Georgia Law Review

Volume 58 | Number 2 Article 6

1-31-2024

Systemic Failures in Health Care Oversight

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Cover Page Footnote

Faculty Fellow, DePaul University College of Law, Jaharis Health Law Institute. The author wishes to thank the faculty at DePaul University College of Law, especially Max Helveston, Wendy Netter-Epstein, Gregory Mark, and Joshua Sarnoff, DePaul librarians, Anne Hudson and Jack Gorman, the scholars who took part in the 2023 Marquette University Works in Progress Conference, Jack Rovner, and the author's family for their support and suggestions in writing this Article.

SYSTEMIC FAILURES IN HEALTH CARE OVERSIGHT

Julie L. Campbell[*]

Hospitals are intentionally shirking their duty to identify and report incompetent medical practitioners, and it is causing catastrophic injuries to patients. Why are hospitals doing this? Two decades of health care reforms have changed the way physicians and hospitals interact in the U.S. health care system, and as a result, the traditional health care oversight tools no longer work to ensure physician competence.

With three out of four physicians now employees of hospitals or health care systems, hospitals have become the guardians of both the internal and external warning systems designed to flag incompetent practitioners. As the guardians, hospitals are required to report incompetent practitioners to the National Practitioner Data Bank (NPDB), the main quality control tool used to identify and weed out incompetent physicians. Hospitals, however, are intentionally circumventing their reporting requirements to avoid institutional embarrassment, medical liability, and physician alienation. This negatively impacts the ability of the more than 24,000 entities that query the NPDB to effectively determine whether a practitioner is competent for purposes of licensing, hiring, and credentialing.

This Article offers a solution—switch the data bank from a blacklist of incompetent providers to a database of the employment and hospital affiliation histories for all medical providers. Have the NPDB or private accreditation organizations require hospitals complete a mandatory questionnaire for all practitioners during the credentialing process. Implementing this solution will achieve three salient

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objectives: (1) improve the process whereby hospitals investigate whether a medical practitioner is competent to practice medicine prior to hiring or offering the practitioner privileges; (2) pave the way for state-based tort claims to hold hospitals accountable for inaccurate disclosures regarding a practitioner's competence to practice medicine; and (3) eliminate the stigma associated with being listed in the NPDB which causes practitioners to practice defensive medicine and avoid admitting mistakes.

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I. INTRODUCTION

The consolidation of hospitals that have been incentivized by numerous statutory changes over the past twenty years was intended to benefit the quality of health care in the United States by allowing for better coordination of care.[1] Unfortunately, consolidation also led to the corporatization of health care in which business considerations began to outweigh the ethical imperative of safeguarding the wellbeing of patients within these large health care systems.[2]

This consolidation and corporatization of health care have changed the way physicians and hospitals interact in the U.S. health care system. Today, approximately three out of four physicians are employees of hospitals or health care systems,[3] making hospitals the guardians of both the internal and external warning systems designed to flag incompetent practitioners.[4] With the current incentive structure of major hospital systems favoring nondisclosure of practitioner incompetence, the traditional health care oversight tools utilized in the United States no longer function to ensure quality care.[5]

Before explaining how dire the situation is, let me clarify two points. First, not all medical errors, "preventable harms or injuries

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[1] *See, e.g.*, MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM 304 (2017) ("[H]ospitals have argued for financial integration by stating it will allow for improved care coordination and better quality of care." (citation omitted)).

[2] *See* PHYSICIANS ADVOC. INST., PAI-AVALERE HEALTH REPORT ON TRENDS IN PHYSICIAN EMPLOYMENT AND ACQUISITIONS OF MEDICAL PRACTICES: 2019-2021 (2022) (expressing concerns "that the growing corporatization of healthcare, if left unchecked, will result in an inappropriate incursion into the practice of medicine").

[3] *See id.* ("Nearly 3 of 4 physicians are now employed by hospitals, health systems and other corporate entities such as private equity firms and health insurers.").

[4] *See* Elizabeth Chiarello, *Barriers to Medical Board Discipline: Culture and Organizational Constraints,* 15 ST. LOUIS U. J. HEALTH L. & POL'Y 55, 67 (2021) ("Hospitals and clinics are legally required to report physician misconduct . . . ."); *see also* BRIETTA R. CLARK, ERIN C. FUSE BROWN, ROBERT GATTER, ELIZABETH Y. MCCUSKEY & ELIZABETH PENDO, HEALTH LAW 207 (9th ed. 2022) ("Medical malpractice claims are an important, and the most publicly visible, legal mechanism for promoting health care quality.").

[5] *See infra* Part III.

to patients that are the direct result of medical interventions,"[6] are the result of physician incompetence. Several studies show that systemic issues within hospitals are a contributing cause of medical errors.[7] This does not, however, eliminate the need to monitor when medical errors are caused by practitioner impairment or incompetence. Unfortunately, now that both internal and external warning systems have been taken functionally offline,[8] it is extremely hard to decipher when medical error is attributable to a system issue versus a practitioner competence issue.

Second, most individuals who become physicians are caring people who want to help patients.[9] Physicians are, however, human and as humans, are bound to make mistakes in their professional careers. Unfortunately, when mistakes are made during patient care, they can have dire consequences for the patient's health and well-being.[10] Effective health care oversight does not necessitate the removal from the profession of physicians who make one or two mistakes over the course of their careers. In fact, according to a recent American Medical Association study, approximately a third of physicians will be the subject of a medical malpractice lawsuit at some point during their practice of medicine.[11] It is the physician who has multiple lawsuits or where the time interval between lawsuits is short that the question of competency starts to factor in.

In the past, our medical malpractice system, and its subsequent reporting requirements to state licensing boards and the National

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[6] Ishani Ganguli, *Systemic Problems and Personal Accountability*, 13 AM. MED. ASS'N J. ETHICS 589, 589 (2011).

[7] *See, e.g.*, Tejal K. Gandhi, Gianna Zuccotti & Thomas H. Lee, *Incomplete Care—On the Trail of Flaws in the System*, 365 NEW ENG. J. MEDICINE 486, 488 (2011) (noting that missing information in electronic medical records contributes to medical error).

[8] *See infra* Part II.

[9] *See, e.g.*, Press Release, Am. Med. Ass'n, Survey: U.S. Physicians Overwhelmingly Satisfied with Career Choice (Mar. 30, 2017), https://www.ama-assn.org/press-center/press-releases/survey-us-physicians-overwhelmingly-satisfied-career-choice [https://perma.cc/EM92-JTRA] ("Three quarters of medical students, residents, and physicians said that helping people is a top motivator for pursuing their career . . . .").

[10] *See infra* section III.A.

[11] *See* JOSÉ R. GUARDADO, AM. MED. ASS'N, POLICY RESEARCH PERSPECTIVES: MEDICAL LIABILITY CLAIM FREQUENCY AMONG U.S. PHYSICIANS 2 (2023), https://www.ama-assn.org/system/files/policy-research-perspective-medical-liability-claim-frequency.pdf [https://perma.cc/YJ78-KMDH] ("In 2022, 31.2 percent of physicians reported that they had been sued in their careers to date.").

Practitioner Data Bank (NPDB), helped to identify and flag physicians who were the subject of multiple malpractice lawsuits so that they could either receive rehabilitative services or be removed from the practice of medicine.[12] Unfortunately, this warning system has become wholly ineffective through the consolidation and corporatization of hospitals into major health care systems.[13]

Some may argue that medical malpractice litigation is just one of a litany of health care oversight tools that are utilized in the United States[14] and that this is not a major threat to health care quality. As this Article will illustrate, however, most of the U.S. health care oversight tools have been silently reliant on this warning system due to the abject failure of the health care profession to properly police itself through the primary warning system of peer review.[15] With the peer review and medical malpractice warning systems not functioning under the control of corporatized health care systems, there is no way to know who a competent practitioner is outside of insider knowledge that is customarily guarded under lock and key and never disclosed to the public or other health care institutions.[16]

Perhaps the best way to illustrate how the medical malpractice warning system was dismantled by the consolidation of health care systems is to journey through a family's experience trying to hold a medical practitioner accountable for the death of a loved one. When reading this family's experience, keep in mind two realities: (1) this is happening to countless families across the United States on a

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[12] *See What Is the NPDB?*, NAT'L PRAC. DATA BANK https://www.npdb.hrsa.gov/resources/whatIsTheNPDB.jsp [https://perma.cc/N7XH-B47P] ("Registered, authorized entities must submit certain information concerning medical malpractice payments, adverse actions, and judgment or conviction reports regarding health care practitioners, providers, and suppliers [to the NPDB].")

[13] *See infra* section III.C.

[14] Richard E. Burney, *Oversight of Medical Care Quality: Origins and Evolution,* 101 J. MED. REG. 8, 9 tbl.1 (2015) (listing as quality oversight tools medical school graduation, post-graduate education, specialty board certification, state licensing, fellowship in national organizations, hospital staff or medical care organization membership and oversight, the legal system, the NPDB, online resources, insurer/payer oversight, Medicare, and commercial insurers).

[15] *See infra* section II.A.*1*.

[16] *See, e.g.*, Chiarello, *supra* note 4, at 58 ("Because of lax enforcement, many physicians harm their patients and face no consequences.").

daily basis;[17] and (2) the goals of most families experiencing this tragedy are to find answers as to why their loved one died, seek acknowledgement from the defendants that mistakes were made, and to ensure this does not happen to another family.[18] Below is the family's story[19]:

> After experiencing the traumatic and unexpected death of their loved one, the family sought out legal counsel to determine whether there was a case for medical negligence. The attorney did the usual request for medical records, records which were vastly more comprehensive than the records given to the family by the hospital. It took no time for the attorney to conclude there was a possible case. The medical records were sent to an expert witness, a physician in the same specialty as the physician in question. Again, in a short period of time, the expert issued a report that the family's loved one did indeed die because of medical negligence on the part of the treating physician.

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[17] *See, e.g.*, Thomas L. Rodziewicz, Benjamin Houseman & John E. Hipskind, *Medical Error Reduction and Prevention*, STATPEARLS (May 2, 2023), https://www.ncbi.nlm.nih.gov/books/NBK499956/ [https://perma.cc/67EC-2542] (noting that "[a]pproximately 400,000 hospitalized patients experience some type of preventable harm each year" and approximately 100,000 die); David W. Bates et al., *The Safety of Inpatient Health Care*, 388 NEW ENG. J. MEDICINE 142, 149 (2023) (finding that "adverse events remain common and are preventable nearly one fourth of the time").

[18] *See* Charles Vincent, Magi Young & Angela Phillips, *Why do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609, 1609 (1994) (noting "[f]our main themes emerged from the analysis of reasons for litigation: concern with standards of care—both patients and relatives wanted to prevent similar incidents in the future; the need for an explanation—to know how the injury happened and why; compensation—for actual losses, pain and suffering or to provide care in the future for an injured person; and accountability—a belief that the staff or organisation should have to account for their actions"); *see also* Gerald B. Hickson, Ellen Wright Clayton, Penny B. Githens & Frank A. Sloan, *Factors That Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 J. AM. MED. ASS'N 1359, 1361 (1992) (finding that families of children with perinatal injuries sue their doctors due to advice from others, financial need to afford long-term care, realization that physicians had lied, realization that their child had no future, and deterrence of future malpractice).

[19] Telephone Interview with Michael Kosner, Partner, Deratany & Kosner (Mar. 10, 2023). Hypothetical taken from a real family's experience of trying to hold a medical practitioner accountable for the death of their loved one.

The medical malpractice lawsuit was filed naming the hospital and physician as defendants. All the relevant parties to the lawsuit were deposed and negligence on the part of the physician was further confirmed. At this point, the hospital which employed the physician signaled its willingness to settle the lawsuit. The physician, on the other hand, refused and demanded to be dismissed. Because the hospital employed the physician, it was responsible for providing the physician's medical malpractice insurance. As is often the case when hospitals employ physicians, the hospital operated its own liability insurance which covered all the defense costs and any payout made in satisfaction of the lawsuit. This tied the defendants together, making settlement with one, but not the other, impossible.

This is when the family was confronted with the "corporate shield loophole." The hospital informed the family's attorney that although it wanted to settle the case, its hands were tied. In order for the case to settle, the family would need to dismiss the culpable physician from the lawsuit. The family's attorney counseled them that success at trial was not guaranteed and that eight out of ten times juries find in favor of the defendant physician despite strong evidence of negligence. Being left with no other viable option, the family reluctantly dismissed the culpable physician from the lawsuit.

Because settlement with the hospital happened after the culpable physician was dismissed, the hospital was not required to report the physician to the National Practitioner Data Bank (NPDB), the databank housing the names and addresses of physicians where payments were made in satisfaction of the medical malpractice claims, or to the state medical licensing board.

Uneasy with this result, the family thought of going to the state medical licensing board themselves to file a formal complaint against the physician. When the family asked their attorney for assistance, they were informed that the licensing board would likely not take

> their complaint seriously because the physician was dismissed from the lawsuit. The attorney went further to explain that the state medical licensing board typically doesn't investigate medical malpractice complaints unless a practitioner has multiple findings of medical negligence on their record.
>
> Left with no other method of drawing attention to the practitioner's incompetence, the family opted to leave poor reviews on internet sites designed to review medical practitioners' competence.

While the family walked away from this experience with money from the settlement—no amount of which could ever equate to the loss of their loved one—they felt no justice. They received no apology from the negligent practitioner and no assurance that the hospital was taking measures to ensure this did not happen again. Instead, the family left this ordeal with the realization that the health care system was indifferent in its responsibility to hold practitioners accountable for medical negligence. For this family, every regulatory tool, governing body, and corporate entity entrusted with holding this practitioner accountable failed to do its job.

What should have happened if the oversight system was functioning properly is: (1) the physician would not have had the leverage to demand dismissal from the lawsuit; (2) the hospital—the medical malpractice payer in this situation[20]—would have reported the physician to the state medical licensing board and the NPDB, the national quality control tool used to identify and weed out incompetent physicians;[21] (3) the report would put any future employer or licensing body which queried the NPDB on notice of the physician's medical negligence in this case;[22] and (4) any future negligent acts by the physician would trigger the need by state

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[20] *See* HEALTH RES. & SERVS. ADMIN., NPDB GUIDEBOOK E-18 (2018) [hereinafter NPDB GUIDEBOOK] (describing the reporting party as medical malpractice payers, including hospitals). The term "entity" specifically includes insurance companies, "which makes a payment under an insurance policy, self-insurance, or otherwise, for the benefit of a health care practitioner." 45 C.F.R. § 60.7(a) (2013).

[21] *What Is the NPDB?*, *supra* note 12.

[22] *See id.* (describing the query process for NPDB reports).

licensing agencies to investigate whether this physician should continue to practice medicine.[23]

In an ideal health care oversight system, internal peer review activities of hospitals and health care organizations would be the most important mechanism for overseeing the quality of medical care and competence of medical providers because they are able to provide immediate identification of impaired or incompetent practitioners.[24] Under peer review requirements, hospitals are required by both state medical licensing boards and the federal NPDB to timely and accurately report incompetent providers.[25] Unfortunately, studies conducted by independent researchers and government oversight agencies investigating the diligence of hospitals in reporting incompetent providers have shown this reporting requirement to be wholly ineffective.[26]

Medical malpractice lawsuits are the secondary, or backup, warning system state licensing boards and the NPDB rely on for

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[23] CLARK ET AL., *supra* note 4, at 45 (noting that "[a]lthough licensing boards generally have the authority to prosecute the physicians they license for malpractice, they tend not to do so unless and until a physician has amassed multiple paid malpractice claims"); *see also* FED'N OF STATE MED. BDS., U.S. MEDICAL REGULATORY TRENDS AND ACTIONS 8 (2018), https://www.fsmb.org/siteassets/advocacy/publications/us-medical-regulatory-trends-actions.pdf [https://perma.cc/59PX-973U] (noting that "[s]ome boards have built-in levels of malpractice that trigger investigations, such as a certain number of malpractice settlements in a certain span of time").

[24] Burney, *supra* note 14, at 11.

[25] *See generally* 42 U.S.C. §§ 11131–11137 (requiring reporting of sanctions and related information in the health care industry); Chiarello, *supra* note 4, at 58 (discussing medical boards as an enforcement mechanism for punishment of providers that do harm); CLARK ET AL., *supra* note 4, at 275 (noting the responsibility of peer review committees is to "examine and assess the competence of physicians who seek and who have privileges at the hospital"); 45 CFR §§ 60.7, 60.12(a) (2013) (describing requirements for reporting medical malpractice payments and reporting adverse actions taken against clinical privileges).

[26] *See* OFF. OF INSPECTOR GEN., DEP'T OF HEALTH AND HUM. SERV., HOSPITAL REPORTING TO THE NATIONAL PRACTITIONER DATA BANK, at ii (1995) (noting that 18 hospitals in Massachusetts with more than 300 beds did not report an adverse action); 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, 351 (1999) ("There was a decrease both in the percentage of hospitals reporting at least 1 privileges action and in the rate of privileges actions over the study period."); Teresa M. Waters, Richard B. Warnecke, Jennifer Parsons, Orit Almagor & Peter P. Budetti, *The Role of the National Practitioner Data Bank in the Credentialing Process*, 21 AM J. MED. QUALITY 30, 36 (2006) ("In 7% of all cases, a preliminary decision was reached prior to receiving NPDB data. . . . [In] 3% of all cases . . . a final decision was reached prior to receiving the NPDB report.").

identifying incompetent practitioners.[27] As Dr. Richard Burney, a life-long advocate for health care oversight, states: "[T]he malpractice system is able to discipline physicians and others who might otherwise fall between the cracks of other quality oversight processes, and who would otherwise not have to acknowledge their responsibility for poor practices nor be held accountable for them."[28] Unfortunately, the rapid increase in the employment of physicians by hospitals and the resultant increased use of the corporate shield loophole has taken this warning system out of operation.

