

PUBLIC ACCESS TO THE NATIONAL PRACTITIONER DATA BANK

HEARINGS BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS OF THE COMMITTEE ON COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED SIXTH CONGRESS SECOND SESSION

MARCH 1, 2000—WHAT CONSUMERS SHOULD KNOW ABOUT THEIR
DOCTORS

MARCH 16, 2000—ASSESSING THE OPERATION OF THE NATIONAL
PRACTITIONER DATA BANK

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WHAT CONSUMERS SHOULD KNOW ABOUT THEIR DOCTORS

WEDNESDAY, MARCH 1, 2000

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:06 a.m., in room 2123, Rayburn House Office Building, Hon. Fred Upton (chairman) presiding.

Members present: Representatives Upton, Bilbray, Ganske, Bryant, Biley (ex officio), Stupak, Green, Strickland, DeGette, and Dingell (ex officio).

Staff present: Charles Symington, majority counsel; Chuck Clapton, majority counsel; Amy Davidge, legislative clerk; Chris Knauer, minority investigator.

Mr. UPTON. Good morning everyone. Let me say that again. Good morning. Welcome to today's hearing by the Oversight and Investigations Subcommittee on the issue of whether or not the National Practitioner Data Bank should be open to the general public.

I want to thank all of our witnesses for agreeing to appear before us today and offer their perspectives on this important and certainly very timely issue.

We are going to hear from two individuals who have had horrific experiences with our health care system, as a consequence of their physicians' incompetence and/or misconduct. No health care system and, particularly one that is touted as offering the most sophisticated, finest quality of care in the world should ever tolerate such conduct or permit such incompetence.

We need to ask some very hard questions this morning. How did our system fail to weed out these doctors? Did the States that licensed them thoroughly investigate them when they applied for licenses? Did the hospitals where they practiced have effective, stringent peer review programs in place and query the Data Bank as required by the law? Do we have all the tools necessary at the State and Federal level to protect patients from incompetent and even criminal doctors?

As these patients' experiences reveal, the question before us this morning should be a much broader one than whether or not we should open up the Data Bank. There is an old saying that has been heard many times before in this committee. Sunshine is the best disinfectant. Well, I say let the sunshine in. We owe it to these individuals and to every American to shine a hard light on our Nation's health care delivery system.

The vast majority of the doctors in this country are able practitioners, dedicated to the welfare of their patients. We owe it to patients and to these doctors to see that the few bad apples are quickly discovered and appropriately disciplined or we will erode patient confidence in all doctors and undermine access to care and quality of care.

I think we all share a common goal here this morning. We want to assure that every American receives high quality health care and that every American can have faith that the doctor who is delivering one's baby or operating on one's child is competent and committed to the patient first.

We also want to give patients access to the information that they need to make informed choices of practitioners. It is important that we debate the implications of opening the Data Bank, but we must not let that debate obscure the need to address the problems in our credentialing and licensing system, which is largely State-based that resulted in the horrible experiences of today's witnesses.

There are no easy answers and I do not pretend to have the end-all solution. This is a complex problem that requires examination of all the various pieces of the puzzle. In this process, we should heed the physicians' oath. First, do no harm. I think we should consider enacting common sense solutions, such as, providing grants to State medical boards to ensure that they have the resources to promptly and professionally review all reports that may warrant disciplinary action.

To more effectively address the issue of physicians crossing State lines and setting up in practice when they lose licenses or face disciplinary action in another State, we should consider giving States incentives to query the National Practitioner Data Bank whenever a physician licensed in another State seeks additional licensure.

I would also like us to look at ways to improve communication between the Medicare professional review organizations and State medical boards and to make sure that Medicaid agencies can and will share information with State medical boards. We need to make sure that HCFA is making sure that its intermediaries are referring cases of apparent unethical practice or unprofessional conduct to State medical boards as well.

