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Constitutional Arguments in Favor of Modifying the HCQIA to Allow the Dissemination of Physician Information to Healthcare Consumers

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Constitutional Arguments in Favor of Modifying the HCQIA to Allow the Dissemination of Physician Information to Healthcare Consumers

Laura A. Chernitsky*

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* Candidate for J.D., Washington and Lee University School of Law, May 2006; B.S., Vanderbilt University, 2003. I would like to thank Professor Timothy Jost for his guidance in writing this Note. I would also like to thank my mother, Linda Chernitsky; twin sister, Sarah; and fiancé, Travis Pyle, for their constant love and support of all my endeavors. Finally, I would like to dedicate this Note to my father, the late Jim Chernitsky. Although taken from us before he could read this finished product, I can almost hear him say: "Good job, Laura Dear."

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I. Introduction

Meet Helen Cara Consumer, a 38-year-old resident of Arkansas. Inspired by the recent reality TV surgery programs, Ms. Consumer put aside a few paychecks and decided to undergo plastic surgery—a little nip here, a little tuck there. Ms. Consumer has collected brochures from several area plastic surgery groups touting the talents of their physicians. Although money is a large concern for Ms. Consumer, choosing the cheapest doctor does not necessarily seem like the best idea. Like any reasonable and responsible patient, Ms. Consumer wants to be sure that the physician she chooses has no skeletons in his closet—literally. She is especially concerned about plastic surgeon competency after reading an article about plastic surgeries gone horribly wrong in a popular women's magazine. Ms. Consumer would like to compare the doctors' practice histories with their prices. Unfortunately, medical malpractice information about specific physicians is not readily available to the public in Arkansas.¹ What should Ms. Consumer do?

1. See Arkansas State Medical Board, Online Directory, <http://www.armedicalboard.org/directory> (allowing users to search for certified physicians who have chosen to be listed in the Arkansas State Medical Board Directory, but not allowing users to view physicians' medical malpractice histories, disciplinary actions, or professional sanctioning information) (last visited Nov. 29, 2005) (on file with the Washington and Lee Law Review).

This Note suggests that Congress could easily and pragmatically solve Ms. Consumer's dilemma. Dissemination of portions of the information in the National Practitioner Data Bank (NPDB) maintained by the federal government—in particular, physician credentials, malpractice judgments, and disciplinary and licensure actions—would facilitate intelligent consumer decisions in the current heavily commercialized healthcare industry. Rather than arguing for the creation of an entirely new system to disseminate physician information to healthcare consumers, this Note concludes that Congress should modify the Health Care Quality Improvement Act (HCQIA) to grant the general public partial access to the information in the NPDB. Part II of this Note will provide background information pertinent to the ongoing debate over public access to the NPDB, including past federal legislative attempts to open the database to the general public. Part III will describe the arguments reflected in the scholarship opposing public access to the NPDB, especially the presumed need for confidential error reporting to encourage patient safety. Finally, Part IV will outline constitutional arguments in favor of granting limited public access to the information in the NPDB—comparing the information in the NPDB to commercial speech and comparing physicians to public figures—and rebut the arguments opposing public access to the NPDB.

II. Background Information

In 1999, the Institute of Medicine (IOM)² released its *To Err is Human: Building a Safer Health System* report.³ Most notably, the IOM Report stated that at least 44,000, and possibly as many as 98,000, Americans die each year

2. See The Institute of Medicine, About, <http://www.iom.edu/about.asp> (describing the Institute of Medicine of the National Academies as a non-profit organization established in 1970 to serve as an adviser to the nation to improve health) (last visited Nov. 29, 2005) (on file with the Washington and Lee Law Review). In particular, the IOM "provides unbiased, evidence-based, and authoritative information and advice concerning health and science policy to policy-makers, professionals, leaders in every sector of society, and the public at large." *Id.* Committees of uncompensated scientists conduct the IOM's research and panels of anonymous external experts review the reports produced by such committees. The Institute of Medicine, More About the Institute of Medicine, <http://www.iom.edu/subpage.asp?id=4091> (last visited Oct. 8, 2005) (on file with the Washington and Lee Law Review).

3. THE INSTITUTE OF MEDICINE, *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* (Linda T. Kohn et al. eds., 2000) [hereinafter IOM REPORT]. The IOM Report also contained recommendations for improving the quality of healthcare in the United States, focusing on leadership and knowledge, identifying and learning from errors, setting performance standards and expectations for safety, and implementing safety systems in healthcare organizations. *Id.* at 6. See also *infra* note 40 (summarizing the full IOM recommendations).

as the result of medical errors.⁴ The report created quite a stir and drew much media attention to the faults of the healthcare industry.⁵ However, long before the infamous IOM Report, physicians, healthcare administrators, legislators, and academics had been grappling with issues of healthcare quality, patient safety, and the public's right to access physician information.

A. *The National Practitioner Data Bank*

At the time of the 1999 IOM Report, Congress had several mechanisms in place for improving patient safety.⁶ Most notably, in response to growing

4. IOM REPORT, *supra* note 3, at 26 (explaining that the figures come from extrapolating the results of two studies—one using 1984 data and one using 1992 data—of preventable adverse events to the total number of hospital admissions in the United States in 1997).

5. See, e.g., Julie Appleby & Robert Davis, *Is Your Doctor Bad? You May Never Know: Limited Access to Data About Medical Errors Hides Potential Dangers*, USA TODAY, Oct. 11, 2000, at 1B (exposing the horrific story of a son who discovered a physician's claims of never losing a patient were false and uncovered the physician's multiple malpractice settlements after losing his father); see also Stacey Singer, *Tragedy Teaches a Lesson: Sharing Data Saves Lives*, SUN-SENTINEL, Oct. 24, 2000, at 1A (describing the death of Florida boy who underwent surgery to remove scar tissue from his ear and was accidentally injected with adrenaline rather than the similar-looking lidocaine with epinephrine).

6. This Note focuses on the National Practitioner Data Bank. However, under the Healthcare Integrity Portability and Accountability Act of 1996 (HIPAA), Congress authorized the creation of another federal databank—the Healthcare Integrity and Protection Data Bank (HIPDB)—to collect healthcare fraud and abuse data. 45 C.F.R. § 61.1 (2004). Government agencies and healthcare plans are required to report final adverse actions taken against physicians to the HIPDB. See Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 221(b)(1), 110 Stat. 1936, 2009–10 (describing the reporting requirements); 45 C.F.R. §§ 61.7–61.11 (2004) (same); see also Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 221(g)(1), 110 Stat. 1936, 2010–11 (defining a "final adverse action" as a civil judgment related to the delivery of a healthcare service or item, a federal or state criminal conviction related to the delivery of a healthcare service or item, actions by federal or state licensing or certification agencies, or exclusion from participation in a federal or state healthcare program. A "final adverse action" does not include malpractice claims, a notable distinction between the HIPDB and the NPDB). In exchange for compliance with reporting requirements, government agencies and health plans may access the information in the HIPDB. See Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 221(d)(1), 110 Stat. 1936, 2010 (stating that the information in the HIPDB will be available to government agencies and health plans); 45 C.F.R. § 61.12 (2004) (same). Information in the HIPDB about specific physicians is not available to the general public, however. See 45 C.F.R. § 61.14 (2004) (limiting access to the HIPDB to the entities listed in the regulations); see also 45 C.F.R. § 61.12(a)(4) (2004) (stating that a person or entity may access non-identifying statistical information from the HIPDB); Department of Health and Human Services, General Public, <http://www.npdb-hipdb.com/genpublic.html> (stating that the law prohibits disclosure of information about a specific physician to the general public and that attorneys may not access the information in the HIPDB except in limited circumstances) (last visited Nov. 29, 2005) (on file with the Washington and Lee Law Review).

concerns about the quality of medical care in the United States, Congress had enacted the Health Care Quality Improvement Act (HCQIA) in 1986.⁷ The HCQIA requires certain healthcare entities—defined as hospitals, entities that provide healthcare services (including HMOs and group medical practices), and professional societies of physicians that follow a formal peer review process to further quality healthcare⁸—to report medical malpractice payments,⁹ medical board licensure actions,¹⁰ and professional review actions¹¹ to the NPDB, which

7. 42 U.S.C. § 11101 (2000). Congress found the following:

- (1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State.
- (2) There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance.
- (3) This nationwide problem can be remedied through effective professional peer review.
- (4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.
- (5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

Id. The National Practitioner Data Bank website states that the "NPDB is primarily an alert or flagging system intended to facilitate a comprehensive review of healthcare practitioners' professional credentials." Department of Health and Human Services, National Practitioner Data Bank (NPDB), www.npdb-hipdb.com/npdb.html (last visited Nov. 29, 2005) (on file with the Washington and Lee Law Review).

8. See 42 U.S.C. § 11151(4)(A) (2000) (defining the term "health care entity").

9. See 45 C.F.R. § 60.7 (2004) (codified at 42 U.S.C. § 11131 (2000)) (stating that each entity, including insurance companies, which makes a payment under an insurance policy to satisfy a medical malpractice settlement or judgment must report the physician's identifying information (name, address, Social Security number, date of birth, professional school attendance, and professional license information), the amount of payment, the names of hospitals with which the physician is affiliated, and a description of the acts and injuries upon which the claim for payment was based to the NPDB and appropriate state licensing boards); see also 45 C.F.R. § 60.5(a) (2004) (stating that the NPDB must be notified of a medical malpractice payment within thirty days from the date of payment).

10. See 45 C.F.R. § 60.8 (2004) (codified at 42 U.S.C. § 11132 (2000)) (stating that a state medical board which revokes, suspends, places a physician on probation for reasons relating to the physician's professional competence or professional conduct, or accepts the surrender of a physician's license must report the physician's identifying information and a description of the acts and reasons for the licensure action to the NPDB); see also 45 C.F.R. § 60.5(b) (2004) (stating that the NPDB must be notified of licensure actions within thirty days from the date of licensure action).

11. See 45 C.F.R. § 60.9 (2004) (codified at 42 U.S.C. § 11133 (2000)) (stating that a healthcare entity that takes a professional review action that adversely affects a physician's clinical privileges for more than thirty days (including surrender of privileges or professional society membership) must report the physician's identifying information, a description of the

the Department of Health and Human Services supervises. In exchange for compliance with reporting requirements, certain medical entities are granted access to the information in the NPDB.¹² In fact, hospitals must consult the NPDB before accepting a physician into its medical staff or granting clinical privileges.¹³ Remarkably, despite its focus on improving the quality of healthcare and patient safety, the HCQIA and final regulations do not allow the public—the recipients of healthcare—to access the information in the NPDB.¹⁴

B. Information Currently Available to the General Public

Various organizations dedicated to improving the quality of healthcare in the United States provide the public with physician information in databases on the Internet. However, no source contains as much valuable, centrally compiled information as the NPDB.¹⁵ For example, the American Medical

acts, and the reasons for sanctioning to the state medical board, and that the state medical board, in turn, must report the information to the NPDB); *see also* 45 C.F.R. § 60.5(c) (2004) (stating that a healthcare entity must report adverse actions to the state medical board within fifteen days from the date of the adverse action, and the state medical board must, in turn, report the information to the NPDB within fifteen days of receiving the information).

12. *See* 45 C.F.R. § 60.11 (2004) (codified at 42 U.S.C. § 11137 (2000)) (stating that the physician, hospitals, state licensing boards, and other healthcare entities (including HMOs) may request information concerning a particular physician from the NPDB). In certain situations a plaintiff's attorney may request information from the NPDB:

An attorney, or individual representing himself or herself, who has filed a medical malpractice action or claim in a State or Federal court or other adjudicative body against a hospital, and who requests information regarding a specific physician, dentist, or other health care practitioner who is also named in the action or claim. Provided, that this information will be disclosed only upon the submission of evidence that the hospital failed to request information from the Data Bank as required by § 60.10(a), and may be used solely with respect to litigation resulting from the action or claim against the hospital.