According to the NPDB website, over 24,000 health-care-related entities query the database for licensing, hiring, and credentialing purposes.[29] This querying function is what makes the NPDB an essential quality control tool in the United States. However, when one of the key warning systems that reports to the NPDB is compromised due to legal maneuvering, entities which query the database have difficulties identifying and preventing bad physicians from practicing within their institutions.[30] When both are compromised, as this Article will illustrate, there can be catastrophic effects for the quality of health care.

This Article proposes that because hospitals are playing an increasing role in delivering medical services through the employment of physicians, their role in ensuring quality control is paramount.[31] Furthermore, because hospitals are the perpetrators hampering both the medical malpractice and peer review warning systems, they are the key targets for health care oversight reform. Putting in place legal mechanisms to hold hospitals accountable for

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[27] Burney, *supra* note 14, at 13 (noting that "[t]he NPDB receives and compiles reports of any adverse actions taken on the credentials or license of a physician. These include both substantiated malpractice claims and adverse actions taken with regard to hospital privileges, such as dismissal from a hospital staff").

[28] *Id.*

[29] *What Is the NPDB?*, *supra* note 12.

[30] *See* CLARK ET AL., *supra* note 4, at 48–49 ("[O]nly 45% of doctors with an NPDB report of adverse privileges actions or malpractice settlements also has a report of a disciplinary action by their state medical board . . . . Most state boards reported that they had been aware of the reports against specific physicians in all but the rarest of cases, but that their board's investigation had concluded the circumstances did not warrant disciplinary action in the specific cases at issue.").

[31] *Id.* at 230 ("Because hospitals . . . are playing an increasing role in delivering medical services, they must also play a greater—if not primary—role in preventing and responding to adverse events.").

identifying and disclosing practitioner incompetence is the best way to safeguard the quality of health care in the United States.

Part II of this Article highlights the state-based and private sector quality control tools currently in place in the U.S. health care system and the factors that impair their ability to reliably monitor practitioner competence. It concludes by focusing on the NPDB as the main tool needing immediate reform and highlighting the flaws inherent in the NPDB's design. Part III examines how the lack of effective quality control tools is causing catastrophic harm to patients. Specifically, it pinpoints the underreporting of adverse actions taken against practitioners' clinical privileges by hospitals and the increased use of the corporate shield loophole by physicians and hospitals as the two main areas causing the greatest harm to the quality control system. Part IV makes the case for reform. By simply capturing the employment and hospital affiliation histories of all medical providers within the NPDB and requiring the use of a mandatory credentialing questionnaire, the reform achieves three goals: (1) it improves the process whereby hospitals investigate whether a medical practitioner has a history of substandard medical care; (2) it paves the way for state-based tort claims to hold hospitals accountable for *inaccurate* disclosures regarding a practitioner's competence to practice medicine; and (3) it eliminates the stigma associated with being listed in the NPDB which causes practitioners to practice defensive medicine and avoid admitting mistakes.

II. STRUCTURAL DEFICIENCIES IN U.S. HEALTH CARE OVERSIGHT

This Part highlights the comprehensive rules and regulations that are supposed to monitor and control the quality of health care offered in U.S. health care institutions. It describes how these tools are intended to function, draws attention to their reliance upon one another, and identifies outside forces that hinder their effectiveness. Finally, it settles on the NPDB as the key quality control tool needing immediate reform and pinpoints the provisions within the NPDB that are causing it to be ineffective.

A. PROBLEMS WITH STATE-BASED AND PRIVATE-SECTOR QUALITY CONTROL TOOLS

The U.S. health care system has multiple legal tools to ensure physician competence. These include medical licensure and discipline, board certification, Medicare Conditions of Participation (COPs), credentialing, accreditation, peer review, medical liability, and reporting to the NPDB.[32] Each of these tools, in their own way, are designed to oversee medical practitioner competence. Unfortunately, many of the tools are reliant on each other's proper functioning. And even more troubling is that all are ultimately reliant upon the medical industry to properly police itself.[33]

1. Medical Licensure Is the First Line of Defense to Ensure Practitioner Competence, but Licensure Boards' Priorities Are Skewed. The first line of defense in making sure incompetent practitioners do not enter the practice of medicine is licensure.[34] Licensure is controlled by state medical boards whose function is to ensure that practitioners meet certain standards of education, training, and professional conduct.[35] To ensure the continued competence of practitioners after initial licensure, practitioners are responsible for engaging in continuing education and have an obligation to notify the medical board of any incompetent or impaired practitioners they come to discover.[36] Notification can be by independent practitioners or through peer-review committees.[37] Peer review committees are housed within health care institutions

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[32] *See id.* at 35, 117 (discussing licensure and accreditation); J. STUART SHOWALTER, THE LAW OF HEALTHCARE ADMINISTRATION 291 (9th ed. 2020) (describing accreditation standards based on general physician competency).

[33] *See* Chiarello, *supra* note 4, at 66 ("Physicians still self-regulate.").

[34] *See* CLARK ET AL., *supra* note 4, at 35 ("State licensing statutes govern entry into the licensed profession, regulate the health care services that licensed professionals may provide, and prohibit unlicensed persons from providing services reserved for the licensed professions . . . . The system also monitors the quality of care provided by licensees and penalizes or removes incompetent practitioners from practice.").

[35] *See* FED'N OF STATE MED. BDS., *supra* note 23, at 6 ('Obtaining a license to practice medicine in the U.S. is a rigorous process . . . ."); Nathan Cortez, *The Law of Licensure and Quality Regulation*, 387 NEW ENG. J. MEDICINE 1053, 1054 (2022) (discussing state medical board licensure).

[36] *See* FED'N OF STATE MED. BDS., *supra* note 23, at 6–8 (describing continuing medical education programs); *see also* Cortez, *supra* note 35, at 1054.

[37] Cortez, *supra* note 35, at 1054.

and consist of multiple medical practitioners who periodically, or in response to a complaint or questionable practice, evaluate the quality of their colleague's work to ensure that the medical standards of care are being applied to patient care.[38] Hospitals and health care facilities are required to notify the medical board if they become aware of a practitioner whose practice of medicine is substandard and/or poses a risk of harm to patients.[39] Finally, states require entities involved in medical malpractice claims where a payment is made in satisfaction of the claim to report the defendant practitioner to the state medical board for review and potential suspension or revocation of the practitioner's license.[40] So, in order for licensure to be an effective quality control tool it relies on: (1) individual practitioners; (2) peer review committees; (3) hospitals and other health care entities; and (4) entities making payments in satisfaction of medical malpractice claims to make timely and accurate reports of another medical practitioner's substandard practice of medicine.[41]

Unfortunately, even if a practitioner is reported to a state licensing board, boards routinely limit their disciplinary action to practitioners with multiple complaints filed against them.[42] Because state medical boards are dependent on state funds to

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[38] *See* Dinesh Vyas & Ahmed Hozain, *Clinical Peer Review in the United States: History, Legal Development and Subsequent Abuse*, 20 WORLD J. GASTROENTEROLOGY 6357, 6358 (2014) (noting that peer review is a mandatory oversight tool required for hospital accreditation).

[39] *See* FED'N OF STATE MED. BDS., *supra* note 23, at 8 ("In some states' Medical Practice Acts, the duty to report issues that may impact patient safety—including inappropriate or unprofessional conduct—is included as a formal requirement of physicians."); Cortez, *supra* note 35, at 1054 (noting state reporting requirements); Chiarello, *supra* note 4, at 67 (noting hospital and clinic reporting requirements).

[40] *See* FED'N OF STATE MED. BDS., *supra* note 23, at 8 ("It is common practice for medical boards to use malpractice data as a tool to detect unprofessional conduct that may violate the Medical Practice Act."); 225 ILL. COMP. STAT. 60 / 23(A)(3) (2023) (requiring that professional liability insurers report settlements).

[41] *See* FED'N OF STATE MED. BDS., *supra* note 23, at 7 (discussing the reporting sources for boards).

[42] *See* CLARK ET AL., *supra* note 4, at 45 ("Although licensing boards generally have the authority to prosecute the physicians they license for malpractice, they tend not to do so unless and until a physician has amassed multiple paid malpractice claims . . . . [B]ased on data from 1990-2016, the likelihood that the Illinois medical licensing agency would take disciplinary action against a physician increased steadily with each paid malpractice claim amassed by a physician.").

effectively function, evidence shows that state licensing agencies use their limited resources to pursue unprofessional behavior, such as sexual misconduct, financial misbehavior, or prescription abuse, rather than incidents of substandard medical care.[43] Thus, physician discipline by state licensing agencies usually addresses problems of "character, not competence," with licensing actions against physicians for malpractice making up only 20% of all disciplinary actions.[44] With regards to peer review activities that result in a report to the state medical board, only 45% of practitioners with a report of adverse privileges actions ultimately received disciplinary action by their state medical board.[45]

2. Hospital Accreditation and the Medicare Conditions of Participation are Additional Weapons in the Quality Control Arsenal, but Financial Conflicts of Interests Impact Objectivity. Hospital accreditation and the Medicare Conditions of Participation (CoPs) are additional quality control tools used to monitor medical practitioner competence.[46] Private organizations are responsible for hospital accreditation, and as a result, accreditation is not required for hospitals and other health care entities to operate in the United States.[47] However, because the Medicare Conditions of Participation[48] rely on private accreditation to vet health care

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[43] *See id.* (citing evidence that "state licensing agencies use their resources to pursue the most egregious forms of unprofessional behavior").

[44] *See* Nadia N. Sawicki, *Character, Competence, and the Principles of Medical Discipline*, 13 J. HEALTH CARE L. & POL'Y 285, 302–03 (2010) (discussing studies revealing the low rate of disciplinary action based on malpractice).

[45] Alan Levine, Robert Oshel & Sidney Wolfe, *State Medical Boards Fail to Discipline Doctors with Hospital Actions Against Them,* PUB. CITIZEN (Mar. 15, 2011) https://www.citizen.org/article/state-medical-boards-fail-to-discipline-doctors-with-hospital-actions-against-them/ [https://perma.cc/9H2M-VYHW].

[46] *See* CLARK ET AL., *supra* note 4, at 117 (discussing accreditation); *see also* SHOWALTER, *supra* note 32, at 291 (describing areas of general competency for accreditation).

[47] *The Joint Commission FAQs*, JOINT COMM'N, https://www.jointcommission.org/who-we-are/facts-about-the-joint-commission/joint-commission-faqs/ [https://perma.cc/24PJ-JAN2] (last visited Mar. 2, 2023).

[48] The CMS website states that:

> CMS develops Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process

entities for quality control metrics, and hospitals rely on payments from Medicare for services rendered to Medicare beneficiaries to stay in business, accreditation is vital to the viability of most U.S. hospitals.[49]

The main accreditation organization in the United States is the Joint Commission.[50] As part of the accreditation process, the Joint Commission requires hospitals to engage in a thorough credentialing process before granting medical practitioners privileges to work within their facilities.[51] Credentialing of practitioners includes "the collection, verification, and assessment of information relating to . . . experience, ability, and current competence to perform the roles, tasks, and procedures that comprise the requested privileges."[52] This mandates that hospitals send letters to other hospitals and physicians inquiring about the practitioner's "ability and current competence to perform the requested privileges."[53]

The Joint Commission also requires hospitals to "initiate peer reviews for all privilege requests made by new physicians and any [additional privilege] requests by existing physicians."[54] Privileging is "the process whereby the specific scope and content of patient care (clinical) services are authorized . . . by a healthcare organization on the basis of evaluation of the individual's credentials and

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called 'deeming') meet or exceed the Medicare standards set forth in the CoPs / CfCs.

Conditions for Coverage (CfCs) & Conditions of Participation (CoPs), CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs [https://perma.cc/E9AX-QV9J].

[49] *See* John Blum, *A Revisionist Model of Hospital Licensure*, 2 REG. & GOVERNANCE 48, 51 (2008) (noting accreditation's gatekeeping role for hospital Medicare access); *see also* Cortez, *supra* note 35, at 1055 (indicating accreditation is voluntary "only in a superficial sense").

[50] Cortez, *supra* note 35, at 1055.

[51] *See* Vyas & Hozain, *supra* note 38, at 6358 (exploring the mandated peer review component of accreditation); *see also* SHOWALTER, *supra* note 32 (describing accreditation standards).

[52] Sallie Thieme Sanford, *Candor After* Kadlec*: Why, Despite the Fifth Circuit's Decision, Hospitals Should Anticipate an Expanded Obligation to Disclose Risky Physician Behavior*, 1 DREXEL L. REV. 383, 393 (2009) (citing JOINT COMM'N, COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: THE OFFICIAL HANDBOOK at MS.4.10, MS.4.15 (2006)).

[53] *Id.*

[54] Vyas & Hozain, *supra* note 38, at 6358; *see also* SHOWALTER, *supra* note 32, at 291 (discussing statutory peer review requirements).

performance."[55] The Joint Commission's accreditation standards for medical staff privileges are based on the following areas of competency: "(1) patient care; (2) medical or clinical knowledge; (3) practice-based learning and improvement; (4) interpersonal and communication skills; (5) professionalism; and (6) systems-based practice."[56]

A pitfall to absolute reliance on private accreditation as an effective tool to identify and weed out incompetent practitioners, however, is its private nature.[57] Because the accrediting bodies are paid by the hospitals they are reviewing, studies have shown that very few hospitals are ever refused accreditation status.[58] This indicates a potential conflict of interest exists in the business model, and that accreditation status may not be as foolproof a quality control metric as one would hope.[59]

In addition, as with licensure, accreditation relies on hospitals and health care entities to engage in diligent credentialing of new physicians and active peer review of existing physicians to identify incompetent or bad physicians. The presumption is that when hospitals identify an incompetent practitioner, they will revoke their privileges and report the practitioner to the state licensing

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[55] SHOWALTER, *supra* note 32, at 282.

[56] *Id.* at 291.

[57] *See* Blum, *supra* note 49, at 51 (noting that "[i]f TJC pursues its tasks with too much vigor, it may result in institutions dropping the process . . . .").

[58] *See* Paige Minemyer, *Investigation: Joint Commission Rarely Revokes Accreditation from Hospitals that Put Patients at Risk,* FIERCE HEALTHCARE (Sept. 11, 2017, 12:15 PM), https://www.fiercehealthcare.com/regulatory/investigation-reveals-joint-commission-unlikely-to-revoke-accreditation-from-hospitals [https://perma.cc/2MN8-29ZY] ("The Joint Commission revoked accreditation for just 1% of hospitals out of compliance with Medicare. More than 30 hospitals retained their accreditations even though the Centers for Medicare & Medicaid Services determined that their violations were significant enough to cause, or likely cause, serious patient injury or death."); *see also* Stephanie Armour, *Hospital Watchdog Gives Seal of Approval, Even After Problems Emerge*, WALL ST. J. (Sep. 8, 2017, 12:45 PM), https://www.wsj.com/articles/watchdog-awards-hospitals-seal-of-approval-even-after-problems-emerge-1504889146 [https://perma.cc/FW3Z-HAJU] (finding that 350 hospitals with Joint Commission accreditation were in violation of Medicare requirements in 2014, and about a third went on to have violations the following three years).

[59] *See* Minemyer, *supra* note 58 ("[Accreditation] is clearly a failed system . . . . [It] is basically meaningless—it doesn't mean a hospital is safe." (quoting Ashish Jha, M.D., Harvard University T.H. Chan School of Public Health)).

board and the NPDB.[60] As Parts III and IV will illustrate, this presumption is naïve. As a result, many practitioners are continuing to practice medicine despite being incompetent.[61] This is where the proper functioning of the NPDB comes into play as a vital component of quality control in U.S. health care.

B. THE NPDB IS THE MASTER LIST OF INCOMPETENT PRACTITIONERS BUT HAS MAJOR FLAWS LIMITING ITS EFFECTIVENESS

The NPDB is the child of the 1986 Health Care Quality Improvement Act (HCQIA).[62] Congress had three main goals in creating the HCQIA: (1) improve the quality of medical care on a national level; (2) "restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the practitioner's previous damaging or incompetent performance;" and (3) "provide incentive and protection for physicians engaging in effective professional peer review."[63] To accomplish these goals, Congress created a national database—the NPDB.[64]

Three laws govern the reports required to be submitted to the NPDB: (1) Title IV of the Health Care Quality Improvement Act of

[60] *See* FED'N OF ST. MED. BDS., *supra* note 23, at 7, 8 (itemizing the various sanctions hospitals may place on an incompetent practitioner); 42 U.S.C. § 11133(a)(1)(B)(i) (mandating health care entities report the review of physicians who have surrendered their clinical privileges while under investigation for possible incompetence or improper professional conduct).

[61] *See* Chiarello, *supra* note 4, at 58 ("Because of lax enforcement, many physicians harm their patients and face no consequences").