I think it would be a good idea if the Drug Enforcement Administration released a monthly report to all State medical and pharmacy boards on all practitioners whose controlled substances have been revoked, surrendered, restricted or denied.

The National Practitioner Data Bank was created by Congress in 1986 in response to several factors, the increasing occurrence of medical malpractice litigation and the need to improve the quality of medical care by increasing the willingness of physicians to participate in diligent peer review programs. The Data Bank Law does this by shielding physicians from liability from antitrust and private damage suits when they're engaged in peer review.

By creating a nationwide flagging system, the Bank was designed to address the problem of physicians who lose their licenses or face other discipline in one State by simply moving to another State to practice. From its inception, the Data Bank was intended to be an additional tool for States and hospitals and other health

care providers engaged in credentialing decisions, not as a tool for use by the general public in evaluating physician competence.

The malpractice information in the Bank, for example, could be quite misleading to those not trained in its interpretation. The number and even the size of malpractice payments may not necessarily indicate a doctor's competence. Insurance companies often settle out of court rather than go to trial, even though there is compelling evidence that the physician's care was appropriate.

Doctors who take on the toughest cases because they are highly skilled may have more malpractice suits than others in their field. Doctors who are in high risk fields, such as, obstetrics, neurology, may face more suits than their peers in other areas of medicines. Doctors who are engaged in cutting edge clinical research to develop and perfect what will be tomorrow's routine standard of care may also have higher rates of malpractice suits.

Opening the Data Bank to the public, including trial lawyers, could discourage doctors from going into high risk fields of medicine, from delivering babies as part of a family practice or from engaging in clinical research. These are outcomes that will reduce not enhance access to care and quality of care, both now as well as in the future.

In the 1999 report, the President's Quality Committee, it noted that current systems to improve the quality of care tend to focus too much on individual practitioners and not enough on system problems. That was brought home in a very dramatic way by the Institute of Medicine's report on Building a Safer Health Care System: *To Err is Human*.

This report came to the startling conclusion that, anywhere from 44,000 to 98,000 folks die every year as a result of medical errors caused largely by failures or glitches in systems of care. The report notes that, more people die from medical errors in a given year than from motor vehicle accidents, AIDS or breast cancer. The report notes that, our systems of care are complex, decentralized and fragmented.

One study found that, an intensive care patient may have as many as 178 different tasks performed on them by medical personnel in a single day. What would seem to be the very straightforward task of getting a drug to a patient actually involves six different activities: the doctor making a decision on which drug to use; the doctor ordering it; usually in the form of a handwritten prescription; the pharmacist dispensing the drug; the aide transporting it to the patient; and, finally, a nurse who actually administers it. An error, potentially fatal, could occur in the execution of any one of those steps.

The report's major recommendation for correcting these problems in the system is reporting of errors, both serious errors resulting in death or serious harm as well as less serious errors or near misses that, if uncaught, could have resulted in serious harm. The report notes that, the effective reporting programs require the fostering of a climate that encourages individuals to come forward and report errors, rather than covering up out of fear of individual punishment or liability suits.

The IOM report recommended a nationwide, mandatory system for reporting serious errors, with public disclosure and a voluntary

reporting system for less serious errors that would be protected from public disclosure as well as litigation. However, the Agency for Health Care Research and Quality, in its review of the report, came down against any mandatory reporting requirement, finding that it could make matters worse and that, allowing disclosure of hospitals in practitioners' names would be counter-productive.

I agree with the Agency for Health Care Research and Quality and with the White House, which has adopted the agency's position. This goes to the heart of my concern about opening up the National Practitioner Data Bank to the general public. When we created the Bank, we assured doctors that we would not open up the Bank to the general public, because the information requires both interpretation and because it could result in an explosion of malpractice suits.

If we break this commitment, how can we expect doctors and other health care providers to trust us when we tell them if they come forward and report errors that they will not be singled out for punishment or be opening themselves up to malpractice suits? If we want to correct this serious problem in our health care delivery system that undermines quality of care for tens of thousands of Americans every year and if we agree that confidential, voluntary reporting systems are the key to fixing our health care systems, then we had better think very carefully about the message we will be sending if we open this Bank up to the public.