45 C.F.R. § 60.11(a)(5)(2004).

13. *See* 45 C.F.R. § 60.10(a) (2004) (codified at 42 U.S.C. § 11135 (2000)) (stating that hospitals must consult the NPDB when a physician applies to be on the medical staff of the hospital or for clinical privileges at the hospital and every two years thereafter).

14. *See* 45 C.F.R. § 60.13(a) (2004) (codified at 42 U.S.C. § 11137(b) (2000)) (restricting access to the NPDB to those entities listed in the regulations); *see also* Department of Health and Human Services, General Public, <http://www.npdb-hipdb.com/genpublic.html> (stating that the law prohibits disclosure of information about a specific physician to the general public) (last visited Nov. 29, 2005) (on file with the Washington and Lee Law Review).

15. The Department of Health and Human Services does publish a quantitative summary—available to the public—of the number of medical malpractice reports; licensure, clinical privileges, and professional society membership reports; and Medicare/Medicaid exclusion reports submitted to the NPDB per state. DEP'T OF HEALTH AND HUMAN SERVS., NPDB SUMMARY REPORT (2005), *available at* <http://www.npdb-hipdb.com/pubs/stats/>

Association (AMA) maintains a database of physician demographic and professional information, such as the physician's educational background, certification, and office locations.¹⁶ The AMA database contains no negative physician information, however, corresponding with the organization's vehement opposition to opening the NPDB to the general public.¹⁷ Several private, commercial sites disseminate information about individual physicians. For example, Health Grades, Inc. allows patients to purchase physician reports, which include any government disciplinary action taken within the past five years.¹⁸ Similarly, ChoiceTrust advertises physician reports, available for consumer purchase, that include credentialing information such as licensure actions, dismissals, and sanctions.¹⁹

Traditionally, the regulation of health, safety, and general welfare has been a power of the states.²⁰ While every state's board of medicine maintains a website listing its licensed physicians²¹ and most state websites list disciplinary information taken against individual physicians, only a portion of the states provide an easily searchable database of such information that the general

NPDB_Summary_Report.pdf. The most recent data covers the time period from September 1, 1990, through September 2, 2005, and does not contain any information on individual physicians. *Id.*

16. See American Medical Association, AMA Physician Select, <http://webapps.ama-assn.org/doctorfinder/disclaimer.jsp> (requiring patients to read a disclaimer—"AMA shall not be liable to you or others for any decision made or action taken by you in reliance on the information obtained from this site"—before searching the database of physician information) (last visited Nov. 29, 2005) (on file with the Washington and Lee Law Review).

17. See American Medical Association, Policy Finder: H-355.985, http://www.ama-assn.org/apps/pf_new/pf_online (stating that the AMA "opposes all efforts to open the National Practitioner Data Bank to public access" and "strongly opposes public access to medical malpractice payment information in the National Practitioner Data Bank") (last visited Nov. 29, 2005) (on file with the Washington and Lee Law Review).

18. See Health Grades, Inc., www.healthgrades.com (leading patients to a searchable database, but requiring users to visit a page explaining how to interpret the physician information before displaying the search results) (last visited Nov. 29, 2005) (on file with the Washington and Lee Law Review).

19. See ChoicePoint Asset Co., ChoiceTrust, www.choicetrust.com (leading consumers to a searchable database) (last visited Nov. 29, 2005) (on file with the Washington and Lee Law Review).

20. See Kevin Outterson, *Health Care, Technology and Federalism*, 103 W. VA. L. REV. 503, 504 (2001) ("The regulation of health care has traditionally been the province of the states, most often grounded in the police power.").

21. See *supra* note 7 and accompanying text (noting that a reason for creating the NPDB was the concern that a physician could just move to a different state and start his or her career from scratch—without anyone knowing—after receiving disciplinary action or a negative medical malpractice outcome in a state).

public can use.²² Furthermore, not all states have made medical malpractice information available to the public on the Internet.²³ Massachusetts was the first state to provide the public with a searchable database of physician information—including medical malpractice and disciplinary data with appropriate explanatory information—on the Internet and remains one of only a few states providing such a service today.²⁴ Medical malpractice judgments and criminal convictions, however, are generally available as a matter of public record.²⁵ Thus, the general public currently has access to a scattered series of databases of physician information, none of which rival the efficiency or completeness of the NPDB.

C. Failed Federal Legislative Attempts to Grant Public Access to Databases

As the NPDB is an efficient source of valuable physician information, several attempts have been made at the federal level to open access to the NPDB to the general public. Each attempt has failed. Under the Health Security Act proposed in 1993, an individual seeking to enroll in a health plan would have been able to access the NPDB profiles of the practitioners participating in the health plan.²⁶ The bill died in committee.²⁷ Under the

22. See JOHN PAUL FAWCETT ET AL., PUBLIC CITIZEN, SURVEY OF DOCTOR DISCIPLINARY INFORMATION ON STATE WEB SITES, <http://www.citizen.org/publications/release.cfm?ID=7168> (grading the user-friendliness and content of each state's board of medicine website based on an April 3, 2002 survey) (last visited Dec. 4, 2005) (on file with the Washington and Lee Law Review). Public Citizen, a national non-profit public interest organization, recommends that each state maintain a publicly accessible, easily searchable database of physician information, including disciplinary data and medical malpractice information. *Id.*

23. *Id.* (noting that the California, Florida, Idaho, Massachusetts, and Tennessee boards do provide medical malpractice information).

24. See Commonwealth of Massachusetts, Physician Profile Search, <http://profiles.massmedboard.org/Profiles/MA-Physician-Profile-Find-Doctor.asp> (providing a searchable database of physician information, which includes explanations of how to properly interpret the data) (last visited Dec. 4, 2005) (on file with the Washington and Lee Law Review).

25. See National Center for State Courts, Public Access to Court Records, www.courtaccess.org (providing links to each state's court system) (last visited Dec. 4, 2005) (on file with the Washington and Lee Law Review). Medical malpractice settlements, however, generally are not available in judicial records.

26. H.R. 3600, 103d Cong. § 5005(d)(1) (1994), available at http://thomas.loc.gov/home/bills_res.html.

27. See The Library of Congress, Bill Summary & Status for the 103d Congress, <http://thomas.loc.gov/bss/103search.html> (listing the last congressional action on the bill as in the Post Office and Civil Service Committee on October 7, 1994) (last visited Dec. 4, 2005) (on file with the Washington and Lee Law Review).

Health Care Quality Improvement Act Amendments proposed in 1994, information in the NPDB—with the exception of certain physician personal information, such as home address and Social Security number, and patient identifying information—would have been available to the public.²⁸ This bill also died in committee.²⁹ Under the Health Care Liability Reform and Quality Assurance Act proposed in 1995, an individual would have been able to request and receive information from the NPDB.³⁰ The section of the bill granting public access to the NPDB was struck, and the bill did not pass.³¹ The Health Care Quality Improvement Act Amendments of 1996 would have provided limited public access to information in the NPDB via the Internet.³² More specifically, only information involving claims of over \$25,000 would have been available and patient identifying information and certain physician personal information would not have been available.³³ This bill died in committee as well.³⁴

The most recent federal attempt to grant public access to the NPDB was the Patient Protection Act of 2000.³⁵ The Patient Protection Act of 2000 would have provided public access to information in the NPDB—with the exception of patient identifying information and certain personal information of the physician—via the Internet.³⁶ The Patient Protection Act of 2000 also would have provided additional information to help the public put medical malpractice claims in their proper context: (1) a comparison of the information in a physician's profile to the experiences of other physicians in the same specialty in the same state; (2) a statement explaining that physicians who work with

28. H.R. 4274, 103d Cong. § 6(c) (1994), available at <http://thomas.loc.gov/bss/103search.html>.

29. See The Library of Congress, Bill Summary & Status for the 103d Congress, <http://thomas.loc.gov/bss/103search.html> (listing the last congressional action on the bill as referral to the Subcommittee on Health and the Environment on May 16, 1994) (last visited Dec. 4, 2005) (on file with the Washington and Lee Law Review).

30. S. 454, 104th Cong. § 203 (1995), available at http://thomas.loc.gov/home/bills_res.html.

31. See *id.* (listing § 203 as "struck out").

32. S. 2004, 104th Cong. § 8(c) (1996), available at http://thomas.loc.gov/home/bills_res.html.

33. *Id.*

34. See The Library of Congress, Bill Summary & Status for the 104th Congress, <http://thomas.loc.gov/bss/104search.html> (listing the last congressional action on the bill as referral to the Committee on Labor and Human Resources on July 31, 1996) (last visited Dec. 4, 2005) (on file with the Washington and Lee Law Review).

35. H.R. 5122, 106th Cong. (2000), available at http://thomas.loc.gov/home/bills_res.html.

36. *Id.* at § 101(a).

high-risk patients are likely to have higher numbers of medical malpractice claims; (3) a statement that certain specialties are more likely to be the subject of litigation; and (4) a statement that "a payment made pursuant to a medical malpractice action or claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician."³⁷ Furthermore, the Patient Protection Act of 2000 would have allowed practitioners to submit an explanation of an incident in the NPDB, which would also have been distributed to the public.³⁸ Like its predecessors, however, this bill died in committee.³⁹

II. Arguments Against Public Access to Physician Information

The vast majority of scholarship addressing the NPDB, especially in the wake of the 1999 IOM Report,⁴⁰ argues that the general public should not have

37. *Id.*

38. *Id.*; *id.* at § 205.

39. See The Library of Congress, Bill Summary & Status for the 106th Congress, <http://thomas.loc.gov/bss/106search.html> (listing the last congressional action on the bill as referral to the House Committee on Commerce on September 7, 2000) (last visited Dec. 4, 2005) (on file with the Washington and Lee Law Review).

40. See IOM REPORT, *supra* note 3, at 5–14 (listing the full IOM recommendations). A summary of the full recommendations follows:

Recommendation 4.1: Congress should create a Center for Patient Safety to set and monitor the progress of national goals for patient safety and coordinate medical error research.

Recommendation 5.1: Congress should establish a standardized mandatory system for all health care organizations to report adverse events that result in harm or death, including providing a mechanism for analyzing the error reports and identifying persistent patient safety problems.

Recommendation 5.2: Encourage development of voluntary, confidential error reporting systems to focus on threats to patient safety rather than past errors.

Recommendation 6.1: Congress should extend peer review protections to patient safety and quality improvement data to encourage error reporting.

Recommendation 7.1: Regulatory standards and consumer expectations for health care organizations should focus greater attention on patient safety.

Recommendation 7.2: The performance standards and expectations set by health professional licensing bodies and societies should focus greater attention on patient safety, including disseminating information on patient safety, setting safety standards, encouraging error reporting, and establishing methods to identify unsafe practitioners.

Recommendation 7.3: The FDA should increase the attention paid to the safe use of drugs through its pre- and post-marketing processes.

Recommendation 8.1: Health care organizations and professionals should make improving patient safety a declared and serious aim by establishing patient safety

access to the physician information in the databank. Arguments against public access to the NPDB fall into categories such as operational concerns, reliability concerns, and unintended consequences.⁴¹ Most importantly, much of the scholarship indicates that error reporting is critical to improving patient safety and links public access to the information in the NPDB with decreased error reporting.⁴²

A. Operational Concerns and Reliability

General concerns with allowing the public to access the NPDB include guaranteeing the accuracy of information in the database, ascertaining the necessary scope of information to be included in the database, and covering the operational costs of maintaining an accurate, up-to-date database.⁴³ Some scholars argue that the costs of maintaining a database accessible to the public are not justified in light of the availability of physician information from other sources.⁴⁴

Concerns with reliability focus on whether the information in the database will adequately predict physician competency for consumers. Studies have suggested that medical malpractice claims may not correlate with physician

programs and developing a culture of safety.

Recommendation 8.2: Health care organizations should universally implement proven medication safety practices.

Id.

41. Mark J. Greenwood, *The Physician Profile Database: Publishing Malpractice Information on the Internet*, 21 J. LEGAL MED. 477, 509 (2000) (categorizing the arguments against public access to databases of healthcare provider information). Interestingly, Dr. Greenwood—who is a flight physician, attending emergency room physician, and attorney—argues that physicians should concede to allowing the dissemination of information to the public and focus, instead, on assuring that the information disseminated is correct. *Id.* at 536.