[62] Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101–11152; *see also NPDB History*, NAT'L PRAC. DATA BANK, https://www.npdb.hrsa.gov/topNavigation/timeline.jsp [https://perma.cc/MY93-QBJ6] ("[T]he HCQIA. . . led to the National Practitioner Data Bank's (NPDB) establishment.").

[63] 42 U.S.C. § 11101.

[64] *NPDB History*, *supra* note 62.

1986;[65] (2) Section 1921 of the Social Security Act;[66] and (3) Section 1128E of the Social Security Act.[67] In general, the reports required from these laws fall into one of two buckets: (1) disclosures of payments made in satisfaction of medical malpractice claims;[68] and (2) disclosures of adverse actions taken against health care practitioners.[69] Because the NPDB is a national repository of information on practitioner competence and all health care entities are required to query the database before granting medical practitioners privileges to practice within their facilities,[70] it is the quality control tool best situated to impact positive change for health care quality across the United States if properly reformed. The following sections will briefly describe the rules and regulations governing the two main reporting requirements of the NPDB and highlight the current limitations hidden within the regulatory language.

1. Limitations in the Reporting Requirements for Payments Made in Satisfaction of Medical Malpractice Claims. According to the

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[65] *See* 42 U.S.C. §§ 11101–11152 (requiring the reporting of medical malpractice payments and adverse action history.) Adverse actions include certain "licensure, clinical privileges, and professional society membership[s]. . . as well as Drug Enforcement Administration (DEA) controlled-substance registration actions and exclusions from participation in Medicare, Medicaid, and other federal health care programs." *General Information*, NAT'L PRAC. DATA BANK, https://www.npdb.hrsa.gov/guidebook/AGeneralInformation.jsp [https://perma.cc/69XK-2T93].

[66] 42 U.S.C. § 1396r–2(g)(3) (requiring disclosure of: (1) state licensure and certification actions against health care practitioners, entities, providers, and suppliers; (2) negative actions or findings by peer review organizations and private accreditation organizations; and (3) certain final actions taken by certain state agencies, including state law enforcement agencies, state Medicaid fraud control units, and state agencies administering or supervising the administration of state health care programs). Final adverse actions that must be disclosed include exclusions from a state health care program, health care-related criminal convictions and civil judgments in state courts, and other adjudicated actions or decisions specified in regulations. *Id.*

[67] *Id.* § 1320a–7e(g) (requiring disclosure of final adverse actions taken by federal agencies and health plans against health care practitioners, providers, and suppliers relating to federal licensure and certification actions, exclusions from participation in a federal health care program, health care-related criminal convictions and civil judgments, and other adjudicated actions or decisions specified in regulations).

[68] *See id.* § 11131 (requiring reporting of medical malpractice actions).

[69] *See id.* § 11133 (requiring reporting of adverse actions against physicians).

[70] *See What Is the NPDB?*, *supra* note 12 ("Entities use [NPDB queries] as a workforce tool for licensing, hiring, and credentialing decisions.").

NPDB Guidebook (the Guidebook), "[e]ach entity that makes a payment for the benefit of a healthcare practitioner in settlement of, or in satisfaction in whole or in part of, a written claim or judgment for medical malpractice against that practitioner must report the payment information to the NPDB."[71] Payments are "limited to exchanges of money and must be the result of a written complaint or claim demanding monetary payment for damages."[72] The Guidebook specifically limits reportable actions to written complaints or claims that are based on the "practitioner's provision of or failure to provide health care services."[73] For the reporting requirement, "[t]he amount of payment is irrelevant; there is no de minimis exception."[74]

Once an entity concludes there is a reportable event, it must submit: "(1) the name of any physician or licensed healthcare practitioner for whose benefit the payment was made; (2) the amount of the payment; (3) the name (if known) of any hospital with which the physician or practitioner was affiliated or associated; and (4) a description of the acts or omissions and injuries or illnesses upon which the action or claim was based."[75] Any malpractice payer that fails to report medical malpractice payments in accordance with NPDB requirements is subject to a civil money penalty of not more than $11,000 for each such payment involved.[76]

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[71] NPDB GUIDEBOOK, *supra* note 20, at E-16. The term "entity" specifically includes insurance companies, which make "payment[s] under an insurance policy, self-insurance, or otherwise, for the benefit of a health care practitioner." 45 C.F.R. § 60.7(a) (2013).

[72] NPDB GUIDEBOOK, *supra* note 20, at E-16. "Payment" is not to include the waiver of an outstanding debt and is therefore not required to be reported. 45 C.F.R. § 60.7(a) (2013); *see also* NPDB GUIDEBOOK, *supra* note 20, at E-18 ("Individuals are not required to report to the NPDB payments they make for their own benefit. Thus, if a practitioner or other individual makes a medical malpractice payment out of personal funds, the payment should not be reported.").

[73] NPDB GUIDEBOOK, *supra* note 20, at E-18.

[74] *Id.* at E-19.

[75] 42 U.S.C. § 11131(b); *see also* 45 C.F.R. § 60.7(b) (2013) (detailing further reporting requirements).

[76] *See* 45 C.F.R. § 60.7(c) (2013) ("Any entity that fails to report information on a payment required to be reported under this section is subject to a civil money penalty. . . ."); *see also* NPDB GUIDEBOOK, *supra* note 20, at E-26 ("The OIG has the authority to impose civil money penalties in accordance with Title IV."); 42 C.F.R. § 1003.810(a) (2023) ("The OIG may impose a penalty of not more than $11,000 for each payment for which there was a failure to report required information in accordance with § 1003.800(a)(1). . . .").

An important limitation to this reporting requirement is that payments made as a result of a suit or claim *solely* against an entity are not reportable to the NPDB.[77] This means that, if a practitioner and hospital are named as codefendants in a lawsuit and the practitioner is subsequently dismissed from the lawsuit without condition prior to settlement or judgment, there is no duty to report the practitioner.[78] This limitation sets the stage for the corporate shield loophole which was discussed in the Introduction and will be discussed in greater detail in Part III of this Article. At this point, it is important to note that this limitation exists within the regulatory language of the NPDB. The following section describes a hospital's reporting requirement when it takes adverse actions against a practitioner's medical privileges.

2. Limitations in the Reporting Requirements for Adverse Actions Against Clinical Privileges and the NPDB's Lax Enforcement Provision. According to the NPDB regulations and underlying statute, reporting of adverse actions against a medical provider is an obligation held by state licensure and certification bodies, peer review and private accreditation organizations, and certain state agencies involved in prosecuting fraud and state health care programs.[79] Because the quality control oversight abilities of state licensure and accreditation organizations have already been covered, this Article focuses its attention on the reporting requirements of hospital peer review committees.[80]

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[77] *See* NPDB GUIDEBOOK, *supra* note 20, at E-19 ("Medical malpractice payments made solely for the benefit of a corporation – such as a clinic, group practice, or hospital – should not be reported to the NPDB.").

[78] *See id*. at E-19 to -20 ("In order for an MMPR to be submitted to the NPDB on a particular health care practitioner, the practitioner must be named, identified, or otherwise described in both the written complaint or claim demanding monetary payment for damages *and* the settlement release or final adjudication, if any.").

[79] *See* 45 C.F.R. §§ 60.8–60.16 (2013) (detailing the reporting requirements of adverse actions against Boards of Medical Examiners, states, peer review organizations or private accreditation entities, and other health care entities); 42 U.S.C. § 11133 (detailing the adverse reporting requirements for health care entities).

[80] *See* 45 C.F.R. § 60.11–60.12 (2013) (providing the requirements for reporting adverse actions taken against peer review organizations, private accreditation entities, and clinical privileges); NPDB GUIDEBOOK, *supra* note 20, at E-31 ("Hospitals and other health care entities must report adverse clinical privileges actions to the NPDB. . . ."). For purposes of this Article, the term "hospital" is used to incorporate "other healthcare entities."

Under the "Reporting of Adverse Clinical Privileges Action" provision, the Guidebook requires the reporting of "[a]ny professional review action that adversely affects the clinical privileges of a physician . . . for a period longer than 30 days" or the physician's voluntary surrender of clinical privileges, or "acceptance . . . of any restriction of such privileges by a physician . . . while the physician . . . is under investigation by the health care entity relating to possible incompetence or improper professional conduct, or . . . [i]n return for not conducting an investigation or proceeding."[81]

Actions taken against a physician's clinical privileges include "reducing, restricting, suspending, revoking, or denying clinical privileges" and also include the decision not to renew a physician's privileges if that decision was based on the practitioner's professional competence or conduct.[82] Those clinical privileges are defined as "privileges, medical staff membership, . . . network participation and panel membership . . . in which a . . . practitioner is permitted to furnish medical care by the healthcare entity."[83]

In order to account for all potential reportable events, the NPDB uses a liberal interpretation of the word "investigation."[84] Under NPDB criteria, "[a]n investigation begins as soon as the health care entity begins an inquiry and does not end until the health care entity's decision-making authority takes a final action or makes a decision to not further pursue the matter."[85] The Guidebook clarifies that only targeted investigations issued in relation to a specific practitioner's professional competence or conduct are subject to the reporting requirement.[86]

To encourage compliance with the reporting mandate, the NPDB has the authority through the Secretary of Health and Human Services (HHS) to issue sanctions against hospitals and other health care entities found to have substantially failed in their

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[81] 45 C.F.R. § 60.12(a) (2013); *see also* NPDB GUIDEBOOK, *supra* note 20, at E-31 (explaining requirements for reporting adverse clinical privileges actions).

[82] 45 C.F.R. § 60.3 (2013) (providing a definition for "adversely affecting").

[83] NPDB GUIDEBOOK, *supra* note 20, at E-31.

[84] *Id.* at E-36.

[85] *Id.* at E-37.

[86] *Id.* ("[I]f a formal, targeted process is used when issues related to a *specific practitioner's* professional competence or conduct are identified, this *is* considered an investigation for the purposes of reporting to the NPDB.").

reporting requirements to the NPDB.[87] These sanctions include the loss, for three years, of the entity's immunity protections provided under Title IV of the HCQIA.[88] This means that the hospital or entity can no longer offer the immunity protections of the HCQIA as a defense to a civil suit alleging undue interference with trade or antitrust violations.[89] In addition, the hospital or entity will lose its right to query the NPDB, will be subject to an outside party's oversight of its reporting requirements, and could potentially lose its accreditation during this period.[90] Finally, the name of the entity will be published in the Federal Register.[91]

While the sanctions authorized under the HCQIA are severe, there is a lengthy process that HHS must undertake before sanctions may be imposed.[92] This process includes the requirement that HHS conduct a formal investigation of the health care entity's

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[87] *See* 45 C.F.R. § 60.12(c)(1) (2013) (authorizing the Secretary to issue sanctions).

[88] *Id.* ("[T]he immunity protections provided under section 411(a) of HCQIA will not apply to the health care entity . . . during the 3-year period [after sanctions begin]."); *see also* NPDB GUIDEBOOK, *supra* note 20, at E-42 (noting sanctions for failing to report to the NPDB). The U.S. Code provides that:

> If the Secretary has reason to believe that a [hospital] has failed to report information in accordance with section 11133(a) of this title, the Secretary shall conduct an Investigation. If, after providing notice of noncompliance, an opportunity to correct the noncompliance, and an opportunity for a hearing, the Secretary determines that a [hospital] has failed substantially to report information in accordance with section 11133(a) of this title, the Secretary shall publish the name of the [hospital] in the Federal Register. The protections of subsection (a)(1) of this section shall not apply to [a hospital] the name of which is published in the Federal Register under the previous sentence with respect to professional review actions of the [hospital] commenced during the 3-year period beginning 30 days after the date of publication of the name.

42 U.S.C. § 11111(b).

[89] *See* 42 U.S.C. § 11111(a) (describing the limitation on damages for professional review actions); *id.* § 11111(b) (removing the limitation with a sanction).

[90] Susan Scheutzow, *State Medical Peer Review: High Cost But No Benefit – Is It Time for a Change?* 25 AM. J.L. & MED. 7, 20 (1999) ("As part of a hospital's overall quality assurance program, peer review is a prerequisite for accreditation by JCAHO and the American Osteopathic Association (AOA).").

[91] 45 C.F.R. § 60.12(c)(1)(iii) (2013); 42 U.S.C. § 11111(b).

[92] *See* 42 U.S.C. § 11111(b) (discussing HHS's investigation, notice, and hearing requirements before issuing sanctions).

failure to report.[93] If the investigation proves the health care entity failed to comply with the reporting requirement, HHS must send the entity formal written notice of its findings.[94] Included in the written notice of noncompliance, HHS allows the entity an opportunity to correct the noncompliance and request a formal hearing.[95]

Two significant limitations exist with regard to this reporting requirement. First, hospitals have figured out ways to limit adverse actions against clinical privileges to less than thirty days. Second, due to the lax enforcement mechanism for holding a hospital accountable for not reporting, most hospitals err on the side of underreporting until caught. Part III of this Article examines how hospitals and health care entities take advantage of these limitations and the detrimental impact underreporting has on patient health and well-being as well as the ability of the NPDB to function as a quality control tool.

III. LACK OF ENFORCEMENT OF NPDB RULES CAUSE HOSPITALS TO FAVOR NONDISCLOSURE AND COMPLICITY WITH THE CORPORATE SHIELD LOOPHOLE

This Article has covered the reporting requirements mandated by the HCQIA, the rules outlined in the Code of Federal Regulations, and the guidelines set forth in the NPDB Guidebook. One would assume that the mandatory reporters are adequately educated about when, where, and who must be reported based on this extensive regulatory framework. Unfortunately, this assumption would be false. Without actual enforcement of these laws, there is no compliance on the part of hospitals. The following section illustrates the catastrophic effect that nonreporting of incompetent practitioners can have on patients' health and well-being.

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[93] NPDB GUIDEBOOK, *supra* note 20, at E-42 ("The secretary of HHS will conduct an investigation if there is reason to believe that a health care entity has substantially failed to report required adverse actions.").

[94] *See id.* (explaining the investigation procedure).

[95] *See id.* (describing the purposes of the written notice).

A. NONREPORTING OF INCOMPETENT PRACTITIONERS CAN HAVE DIRE CONSEQUENCES FOR PATIENTS

The case of Baylor Regional Medical Center (Baylor) and Dr. Christopher Duntsch (Duntsch) is the perfect example of the catastrophic impact nonreporting can have on patient care. The case involved several well-respected hospitals: Baylor, Dallas Medical Center (DMC), Legacy Surgery Center, and University General Hospital Dallas.[96] To these hospitals, Duntsch was an MD/PhD neurosurgeon with impressive academic and professional credentials with the ability to bring in approximately *$2.4 million* in annual revenues.[97] In the two years that Duntsch worked at the four Texas health care centers, he killed two and injured thirty-one out of the thirty-seven patients he operated on.[98]

Duntsch began his surgical career at Baylor in 2011.[99] For the first couple of months, Duntsch was only allowed to assist in surgeries; however, when his relationship soured with the supervising physician because Duntsch abandoned his on-call duties, Baylor allowed Duntsch to conduct surgeries on his own.[100] Duntsch performed his first solo surgery at Baylor on November 14, 2011,[101] and by February of 2012 had already left several patients with permanent and severe disabilities.[102] Baylor did not begin to

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[96] Yahitza Nuñez, *"Dr. Death" Loses Appeal, Court Upholds Life Sentence*, LOY. UNIV. CHI. SCH. OF L.: INSIDE COMPLIANCE (Feb. 7, 2019), https://blogs.luc.edu/compliance/?p=2275 [https://perma.cc/3844-YWB8].

[97] Laura Beil, *A Surgeon So Bad It Was Criminal,* PROPUBLICA (Oct. 2, 2018, 5:00 AM), https://www.propublica.org/article/dr-death-christopher-duntsch-a-surgeon-so-bad-it-was-criminal [https://perma.cc/BTA2-3GUD].

[98] *Id.*

[99] *Id.*

[100] *See id.* (recounting Duntsch's deteriorating relationship with a supervising physician but noting that "Duntsch still had [operating] privileges at Baylor-Plano").

[101] *See* Expert Report and Affidavit of John Dale Dunn at 4, Fennell v. Duntsch, No. DC-13-13512, 2015 WL 9687658 (Tex. Dist. Ct. Mar. 3, 2015) (providing a background of Duntsch's surgeries). Duntsch performed surgery on Kenneth Fennell at Baylor, which in the opinion of Dr. Robert Henderson was the incorrect procedure, "setting Mr. Fennell up for a second surgery to occur just over a year later." *Id.*

[102] *See* Beil, *supra* note 97 (recounting the surgeries on the patients and their disabling effects). Duntsch performed surgery on Lee Passmore on December 30, 2011. *Id.* As a result of several blatant medical errors made during the surgery, Lee was left with chronic pain and difficulty walking. *Id.* Duntsch's next patient was Barry Morguloff, who required a routine

investigate Duntsch's conduct until his friend, who he left as a quadriplegic after neck surgery, informed the hospital that he was doing cocaine with Duntsch the night before his surgery.[103] Despite being investigated for drug use, Baylor allowed Duntsch to continue to perform minor procedures.[104] Three weeks after Baylor concluded its investigation, Duntsch operated on Kellie Martin.[105] Martin, who needed treatment for a compressed nerve, which is considered a minor surgery with few complications, died from massive blood loss.[106] At this point, hospital administrators at Baylor organized a comprehensive review of Duntsch's cases and ended Duntsch's tenure at Baylor.[107]

Instead of reporting Duntsch to the NPDB, Baylor and Duntsch reached an agreement in which Duntsch voluntarily resigned from Baylor on April 20, 2012, in return for a reference letter to be used during future credentialing proceedings stating: "All areas of concern with regard to Christopher D. Duntsch have been closed. As of this date, there have been no summary or administrative restrictions or suspensions of Duntsch's medical staff membership or clinical privileges during the time he has practiced at Baylor Reg. Medical Center at Plano."[108]

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anterior lumbar spinal fusion. *Id.* The surgery took place on January 11, 2012 and left Morguloff with debilitating pain and a future prognosis of being wheelchair-bound. *Id.* In February of 2012, Duntsch operated on his friend, Jerry Summers. *Id.* Summers went into the operation complaining of chronic neck pain and left the surgery a quadriplegic. *Id.* For information on additional patients, see, for example, Complaint at 9, Morguloff v. Baylor Health Care Sys., No. 3:14-CV-01065 (N.D. Tex. Mar. 25, 2014) (alleging that on December 6, 2011, Duntsch performed surgery on Mary Efurd which was unnecessary and inappropriate and set her up to require corrective surgery later).