I yield to my friend, Mr. Stupak.

Mr. STUPAK. Well, thank you, Mr. Chairman and thank you for yielding.

This hearing will allow us to explore and raise some very interesting questions regarding the information available to patients about their doctors. I believe that patient should have access to reasonable and reliable information about physicians, collected by the government, to improve their abilities to choose a physician to provide quality care.

However, Mr. Chairman, I am very concerned about press reports that this hearing is in retribution by members of the majority for the American Medical Association's support of a real patients' bill of rights. I certainly do not believe that this subcommittee should be used as an instrument of retaliation for political agendas. I hope this is not the case.

Putting aside the motivation for this hearing, I believe this hearing will raise a number of very interesting questions. Members of the public have a right to accurate, relevant information about their health care providers. If the Federal Government collects accurate and relevant information about health care providers, we should seriously consider whether or not it should be made available to the public.

Currently the National Practitioners' Data base collects data about physicians, medical practice liability, adverse disciplinary actions taken by State medical and dental boards, suspensions of clinical privileges by hospitals, sanctions by professional societies, exclusion from participating in Medicare and Medicaid, an action taken by the Drug Enforcement Agency, DEA. Access to the National Practitioner Data base is not available to the general public.

It is restricted to health care entities and physicians, seeking their own information.

Before we open up the National Practitioners' Data base to the general public, we should ensure that the information is accurate and relevant to the patient's choice of a doctor. I am concerned that some of the reported categories may not have the required level of accuracy. Any reported action should ensure that the due process rights of the practitioners have been followed. In addition, the categories should provide information that are reliable indicators of medical quality.

Clearly, any action by a Federal or State agency have constitutional procedure requirements. Thus, the categories reported by the NPD that require State action, seem to meet the accuracy requirement. On the other hand, an adverse action by a hospital by a physician, may not follow procedural safeguards to insure the action was brought in good faith and followed a proper procedure.

In addition, there is a second data base called a Health Care Integrity and Protection Data Bank. It is pronounced HIPTB. HIPTB reports only adverse final actions brought by State and governmental agencies against practitioners. All the reporting categories provide information only after a governmental agency has taken action against a provider. I would be interested to know whether the information in HIPTB should be made available to the public.

I look forward to the hearing, the witnesses, their views on what information, if any, should be made available from the NPD or the HIPTB. With that, Mr. Chairman, I yield back and thank you for the time.

Mr. UPTON. I yield to the committee chair, the Commerce Committee Chair, Mr. Bliley.

Chairman BLILEY. Thank you, Chairman Upton and thank you for holding this hearing, so that the committee can explore an increasingly important issue facing health care consumers today, access to quality information about the doctors to whom they entrust their lives and those of their children.

The United States is blessed with the best doctors and the finest health care in the world. However, as we have moved away from a health care model in which physicians were well known by their patients to a more complex system of managed care, HMOs and layers of specialists, patients now may choose a doctor from a list of health care providers about whom they know very little.

As a result, the general public now has a greater need for access to quality, comparative information about doctors practicing in their community. As we all know, knowledge is power. When consumers have accurate information, they are able to make sound health care choices, but to date, most patients have not been able to gain access to important information about their doctors' malpractice or disciplinary histories from any single source, even though taxpayers have established a source for this information. That is unacceptable.

Today I want to empower patients by giving them the keys to this locked national data base. The National Practitioner Data Bank, a clearing house of information concerning doctor malpractice and disciplinary histories, has been operating pursuant to congressional mandate since 1990, but for reasons that have not

withstood the test of time, the critical information in this Data Bank has not been available to the general public for the past 10 years.