42. See Jason M. Healy et al., *Confidentiality of Health Care Provider Quality of Care Information*, 40 BRANDEIS L.J. 595, 596 (2002) (asserting that "quality experts almost universally agree that an important predicate to quality improvement is for providers themselves to identify medical errors and other quality problems").

43. See Greenwood, *supra* note 41, at 509–11 (describing general concerns with allowing the public to access physician profiles). Consumer access to both negative information, such as criminal convictions, and positive information, such as physicians' professional achievements, should allow consumers to make informed identifications of the best and worst choices among a group of physicians. *Id.* at 510.

44. See Steven K. Berenson, *Is It Time for Lawyer Profiles?*, 70 FORDHAM L. REV. 645, 668–69 (2001) (noting that disciplinary actions by state medical boards, the criminal records of physicians, and medical malpractice judgments are matters of public records, and several groups already collect and disseminate information about physicians).

competence,⁴⁵ yet scholars note that consumers seriously consider such information, if given the opportunity, when selecting a physician.⁴⁶ In addition, the usefulness of the information in the database to consumers depends on the accuracy and timeliness of the information,⁴⁷ which would place a huge burden on the administrators of a publicly accessible system to keep the database updated. Thus, some scholars suggest that allowing the public to access negative physician information would mislead, rather than enlighten, the typical consumer who is not familiar with the frequency and the significance of medical malpractice claims and disciplinary sanctions.⁴⁸ In other words, less information is better than misinterpreted information.

B. Unintended Consequences

Scholars also suggest several possible unintended consequences to granting the public access to physician databases.⁴⁹ For example, public access to physician databases may limit the availability of medical procedures and experimental treatments, as the threat of disseminating negative information may deter physicians from performing certain high-risk procedures that are more likely to tarnish a physician's record with a negative outcome and provoke expensive litigation.⁵⁰ Scholars also argue that public access to the NPDB might encourage litigation, as a physician whose public reputation is at stake would have a greater incentive not to settle a claim, and lawyers, theoretically, could use the data bank to identify problem doctors as defendants

45. See Troyen A. Brennan et al., *Relation Between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation*, 335 NEW ENG. J. MED. 1963, 1967 (1996) (concluding that the severity of the patient's disability, not the physician's negligence, determines a plaintiff's malpractice award); see also *supra* note 4 (referring to the Harvard Medical Practice Study—a source of the IOM Report statistics—co-authored by Troyen Brennan).

46. See Greenwood, *supra* note 41, at 511–14 (describing concerns with reliability). Negative media attention to sensational medical malpractice cases may explain consumer reliance on negative physician information. *Id.* at 521–23. However, consumer reliance on such negative information may make informed decisions even more difficult. *Id.* at 523–26.

47. Berenson, *supra* note 44, at 669–70.

48. *Id.* at 664–65.

49. See Greenwood, *supra* note 41, at 514 (identifying unintended consequences such as limiting access to physicians, inappropriate use of the database, increases in healthcare costs due to the cost of physicians defending themselves against adverse actions, decreases in peer reporting, and infringement of consumer privacy).

50. See *id.* at 516 (suggesting that physicians will avoid a negative databank profile and litigation by avoiding complex procedures).

in lawsuits.⁵¹ Furthermore, the more time a physician spends in court, the less time the physician has to spend with patients.⁵² Thus, many scholars conclude that, in light of concerns of healthcare access, the dissemination of physician information to the general public should be discouraged.

C. Facilitating Error Reporting⁵³

Many health law scholars have focused on the need to improve error reporting in the healthcare system in order to enhance the quality of available healthcare services, including physician competency.⁵⁴ Some scholars describe the argument that malpractice liability precludes adequate attention to patient safety issues by discouraging error reporting as "an article of faith" in the healthcare sector.⁵⁵ In the first place, a physician's good business sense precludes reporting errors—either the physician's own errors or the errors of a colleague—if consumers will use such information either to select a physician⁵⁶ or to bolster medical malpractice claims against physicians.⁵⁷ Such behavior on

51. See Berenson, *supra* note 44, at 666 (suggesting that a consequence of public access to physician profiles would be increased litigation).

52. *Id.* at 666–67; Greenwood, *supra* note 41, at 514, 516 (noting that a "cost" of defending medical malpractice suits resulting from public access to negative physician information is time spent away from patients in court).

53. The IOM Report notes that the terminology for discussing medical error is not firmly established, but provides specific definitions for the terms used in the Report. IOM REPORT, *supra* note 3, at 49–65. According to the IOM, a system is "a set of interdependent elements interacting to achieve a common aim. The elements may be both human and non-human (equipment, technologies, etc.)." *Id.* at 52. An accident is "an event that involves damage to a defined system that disrupts the ongoing or future output of that system." *Id.* Error is "the failure of a planned action to be completed as intended (e.g., error of execution) or the use of a wrong plan to achieve an aim (e.g., error of planning)." *Id.* at 53. Safety is "freedom from accidental injury." *Id.* at 58.

54. See Healy et al., *supra* note 42, at 612–13 (noting that peer review improves patient safety by evaluating practicing physicians' quality of care); see also Bryan A. Liang, *Promoting Patient Safety Through Reducing Medical Error: A Paradigm of Cooperation Between Patient, Physician, and Attorney*, 24 S. ILL. U. L.J. 541, 564 (2000) [hereinafter Liang, *Promoting Patient Safety Through Reducing Medical Error*] (recommending changes to the medical error reporting systems to improve patient safety).

55. David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 910 (2005).

56. See Greenwood, *supra* note 41, at 519 (describing factors that deter physician error reporting).

57. See Hyman & Silver, *supra* note 55, at 909–14 (noting the prominent physicians, scholars, and individuals at the AMA who agree with the conventional wisdom that medical malpractice liability precludes improving patient safety).

the part of physicians would undermine the very reason for granting access to the database, as the database would not contain profiles that accurately reflect physician competence. The IOM Report and many scholars focus on the need to move from blaming individuals for medical error to understanding and preventing error, and conclude that physician information should be kept confidential.⁵⁸

1. *Medical Errors and Error Reporting: The Need for Confidentiality*

The healthcare industry, a complex system⁵⁹ characterized by specialization and interdependency of its component factors,⁶⁰ will never be able to rid itself of errors entirely, however, as errors—especially human errors—in complex systems are inevitable.⁶¹ In addition, errors in the healthcare industry are difficult to measure, as one patient might survive deplorable medical care, while another patient might die from the best medical care available.⁶² Yet, analysis of medical error—covering mistakes that cause injury and mistakes that do not cause injury, but excluding purposeful or reckless actions or the underlying patient illness—is crucial.⁶³ Scholar Bryan Liang M.D., J.D., Ph.D., stresses the special importance of studying errors that do not result in patient injury, noting that "those mistakes lay latent in the system, increasing the probability that there will be patient injury in the future associated with this same mistake."⁶⁴ In other words, ignoring these hidden errors will "[make] the system more prone to future failure."⁶⁵

58. See IOM REPORT, *supra* note 3, at 49 (noting that the problem in healthcare is not bad people, but rather a system that needs to be made safer).

59. See *id.* at 60 (suggesting that healthcare is a complex system).

60. See *id.* at 58–59 (describing the characteristics of a complex system).

61. See Hyman & Silver, *supra* note 55, at 948 (noting the "frailties that afflict human behavior—including sensory limitations, flawed decision heuristics and empirical theories, information overload, emotions and other distractions, fatigue and other physical problems, defective motivations, training limitations, and forces beyond human control").

62. See *id.* at 949–50 (noting that patients who die for no apparent reason and patients who survive against all odds may mask errors).

63. See Liang, *Promoting Patient Safety Through Reducing Medical Error*, *supra* note 54, at 542 (defining medical error as "a mistake, inadvertent occurrence, or unintended event in a health care delivery which may, or may not, result in patient injury"); see also IOM REPORT, *supra* note 3, at 29 (defining an "adverse event" as "an injury caused by medical management rather than by the underlying disease or condition of the patient").

64. Liang, *Promoting Patient Safety Through Reducing Medical Error*, *supra* note 54, at 542.

65. IOM REPORT, *supra* note 3, at 56.

In light of the need to deter preventable medical errors, the IOM Report recognized the importance of both mandatory and voluntary error reporting systems in medicine.⁶⁶ Mandatory reporting systems focus on errors associated with serious injury or death, and reports may prompt investigations that lead to sanctioning wrongdoers.⁶⁷ Mandatory systems improve patient safety by addressing at least the most serious errors and requiring healthcare organizations to make at least minimal investments in patient safety to avoid sanctions and public exposure.⁶⁸ Voluntary reporting systems, on the other hand, strive to improve safety by focusing on errors that result in little or no harm.⁶⁹ Voluntary systems of error reporting improve patient safety by addressing infrequent errors and patterns of errors.⁷⁰

Scholars have identified several problems with both mandatory and voluntary error reporting systems: (1) medical error is common,⁷¹ (2) the healthcare system has not recognized the complex system's nature of medical error, (3) risk management does not promote patient safety and reduce medical error,⁷² and (4) the legal system does not decrease the risk of patient

66. See IOM REPORT, *supra* note 3, at 87 (stressing the need to analyze, not just compile, the information received by either type of system). According to the IOM Report, reporting systems in general improve patient safety by gathering information from multiple sources to understand the various factors that contribute to errors, by distributing information to create awareness of recurring safety problems, and by analyzing larger numbers of "rare" errors to better identify trends of safety problems and unusual problems. *Id.* at 98.

67. See *id.* at 86 (describing mandatory reporting systems as those in which the primary purpose is to hold providers accountable).

68. *Id.* At least one-third of the states have mandatory reporting systems. *Id.* at 91.

69. See *id.* at 87 (describing voluntary reporting systems).

70. *Id.* The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the organization responsible for hospital accreditations, maintains a sentinel event database. See *id.* at 93–94 (defining a sentinel event as an unexpected occurrence involving the risk of death or serious physical or psychological injury and classifying the sentinel event program as a voluntary reporting system). Under the JCAHO sentinel event program, hospitals are required to conduct an investigation to discover the cause of certain sentinel events—unanticipated death or serious injury unrelated to the natural course of the patient's condition, patient suicide in a supervised environment, patient abduction or inappropriate discharge, erroneous use of incompatible blood products, and surgery on the wrong patient or body part—and submit the report to JCAHO, either voluntarily or at the Joint Commission's request. *Id.* The investigations are kept confidential, but unacceptable reports put the hospital's accreditation at risk. *Id.*

71. See Liang, *Promoting Patient Safety Through Reducing Medical Error*, *supra* note 54, at 554 (citing the statistic that 98,000 patients die from medical error each year); see also IOM REPORT, *supra* note 3, at 26 (asserting that at least 44,000 and possibly as many as 98,000 patients die from medical error each year).

72. See Liang, *Promoting Patient Safety Through Reducing Medical Error*, *supra* note 54, at 546 (giving examples of "risk management," such as educating doctors about the medical malpractice system and clinical techniques and establishing clinical practice guidelines). Liang

injury.⁷³ Scholars suggest that certain impediments to reporting medical errors must be removed in order for the healthcare industry to adequately understand and, therefore, be in a position to address the underlying sources of the medical error problem.⁷⁴ In particular, physicians are discouraged from reporting errors because patients may use such reports against the physician in a medical malpractice lawsuit and an HMO or healthcare plan may use them to terminate the physician's contract.⁷⁵ Thus, scholars suggest that creating stricter discovery protections,⁷⁶ eliminating termination-without-cause provisions in physician contracts,⁷⁷ creating independent third-party review groups,⁷⁸ and reserving the tort litigation system for intentional injuries and reckless actions⁷⁹ will remove basic financial disincentives to error reporting.⁸⁰ The Institute of

notes that the current system of risk management does not adequately promote patient safety and reduce medical error because doctors still do not understand the legal standards of medical malpractice, are unable to predict jury verdict outcomes, and do not agree on the clinical standards for appropriate medical care. *Id.* at 547–48.

