a 6-year period ending in December 2007.”).

¹¹⁶ Mary Coombs, *The Medical Malpractice Myth*, 27 J. LEGAL MED. 243, 243 (2006) (reviewing BAKER, *supra* note 114).

¹¹⁷ *Id.* at 243–45; see also Thomas Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 DEPAUL L. REV. 393, 396–422 (2005) (providing a “primer on the liability insurance underwriting cycle that draws on the research prompted by the mid-1980s insurance hard market”).

¹¹⁸ See *infra* notes 258–59 and accompanying text.

¹¹⁹ BAKER, *supra* note 114, at 23.

¹²⁰ Don Harper Mills, *Medical Insurance Feasibility Study: A Technical Summary*, 128 W. J. MED. 360 (1978).

¹²¹ BAKER, *supra* note 114, at 25–26.

current tort system as every one of these patients would merit compensation that would be far more than what the tort system was paying out.¹²²

The Harvard Medical Practice Study (HMPS)¹²³ came out in the mid-1980s, during the second medical malpractice insurance “crisis.”¹²⁴ This study was commissioned and paid for by the State of New York and was performed by researchers from Harvard.¹²⁵ The results were basically the same as the California study.¹²⁶ Doctors injured one out of twenty-five patients and one out of every four of these cases was caused by negligence.¹²⁷ There were 27,000 injuries from medical malpractice in New York in 1984.¹²⁸ This study suggests that there are 150,000 patient deaths every year inadvertently caused by physicians, half of which are the result of medical malpractice.¹²⁹

The seminal report on medical errors in hospitals came from the Institute of Medicine (IOM) in 1999 and is entitled *To Err Is Human*. This report documented the fact that between 44,000 and 98,000 patients die each year in hospitals due to preventable medical mistakes.¹³⁰ And in 2010, a follow-up study of ten hospitals in North Carolina found that “harms remain common, with little evidence of widespread improvement.”¹³¹

While the rationales that motivated the creation of the NPDB in the first instance are suspect, the fact that there is a real and continuing medical malpractice crisis means that the NPDB is actually a good idea. The problem is that it is currently constructed in a way that does not fairly balance the interests of the stakeholders, including the patients, the doctors, and the hospitals. It also has very questionable efficacy as the data that it contains is likely to be misleading or incorrect. In addition, because of the reporting sources that it relies on to create this data, it is also likely to actually be negatively impacting healthcare quality, cost, and access. This Article does not suggest that the NPDB be discontinued; instead, this Article suggests a revision of the processes that the data bank relies upon to greatly improve the NPDB’s impact on quality, cost, and access to healthcare.

¹²² *Id.* at 26–27.

¹²³ T.A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I*, 13 B.M.J. QUALITY & SAFETY HEALTH CARE 145 (2004).

¹²⁴ BAKER, *supra* note 114, at 27.

¹²⁵ *Id.*

¹²⁶ *Id.* at 29.

¹²⁷ *Id.*

¹²⁸ *Id.*

¹²⁹ *Id.* at 30.

¹³⁰ INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* 26 (Linda T. Kohn et al. eds., 2000).

¹³¹ Landrigan et al., *supra* note 115, at 2130.

B. *The National Practitioner Data Bank Reporting and Query Mandates*

In addition to creating “immunity” from suit, HCQIA also set up the NPDB.¹³² The Health Resources and Services Administration (HRSA) has federal responsibility for oversight of the NPDB.¹³³ HRSA completed the regulations that established the operation of the NPDB in October of 1989.¹³⁴ While HRSA is responsible for ensuring compliance with these regulations, the actual day-to-day operation of the NPDB is performed by a private operator.¹³⁵

The Act and its regulations established mandatory reporting requirements.¹³⁶ Insurance companies must report malpractice payments and settlements on behalf of physicians.¹³⁷ State licensing boards must report disciplinary actions.¹³⁸ Healthcare providers, for example, hospitals and health plans, must report disciplinary actions that restrict a physician’s clinical privileges for more than thirty days.¹³⁹ Even private professional societies such as the American Medical Association (AMA) and the American Dental Association must report sanctions that negatively impact membership.¹⁴⁰ HRSA also negotiated a private agreement with some federal agencies, such as the Department of Veterans Affairs, to report on physicians who they insure, employ, or regulate.¹⁴¹ Since 1997, practitioners who are excluded from participating in the Medicare and Medicaid Programs who either default on federal loan agreements or who engage in fraud or abuse must also be reported to the NPDB.¹⁴²

Hospitals also have an obligation to query the NPDB every two years on each physician who already has staff privileges and for every physician applying for staff privileges.¹⁴³ Others, such as professional societies and state licensure boards, are allowed to query but are not

¹³² 42 U.S.C. § 11134 (2006); 45 C.F.R. § 60.1 (2010) (“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.”).

¹³³ U.S. GEN. ACCOUNTING OFFICE, *supra* note 108, at 7.

¹³⁴ See 45 C.F.R. § 60.3 (2010); National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners, 54 Fed. Reg. 42,722, 42,730 (Oct. 17, 1989).

¹³⁵ U.S. GEN. ACCOUNTING OFFICE, *supra* note 108, at 7.

¹³⁶ *Id.*

¹³⁷ *Id.*

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ *Id.* at 7–8.

¹⁴² *Id.* at 8–9.

¹⁴³ *Id.* at 9.

obligated to do so.¹⁴⁴ Individual physicians are allowed to query, but only for information about themselves.¹⁴⁵

C. *Recent Expansion to Include Blacklisting of All Healthcare Practitioners*

On March 1, 2010, new regulations significantly expanded the list of healthcare professionals that the NPDB reports on from just physicians and dentists to *all* healthcare practitioners.¹⁴⁶ The new regulations also expanded the kind of events that must be reported to include *any* negative action or finding, not just those related to competence or professionalism.¹⁴⁷

In addition, the list of entities that can query the NPDB has expanded to include “private sector hospitals, nursing homes, and other organizations so that [disciplinary records] may be used when making employment, affiliation, certification, or licensure decisions.”¹⁴⁸ Thus:

Hospitals and their human resource departments and nurse recruitment offices now have access to licensure actions on all types of health care professionals. They may query the Data Bank on all types of health care professionals including nurses, nurse aides, and other allied health care professionals when making their hiring decisions. The ability to perform pre-employment screenings of potential health care employees is an invaluable resource that can enhance the hiring process and increase an organization’s efforts towards patient safety.¹⁴⁹

III. THE HOSPITAL PEER REVIEW HEARING PROCESS

There are three major systems in place that act to monitor the quality of patient care: the state medical malpractice system, the state licensure system, and the private hospital peer review system. The first two systems are public and therefore afford due process to physician defendants prior to providing negative reports to the NPDB. Unless it is a government-run hospital, like those run by the Veterans Administration (VA), hospital peer review is private and there is no obligation to pro-

¹⁴⁴ *Id.*

¹⁴⁵ *Id.*

¹⁴⁶ See *supra* note 3 and accompanying text.

¹⁴⁷ 45 C.F.R. § 60.10 (2011).

¹⁴⁸ U.S. Dep’t of Health and Human Servs., *Why Is Section 1921 So Important?*, THE NATIONAL PRACTITIONER DATA BANK, <http://www.npdb-hipdb.hrsa.gov/resources/section1921.jsp> (last visited Aug. 11, 2011).

¹⁴⁹ *Id.*

vide physicians with due process protections during the hearing process. Private peer review is a self-policing system where physicians informally evaluate each other and turn in those physicians who are allegedly failing to provide quality patient care.¹⁵⁰

If, after an investigation and hearing conducted by the hospital, a physician is found to have provided poor quality of care, that physician may be penalized in a variety of ways, including the termination of the physician's hospital staff privileges.¹⁵¹ Hospitals must send reports of all actions "that adversely affect[] the clinical privileges of a physician for a period of longer than 30 days"¹⁵² to the state licensure board, which, in turn, is required to report this information to the NPDB.¹⁵³ Hospitals must check the NPDB for negative reports before granting staff privileges to a physician.¹⁵⁴ The NPDB reporting and publication system has the intended impact on the targeted physician as, once the NPDB has published a negative report on a physician, the physician's reputation is irreparably damaged. Physicians report that a negative report is a "career ender" because it is difficult, if not impossible, to find a new position after a negative NPDB report.¹⁵⁵ As explained *infra*,¹⁵⁶ the inability to obtain hospital staff privileges seriously curtails the scope of the license to practice medicine granted by the state.

A. *The Hospital Process*

In the context of the delivery of healthcare, the term "peer review" refers to the evaluation of the performance of a physician by other physicians¹⁵⁷ pursuant to the obligations of the hospital medical staff to ensure "the quality of care, treatment, and services delivered by practitioners who are credentialed and privileged through the medical staff

¹⁵⁰ Van Tassel, *supra* note 110, at 1190. There are several general categories of conduct that could trigger the imposition of formal sanctions. Examples include inadequate clinical competence, physical and mental impairment, disruptive behavior, loss of license or malpractice insurance, or repeated violations of medical staff bylaws. This Article focuses on the standards that are used to evaluate clinical competence. This evaluation can occur in situations in which a physician is either denied staff privileges in the first instance based on clinical competence concerns, or when staff privileges are curtailed, terminated, or not renewed as a result of allegations of clinical incompetence. *Id.* at 1190–91.

¹⁵¹ *Id.* at 1191–94.

¹⁵² 42 U.S.C. § 11133(a)(1)(A) (2006).

¹⁵³ 45 C.F.R. § 60.5(d) (2011).

¹⁵⁴ 42 U.S.C. § 11135(a)(1) (2006).

¹⁵⁵ See *infra* Part IV; see also Sheree Lynn McCall, *A Hospital's Liability for Denying, Suspending and Granting Staff Privileges*, 32 BAYLOR L. REV. 175, 175 (1980) ("A physician's livelihood is dependent on acquiring and maintaining hospital staff privileges.").

¹⁵⁶ See *infra* Part IV.

¹⁵⁷ SLEE'S HEALTHCARE TERMS 474 (4th ed. 2001).

process.”¹⁵⁸ A hospital medical staff committee charged with performing peer review to maintain or improve the quality of patient care has multiple responsibilities, including completing the credentialing of physicians. The credentialing process involves the assembly and assessment of information dealing with the competence and professional conduct of physicians who apply for hospital staff privileges, either for the first time or when applying for the renewal of those privileges.¹⁵⁹

When a physician already has staff privileges, the formal peer review process can be used to investigate the report of an incident involving poor patient care.¹⁶⁰ The institution’s medical staff bylaws describe

¹⁵⁸ JOINT COMM’N ON ACCREDITATION OF HEALTHCARE ORGS., COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: THE OFFICIAL HANDBOOK, P MS.1, at MS-2 (2005) [hereinafter CAMH].

¹⁵⁹ PEER REVIEW GUIDEBOOK, *supra* note 49, at 60; CAMH, *supra* note 158, at MS-1. The credentialing committee gathers and analyzes the qualifications of the applicants. CAMH, *supra* note 158, at MS-17 to MS-24. It then provides a summary of this information to the medical staff executive committee. The medical staff executive committee then makes a recommendation to the governing body, usually a board of directors. *Id.* at MS-17. The board of directors is commonly comprised of lay persons who generally accept the medical judgments of the medical executive committee. John H. Colteaux, Note, *Hospital Staff Privileges: The Need for Legislation*, 17 STAN. L. REV. 900, 907 (1965). The competence and professionalism of each physician who is a current member of the hospital staff must also be evaluated by the credentialing committee. CAMH, *supra* note 158, at MS-17 to MS-24. According to CAMH, the continued accreditation of the hospital is dependent upon the medical staff of hospitals ongoing participation in “performance improvement activities,” including the implementation of a properly designed peer review process. *Id.* at MS-16 to MS-17, MS-17 to MS-26. Another source for the requirement that hospitals engage in peer review is Medicare’s Conditions of Participation for Hospitals. These conditions for participation mandate that hospitals conduct ongoing periodic evaluations of their physicians as part of “an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. . . . [The program must] involve[] all hospital departments and services,” and “track medical errors and adverse patient events, analyze their causes, and implement preventative actions and mechanisms.” 42 C.F.R. § 482.21 (2011). If a physician is identified through these processes who does not appear to be providing quality patient care, either informal or formal punitive or restrictive sanctions may be imposed to attempt to improve the targeted physician’s performance. Informal measures can include assistance by colleagues, self-correction, guidance with later reassessment, or supervisory oversight. PEER REVIEW GUIDEBOOK, *supra* note 49, at 2–3. The targeted physician usually completes the informal measures under the supervision of the department chair and the chief of staff. If informal measures do not work or are inappropriate from the start, what this Article will refer to as the formal peer review process will be initiated. The formal peer review process could result in restrictions on the scope of practice the physician may engage in within the hospital, a suspension of staff privileges until corrective measures are taken by the physician or further education is received by the physician, or staff privileges could be terminated altogether. *Id.*

¹⁶⁰ *Id.* at 22. It is possible that a physician could have a negative report made to the NPDB at the very start of his or her career. Usually, a brand new physician is placed on a one-to-two-year probationary period with probationary staff privileges. At the end of the probationary period, the medical executive committee reviews the physician’s records and then decides if that new physician should have an extension of the probationary period, be promoted to full medical staff status, or be terminated. *See, e.g.*, Chessick v. Sherman Hosp. Ass’n, 546 N.E.2d 1153, 1155–56 (Ill. App. Ct. 1989) (restrictions placed on advancement from probationary status to full staff based on “substandard” care). Termination can also take the form of a nonrenewal of privileges. A physician’s medical staff appointment is generally only for one to two years. This creates a continuous need to reapply. This renewal period commonly coincides with an investigation into the level of a

the process that is to be followed. While the processes can vary in their details from hospital to hospital, there are several features common to most hospital peer review hearing processes. First, medical staff bylaws are considered to be enforceable contracts between the members of the medical staff and the hospital.¹⁶¹ These bylaws dictate who, or the bodies which, can file a complaint or a request for corrective action, which can trigger an investigation. The person, or body, that decides whether to initiate the investigation is also listed in the bylaws.¹⁶² Unless there is an emergency,¹⁶³ this decision is normally made by the medical staff executive committee.¹⁶⁴

If a decision is made to investigate a complaint, as a general rule, the physician will be notified.¹⁶⁵ Either the executive committee will conduct the investigation itself, or it will appoint an ad hoc committee made up of members of the general medical staff to do so. Beyond the possibility of being interviewed, which may or may not happen, the physician has no role in the investigation phase.

Once the investigation is complete, the next step depends on whether the medical executive committee or an ad hoc committee of the

physician's quality of care. *See, e.g.*, *Dayan v. Wood River Twp. Hosp.*, 152 N.E.2d 205, 206 (Ill. App. Ct. 1958); *Duby v. Jordan Hosp.*, 341 N.E.2d 876, 878–79 (Mass. 1976) (noting that an attempted termination of physician's privileges failed as the necessary two-thirds vote under the bylaw for termination was not obtained; physician's privileges were not renewed as a result of the same charges based on a less rigorous provision of the bylaws dealing with renewal that only required a simple majority). If a renewal is denied, the appeal of the denial of renewal is generally made directly to the board of directors. Consequently, the board of directors will act as the investigator, prosecutor, jury, and appellate body.