Back then, the idea was that patients would be protected from bad doctors by self-reporting and self-policing among the health care providers. After too many tragedies over the past 10 years, we now know that patients remain prey to certain highly questionable doctors. We will hear today that patients are suffering serious injury and sometimes even death due to a very small number of problem doctors, doctors who had numerous reports in the Data Bank, but nonetheless, continued to be licensed by State medical boards and hired by hospitals to care for patients.

For example, there is one doctor in the Data Bank with a history of almost 300 malpractice payments. There's a box right over here that contains it. I say that his patients had a right to know about this history before seeking his care.

I believe now is the time to open the Data Bank to the public. It is unconscionable that consumers have more comparative information about the used car they purchase or the snack foods they eat than they have about the doctor who has a history of malpractice sanction, even though we entrust their care to these doctors and enough information about a doctor's prior criminal convictions is not presently reported to the National Data Bank.

I believe it should be available to consumers in the same manner.

The arguments of those opposed to public access, such as, the American Medical Association, do not make sense. They argue that the information reported to the Data Bank is not detailed enough to be useful. They say that consumers will misunderstand it.

I submit to you, those are reasons for improving the Data Bank, not keeping it under lock and key.

They also make a valid case that, not all malpractice settlements reflect poor quality of care, but many other malpractice cases do reflect poor medical care. Certainly, an extreme history of malpractice is cause for concern. Can the AMA or other opponents of public access really look Dr. Liana Gedz or Anderson Smart in the eye and tell them, that the next time they choose a physician, they still should not be allowed to view the critical information about doctors that the Federal Government already collects in the Data Bank.

We also know that public access to this type of information works and without the ill effects predicted by some. A few States, through physician profiles legislation, already have taken positive steps to provide consumers with information about doctors practicing within their jurisdiction. These efforts are impressive and I believe they can serve as a model for using the information currently in the National Data Bank and improving upon it as necessary.

The testimony we will hear today also will raise serious questions about how well State licensing boards and hospitals screen, investigate and discipline doctors. While it is clear that States must do a better job in protecting patients from dangerous doctors, I firmly believe that State laws will not alone solve this problem, given the demonstrated ability of questionable doctors to move from State to State and slip through the regulatory cracks.

With a National Data Bank, we have a unique opportunity to assist the States with their initiative, to offer consumers one central source of information and to give patients in those States that have not passed physician history legislation access to information about their doctors. We should seize this opportunity. It is sound public policy. Given the remarkable growth of and advances of Internet communication, it is very easy.

We now have the ability to give the public with the click of a button access to critical information about their doctors—days, hours or even minutes before an appointment. How can we not do so? I reject the claim that consumers cannot be trusted to understand and use this information. I do not believe that patients should have to rely solely on State medical boards or hospitals to make such critical health care decisions for them.

Today's hearing also reflects the committees larger focus this year on patient safety issues. I believe that public access to the National Practitioner Data Bank may be one of the best and quickest ways to improve patient safety. The sunshine of disclosure, coupled with the pressures of an efficient and competitive marketplace of informed consumers will help to weed out the few bad apples and insure a safer health care system for all patients.

I would like to thank all the witnesses appearing before the committee today and I look forward to hearing their testimony.

Thank you, Mr. Chairman.

Mr. UPTON. Thank you, Mr. Chairman.

I now recognize a ranking member of the full committee from the great State of Michigan, Mr. Dingell.

Mr. DINGELL. Mr. Chairman, I thank you. Good morning to you and good morning to my colleagues and to the witnesses.

I want to say that, this is a very important hearing. The subject of protecting consumers from sub-standard medicine and from dangerous doctors who do not provide the highest quality of care is a serious one. It needs careful, thoughtful and serious consideration. Giving the consumer the ability to make more informed choices when selecting a doctor is also extremely important. Seeing to it that the consumer has the tools that are necessary to do that well and intelligently and seeing that he has truthful information is, of course, a matter of the highest urgency and importance.