[103] *See* Complaint, *supra* note 102, at 14 ("Mr. Summers . . . [told] the ICU nursing staff he witnessed Duntsch using drugs the night before his surgery. Baylor Medical suspended Duntsch's privileges . . . ."); Beil, *supra* note 97 (explaining that, although Summers later retracted this accusation, "Baylor officials took [the] accusation seriously and ordered Duntsch to take a drug test.").

[104] Beil, *supra* note 97.

[105] *Id.*

[106] *Id.*; *see also* Expert Report and Affidavit of John Dale Dunn, *supra* note 101, at 4 (noting that "Kellie Martin . . . died from blood loss described by the . . . Coroner as a treatment-related death").

[107] Beil, *supra* note 97.

[108] Complaint, *supra* note 102, at 16.

After leaving Baylor, DMC granted Duntsch medical privileges.[109] In the span of two days, Duntsch operated on two patients leaving one dead and the other severely injured.[110] By the end of the week, DMC hospital administrators and Duntsch worked out a similar agreement allowing Duntsch to resign.[111] DMC never reported Duntsch to the NPDB.[112]

Duntsch's next job was at Legacy Surgery Center, an outpatient clinic.[113] Here, he operated on Jacqueline Troy to address her neck pain, and during the surgery severed her vocal cords leaving her unable to speak.[114] It wasn't until January 15, 2013, that Duntsch was finally reported to the NPDB by Methodist Hospital after it denied Duntsch privileges based on his substandard care at Baylor.[115]

Despite being reported to the NPDB, a struggling hospital, University General Hospital Dallas, welcomed Duntsch in May of 2013.[116] Here he operated on Kenneth Fennell and Jeff Glidewell.[117] Fennell's surgery resulted in a femoral nerve injury, and Glidewell's surgery left him with severe nerve damage and difficulty eating.[118]

Seeing no other way to stop Duntsch from operating on patients, two surgeons, Dr. Randall Kirby and Dr. Robert Henderson, went to the district attorney general hoping to have Duntsch criminally

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[109] Beil, *supra* note 97; *see also* Expert Report and Affidavit of John Dale Dunn, *supra* note 101, at 4 (noting that DMC granted privileges to Duntsch).

[110] Expert Report and Affidavit of John Dale Dunn, *supra* note 101, at 4. Duntsch operated on one patient who "died within a week from a vertebral artery injury with a massive posterior circulation stroke." *Id.* Within days of the first surgery, Duntsch operated on a second patient "resulting in terrible injuries." *Id.*

[111] *See* Beil, *supra* note 97.

[112] *Id.*; *see also* Expert Report and Affidavit of John Dale Dunn, *supra* note 101, at 5 ("The consequences of DMC's failure to report this unusual and most terrible event to proper licensure and professional agencies were predictable and foreseeable—a high likelihood of injury to other patients receiving care by Dr. Duntsch at some other facility at some time after the DMC disasters.").

[113] Beil, *supra* note 97.

[114] *Id.*

[115] *Id.*

[116] *Id.*

[117] *Id.*; *see also* Expert Report and Affidavit of John Dale Dunn, *supra* note 101, at 5 (discussing the Fennell operation).

[118] Expert Report and Affidavit of John Dale Dunn, *supra* note 101, at 5; *see also* Beil, *supra* note 97 (describing the effects of Glidewell's surgery).

charged.[119] After conducting a thorough investigation, the State of Texas brought a criminal suit against Duntsch alleging he intentionally or knowingly caused serious bodily injury to an elderly individual while using or exhibiting a deadly weapon.[120] Duntsch is the "first surgeon known to be sentenced to [life in] prison for a botched surgery."[121] Baylor, DMC, and Legacy never filed a report to the NPDB.[122] The attorney who represented fourteen former patients of Duntsch stated, "[i]t seems to be the custom and practice. . . . Kick the can down the road and protect [the hospital] first, and protect the doctor second and make it be somebody else's problem."[123]

Although the hospitals were held civilly liable for failure to monitor and supervise Duntsch,[124] what is noticeably absent from the litigation were lawsuits or federal agency action directed at the hospitals for failure to report Duntsch to the NPDB.[125] There are three reasons no lawsuits were filed or penalties assessed: (1) there is no private right of action articulated in the HCQIA for a hospital's

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[119] Beil, *supra* note 97.

[120] Duntsch v. State, 568 S.W.3d 193, 198 (Tex. App. 2018) (stating that Dr. Duntsch "'intentionally, knowingly, recklessly and with criminal negligence cause[d] serious bodily injury to MARY EFURD, an elderly individual 65 years of age or older, . . . by MALPOSITIONING AN INTERBODY DEVICE AND MALPOSITIONING PEDICLE SCREWS AND AMPUTATING THE LEFT L5 NERVE ROOT,' and 'use[d] a deadly weapon, to-wit: HANDS AND SURGICAL TOOLS AND A PEDICLE SCREW, during the commission of the offense'" (alterations in original) (quoting the indictment in the case)).

[121] *See* Tanya Eiserer, *Doctor Convicted of Botched Surgery Gets Life Sentence*, WFAA (Feb. 21, 2017), https://www.wfaa.com/article/news/crime/doctor-convicted-of-botched-surgery-gets-life-sentence/287-410166098 [https://perma.cc/9WXA-WNM2]; State v. Duntsch, No. F1500411, 2017 WL 1292879 at *1 (Tex. Dist. Ct. Feb. 20, 2017) (showing that the jury imposed a life sentence).

[122] *See* Beil, *supra* note 97 (noting Duntsch was not reported by any of his previous employers).

[123] *Id.* (quoting Kay Van Wey).

[124] *See, e.g.*, Complaint, *supra* note 102, at 20 (alleging that the defendant hospitals failed "to properly monitor and/or supervise Duntsch after they granted him privileges to perform spinal surgeries," thus causing the plaintiffs to suffer from injuries).

[125] *See* Beil, *supra* note 97 (stating that, two years after Duntsch left Baylor, the Texas Health and Human Services Commission investigated Baylor's failure to report Duntsch, where Baylor was initially found in violation of the state's reporting requirements and fined $100,000, but a year later the citation and penalty were withdrawn).

failure to report;[126] (2) the hospitals in question, at least on paper, avoided the reporting requirements by limiting Duntsch's privileges to less than 30 days;[127] and (3) HHS has never penalized a hospital for failing to report.[128] The following section will lay out how and why hospitals are circumventing their reporting requirements to the NPDB.

B. SEVERAL STUDIES CONFIRM THAT HOSPITALS DO NOT REPORT PRACTITIONER INCOMPETENCE

As discussed earlier, the NPDB requires that hospitals report situations in which a physician's privileges are: (1) revoked during reprivileging; (2) restricted or revoked for more than 30 days because of a disciplinary investigation; or (3) where the physician resigns during a peer review investigation.[129] Despite this requirement, "several studies have shown . . . significant evidence of hospital underreporting to the NPDB every year."[130]

In 1995, the Office of the Inspector General (OIG) of the Department of Health and Human Services conducted an audit to

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[126] *See* 42 U.S.C. §§ 11101–11152 (providing only for sanctions to be imposed for a hospital's failure to report when adverse actions have been taken against a practitioner's privileges).

[127] *See* 45 C.F.R. 60.12(a)(1)(i) (2013) (requiring actions lasting longer than 30 days to be reported to the NPDB). Although it could be argued that Duntsch's resignation was done in exchange for not revoking his privileges and that Baylor did investigate Duntsch's competency to perform surgeries, both are reportable actions. *See* 45 C.F.R. § 60.12(a)(1)(ii)(A) (2013) (requiring reporting of acceptances of clinical privilege surrenders while a physician is under investigation for competency); *see also* William Quirey & Jeannie Adams, National Practitioner Data Bank Revisited – The Lessons of Michael Swango, M.D. 4 (n.d.) (unpublished manuscript) (on file with the State Bar of Virginia) (noting no direct penalties were assessed for failing to report to the NPDB).

[128] Searches of the Federal Register for health care entities reported under 42 U.S.C. 11111(b) conducted by myself and my colleagues, Anne Hudson and Jack Gorman, have proved to be fruitless in finding any institution actually sanctioned under this provision. *See also* Scheutzow, *supra* note 90, at 37 ("[N]o hospital has ever lost its HCQIA immunity because it failed to report information to the NPDB." (citing Conversation with Robert Oshel, Ph.D., Associate Director of Research and Design of the Division of Quality Assurance, Health Resource and Services Administration, U.S. Department of Health and Human Services (Aug. 7, 1998))); QUIREY & ADAMS, *supra* note 127, at 4 (noting that "as of 1998, no hospital had ever been so penalized").

[129] 42 U.S.C. § 11133(a)(1); *see also* Waters et al., *supra* note 26, at 36 (discussing the requirements).

[130] Vyas & Hozain, *supra* note 38, at 6361.

determine whether hospitals were satisfying their reporting obligations for the adverse actions they took against health care practitioners.[131] It found that from the database's inception, September 1, 1990 to December 31, 1993, "about 75 percent of all hospitals in the United States never reported an adverse action to the NPDB."[132] The audit found that many large hospitals were not reporting,[133] and hospitals in less populated and predominately rural states had the highest rate of nonreporting.[134] The OIG noted that there were 3,154 adverse clinical privilege reports submitted to the NPDB during this three-year period.[135] During this same period of time, however, state licensure boards reported nearly 9,000 adverse licensure actions, and malpractice insurers reported over 60,000 malpractice payments.[136] Based on these findings, the OIG concluded that there was "a sufficient basis for concern about the hospitals' response to the Data Bank reporting requirements."[137]

In a 1999 study conducted by Laura-Mae Baldwin and colleagues spanning the years 1991–1995, the researchers found that more than 65% of hospitals did not report a single adverse event to the NPDB.[138] A 2006 study conducted by researchers from Northwestern University and the University of Illinois at Chicago surveyed over 1,600 health care entities in an effort to evaluate the effectiveness of the NPDB.[139] The survey included 1,220 hospitals, 170 managed care organizations, 120 group practices, 32 professional societies, 97 other nonfederal entities, and 42 state licensing boards.[140] Of those required to report on adverse actions, the study found that only 25% of actions that were "potentially reportable" and only 40% of actions that were "unquestionably reportable" were actually reported to the NPDB.[141]

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[131] OFF. OF INSPECTOR GEN., *supra* note 26, at i.

[132] *Id.*

[133] *See id.* at ii (noting that 18 hospitals in Massachusetts with more than 300 beds did not report an adverse action).

[134] *Id.*

[135] *Id.* app. at B-1.

[136] *Id.*

[137] *Id.* at ii.

[138] Baldwin et al., *supra* note 26, at 351.

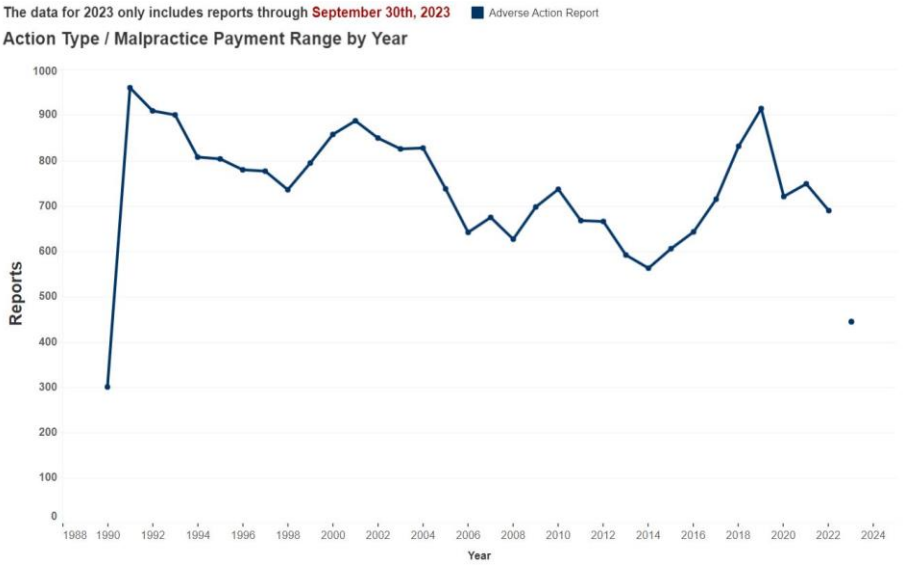
[139] Waters et al., *supra* note 26, at 31, 33.

[140] *Id.* at 35.

[141] *Id.* at 36.

Figure 1 illustrates the number of reports made to the NPDB by hospitals and health care entities required to report when adverse actions are taken against a practitioner's privileges. If we apply the results of the OIG audit from 1991–1993, and the two subsequent studies spanning 1991– 2006, to the data collected by the NPDB for these same years and then look at the data reported for the subsequent years, it is apparent that the underreporting of adverse actions is still at the same relative level.[142]

Figure 1.
National Practitioner Data Bank, Adverse Action Reports Submitted in Relation to Clinical Privileges and Panel Membership 1990 – September 30, 2023[143]



[142] During the 1991–1993 period covered by the OIG audit, there was an average of 923 reports per year. During the 1999–2006 period covered by the 2006 study, there was an average of 802 reports per year. From 2007–2022, there was an average of 693 reports per year.

[143] *Data Analysis Tool: Malpractice Payment Range by Year*, NAT'L PRAC. DATA BANK (2023), https://www.npdb.hrsa.gov/analysistool/ [https://perma.cc/U4KD-J3ST] (choose "Graph" under "Display Map or Graph;" choose "Action Type / Malpractice Payment Range" under "Rows"; choose "Year (Line)" under "Columns"; choose "Adverse Action Report" under "Report Type"; choose "Clinical Privileges/Panel Membership" under "Action Type / Malpractice Payment Range"; choose "Physician (MD)" and "Physician (DO)" under "Practitioner Type").

Notably, the 1999 study conducted by Baldwin and her colleagues found that hospitals and health care entities in states that imposed significant penalties for failing to report peer review actions to state licensing boards had higher incidents of reporting to the NPDB than states without such penalties.[144] The authors concluded that the discrepancy between states with strict laws requiring reporting and those with lax or no laws was an indicator that the penalty provision of the NPDB was insufficient to induce compliance with the reporting requirements.[145] What seems clear is that it is not whether the laws are strict or lax, but rather whether they are enforced or not.

One need only look at the language of the penalty provision to see that the provision was poorly conceived when drafted and has severely limited HHS's ability to sanction hospitals for failing to report. To encourage reporting by hospitals engaged in peer review, the HCQIA includes an immunity provision.[146] This provision provides that any person or professional review body which assists in the professional review of a physician's conduct "shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action."[147] However, the penalty for failing to report an adverse action to the NPDB is to lose the immunity privilege offered by the HCQIA.[148] The counterintuitive nature of this penalty is one of the primary causes for the NPDB's ineffectiveness.[149]

Logically, if the HCQIA needs to promise immunity from litigation to incentivize hospitals to engage in peer review, a penalty

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[144] Scheutzow, *supra* note 90, at 11.

[145] *Id.* at 12.

[146] *See* 42 U.S.C. § 11111(a) (providing that people associated with "a professional review action" meeting statutory standards "shall not be liable in damages under any law . . . with respect to the action" and that "no person . . . providing information to a professional review body regarding the competence or professional conduct of a physician shall be held . . . liable . . . unless such information is false").

[147] *Id.* The immunity offered by the HCQIA is broad and applies to damage actions under both state and federal law; however, it specifically exempts any state or federal damage actions arising from violations of civil rights and federal antitrust laws. *Id.* § 11111(a)(1)(D).

[148] *See id.* § 11111(b) (denying immunity protections to "health care entit[ies which] failed substantially to report information" to the NPDB).