¹⁶¹ *See* MICHAEL A. CASSIDY, IMMUNITY FOR CREDENTIALING DECISIONS UNDER FEDERAL AND STATE LAW 38 (2003). If the act of adopting medical staff bylaws is not considered to be the creation of a contract, courts have found consideration to support finding a contract in subsequent acts. *See, e.g.*, *Virmani v. Presbyterian Health Servs.*, 488 S.E.2d 284, 287–88 (N.C. Ct. App. 1997) (holding that enactment of bylaws pursuant to preexisting duty does not create a contract but that offering staff privileges is sufficient consideration to create same); *see also* *Sadler v. Dimensions Health Corp.*, 787 A.2d 807 (Md. Ct. Spec. App. 2001), *rev'd and remanded*, 836 A.2d 655 (Md. 2003); *cf. Monroe v. AMI Hosps. of Tex., Inc.*, 877 F. Supp. 1022, 1029 n.5 (S.D. Tex. 1994) (noting that bylaws do not constitute contract under Texas law).

¹⁶² PEER REVIEW GUIDEBOOK, *supra* note 49, at 23.

¹⁶³ *Id.* When the situation poses "immediate danger" to patients warranting immediate summary suspension of the physician's staff privileges, one individual can be designated as the decision-maker, commonly the chief of staff, or the decision can be made by the executive committee. *Id.*

¹⁶⁴ In *Pulido v. St. Joseph Memorial Hospital*, 547 N.E.2d 1383 (Ill. App. Ct. 1989), summary judgment was granted against a physician who pointed out that the same four-member executive committee conducted the investigation, found that summary suspension of staff privileges was warranted, and then also heard the appeal of their own decision, which they affirmed. *Id.* at 1387–90. The hospital board of trustees then affirmed. *Id.*

¹⁶⁵ The *Peer Review Guidebook* advocates giving the physician the full details of the complaint. PEER REVIEW GUIDEBOOK, *supra* note 49, at 23; *see also, e.g.*, *Campbell v. St. Mary's Hosp.*, 252 N.W.2d 581, 584 (Minn. 1977) (noting that the physician was notified of the investigation). It is not always the case that physicians are given notice that an investigation is being undertaken. *See, e.g.*, *Islami v. Covenant Med. Ctr., Inc.*, 822 F. Supp. 1361, 1365 (N.D. Iowa 1992) (noting that physician was not informed of investigation).

medical staff has conducted the investigation. If the medical staff executive committee has conducted the investigation, it will draw up the list of charges and its recommended corrective action. This judgment can then be appealed by the physician to the governing body of the hospital.¹⁶⁶ The appeal is not reviewed *de novo* but is based on the record created by the hearing in front of the executive committee.¹⁶⁷ The board of directors is commonly comprised of lay persons who are likely to concur with the medical judgments of the medical executive committee.¹⁶⁸ If the investigation has been undertaken by an *ad hoc* committee, it will draft the set of charges and make recommendations for corrective actions. The recommended corrective action of the *ad hoc* committee will be sent to the targeted physician who can file an appeal with the executive committee. The executive committee will have a summary, highly informal “hearing” in order to reach a decision. This decision can then be appealed to the board of directors.

Importantly, the HCQIA¹⁶⁹ grants immunity from suit for those who participate in the formal peer review hearing process if this hearing process was “fair.”¹⁷⁰ While this process sounds good on paper, in operation it creates a high risk that physicians will be sanctioned for a whole list of reasons that are unrelated to the quality of patient care.¹⁷¹ And the fairness precondition is currently being given no teeth by the reviewing courts and access to the court system to review peer review hearing

¹⁶⁶ See Van Tassel, *supra* note 110, at 1189–94; CAMH, *supra* note 158, at MS-24. After a highly informal “hearing” on the matter, the decision of the board of directors then constitutes a final action of the hospital that the physician can appeal to a trial court. PEER REVIEW GUIDEBOOK, *supra* note 49, at 28. This hearing is likely to be *pro forma* and informal as

hospital governing boards are normally composed of medical laymen who are unable to question the judgment of the staff on the evidence presented. Moreover, the board is dependent on the loyalty and goodwill of the medical staff and will be inclined to follow its recommendations for the sake of harmony in the hospital. Under these conditions, a board level hearing will often involve no more than the *pro forma* approval of the medial board’s decision.

Colteaux, *supra* note 159, at 907–08.

¹⁶⁷ PEER REVIEW GUIDEBOOK, *supra* note 49, at 28. In *Carson v. Northwest Community Hospital*, 548 N.E.2d 579 (Ill. App. Ct. 1989), the executive committee both conducted the investigation and recommended that the physician be summarily suspended. *Id.* at 580. The physician requested a hearing before the executive committee. After the hearing, the executive committee issued a decision sustaining the suspension based on its finding that the physician provided “inadequate post-operative care.” *Id.* The physician appealed and an *ad hoc* panel of five physicians convened nine times over six months to hear the case. *Id.* The panel found that the summary suspension should be lifted, conditioned on completion of training and one-year probationary status. *Id.* The hospital board of directors rejected the panel’s recommendation and reinstated the summary suspension. *Id.*

¹⁶⁸ Colteaux, *supra* note 159, at 907.

¹⁶⁹ 42 U.S.C. §§ 11101–11152 (2006); see also *supra* notes 109–13 and accompanying text (describing the HCQIA).

¹⁷⁰ Van Tassel, *supra* note 110, at 1194–97.

¹⁷¹ See *infra* Part V.B.2.

decisions is almost nonexistent.¹⁷² Importantly, as a result of the interpretation by the courts that the bad faith of the decision-makers does not render the proceeding unfair, peer review can be used to silence whistleblowers who attempt to improve quality of care.¹⁷³

IV. BLACKLISTED: THE END OF A PHYSICIAN'S CAREER

A physician clearly has a property interest in his or her license to practice medicine.¹⁷⁴ Many states¹⁷⁵ also acknowledge staff privileges as a property right standing alone because the loss of staff privileges has major implications for a physician's ability to practice medicine and negatively impacts the scope of the license to practice granted by the state.¹⁷⁶ A good example is that of a surgeon. For a surgeon, the inability to use hospital facilities to treat patients so greatly curtails the physician's ability to practice his or her profession that it is, in effect, the end of that physician's career and his or her license to practice medicine is worthless.¹⁷⁷ The clearest example of this impact is when there is only

¹⁷² See Kadar, *supra* note 87, at 18–20 (explaining how this lack of access to the judicial system is insulating bad faith peer review as courts engage in circular reasoning by, first, refusing to find bad faith relevant as long as there was a reasonable belief that the sanction was justified and, second, deferring to the judgment of the decision-makers on whether the judgment was reasonably justified).

¹⁷³ See *infra* Part V.B.2.b.

¹⁷⁴ That a professional license is property and is protected by the Constitution is recognized by both state courts, *see, e.g.*, *State ex rel. Kassabian v. State Bd. of Med. Exam'rs*, 235 P.2d 327, 331 (Nev. 1951), and by federal law, *see Schware v. Bd. of Bar Exam'rs*, 353 U.S. 232, 238–39 (1957).

¹⁷⁵ In many states, the general rule is that a physician's staff privileges constitute a property interest protected by the Due Process Clause of the Fourteenth Amendment. *See, e.g.*, *Darlak v. Bobear*, 814 F.2d 1055, 1061 (5th Cir. 1987) (“Where medical staff privileges have been held to constitute an interest protected by the fourteenth amendment, it has been because there was an explicit or implicit agreement providing for no termination of the privileges without cause and a hearing, or because denial of staff privileges ‘might effectively foreclose . . . practicing in the area because of harm to [a] professional reputation and because of the lack of other [comparable] facilities.’” (quoting *Daly v. Sprague*, 675 F.2d 716, 727 (5th Cir. 1982))); *Lew v. Kona Hosp.*, 754 F.2d 1420, 1424 (9th Cir. 1985) (“The state of Hawaii has recognized a licensed doctor's property right in employment as a probationary hospital staff member.”); *Anton v. San Antonio Cmty. Hosp.*, 567 P.2d 1162, 1174 (Cal. 1977) (“[T]he essential nature of a qualified physician's right to use the facilities of a hospital is a property interest which directly relates to the pursuit of his livelihood.’ This interest is clearly fundamental . . .”).

¹⁷⁶ See BARRY R. FURROW ET AL., *HEALTH LAW* § 7-1, at 374 (5th ed. 2004) (explaining that a precondition to the practice of medicine is access to hospitals); *McCall, supra* note 155, at 175 (“A physician's livelihood is dependent on acquiring and maintaining hospital staff privileges. This access to hospital facilities is necessary for most physicians to adequately treat and care for patients, to maintain their medical practice, and to pursue their medical career.”); Note, *The Physician's Right to Hospital Staff Membership: The Public-Private Dichotomy*, 1966 WASH. U. L.Q. 485, 510–11 (noting that a successful doctor must have access to hospitals).

¹⁷⁷ *McCall, supra* note 155, at 175; *FURROW, supra* note 176, at 374 (explaining that precondition to the practice of medicine is access to hospitals).

one hospital facility in the community.¹⁷⁸ Termination of clinical privileges at that one hospital means that the physician will be barred from the practice of medicine in that community.¹⁷⁹

Even for a physician who practices in a very large community with multiple hospitals, an adverse peer review outcome can have the same disastrous result. All hospitals must check the NPDB for negative reports as part of the background check done as part of the credentialing process before the physician will be allowed to admit and treat patients in that hospital.¹⁸⁰ Once a physician has had his hospital staff privileges terminated or curtailed at one hospital, a second hospital is highly unlikely to allow the physician staff privileges as, in so doing, the second hospital places itself at risk of being sued for negligent credentialing.¹⁸¹

In addition, if a physician has staff privileges at several hospitals, as many do, the termination or limitation of staff privileges at one hospital is highly likely to result in the same limitation (or greater limitations or termination) at the other hospitals.¹⁸² This is because all hospitals are obligated to check the NPDB on all physicians who have staff privileges every two years.¹⁸³

¹⁷⁸ *Kiracofe v. Reid Memorial Hosp.*, 461 N.E.2d 1134, 1142 (Ind. Ct. App. 1984) (Ratliff, J., concurring) (noting that when a hospital is the only one in a community, “its economic impact is great, and the denial of hospital privileges, in many cases, is tantamount to denying a physician the opportunity to practice his or her chosen profession”). In *Greisman v. Newcomb Hospital*, 192 A.2d 817 (N.J. 1963), the court described the situation as follows:

The Newcomb Hospital is the only hospital in the Vineland metropolitan area and it is publicly dedicated, primarily to the care of the sick and injured of Vineland and its vicinity Doctors need hospital facilities and a physician practicing in the metropolitan Vineland area will understandably seek them at the Newcomb Hospital. Furthermore, every patient of his will want the Newcomb Hospital facilities to be readily available. It hardly suffices to say that the patient could enter the hospital under the care of a member of the existing staff, for his personal physician would have no opportunity of participating in his treatment; nor does it suffice to say that there are other hospitals outside the metropolitan Vineland area, for they may be too distant or unsuitable to his needs and desires. All this indicates very pointedly that, while the managing officials may have discretionary powers in the selection of the medical staff, those powers are deeply imbedded in public aspects, and are rightly viewed, for policy reasons . . . as fiduciary powers to be exercised reasonably and for the public good.

Id. at 824.

¹⁷⁹ *Kiracofe*, 461 N.E.2d at 1142; *Greisman*, 192 A.2d at 824.

¹⁸⁰ See *supra* note 143 and accompanying text.

¹⁸¹ In a U.S. General Accounting Office (GAO) report on the problems with the accuracy of the data contained in the NPDB, the agency acknowledged that the information contained in the data bank “can affect a practitioner’s reputation and livelihood.” U.S. GEN. ACCOUNTING OFFICE, *supra* note 108, at 3. A HRSA survey revealed that NPDB users, including credentialing committees, chiefs of the medical staff, department chairs, and the chief executive officers, found the reports to be an important part of the credentialing process. See Teresa Waters et al., *The Role of the National Practitioner Data Bank in the Credentialing Process*, 21 AM. J. MED. QUALITY 30, 34 (2006).

¹⁸² See *infra* note 185.

¹⁸³ See *supra* note 143 and accompanying text.

As explained by Dr. Edward Dench, Jr., former president of the Pennsylvania Medical Society, a data bank report “can essentially make you unemployable, and it can be the difference between getting insurance and not getting insurance.”¹⁸⁴ This opinion is confirmed by an extensive study commissioned by the State of California into the reasons for the low and declining level of reporting of negative peer review actions to the NPDB:

[P]hysicians who have been the subject of a[] [negative peer review] state that it is difficult or impossible to find a new position, their professional lives are ruined, other entities will not grant privileges even if they have fulfilled the terms of the discipline, and they spend years and hundreds of thousands of dollars in court trying to clear their professional names and reputations. . . . Physicians who had experienced [having a negative peer review report state that it] . . . was a “career ender.”¹⁸⁵

Take the case of Dr. John Ulrich, Jr. Dr. Ulrich protested the layoffs of the people who filled two staff positions at the county-owned Laguna Honda Hospital and then joined several others in sending a letter of protest as the layoffs would harm patient care.¹⁸⁶ In less than two weeks, Dr. Ulrich was informed that he was being investigated for clinical incompetence,¹⁸⁷ charges that were later determined by the state board of medial licensure to be unfounded.¹⁸⁸ When Dr. Ulrich heard of the charges, he resigned his staff privileges, not realizing that the charges and his resignation would be reported to the NPDB.¹⁸⁹ The report the hospital sent to the California Medical Board and the NPDB stated:

Dr. Ulrich resigned from the Medical Staff, and relinquished his privileges, following receipt of a letter announcing the commencement of a formal investigation into his practice and professional conduct as a member of the Medical Staff and while caring for patients at the Hospital. That investigation was prompted as a result of concerns regarding apparent deficiencies in his practice and conduct spanning the full range of Hospital care, including incomplete diagnoses, inappropriate diagnostic and therapeutic orders, failures to ac-

¹⁸⁴ Steve Twedt, *A Negative Data Bank Listing Isn't Easy To Erase*, PITT. POST-GAZETTE, Oct. 27, 2003, at A7.

¹⁸⁵ JEAN ANN SEAGO ET AL., LUMETRA, COMPREHENSIVE STUDY OF PEER REVIEW IN CALIFORNIA: FINAL REPORT 65, 94 (2008), available at http://www.mbc.ca.gov/publications/peer_review.pdf (“[Physicians with negative peer review reports] described not being able to find any position or job after having a[] [negative] report filed and spending three to five years in [peer review] hearings and other procedures to fight for their reputations, even after the [licensure board] found no wrongdoing on their part. They reported spending thousands of dollars to fight the charges so they could again practice as physicians”).

¹⁸⁶ *Ulrich v. San Francisco*, 308 F.3d 968, 972 (9th Cir. 2002).

¹⁸⁷ *See id.*

¹⁸⁸ *Id.* at 973–74.