Our goal here should be to make medicine safer and empower consumers further. I hope this hearing will assess the various approaches to accomplishing these goals and demonstrate why some choices are more useful or better than others. We need to look at all the options before us, find out what is good, find out what is bad, find out what protects the consumer, find out what empowers the consumer, but find out also what gives the consumer truthful and adequate information to make proper judgments.

Mr. Chairman, the practice of medicine is regulated by the States. To that end, they decide who should and who should not get a license, who should continue practicing. They also decide who remains competent and who should be allowed to continue that practice. The States have established these regulatory systems to protect consumers, with little intervention by the Federal Government.

Nevertheless, as our witnesses will demonstrate today, sometimes dangerous doctors who should not practice, do practice and often with little or no intervention by the State's authorities. Why? Do we know? What can and what should be done?

There is also a question of then whether we grant public access to the National Practitioner Data Bank. To answer that question, we first have to address a number of other questions, one of which is the first and, that is, there are certain fields of discrete data collected by the Data Bank that, if released, could help the public make more informed choices when selecting a doctor.

Now, I call on my colleagues and everybody else to remember. Patients have very important rights here. They need to know these things to assure they receive proper care. But so also do the doctors, whose reputations and good names are their most precious possessions. This raises then questions about the reliability of the input into the National Data Bank.

Is it going to provide the necessary information the patient needs? Is it going to consider the rights of the doctor to be fairly treated and to have his or her good name properly protected?

Second, are the present methods used to collect such data thorough enough and consistent enough to allow it to be used as a public tool in rejecting or selecting doctors? Doctors need this; patients need this. The system requires it.

Finally, can we define precisely what problems we are attempting to solve by opening the Data Bank to the public? Again, is the Data Bank an adequate tool for a fair appraisal of the doctor's capability on the part of the patient and also a fair appraisal of the doctor's capability with regard to the doctor himself? Is he being properly treated here?

Whatever decisions we make, we must improve patient safety and not merely make a symbolic gesture toward that goal or a symbolic effort to punish anyone. Remember, we may very well wind up, if we are careless, protecting wrongdoing and punishing innocent practitioners because of slovenly data base management and input. Let's address that then the first question.

Any data released from the National Practitioner Data Bank should help the consumer make better choices. In other words, the data must be a solid predictor of doctor quality. For example, when a doctor has his or her license revoked or suspended by a particular State or when a doctor is convicted of a criminal offense, patients can infer some degree of doctor quality because the State authority has taken a specific action against a practitioner relating to medical competency.

But not all data is this useful. Let's consider, for example, the Data Bank's collection of malpractice claims and settlements. Now, there are many variations on how these claims can be made and settled. This data cannot readily predict physician competency. For example, some States do not limit malpractice damage awards; others do. Of those that do, a range exists from one State to another. The obvious problem with data aggregated from these many sources is, that it is subject to significant predictive error. You are assembling a large body of statements which may or may not relate one to the other, or be interpreted fairly or properly together.

If Dr. "A" settles a suit for 50,000, is he more or less competent than Dr. "B," who settles a claim for \$25,000 in another State? Ask yourself, does this settlement mean that the doctor had done something wrong. The settlement doesn't tell you that.

Let's assume that Dr. "C" has two suits, each for 10,000. Is that doctor more competent or twice as incompetent as Dr. "B." Again, the question of the settlement. Does it signify, in fact, that this doctor is less than competent or that the claim was a valid one or was settled simply because it cost too much to fight out in court?

Certain specialties have medical procedures prone to greater risks than other specialties and thus, are more likely to attract litigation. Should a particular doctor specializing in high risk procedures be judged against doctors specializing in lower risk procedures or in different medical disciplines?

What about doctors who have more than one specialty? Can we control for such variations? If so, how? Finally, many claims against doctors are settled by the insurance companies, because as I have pointed out earlier, that is cheaper than litigation and insurance companies often times compel doctors to settle to save money for the insurance companies. In such a case, then, the doctor has little or no input as to whether litigation should be carried forward and the question of how the doctor's good name should be protected under these conditions.