[149] *See* QUIREY & ADAMS, *supra* note 127, at 5 (describing how the immunity provision "actually provided a paradoxical disincentive to effective peer review and discipline").

that takes away the immunity will result in no reporting at all. In fact, if the penalty were assessed, the hospital would likely lose its accreditation and thereby its ability to participate in the Medicare and Medicaid programs.[150] This would ultimately result in the hospital's closure. Since the closure of a hospital negatively impacts an entire community of patients, it is no wonder why Congress chose to afford the hospital every opportunity to report the incompetent practitioner once flagged as being noncompliant.[151]

Because hospitals are given such latitude to correct their noncompliance, the penalty provision of section 11111(b) of the HCQIA has never been enforced.[152] In fact, as Public Citizen's Health Research Group noted in its January 9, 1995 letter commenting on the OIG report, the group was "unaware of any instance since the [NPDB's] inception in which a hospital was penalized for failing to submit reports."[153] Three years later, Susan Scheutzow, an assistant professor of law who collaborated with Dr. Laura-Mae Baldwin on the 1999 study mentioned above, stated that she was also unable to find a single incidence where a hospital was penalized for failing to submit a report to the NPDB.[154] In conducting research for this Article, my colleagues and I were similarly unable to locate a single instance in which a health care entity was penalized for not reporting.[155]

Many theories have been proposed as to how and why hospitals fail or refuse to report adverse actions. These include: (1) they are deliberately taking actions that fall below the threshold that calls for reporting, which was the case with Baylor and Duntsch; (2) they are reluctant to assign blame; (3) they agreed not to report the practitioner; and (4) they are worried that this type of reporting will hurt the institution reputationally and financially.[156] One of the

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[150] S*ee supra* section II.A.*2*.

[151] *See* 42 U.S.C. § 11111(b) (requiring "notice of noncompliance, an opportunity to correct the noncompliance, and an opportunity for a hearing").

[152] *See supra* note 128.

[153] OFF. OF INSPECTOR GEN., *supra* note 26, app. at B-1.

[154] *See* Scheutzow, *supra* note 90, at 37 (asserting that as of 1998, "no hospital has ever lost its HCQIA immunity because it failed to report information to the NPDB").

[155] *See supra* note 128.

[156] *See* Waters et al., *supra* note 26, at 38 (explaining why institutions willingly fail to report adverse actions despite the threat of losing immunity); *see also* Chiarello, *supra* note 4, at 67–68 (offering reasons for failing to report); QUIREY & ADAMS, *supra* note 127, at 4

most obvious reasons, however, is that reporting would expose the hospital to potential liability—both from the physician now having a difficult time finding a job and from past patients of the physician who were injured as a result of his or her care. Not reporting, in the hospital's liability risk assessment, has no economic downside.

At this point, one might ask whether there is an urgent need to fix the reporting system if it has never functioned properly. There is. In the past, the reporting of medical malpractice payments was able to weed out a significant number of physicians, many of whom would have qualified as reportable under the adverse action reporting requirement.[157] Now, however, nearly 75% of physicians are employees of hospitals and health care entities, which both enables them to take advantage of the corporate shield loophole and increasingly makes the reporting of medical malpractice payments an ineffective mechanism.[158]

C. THE CORPORATE SHIELD LOOPHOLE ALLOWS PHYSICIANS TO ESCAPE BEING REPORTED TO THE NPDB

The corporate shield loophole is a well-known escape hatch for reporting physicians to the NPDB.[159] It takes advantage of the first limitation highlighted in Part II—physicians dismissed from a complaint prior to settlement are not required to be reported to the

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(same); OFF. OF INSPECTOR GEN., *supra* note 26, at iii (identifying four similar issues causing institutions to fail to report adverse actions).

[157] *See* Petition from Pub. Citizen to the Dep't of Health & Hum. Servs. 9 (May 29, 2014) [hereinafter Pub. Citizen Petition] ("When the regulations were promulgated in 1989, most physicians were self-employed in private practice and thus were named routinely in malpractice claims. In the case of malpractice claims paid against the U.S. government, the government reported payments to the NPDB and named practitioners when applicable."), https://www.citizen.org/wp-content/uploads/2203.pdf [https://perma.cc/35AR-4GT8].

[158] *See* PHYSICIANS ADVOC. INST., *supra* note 2 ("Nearly 3 of 4 physicians are now employed by hospitals, health systems and other corporate entities such as private equity firms and health insurers.").

[159] *See* Gabriel H. Teninbaum, *Reforming the National Practitioner Data Bank to Promote Fair Med-Mal Outcomes*, 5 WM. & MARY POL'Y REV. 83, 86 (2013) ("'[C]orporate shielding' . . . is estimated to be used in up to 50% of all malpractice settlements."); *see also* Lawrence E. Smarr, *A Comparative Assessment of the PIAA Data Sharing Project and the National Practitioner Data Bank: Policy, Purpose, and Application*, 60 L. & CONTEMP. PROBS. 59, 67 (1997) (discussing the corporate shield and how it leads to underreporting of negligent doctors).

NPDB—as well as the structural limitation of the NPDB only applying to individual practitioners and not health care entities.[160] These two limitations, along with the increased vertical integration of physicians into hospitals, are causing the corporate shield loophole to morph into a black hole of practitioner unaccountability.

As illustrated in Part I, the corporate shield loophole involves "a practice in which a plaintiff in a medical malpractice action agrees to dismiss a defendant health care practitioner from a proceeding" in return for obtaining a monetary settlement from the co-defendant hospital or corporate entity that employs the practitioner.[161] For the injured plaintiff, this loophole, and the coercion used to force the plaintiff to dismiss the culpable practitioner, is tantamount to a physician "hit and run" in the context of a medical malpractice claim.

1. The Loophole Was Less of a Threat to Quality Health Care when Practitioners Practiced Independently from Hospitals. The loophole has been well-known in the medical malpractice defense arena, as well as by the Health Resources and Services Administration (HRSA), dating back to 1998, when HRSA first issued a Notice of Proposed Rule Making (NPRM) in an attempt to close the loophole.[162] HRSA recognized that this practice was

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[160] *See* NPDB GUIDEBOOK, *supra* note 20, at E-19 ("[A medical malpractice payment report] is submitted on a particular health care practitioner, not an organization."). According to the NPDB rules, a payment made as a result of a suit or claim solely against an entity (for example, a hospital, clinic, or group practice) that does not identify an individual practitioner is not reportable to the NPDB. *Id.* The rules specifically state that "[a] practitioner named, identified, or described in the written complaint or claim who is subsequently dismissed from the lawsuit and not named, identified, or described in the settlement release should not be reported to the NPDB unless the dismissal results from a condition in the settlement or release." *Id.* at E-20.

[161] Pub. Citizen Petition, *supra* note 157, at 1. Plaintiffs such as the family illustrated in Part I often feel coerced into dismissing the practitioner to receive a settlement.

[162] The notice stated that:

> It has come to the Department's attention that there have been instances in which a plaintiff in a medical malpractice action has agreed to dismiss a defendant health care practitioner from a proceeding, leaving or substituting a hospital or other corporate entity as defendant, at least in part for the purpose of allowing the practitioner to avoid having a report on a malpractice payment made on his or her behalf submitted to the Data Bank.

National Practitioner Data Bank: Medical Malpractice Payments Reporting Requirements, 63 Fed. Reg. 71255, 71255 (Dec. 24, 1998).

especially predominant in cases in which a self-insured hospital or corporate entity employed the defendant physician.[163] The proposed rule advised that the regulation be amended "to include reports on payments made on behalf of those practitioners who provided the medical care that is the subject of the claim or action, whether or not they were named as defendants in the claim or action."[164]

Despite acknowledging that the corporate shield loophole was "clearly inconsistent" with the congressional purpose of the NPDB, HSRA withdrew the NPRM and no changes were made to the reporting requirement.[165] In the NPRM, HRSA acknowledged that physicians could evade reporting even when their "negligent or substandard care . . . resulted in compensable injury to patients," because "the payment [was] arguably not in satisfaction of a claim or judgment."[166] However, HRSA failed to fulfill their 2001 promise to amend the rule, then withdrew it in 2009, corresponding with a likely increase in use of the corporate shield loophole.[167]

While the withdrawal of the proposed rule was undeniably a setback to the effectiveness of the NPDB's ability to weed out bad physicians, the majority of physicians in 1998 were not employed by hospitals and therefore use of the loophole was limited in its scope.[168] Unfortunately, the rise of vertical integration of physicians and physician practices within hospitals and health care systems has made HRSA's continued reckless indifference to this loophole no longer tolerable.[169]

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[163] *Id.* at 71256.

[164] *Id.* at 71255.

[165] *See* Pub. Citizen Petition, *supra* note 157, at 9 (recounting HRSA's subsequent actions with the NPRM).

[166] National Practitioner Data Bank: Medical Malpractice Payments Reporting Requirements, 63 Fed. Reg. at 71256.

[167] *See supra* Figure 1; *see also* Pub. Citizen Petition, *supra* note 157, at 2 (recounting the NPRM history).

[168] *See* Pub. Citizen Petition, *supra* note 157, at 9 (noting the change in physician employment structure).

[169] Outside groups have noted HRSA's indifference to the corporate shield loophole and are demanding action. For instance, in 2014, Public Citizen petitioned HRSA to issue a new NPRM to close the loophole. Public Citizen, *supra* note 31, at 11 After HRSA did not respond to their petition, Public Citizen filed suit in July 2016 to "compel agency action" on the petition. Complaint at 1–2, Pub. Citizen v. Dept. of Health and Hum. Servs., (D.D.C 2016) (No. 1:16-cv-01520). HRSA responded in September 2016 to "den[y] Public Citizen's petition for HRSA to engage in rulemaking to address the 'corporate shield.'" Letter from James

2. Vertical Integration of Physicians Is Transforming the Corporate Shield Loophole into a Black Hole of Unaccountability. As mentioned earlier, the employment status of physicians is a key factor to the utilization of the corporate shield loophole.[170] As more and more physicians become vertically integrated into hospitals, health systems, and other corporate health care entities, the corporate shield loophole is transforming into a potential black hole for the underreporting of payments made on behalf of a physician in satisfaction of a medical malpractice claim.

Vertical integration occurs when multiple stages of production or distribution, which were initially separate, are brought under common ownership.[171] Within the health care setting, vertical integration involves the purchase of physician practices or the direct employment of physicians by hospitals, health systems, or other forms of corporate entities.[172] According to an American Medical Association study, the year 2020 marked the first time more than half of all physicians were employed directly by hospitals or groups owned by a hospital.[173] A study conducted from 2019–2021 and

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Macrae, Acting Administrator of HRSA to Michael Carome, M.D., Director of Public Citizen's Health Rsch. Grp. 1 (Sept. 21, 2016), https://www.citizen.org/wp-content/uploads/2203_HRSA-Final-Response-Denying-Petition_Sept-212016.pdf [https://perma.cc/JB3D-GLU2]. HRSA noted that it was siding with "the large majority of commenters" who had "voic[ed] opposition" to the original NPRM. *Id.* HRSA reported that it was following the commenters' reasoning that "(i) the method chosen in the NPRM was overbroad; (ii) the current regulations are adequate to address the problem; (iii) HHS may not have the legal authority to address this issue through regulation; (iv) the NPRM's assertion that the current regulations are inconsistent with the intent and purposes of the statute may not be accurate; and (v) addressing the corporate shield needs to be done in a manner that is both fair to practitioners and not burdensome for medical malpractice payers." *Id.*

[170] *See* National Practitioner Data Bank: Medical Malpractice Payments Reporting Requirements, 63 Fed. Reg. 71255, 71256 (Dec. 24, 1998) (recognizing that the use of the corporate shield loophole was especially predominant in cases in which a self-insured hospital or corporate entity employed the defendant physician).

[171] Soroush Saghafian, Linda D. Song, Joseph P. Newhouse, Mary Beth Landrum & John Hsu, *The Impact of Vertical Integration on Physician Behavior and Healthcare Delivery: Evidence from Gastroenterology Practices* 6, (Harv. Kennedy Sch. Fac. Rsch. Working Paper Series, RWP20–031, Nov. 2022), https://dash.harvard.edu/handle/1/37373579.

[172] *Id.* at 1.

[173] *See* CAROL KANE, RECENT CHANGES IN PHYSICIAN PRACTICE ARRANGEMENTS: PRIVATE PRACTICE DROPPED TO LESS THAN 50 PERCENT OF PHYSICIANS IN 2020, AM. MED. ASS'N 1, 4 (2021) ("In 2020, 50.2 percent of physicians were employees compared to 47.4 percent in 2018

updated in 2022 by the Physicians Advocacy Institute in conjunction with Avalere Health concluded that nearly three of four physicians are now employed by hospitals, health systems and other corporate entities.[174] Overall, the number of physicians directly employed by hospitals has nearly doubled since 2012.[175] Experts predict this trend in vertical integration will only continue in the coming years.[176]

Several factors have contributed to the rise in vertical integration of physician practices, including the passage of major health care legislation impacting office administrative practices and reimbursement, the cost of medical malpractice insurance, and work-life balance concerns.[177] Among these factors, perhaps the most significant were the passage of the 2009 Health Information Technology for Economic and Clinical Health Act (HITECH) and the 2010 Affordable Care Act (ACA).[178]

HITECH incentivized physician practices to adopt electronic health records (EHRs) by offering incentive payments for costs associated with the migration to EHRs.[179] However, HITECH also

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and 41.8 percent in 2012."); *see also* CLARK, *supra* note 23, at 235 ("As of January 1, 2021, hospitals directly employed more than 301,000 physicians, including an increase of 18,600 physicians after the start of the COVID-19 pandemic.").

[174] *See* PHYSICIANS ADVOC. INST., *supra* note 2 ("Nearly 3 of 4 physicians are now employed by hospitals, health systems and other corporate entities such as private equity firms and health insurers.").

[175] CLARK ET AL., *supra* note 4, at 235 (citing AHA Hospital Statistics, 2012 edition).

[176] Saghafian et al., *supra* note 171, at 1 ("The number of physicians who have "vertically integrated" (i.e., consolidated) with hospitals has doubled in the past decade, and the trend is expected to continue.").

[177] SHOWALTER, *supra* note 32, at 247 (noting that lifestyle preferences, various economic forces, the effects of the Affordable Care Act (ACA) reforms, and fraud laws that provide "safe harbors" for many transactions with employees causes more and more physicians to become hospital employees).

[178] Health Information Technology for Economic and Clinical Health Act, Pub. L. No. 111-5, 123 Stat. 226 (2009); Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010); *see also* CLARK ET AL., *supra* note 4, at 229–30 (noting that "hospitals have been acquiring physician practices in response to the incentives of the ACA" and that "[t]he high cost of [HITECH's] mandate for electronic health records and other regulatory mandates has created an additional reason for freestanding hospitals to join systems").

[179] Steve Alder, *What Is the HITECH Act?*, HIPAA JOURNAL, https://www.hipaajournal.com/what-is-the-hitech-act/ [https://perma.cc/3728-2232] ("The HITECH Act introduced incentives to encourage hospitals and other healthcare providers to

included a penalty for not adopting EHRs.[180] Starting in 2015, if Medicare-eligible professionals did not comply with the HITECH EHR requirements, they saw their reimbursement of Medicare claims penalized by 1%, and by 2017, the penalty increased to 3%.[181] While large physician practices could absorb the cost of transferring to EHRs, many smaller and solo practices saw this requirement as a major expense.[182]

In addition, one of the main goals of the ACA was to improve the coordination of care among providers and health care facilities.[183] To achieve this goal, the ACA encouraged vertical integration of physicians by increasing reimbursement rates for hospital-based services.[184] This translated into the financial reality that a procedure occurring in a hospital outpatient department was reimbursed at a significantly higher rate than the same procedure performed in a physician's office or ambulatory surgery center.[185] Physicians faced with decreased Medicare reimbursements from both the ACA and HITECH, along with the yearly bombardment of new Medicare rules and reimbursement schemes, constant negotiations with private insurers, and numerous state and federal

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make the change [from paper records to EHRs]. Had the Act not been passed, many healthcare providers would still be using paper records.").

[180] *See id.* (detailing the "increased penalties for violations of the HIPAA Privacy and Security Rules").

[181] *Id.*; *see also* CLARK ET AL., *supra* note 4, at 229 ("Hospitals have been acquiring physician practices in response to the incentives of the ACA and the pressures for a better coordinated health care system . . . . the ACA authorizes and—through the Medicare Shared Savings Program (MSSP)—incentivizes institutional and professional providers to coordinate with each other through 'Accountable Care Organizations' (ACOs).").

[182] *See, e.g.*, CLARK ET AL., *supra* note 4, at 230 (discussing the effects of the "high cost" of HITECH compliance).

[183] Assistant Secretary for Public Affairs (ASPA), *About the Affordable Care Act,* HHS.GOV, https://www.hhs.gov/healthcare/about-the-aca/index.html [https://perma.cc/WG7V-Z3WY] (listing the 3 primary goals of the Affordable Care Act).

[184] Robert Berenson, *A Physician's Perspective on Vertical Integration*, 36 HEALTH AFFS. 1585 (2017) (finding vertical integration created the ability to "acquire managed care contracts and sometimes accept and manage financial risk")

[185] Saghafian et al., *supra* note 171, at 3 ("Medicare reimburses $917 on average for colonoscopies that occur in [hospital outpatient departments] in 2019, but only $413 for those in physician offices.").

law changes, saw vertical integration as a way to escape the administrative burden of running a private practice.[186]

To further entice the vertical integration of physician practices and take advantage of the higher Medicare reimbursement rates, hospitals and health care systems promised physicians a better work-life balance.[187] For the solo practitioner who was on call 24/7 and often working from 7:00 a.m. to 9:00 p.m. five to six days a week, the offer of a better work-life balance was appealing.[188] By integrating within the health system, the physician could become a nine-to-five employee with rotating call.[189]

But a final selling feature for physicians was the reprieve from paying the high cost for medical malpractice insurance. Once the physician became an employee of the hospital, the hospital became responsible for providing malpractice insurance for the physician. This was often done through self-insurance by the hospital.[190] Ultimately, the integration of physician practices into the hospital system, and the employment of physicians within the hospital setting, disrupted the natural order of medical malpractice litigation and with it, the reporting of medical malpractice payments to the NPDB.