¹⁸⁹ *Id.* at 973.

cept appropriate responsibility for the course of patient treatment, and an overall absence of clear, effective management of hospitalizations. Dr. Ulrich submitted his resignation before this investigation had progressed to any findings or recommendations.¹⁹⁰

When he learned of the NPDB report, Dr. Ulrich tried to rescind his resignation.¹⁹¹ The hospital refused, so Dr. Ulrich sued. The NPDB refused to remove the report in spite of the California Medical Board's findings that the charges were unfounded.¹⁹² At the trial, the presidents of two California medical associations told the court that "it will be virtually impossible" for Dr. Ulrich to find work at any U.S. hospital with that report in the data bank.¹⁹³

The federal district court held that, once the hospital accepted Dr. Ulrich's resignation, the hospital had no obligation to rescind the report that it made to the NPDB.¹⁹⁴ Thus, the fact that there was a report by the hospital that detailed the charges against Dr. Ulrich, and the fact that he resigned his privileges in the face of those charges, was an accurate reflection of the facts. This meant that the report contained in the NPDB was an accurate reflection of what had occurred at the hospital level.¹⁹⁵ Ultimately, the Ninth Circuit Court of Appeals held that Dr. Ulrich could pursue his argument that he had been retaliated against for exercising his free speech rights.¹⁹⁶ As of 2003, five years after the report was made to the NPDB, Dr. Ulrich was still fighting to have the report removed.¹⁹⁷

An analysis of the NPDB Public Use File for 1990 to 2009 found that, of 10,672 physicians who had been sanctioned by either a restriction or termination of their clinical privileges, 3218 lost their privileges permanently and 389 lost their privileges for more than a year.¹⁹⁸ The bottom line for these 3218 physicians is that their ability to practice medicine by admitting their patients into hospitals for treatment has either been seriously curtailed or completely eliminated. This inability to treat their patients results in severe contraction of the scope of their license to practice medicine granted by the state. For some, this limitation on the scope of the ability to practice medicine, or the effective extinguishment of the license to practice, will further the public's inter-

¹⁹⁰ *Id.*

¹⁹¹ *Id.*

¹⁹² *Id.* at 974.

¹⁹³ *Id.*

¹⁹⁴ *Id.*

¹⁹⁵ *Id.*

¹⁹⁶ *Id.* at 981.

¹⁹⁷ Tweet, *supra* note 184.

¹⁹⁸ ALAN LEVINE ET AL., STATE MEDICAL BOARDS FAIL TO DISCIPLINE DOCTORS WITH HOSPITAL ACTIONS AGAINST THEM 1 (2011), available at <http://www.citizen.org/documents/1937.pdf>. Hospitals are required to forward their NPDB reports to each of the state licensure boards where the targeted physician is licensed. 45 C.F.R. § 60.5 (2011).

est in protecting patients from harm. But others will have suffered from a grave injustice as fully explained *infra* in Part VI.B.2.

Over and above the almost immediate impact of a negative NPDB report on employment on the scope of the license to practice medicine and on the ability to properly treat patients, the more long-term problem the physician will face is whether the negative peer review report will trigger an investigation by the state licensure board. One study has revealed that there is a state-to-state disparity between licensure boards on whether to pursue licensure actions based on information received from hospital peer review.¹⁹⁹ Importantly, forty-five percent of the physicians who were reported to the NPDB faced follow-up state licensure board actions against them.²⁰⁰

With regard to the broad impact that the NPDB reports have on physicians and their employment prospects generally, as well as physicians' access to hospital facilities in order to practice medicine, a national survey conducted by HRSA revealed that in 2007 alone, 48,075 licensure, credentialing, or membership decisions were affected by information contained in the NPDB.²⁰¹

Adding to the cascade of negative effects a physician faces from a negative peer review report is the loss of both medical insurance and the termination of managed care contracts. In most states, a physician cannot practice without liability insurance. The inability to obtain insurance then turns the license to practice medicine into a useless piece of paper. And the loss of managed care contracts alone can destroy a physician's practice, even without all of the other negative consequences of being blacklisted.²⁰² The amazing growth of managed care compels the participation of almost all healthcare providers in managed care contracts. Physicians who are not part of a practice group with managed care con-

¹⁹⁹ ALAN LEVINE & SIDNEY WOLFE, HOSPITALS DROP THE BALL ON PHYSICIAN OVERSIGHT: FAILURE OF HOSPITALS TO DISCIPLINE AND REPORT DOCTORS ENDANGERS PATIENTS 13 (2009), available at <http://www.citizen.org/documents/18731.pdf>. The acting director of the Office of Professional and Medical Conduct in New York state said that thirty-one percent of the facility reports her board receives have led to charges of misconduct or surrender of license. This means that nearly one in three mandatory reports results in the board opening a disciplinary action. In many states, fewer than ten percent of consumer complaints lead to disciplinary complaints. *Id.*

²⁰⁰ LEVINE ET AL., *supra* note 198, at 1; LEVINE & WOLFE, *supra* note 199, at 13.

²⁰¹ *Id.* at 6 & n.7. The question that the HRSA survey asked was, "Would your decision regarding the practitioner have been different if you had not received the NPBD response?" *Id.* at n.7.

²⁰² *Potvin v. Metro. Life Ins. Co.*, 997 P.2d 1153, 1160 (Cal. 2000) ("[T]he American Medical Association and the California Medical Association, assert in their joint brief that . . . 'the control exercised by managed care organizations makes access to provider panels a practical prerequisite to any effective practice as a health care provider.' Various legal commentators agree. . . . [R]emoving individual physicians from preferred provider networks . . . could significantly impair those physicians' practice of medicine."); see also John P. Little, Note, *Managed Care Contracts of Adhesion: Terminating the Doctor-Patient Relationship and Endangering Patient Health*, 49 RUTGERS L. REV. 1397, 1448 (1997) ("Many physicians rely on [managed care] participation to maintain their practices.").

tracts, or who are not preferred providers with multiple managed care organizations, have a difficult time maintaining a practice. In order to be considered for, or maintain, these contracts, healthcare providers must work to stay in good standing with these managed care organizations. Physicians who lose hospital staff privileges for quality of care reasons are highly likely to face the immediate termination of managed care contracts.

V. THE CONSTITUTIONALITY OF NPDB PHYSICIAN BLACKLISTING

Unfortunately, in light of the serious consequences to the physician, it appears that the NPDB is based on private hospital peer review processes that fail to fairly protect the property and liberty rights of those targeted physicians. The private hospital peer review processes employed by many hospitals not only fail to offer any quality of care benefits to off-set these fairness and constitutional concerns, many of these processes may actually act to negatively impact the quality of patient care, increase the cost of healthcare, and decrease access to healthcare.

It is important to note that the state action necessary for the constitutional violations discussed in the next Section arises when the federally run NPDB sends negative peer review reports to the private hospitals, other healthcare providers, insurance companies, or managed care entities. This act of blacklisting by the federal government is the state action that is the predicate for the due process claims discussed in the next Section.

A. *Infringement on Protected Liberty and Property Interests*

The Fifth and Fourteenth Amendments state that the government may not deprive a person of life, liberty, or property without due process of law.²⁰³ Physician blacklisting negatively impacts both the physician's liberty interest in his or her name, reputation, and integrity, as well as the physician's property interest in the state-issued license to practice medicine. Both of these deprivations occur without due process of law.

²⁰³ U.S. CONST. amend. V ("No person shall . . . be deprived of life, liberty, or property, without due process of law . . ."); U.S. CONST. amend. XIV, § 1 ("No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.").

1. A Physician's Property Interest in the License to Practice Medicine

As discussed *supra*,²⁰⁴ a physician clearly has a property interest in his or her license to practice medicine.²⁰⁵ Many states²⁰⁶ also acknowledge staff privileges as a property right in and of itself because loss of staff privileges has major implications for a physician's ability to practice medicine and negatively impacts the scope of the license to practice granted by the state.²⁰⁷ Once again, a good example of how the scope of a physician's license to practice medicine is curtailed is when a surgeon is barred from obtaining privileges at a hospital so that the physician cannot treat his or her patients. This is the functional equivalent of a state licensure board placing restrictions on a physician's license to practice, which, obviously, cannot be done without providing a full due process hearing.

2. A Physician's Liberty Interest in Reputation

A series of three U.S. Supreme Court cases, *Wisconsin v. Constantineau*,²⁰⁸ *Goss v. Lopez*,²⁰⁹ and *Paul v. Davis*,²¹⁰ setup the legal framework for evaluating a physician's liberty interest to determine if it rises to the level of importance necessary to invoke due process protections. The first case, *Wisconsin v. Constantineau*,²¹¹ involved a statute that created a police-maintained blacklist of people who were labeled "excessive" drinkers.²¹² The statute allowed the police to distribute these lists to local liquor stores to prevent those who were blacklisted from being allowed to purchase liquor.²¹³ The Supreme Court agreed that this blacklisting infringed on Constantineau's liberty interest in her reputation without due process.²¹⁴ The Court found that being blacklisted was

²⁰⁴ See *supra* notes 174–76 and accompanying text.

²⁰⁵ See *supra* notes 174–76 and accompanying text.

²⁰⁶ See *supra* note 175 and the authorities cited therein.

²⁰⁷ FURROW, *supra* note 176, at 374 (explaining that a precondition to the practice of medicine is access to hospitals); McCall, *supra* note 155, at 175 ("A physician's livelihood is dependent on acquiring and maintaining hospital staff privileges. This access to hospital facilities is necessary for most physicians to adequately treat and care for patients, to maintain their medical practice, and to pursue their medical career."); Note, *supra* note 176, at 510–11 (noting that a successful doctor must have access to hospitals).

²⁰⁸ 400 U.S. 433 (1971).

²⁰⁹ 419 U.S. 565 (1975).

²¹⁰ 424 U.S. 693 (1976).

²¹¹ 400 U.S. 433.

²¹² *Id.* at 435–36.

²¹³ *Id.* at 435.

²¹⁴ *Id.* at 436.

“degrading” and that “a person’s good name, reputation, honor or integrity” was at stake and that the blacklisted individual was entitled to notice and an opportunity to be heard.²¹⁵

Four year later, the Court in *Goss* held that a high school that suspended a group of students for ten days without a hearing violated the Fourteenth Amendment as “[t]he fourteenth amendment forbids the State to deprive any person of life, liberty, or property without due process of law.”²¹⁶ The Court explained that “[p]rotected interests in property are normally ‘not created by the Constitution. Rather, they are created and their dimensions are defined’ by an independent source such as state statutes or rules entitling the citizen to certain benefits.”²¹⁷ The Court found that the students had a property interest in education by virtue of the State of Ohio’s recognition of a right to an education.²¹⁸ The Court went on to hold that this interest in education was negatively impacted without due process of law:

The authority possessed by the State to prescribe and enforce standards of conduct in its schools although concededly very broad, must be exercised consistently with constitutional safeguards. Among other things, the State is constrained to recognize a student’s legitimate entitlement to a public education as a property interest which is protected by the Due Process Clause and which may not be taken away for misconduct without adherence to the minimum procedures required by that Clause.²¹⁹

Importantly, the Court also found that the student’s liberty interests were also negatively impacted without due process of law:

The Due Process Clause . . . forbids arbitrary deprivations of liberty. “Where a person’s *good name, reputation, honor, or integrity* is at stake because of what the government is doing to him,” the minimal requirements of the Clause must be satisfied. School authorities here suspended [the high school students] from school for periods of up to 10 days based on charges of misconduct. If sustained and recorded, those charges *could seriously damage the students’ standing with their fellow pupils and their teachers as well as interfere with later opportunities for higher education and employment.*²²⁰

The Court in *Goss* was unimpressed with the high school’s argument that

²¹⁵ *Id.* at 437.

²¹⁶ *Goss v. Lopez*, 419 U.S. 565, 572 (1975).

²¹⁷ *Id.* at 572–73 (citing *Bd. of Regents v. Roth*, 408 U.S. 564, 577 (1972)).

²¹⁸ *Id.* at 573–74.

²¹⁹ *Id.* at 574.

²²⁰ *Id.* at 574–75 (emphasis added) (citations omitted) (quoting *Constantineau*, 400 U.S. at 437).

even if there is a right to a public education protected by the Due Process Clause generally, the Clause comes into play only when the State subjects a student to a “severe detriment or grievous loss.” The loss of 10 days . . . is neither severe nor grievous and the Due Process Clause is therefore of no relevance.²²¹

The Court stated that it does not decide whether there is a protected interest at stake by looking at the weight of the interest at stake, but does so by looking at the *nature* of that interest²²²:

[The students] were excluded from school only temporarily, it is true, but the length and consequent severity of a deprivation, while another factor to weigh in determining the form of the hearing, ‘is not decisive of the basic right’ to a hearing of some kind.’ The Court’s view has been that, as long as a property deprivation is not *de minimis*, its gravity is irrelevant to the question whether account must be taken of the Due Process Clause. A 10-day suspension from school is not *de minimis*, in our view, and may not be imposed in complete disregard of the Due Process Clause. . . . Neither the property interest in educational benefits temporarily denied nor the liberty interest in reputation . . . is so insubstantial that suspensions may constitutionally be imposed by any procedure the school chooses, no matter how arbitrary.²²³

One year later, in the last of the trio, the Court in *Paul v. Davis*²²⁴ narrowed the due process protection afforded a person’s liberty interest in his or her reputation by finding that the publication of the name of an individual on a blacklist of shoplifters prior to any actual conviction did not rise to the level of a constitutional violation.²²⁵ In *Paul*, Edward Davis was arrested for alleged shoplifting. Davis’s name and photo were then placed on a blacklist of “active” shoplifters that was posted in local shops before the shoplifting charges were proven in court.²²⁶ Davis sued under § 1983 claiming that he had been deprived of his “liberty” without due process of law.²²⁷ As in *Constantineau*, Davis was blacklisted without any notice or hearing opportunity.²²⁸

The *Paul* Court found that the publication of the shoplifter’s list did not violate the Due Process Clause.²²⁹ The Court distinguished *Constantineau* and *Goss* by stating that an interest in reputation alone is not enough to create a protected interest. In addition to damage to reputa-

²²¹ *Id.* at 575.

²²² *Id.* at 575–76.

²²³ *Id.* at 576 (citations omitted) (quoting *Fuentes v. Shevin*, 407 U.S. 67, 86 (1972)).

²²⁴ 424 U.S. 693 (1976).

²²⁵ *Id.* at 712.

²²⁶ *Id.* at 694–96.

²²⁷ *Id.* at 696–97.

²²⁸ *Id.* at 696.

²²⁹ *Id.* at 712.

tion by virtue of state action, the complainant must have had “a right or status previously recognized by state law” that was “distinctly altered or extinguished.”²³⁰ The narrowing of the scope of the liberty interest in reputation by the Court in *Paul* has come to be known as the “stigma-plus” test.²³¹

The publication of the negative peer review reports by the NPDB is more analogous to *Constantineau* and *Goss* than to *Paul*. As in all three of the cases, the reports published by the NPDB officials caused damage to the physicians’ reputations. However, unlike Davis in *Paul*, the targeted physicians have a right recognized by state law—the license to practice medicine that has been “distinctly altered” and, in some cases, effectively “extinguished” similar to the situations in *Constantineau* and *Goss*. And compared to the interests at stake in *Constantineau* and *Goss*—namely, the right to purchase liquor and the right not to be excluded from school for ten days—physician blacklisting implicates far more pressing state-recognized rights: the right to practice medicine and the right to provide the full range of medical services to the patients in a physician’s practice as granted by the state. As described earlier,²³² when the NPDB publishes the negative results of peer review hearings, it is clear that it damages the good name, reputation, honor, and integrity of the targeted physician, seriously damaging the physician’s standing with their fellow physicians and patients. In addition, the targeted physician’s ability to practice medicine pursuant to the state-granted license is irreparably damaged. Once again, a cardiovascular surgeon or a neurosurgeon who is unable to obtain hospital admitting privileges because they have been blacklisted will be unable to perform surgeries, severely circumscribing the scope of their license to practice medicine. In many cases, a physician’s ability to treat his or her patients will be effectively barred.²³³

²³⁰ *Id.* at 711.

²³¹ DAVID W. LEE, HANDBOOK OF SECTION 1983 LITIGATION § 5.05[A], at 605 (2010 ed.) (“The stigma-plus refers to a claim brought for injury to one’s reputation (the stigma), coupled with the deprivation of some tangible interest, such as the loss of government employment or property right (the plus), without adequate process.”).

²³² See *supra* Part IV.