Such claims do not necessarily indicate physician incompetence, although they could, but rather, they are business decisions. The question is, are they business decisions by lawyers, insurance companies or doctors? What does this tell you about the particular case in question?

The point then is this. Before we agree that any category of information should be released, we have to be sure that the data will allow the consumer to make better choices, that it is reliable data, that it, in fact, constitutes good information when properly assembled, and that the end result is, that the consumer makes fair and better choices.

We also have to see to it, again, that the good name of the doctor is properly protected, because here is a rich opportunity for significantly hurting the good name of a professional person whose good name is really all that he has.

There are other significant problems with the National Practitioner Data Bank as it currently stands. Before the public can use it as a valuable tool to select their doctors, we must improve collection consistency. There is ample evidence that these entities required to report to the National Practitioner Data Bank have not done so on a consistent or regular basis. There are considerable variations across States amongst providers, such as, hospitals regarding reporting frequency.

In fact, it was reported in the 1999 National Practitioner Data Bank executive meeting that, as many as 60 percent of all hospitals, at the time of that session, had yet to file a single adverse action report to the Data Bank. What then does this mean? I don't know and I don't think anybody else does. I do know that it does not clearly support the argument that the National Practitioner Data Bank is a uniform or fully reliable repository of data and facts.

Certainly, if we want the Data Bank to be improved as a consumer tool, these areas need significant improvement. I remind the subcommittee that it was always intended that the information contained in the repository would be considered together with other relevant data in evaluating a practitioner's credentials for this precise reason. Incomplete data on bad doctors could be dangerous if it led to a consumer falsely concluding on the basis of the information presented to him that a doctor was safe if he or she was, in fact, not.

Similarly, it would be unfair to lead a consumer to falsely conclude that a doctor was safe if he or she were fully competent because we have required release of data and information which, again, does not correctly inform the consumer of the facts and, again, protect the concerns of the legitimate practitioners of medicine.

Finally, patients have a right to expect State authorities to do their jobs properly by finding and removing dangerous and incompetent practitioners. This is a responsibility of the States, under their licensing authority and it needs to be exercised properly. If, indeed, that is done, much less need exist for other kinds of judgments that will have to be made.

We need to determine if States are failing to do this and if so, why. Opening the National Practitioner Data Bank addresses only the symptoms of a much deeper problem and one in which the patient has, at best, limited ability to make a real wise and informed medical decision on the care that he or she is receiving or would receive.

Mr. Chairman, my mind is open regarding ways in which to make the National Practitioner Data Bank more useful to consumers. Certainly, that is an important step that this subcommittee can take and should indeed do. Any foray into this matter should be done with care and should be done in close consultation with both the consumers and the provider community to make sure that our action is wise and does credit to this committee, to consumers, and to practitioners of medicine. A perfunctory approach could cause more consumer harm than good and probably will.

Mr. Chairman, I have one last concern, which I express to you today. Just days after the House passed the Patients' Bill of Rights by an overwhelming bipartisan vote, with an enthusiastic endorsement of doctors and over the vehement objections of my good friends in the Republican leadership, the prospects of hearing an action on the National Practitioner Data Bank was explicitly linked to retaliation against the American Medical Association and other practitioner groups for their support of the Norwood-Dingell bill.

I would read here something from Roll Call on October 21, 1999. I hope that these hearings will rebut the statement that I read at this time.

"In a move that several Republicans said is pay back for the American Medical Association's position on HMO reform legislation, Commerce Chairman, Tom Bliley, (R) VA, wants to make public a sealed data base that holds the names of all doctors sued for malpractice. They teamed up with trial lawyers on HMO reform after all we did for them." This is a quote. "That is pretty much

Bliley's beef," continuing the quote, "said a senior GOP source familiar with the situation. A GOP official said that Representative Fred Upton, who chairs the Commerce Committee on Oversight and Investigations, is uneasy with the idea of holding hearings on a topic that will be viewed as retaliation against the AMA."