3. The Impact of Vertical Integration on Medical Malpractice Litigation. Medical malpractice litigation has experienced significant changes since the rise of vertical integration of physician practices. In the good old days of medical malpractice litigation, when multiple defendants were named in a medical malpractice lawsuit, they were all represented by their own malpractice carrier

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[186] *See generally* Berenson, *supra* note 184, at 1586, 1587, 1588–89 (summarizing how and why "physicians are seeking hospital employment for the sake of less demanding professional responsibilities").

[187] *Id.* at 1588 ("The trend toward hospital affiliation meets the needs of younger physicians, who seem interested in financial security, work-life balance, and shelter from an increasingly complex and unstable health care marketplace . . . .")

[188] *See id.* (explaining how the new system "can offer the predictable working hours, freedom from administrative demands, management expertise, and capital that small practices lack, while also providing higher incomes")

[189] *Id.*

[190] Justin Nabity, *Full Guide to Physicians Malpractice Insurance,* PHYSICIANS THRIVE https://physiciansthrive.com/financial-planning/malpractice-insurance/ [https://perma.cc/AWT2-FE8C] ("[I]f you work as an employee of a hospital or healthcare network, your employer may cover the cost for you.").

and defense team.[191] Physicians were often considered independent contractors responsible for their own negligence, while hospitals were thought to be merely the facility where physicians engaged in the practice of medicine.[192] If a hospital were to be named as a defendant, its liability was typically limited to corporate negligence and the duty to vet providers prior to awarding privileges.[193]

A shift in medical malpractice liability began when plaintiffs' attorneys asserted the novel concept of apparent authority to hold the hospital liable for the negligent acts of the physicians it allowed to work within its facility.[194] Under apparent agency, even though the physician is technically an independent contractor and not under the direction and control of the hospital, a plaintiff who reasonably believed the physician was an employee of the hospital could claim that the hospital was responsible for the negligence committed by the physician.[195] At this point, it was in the hospital's best interest to employ certain physicians so it could exert direction and control over how the physician practiced. [196] And so began the shift to hospital employment of physicians and the birth of vertical integration.

One of the perks to becoming an employee of the hospital for the physician was that the hospital would cover the physician's medical malpractice insurance.[197] This could require the hospital to

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[191] *See* SHOWALTER, *supra* note 32, at 247 ("Hospitals were, in effect, viewed merely as 'doctors' workshops' and thus were not liable for the physicians' medical negligence.").

[192] *See id.* at 246–49 ("[T]he hospital could use the physician's independent status to avoid liability for the doctor's alleged malpractice."); *see also* Heins v. Synkonis, 227 N.W.2d 247, 249 (Mich. Ct. App. 1975) (noting that the hospital was not held liable for the negligence of a private physician because the hospital merely provided office space for the doctor's outpatient clinic).

[193] *See* SHOWALTER, *supra* note 32, at 250–52 ("Before the mid-1960s, courts generally limited hospitals' corporate duties to such issues as selection and retention of employees and maintenance of hospital equipment, buildings, and grounds . . . .").

[194] *See id.* at 246 ("The concept [] of apparent agency . . . can also counter the independent contractor defense.").

[195] *See id.* ("[L]iability may attach, though no actual authority was given and the physician was technically an independent contractor.").

[196] *See id.* at 249 ("[T]he courts seem generally inclined to find a hospital liable irrespective of a purported independent contractor status . . . . We thus see the gradual demise of the hospital's independent contractor defense.").

[197] *See Hospital Professional Liability Insurance*, IRMI, https://www.irmi.com/term/insurance-definitions/hospital-professional-liability-insurance

purchase a private policy from a third party, or as is the recent trend, self-insure their medical malpractice liability exposure.[198] Under either method, the interests of the physician and hospital became aligned as the potential payout to the plaintiff-patient came from the same pot of money—the hospital.[199] In addition to the payout coming from a common source, the alignment of the physician and hospital allowed for a single defense team to represent both defendants.[200] Because the plaintiff attorney's main target was the hospital with the big pot of money, the defendant physician became unnecessary to the settlement endgame.[201] As a result, neither the defense attorney nor the plaintiff's attorney had a strong desire to keep the physician in the case if the physician was refusing to settle.[202] In cases where there was strong evidence of malpractice, hospitals were willing to settle to reduce defense costs and limit the publicity associated with the continued litigation.[203]

[https://perma.cc/SYB7-Z6HR] ("Hospital professional liability insurance is purchased by hospitals to cover their liability for professional acts, errors, or omissions. HPL forms are usually written on a combined basis with commercial general liability (CGL) policies to avoid 'gray area' situations in which coverage could apply under either policy. HPL forms cover hospital employees but not independent contractor staff physicians who have been granted admitting privileges.")

[198] Bill Fleming, *Malpractice Insurers Adapt with Consolidation*, PHYSICIANS PRAC. (Feb. 13, 2020), https://www.physicianspractice.com/view/malpractice-insurers-adapt-consolidation [https://perma.cc/L4QF-LGRL] ("Consolidation in healthcare continues to fuel the trend toward self-insuring against medical liability, a strategy that has long been popular among some large institutions as a way to maintain more control over the costs of malpractice claims.").

[199] See SHOWALTER, *supra* note 32, at 245–46 (discussing hospital vicarious liability and plaintiff damages recovery strategy).

[200] *See, e.g.*, Heins v. Synkonis, 227 N.W.2d 247, 249 (Mich. Ct. App. 1975) ("Robert E. Dice, Dice, Sweeney & Sullivan, P. C., Detroit, for defendants-appellants [hospital and physician].").

[201] *See* SHOWALTER, *supra* note 32, at 246 ("The employee who committed the tort can also be held liable for the wrongful act or omission, so the employer and the employee are often sued together; however, the employer is usually the main target because of its 'deep pockets.'").

[202] *See id.* ("The employer usually has insurance coverage or superior financial means to compensate for the damage caused by the employee's tort.").

[203] *See generally* Ralph Peeples, Catherine T. Harris & Thomas B. Metzloff, *The Process of Managing Medical Malpractice Cases: The Role of Standard of Care*, 37 WAKE FOREST L. REV. 877, 886–88 (2002) ("The insurer consistently made an offer when it concluded that the standard of care was breached, and only once made an offer when it had concluded that the standard of care had not been breached.").

Because the hospital was responsible for paying for its liability as well as the liability of the physician, when confronted with a physician who was refusing to settle, the best strategy was to pressure the plaintiff into dismissing the physician, threatening that settlement could not be reached if the physician remained a party to the lawsuit.[204] Hence, the corporate shield loophole was born.[205]

4. Key Indicators that the Corporate Shield Loophole Is Becoming a Black Hole. Perhaps the most blatant indicator that vertical integration of physicians is expanding the use of the corporate shield loophole is the advertisements from medical malpractice defense firms and attorneys who represent hospital systems. A prominent corporate attorney recently wrote an article for Age Management Medicine Group in which he characterized the NPDB as a "dark shadow" for physicians and the corporate shield as the "light that pierces through [it]."[206] In his article, he describes how the corporate shield loophole works, how professionals who are dismissed from the lawsuit "without separate payment" can avoid being reported, and how a carefully drafted non-claim/non-complaint allows for settlement without reporting.[207] In his final pitch, he states, "it often takes a lawyer's careful look at the law to figure out how to navigate it to keep the medical professional unscathed . . . . But these paths are not uncharted. They are *well traveled* for those who know the path."[208]

In fact, these paths have been well-charted for some time. A 2014 petition filed by Public Citizen, a nonprofit consumer advocacy organization, made note of several instances in which the corporate

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[204] *See* Pub. Citizen Petition, *supra* note 157 ("The use of the corporate shield loophole involves a practice in which a plaintiff in a malpractice action agrees to dismiss a defendant health care practitioner from a proceeding, thereby leaving or substituting a hospital or other corporate entity as the defendant.").

[205] *See id.* (describing the relationship between the loophole and the NPDB).

[206] Zachariah B. Parry, *The Corporate Shield: A Light that Pierces Through the National Practitioner Data Bank's Dark Shadow,* AGE MGMT. MED. GRP. (Mar. 25, 2022), https://agemed.org/e-journal/feature-article-march-april-2022-the-corporate-shield-a-light-that-pierces-through-the-national-practitioner-data-banks-dark-shadow [https://perma.cc/V6B2-C2NG].

[207] *Id.*

[208] *Id.* (emphasis added).

shield loophole was being utilized.[209] The petition noted that "doctors often insist on being dismissed as defendants in lawsuits to avoid reporting to the NPDB."[210] The petition went on to cite two examples reported by media outlets, the first occurring in 2004 when a thirty-three-year-old woman was misdiagnosed in a Chicago hospital and "suffered a massive stroke, leaving her paraplegic with half her brain removed."[211] The second was from 2012 when a sixty-two-year-old man was admitted to a Pittsburgh hospital with a treatable brain hemorrhage and subsequently died.[212] In both examples, the plaintiffs were coerced into dismissing the defendant doctors in order to reach settlement with the hospitals, and in both cases, the settlements were never reported to the NPDB.[213]

One need only look to the NPDB's own data on reports made for medical malpractice payments to see that years of HRSA inaction in closing the loophole combined with the exponential growth of vertical integration of physicians into hospitals and health systems has caused the loophole to morph into a black hole of unaccountability.[214] Over the course of two decades, the number of malpractice claim reports has gone from over 14,000 reports in 2001 to less than 4,000 in 2021.[215] This rampant use of the corporate shield loophole has taken the once semi-effective NPDB and caused it to flatline into a data bank with limited functional purpose in ensuring quality health care.[216]

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[209] Pub. Citizen Petition, *supra* note 157, at 10.

[210] *See id.* (citing Sandra G. Boodman, *Study Raises Doubts About Doctors' Database Hospitals Take Fewer Actions Against Physicians, Sparing Them from Scrutiny*, WASH. POST, (Aug. 3, 1999), https://www.washingtonpost.com/archive/lifestyle/wellness/1999/08/03/study-raises-doubts-about-doctors-database/8a1e5c4c-b79d-47fc-82c9-a49a00c29b57/ (noting that one plaintiff's attorney in Washington D.C. said the loophole was a "common subterfuge").

[211] *Id.* (quoting Editorial, *A Malpractice Loophole*, BANGOR DAILY NEWS, Sept. 3, 2004).

[212] *Id.* (citing Sean D. Hamill, *Removing Doctors in Settlements Can Deflect Oversight*, PITT. POST-GAZETTE, May 20, 2012, at A-1).

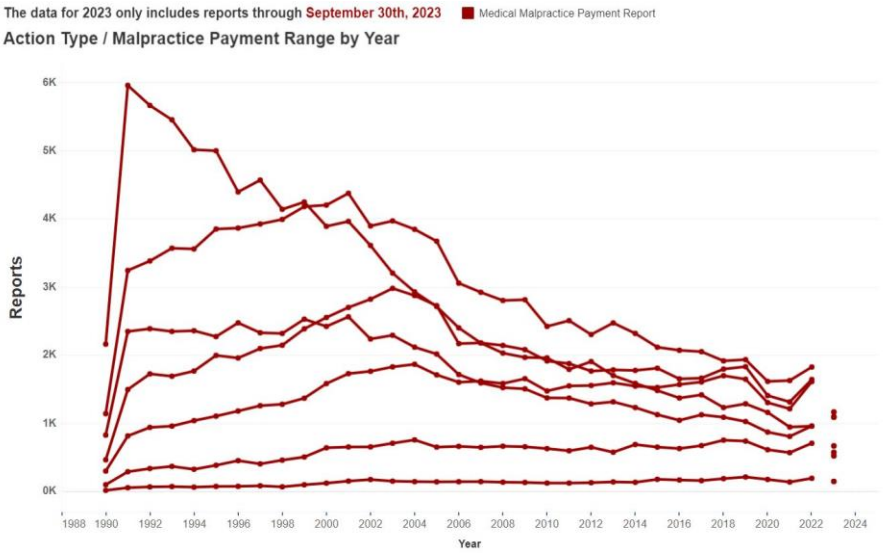
[213] *Id.*

[214] *See infra* Figure 2; *see also* David M. Studdert & Mark A. Hall, *Medical Malpractice Law – Doctrine and Dynamics*, 387 NEW ENG. J. MEDICINE 1533, 1536 (2022) (noting that the plummet in malpractice claims could be due to the practice of "corporate shielding," where "reporting requirements" evaporate due to institutions "assum[ing] liability" and paying for claims instead of the physicians themselves).

[215] Studdert & Hall, *supra* note 214, at 1536 fig.A.

[216] *See id.* at 1537 (noting that the NPDB databank has been "largely disconnected from wider efforts to improve the quality and safety of patient care").

Figure 2.
National Practitioner Data Bank, Medical Malpractice Payments by Payment Range 1990 – September 30, 2023[217]



IV. REPURPOSING THE NPDB TO IMPROVE THE CREDENTIALING PROCESS AND PAVE THE WAY FOR THIRD PARTY TORT CLAIMS

As discussed in Part III, the underreporting of adverse actions by hospitals, lack of enforcement by the NPDB, and the increased employment of physicians by hospitals has greatly impacted the NPDB's effectiveness to weed out incompetent medical practitioners. Despite this grim picture of the NPDB, all is not lost. Because "[t]he initial recruitment, credentialing[,] and privileging of physicians by hospitals . . . plays a critical role in ensuring quality,"[218] changing the purpose of the NPDB from a blacklist of incompetent practitioners to a database capturing the contact information and employment history/hospital affiliation for *all*

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[217] *Data Analysis Tool*, *supra* note 143 (choose "Graph" under "Display Map or Graph"; choose "Action Type / Malpractice Payment Range" under "Rows"; choose "Year (Line)" under "Columns (Graph)"; choose "Medical Malpractice Payment Report" under "Report Type"; choose "Physician (MD)" and "Physician (DO)" under "Practitioner Type").

[218] Burney, *supra* note 14, at 11.

medical practitioners will help to streamline the credentialing process. This proposal should be coupled with the requirement that hospitals use a mandatory credentialing questionnaire to evaluate applicants for employment or privileges.

This Part outlines how these changes can be used to establish state-based tort claims to hold both the hospital issuing the credentialing questionnaire and the hospital responding accountable for ensuring accurate disclosures of practitioners' competence. It then provides the benefits these changes can have on the credentialing process, and in realigning the hospital's liability risk assessment to place patient welfare ahead of corporate considerations. Finally, this Part concludes with the potential limitations to this reform effort but argues that given the current state of health care oversight in the United States, this reform strategy is best situated to protect the greatest number of patient lives.

A. NEGLIGENT MISREPRESENTATION CLAIMS INCENTIVIZE EMPLOYERS TO ACCURATELY REPORT ON AN EMPLOYEE'S WORK PERFORMANCE

Negligent misrepresentation claims against previous employers for providing inaccurate or false information in reference letters are an effective tool that third parties have used to seek damages for harms caused by the employee in their current role.[219] The elements

[219] *See, e.g.*, Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs., 527 F.3d 412, 418–19 (5th Cir. 2008) (holding that the defendant hospital and anesthesia provider had a duty not to make affirmative misrepresentations in their reference letters for an anesthesiologist who was known to have previously used drugs at work); Davis v. Bd. of Cnty. Comm'rs, 987 P.2d 1172, 1179–80 (N.M. Ct. App. 1999) (holding that the county had a duty not to make affirmative misrepresentations to a psychiatric hospital that hired the county's former detention sergeant). Most states have adopted this theory of negligent misrepresentation involving risk of physical injury, but Nevada, Vermont, Washington, Indiana, Kentucky, Massachusetts, Minnesota, Missouri, and Wyoming have not. For cases documenting these states' rejection of the tort, see Baymiller v. Ranbaxy Pharms., Inc., 894 F. Supp. 2d 1302, 1309 (D. Nev. 2012); Kellogg v. Wyeth, 762 F. Supp. 2d 694, 706 n.7 (D. Vt. 2010); Isakson v. WSI Corp., 771 F. Supp. 2d 1257, 1264 (W.D. Wash. 2011); Passmore v. Multi-Mgmt. Servs., Inc., 810 N.E.2d 1022, 1026–27, 1028 (Ind. 2004); Johnson v. United Parcel Serv., Inc., 326 S.W.3d 812, 817 (Ky. Ct. App. 2010); Gianocostas v. Interface Grp.-Mass., Inc., 881 N.E.2d 134, 143–44 (Mass. 2008); Smith v. Brutger Companies, 569 N.W.2d 408, 413–14 (Minn. 1997); Doe *ex rel.* Doe v. Ozark Christian Coll., 579 S.W.3d 220, 221–22, 224–25 (Mo. Ct. App.

of negligent misrepresentation claims are set out in section 311 of the Restatement (Second) of Torts. Section 311 states:

> (1) One who negligently gives false information to another is subject to liability for physical harm caused by action taken by the other in reasonable reliance upon such information, where such harm results
> (a) to the other, or
> (b) to such third persons as the actor should expect to be put in peril by the action taken.
> (2) Such negligence may consist of failure to exercise reasonable care
> (a) in ascertaining the accuracy of the information, or
> (b) in the manner in which it is communicated.[220]

These claims have been asserted in a multitude of contexts, including against school districts, pharmaceutical companies, foster child placement agencies, church groups, the Boy Scouts, county correctional facilities, nursing centers, and medical practices.[221] The

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2019); Dullmaier v. Xanterra Parks & Resorts, 883 F.3d 1278, 1284–85 (10th Cir. 2018) (citing Corsi v. Jensen Farm, No. 2:12-CV-052, 2013 WL 11330880, at *3 n.5 (D. Wyo. Oct. 11, 2013).