73. *Id.* at 554. In fact, Liang's research casts doubt on the entire medical malpractice system as a deterrent to inferior healthcare delivery. See Bryan A. Liang, *Assessing Medical Malpractice Jury Verdicts: A Case Study of an Anesthesiology Department*, 7 CORNELL J.L. & PUB. POL'Y 121, 145–47 (1997) (describing a small study of an anesthesiology department that suggests a system of medical malpractice liability in which physicians do not understand the legal standards and are unable to accurately predict the outcome of jury verdicts likely does not deter the delivery of inferior healthcare).

74. See Liang, *Promoting Patient Safety Through Reducing Medical Error*, *supra* note 54, at 563–67 (emphasizing the importance of physicians reporting errors).

75. See *id.* at 555–61 (describing disincentives to reporting error information); see also Berenson, *supra* note 44, at 660 (noting that the impact of sanctions on a medical practice also deters physicians' effective peer review of their colleagues).

76. See Liang, *Promoting Patient Safety Through Reducing Medical Error*, *supra* note 54, at 564 (arguing the need for federal legislation to protect safety and error information from legal discovery). Traditional protections against the discovery of information, such as the peer review privilege and the attorney-client privilege, usually fail in the medical malpractice context. *Id.* at 555–59. Liang notes that "[p]unishment only deters the provider from doing anything; it doesn't correct the latent errors in the system." *Id.* at 564.

77. *Id.* at 565 (suggesting termination-without-cause provisions discourage physician participation in error reporting systems). Such contracts likely deter participation by encouraging the physician to cover mistakes, rather than report them, in order to maintain employment.

78. See *id.* at 566 (arguing the need for independent third-party review groups to separate financial decisionmaking from clinical decisions regarding patient safety and ways to reduce medical error).

79. *Id.* at 567 (noting that medical errors do not include intentional injuries or reckless behavior, so litigation for such actions would not preclude error reporting).

80. See *id.* at 555 (noting that "accepting reality, without protections, no one is going to report because no one likes being sued"); see also *id.* at 560 (noting that no physician actually would be "so brazen as to ignore [his or her] financial lifeline" and risk termination by admitting error, especially if "[the physician has] a family to feed; [has] kids in college; [has] a set of

Medicine strongly agrees that liability discourages error reporting and also recommends strengthening the practical⁸¹ and legal protections afforded to the individuals who make error reports, to the individuals who receive and handle error reports, and to the information contained in the error reports.⁸² In light of the varying protections that state evidentiary rules and peer review statutes afford, the IOM Report suggests that Congress should enact federal protective legislation to protect error information.⁸³ While scholars recognize that patients have an important role in encouraging safety and reducing medical error,⁸⁴ their recommendations strongly suggest keeping error information within the healthcare system. Similarly, in order to balance the public's right to understand safety concerns in the healthcare industry with providers' desire to maintain confidentiality and protection from liability, the IOM Report recommends mandatory reporting and public disclosure of only the most serious errors in the healthcare system and confidential, voluntary reporting for more minor injuries and near misses.⁸⁵

2. *The Ideal: A Comparison to Aviation*

Aviation has been cited as the "classic" example of an industry that has achieved a higher standard of consumer safety by recognizing the complex system's nature of flight errors and taking the appropriate steps to successfully reduce error within the system.⁸⁶ Liang notes that the 98,000 deaths from medical error each year equates to 270 deaths per day, which would be

parents in a nursing home; or [has] patients relying on [him or her]").

81. See IOM REPORT, *supra* note 3, at 124 (describing practical protections to the information in error reports as promises of confidentiality and anonymous or de-identified error reporting).

82. See *id.* at 127 (noting that protection of all three components of error reporting systems—the reporter, the recipient, and the substantive information—is necessary).

83. See *id.* at 127–28 (noting the immediate and uniform impact such legislation could have on the healthcare industry). The IOM Report notes that the information in the National Practitioner Data Bank is protected from discovery in lawsuits. *Id.* at 122. The IOM Report also notes the federal protection afforded by the HCQIA to good faith peer review participants. *Id.* at 121.

84. See Liang, *Protecting Patient Safety Through Reducing Medical Error*, *supra* note 54, at 566 (suggesting that patients have the greatest incentive to learn about the healthcare system, report potential patient safety concerns, and encourage legislatures to act).

85. IOM REPORT, *supra* note 3, at 101–02.

86. See, e.g., Liang, *Protecting Patient Safety Through Reducing Medical Error*, *supra* note 54, at 543–45 (comparing medicine to aviation—"the classic example" of reducing error within a complex system).

comparable to more than one 757 airplane crashing and killing each passenger on board every day each year in the airline industry.⁸⁷ While accidents are likely to occur at some point in any complex system,⁸⁸ the commercial airline industry has had years in which no deaths have occurred.⁸⁹

The IOM Report indicates that characteristics of a highly reliable industry, such as aviation, include: an organizational commitment to safety, high levels of redundancy in personnel and safety measures, and a culture that demands learning and willingness to change.⁹⁰ While some deaths in the healthcare industry are inevitable as the result of old age or incurable disease, scholars argue that conformity with the airline industry's model may help to reduce deaths by medical error.

More specifically, the airline industry recognizes that the pilot is not exclusively responsible for the safety of a flight. Rather, the pilot, flight attendants, ground crew, maintenance crew, and air traffic controllers form a team, and each member of the team contributes to the outcome of a flight.⁹¹ The key feature of the airline industry's error reporting system is its dual nature: certain error reports go to an independent and neutral third party rather than to the Federal Aviation Administration (FAA), which can sanction pilots.⁹² The third party, the National Aeronautics and Space Administration (NASA), maintains the Aviation Safety Reporting System (ASRS).⁹³ Individuals anonymously submit incident reports to the ASRS.⁹⁴ NASA solicits follow-up reports, removes identifying information from the

87. *Id.* at 543.

88. IOM REPORT, *supra* note 3, at 57.

89. Liang, *Protecting Patient Safety Through Reducing Medical Error*, *supra* note 54, at 545.

90. IOM REPORT, *supra* note 3, at 57. Like the healthcare industry, aviation is an extremely complex system of interdependent and often unpredictable components. For example, the sequences of activities on an aircraft carrier vary depending on weather and visibility, sea conditions, time of day, and flight schedules. Both industries require a strong emphasis on safety—especially in the use of hazardous technology—to run efficiently. *See id.* at 162 (comparing the aviation and healthcare industries).

91. *See* Liang, *Protecting Patient Safety Through Reducing Medical Error*, *supra* note 54, at 544 (describing the team approach in the airline industry).

92. *See id.* at 561–62 (describing the airline industry's error reporting system).

93. *See* Aviation Safety Reporting System, Program Overview, http://asrs.arc.nasa.gov/overview_nf.htm (stating that NASA operates the ASRS through an independent contractor selected via competitive bidding) (last visited Dec. 4, 2005) (on file with the Washington and Lee Law Review).

94. *See* IOM REPORT, *supra* note 3, at 95–96 (defining an incident as "an occurrence associated with the operation of an aircraft that affects or could affect the safety of operations" and distinguishing an incident from an accident).

reports, analyzes the information, and distributes the results.⁹⁵ In order to remain a neutral third party, NASA does not suggest solutions to the recurring problems the agency identifies.⁹⁶ Again, the ASRS operates independently of the FAA, and NASA has no regulatory or sanctioning powers.⁹⁷ Without the threat of punishment, pilots feel more comfortable submitting errors or hazards to the ASRS. Furthermore, the appropriate organization can address reported issues, making the airline industry safer. The FAA also oversees the National Aviation Safety Data Analysis Center (NASDAC), which disseminates safety and error information, another important feature of the relatively safe airline industry.⁹⁸

IV. Arguments For Public Access to Physician Information

The general public currently has scattered access to incomplete physician information via state websites, commercial websites, and court records. None of these sources of information rival the efficiency or completeness of the information in the NPDB. Allowing the public access to pertinent information in the NPDB—via modifying the HCQIA—would benefit the general public by giving consumers more information to make better-informed choices when selecting healthcare practitioners. While many of the arguments in support of granting public access to the information in the NPDB fall within the context of consumerism, some scholars have also questioned the accuracy of the more traditional arguments—namely the necessity of confidential error reporting—against allowing the public to access the information.

95. See Liang, *Protecting Patient Safety Through Reducing Medical Error*, *supra* note 54, at 561–62 (describing NASA's role as an independent third party in the airline industry's error reporting system); see also IOM REPORT, *supra* note 3, at 71–73 (commending aviation's recognition of the need to expand and disseminate safety knowledge and suggesting the need for a similar approach in the healthcare industry).

96. See IOM REPORT, *supra* note 3, at 96–97 (noting that NASA investigates reported incidents and issues safety alerts to the airline industry and the FAA as needed).

97. See *id.* at 96 (noting that the programs are operated independently due to pilot reluctance to report accidents to the FAA, which does have regulatory authority).

98. See Federal Aviation Administration, The National Aviation Safety Data Analysis Center, www.nasdac.faa.gov (classifying the NASDAC as "a facility for the integration and analysis of aviation safety data") (last visited Dec. 4, 2005) (on file with the Washington and Lee Law Review).

A. *Public Access to Healthcare Information Is a Natural Consequence of the Commercialization of Healthcare*

With the strong commercialization of healthcare and the variety of medical practitioner choices available to individual consumers and to members of HMOs and healthcare plans, more information would lead to better-informed decisions.⁹⁹ A medical practitioner sells a product—healthcare services—to the public. Quantifiable and comparable characteristics of that service include the practitioner's educational background, achievements, and negative outcomes. The NPDB is a centrally compiled, easily accessible source of such product characteristics.

1. *Focus on Consumerism*

One author identified "consumerism" as a "buzzword" of the healthcare industry in 2004.¹⁰⁰ She noted that a healthcare consumer has both a positive definition—a more informed patient—and a negative definition—a patient who has to pay more out-of-pocket to cover the host of healthcare services.¹⁰¹ In its 1999 report, the Institute of Medicine had identified two categories of factors that can influence the quality of medical care: (1) regulation and legislation and (2) economic incentives.¹⁰² According to the IOM Report, market incentives direct the values and priorities of healthcare organizations.¹⁰³ In fact, despite recommending that negative physician information be kept confidential, the IOM Report specifically discusses the emergence of comparative performance data, available to the public "to assist purchasers and consumers in identifying high quality providers."¹⁰⁴ In addition, some states—Massachusetts, for example—have also recognized the importance of allowing consumers to

99. Although the purchase of healthcare services may be distinguished from the purchase of material items, consider the large amount of research many consumers conduct when making other significant purchases, such as the purchase of a car, appliance, electronic device, or pet.

100. See Laura Stokowski, *Trends in Nursing: 2004 and Beyond*, TOPICS IN ADVANCED PRAC. NURSING EJOURNAL (January 13, 2004), www.medscape.com/viewarticle/466711_1 (identifying trend number six as healthcare consumerism and "e-health") (on file with the Washington and Lee Law Review).

101. *Id.*

102. IOM REPORT, *supra* note 3, at 19.

103. *Id.*

104. See *id.* at 20 (noting the Health Plan Employer Data and Information Set (HEDIS) of the National Committee for Quality Assurance and the Consumer Assessment of Health Plans (CAHPs) survey from the Agency for Healthcare Research and Quality).

make informed choices and, therefore, disseminate physician information.¹⁰⁵ The commercialization of healthcare has become a reality, a reality that Congress should address by providing consumers with more information to make informed choices.

2. *A Parallel to Commercial Free Speech*

With such a focus on consumerism in the healthcare industry, any information about the product sold—the characteristics of healthcare services and providers—might qualify as commercial speech. As the NPDB contains information about the quality of healthcare providers, the information itself might constitute commercial speech and, as such, receive constitutional protections. Constitutionally protected speech should not be suppressed; therefore, Congress should revise the HCQIA to allow the general public to access pertinent physician information in the NPDB.

a. Commercial Free Speech Generally

In the watershed case of *Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council, Inc.*,¹⁰⁶ the U.S. Supreme Court decided that

105. See *supra* note 24 and accompanying text (naming Massachusetts as the first state to provide the public with standardized physician profiles).