²³³ In contrast to the situation that occurs when a physician is blacklisted by the NPDB is the case of *Siegert v. Gilley*, 500 U.S. 226 (1991). In *Siegert*, a physician voluntarily resigned his position at a federal hospital to avoid being terminated. *Id.* at 227–28. He obtained a new position at an Army hospital conditioned upon a background check that included obtaining references from his prior position. *Id.* at 228. The supervisor at the physician’s former job sent a negative reference letter and the physician was terminated from the Army hospital. *Id.* The physician sued for money damages claiming a violation of his liberty interest in reputation without due process. *Id.* at 229. The Court held that the physician’s claim was an attempt to constitutionalize the tort of defamation similar to the claim of the plaintiff in *Paul*. *Id.* at 232–34. As in *Paul*, the physician in *Siegert* failed to claim that, in addition to damage to reputation by virtue of state action, he had “a right or status previously recognized by state law” that was “distinctly altered or extinguished.” *Paul*, 424 U.S. at 711. Unlike the situations in *Paul* and *Siegert*, which both dealt solely with

It is important to note that the impact of physician blacklisting reaches far beyond the physician. When a licensed physician can no longer practice medicine, that physician's patients are deprived of access to their choice of healthcare provider and many of those same patients who are on Medicare and Medicaid may lose access to healthcare entirely.²³⁴

As the physician blacklisting by the NPDB negatively impacts a physician's constitutionally protected liberty and property interests, the next step is to determine what procedures are necessary to avoid erroneous deprivation of these interests.

B. *Applying Mathews v. Eldridge*

In *Mathews v. Eldridge*,²³⁵ the U.S. Supreme Court established a three-part rubric for determining whether state and federal procedures meet due process requirements. As recently explained in *Hamdi v. Rumsfeld*, the *Mathews* test is “[t]he ordinary mechanism that we use for balancing such serious competing interests, and for determining the procedures that are necessary to ensure that a citizen is not ‘deprived of life, liberty, or property, without due process of law.’”²³⁶ The *Mathews* test involves the balancing of three factors:

[T]he private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional and substitute procedural requirement would entail.²³⁷

Application of this balancing test indicates that the practice of the NPDB of relying on incorrect and misleading data and relying on the

claims of damage to reputation, blacklisting by the federally run NPDB negatively impacts the scope of the state-granted license to practice medicine. Additional differences include the fact that the physician in *Seigert* voluntarily left his first position, waiving his due process rights, and the fact that the case dealt with one reference letter. *Id.* at 228. In juxtaposition, the NPDB is a national system for the mandated dissemination of negative peer review reports created without due process that incorporates all hospitals and a significant number of other healthcare providers, state licensure departments, insurance companies, and managed care entities in the entire country.

²³⁴ See Katharine A. Van Tassel, *Does the Hospital Peer Review Process Negatively Impact Healthcare Quality, Cost and Access?*, STETSON L. REV. (forthcoming 2012) (describing how the hospital peer review hearing process, coupled with the NPDB reporting system, could be negatively impacting healthcare quality, cost, and access with a particularly negative potential impact on minority physicians and minority and low-income patients).

²³⁵ 424 U.S. 319 (1976).

²³⁶ 542 U.S. 507, 528–29 (2004) (quoting U.S. CONST. amend. V).

²³⁷ *Mathews*, 424 U.S. at 335; see also Wright, *supra* note 51, at 137.

reports of private hospital peer review hearings to create its blacklist violates due process. As such, additional protections are required to avoid the erroneous blacklisting of physicians.

1. The Private Interest Affected by the Official Action

As discussed, the liberty and property interests at stake for blacklisted physicians are significant. Importantly, the physician's inability to practice medicine continues for as long as the physician remains on the blacklist, which will be the rest of the physician's lifetime. While violent sexual predators are also blacklisted for life, nonviolent sexual predators are subject to far shorter blacklisting—ten years for some—and some sexual predators are not blacklisted at all. Once again, unlike physicians, all sexual predators are provided with full due process hearings before being blacklisted. It is unclear why physicians, who are serving the community, are not afforded the same protection as sexual predators prior to being blacklisted.

2. The Risk of Erroneous Deprivation Through the Procedures Used

There is a very high risk that a physician will be erroneously blacklisted by the NPDB and will be subject to loss of liberty and property without recourse. The blacklisting database contains misleading and inaccurate data.²³⁸ In addition, it appears to suffer from serious underreporting of data.²³⁹ Finally, and maybe most importantly from a policy standpoint, the NPDB relies on reports from private hospital peer review processes that are flawed both in theory and in practice.²⁴⁰ These processes, at best, rely on the application of inherently vague and subjective criteria. But in practice, they are much worse. These vague standards can be applied to create a negative peer review report based on reasons that are unrelated to quality of patient care. These reasons could be to silence whistleblowers who report poor quality of care, to remove economic competition, to give vent to personal animus, or to discriminate.²⁴¹ In addition, many of these standards allow for decision-making that relies upon highly unreliable evidence of what constitutes

²³⁸ See *infra* Part V.B.2.a.

²³⁹ See *infra* Part V.B.2.a.

²⁴⁰ In order to resolve questions regarding underreporting, the California legislature commissioned an independent review of peer review in the state. The resulting report confirmed the concerns of many: "This report cites inconsistencies in the way [healthcare] entities conduct peer review, select and apply criteria . . . and interpret [state] law . . ." JEAN ANN SEAGO ET AL., *supra* note 185, at 1.

²⁴¹ See *infra* Part V.B.2.b.ii.

quality of care.²⁴² These processes are both over broad in that they allow negative reports to be created for physicians who use best practices²⁴³ and are under inclusive in that they allow physicians who ignore best practices to escape criticism.²⁴⁴ Adding to all of these other problems is that the likelihood that a choice of treatment will lead to a negative peer review report is more closely linked to the particular hospital and state where the care is provided than to the quality of that treatment.²⁴⁵

In comparison, the standards that are contained in the statutes that criminalize sex offenses are clearly articulated, providing both notice of the conduct that will be penalized and placing strict limitations on arbitrary and capricious decision-making. And the likelihood of prosecution is linked to the nature of the criminal conduct and not to the location where the conduct occurred.

The first of the following Subsections describes the misleading and inaccurate data contained in the database. Then, the next two Subsections explain the different risks of error inherent in the two main standards that hospital peer review processes rely upon to evaluate physician competence. The two main categories of standards²⁴⁶ are: (1) those that allow complete discretion of the hospital administrators; and (2) those that rely on customary care standards.

a. The NPDB Contains Misleading and Inaccurate Data

The NPDB contains misleading data as there is significant underreporting of clinical privilege restrictions by hospitals and other healthcare providers²⁴⁷ as well as underreporting of medical malpractice payments.²⁴⁸ In the context of hospital peer review, underreporting has been a significant and ongoing problem. Early estimates by the AMA were that there would be about 10,000 reports annually.²⁴⁹ This estimate appears extremely conservative in light of the IOM report that 98,000 people are killed each year in hospitals as a result of preventable medical mistakes.²⁵⁰ However, for the entire period from 1990 to 1999, fewer than 9000 reports were made.²⁵¹ From 2000 until 2007, the range of

²⁴² See *infra* Part V.B.2.b.ii.

²⁴³ See *infra* Part V.B.2.b.ii.

²⁴⁴ See *infra* Part V.B.2.b.ii.

²⁴⁵ See *infra* Part V.B.2.b.iii.(A).

²⁴⁶ For a full discussion of all of the standards used to measure clinical competence in hospital peer review, see Van Tassel, *supra* note 110, at 1207–41.

²⁴⁷ See U.S. GEN. ACCOUNTING OFFICE, *supra* note 108, at 10.

²⁴⁸ *Id.* at 10–12.

²⁴⁹ *Id.* at 13.

²⁵⁰ See INST. OF MED., *supra* note 130, at 26.

²⁵¹ U.S. GEN. ACCOUNTING OFFICE, *supra* note 108, at 13.

reporting has been from the low in 2006 of 532 to the high of 687 in 2003.²⁵²

Even more troubling is the wide variation in reporting from hospital to hospital. By December of 2007, approximately fifty percent of hospitals in the United States had never reported a single negative peer review action to the NPDB.²⁵³ And reporting varies from state to state, with seventy-five percent of hospitals in Connecticut participating by filing reports but only thirty percent of hospitals in Louisiana participating in the program by reporting.²⁵⁴ In fact, relying on hospital-specific studies, a HRSA analysis concluded that “clinical privilege reporting seemed to be concentrated in a few facilities even in States with comparatively high overall hospital clinical privileging reporting levels.”²⁵⁵ This data suggests that the likelihood of being reported to the NPDB is more related to the location where the physician is practicing than the quality of the care that is provided.²⁵⁶

While some claim that the low and declining level of reporting²⁵⁷ is related to a continued fear of retaliatory litigation, it is likely that other factors are at play in light of how well-known it is that lawsuits by targeted physicians will be summarily dismissed.²⁵⁸ With regard to the consistently low level of reporting, studies suggest that physicians as a group have traditionally had a “cultural aversion” to turning in a peer

²⁵² LEVINE & WOLFE, *supra* note 199, at 37.

²⁵³ *Id.* at 2.

²⁵⁴ *Id.*

²⁵⁵ *Id.* at 9–10 (citing HEALTH RES. & SERVS. ADMIN., 2005 HRSA ANNUAL REPORT 8 (2005)).

²⁵⁶ Reporting avoidance is not hard to do. Hospitals can engage in workarounds by leveling sanctions that impact clinical privileges by less than thirty days, by placing physicians on a leave of absence, or using other types of nonreportable interventions. “[E]ntities try numerous remedial interventions (peer counseling, education, training, mentoring, observation, behavioral counseling, UCSD Physician Assessment and Clinical Education (PACE) Program) before informing the physician that a ‘final proposed action’ is being taken.” JEAN ANN SEAGO ET AL., *supra* note 185, at 64.

²⁵⁷ Laura-Mae Baldwin et al., *Hospital Peer Review and the National Practitioner Data Bank: Clinical Privileges Action Reports*, 281 J. AM. MED. ASS’N 349 (1999) (finding that NPDB reporting is low and declining). In the January 1995 issue of the California Medical Board’s newsletter, the president stated that “[o]ver the past year we have noted a deterioration in the cooperation required between hospitals and the Board in protecting consumer/patient safety. We have experienced incomplete reports . . . and, on some occasions, excuses for not reporting at all.” LEVINE & WOLFE, *supra* note 199, at 17 (quoting Rebecca Cohen & David Swankin, *Hospital Reporting to State Regulators and to the National Practitioner Data Bank*, CITIZEN ADVOC. CENTER, March 1997, at 2, 3).

²⁵⁸ For example, concerned about underreporting, the California legislature requested an independent review of peer review in the state. This study surveyed physicians across the state. The study revealed that more than one-half of the respondents had no reluctance in reporting poor physician performance of colleagues to hospital administrators, one-third were reluctant to report a friend or colleague, and only one-fifth were “fearful of being sued for restricting trade or some other potential retribution. JEAN ANN SEAGO ET AL., *supra* note 185, at 1.

for poor performance.²⁵⁹ With regard to the decline in reporting, it is possible that the NPDB itself may be serving as a disincentive to effective hospital peer review practices as there is a growing concern among physicians regarding the fairness of the NPDB reporting process.²⁶⁰

This underreporting is very misleading as it is likely to result in significant errors in hiring choices and the allocation of staff privileges. When choosing between two physicians who are both applying for hospital staff privileges, the hospital is likely to choose the physician who has no or fewer negative reports in the NPDB. In fact, because of the significant problem with underreporting, there is a very real possibility that the chosen physician actually has far more actual problems with the quality of patient care than the physician who is not chosen. As mentioned previously, in 2007 alone, 48,075 licensure, credentialing, or membership decisions were affected by information contained in the NPDB.²⁶¹

In the context of medical malpractice, many practitioners have been protected from being reported to the NPDB in situations involving the use of the “corporate shield.”²⁶² This is when the parties remove the physician’s name from claims and pleadings, leaving only the name of the hospital or other corporate entity. As the malpractice payment is made on behalf of the corporate entity, there is no obligation to report.²⁶³ Some opine that as many as “50% of other-wise required NPDB

²⁵⁹ LEVINE & WOLF, *supra* note 199, at 17–18.

²⁶⁰ Baldwin et al., *supra* note 257, at 354 (reporting “the high degree of dissatisfaction with the concept of the NPDB and its operation”); Nicholas Kadar, *How Courts Are Protecting Unjustified Peer Review Actions Against Physicians by Hospitals*, 16 J. AM. PHYSICIANS & SURGEONS 17, 21 (2011) (noting that courts are twisting HCQIA by finding that the bad faith of peer review decision-makers is not relevant); Lawrence R. Huntoon, *Sham Peer Review: Disaster Preparedness and Defense*, 16 J. AM. PHYSICIANS & SURGEONS 2 (2011) (detailing how doctors can be targeted based on politics and suggesting proactive defensive measures); John Dale Dunn, *The Art of War Adapted to U.S. Medicine 2011*, 16 J. AM. PHYSICIANS & SURGEONS 25 (2011) (using analogy to Sun Tzu’s *The Art of War* to deal with misconduct on the part of the hospital in pursuing peer review); *Hospitals Make War on Doctors*, ASS’N FOR AM. PHYSICIANS & SURGEONS (Mar. 31, 2011), http://www.aapsonline.org/index.php/site/article/hospitals_make_war_on_doctors (detailing how hospitals can abuse the peer review process); Yann H.H. van Geertruyden, Comment, *The Fox Guarding the Henhouse: How the Health Care Quality Improvement Act of 1986 and State Peer Review Protection Statutes Have Helped Protect Bad Faith Peer Review in the Medical Community*, 18 J. CONTEMP. HEALTH L. & POL’Y 239 (2001). An excellent and well-researched series on the number of physicians who have been targeted by abusive uses of peer review is detailed in an extensive series of articles written by Steve Twedt and John Beale of the *Pittsburgh Post-Gazette*. See, e.g., Steve Twedt, *The Cost of Courage: How the Tables Turn on Doctors*, PITT. POST-GAZETTE, Oct. 26, 2003, at A1 (first of the series). Additionally, there are a growing number of organizations that support physicians in their allegations against “sham peer review,” such as The Center for Peer Review Justice, Inc., the Semmelweis Society, the Association of American Physicians and Surgeons, Inc., and the Alliance for Patient Safety.

²⁶¹ LEVINE & WOLFE, *supra* note 199, at 6 & n.7.

²⁶² Haavi Morreim, *Malpractice, Mediation, and Moral Hazard: The Virtues of Dodging the Data Bank*, 27 OHIO ST. J. ON DISP. RESOL. 109, 137–41 (2012).

²⁶³ *Id.*

reports were thought to be diverted via the corporate shield.”²⁶⁴ Adding to the underreporting are the multiple legal ways that NPDB reporting can be avoided including paying out-of-pocket, waiving a patient’s debt or reimbursing a prior payment, payment of a claim via verbal demand, payments pursuant to mediation where there has been no written demand for payment, high–low agreements, and statutory presuit notification periods.²⁶⁵

In addition, when insurance companies do actually make a report, it can be misleading as many cases are settled for business reasons unrelated to problems with the care provided to the patients. For example, insurance companies may settle a case merely because the settlement demand is less than the cost of litigation, even if it is likely that the physician will ultimately prevail. This is especially the case in the large number of states that allow insurance companies to settle malpractice claims in spite of the protests of the physician that she or he met the standard of care and the case is frivolous.