[220] RESTATEMENT (SECOND) OF TORTS § 311 (AM. LAW. INST. 1965); *see also id.* cmt. c ("The rule stated in this Section may also apply where the information given is purely gratuitous, and entirely unrelated to any interest of the actor, or any activity from which he derives any benefit. . . . Where, as under the rule stated in this Section, the harm which results in bodily harm to the person, or physical harm to the property of the one affected, there may be liability for the negligence even though the information is given gratuitously and the actor derives no benefit from giving it.").

[221] *See Kadlec Med. Cntr.*, 527 F.3d at 418–19 (holding former medical practice liable for negligent misrepresentation where former employer had a duty not to make affirmative misrepresentations to clinic in their referral letters concerning anesthesiologist and the statements made in the referral letters were materially misleading); *Davis*, 987 P.2d at 1179–80 (holding that once county supervisory employees undertook to make an employment recommendation, they owed prospective employers and foreseeable third parties a duty of reasonable care not to misrepresent material facts about former employee's history of sexual assault at previous employment); Golden Spread Council, Inc. v. Akins, 926 S.W.2d 287, 291–92 (Tex. 1996) (recognizing a cause of action for negligent misrepresentation causing physical harm to a third party when the local Boy Scout Council recommended a scout master the Council knew or should have known was a sexual predator); M.B. v. Schuylkill County, 375 F. Supp. 3d 574, 586, 601–03 (E.D. Pa. 2019) (recognizing a cause of action for negligent misrepresentation brought by a foster child who was allegedly sexually abused by her foster brother where the foster-placement organization negligently misrepresented to the foster

basis of these claims is that, but for the previous employer's positive recommendation of the employee, the current employer would never have hired the individual and that the employment resulted in the plaintiff coming into contact with the employee and being physically harmed.[222] In order to succeed on a negligent misrepresentation claim in the employment context, the plaintiff must prove: (1) that the previous employer negligently gave false or misleading information to the current employer; (2) that the current employer reasonably relied on the information; (3) that it was foreseeable that the employee could harm someone in their future employment; and (4) that the negligence resulted in the previous employer's failure to exercise reasonable care in ascertaining the accuracy of the information or in ensuring it was effectively communicated.[223]

An excellent example of a successful negligent misrepresentation claim in the employment context is *Davis v. Board of County Commissioners of Dona Ana County*.[224] At issue in *Davis* was "whether an employer owes prospective employers and foreseeable third persons a duty of reasonable care not to misrepresent material facts in the course of making an employment recommendation about

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parents that foster brother had no history of sexual abuse); Randi W. v. Muroc Joint Unified Sch. Dist., 929 P.2d 582, 584, 587–88, 591, 593 (Cal. 1997) (recognizing a middle school student's negligent misrepresentation claim against the former employer of a vice principal who sexually molested and assaulted the plaintiff, where the former employer issued a letter of recommendation that was incomplete and consisted of misleading half-truths and misrepresentations that created a foreseeable risk of physical injury to a third party, and the current employer reasonably relied on the truth of the information contained in the letter); Doe v. Cochran, 210 A.3d 469, 472–73, 481, 487 (Conn. 2019) (recognizing that physician owed a duty under Restatement (Second) of Torts § 311 to girlfriend of patient for the defendant's negligent misrepresentation that the boyfriend tested negative for herpes where girlfriend was a third person the defendant should have expected to be put in peril); Jane Doe-3 *ex rel.* Julie Doe-3 v. White, 951 N.E.2d 216, 219, 227–28 (Ill. Ct. App. 2011) (holding that plaintiffs, students who were sexually abused by their teacher, sufficiently alleged that prior school district which employed the teacher assumed a duty to plaintiffs by voluntarily undertaking the act of writing a letter of reference for teacher and sending it to plaintiffs' school district, despite having knowledge of the teacher's prior sexual abuse of students). *But c.f.* note 219 (noting jurisdictions that have not adopted a negligent misrepresentation tort).

[222] *See generally, e.g.*, *Davis*, 987 P.2d 1172 (establishing grounds for liability); Randi W. v. Muroc Joint Unified Sch. Dist., 929 P.2d 582 (Cal. 1997) (same).

[223] *See Davis*, 987 P.2d at 1179 (discussing the elements of negligent misrepresentation as applied to a psychiatric hospital patient's claim against a county); *Randi W.* 929 P.2d at 587 (same, as applied to a student's claim against a school district).

[224] *Davis*, 987 P.2d 1172.

a present or former employee, when a substantial risk of physical harm to third persons by the employee is foreseeable."[225] The plaintiff, a former patient in a psychiatric hospital, brought a negligent misrepresentation claim against the county, alleging that her injuries from sexual and physical abuse by a former detention officer hired by the hospital resulted from the hospital's reliance on county law enforcement officers' unqualifiedly favorable employment reference.[226] In ruling in favor of the plaintiff, the court held that: (1) when the county's law enforcement officers undertook to give the employment reference, the county owed a duty not to make negligent misrepresentations to the psychiatric hospital that hired the former employee as a mental health technician; and (2) such a duty extended to the patient where a substantial risk of physical harm to third parties was foreseeable.[227]

The court noted that "of particular importance to the accuracy of the recommendations [was] a report authored by [the employee's former supervisor] after [the employee] was investigated for allegedly sexually harassing female inmates under his authority at the Detention Center."[228] As a result of the investigation, the employee was given a written reprimand that any further complaints of this nature would result in his termination.[229] When a second report was filed by another female inmate, the employee was placed on administrative leave.[230] The County Sheriff's Department investigated the reports and concluded that while not all the allegations could be confirmed, the employee's "conduct and performance of duty had been 'questionable' and 'suspect'" and that disciplinary action would be recommended including suspension without pay, demotion, and reassignment.[231] Before the official disciplinary hearing was held, the employee resigned and asked for a recommendation letter from his supervisor.[232] The recommendation letter, written by the same supervisor who

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[225] *Id.* at 1174–75.
[226] *Id.* at 1176.
[227] *Id.* at 1180.
[228] *Id.* at 1175.
[229] *Id.*
[230] *Id.*
[231] *Id.* at 1176.
[232] *Id.*

recommended disciplinary action, gave the employee a positive endorsement and "omitted any reference to either the reprimand, the allegations of sexual harassment, the results of the investigation, or the recommended discipline."[233]

The court expressly accepted the principles set forth in the Restatement § 311, "as they apply to an employer's duty of care in making employment references and the circumstances under which that duty applies to foreseeable third parties."[234] In applying these principles it found that the assault and battery suffered by the plaintiff was neither "too remote as a matter of policy [nor] unforeseeable as a matter of law."[235] Further, it concluded that "a victim of physical violence need not rely on the negligent misrepresentation, or even be a party to it, as long as the injury is a result of the *recipient's* reliance on the employer's misrepresentation."[236]

The only limitation to the negligent misrepresentation claim noted by the court was that an employer is not obligated to speak on behalf of an employee or former employee when asked for a recommendation.[237] If, however, an employer elects to make an employment recommendation, the employer then owes a duty of care to ensure that the representations made are truthful, accurate, and not misleading and this duty is owed to both the future employer as well as any foreseeable third-party victims.[238]

Kadlec Medical Center v. Lakeview Anesthesia Associates illustrates what types of misrepresentations will result in a negligent misrepresentation claim.[239] *Kadlec* involved two defendants, a private physician practice and a hospital, both being

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[233] *Id.*

[234] *Id.* at 1179 (citing RESTATEMENT (SECOND) OF TORTS § 311 (AM. LAW. INST. 1965)).

[235] *Id.*

[236] *Id.* at 1180.

[237] *See id.* at 1179–80 (noting that there is no duty to protect a plaintiff from harm from a former employee where there is no special relationship between the defendant and the plaintiff).

[238] *See id.* at 1179 ("A misrepresentation under Section 311 may breach a duty of care owed not only to the person to whom it is addressed, and whose conduct it is intended to influence, but also a duty of care owed to third parties whom the speaker should recognize as likely to be imperiled by action take in reliance upon the misrepresentation.")

[239] *See* Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs., 527 F.3d 412, 420 (5th Cir. 2008) (distinguishing between types of misrepresentation).

sued under the negligent misrepresentation theory of liability.[240] Whereas that physician practice made affirmative statements that their former colleague, an anesthesiologist, was an "excellent clinician, and that he would be an asset to any anesthesia service,"[241] the hospital chose to be more circumspect in its response and only disclosed information relating to the dates the anesthesiologist was on staff at the hospital.[242] Given these facts, the appellate court determined that the physician practice did make false statements which the hospital reasonably relied upon when granting the anesthesiologist privileges to work in its facility, and therefore the negligent misrepresentation claim and subsequent jury verdict was proper.[243] When the appellate court reviewed the limited disclosure made by the hospital—merely the dates the anesthesiologist was on staff—it concluded that the information disclosed was not sufficient to establish a negligent misrepresentation claim.[244]

Kadlec and *Davis* illustrate how negligent misrepresentation claims can be brought to hold former employers liable for false or misleading statements relating to a former employee's competence. *Davis* also provides support that a negligent misrepresentation claim can induce a former employer to accurately report on an employee's competence. The defendant in *DiMarco v. Presbyterian Healthcare Services, Inc.* directly referenced the *Davis* decision as legal authority compelling it to provide accurate and truthful responses to an employment evaluation form request.[245]

In *DiMarco,* the plaintiff alleged that the defendant hospital's responses to an employment evaluation form provided by the plaintiff's new employer caused the plaintiff to lose his employment with the new employer.[246] According to the facts in *DiMarco,* the hospital failed to respond in full to the initial employment

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[240] *Id.* at 417.

[241] *Id.* at 416.

[242] *Id.*

[243] *Id.* at 425.

[244] *See id.* at 420 (determining the hospital "did not present evidence that this could have affirmatively misled it into thinking [the anesthesiologist] had an uncheckered history" throughout his employment at the hospital).

[245] *See* DiMarco v. Presbyterian Healthcare Servs., Inc.,160 P.3d 916, 921 (N.M. Ct. App. 2007).

[246] *Id.* at 918.

evaluation form, confirming only the plaintiff's time of employment, but declining to answer specific questions about the plaintiff's job performance while at the hospital.[247] It wasn't until the plaintiff, his wife, and the new employer asked the hospital to provide more information that the medical director for the hospital completed the evaluation form by answering the specific questions.[248] Unfortunately for the plaintiff, some of the responses reflected negatively on his work history and as a result the new employer did not hire him.[249]

The hospital defended its actions by arguing that it was required to respond truthfully to the inquiry because the hospital would have been subject to liability to any third person for an injury caused by the plaintiff at the new employer's place of business.[250] In support of this position, the hospital cited to *Davis* and the court's adoption of the Restatement § 311 applied within the context of employment recommendations.[251]

Taken together, *Davis* and *DiMarco* illustrate how a potential state-based negligent misrepresentation claim is effective in incentivizing a former employer to truthfully, accurately, and without ambiguity account for a former employee's competence to perform their job.[252] *DiMarco* also indicates how courts will defer to a former employer's accounting so long as made in good faith, thus providing former employers with a sense of security from potential liability as a result of honestly responding to an employment evaluation.[253] Lastly, *DiMarco* exemplifies how an evaluation form with specific questions designed to investigate a potential employee's competence is effective in weeding out potentially dangerous or incompetent providers.[254]

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[247] *Id.*

[248] *Id.*

[249] *Id.*

[250] *Id.* at 919.

[251] *Id.*

[252] *See id.* at 921 ("Public policy supports full and accurate disclosure of non-confidential information by employers, and we seek to encourage employers in that direction." (quoting Davis v. Bd. of Cnty. Comm'rs, 987 P.2d 1172, 1172 (N.M. Ct. App. 1999))).

[253] *See id.* at 920 (explaining the common law theory of conditional privilege that applies to employers when providing information about a former employee).

[254] *See generally id.* at 922 (explaining that although employers have a right to remain silent, when they elect to respond to questions on an evaluation form, their answers must not

B. A STATUTORY FORM COULD REMOVE BARRIERS TO NEGLIGENT MISREPRESENTATION LIABILITY

It seems to be common practice for hospital administrators and/or attorneys to provide minimal information in response to credentialing inquiries. This was illustrated in Part III with the recommendation letter that Baylor Medical and Duntsch negotiated when Duntsch left that hospital.[255] It was at least attempted by the hospital in *DiMarco* until the new employer and the former employee demanded more detailed responses to the employment evaluation.[256] And it was the shield that Lakeview Medical Center used to evade a negligent misrepresentation claim in *Kadlec*.[257]

As noted in *Davis* and *Kadlec*, a limitation to the use of a negligent misrepresentation claim is that employers are not required to respond to a recommendation request.[258] Hence, a negligent misrepresentation claim will only work if and when the former employer makes an affirmative *misstatement*.[259] To overcome this obstacle, this Article advocates for the use of a mandatory credentialing questionnaire, similar to what was used in *DiMarco,* to take away the ability of hospital administrators and lawyers to evade answering direct questions regarding the medical practitioner's competence.

At a minimum, the credentialing form should include the information that is currently required to be reported to the NPDB, but without date restrictions for adverse action reports or the

include misrepresentations if such representations would create a foreseeably risk of third-party injury).

[255] *See* Complaint, *supra* note 102, at 16 (showing the Baylor letter that informed Dr. Duntsch that all investigations against him have been closed).

[256] *See DiMarco*, 160 P.3d at 918 ("Presbyterian failed to respond in full to this initial request.").

[257] Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs., 527 F.3d 412, 420 (5th Cir. 2008) (holding that the letter from Lakeview Medical was not affirmatively misleading, in part because it did not offer an opinion of Dr. Berry's competence and was under no duty to disclose information about Dr. Berry).

[258] *See* Davis v. Bd. of Cnty. Comm'rs, 987 P.2d 1172, 1178 (N.M. Ct. App. 1999) ("[S]everal [jurisdictions] have concluded that . . . employers generally may not have an affirmative duty to disclose negative information . . . .").

[259] *See id.* ("[E]mployers may be held liable for negligent misrepresentations, or misleading half-truths . . . .").

dismissal exception for medical malpractice payouts. A "yes" response would not automatically indicate the practitioner is incompetent, but rather that additional inquiry should be done by the credentialing hospital. A field allowing for explanation or comment could immediately follow the "yes/no" response. Red flags would be waved if former employers/hospitals refuse to complete the form when queried or refuse to provide additional information when they check "yes" in response to questions regarding possible adverse actions or medical malpractice payouts. Appendix A of this Article proposes several questions to include in a mandatory credentialing questionnaire.

Perhaps the best way to design a mandatory credentialing questionnaire of this nature would be to involve key stakeholders. This might include: (1) the physicians that head the Public Citizen Health Research Group which filed the petition against HHS in 2014 and the subsequent lawsuit in 2016; (2) the physicians responsible for ending Dr. Duntsch's medical career, Dr. Randall Kirby and Dr. Robert Henderson; (3) the attorney who handled the fourteen medical malpractice cases filed by Dr. Duntsch's former patients; (4) private industry representatives from the American Medical Association, the American Hospital Association, and the Joint Commission; and (5) governmental representatives from HHS, the OIG, and HRSA. Each of these individuals, associations, and agencies possess valuable knowledge of the deficiencies of the current system and the benefits and burdens a mandatory credentialing questionnaire will place on health care entities.

As with the original design of the NPDB, responses to the mandatory credentialing questionnaire would be covered by an immunity provision so long as they are made in "good faith" and to the best of the institution's knowledge. Failure to respond to a request for information would expose the institution required to respond to potential intentional interference with contractual relations, prima facie tort, and intentional infliction of emotion distress claims from the practitioner attempting to seek privileges at another hospital.[260] If a credentialing institution opts to allow a

[260] These are the claims the practitioner alleged against the former hospital in *DiMarco* when it initially provided incomplete responses to the employment evaluation form. *See DiMarco*, 160 P.3d at 918 ("[The plaintiff] alleg[ed] intentional interference with contractual relations, prima facie tort, and intentional infliction of emotional distress.").

practitioner privileges without receiving responses to the credentialing questionnaire or despite receiving negative findings, the institution exposes itself to potential negligent credentialing claims if a patient is subsequently harmed as a result of the practitioner's care.[261] Ultimately, the mandatory credentialing questionnaire will help to (1) induce the accurate disclosure of a practitioner's competence to practice medicine; and (2) lay the foundation for state-based negligent misrepresentation and negligent credentialing claims to hold both hospitals accountable for actively engaging in the credentialing process and policing their profession.