106. *Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council, Inc.*, 425 U.S. 748 (1976). In *Virginia State Board of Pharmacy*, the Supreme Court considered whether the First Amendment protects commercial speech. *Id.* at 760–61. The Virginia statute in dispute stated that any pharmacist who "publish[ed], advertis[ed], or promot[ed], directly or indirectly, in any manner whatsoever any amount, price, fee, premium, discount, rebate or credit terms . . . for any drugs which may be dispensed only by prescription" would be guilty of unprofessional conduct. *Id.* at 749–50. Essentially, the statute prohibited pharmacists from advertising drug prices. *Id.* at 752. Prescription drug consumers, not the pharmacists subject to the regulation, brought the suit arguing that the First Amendment entitled them to information about drug prices. *Id.* at 753–54. The Court recognized important individual and societal interests in advertising prescription drug prices, namely providing money-conscious consumers with information to choose inexpensive drugs and disseminating information to allow consumers to make well-informed decisions. *Id.* at 763–65. The Court also recognized the strong competing justifications for banning prescription drug advertising, especially maintaining the professional nature of the pharmaceutical business and of the pharmaceutical profession. *Id.* at 766–68. The Court noted, however, that the government's justifications boiled down to protecting consumers from the potential dangers of advertising by keeping them in ignorance. *Id.* at 769. The Court emphasized that the First Amendment does not allow a choice "between the dangers of suppressing information, and the dangers of its misuse if it is freely available"—instead, information may not be suppressed. *Id.* at 770. The Court concluded that the First Amendment protects commercial speech—especially commercial speech that is not false or misleading and

commercial speech merits First Amendment protection.¹⁰⁷ In fact, the Court in that case decided that a statute that perpetuated consumer ignorance in healthcare was unconstitutional.¹⁰⁸ Subsequent Supreme Court cases refined the commercial speech protection, including further applications of the protection in the healthcare industry. In *Carey v. Population Services International*,¹⁰⁹ the Court decided that a contraceptive company had standing to bring suit on behalf of its potential customers and determined that a New York statute completely banning the advertisement of contraceptives violated the First Amendment.¹¹⁰ Assuming, for the moment, that the NPDB qualifies as commercial speech, healthcare consumers would have standing to bring a suit challenging federal restrictions on the dissemination of physician information much like the prescription drug consumers in *Virginia State Board of Pharmacy*.

More specifically, the Supreme Court in *Virginia State Board of Pharmacy* suggested that "[i]f there is a right to advertise, there is a reciprocal right to receive the advertising."¹¹¹ The Court in that case emphasized that a

not advertising illegal activity—and affirmed the district court's judgment enjoining the Virginia State Board of Pharmacy from enforcing the statute in question. *Id.* at 771–73.

107. See *id.* at 773 (holding that commercial speech merits First Amendment protection).

108. See *id.* (striking down a Virginia law that prevented informed consumer decisionmaking).

109. *Carey v. Population Servs. Int'l*, 431 U.S. 678 (1977). In *Carey*, the Court considered the constitutionality under the First Amendment of a New York statute that criminalized the distribution of contraceptives to minors, the sale of contraceptives by anyone other than a licensed pharmacist, and the advertisement or display of contraceptives. *Id.* at 681–82. The Court first determined that a contraceptive company had standing to bring suit for itself and on behalf of potential customers who seek access to their product. *Id.* at 683–84. With respect to the restriction on advertising, the Court held the restriction violated the First Amendment. *Id.* at 701–02. The Court protected the dissemination of information about the availability and price of contraceptives by citing its decision in *Virginia State Board of Pharmacy*, which held that a State cannot "completely suppress the dissemination of concededly truthful information about entirely lawful activity" just because the information could be categorized as commercial speech. *Id.* at 700. The Court noted that the New York statute did not prohibit only misleading or deceptive advertisements or the advertisements of illegal activity. *Id.* In fact, the Court noted that the subject of the advertisements—contraception—constituted a zone of personal privacy protected by the Due Process Clause of the 14th Amendment. *Id.* at 684–85. The Court also acknowledged the "'substantial individual and societal interests' in the free flow of commercial information" emphasized in *Virginia State Board of Pharmacy*. *Id.* at 700. Finally, the Court discredited each justification for the restriction suggested by the State, namely to protect the public from offensive or embarrassing advertisements and to prevent legitimizing illicit sexual behavior. *Id.* at 701–02.

110. See *id.* at 683–84 (holding company had standing to bring suit); *id.* at 701–02 (holding New York statute unconstitutional for completely banning the advertisement of contraceptives).

111. *Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council, Inc.*, 425 U.S. 748, 757

public policy interest in allowing money-conscious consumers to choose inexpensive prescription drugs favored advertising drug prices.¹¹² The Court stated:

As to the particular consumer's interest in the free flow of commercial information, that interest may be as keen, if not keener by far, than his interest in the day's most urgent political debate. [Prescription drug consumers'] case in this respect is a convincing one. Those whom the suppression of prescription drug price information hits the hardest are the poor, the sick, and particularly the aged. A disproportionate amount of their income tends to be spent on prescription drugs; yet they are the least able to learn, by shopping from pharmacist to pharmacist, where their scarce dollars are best spent. When drug prices vary as strikingly as they do, information as to who is charging what becomes more than a convenience. It could mean the alleviation of physical pain or the enjoyment of basic necessities.¹¹³

This public interest rationale logically applies to healthcare services, including selecting a competent physician. Healthcare services, like drug prices, are expensive and vary greatly. Consumers have a strong interest in comparing the quality and prices of healthcare services so as to spend their money wisely,¹¹⁴ creating an argument for standing in a case to gain access to more information about various healthcare options.

Furthermore, the Court in *Virginia State Board of Pharmacy* emphasized a strong public interest in making well-informed decisions:

(1976).

112. *Id.* at 764–65.

113. *Id.* at 763–64.

114. *See supra* note 24 and accompanying text (noting that Massachusetts was the first state to make standardized physician profiles available to consumers on the Internet). Massachusetts explains: "The 'Physician Profiles' program is one tool patients can use to make the right health care decisions." *Id.*; *see also* Frances H. Miller, *Illuminating Patient Choice Releasing Physician-Specific Data to the Public*, 8 LOY. CONSUMER L. REV. 125, 126 (1996) (suggesting that competition in any market depends on price and quality). More specifically, customers purchase goods or services at the price and quality combination that will suit their needs and preferences. *Id.* Professor Miller argues that in the market for healthcare services, health insurance eliminates price from consumers' purchasing considerations. *Id.* Thus, consumers must use quality comparisons to determine appropriate healthcare services. *Id.* However, as Professor Miller notes, "patients must possess sufficient factual information to impart some measure of meaning to their choices if their decisions are to constitute anything more than a charade." *Id.*; *see also* Melissa Chiang, *Promoting Patient Safety: Creating a Workable Reporting System*, 18 YALE J. ON REG. 383, 386–87 (2001) (noting that healthcare entities could compete by improving the quality of healthcare services if consumers had accurate and sufficient quality data).

So long as we preserve a predominantly free enterprise economy, the allocation of our resources in large measure will be made through numerous private economic decisions. It is a matter of public interest that those decisions, in the aggregate, be intelligent and well informed. To this end, the free flow of commercial information is indispensable.¹¹⁵

The public interest in making well-informed decisions is most pertinent in healthcare. Any reasonable patient would want to make a well-informed decision when choosing a physician, as patients often follow the advice of physicians without question. A sensible patient would want to assess a physician's malpractice history before surrendering his or her health, well-being, and money carte blanche¹¹⁶ and would have standing under this line of case law to do so.

b. The Central Hudson Test

The argument for consumer standing to bring suit assumed that the information in the NPDB could be classified as commercial speech. But, would it? In *Central Hudson Gas & Electric Corp. v. Public Service Commission of New York*,¹¹⁷ the Supreme Court fine-tuned its commercial

115. *Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council, Inc.*, 425 U.S. 748, 765 (1976) (citation omitted).

116. See Robert Gatter, *Faith, Confidence, and Health Care: Fostering Trust in Medicine Through Law*, 39 WAKE FOREST L. REV. 395, 444–45 (2004) (distinguishing a patient's blind faith in a physician from a patient's rational trust in medicine and concluding that the latter mindset should be embraced by lawmakers in light of "the realities of our market-based health care delivery system").

117. *Cent. Hudson Gas & Elec. Corp. v. Public Serv. Comm'n of N.Y.*, 447 U.S. 557 (1980). In *Central Hudson*, the Court considered the constitutionality under the First Amendment of a New York Public Service Commission regulation banning promotional advertising by electric companies. *Id.* at 558. The Court applied a four-part test, compiled from commercial speech cases, to the regulation. *Id.* at 566. First, the Court noted that Commission conceded that the electric company's promotional advertisements were not inaccurate or relating to unlawful activity. *Id.* Second, the Court noted the Commission's substantial interests in energy conservation and assuring the availability of fair and efficient electricity rates. *Id.* at 568–69. Third, the Court determined that the restriction on promotional advertising would not directly advance the government's interest in the availability of fair and efficient electricity rates because the restriction was too tenuously linked to Central Hudson's rate structure. *Id.* at 569. However, the Court determined that the restriction would directly advance the government's interest in energy conservation because of the direct connection between advertising and demand. *Id.* Fourth, the Court determined that the government's important energy conservation interest did not justify a complete ban on promotional advertising because the ban precluded Central Hudson from advertising services that would divert energy demand to more efficient sources and the Commission failed to demonstrate that restrictions on the advertisements' content would not serve the energy conservation purpose just as well as the complete ban. *Id.* at

speech analysis and developed a four-part test for determining whether the restrictions on commercial speech are constitutional: (1) the speech concerns lawful activity and is not misleading; (2) the asserted government interest is substantial; (3) the regulation directly advances the government interest; and (4) the regulation is not more extensive than necessary to serve the government interest.¹¹⁸

In a recent application of the *Central Hudson* test, the Court in *Thompson v. Western States Medical Center*¹¹⁹ found a Food and Drug Administration Modernization Act of 1997 (FDAMA) prohibition on advertising or promoting particular compounded drugs to be an unconstitutional restriction of commercial speech under the First Amendment.¹²⁰ In assessing the first *Central Hudson* factor, the Court in *Thompson* noted the government's concession that the advertisements in question would not be about unlawful activity and would not be misleading.¹²¹ With respect to the second *Central Hudson* factor, the Court accepted the government's asserted interests behind the challenged FDAMA provision—"preserv[ing] the effectiveness and integrity of the FDCA's new drug approval process and the protection of the public health that it provides" and "preserv[ing] the availability of compounded drugs for those individual patients who, for particularized medical reasons, cannot use commercially available products that have been approved by the FDA"¹²²—as sufficiently compelling.¹²³ The Court recognized that the government needed to draw a line between small-scale compounding, a process

570–71. Consequently, the Court decided that the complete ban on promotional advertising violated the First and Fourteenth Amendments. *Id.* at 571–72.

118. *Id.* at 566.

119. *Thompson v. W. States Med. Ctr.*, 535 U.S. 357 (2002). In *Thompson*, the Court considered the First Amendment implications of Food and Drug Administration Modernization Act of 1997 (FDAMA) Section 127(a), which prohibited advertising or promoting particular compounded drugs. *Id.* at 360. A group of licensed pharmacists specializing in drug compounding brought suit to enjoin the advertising restrictions. *Id.* The Court applied the *Central Hudson* analysis and determined that, while the government had sufficiently compelling interests in preserving the new drug approval process and in preserving the drug compounding process for individuals who cannot use commercial drugs, the advertising restriction was more extensive than necessary to meet those interests. *Id.* at 368–73. The Court noted that the government failed to consider alternatives for drawing the line between small-scale and large-scale drug manufacturing (necessary to determine which drugs should be subject to an extensive approval process) that would be less restrictive on speech. *Id.* at 371–72. Consequently, the Court decided that the FDAMA § 127(a) violated the First Amendment. *Id.* at 377.