I certainly understand that our chairman today does feel those sensitivities and I commend him for it. I know that as this matter goes forward, he will assure that this proceeding is conducted fairly and perhaps we are finding that my dear friend, the chairman, has been erroneously quoted on these matters and that we will look to both achieve a correct determination of how we should proceed and how to protect the patient's right to know and also how to protect in the fairest possible fashion the good names and the reputations of medical practitioners who are out there trying to serve their patients.

I hope that this will not be seen then as an effort to intimidate doctors because of their support of patients' rights or an attempt to delay meaningful and enforceable reforms in managed care. These are significant issues that are worthy of careful and constructive attention. I hope that all my colleagues on the committee, patients, the other providers, and the Nation's doctors will be able to work together with us in a harmonious fashion to address these and other concerns which are legitimately raised in this hearing this morning.

Thank you, Mr. Chairman.

Mr. UPTON. Thank you and the gentleman's time has expired.

I just want to say that, this hearing, as all hearings, will be conducted in a very fair, thoughtful and reasonable way. With that, I yield to the gentleman from Iowa, Dr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman. I will be even more brief, otherwise Senator Wyden's finger will be healed by the time we get to his testimony.

Rumors are rife on Capitol Hill that the motivating factor behind these hearings is to poke a stick in the eye of the American Medical Association for bucking the Republican leadership in Congress on backing a strong patient bill of rights. I'm not going to comment on that. The statements that have been read already allude to that.

I would say this to the provider groups. This is an opportunity, in my opinion, to bring up some of the problems that we have seen in the National Practitioner Data Bank. The testimony by the physicians and the hospitals and the others that have to deal with this will point out some real inequities as well as inadequacies in the National Practitioner Data Bank. So, I welcome these hearings, whatever the motivation was behind those who chose to have them, because I think that this offers an opportunity to improve the system, both for consumers and for the practitioners.

Many physicians work with patients that suffer from very debilitating or life-threatening conditions that require high risk treatments or procedures, such as, open heart surgery or brain surgery. Both of these high risk areas have been noted by Chairman Bliley and Ranking Member Dingell.

Well, in my prior life, before being a congressman, I was a physician who did high risk procedures. Let me give you an example.

As a reconstructive surgeon, I took care of a gentleman who was involved in an automobile accident. He and a friend were riding along in a car. His friend reached over to put a cassette in. The car veered and went through a barrier—and a steel rail came through the windshield, right through the left side of the head of my patient and he lost a lot of his brain on that side as well as almost his entire skull on the left side of his head. This left him with a tremendous defect there. He couldn't go out in public. Yet, he was amazingly functional. He was certainly aware of this tremendous deficit and how if he would go to a grocery store, people would just look at him. He couldn't go out in public.

So, I did a procedure in which I took bone from other parts of his skull, bone from his ribs, bone from his hip, wired it all together, carved it, molded it and created a new skull for him. This was a high risk procedure. I mean, the risk of complication when you're operating around the residual brain, going in through the dura, having your reconstruction fall apart, cave in and ending up with a big infection, losing all the bone, whatever, the risk is significant when you take on procedures like that.

Yet, what we have is, a Data Bank which, in my opinion, does not provide a fair and objective medium for public review of information that takes into account the inherent risks associated with those high risk procedures. So, as I said before, I am glad we are having this discussion today. I think we are going to have some interesting testimony that points out some serious, serious deficiencies in the National Practitioner Data Bank.

Last year, the President's Quality Committee released its final report on improving and sustaining the quality of health care, in which it considered and rejected open access to Data Bank information to improve quality because, this is a quote from the President's Quality Committee. On opening up the Data Bank they said, "evidence shows that consumers have a tendency to perceive risks inaccurately."

The information available in the Data Bank is misleading for a lay person, untrained in the complexities of high risk operations like the ones that I took care of. We need to address that issue.