C. THE BENEFITS OF A REPURPOSED NPDB

As discussed in Part II, the Joint Commission and other accreditation organizations require hospitals to engage in a thorough credentialing process before granting medical practitioners privileges to work within their facilities.[262] This includes "the collection, verification, and assessment of information relating to . . . experience, ability, and current competence to perform the roles, tasks, and procedures that comprise the requested privileges."[263] Specifically, this mandates that hospitals "send letters to other hospitals and physicians inquiring about the practitioner's ability and current competence to perform the requested privileges."[264]

If the NPDB were turned into a central repository of all practitioners' employment histories, it would yield several benefits with regards to the credentialing process. First, the record of previous employers and hospital affiliations would be listed in a single national database. Second, a comprehensive repository would safeguard against practitioners who intentionally omit from their applications for privileges any employment histories that negatively

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[261] *See* JON BURROUGHS, REDESIGN THE MEDICAL STAFF MODEL: A GUIDE TO COLLABORATIVE CHANGE 64 (2015) (describing the elements required to establish a valid negligent credentialing claim).

[262] Vyas & Hozain, *supra* note 38, at 6358 (describing how the credentialing process is "now required by the [Joint Commission] for hospital accreditation.").

[263] Sanford, *supra* note 52, at 393.

[264] *Id.*

reflect on their competence.[265] Finally, the repository would be able to identify practitioners who are moving quickly from institution to institution, similar to how Duntsch relocated from Baylor to DMC to Legacy and then Dallas General all within the span of two years.[266] Although the information catalogued by the repurposed database is general, credentialing hospitals would be able to identify the red flags and conduct further investigation to determine whether the practitioner is qualified.

The use of the mandatory credentialing questionnaire would be beneficial because it would allow for a standardized credentialing process where both health care institutions—the issuing hospital and the responding hospital—bear responsibility for the accuracy of the disclosures made. The questionnaire would consist of yes/no questions about the medical practitioner's competence while employed at the health care entity in question. By mandating responses to carefully crafted yes/no or checkbox queries, the responding hospital would be forced to make affirmative statements about the practitioner's competence. These affirmative statements would then expose the responding hospital to state-based negligent misrepresentation claims from patients harmed by the practitioners and from future employers of the practitioners. Exposing hospitals to this liability would be a powerful motivator for them to make more accurate disclosures about their practitioners' competence.[267]

In addition, if a credentialing hospital—the hospital issuing the mandatory credentialing questionnaire—fails to utilize the questionnaire, or chooses to ignore negative feedback provided on the questionnaire, it could be exposed to a potential negligent

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[265] Practitioners have been known to intentionally omit entities from their employment history to improve their likelihood of future employment. *See, e.g.*, Brendan J. Lyons, *Former SUNY Upstate Medical Official Pleads Guilty to Falsifying Resume*, TIMES UNION (Sep. 30, 2020), https://www.timesunion.com/news/article/Former-SUNY-Upstate-Medical-official-pleads-15608835.php [https://perma.cc/6542-JY88]; *M.L.B. Medical Adviser Falsifies Resume*, N.Y. TIMES (Mar. 29, 2005), https://www.nytimes.com/2005/03/29/sports/baseball/mlb-medical-adviser-falsifies-resume.html [https://perma.cc/6KZ9-UJJS]. Therefore, a central repository would make intentional omissions impossible.

[266] *See* discussion *supra* section III.A.

[267] *See generally* DiMarco v. Presbyterian Healthcare Servs., Inc., 160 P.3d 916 (N.M. Ct. App. 2007) (involving a plaintiff who allegedly lost his job after his previous hospital of employment completed an employee evaluation form and provided it to his next workplace).

credentialing claim.[268] The premise of a negligent credentialing claim is that the credentialing hospital has a "duty to make sure physicians appointed and reappointed to the medical staff are qualified to exercise [the] clinical privileges granted to them."[269] If the hospital fails to conduct a thorough investigation into the practitioner's competence or ignores red flags that are found during the credentialing process, the breach element of the claim is established.[270] If that breach causes the patient to suffer damages, the hospital is liable for its careless choice to credential a practitioner before a diligent investigation into his or her competence is complete.[271]

Ultimately, the repository and credentialing questionnaire would have the effect of altering the hospital's liability risk assessment. Under a hospital's current risk assessment, it has little incentive to engage in disclosure. As Part III indicated, penalties are never assessed against hospitals for failing to make a report to the NPDB.[272] The very worst a hospital will face is an investigation by HHS which may culminate in HHS instructing the hospital to file a report. If, however, the hospital files a report or discloses a practitioner's incompetence, three negative outcomes exist: (1) the practitioner who is the subject of the disclosure may attempt to sue the hospital for interfering with their ability to practice their

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[268] CLARK ET AL., *supra* note 4, at 257 ("Direct institutional liability of hospitals for negligent credentialing of a physician is based on the duty of the hospital's board of directors to oversee the hospital's quality of care and quality improvement mechanisms.").

[269] BURROUGHS, *supra* note 261, at 64.

[270] *See id.* at 66 (explaining that "hospitals and medical staffs must expend reasonable efforts in determining whether a physician is qualified for membership and clinical privileges").

[271] *See id*. at 64 ("If the hospital fails in its duty and knew, or should have known, that the physician is unqualified and the physician subsequently commits an act of negligence that injures a patient . . . the hospital can be held separately liable . . . ."). In the current system, hospitals and health care entities use the fact that they queried the National Practitioner Data Bank (NPDB) during the credentialing process as a defense to negligent credentialing claims. *See* 42 U.S.C. § 11135(c) (indicating that hospitals may rely on reported information without liability unless they knew it was false); Sanford, *supra* note 52, at 395 ("Conversely, a hospital that fails to query the NPDB when credentialing a physician is presumed to have knowledge of any information in the NPDB about that physician."). This is especially distressing given the fact that the health care entities must be the causes of the NPDB's defective accounting of incompetent practitioners.

[272] *See supra* note 128.

profession;[273] (2) the disclosure might cast a poor public image of the hospital; and (3) former patients who experienced poor outcomes because of the practitioner's care may come forward with their own medical malpractice claims against the hospital. When weighed against the liability the hospital currently faces for not reporting—which equates to essentially no liability—the answer is easy.

If the NPDB is repurposed, the exposure to potential negligent misrepresentation and negligent credentialing claims makes both hospitals—the credentialing hospital and the responding hospital—responsible for ensuring the fidelity of the information disclosed. This would represent the first time since the NPDB's creation where enforcement of the provisions designed for quality control would come from state-based players with limited political accountability and significant monetary motivation to hold hospitals accountable.

D. THE LIMITATIONS OF A REPURPOSED NPDB

There are limitations to the proposed reform of the NPDB. These include: (1) a handful of states do not recognize negligent misrepresentation or negligent credentialing claims; (2) hospitals will not like being exposed to increased state-based tort liability related to their credentialing and privileging duties; and (3) physicians will no longer be able to omit negative work history from their applications for hospital privileges.

First, not all states recognize negligent misrepresentation and negligent credentialing claims.[274] For these states, the benefits of the proposal will be limited to the credentialing hospital's ability to: (1) quickly identify all health care institutions the practitioner has worked with in the past during the credentialing process; (2) identify red flags when a practitioner hospital affiliation history shows frequent moves from one institution to another; and (3) identify hospitals the practitioner left off their application for privileges due to a negative employment relationship. Unfortunately, the lack of state-based tort claims will not motivate hospitals to properly attest to a practitioner's competence.

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[273] It should be noted that this lawsuit will likely fail due to the immunity protections offered by the HCQIA. *See supra* notes 146–148 and accompanying text.

[274] *See supra* note 219.

However, states that recognize one of these claims but not the other may still benefit from this reform. In the case where the state does not recognize a negligent misrepresentation claim, while the responding hospital is not necessarily incentivized to respond fully, the credentialing hospital is still obligated to diligently investigate the practitioner and will likely pressure the responding hospital to provide complete responses to the questionnaire, as was the case in *DiMarco*.[275] The same is true in the reverse. If the state does not recognize a negligent credentialing claim[276] but recognizes a negligent misrepresentation claim, the responding hospital will be motivated to respond truthfully to the mandatory credentialing questionnaire because to do otherwise would risk potential liability from foreseeable third parties. Thus, while a small number of states may not reap all the benefits of the reform, the reform does provide improvements to their current ability to monitor health care quality.

The second limitation involves the resistance that hospital associations will likely mount towards this change. Hospitals will not like the reform because it exposes them to increased tort liability. Currently, hospitals reap the rewards of their own inaction. Incompetent practitioners are grossly underreported to the NPDB due in large part because of hospital refusal to report practitioners.[277] As a result, when hospitals are required to query the database during the credentialing process, the database will likely not register a negative finding. Hospitals can then use the fact that they queried the database as a defense to a negligent

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[275] *See* DiMarco, v. Presbyterian Healthcare Servs., 160 P.3d 916, 918 (recounting that the plaintiff requested more information on an evaluation form).

[276] One legal strategy that could be attempted if a state does not recognize a negligent credentialing claim is to assert a negligent retention or negligent supervision claim. *See, e.g.*, RESTATEMENT (SECOND) OF TORTS § 317 cmt. c (AM. LAW. INST. 1965) ("[T]he master may subject himself to liability under the rule stated in this Section by retaining in his employment servants who, to his knowledge, are in the habit of misconducting themselves in a manner dangerous to others."). As more physicians become employees of hospitals, success of this type of claim seems possible.

[277] *See* Scheutzow, *supra* note 90 at 12 (raising concerns about hospitals failing to report adverse peer review actions).

credentialing claim.[278] This reform turns this dynamic upside down for hospitals. Not only will hospitals be required to conduct a diligent and thorough credentialing process, but they will also be required to attest to a practitioner's competence to practice medicine. Enforcement of these obligations will rest in the hands of plaintiff's attorneys who are very motivated and equipped to hold negligent hospital actors accountable.

Ultimately, this reform will be in the hospitals' best interest. First, by properly vetting practitioners before granting privileges, hospitals decrease the likelihood that practitioners will engage in the negligent practice of medicine while at their facilities. This should result in a decreased exposure to medical malpractice liability from negligent actions of their employees/agents. Second, the credentialing hospital can file a cross-claim against the former hospital under the negligent misrepresentation theory, seeking damages from the former hospital for failing to disclose the practitioner's incompetence in the credentialing questionnaire. This will help the credentialing hospital offset any monetary damages it suffers as a result of lawsuits filed by plaintiffs injured while being treated at its facility. This is similar to how the plaintiff medical center in *Kadlec* was able to successfully sue their negligent physician's former medical practice.[279]

Finally, physicians may have mixed feelings about the proposal. On the positive side, the proposal eliminates the use of the database as a blacklist for practitioners, which physicians have already been advocating for.[280] On the negative side, physicians will not be able to hide adverse employment or hospital affiliation histories. For physicians, the proposed change has minimal negative impact and will take away the stigma associated with being listed on the database. This has the potential to reduce the practice of defensive

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[278] *See* BURROUGHS, *supra* note 261, at 214 ("Healthcare entities must query the NPDB at the time of medical staff appointment, reappointment, and consideration of new privileges for existing members.").

[279] *See* Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs., 527 F.3d 412, 427 (5th Cir. 2008) (outlining the elements of negligent misrepresentation and upholding plaintiff medical-center's recovery under that theory).

[280] Lawrence R. Huntoon, *Sham Peer Review: The Destruction of Medical Careers*, J. AM. PHYSICIANS & SURGEONS 99, 100 (2019) (describing one of many physicians concerned about the "blacklisting" effect of a negative NPDB report).

medicine and increase physicians' willingness to admit mistakes and engage in disclosure and apology settlement discussions.[281]

V. CONCLUSION

Physicians, patient advocates, and even some federal agencies have called for the NPDB to be reformed.[282] However, each time a call to action is made the political process intercedes, and no action is taken.[283] With nearly three out of every four physicians now employed by hospitals or health care systems, reliance on the current NPDB's requirements for quality oversight is no longer tenable. Incompetent practitioners are not identified, competent practitioners practice defensive medicine in fear of being reported to the database, and instead of admitting that mistakes were made, practitioners zealously fight malpractice complaints to avoid being reported. All this can be mitigated. By repurposing the NPDB from a blacklist to a database listing the employment and hospital affiliation histories of *all* medical practitioners and having the NPDB or private accreditation organizations require hospitals complete a mandatory questionnaire for all practitioners during the

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[281] *See* CLARK ET AL., *supra* note 4, at 707 (noting that the NPDB's current role "has generated widespread underreporting and evasion rather than disclosure"); *see also* Haavi Morreim, *Moral Hazard: The Pros and Cons of Avoiding Data Bank Reports*, 4 DREXEL L. REV. 265, 266–67 (2011) (noting that the current NPDB structure discourages early settlement and disclosure); Katharine A. Van Tassel, *Blacklisted: The Constitutionality of the Federal System for Publishing Reports for "Bad" Doctors in the National Practitioner Data Bank*, 33 CARDOZO L. REV. 2031, 2071 n.260 (2012) (describing the current state of physician wariness towards the NPDB); Gabriel H. Teninbaum, *supra* note 159, at 85 (describing how aversion to the current NPDB materially impacted a defendant's acceptance of responsibility during settlement negotiations).

[282] *See* Van Tassel, *supra* note 281, 2071 n.260 (recounting criticisms of the NPDB throughout the medical field); *see also* U.S. GOV'T ACCOUNTABILITY OFF., GAO-01-130, NATIONAL PRACTITIONER DATA BANK: MAJOR IMPROVEMENTS ARE NEEDED TO ENHANCE DATA BANK'S RELIABILITY 3 (2000) ("[Q]uestions have arisen about NPDB's operational efficiency and effectiveness.").

[283] *See supra* note 128. If politics somehow intercedes with this suggestion to reform the NPDB, perhaps the next resort would be to have the private organizations responsible for hospital accreditation require the mandatory credentialing questionnaire be utilized during the credentialing process. Hospitals that fail to utilize the form or fail to respond to queries using the form would be subject to adverse findings on accreditation reviews. An additional avenue for reform would see Medicare adopting a rule requiring hospitals to use the mandatory credentialing questionnaire as part of the Medicare Conditions of Participation.

credentialing process, we achieve three goals: (1) the creation of a repository for the employment histories and hospital affiliations for all medical practitioners that can aid in the credentialing process; (2) a mandatory credentialing questionnaire that lays the foundation for private rights of action through state-based negligent misrepresentation and negligent credentialing claims; and (3) the elimination of the stigma associated with the NPDB which causes practitioners to practice defensive medicine and avoid admitting mistakes. The ability to police one's profession is a privilege given to the medical profession. The time has come for the profession to honor this privilege and put patients' health and well-being before its own.

VI. APPENDIX: SAMPLE QUESTIONNAIRE

Over the past [five/ten] years:[284]

1. Has the practitioner been on staff at your institution?[285]

(Yes/No)

Please list the specific dates.

_____

2. Was the practitioner "in good standing" at all times during their tenure at your institution?

(Yes/No)

How does the institution define "good standing"?

_____

3. What type of affiliation did the practitioner have with your institution?

(active / courtesy / temporary / other)

If selecting "other", please describe the affiliation below:

_____

4. What was/is the practitioner's specialty?

_____

[284] Five years is probably adequate, but some institutions request information going back ten years. The time frame could be left to the discretion of the requesting institution, but at a minimum cover five years.

[285] This would also cover medical schools and residency programs where the practitioner received his or her training if it falls within the five- or ten-year time frame.

5. Has the practitioner held clinical privileges at your institution?

(Yes/No)

If so, please list the specific dates.

_____

6. Did the practitioner have a substantial volume[286] of clinical activity while at your institution?

(Yes/No)

Please circle all applicable types of activity.

(admissions / procedures / consultations / other)

If selecting "other", please describe the activity below:

_____

7. Were performance reports maintained on the practitioner while at your institution?

(Yes/No)

Please include all performance reports for the past two years with the submission of this form.

8. Has the institution made a payment in satisfaction of a medical malpractice claim in which the practitioner was a *treating* physician?[287]

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[286] "Substantial volume" will need to be defined to ensure uniform application. Ultimately, there should be a committee convened to represent the various stakeholders that will decide the precise language of the questionnaire. The purpose of this Article is to provide a starting point for these questions.

[287] Had the hospital in the medical malpractice case study in Part I been required to respond to this question, a truthful response would necessitate answering "yes." The hospital

(Yes/No)

Please provide the case name, docket number, and jurisdiction for the malpractice complaint.

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9. Has the health care entity *ever* acted to restrict, revoke, reprimand, suspend, censure, place on probation, or accept the voluntary surrender of the practitioner's clinical privileges?[288]

(Yes/No)

Was the action in response to the practitioner's clinical competence to provide care to patients?

(Yes/No)

Please list the specific actions taken against the practitioner's clinical privileges and why.

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would then be responsible for providing the additional information requested. This would then trigger an obligation for the requesting institution to further investigate the practitioner's involvement in the medical malpractice case or risk being exposed to a negligent credentialing claim if it offers privileges to the practitioner and a patient is harmed in a similar manner.

[288] Had the hospitals in the Christopher Duntsch scenario discussed in Part III been required to respond to this question, a truthful response would necessitate answering "yes." The hospitals would then be responsible for providing the additional information requested. This would then trigger an obligation for the requesting institution to further investigate the practitioner's competence or risk being exposed to a negligent credentialing claim if it offers privileges to the practitioner and a patient is harmed.