Finally, with regard to the over probative value that decision-makers place on reports of medical malpractice payments generally, the HMPS, mentioned previously, concluded that there was a very weak correlation between malpractice claims or payments and negligence.²⁶⁶ The study demonstrated that medical malpractice claims are actually rarely made after a patient has been injured from a negligent act and that claims are frequently made when the injury was not caused by negligence.²⁶⁷ The Armed Forces Institute of Pathology reached a similar conclusion in its study of the relationship between malpractice payments and substandard care.²⁶⁸ The study found that malpractice-claim payments and amounts correlate poorly with standard of care determinations.²⁶⁹ Compounding this situation, a large number of the malpractice reports made to the NPDB do not make any mention of the role that the standard of care made in the decision to settle the claim.²⁷⁰

Thus, when choosing between two physicians who are both applying for hospital staff privileges, the hospital is likely to choose the physician who has fewer malpractice reports in the NPDB. In fact, just like the situation with negative peer review reports, because of the signifi-

²⁶⁴ *Id.* at 138.

²⁶⁵ *Id.* at 132–41

²⁶⁶ 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 (1991).

²⁶⁷ *Id.*

²⁶⁸ Richard L. Granville & Stephen V. Mawn, *A Threshold Question: How Do Payment Amounts in Medical Malpractice Claims Relate to the Medical Care Rendered?*, 94-1 *LEGAL MED. OPEN FILE* 6 (1994).

²⁶⁹ *Id.* at 6–9.

²⁷⁰ *Id.* at 5.

cant problem with underreporting, there is a very real possibility that the chosen physician actually has far more medical malpractice claims and settlements than the physician who is not chosen.

There are also serious weaknesses in the compilation of the data that raises questions about their reliability.²⁷¹ In a U.S. General Accounting Office (GAO) report of an investigation of the NPDB, it was noted that there are duplicate reports that overstate, and may in fact double, the amount of negative reports that the data bank has on any particular physician.²⁷² According to this study, one-third of the hospital peer review reports are inaccurate and a large number of the state licensure actions contained misleading or inaccurate information on the level of discipline given or the actual number of times a practitioner was subjected to discipline.²⁷³ Unfortunately for these physicians, the mechanisms for correcting these problems were also found by the GAO to be defective.²⁷⁴

Finally, there does not appear to be any mechanism to remove negative peer review reports in light of a subsequent finding by medical licensure boards that there is no merit to hospital charges of incompetence,²⁷⁵ even though medical licensure board proceedings are far more rigorous than private peer review and are conducted by disinterested third parties in keeping with due process requirements.

b. The Reliance on Vague Standards Used to Identify “Bad” Doctors Creates a High Risk of Error

After explaining the basic principles that animate the vagueness doctrine, the next two Subsections explain the different nature of the risks of error inherent in the two most common standards that hospital peer review processes rely upon to evaluate physician competence. The two main categories of standards²⁷⁶ are: (1) those that allow complete

²⁷¹ U.S. GEN. ACCOUNTING OFFICE, *supra* note 108, at 16.

²⁷² *Id.* at 14.

²⁷³ *Id.* at 22–24.

²⁷⁴ *Id.* at 16. It is important to note that this study was conducted in 2000 and that HRSA claims that the processes used by the NPDB to collect and record data have improved since that time. However, there has been no follow-up study or outside evaluation that documents whether these improvements have actually worked to improve the reliability of the data. An independent evaluation is particularly important before reaching any conclusions that these problems have been corrected as HRSA previously disagreed with many of the GAO’s findings that the NPDB processes were inadequate causing inadequate data. *Id.* at 16.

²⁷⁵ See *supra* notes 186–97 and accompanying text.

²⁷⁶ For a full discussion of all of the standards used to measure clinical competence in hospital peer review, see Van Tassel, *supra* note 110, at 1214–32.

discretion of the hospital administrators; and (2) those that rely on customary care standards.²⁷⁷

i. The Vagueness Doctrine

Vagueness principles call for clearly articulated standards that limit the discretion of the decision-makers and that provide notice of the conduct that will trigger penalties. As Justice Brennan explained, the absence of clearly articulated standards that are capable of objective application creates an unacceptable risk of arbitrary and capricious decision-making leading to a high risk of error²⁷⁸:

By demanding that government articulate its aims with a reasonable degree of clarity, the Due Process Clause ensures that state power will be exercised only on behalf of policies reflecting a conscious choice among competing social values; reduces the danger of caprice and discrimination in the administration of the laws; and permits meaningful judicial review of state actions.²⁷⁹

Clearly articulated rules are essential to avoiding the risk of error as “known standards . . . limit the allocation choices of . . . officials. They require that choices be made according to principle rather than the preference of the official.”²⁸⁰ As such,²⁸¹ courts reject claims that “a

²⁷⁷ See *infra* Part V.B.2.b.ii, iii.

²⁷⁸ These questions parallel the vagueness analysis most courts follow in the context of vagueness challenges to criminal statutes. See generally Robert Batey, *Vagueness and the Construction of Criminal Statutes—Balancing Acts*, 5 VA. J. SOC. POL’Y & L. 1, 25–26 (1997) (“In resolving questions under the vagueness doctrine, courts must first evaluate whether the allegedly deficient language raises problems of fair notice of the requirements of criminal law or of arbitrary and discriminatory enforcement by police or prosecutors. If there is sufficient concern on either of these fronts, a judge should balance the necessity for the ambiguous language to achieve the legislative goal against the chilling effect of the ambiguity on protected or desirable conduct.”).

²⁷⁹ *Whisenhunt v. Spradlin*, 464 U.S. 965, 969 (1983) (Brennan, J., dissenting).

²⁸⁰ ALFRED C. AMAN, JR. & WILLIAM T. MAYTON, *ADMINISTRATIVE LAW* 170–71 (2d ed. 2001). And, of equal importance, “[k]nown standards allow a person to better understand what . . . [is expected] of her, so that she can plan her life in some forehanded way.” *Id.* at 170. As Professor Lon Fuller observed, “[t]he first desideratum of a system for subjecting human conduct to the governance of rules is an obvious one: there must be rules.” LON L. FULLER, *THE MORALITY OF LAW* 46 (rev. ed. 1969); see also *Mayer v. Wing*, 922 F. Supp. 902, 911–12 (S.D.N.Y. 1996) (holding that a regulation that allowed for termination of in-home healthcare benefits when it was “inappropriate” allowed for arbitrary decision-making in violation of procedural due process as “[d]ue process demands that decisions regarding entitlements to government benefits be made according to ‘ascertainable standards’”).

²⁸¹ Professors Aman and Mayton, in their administrative law hornbook, explain that:

Using a due-process based prescription of standing rules, the courts, along with trying to assure evenhandedness, have also tried to assure a measure of stability in agency action. They have required agencies to develop, codify, and publish rules so that the private sector is informed of what it can expect from government and manage its af-

discretion to proceed by ad hoc orders rather than by rules is necessary to permit an agency to make decisions finely tuned to the facts and circumstances of an individual case.”²⁸²

In the context of a medical administrative proceeding like peer review,²⁸³ the vagueness doctrine is being used to challenge the hospital’s process for its neglect in failing to clarify vague standards through specific rules. Thus, fairness in this civil context refers to actions taken “according to known standards that are impartially applied through revealed procedures.”²⁸⁴ A good example that arose in a different context, but that is equally applicable here, is the case of *Soglin v. Kauffman*.²⁸⁵ In *Soglin*, several students were expelled by the administration of the University of Wisconsin which applied a “misconduct” standard. In finding that this standard was unconstitutionally vague, the court stated:

No one disputes the power of the University to protect itself by means of disciplinary action against disruptive students. Power to punish and the rules defining the exercise of that power are not, however, identical. Power alone does not supply the standards needed to determine its application to types of behavior or specific instances of “misconduct.”²⁸⁶

fairs accordingly. In this context, a requirement of rules has been described and applied as an aspect of a vagueness doctrine.

But unlike the usual vagueness doctrine case, the claim is not against the statute itself. Rather, the claim is against an agency, for its failure to render a vague statute more specific by implementing it through rules.

AMAN & MAYTON, *supra* note 280, at 72.

²⁸² *Id.* at 73. In *Dixon v. Love*, 431 U.S. 105, 115 (1977), the Supreme Court maintained that the ability of an agency to suspend a driver’s license by using a subjective case-by-case decision-making process that turned upon an “ordinary and reasonable care” standard, rather than objective rules, would reduce the fairness of the system. The Court also stated that “[t]he decision to use objective rules in this case provides drivers with more precise notice of what conduct will be sanctioned and promotes equality of treatment among similarly situated drivers.” *Id.*

²⁸³ In the context of private hospitals, courts have treated peer review as an administrative proceeding. In *Balkissoon v. Capitol Hill Hospital*, 558 A.2d 304 (D.C. 1989), the court explained that

[t]he actions of hospitals in regard to staff privileges can be analogized to administrative agencies. “Both the administrative agency and the hospital board of trustees do exercise discretion and bring expertise to their respective tasks. Both must also pay due respect to procedural safeguards whether because of constitutional due process or fundamental fairness.”

Id. at 308 n.8 (quoting *Garrow v. Elizabeth Gen. Hosp.*, 401 A.2d 533, 537–38 (N.J. 1979)); *see also* *Storrs v. Lutheran Hosps. & Homes Soc’y of Am., Inc.*, 609 P.2d 24, 29 n.14 (Alaska 1980) (holding that via stipulation of the parties, the decision made pursuant to the peer review process “should be treated as an administrative decision and that the review of that decision should be treated as a review of an administrative decision”).

²⁸⁴ *Id.* at 170.

²⁸⁵ 418 F.2d 163 (7th Cir. 1969).

²⁸⁶ *Id.* at 167.

Clearly, “[p]rocedures and hearings offer little protection without such rules and standards as might give content to the hearings.”²⁸⁷ Or, as the Fifth Circuit has so succinctly stated, “[t]he idea of a hearing is fine. But what is to be heard?”²⁸⁸

ii. Standards that Rely on the Unfettered Discretion of Hospital Administrators

Applying the vagueness doctrine to evaluate the standards used in hospital peer review leads to the conclusion that these standards afford few limitations on the discretion of the decision-makers leading to a high risk of arbitrary and capricious decision-making and error. In addition, these standards fail to provide notice to the physicians of the kind of conduct to avoid in order to avoid sanctions.

The most obvious example of a vague standard that is commonly used in peer review is one that expressly vests complete and unfettered discretion in decision-makers is one that gives a hospital’s governing body “the right to remove any member of the medical staff or to deprive any physician or surgeon of the privileges of the hospital whenever in their sole judgment the good of the hospital or the patients therein may demand it.”²⁸⁹ Also included in this category are those bylaws that are less blatant but, in application, still call for a purely subjective determination. These standards define the required level of competence as that which the decision-makers determine is the “best possible care,”²⁹⁰ or “adequate medical care,”²⁹¹ or “high quality medical care.”²⁹²

²⁸⁷ AMAN & MAYTON, *supra* note 280, at 73.

²⁸⁸ *Block v. Thompson*, 472 F.2d 587, 588 (5th Cir. 1973) (per curiam) (noting that in the absence of specific objective criteria, after a hearing on the pros and cons of granting or denying a privilege, the decision-makers could “take a show of hands and then adapt its decision to this momentary plebiscite”). This query was echoed by the Seventh Circuit when it stated that “[t]he requirements of due process include a determination of the issues according to articulated standards. The lack of such standards in this case deprives any hearing, whether before an agency or a court, of its meaning and value as an opportunity for the plaintiffs to prove their qualifications for assistance.” *White v. Roughton*, 530 F.2d 750, 754 (7th Cir. 1976); *see also Raper v. Lucey*, 488 F.2d 748 (1st Cir. 1973).

²⁸⁹ *N. Broward Hosp. Dist. v. Mizell*, 148 So. 2d 1, 2–5 (Fla. 1962); *see also Tasher v. St. Tammany Parish Hosp.*, No. 87-1139, 1988 U.S. Dist. LEXIS 1018, at *5 (E.D. La. Feb. 9, 1988) (holding that the executive committee had complete discretion to summarily suspend privileges “whenever action must be taken immediately in the best interest of patient care in the hospital”).

²⁹⁰ *Wyatt v. Tahoe Forest Hosp. Dist.*, 345 P.2d 93, 95 (Cal. Ct. App. 1959) (noting that only physicians and surgeons who, in the judgment of the board, would provide the “best possible care and professional skill” were granted staff privileges); *see also Duby v. Jordan Hosp.*, 341 N.E.2d 876, 880 (Mass. 1976) (judging the level of a physician’s competence by determining if it met the “best possible care”).

²⁹¹ *Koelling v. Bd. of Trs. of Mary Francis Skiff Mem’l Hosp.*, 146 N.W.2d 284, 296–97 (Iowa 1966) (noting the board of trustees conclusion that the physician had failed to provide “adequate” medical care); *see also Bock v. John C. Lincoln Hosp.*, 702 P.2d 253, 255 (Ariz. Ct.

None of the standards in this category contain any limits on the discretion of decision-makers which creates an extraordinary risk that decisions to exclude certain physicians could be made based on reasons having nothing to do with the interests of patient safety.²⁹³ These reasons could be economic,²⁹⁴ based upon personal dislike,²⁹⁵ or discriminatory in nature.²⁹⁶ Another growing concern is that peer review is being used to silence whistleblowers who are trying to call attention to poor quality of care or risky practices that could cause patient harm.²⁹⁷

This broad category of standards also fails to provide notice to physicians of what conduct will place them at risk of being investigated and reported to the NPDB.²⁹⁸ Thus, what constitutes “incompetence” can be defined by administrative decision-makers in a “we know it when we see it” fashion, making the standard a moving target that varies with the make-up of the deciding body. The list of process protections that most hospitals now provide (and are required under HCQIA as a condition for judicial immunity), such as a hearing and the right to counsel, are all empty formalities if, after the hearing is completed, the decision-makers can take the course of action their personal inclinations dictate. This is especially the case as many courts have seen fit to conclude that the absence of good faith is irrelevant to the question of whether the proceeding was fair.²⁹⁹ Physicians’ interests in the ability to

App. 1985) (noting that physician’s staff privileges were terminated because the executive committee determined that the physician “failed to demonstrate to the Medical Committee that [he was] qualified to practice as an Internal Medicine specialist”).

²⁹² *Gaenslen v. Bd. of Dirs. of St. Mary’s Hosp. & Med. Ctr.*, 232 Cal. Rptr. 239, 242 (Cal. Ct. App. 1985) (applying the standard in bylaws that excluded physicians from staff privileges who did not provide “high quality” care); *Huffaker*, 540 P.2d at 1399–1401 (applying requirement that physicians provide a “high quality of medical care”).

²⁹³ The immunity protections put into place by both HCQIA and state immunity legislation result in a loss of access to the judicial system by these aggrieved physicians. If peer review is being used for purposes unrelated to quality of care, then this loss of legal recourse is unjustified.

As HCQIA immunity was put into place to encourage peer review that enhanced the quality of patient care while at the same time protecting physicians’ interests, it is questionable whether peer review proceedings that act merely to protect hospital autonomy in decision-making should enjoy HCQIA protections. This type of standard coupled with HCQIA immunity unjustifiably cuts off a physician’s ability to challenge staffing decisions unrelated to quality of care concerns through a judicial appeal.

²⁹⁴ See generally John D. Blum, *Economic Credentialing: A New Twist in Hospital Appraisal Processes*, 12 J. LEGAL MED. 427 (1991); John D. Blum, *Hospital-Medical Staff Relations in the Face of Shifting Institutional Business Strategies: A Legal Analysis*, 14 U. PUGET SOUND L. REV. 561 (1991); Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431 (1988); Judith E. Orie, *Economic Credentialing: Bottom-Line Medical Care*, 36 DUQ. L. REV. 437 (1998).