120. *See id.* at 377 (holding FDAMA restriction on pharmaceutical advertising unconstitutional).

121. *Id.* at 368.

122. *Id.*

123. *Id.* at 369.

which does not generate enough profit to make a requirement of expensive safety and efficacy testing feasible, and large-scale drug manufacturing, a process that does create enough profit to make extensive testing feasible and necessary, to meet its interests.¹²⁴ The Court accepted the government's argument that the FDAMA provision directly advanced the government's interest by providing a way to draw that line—through the presence or absence of advertising—thus meeting the third prong of the *Central Hudson* test.¹²⁵ The FDAMA provision, however, failed the fourth prong of the *Central Hudson* test, as the Court determined that the government failed to consider alternative means for distinguishing between small-scale and large-scale drug manufacturing that would be less restrictive of speech, such as banning commercial-scale manufacturing or testing equipment, prohibiting pharmacists from providing compounded drug products to commercial businesses for sale, limiting the volume or amount of compounded drugs made or sold, or limiting compounding to responding to prescriptions.¹²⁶ The Court stated that, as a general rule, "if the Government could achieve its interests in a manner that does not restrict speech, or that restricts less speech, the Government must do so."¹²⁷ *Thompson* represents the Court's most recent step in protecting the direct dissemination of medical information to consumers.

c. Classifying the NPDB as Commercial Speech

Classifying the information in the NPDB as constitutionally protected commercial speech does not constitute a typical restriction of commercial speech argument. The *Central Hudson* test generally applies when a government regulation prevents a private actor from releasing information to the public. Here, however, the government both controls the information in the NPDB and restricts dissemination of that information.¹²⁸ Regardless, the important policy interest noted in *Virginia State Board of Pharmacy* and *Thompson* for classifying information as commercial speech—allowing the public to assess the information and make intelligent, well-informed

124. *Id.* at 369–70.

125. *See id.* at 370–71 (noting the government's argument that pharmacists would not need to advertise particular products to meet the individual needs of customers who require compounded drugs, and the advertisement of particular products generally indicates a large-scale production of that product).

126. *See id.* at 372 (listing alternative methods for meeting the government's interest in drawing the line between small-scale and large-scale manufacturing).

127. *Id.* at 371.

128. Special thanks to Professor Jost for pointing out this subtlety.

decisions¹²⁹—supports the argument that the information in the NPDB is protected commercial speech or, at least, analogous to commercial speech. Note that this argument does not suggest that legislative attempts to protect the privacy of patient information are unconstitutional. Rather, the argument is that withholding information vital to consumer choice—physician information—is analogous to restricting commercial speech. Thus, a comparative application of the *Central Hudson* test in a hypothetical lawsuit brought by consumers to gain public access to the NPDB will be informative.

To begin, under the first prong of the *Central Hudson* test, the information that the Health Care Quality Information Act requires the healthcare industry to report to the NPDB, such as physician malpractice information, is not illegal. In fact, the information is freely available to the public in court documents and on many state medical board websites.¹³⁰ The government could argue that physician malpractice information is misleading because ordinary consumers do not understand the complex, and often frivolous, nature of medical malpractice litigation and settlements.¹³¹ However, such an argument would likely fail, as the Supreme Court has recognized the public's interest in acquiring information to make commercial decisions, regardless of the foolishness of the resulting decision.¹³² Moreover, other sources of physician information, such as state or commercially sponsored websites, explain how to interpret the information¹³³ properly, and the Department of Health and Human Services could easily add such explanations and caveats to publicly accessible information.¹³⁴

129. See *Thompson v. W. States Med. Ctr.*, 535 U.S. 357, 366–67 (2002) (referring to the importance of the availability of information to make intelligent, well-informed decisions described in *Virginia State Board of Pharmacy* and noting that "the general rule is that the speaker and the audience, not the government, assess the value of the information presented").

130. See *supra* notes 15–25 and accompanying text (describing current sources of physician information available to the public). *But see generally* Guillermo A. Montero, *If Roth Were a Doctor: Physician Reputation Under the HCQIA*, 30 AM. J.L. & MED. 85 (2004) (arguing that a listing in the NPDB is unconstitutional, as it constitutes a deprivation of a liberty interest in good reputation without due process).

131. See *supra* notes 43–48 and accompanying text (describing the detrimental consequences of releasing medical malpractice information to consumers who do not know how to interpret such information).

132. See *Thompson v. W. States Med. Ctr.*, 535 U.S. 357, 374 (2002) (noting that "[the Supreme Court] ha[s] previously rejected the notion that the Government has an interest in preventing the dissemination of truthful commercial information in order to prevent members of the public from making bad decisions with the information").

133. See *supra* notes 15–25 and accompanying text (explaining information available to the general public, including information available under state law).

134. See *supra* notes 35–39 and accompanying text (describing the failed Patient Protection Act of 2000, which would have opened the NPDB to the public and which would have included provisions to put the information in context: (1) a comparison of the information

Next, under the second and third prongs of the *Central Hudson* analysis, the government does have a compelling interest in encouraging error reporting and would have a good argument that the NPDB access restriction directly serves that interest by preserving confidential error reporting.¹³⁵ However, the availability of such information to the public through various other means would undermine the government's alleged need for strict confidentiality.¹³⁶ In addition, most of the arguments for confidentiality simply assume that the information would be used for medical malpractice litigation¹³⁷ without truly considering the public's legitimate interest in obtaining the information for comparison purposes.

Moreover, the NPDB public-access restriction would likely fail the fourth prong of the *Central Hudson* analysis, as the regulation is more restrictive to speech than necessary to preserve the government's interest in encouraging error reporting. For example, rather than drawing the line at access to physician information, Congress should consider drawing the line at the extent of access to physician information.¹³⁸ Rather than granting the public complete access to the current NPDB, Congress should reconsider granting the public access to centrally compiled positive physician information, such as academic and professional achievements, and negative physician information, such as medical malpractice and disciplinary data. Such access would represent a compromise between the public's interest in easily accessing a centrally compiled source of accurate information to make well-informed healthcare decisions and the government's interest in preserving confidential error

in a physician's profile to the experiences of other physicians in the same specialty in the same state; (2) a statement explaining that physicians who work with high-risk patients are likely to have higher numbers of medical malpractice claims; (3) a statement that certain specialties are more likely to be the subject of litigation; and (4) a statement that "a payment made pursuant to a medical malpractice action or claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician").

135. See *supra* notes 54–85 and accompanying text (explaining the argument that public access to the information in the NPDB would diminish error reporting and, therefore, preclude improving patient safety).

136. See *supra* notes 15–25 and accompanying text (describing the current availability of physician information to the general public).

137. See *supra* note 12 and accompanying text (explaining that a plaintiff's attorney may access the information in the NPDB in limited circumstances anyway); see also *infra* notes 180–85 and accompanying text (casting doubt on the traditional arguments against medical malpractice litigation).

138. As access to the NPDB and the HIPDB are already password-protected, implementing this option should not be excessively difficult. Note, too, that Congress could consider adding medical malpractice liability statistics directly to the NPDB search result page to mitigate confusion in interpreting the information and to allow for more accurate comparisons among doctors.

reporting, such as the reporting of near-misses.¹³⁹ Importantly, while such information is currently available to the public through court documents and state medical board websites,¹⁴⁰ the information is not easily accessible to the average consumer who likely has little time available to wade through court records and fifty-one medical board websites to assess a particular physician's history. Access to physician information that excludes the more sensitive peer review information and includes information on how to interpret the data properly is an alternative method of information dissemination that would be less restrictive to constitutionally protected speech than the system currently in place.

B. Rebutting Other Arguments Opposing Public Access to the NPDB

The arguments against allowing the public to access the information in the NPDB are strong and prevalent. However, another constitutional law consideration casts doubt on some of the traditional arguments against allowing the public to access such information, and a group of scholars has questioned the presumed need for confidential error reporting. In light of any doubt in an area of such importance—patient health and safety—Congress should reconsider revising the HCQIA.

1. Releasing Information About Physicians Generally

Discussions of public access to the information in the NPDB often raise issues of physician privacy, as the database contains embarrassing information that physicians would prefer to keep private—their mistakes and the consequences of those mistakes.¹⁴¹ With reputations at stake, much of the discussion in this section will focus on libel suits. Consider the following scenario—Congress decides to release some of the information in the NPDB to the general public and a physician finds a grossly incorrect medical malpractice settlement listed in his profile. The physician could allege defamation and sue the Department of Health and Human Services for libel,¹⁴² claiming damages

139. Note that this compromise would create a system more analogous to the airline industry's error-reporting system without requiring a complete overhaul.

140. See *supra* notes 15–25 and accompanying text (describing the physician information available to the public under state law).

141. See Berenson, *supra* note 44, at 668 (noting that the profile might even include a criminal conviction).

142. See BLACK'S LAW DICTIONARY 183–84 (2d pocket ed. 2001) (defining defamation as

for harm to his reputation and subsequent loss of business. Furthermore, discussion of public access to the information in the NPDB also raises issues of patient privacy, as disclosure of physician error may include disclosure of confidential information about the injured patient. However, with appropriate protections, modifying the HCQIA to allow the general public to access physician information in the NPDB would not breach physicians' or patients' rights of privacy. The physician information in the NPDB could be disseminated to the public either under the Freedom of Information Act or generally by classifying physicians as "limited public figures" who sell commercial products.

a. Disclosure Under FOIA

The argument that the information in NPDB could be disclosed to the general public through the Freedom of Information Act (FOIA) is not novel.¹⁴³ Under the FOIA, government agencies must make certain information available to the public.¹⁴⁴ However, FOIA exempts certain information from disclosure.¹⁴⁵ As the law presently stands, the information in the NPDB falls under the 5 U.S.C. § 552(b)(3) exception to FOIA¹⁴⁶—dissemination of the information would not be required because the HCQIA prohibits disclosure. Even assuming that Congress eventually grants limited access to the NPDB, the information in the NPDB also could fall under the 5 U.S.C. § 552(b)(6) exception for "files the disclosure of which would constitute a clearly

"the act of harming the reputation of another by making a false statement to a third person" or "a false written or oral statement that damages another's reputation"); *see also id.* at 417 (defining libel as "a defamatory statement expressed in a fixed medium, esp. writing but also a picture, sign, or electronic broadcast").

143. *See, e.g.,* Julie Barker Pape, Note, *Physician Data Banks: The Public's Right to Know Versus the Physician's Right to Privacy*, 66 *FORDHAM L. REV.* 975, 1013–17 (1997) (noting that arguments to release the information in the NPDB to the public under FOIA usually fail).

144. *See* 5 U.S.C. § 552(a) (2000) (listing required agency disclosures).

145. *See id.* § 552(b) (listing the exemptions to FOIA's disclosure requirements); *see also id.* § 552(c) (listing the criminal law enforcement and classified information exclusions to FOIA's disclosure requirements).

146. *Id.* § 552(b)(3) exempts from disclosure matters that are:

[S]pecifically exempted from disclosure by statute (other than section 552b of this title), provided that such statute (A) requires that the matters be withheld from the public in such a manner as to leave no discretion on the issue, or (B) establishes particular criteria for withholding or refers to particular types of matters to be withheld.

unwarranted invasion of personal privacy."¹⁴⁷ In other words, if disclosure of the information in the NPBD would violate personal privacy—either of the patient, of the physician, or of both—the exception would preclude dissemination under FOIA. However, dissemination of such information would not violate patients' or physicians' rights of privacy.

(1). *The Patient's Right of Privacy*

Under *Whalen v. Roe*,¹⁴⁸ the dissemination of information in the NPDB would not compromise a patient's right of privacy. In *Whalen*, the Supreme Court considered the constitutionality of a New York statute that required maintaining a database of patients who receive prescriptions for controlled substances.¹⁴⁹ The plaintiffs in that case—patients who regularly receive prescriptions for controlled substances, physicians who prescribe such drugs, and two physician associations—sued just prior to the statute going into effect.¹⁵⁰ The Court first determined that New York had the authority to create the database, as states have power to experiment with solutions to local problems.¹⁵¹ In addressing the plaintiffs' argument that the database violated patients' privacy, the Court noted that public disclosure of the patient information maintained in the database could occur if New York Health Department officials failed to maintain proper database security; if the information was mishandled as part of a judicial proceeding for a controlled substance violation; or if a patient, doctor, or pharmacist voluntarily disclosed the information.¹⁵² The Court decided that such risks of public disclosure of patient information did not warrant invalidating the New York statute, as such risks either were present without the statute or unnecessarily assumed the misuse of information.¹⁵³ Most notably, the Court found no support in the record "for an assumption that the security provisions of the [New York] statute will be administered improperly" and that "the remote possibility that judicial supervision of

147. See *id.* § 552(b)(6) (exempting from disclosure matters that are "personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy").

148. *Whalen v. Roe*, 429 U.S. 589 (1997).

149. *Id.* at 591.

150. *Id.* at 595.

151. See *id.* at 597–98 (stating that New York's assumption that the database might aid in the enforcement of drug misuse laws and deter potential drug misuse violations was reasonable).

152. *Id.* at 600. The Court noted plaintiffs' concern that such public disclosure of patient information would adversely affect patient reputations and, as a result, deter patients from using medically proper controlled substances. *Id.*

153. *Id.* at 601–02.

the evidentiary use of particular items of stored information will provide inadequate protection against unwarranted disclosures is surely not a sufficient reason for invalidating the entire patient-identification program.¹⁵⁴ The Court also decided that the disclosure of patient information in the normal healthcare setting is "an essential part of modern medical practice," even if such disclosure negatively reflects the patients' character or deters the use of prescribed controlled substances and, therefore, held the statute would not invade the patient's right of privacy.¹⁵⁵ The Court also held that the statute did not violate physicians' right to practice medicine.¹⁵⁶

Under this precedent, limited access to physician information in the NPDB would not violate a patient's right of privacy. As patient-identifying information could be redacted from the portions of the NPDB to which the public would be granted access, disclosure of patient-identifying information would be minimal. The Court's decision in *Whalen* suggests that patients may rely on the Department of Health and Human Services, and any court that may oversee the use of such information in litigation, to enforce the security provisions of the databank. Thus, the patient's right of privacy does not cause the information in the NPDB to fall under the 5 U.S.C. § 552(b)(6) exemption and would not exclude dissemination of physician information under the FOIA.¹⁵⁷

(2). *The Physician's Right of Privacy*

Courts have held that "public figures" often waive the "right" to privacy in the context of defamation and libel proceedings. In *New York Times Co. v. Sullivan*,¹⁵⁸

154. *Id.*

155. *Id.* at 602–04.

156. *Id.* at 604.

157. This Note also argues that the better approach would be to change the provision of the HCQIA to allow the public limited access to the information in the NPDB.

158. *N.Y. Times Co. v. Sullivan*, 376 U.S. 254 (1964). In *New York Times*, the Court addressed the constitutionality of limiting criticism of a public official's conduct. *Id.* at 268. The plaintiff, an elected city commissioner, filed suit against the *New York Times* for publishing inaccurate criticisms of the city police department he ran. *Id.* at 256–58. The plaintiff recovered \$500,000 and his judgment was affirmed by the Alabama Supreme Court. *Id.* at 256. The Supreme Court, however, determined that the libel standard applied by Alabama—allowing a presumption of malice in the determination of general damages—to be unconstitutional under the First and Fourteenth Amendments. *Id.* at 283–84. The Court, therefore, set forth a new federal standard for libel actions involving public officials: the public official must prove that the alleged libelous statement "was made with 'actual malice'—that is, with knowledge that it was false or with reckless disregard of whether it was false or not." *Id.* at 279–80. Under the new standard, the Court determined that the plaintiff did not present evidence of actual malice, reversed the judgment against the *New York Times*, and remanded

the Supreme Court established the following standard for recovery in the defamation action of a public official: "[proof] that the statement was made with 'actual malice'—that is, with knowledge that it was false or with reckless disregard of whether it was false or not."¹⁵⁹ The Court extended the *New York Times Standard* to "public figures," best defined in *Gertz v. Robert Welch, Inc.*,¹⁶⁰ as those people who hold government office, have notorious achievements, vigorously pursue the public's attention, or occupy positions of persuasive power and influence.¹⁶¹ Such decisions suggest that the dissemination of information—even negative information—is useful. In fact, the Court in *New York Times* stated: "criticism of [a public official's] official conduct does not lose its constitutional protection merely because it is effective criticism and hence diminishes their official reputations."¹⁶²

For example, consider the public's interest in obtaining information about the candidates in the 2004 presidential election. As the public trusts the President to address issues immediately impacting their lives,¹⁶³ the public wanted access to as much information as possible in order to make an informed decision. In the election context, dissemination of accurate information is a purely logical and primary concern of each candidate. President Bush and Senator Kerry each established a

the case. *Id.* at 287, 292.

159. *See id.* at 279–80 (creating the federal standard for a public official's recovery in a defamation action).

160. *See Gertz v. Robert Welch, Inc.*, 418 U.S. 323, 352 (1974) (holding that the plaintiff was not a "public figure" in the context of this case and that the *New York Times* standard does not apply to private individuals). The Court in *Gertz* considered whether its *New York Times* standard of proof for defamation actions applies to private individuals. *Id.* at 325. The plaintiff, a lawyer who had represented the family of a young man killed by a police officer, sued a magazine for asserting that the suit against the police officer was part of a Communist campaign against the police and other false information. *Id.* at 325–26. As a defense, the magazine claimed that the lawyer was a public figure and, thus, actual malice would be required to override the constitutional protections of negative press under the *New York Times* standard. *Id.* at 327. The trial court decided that the lawyer was not a public figure to which the *New York Times* standard would apply to protect the magazine's negative discussion of a public issue, the plaintiff did not show that the magazine acted with actual malice, and that judgment should be entered for the magazine. *Id.* at 329–30. The Seventh Circuit affirmed. *Id.* at 330. The Supreme Court, however, held that the *New York Times* standard should not apply to private individuals and remanded the case. *Id.* at 352. In other words, a non-"public figure" plaintiff does not have to prove actual malice in a libel action. *Id.* at 342–43. The Court noted that the greater vulnerability of private individuals to reputation injury, due to a lesser access to open channels of communication than public officials, merited a higher level of protection. *Id.* at 344–45.

161. *See id.* at 342, 345 (defining "public figure"). However, the Court suggested that an individual's status as a public figure might be contextually limited. *Id.* at 352.

162. *N.Y. Times Co. v. Sullivan*, 376 U.S. 254, 273 (1964).

163. At least in theory. Of course, not everyone trusts the president.

website for the very purpose of disseminating such information and fought hard to prevent the dissemination of false information.¹⁶⁴ In addition, neutral third parties established websites that attempted to disseminate unbiased, accurate information about the candidates.¹⁶⁵ The public, too, felt it had a right to receive such information, as the Court in *Gertz* noted:

An individual who decides to seek governmental office must accept certain necessary consequences of that involvement in public affairs. He runs the risk of closer public scrutiny than might otherwise be the case. And society's interest in the officers of the government is not strictly limited to the formal discharge of official duties. . . . [T]he public's interest extends to 'anything which might touch on an official's fitness for office. . . . Few personal attributes are more germane to fitness for office than dishonesty, malfeasance, or improper motivation, even though these characteristics may also affect the official's private character.'¹⁶⁶

In the more recent case of *McIntyre v. Ohio Elections Commission*,¹⁶⁷ the Supreme Court held unconstitutional an Ohio statute prohibiting the distribution

164. See The White House, www.whitehouse.gov/president (containing links to President Bush's biography, current issues, and President Bush's goals for his second term in office) (last visited Dec. 4, 2005) (on file with the Washington and Lee Law Review); see also Friends of John Kerry, Inc., www.johnkerry.com (containing links to biographical information about Senator Kerry and Senator Kerry's vision for America) (last visited Dec. 4, 2005) (on file with the Washington and Lee Law Review).

165. See, e.g., Project Vote Smart, www.vote-smart.org (attempting to provide "abundant, accurate, unbiased and relevant information") (last visited Dec. 4, 2005) (on file with the Washington and Lee Law Review). Project Vote Smart was established in 1992 as a nonpartisan, objective entity to protect voters from political campaign abuses by providing a centrally compiled, free source of accurate information about political candidates and issues. See Project Vote Smart, About Project Vote Smart, http://www.vote-smart.org/program_about_pvs.php (describing Project Vote Smart) (last visited Dec. 4, 2005) (on file with the Washington and Lee Law Review).

166. *Gertz v. Robert Welch, Inc.*, 418 U.S. 323, 344–45 (1974).

167. *McIntyre v. Ohio Elections Comm'n*, 514 U.S. 334 (1995). In *McIntyre*, the Court addressed the constitutionality of an Ohio statute that prohibited the distribution of anonymous campaign materials. *Id.* at 336. Ms. McIntyre had distributed leaflets opposing a school board's proposed tax levy. *Id.* at 337. While some of the leaflets identified McIntyre as the author, other leaflets only identified the views as belonging to "concerned parents and tax payers." *Id.* Under Ohio election law, any political advertising must bear the name of the author. *Id.* at 338. The Ohio Supreme Court affirmed a judgment against McIntyre, holding the Ohio statute valid because the burdens on First Amendment rights were reasonable and nondiscriminatory. *Id.* at 339–40. The Court, however, decided that the decision to remain anonymous is an aspect of the First Amendment's freedom of speech. *Id.* at 342. The Court noted the state's interests in preventing the dissemination of false information during elections, but found that the Ohio statute regulated a broad array of pure speech rather than just fraudulent statements. *Id.* at 349–53. As the Ohio statute failed an exacting scrutiny analysis, the Court held the statute to be unconstitutional. *Id.* at 357.

of anonymous campaign literature. While the *McIntyre* case turned on the constitutionality of allowing the dissemination of anonymously authored political information, the Court addressed the state's interest in the public receiving information about political candidates.¹⁶⁸ In particular, the Court stated: "In a republic where people are sovereign, the ability of the citizenry to make informed choices among candidates for office is essential, for the identities of those who are elected will inevitably shape the course that we follow as a nation."¹⁶⁹

The dissemination of accurate information about healthcare providers is completely analogous to the dissemination of accurate information about political candidates. Just as the public trusts the President to address safety issues, patients trust their doctors to address health issues. Just as the public requests accurate information to make informed political decisions, the public requests accurate information to make informed healthcare decisions. The illogical ending point of the analogy is that while the public has easy access to information concerning individual political candidates, the public does not have access to information concerning individual physicians. Political candidates are quintessential "public figures." The Supreme Court named "occupy[ing] positions of . . . persuasive power and influence" as a characteristic of a "public figure" in *Gertz*.¹⁷⁰ Physicians certainly occupy positions of persuasive power and influence. At the micro level, physicians' everyday decisions impact the health and well-being of individual patients. At the macro level, physicians' decisions, such as research efforts and willingness to use new technology, affect the overall health and well-being of the nation. Thus, if physicians are classified as "public figures" who have waived their "right" to privacy, such as in the context of medical malpractice judgments or licensure proceedings, the 5 U.S.C. § 552(b)(6) exemption of the FOIA would not apply to the information in the NPDB and limited physician information could be disseminated to the public under the FOIA.¹⁷¹

b. Physicians' Services as Commercial Products

A physician has entered the marketplace to sell a product—his services. As has been stressed throughout this Note, consumers need an adequate knowledge base by which to choose a physician. In other words, consumers

168. *See id.* at 349–53 (describing Ohio's interest in the dissemination of truthful information about political candidates).

169. *Id.* at 346–47.

170. *Gertz v. Robert Welch, Inc.*, 418 U.S. 323, 345 (1974).

171. Again, the better solution would be for Congress to amend the HCQIA to allow the public limited access to information in the NPDB.

need information about the product they are purchasing. As with any product, the physician's product has positive and negative attributes—pros and cons the consumer must weigh. The positive aspects of a physician's product include, for example, the knowledge accompanying his medical degree, the experience derived from his years of residency and practice, his time, and his personal skills. The negative aspects of a physician's product include his medical malpractice history and professional sanctions.