²⁹⁵ See generally PEER REVIEW GUIDEBOOK, *supra* note 49, at app. B.

²⁹⁶ See, e.g., *id.* at app. A.

²⁹⁷ See *infra* Part V.B.3.b.

²⁹⁸ See, e.g., *Moore v. Bd. of Trs. of Carson-Tahoe Hosp.*, 495 P.2d 605, 607–09 (Nev. 1972) (noting a bylaw that allowed for termination for “unprofessional conduct”).

²⁹⁹ See *Kadar*, *supra* note 87, at 21.

practice their profession and to avoid being blacklisted, as well as patients' interests in choosing their own physicians, find little to no protection in these standards. This variety of vague standard create a high risk that physicians who provide high-quality patient care will be erroneously reported to the NPDB.

Tying into this consideration is the fact that these vague standards raise questions about the meaningfulness of judicial review. As one court described, absent clearly articulated criteria, "it is impossible for any reviewing body to objectively and independently determine if an applicant has established 'competence.'"³⁰⁰ Thus, courts will be unable to determine if the peer review result was driven by considerations unrelated to the quality of patient care.

iii. Customary Care Standards

Examples of the second category of standards include those that hold physicians to a standard of care as measured by the "[hospital's] standard of competence,"³⁰¹ or the "standard of the hospital or the medical staff,"³⁰² or "the general standards of the surgical committee."³⁰³ This Article labels these standards as "customary care" standards. As a general matter, "customary care" is that care which would customarily be given by other physicians under the same or similar circumstances. This practice of providing customary care is also referred to by many as "eminence-based medicine."

Arguably, the standards that fall into this category could be said to provide greater clarity which should provide a greater limitation on the decision-makers' ability to terminate staff privileges based on personal predilections unrelated to the quality of patient care. In addition, this clarity should provide greater notice to physicians of what conduct falls below a hospital's expectations. Unfortunately, a growing body of evidence demonstrates that there is a wide variation in customs across the

³⁰⁰ *Kiester v. Humana Hosp. Alaska, Inc.*, 843 P.2d 1219, 1226 (Alaska 1992).

³⁰¹ *Adkins v. Sarah Bush Lincoln Health Ctr.*, 544 N.E.2d 733, 736 (Ill. 1989) (noting disciplinary proceedings begun as a result of a physician's treatment of patients allegedly failing to conform to "the Center's standard of competence").

³⁰² *Campbell v. St. Mary's Hosp.*, 252 N.W.2d 581, 588 (Minn. 1977) (noting hospital bylaw that held corrective action appropriate when "professional conduct of any member of the staff shall be considered to be lower than the standard of the hospital or the medical staff"); *see also* DAN B. DOBBS, *THE LAW OF TORTS* § 242, at 633 (1st ed. 2000).

³⁰³ *Rhee v. El Camino Hosp. Dist.*, 247 Cal. Rptr. 244, 246, 248-49, (Cal. Ct. App. 1988) (discussing how a newly minted surgeon who had excellent credentials and training evaluations during his residency ran afoul of a group of surgeons in the hospital where he started his practice and how members of this group of physicians, who served on the peer review panels charged with judging whether the new surgeon met the in-house standard, testified that the new surgeon "did not 'meet the general standards of the surgical community at El Camino Hospital'").

country and that the choice of customary treatment is more linked to geography than to quality.³⁰⁴ In addition, many customary treatment choices have a negative impact on quality of care.³⁰⁵

These problems with the “customary care,” or eminence-based, model of medical practice have led to the new push to move the United States to a modern, evidence-based model of medical practice.³⁰⁶ Customary care is based on physician preference and not on objective, scientific evidence.³⁰⁷ The evidence-based model for medical practice is based on empirical data generated by clinical outcomes and effectiveness research that suggests the optimum treatment for a rapidly growing number of clinical conditions.³⁰⁸ This use of empirical data generated through scientific methodology to make medical decisions shows great promise for enhancing quality of care while decreasing the cost of care.³⁰⁹

For example, empirical studies recently demonstrated that the long-held belief that hormone replacement therapy would help prevent heart disease in women was not true.³¹⁰ Another example is the long-time, customary practice by physicians of giving antiarrhythmia drugs to all patients who experienced irregular heartbeats after a heart attack.³¹¹ A

³⁰⁴ See *infra* Part V.B.2.b.iii.(A).

³⁰⁵ See *infra* Part V.B.2.b.iii.(B).

³⁰⁶ See, e.g., SHANNON BROWNLEE ET AL., IMPROVING PATIENT DECISION-MAKING IN HEALTH CARE: A 2011 DARTMOUTH ATLAS REPORT HIGHLIGHTING MINNESOTA (2011); Elliot S. Fisher et al., *The Implications of Regional Variations in Medicare Spending Part 1: The Content, Quality and Accessibility of Care*, 138 ANNALS INTERNAL MED. 273 (2003).

³⁰⁷ James N. Weinstein et al., *Trends and Geographic Variations in Major Surgery for Degenerative Diseases of the Hip, Knee, and Spine*, HEALTH AFF., Oct. 2004, at 81, 82 (“[I]n the absence of professional consensus based on outcomes, individual or small groups of physicians can hold onto idiosyncratic clinical rules of thumb defining who needs surgery. In a given region, local physicians tend to apply their rules of practice consistently, which results in the ‘surgical signature’ phenomenon: rates for specific surgical procedures that are idiosyncratic to a region, sometimes deferring dramatically among neighboring regions.”).

³⁰⁸ Richard E. Leahy, *Rational Health Policy and the Legal Standard of Care: A Call for Judicial Deference to Medical Practice Guidelines*, 77 CALIF. L. REV. 1483, 1506 (1989). As clinical practice guidelines are created using empirical data generated through scientific methodology, physicians who incorporate clinical practice guidelines into medical decision-making are said to be practicing evidence-based medicine.

³⁰⁹ Van Tassel, *supra* note 110, at 1241–55 (explaining how Clinical Practice Guidelines (CGPs) will enhance quality of care); see also Ronen Avraham, *Private Regulation*, 34 HARV. J.L. & PUB. POL’Y 543, 550–52 (2011) (advocating this same use of CPGs by hospitals but adding a proposal of providing immunity from suit for those who apply CPGs).

³¹⁰ Mark A. Hlatky et al., *Quality-of-Life and Depressive Symptoms in Postmenopausal Women After Receiving Hormone Therapy: Results from the Heart and Estrogen/Progestin Replacement Study (HERS) Trial*, 287 J. AM. MED. ASS’N 591 (2002) (noting results of study where 2763 postmenopausal women with preexisting coronary artery disease who were randomly assigned to take either estrogen/progestin HRT or a placebo, researchers found no overall reduction in the rate of coronary heart disease events among the women receiving HRT compared to those receiving the placebo).

³¹¹ Christine Gorman, *Are Doctors Just Playing Hunches?*, TIME (Feb. 15, 2007), <http://www.time.com/time/magazine/article/0,9171,1590448,00.html>.

recent randomized clinical trial demonstrated that patients with mild arrhythmias are actually *more* likely to die if they are given anti-arrhythmia drugs.³¹² Based on this empirical evidence, many, but not all, physicians have modified their practice and adopted the evidence-based choice and only give the medication to those with severe cardiac arrhythmias post-heart attack.³¹³ Time and again, the switch by physicians from customary care choices to evidence-based choices has avoided errors in patient care and saved lives.³¹⁴

On the other hand, some physicians adhere to customary practice even in the face of empirical evidence to the contrary, placing their patients at risk of death. While it might be hard to imagine that physicians would ignore empirical evidence that one of their customs is actually hurting their patients, unfortunately, this occurs all too frequently. In 2004, a major study revealed that doctors and hospitals “fail with alarming frequency to deliver essential lifesaving treatments for some of the most common causes of death—heart attack, pneumonia and heart failure.”³¹⁵ For example, patients who are given aspirin within the first twenty-four hours after a heart attack can have up to a thirty percent increase in the rate of survival.³¹⁶ However, of 3500 hospitals studied, physicians in those hospitals failed to give aspirin to one out of every sixteen patients.³¹⁷ In the first half of 2004, a total of 12,000 patients in these hospitals alone did not receive this simple lifesaving treatment.³¹⁸ The report shows there is a wide variation, from state to state and region to region, in whether this simple lifesaving treatment is provided to patients.³¹⁹ For example, the data showed that the hospitals studied in Massachusetts provided this treatment ninety-seven percent of the time,³²⁰ whereas the hospitals in Arkansas provided the treatment only eighty-five percent of the time.³²¹

³¹² *Id.*

³¹³ *Id.*

³¹⁴ *Id.*

³¹⁵ Ford Fessenden, *It's the Simple Things, but Some Hospitals Don't Do Them*, N.Y. TIMES, Aug. 21, 2005, § 4 (The Nation), at 3; Ashish K. Jha, Et AL., *Care in the U.S. Hospitals—The Hospital Quality Alliance Program*, 353 NEW ENG. J. MED. 265, 266 (2005) (“A consortium of organizations, including the Centers for Medicare and Medicaid Services (CMS), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Hospital Association, and consumer groups such as the American Association of Retired Persons, initiated an effort now called the Hospital Quality Alliance (HQA) to [convince] hospitals nationwide [to] report data to the CMS on indicators of the quality of care for acute myocardial infarction, congestive heart failure, and pneumonia.”); U.S. Dep’t of Health & Human Servs., *Hospital Compare*, MEDICARE.GOV, <http://www.hospitalcompare.hhs.gov/> (last visited Apr. 16, 2012). This project is called the Hospital Quality Alliance Project. *Id.*

³¹⁶ Fessenden, *supra* note 315.

³¹⁷ *Id.*

³¹⁸ *Id.*

³¹⁹ *Id.*

³²⁰ *Id.*

³²¹ *Id.*

A 2010 *New England Journal of Medicine* study of ten hospital systems demonstrated that the rate of injuries in hospitals from physician errors remains unchanged in the ten years since the IOM report.³²² Unfortunately, 98,000 people still die each year from avoidable medical errors in hospitals.³²³ Importantly, the study found that “the penetration of evidence-based safety practices has been quite modest. For example, . . . [c]ompliance with even simple interventions such as hand washing is poor in many centers.”³²⁴

As discussed below, a similar change in hospital peer review from the customary care model to an evidence-based care model in order to evaluate physician competence will also reduce the risk of error in physician blacklisting. The bottom line is that customary care is a highly unreliable gauge of the quality of patient care that leads to a high risk of error in physician blacklisting.

(A) “Customary” Medical Care Is More Closely Related to Location than to Quality

In the 1980s, a group of startling empirical studies suggested that customary care was more closely linked to geography than quality. These studies revealed that the choices that physicians made in the diagnosis and treatment of the same clinical condition were based on the location that the physician happened to be practicing³²⁵ and that there was a wide variation in customary care for the same condition that existed from region to region.³²⁶ For example:

[I]n Maine, by the time women reach seventy years of age in one hospital market the likelihood they have undergone a hysterectomy is

³²² See *supra* note 130 and accompanying text.

³²³ See *supra* note 131 and accompanying text.

³²⁴ Landrigan et al., *supra* note 115, at 2130.

³²⁵ Mark A. Hall & Michael D. Green, *Introduction*, 37 WAKE FOREST L. REV. 663, 670–71 & n.11 (2002) (citing Bruce E. Landon et al., *Personal, Organizational, and Market Level Influences on Physicians’ Practice Patterns: Results of a National Survey of Primary Care Physicians*, 39 MED. CARE 889, 889 (2001) (failing to find, through the use of clinical vignettes, any evidence of “a consistent practice style” for certain common discretionary medical decisions)).

³²⁶ See generally John Wennberg & Alan Gittelsohn, *Small Area Variations in Health Care Delivery*, 182 SCIENCE 1102 (1973); John E. Wennberg et al., *Professional Uncertainty and the Problem of Supplier-Induced Demand*, 16 SOC. SCI. MED. 811, 812–17 (1982) (detailing differences in surgical practices); John E. Wennberg, *Dealing with Medical Practice Variations: A Proposal for Action*, HEALTH AFF., May 1984, at 6, 7 [hereinafter Wennberg, *Dealing with Medical Practice Variations*] (documenting variations in surgical procedures and medical treatments); David M. Eddy, *Variations in Physician Practice: The Role of Uncertainty*, HEALTH AFF., May 1984, at 74, 77–80 (detailing physician variations in choice of diagnosis and procedure); MARK R. CHASSIN ET AL., VARIATIONS IN THE USE OF MEDICAL AND SURGICAL SERVICES BY THE MEDICARE POPULATION 2–3 (1986), available at <http://www.rand.org/pubs/notes/2009/N2678.pdf> (measuring variation in rates of use by Medicare beneficiaries).

20 percent while in another market [it] is 70 percent. In Iowa, the chances that male residents who reach age eighty five have undergone prostatectomy range from a low of 15 percent to a high of more than 60 percent in different hospital markets. In Vermont, the probability that resident children will undergo a tonsillectomy has ranged from a low of 8 percent in one hospital market to a high of nearly 70 percent in another.³²⁷

The studies that gave us this data on practice variations prompted the creation of The Dartmouth Atlas of Health Care.³²⁸ The Dartmouth Atlas uses very large healthcare-claims databases, including Medicare and Blue Cross organizations, to provide data on the wide variation of treatments for the same condition from region to region across the entire United States.³²⁹ For example, a patient is twenty times more likely to have surgery if that patient lives in Idaho Falls, Missoula, or Mason City than if that patient lives in Newark, Bangor, or Terre Haute.³³⁰ Other examples include: the rate of spinal surgery in Bradenton, Florida is seventy-five percent greater than in its neighbor to the north, Tampa, Florida,³³¹ and a patient is fifty percent more likely to have hip surgery if that patient lives in Ft. Lauderdale than in neighboring Miami.³³² And this surgical signature repeats itself all over the country.³³³

These studies demonstrate that what is customary care is based on physician preferences unlinked from best practices and that these preferences can be highly dependent on the region in which the physician practices. Importantly, a treatment choice that is a customary choice for a region does not mean that this is a quality choice; it simply means that it is the treatment of choice for that particular region. Consequently, there is a high risk that physicians who are practicing high-quality, evidence-based patient care will be erroneously reported to the NPDB

³²⁷ Wennberg, *Dealing with Medical Practice Variations*, *supra* note 326, at 9; see also James F. Blumstein, *The Legal Liability Regime: How Well Is It Doing in Assuring Quality, Accounting for Costs, and Coping with an Evolving Reality in the Health Care Marketplace?*, 11 ANNALS HEALTH L. 125, 137 (2002) (stating that “to ask an expert . . . what the ‘customary practice’ is [for a particular condition] on a national basis . . . is to ask a question to which there cannot be, for many diagnosis and treatment decisions, a coherent answer”).

³²⁸ THE DARTMOUTH ATLAS OF HEALTH CARE, <http://www.dartmouthatlas.org> (last visited Feb. 19, 2012).

³²⁹ *Research Methods*, THE DARTMOUTH ATLAS OF HEALTH CARE, <http://www.dartmouthatlas.org/tools/faq/researchmethods.aspx> (last visited Aug. 10, 2011).

³³⁰ CTR. FOR THE EVALUATIVE CLINICAL SCIS., DARTMOUTH ATLAS OF HEALTH CARE: STUDIES OF SURGICAL VARIATION (SPINE SURGERY) 7 (2006), *available at* http://www.dartmouthatlas.org/downloads/reports/Spine_Surgery_2006.pdf.

³³¹ *Id.* at 19.

³³² ELLIOTT S. FISHER ET AL., TRENDS AND REGIONAL VARIATION IN HIP, KNEE, AND SHOULDER REPLACEMENT 17 (2010), *available at* http://www.dartmouthatlas.org/downloads/reports/Joint_Replacement_0410.pdf.

³³³ *Id.*

merely because they did not choose the treatment that is customary in that region.

(B) Customary Care Can Be “Bad” Patient Care

Not only can customary care be unrelated to quality of care, it may actually be “bad” patient care. The 1980s brought another group of studies that revealed “serious weaknesses in the scientific underpinnings of many customary practices.”³³⁴ These studies also disclosed the “substantial overuse of many medical and surgical procedures.”³³⁵

In a recent article in *The New Yorker*, Harvard Professor Atul Gawande examined the reasons that McAllen, Texas is one of the most expensive markets in the country, second only to Miami, Florida.³³⁶ Medicare spends twice the national average on Medicare enrollees in McAllen—\$15,000 per enrollee per year.³³⁷ Compared to neighboring El Paso, a similar community, McAllen’s hospitals performed worse

³³⁴ Clark C. Havighurst, *Practice Guidelines As Legal Standards Governing Physician Liability*, 54 L. & CONTEMP. PROBS. 87, 89 (1991). For example, the use of certain respiratory techniques and gastric freezing of ulcers, which were quickly adopted as “standard practice,” were ultimately discredited by scientific studies. *Id.* at 88–89 & n.6 (citing David Eddy & John Billings, *The Quality of Medical Evidence: Implications for Quality of Care*, HEALTH AFF., Spring 1988, at 19, 20 (“[F]or at least some important practices, the existing evidence is of such poor quality that it is virtually impossible to determine even what effect the practice has on patients, much less whether that effect is preferable to the outcomes that would have occurred with other options.”); David Eddy, *Clinical Policies and the Quality of Clinical Practice*, 307 NEW ENG. J. MED. 343, 343 (1982) (“There is reason to believe that there are flaws in the process by which the profession generates clinical policies.”)); *see also* FURROW, *supra* note 176, at 33.

³³⁵ Havighurst, *supra* note 334, at 88–89 & n.7. There are wide variations in the use of “laboratory tests, prescription drugs, X-rays, return appointments, and telephone consultations among similarly trained doctors in a wide variety of practice settings. Research on appropriateness indicates that from one quarter to one third of medical services may be of no value to patients.” FURROW, *supra* note 176, at 34 (citing Robert Brook & Kathleen Lohr, *Will We Need to Ration Effective Medical Care?*, ISSUES IN SCI. & TECH., Fall 1986, at 68). Another study found a “seventeen-fold variation in lab use among internists dealing with clinical patients.” *Id.* at 34 (citing Steven A. Schroeder et al., *Use of Laboratory Tests and Pharmaceutical Variation Among Physicians and Effect of Cost Audit on Subsequent Use*, 225 J. AM. MED. ASS’N 969 (1973)). For example, one study on the insertion of pacemakers in a large group of individuals indicated that “44% of the implants were definitely indicated, 36% possibly indicated, and 20% were not indicated.” *Id.* (citing Lee Goldman et al., *Costs and Effectiveness of Routine Therapy with Long-Term Beta-Adrenergic Antagonists After Acute Myocardial Infarction*, 319 NEW ENG. J. MED. 52 (1988)). Another example is a study that demonstrated that carotid endarterectomies, which remove blood clots in the arteries leading to the brain, were only indicated in thirty-two percent of the cases reviewed. *See* Havighurst, *supra* note 334, at 88–89 & n.7 (citing Robert Brook et al., *Predicting the Appropriate Use of Carotid Endarterectomy, Upper Gastrointestinal Endoscopy, and Coronary Angiography*, 323 NEW ENG. J. MED. 1173, 1173 (1990) (“We concluded that 17 percent of coronary angiographies, 17 percent of endoscopies, and 32 percent of endarterectomies represented inappropriate overuse [using a liberal standard].”)).

³³⁶ Atul Gawande, *The Cost Conundrum*, NEW YORKER, June 1, 2009, at 36.

³³⁷ *Id.*

than El Paso's on the twenty-five metrics that Medicare uses to rate quality.³³⁸ And yet:

Between 2001 and 2005, critically ill Medicare patients received almost fifty percent more specialist visits in McAllen than in El Paso, and were two-thirds more likely to see ten or more specialists in a six month period. In 2005 and 2006, patients in McAllen received twenty percent more abdominal ultrasounds, thirty percent more bone-density studies, sixty percent more stress tests with echocardiography, two hundred per cent more nerve-conduction studies to diagnose carpal-tunnel syndrome, and five hundred and fifty percent more urine-flow studies to diagnose prostate troubles. They received one-fifth to two-thirds more gall bladder operations, knee replacements, breast biopsies, and bladder scopes. They also received two to three times as many pacemakers, implantable defibrillators, cardiac-bypass operations, carotid endarterectomies, and coronary artery stents. And Medicare paid for five times as many home-nurse visits.³³⁹

Based on extensive research, Professor Gawande concluded that “[t]he cause of McAllen’s extreme costs was, very simply, the across-the-board overuse of medicine.”³⁴⁰ And each time a patient is subjected to unnecessary invasive tests and surgery, that patient is subjected unnecessarily to the risks associated with the procedure. In some cases, these risks can not only be physically disabling, they can be life-threatening.³⁴¹

So, again, these series of studies strongly suggest that using customary care³⁴² as the measure for physician competence translates into a high risk of error in blacklisting physicians as, not only can customary care be unrelated to quality of care, it may actually be “bad” patient

³³⁸ *Id.*

³³⁹ *Id.*

³⁴⁰ *Id.*

³⁴¹ A recent study of 1200 patients revealed that lumbar discectomy, the most common surgery in the United States for people with back and leg pain, is largely unnecessary. James N. Weinstein et al., *Surgical vs. Nonoperative Treatment for Lumbar Disc Herniation*, 296 J. AM. MED. ASS'N 2441, 2447 (2006). The study demonstrated that patients who had surgery and those that had more conservative treatments, such as physical therapy, enjoyed the same level of recovery. *Id.* This means that surgery patients who receive the customary treatment of lumbar discectomy are unnecessarily exposed to the serious risks and costs associated with the surgery.

³⁴² Compounding this problem are the conclusions drawn by a series of studies conducted in the 1990s that found that “physician agreement regarding quality of care is only slightly better than the level expected by chance.” Ronald L. Goldman, *The Reliability of Peer Assessments of Quality of Care*, 267 J. AM. MED. ASS'N 958, 958 (1992); see also Rodney A. Hayward et al., *Evaluating the Care of General Medicine Inpatients: How Good Is Implicit Review?*, 118 ANNALS INTERNAL MED. 550, 550 (1993); Haya R. Rubin et al., *Watching the Doctor-Watchers: How Well Do Peer Review Organization Methods Detect Hospital Care Quality Problems?*, 267 J. AM. MED. ASS'N 2349, 2349 (1992). The conclusions drawn by these studies are not surprising in light of the remarkably wide variation in practices utilized by physicians evidenced by the studies described in the prior Sections.

care. This not only impacts quality of care, it has major implications for cost of care. It is estimated that thirty percent of the cost of Medicare could be saved if this overuse generated by regional customs was avoided.³⁴³

All together, these studies on the variation and effectiveness of customary treatment and the very low level of agreement among physicians regarding what care is quality care, raise serious questions regarding the appropriateness of the use of customary care as a proxy for measuring physician competence.

c. State-to-State Variation in the Amount of Judicial Review of Hospital Peer Review to Correct for Errors

Unlike the system of judicial review for sex offenders that uniformly provides full due process review, there is a wide range in the amount of review that the courts provide for physicians who have been sanctioned through the peer review process. Some state courts will only review hospital peer review decisions for compliance with the procedures required by the hospital's bylaws.³⁴⁴ Consequently, many state courts defer completely to hospital decision-makers on findings of physician competence. These courts opine that, because such a decision is so subjective, it is effectively unreviewable.³⁴⁵ On the other hand, one group of state courts found that specific criteria that can be objectively applied in measuring physician competence are achievable and felt competent to ensure that peer review fairly created and applied such criteria.³⁴⁶ This disparity in judicial review means that some physicians

³⁴³ Guwande, *supra* note 336.

³⁴⁴ FURROW, *supra* note 176, § 4-6, at 104-05.

³⁴⁵ Representative of those courts that take the position that it is not possible, or desirable, to create clearly articulated standards to evaluate physician competence is the case of *Jackson v. Fulton-DeKalb Hospital Authority*, 423 F. Supp. 1000 (N.D. Ga. 1976). In *Jackson*, a physician appealed the suspension of his surgical privileges, which were found by the hospital to be "detrimental to the maintenance of proper standards of medical practice." *Id.* at 1005. The U.S. District Court for the Northern District of Georgia upheld the suspension in the face of a challenge that the standard was "impermissibly vague and arbitrary." *Id.* at 1006. In doing so, the court threw up its hands in defeat, thereby abdicating its obligation to ensure that the peer review process conforms to basic principles of fairness:

In the area of personal fitness for medical staff privileges precise standards are difficult if not impossible to articulate. . . . The subjectives of selection simply cannot be minutely codified. The governing board of a hospital must therefore be given great latitude in prescribing the necessary qualifications for potential applicants.

Id. (quoting *Sosa v. Bd. of Managers of the Val Verde Mem'l Hosp.*, 437 F.2d 173, 176 (5th Cir. 1971)).

³⁴⁶ See, e.g., *Wyatt v. Tahoe Forest Hosp. Dist.*, 345 P.2d 93, 97 (Cal. Ct. App. 1959) (noting that the standard set up was so vague and uncertain "that admission to the staff can depend on the whim and caprice of the directors"); *Kiester v. Humana Hosp. Alaska, Inc.*, 843 P.2d 1219, 1225-

will be protected from the publication by the NPDB of a negative report based on an erroneous finding of incompetence and some will not receive the same protection.³⁴⁷

These different levels of judicial review can determine whether a damaging report will be made to the federally supported NPDB. For example, if two physicians in two different states with different standards of review are targeted for the *very same conduct*, one could be reported to the NPDB because there was no judicial review while the other is not reported because judicial review is provided that exonerates the physician. If both apply for staff privileges in a third state, the physician who was reported to the NPDB will be barred from the appointment. These disparate levels of judicial review raise serious due process concerns.

It almost defies credibility that the process that the federal government relies upon to blacklist targeted physicians through the NPDB reporting system is more closely tied to the location of the physician's practice than quality.³⁴⁸ As this Section establishes, the location of a physician's practice can dictate whether a physician's choice of a treatment for a particular patient comports with the customary choice.³⁴⁹ The location of a physician's practice can dictate whether the hospital participates in peer review or not.³⁵⁰ If the hospital does participate in peer review, it may be one that actively chooses to impose sanctions that will avoid the NPDB reporting requirements or one that simply does not report at all.³⁵¹ The location of a physician's practice can also dictate whether the state licensure board investigates physicians who are the subject of negative peer review reports.³⁵² Finally, the location of a physician's practice can dictate whether or not the state courts provide judicial review of peer review proceedings.³⁵³

Adding together all of the points in the process where reporting or not is simply a matter of geography leads to a disquieting conclusion: it appears that the chances that a physician's practice and life are destroyed are more closely related to geography than to the quality of care

26 (Alaska 1992); *see also* Miller v. Eisenhower Med. Ctr., 614 P.2d 258, 265 (Cal. 1980) (finding that rules governing the admission of physicians cannot stand if the standard is "unreasonably susceptible of arbitrary or discriminatory application"); Williams v. Kleaveland, 534 F. Supp. 912, 917 (W.D. Mich. 1981) (holding that "rules established by hospitals to regulate the conduct of doctors must be capable of objective application"); Martino v. Concord Cmty. Hosp. Dist., 43 Cal. Rptr. 255, 258-60 (Cal. Ct. App. 1965) (stating a hospital must set up standards that are clear, and not vague, ambiguous, or uncertain).

³⁴⁷ For a full discussion of this series of cases, see Van Tassel, *supra* note 110, at 1207-32.

³⁴⁸ *See supra* Part V.B.2.b.iii.(A).

³⁴⁹ *See supra* Part V.B.2.b.iii.

³⁵⁰ *See supra* notes 253-56 and accompanying text.

³⁵¹ *See supra* note 256 and accompanying text.

³⁵² *See supra* notes 200-01 and accompanying text.

³⁵³ *See supra* Part V.B.2.c.

that the physician provides to patients. In contrast, the chances that an alleged sexual offender will be prosecuted are not dependant on the location where the conduct occurred, but on the nature of that conduct.

3. Probable Value of Additional Procedural Safeguards Including Impact on Healthcare Quality, Cost, and Access

The next step in the *Mathews* analysis requires an analysis of the “probable value, if any, of additional or substitute procedural safeguards.”³⁵⁴ It is clear that adding the same procedural safeguards to the hospital peer review process that are provided to alleged sexual predators will dramatically improve the accuracy of the information in the database. It will prevent physicians from being added to the database for reasons unrelated to the quality of patient care (the over breadth problem),³⁵⁵ and will add physicians who are practicing poor quality patient care (the under inclusive problem).³⁵⁶ It will also deal with the problem of inaccurate and misleading information as clearly articulated standards based on the practice of evidence-based medicine will allow both for judicial review and for very clearly stating in the NPDB the circumstances under which a physician was disciplined and in what way he or she failed to provide quality of care.

a. Requiring Clearly Articulated Standards Encourages the Use of Evidence-Based Medicine

Moving away from the use of custom as a proxy for quality has additional benefits on the quality and cost of healthcare. For example, state tort systems are moving away from using customary care as the exclusive proxy for quality of care. In a medical malpractice case, in order to meet the “standard of care,” a physician must “possess and use the care, skill and knowledge ordinarily possessed and used under like circumstances.”³⁵⁷ States are slowly moving away from what is currently the majority rule that uses customary practice as conclusive evidence of the standard of care as they are recognizing the problems with using

³⁵⁴ 424 U.S. 319, 335 (1976).

³⁵⁵ See *supra* Part V.B.1–2.

³⁵⁶ See *supra* Part V.B.1–2.

³⁵⁷ *Burns v. Metz*, 513 N.W.2d 505, 508 (Neb. 1994); *Vergara ex rel. Vergara v. Doan*, 593 N.E.2d 185, 188 (Ind. 1992) (holding that jurors “may judge the doctor’s conduct by [the] minimum standard of care for the particular practice”). For an excellent overview of medical malpractice law, see DOBBS, *supra* note 302, § 242, at 634–35.

custom, as discussed above, as a proxy for quality.³⁵⁸ For these reasons, among others, these states are allowing the introduction of risk-benefit analysis grounded in empirical science as evidence of what is reasonable quality care. Thus, the tort system is operating instrumentally to encourage the transition away from custom-based medical practice to evidence-based medical practice.

The positive impact that an evidence-based standard of care has, in both the medical malpractice and the hospital peer review context, is borne out by a recent empirical study that used data on treatment utilization rates from the 1977 to 2005 compiled by the National Hospital Discharge Surveys. This study estimated that there was “a 30–50% reduction in the gap between the state and national utilization rates of various obstetric, cardiac and diagnostic procedures following the abandonment of a rule requiring physicians to meet the standards set by local physicians and the contemporaneous adoption of a national-standard rule.”³⁵⁹ The author of the study finds, in the context of medical malpractice, that “custom-based liability standards may indeed encourage the perpetuation of customary practices and likewise discourage deviations from custom.”³⁶⁰ He concludes that

the results of this study more generally suggest that a malpractice rule that bases standards of care on customary physician practices may indeed incentivize the perpetuation of those customary practices and, at the same time, discouraging deviations from custom. . . .