Information about both the positive and the negative characteristics of a product helps consumers make informed choices. For example, in *Pegasus v. Reno Newspapers, Inc.*,¹⁷² the Supreme Court of Nevada considered the constitutional protections of negative restaurant reviews,¹⁷³ which provide the public with advice about which restaurants to avoid. The result in the *Pegasus* case—the newspaper ultimately was not liable for publishing allegedly false statements in a review of plaintiffs' restaurant—partially turned on the Court's finding that the statements constituted opinions in the context of the entire review, as the Nevada Supreme Court noted that only statements of facts are actionable as defamation.¹⁷⁴ Admittedly, the statements in the NPDB differ

172. *Pegasus v. Reno Newspapers, Inc.*, 57 P.3d 82 (Nev. 2002). In *Pegasus*, the Nevada Supreme Court considered whether a negative restaurant review constituted defamation. *Id.* at 85. A restaurant critic published a negative review of plaintiffs' Mexican restaurant in a Nevada newspaper. *Id.* Plaintiffs alleged the review contained false statements, such as suggesting that the restaurant served prepared, rather than fresh, guacamole. *Id.* The newspaper claimed that the statements made in the critique were true and, furthermore, constituted a constitutionally protected opinion on a matter of public interest. *Id.* The court's standard for determining whether the newspaper's statements were actionable for defamation was "whether a reasonable person would be likely to understand the remark as an expression of the source's opinion or as a statement of existing fact." *Id.* at 88. Considering the allegedly false statements in the context of the entire restaurant review, the court determined that, while a reader may infer true statements of fact from the review,—that the food served in plaintiffs' restaurant is packaged—the statements constituted the author's opinion that the food was not freshly prepared. *Id.* at 89. As such, the court determined that the statements were not actionable as defamation. *Id.* Furthermore, the court applied the Supreme Court's *New York Times* and *Gertz* standards—a defendant is not liable for damages in a defamation action involving a public official or public figure unless the plaintiff proves actual malice by clear and convincing evidence—to determine that the plaintiffs' restaurant constituted a limited-purpose public figure in the context of restaurant reviews. *Id.* at 90–92. In particular, the court stated that the restaurant was a limited-purpose public figure "because it has voluntarily entered the public spectrum by providing public accommodation and seeking public patrons." *Id.* at 92. In determining that the plaintiff restaurant had not proven actual malice, the court noted that the restaurant failed to show that the newspaper knew its statements in the review were false or seriously doubted the truth of its statements. *Id.* at 92–93.

173. *See id.* at 93–94 (concluding restaurant reviews are not necessarily protected opinions and that restaurants are limited-purpose public figures).

174. *See id.* at 87 (noting that "[s]tatements of opinion cannot be defamatory because there is no such thing as a false idea").

from reviews of the sort the Nevada Supreme Court discussed in *Pegasus*, as the information in the NPDB definitely constitutes statements of fact. Thus, in the scenario contemplated above—Congress has granted limited public access to the information in the NPDB and a physician has found an error in his profile—and with issues of sovereign immunity aside, the physician could bring a defamatory action against the Department of Health and Human Services. However, the *Pegasus* Court also noted: "[r]estaurants and other establishments that actively advertise and seek commercial patronage have been routinely held to be public figures, at least for the limited purpose of consumer reporting on their goods and services."¹⁷⁵ Thus, with respect to reviews of quality, a restaurant meets the limited-purpose public figure definition set forth by the Supreme Court in *Gertz*—holding a voluntary and prominent role in a matter of public concern.¹⁷⁶ Note that the Supreme Court denied certiorari to this case, leaving the decision standing as good law and open to use as persuasive authority.¹⁷⁷ Physicians hold voluntary and prominent roles in an extremely important matter of public concern—quality healthcare. Thus, physicians may qualify as limited-purpose public figures with respect to the dissemination of information regarding the quality of their products, leaving open the possibility of granting the public partial access to the NPDB.

2. *Maintaining Confidential Error Reporting and Deterring Unintended Consequences*

The arguments against granting the public access to the NPDB do not entirely convince several health law scholars. In particular, these scholars have cast doubt on the argument that public access to negative physician information will discourage error reporting, encourage litigation, and, therefore, preclude improving patient safety.¹⁷⁸ Most recently, Professors Hyman and Silver

175. *Id.* at 91–92.

176. *See id.* at 91 (stating the Supreme Court's test from *Gertz* for determining whether a person is a limited public figure as "whether a person's role in a matter of public concern is voluntary and prominent"); *see also supra* note 160 and accompanying text (describing *Gertz*).

177. *Pegasus v. Reno Newspapers, Inc.*, 540 U.S. 817 (2003) (denying writ of certiorari to Supreme Court of Nevada).

178. *See Hyman & Silver, supra* note 55, at 913 (noting that few scholars disagree with the "conventional wisdom"). However, Hyman and Silver also state:

[Professor] Jost writes that "advocates [of the conventional wisdom] do not convincingly explain why health care institutions and professionals will undertake the hard work of looking for and fixing quality of care problems if they no longer have to worry about blame or shame." [Professor] Sage similarly observes that "tort reform is not an intuitive solution to rampant medical error" and that it is

concluded, "[i]t is naïve to think that progress on the patient safety front would occur automatically if the threat of liability were removed."¹⁷⁹ Hyman and Silver note that the literature that criticizes medical malpractice liability rarely cites any authority for good reason: "[n]o statistical study shows an inverse correlation between malpractice exposure and the frequency of error reporting" or an inverse correlation between tort liability and healthcare quality.¹⁸⁰ The professors indicate that the plausibility of the arguments against medical malpractice liability, rather than the actual truth behind them, may have turned the arguments into conventional wisdom.¹⁸¹ In the context of the NPDB, Professors Hyman and Silver's idea suggests that the public has been denied access to physician information as a result of assumptions that such access would have deleterious effects to the healthcare industry. Withholding information that could aid consumers in a critical task—choosing a physician to whom a consumer will trust his or her health and well-being—should be based on more than an assumption. In fact, the professors cite the Harvard Medical Practice Study as empirical evidence that liability may actually improve patient safety by making physicians more careful to avoid malpractice claims—exactly the opposite of the conventional wisdom.¹⁸² The professors also discuss the Veterans Health Administration (VHA) as an example of conventional wisdom failing because VHA medical professionals face no medical malpractice liability individually, yet did not develop a strong error reporting culture *sua sponte*.¹⁸³ Finally, Hyman and Silver suggest that medical malpractice lawsuits are not necessarily horrible, as lawsuits have motivated medical providers to address safety issues, have prompted the creation of the informed consent doctrine, and have encouraged communication about errors.¹⁸⁴ Arguments that

unclear why "the medical profession, which historically criticized lawyers for inventing medical errors where none existed, [should] receive even greater protection from lawyers now that we know errors to be widespread."

Id. (citations omitted); *see also supra* notes 54–85 and accompanying text (describing the push for confidential error reporting to improve patient safety).

179. Hyman & Silver, *supra* note 55, at 991.

180. *Id.* at 914.

181. *Id.*

182. *Id.* at 916–17. While the Harvard Medical Practice Study did not produce statistically strong results, the study found that as the risk of liability increased, the frequency of mistakes and negligence decreased. *Id.* at 916. Also note that the Harvard Medical Practice Study was one of the sources of the startling statistics of medical error in the IOM's Report, described *supra* note 4.

183. *See* Hyman & Silver, *supra* note 55, at 933–34 (suggesting that freedom from medical malpractice liability may not necessarily increase error reporting).

184. *See id.* at 948 (concluding that the "[medical malpractice] liability system is not responsible for the continuing failure of providers to improve health care quality").

cast doubt on conventional wisdom provide justification for Congress to reconsider modifying the HCQIA to allow the public to access certain information in the NPDB.

As noted, some health law scholars have suggested revamping the healthcare industry's error-reporting system to model the error reporting system of the airline industry so as to encourage error reporting and improve patient safety.¹⁸⁵ However, allowing the public to access portions of the NPDB would not necessarily defeat the confidential error-reporting goal. Upon deciding to hire a pilot, a commercial airline has access to that pilot's error history by requiring an FAA license.¹⁸⁶ However, the airlines do not have access to the confidential error-reporting system maintained by NASA. Allowing the public to access certain physician information, such as academic achievements and malpractice information, but not access other information, such as near misses, within the NPDB, would seem to promote a dual system analogous to the airline industry rather than preclude confidential error reporting.¹⁸⁷

3. Federal Regulation of the Healthcare Industry

Healthcare, especially physician licensing, has traditionally been an area of state regulation.¹⁸⁸ Arguably, the NPDB impinges on traditional state regulation.¹⁸⁹ However, that argument is generally irrelevant in light of the plethora of federal healthcare regulations that have superseded traditional state police powers, such as regulations promulgated by the Drug Enforcement

185. See *supra* notes 86–98 and accompanying text (praising the airline industry's error reporting system).

186. See, e.g., Southwest Airlines, Southwest Airlines Flight Operations Department Information for Prospective Pilots, <http://www.southwest.com/careers/pilots.html> (requiring Southwest Airline pilot applicants to hold an FAA Airline Transport Pilot Certificate) (last visited Dec. 4, 2005) (on file with the Washington and Lee Law Review).

187. Restricting access to certain information would be a way to create a dual-system analogous to the airline industry without requiring a complete overhaul of the healthcare industry's present error reporting systems. See also Hyman & Silver, *supra* note 55, at 953 (noting that the safety successes of the airline industry are also attributed to "cookbook" practices—specific pre-flight checklists, routine maintenance guidelines, practice in flight simulators, training programs—that pilots initially interpreted as precluding individual judgment and discretion). Thus, the airline industry has recognized the value of communication and cooperation that members of the healthcare industry have not yet embraced. *Id.* at 954.

188. See *supra* notes 15–25 and accompanying text (describing state regulation of healthcare and physician information available to the general public under state law).

189. See Outterson, *supra* note 20, at 529 (describing the traditional state police power to regulate healthcare, but arguing that state licensing and peer review are "duplicative and unnecessary" in light of the federal NPDB).

Agency and the Food and Drug Administration.¹⁹⁰ In addition, the federal government has a strong interest in regulating the healthcare industry, as a large portion of the federal budget goes to funding federal Medicare and Medicaid programs.¹⁹¹ Finally, from a more theoretical perspective, federal legislation giving the public access to the NPDB does not give the federal government more regulatory power. In fact, such legislation should be considered neutral as to the division of power between federal and state governments and, instead, be viewed as giving individuals more power over the quality of healthcare they receive. Thus, traditional state regulation of the practice of medicine would not preclude Congress from amending the HCQIA to allow the public to access portions of the federal NPDB.

IV. Conclusion

In light of the commercial nature of the healthcare industry, especially the status of physicians as limited public figures selling medical services, Congress should reconsider its refusal to amend the Health Care Quality Improvement Act to allow the public to access physician information in the National Practitioner Data Bank. Most importantly, access to a centrally compiled, accurate source of the positive and negative characteristics of physician services will facilitate intelligent consumer healthcare purchases. Furthermore, the commercial nature of the information in the NPDB suggests that the information is commercial speech entitled to constitutional protections. Allowing the public to access only physician information and not more sensitive error information appropriately balances the public's interest in choosing the best physician and the government's interest in facilitating error reporting to promote patient safety.

190. See *id.* at 538 (concluding that technology—advances in medicine, advances in transportation, and the creation of the Internet—"weakens the presumption that there is something uniquely local about healthcare" and supports an expansion of federal power over healthcare).

191. See, e.g., VICTORIA WACHINO ET AL., KAISER COMMISSION ON MEDICAID AND THE UNINSURED, FINANCING THE MEDICAID PROGRAM: THE MANY ROLES OF FEDERAL AND STATE MATCHING FUNDS 18 (Jan. 2004), <http://www.kff.org/medicaid/7000.cfm> ("Medicaid is by far the single largest form of federal grant support to states, accounting for 43 percent of all federal grant funds to states. . . .").