The employment of custom-based standards, moreover, carries a number of important policy implications, particularly with respect to the possible role that they may play in discouraging cost-reducing innovations in delivery practices. Legal scholars have long recognized that the effectiveness of managed care and related strategies may be blunted by a medical liability system that holds physicians to a standard of care determined according to customary physician practices, where those practices were developed in a predominantly fee-for-service environment that may have encouraged excessive practice styles.³⁶¹

The author goes on to state that

³⁵⁸ See generally Philip G. Peters, Jr., *The Role of the Jury in Modern Malpractice Law*, 87 IOWA L. REV. 909 (2002) (discussing the merits of the role of custom as conclusive evidence of the standard of care in malpractice litigation and the movement by many states to use custom as only some evidence of the standard of care).

³⁵⁹ Michael Frakes, *The Impact of Medical Liability Standards on Regional Variations in Physician Behavior: Evidence from the Adoption of National-Standard Rules*, 102 AM. ECON. REV. (forthcoming) (manuscript at 1), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1432559.

³⁶⁰ *Id.*

³⁶¹ *Id.* at 37–38.

[b]y arguably establishing the empirical relevancy of the customary component to malpractice standards, this study validates these concerns and thereby lends support to proposals that call for a relaxation of customary-standard requirements, including those that argue for a stronger role for “reasonableness” in malpractice-standard determinations or, as above, a more definitive role for clinical practice guidelines in malpractice proceedings.³⁶²

As is the case with the use of customary care standards in medical malpractice litigation, the reliance in peer review on customary care acts to entrench custom-based decision-making at the cost of quality of care. This conclusion finds support in a 2010 *New England Journal of Medicine* study of ten hospital systems that demonstrated that the rate of injuries in hospitals from physician errors remains unchanged in the ten years since the IOM report in spite of multiple initiatives to improve quality.³⁶³ The 2010 report concludes that 98,000 people still die each year from medical errors in hospitals.³⁶⁴ Importantly, the study found that “the penetration of evidence-based safety practices has been quite modest. For example, . . . [c]ompliance with even simple interventions such as hand washing is poor in many centers.”³⁶⁵

Finally, as discussed above by Professor Guwande, adherence to the custom-based approach acts to increase the cost of medical care as many treatments, surgeries, tests, and physician visits are unnecessary.³⁶⁶

b. Requiring Good Faith in Accord with Due Process Protects
Against Blacklisting Whistleblowers

Another implication of maintaining the status quo is the impact that the current NPDB process is having on whistleblowers and what this means to quality of care. The story of Dr. Ulrich, discussed earlier, is a good example of how the current vague standards, coupled with the broad judicial interpretation of HCQIA immunity, can have a negative impact on quality of patient care. Recall that Dr. Ulrich raised red flags about the negative impact that staffing cuts would have on the quality of patient care. Within two weeks, he learned that he was being investigated for alleged clinical incompetence. After he resigned, he was reported to the state licensure board and the NPDB.

³⁶² *Id.* at 38. And, as I argue in my first article on hospital peer review, a greater role for Clinical Practice Guidelines in the hospital peer review process. Van Tassel, *supra* note 110, at 1241–55.

³⁶³ Landrigan et al., *supra* note 115, at 2130.

³⁶⁴ *Id.* at 2125.

³⁶⁵ *Id.* at 2130.

³⁶⁶ See *supra* notes 331–40 and accompanying text.

This story is being repeated across the country with whistleblowers who protest problems with quality of patient care being threatened with peer review investigation and NPDB reporting to silence their criticisms³⁶⁷:

“It is clear that we are hearing more cases of these kind of really difficult conflicts occurring between hospitals, and, in some instances, hospital boards, and the medical staff,” said Dr. Paul M. Schyve, senior vice president of the Joint Commission on Accreditation of Healthcare Organizations, which accredits most U.S. hospitals. Schyve said one factor driving these disputes is the economic pressure hospitals face to keep costs down and maintain a good image.³⁶⁸

However, when these conflicts arise, physician whistleblowers “face a unique vulnerability, one that can make disagreeing with their hospital administrators a career-ending move. Once they’ve been labeled disruptive, doctors may face sanctions and effective banishment from the profession. That gives hospitals considerable leverage when conflicts occur.”³⁶⁹ In one extreme example of this situation, one physician faced exactly this situation for pushing for an investigation into a nurse who was allegedly murdering patients night after night.³⁷⁰

In one survey of 448 emergency room physicians across the United States, twenty-three percent reported that they had lost a job, or had been threatened with termination, when they had raised quality of care concerns.³⁷¹ These types of narratives raise the question of whether the courts’ broad interpretation of HCQIA immunity for hospital peer review is having the unintended effect of silencing the very people who are in the best position to point out problems with the quality of patient care.³⁷²

³⁶⁷ See Twedt, *supra* note 260 (“In medical centers as small as Centre Community Hospital in State College and as prestigious as Yale and Cornell, doctors who step forward to warn of unsafe conditions or a colleague’s poor work say they have been targeted by hospital administrators or boards.”).

³⁶⁸ *Id.*

³⁶⁹ *Id.* A University of Baltimore study ordered by the Maryland General Assembly on credentialing found that “whistleblower physicians who alienate hospital officials are vulnerable to having their admitting privileges taken away, with devastating effects on their practices.” Steve Twedt, *The Cost of Courage: Doctor Says Whistleblowers Need More Protection*, PITT. POST-GAZETTE, Oct. 29, 2003, at A1.

³⁷⁰ Steve Twedt, *Doctors Pay for Reporting Suspicions*, PITT. POST-GAZETTE, Oct. 28, 2003, at A6.

³⁷¹ Twedt, *supra* note 260.

³⁷² See *id.* (“‘We’re the only people who can stand up for patients,’ said Dr. Scott Plantz, an emergency medicine specialist who headed the survey of emergency physicians. ‘The nurses can’t, because they’re employees of the hospital. But doctors aren’t, or at least they weren’t in the past. With managed care and doctors working for hospitals, it gets worse and worse and worse.’”).

Importantly, before the advent of blacklisting by the NPDB, physicians were the one group in the hospital who had the power to speak up without fear of retribution if hospital practices were placing patients at risk of harm. It appears that the current system insulates the use of sham peer review to silence these voices.

Finally, requiring good faith in peer review recognizes that the power to select the medical staff “is deeply imbedded in public aspects, and [is] rightly viewed, for policy reasons . . . as [a] fiduciary power[] to be exercised reasonably and for the public good.”³⁷³

4. Government’s Interest and Administrative Burdens of Additional Safeguards

The final step in the *Mathews* analysis is to examine the weight of the governmental interest in keeping the status quo with regard to current procedures, adding in the administrative burden to the government of adding certain procedural safeguards.³⁷⁴ The purpose of the NPDB is to improve the quality of patient care by preventing a physician who is a poor practitioner from traveling to a new location and providing the same level of poor care to a second, unsuspecting group of patients. So the governmental interest is in increasing the quality of patient care by identifying and labeling poor-quality physicians. First, it is important to point out that there have been no empirical studies that demonstrate that the NPDB has had any impact on the quality of patient care. Thus, any benefit that the current system may have is based on speculation grounded upon the highly suspect presumption that the system the NPDB relies upon for its data does, in fact, accurately identify poor-quality practitioners. As demonstrated, the standards used in the hospital peer review hearing process lead to both under and over inclusive results. This lack of accuracy leads to the logical (though also non-empirically tested) conclusion that, as currently constructed, the NPDB is unlikely to be properly identifying poor-quality physicians and, thus, does not have the positive impact on the quality of patient care that it would have if its accuracy was improved.

Regardless, providing physicians with full due process during the hospital peer review hearing process will not negatively impact the government’s mission; in fact, adding this procedural protection will have a dramatically positive impact on the accuracy of the database and, thus, on the quality of patient care which is consistent with government interests. Moreover, the procedural due process protections that this Article

³⁷³ *Kiracofe v. Reid Mem’l Hosp.*, 461 N.E.2d 1134, 1143 (Ind. Ct. App. 1984).

³⁷⁴ *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976).

suggests will also have a positive impact on the cost of healthcare and on access to healthcare.³⁷⁵ These due process protections should include the requirement that hospital peer review be based on clearly articulated standards that adopt best practices to encourage evidence-based patient care. In a prior article, I set forth a very detailed, step-by-step system for establishing best practices that is built upon the committee system already in use by hospitals.³⁷⁶ This committee system would allow for physician choice among Clinical Practice Guidelines³⁷⁷ which will suggest treatment choices based on best outcomes derived from empirical studies.³⁷⁸

In order to make these changes, Congress could amend the HCQIA to limit participation in federal healthcare programs like Medicare and Medicaid to only those hospitals that agree to provide full due process protections during the hospital peer review hearing process.³⁷⁹ This requirement is similar to the tool used by the federal government to “persuade” states to adopt Megan’s Law, which required the blacklisting of sexual predators. Congress conditioned major federal funding for law

³⁷⁵ See *supra* Part V.B.3.a.

³⁷⁶ Van Tassel, *supra* note 110, at 1241–55.

³⁷⁷ Clinical Practice Guidelines are based on empirical data generated by clinical outcomes and effectiveness research that suggest the optimum treatment for a rapidly growing number of clinical conditions. Leahy, *supra* note 308, at 1506.

³⁷⁸ *Id.* This use of empirical data generated through scientific methodology to make medical decisions shows great promise for enhancing quality of care while decreasing the cost of care. Van Tassel, *supra* note 110, at 1241–55; see also Avraham, *supra* note 309 (advocating this same use of CPGs by hospitals but adding a proposal for providing immunity from suit for those who apply CPGs).

³⁷⁹ If congressional action is not forthcoming, then physicians who have been blacklisted should join together in a class-action suit against the federal government asserting that their due process rights have been violated resulting in damage to their property and liberty interests under *Goss v. Lopez*. The class-action suit could seek to enjoin the NPDB from publishing reports from hospitals that use peer review processes that do not provide due process protections. Another avenue is to bring § 1983 claims against state governments and state officials. As currently required by the new 2011 regulations, hospitals are required to report negative peer review sanctions to their state licensure boards and these state licensure boards are required to provide these private peer review reports to the NPDB. See 45 C.F.R. § 60.5 (2011). This participation in the NPDB reporting process provides the state action that is the predicate for this type of claim. Title 42, § 1983 of the U.S. Code provides:

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress

To be cognizable under § 1983, the claims of the targeted physicians must establish both a deprivation of a constitutional right and the effectuation of the deprivation of that right under color of state law. See *Paul v. Davis*, 424 U.S. 693, 696–97 (1976); *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 150 (1970). The actions of NPDB officials, at issue in this Article, in reporting the peer review hearing results involving the targeted physicians typically are intentional and performed in their official capacities.

enforcement programs provided by the Byrne Formula Grant Program on compliance with Megan's Law.³⁸⁰

Comparing this situation to that of the parties in the recent Supreme Court case in *Hamdi v. Rumsfeld* is instructional. In *Hamdi*, the government asserted that the war on terror would be adversely impacted by providing due process to defendants accused of being terrorists.³⁸¹ According to the government, this litigation would distract military officers from their day-to-day duties and would risk disclosure of military secrets.³⁸² In the matter at hand, there is no risk of any distraction from the government's mission. In fact, as described above, additional safeguards facilitate the government's pursuit of its "mission" to enhance the quality of patient care. The *Hamdi* Court concluded that:

The "risk of erroneous deprivation" of a detainee's liberty interest is unacceptably high under the government's proposed rule [The court held] that a citizen-detainee seeking to challenge his classification as an enemy combatant must receive notice of the factual basis for his classification, and a fair opportunity to rebut the Government's factual assertions before a neutral decisionmaker.³⁸³

As in *Hamdi*, the risk of erroneous deprivation of a physician's liberty and property interests based on the processes used by the NPDB is extremely high. And one is hard pressed to harmonize a rule that guarantees enemy combatants due process while denying these same protections to physicians who are serving their communities.

Moving to the second governmental interest consideration—that of cost—adding these safeguards does not increase the administrative costs for the government. Government-run hospitals, like the VA, are already required to provide due process to physicians in peer review. This proposal brings private hospitals into line with government hospitals.

Consequently, applying the *Mathews* balancing test is outcome determinative. The risk of erroneous deprivation is high. The cost of the loss is extraordinary to physicians. And there is no cost to the government in the form of hampering its interests in pursuing its mission to

³⁸⁰ The remarkable increase in sexual offender registration laws was the result of the Federal Jacob Wetterling Crimes Against Children and Sexually Violent Offender Registration Act, Pub. L. No. 103-322, 108 Stat. 2038, 2042 (1994) (codified as amended at 42 U.S.C. § 14071 (2000)), repealed by Adam Walsh Child Protection and Safety Act of 2006, Pub. L. No. 109-248, § 129, 120 Stat. 587, 600. The Wetterling Act relied upon Congress's spending power to "encourage" states to pass registration and permissive community-notification laws to avoid losing ten percent of their Federal Byrne Formula Grant Program funds. See 42 U.S.C. § 14071(f)(2) (1994), repealed by Adam Walsh Child Protection and Safety Act of 2006, Pub. L. No. 109-248, § 129, 120 Stat. 587, 600. The reliance by state criminal justice programs on the funds afforded them by the Byrne Program meant that every state quickly adopted registration laws. LOGAN, *supra* note 11, at 65.

³⁸¹ *Hamdi v. Rumsfeld*, 542 U.S. 507, 507 (2004).

³⁸² *Id.* at 531–32.

³⁸³ *Id.* at 532–33.

enhance quality of care or adding to the costs of pursuing that mission through the use of the NPDB. In fact, the accuracy of the NPDB is enhanced, making it more likely to improve the quality of patient care while also decreasing the cost of that care and increasing patient access to healthcare.

CONCLUSION

Addressing the systematic problems with the methods used to construct and maintain the NPDB has become an issue of pressing national importance for several reasons. First, it appears that the NPDB reporting system encourages the perpetuation of custom-based practices and discourages deviations from these customs undermining efforts to improve quality and cost of care through the practice of evidence-based treatment choices. Second, the NPDB system as currently constructed is being used to silence physician whistleblowers, once again negatively impacting quality of care. Third, the NPDB has very recently expanded its scope to take on blacklisting of *all* licensed healthcare practitioners in the United States, including dentists, nurses, physician's assistants, social workers, dental hygienists, physical therapists, and pharmacists, extending its reach to over six million people.³⁸⁴ This means that the negative impact that the NPDB may have on the quality and cost of care is being magnified exponentially as it begins to affect the practice habits of all healthcare professionals. Finally, the lives of physicians are being unfairly destroyed by a process that fails to properly safeguard their property and liberty interests.

The problems with the NPDB can be resolved by providing physicians, and other healthcare providers, with the same kind of due process protections that are provided to alleged sexual offenders before they are blacklisted. These due process protections should include the requirement that hospital peer review be based on clearly articulated standards that adopt best practices to encourage evidence-based patient care. In order to make these changes, Congress could amend HCQIA to limit participation in federal healthcare programs like Medicare and Medicaid to those hospitals that agree to provide full due process protections during the hospital peer review hearing process. Providing physicians with full due process protections before including them on the NPDB blacklist will better protect physicians from the erroneous destruction of their careers while increasing the accuracy of the NPDB. These solutions will

³⁸⁴ See BUREAU OF LABOR STATISTICS, *supra* note 3 (indicating that the number of healthcare professionals in the United States is 6,283,900).

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improve the efficacy of the database in furthering quality of patient care while improving healthcare cost and access.