Finally, Mr. Chairman, I ask unanimous consent to enter into the record the statement by Congressman Norwood, who could not be here today. I want to just read a portion of his statement, because with characteristic reserve, Dr. Norwood states: Yet here we are today considering the idea that making the National Practitioner Data Bank public will help improve health care quality.

As I said, with characteristic reserve Congressman Norwood continues: It is an asinine idea that just makes no sense to me. The problem with this approach are twofold. First, it attaches a level of sophistication to the National Practitioner Data Bank that is just not appropriate. Second, it ignores State-based approaches that make more sense and are already in place today.

Mr. Chairman, I look forward to the hearing. I look forward to hearing from Senator Wyden and thank you for having this hearing.

Mr. UPTON. Thank you.

Without objection, his statement will be made part of the record. In fact, all members of the subcommittee statements will be made part of the record.

[The prepared statement of Hon. Charlie Norwood follows:]

PREPARED STATEMENT OF HON. CHARLIE NORWOOD, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF GEORGIA

I would like to express my debt of gratitude to the Chairman for allowing me to submit my statement for the record. Although I do not sit on the Oversight and Investigations Subcommittee, I feel it is very important for me to participate in this hearing. I appreciate my friend, Dr. Ganske, submitting this statement for the record.

It is my view that the practice of medicine is local. I have made this view known in many forums over the past several years. When I was a practicing dentist, I was licensed by the state of Georgia, practiced in my local Augusta community, and was subject to the medical malpractice laws of Georgia. In trying to address quality of care issues, it has always been my preference that we consider state and local approaches rather than federal cookie-cutter approaches.

Yet here we are today considering the idea that making the National Practitioners Data Bank (NPDB) public will help improve health-care quality. It is an asinine idea that just makes no sense to me. The problems with this approach are twofold. First, it attaches a level of sophistication to the NPDB that is just not appropriate. Second, it ignores state-based approaches that make much more sense and are already in place today.

The problems with releasing the NPDB are well documented. The NPDB is simply gathered information. It shows no context. Information does not in anyway explain the conditions behind judgments made in specific cases. As my colleagues Dr. Coburn and Dr. Ganske will attest, simply saying whether a judgment was rendered hides the incredibly complex decisions that doctors make in every case.

It was never the intent of Congress that the NPDB be made public. The Committee Reports written by this very committee in 1986 make clear that information in the NPDB should only be available to those who understand its' meaning and are charged with making decisions about professional conduct.

States and their medical licensing boards are making tremendous strides in holding physicians accountable. Thirty states have responded to interest for information about physicians and other health care practitioners. Twelve states have enacted laws that mandate the provision to consumers of information about physicians who practice medicine within those states.

I strongly believe that state medical licensing boards should have the primary role on governing the practice of medicine. In many states, the state legislatures and state medical boards are working together to proactively create a stronger role for licensing boards. They are using the Internet, in many cases, to put important physician information on the web for consumers to be able to review.

We should also look to the Federation of State Medical Boards as the appropriate venue for sharing information. Though underfunded, they are the appropriate, private-sector mechanism to share information among and between states regarding physician profiling.

If there is a doctor out there who is incompetent or unethical, we need a system that identifies them and makes sure the public is adequately protected. We need to use organizations like the Federation of State Medical Boards to move information across state borders. Simply opening up the NPDB is a bad idea that will do nothing to improve quality of care. I hope that we will look to the states to build on existing processes to address the quality of care patients receive.

Mr. UPTON. Mr. Green?

Mr. GREEN. Thank you, Mr. Chairman. And, again, I appreciate your calling this hearing and look forward to the testimony. Hopefully, we will be able to deal with the issues in its entirety, instead of using it as a response to other legislation that this house had considered.

Hopefully, our patients will have as much information as possible about their health care providers and allow them to make an informed and intelligent decision about their health care. I think, as a community and our country, we share that. And so I hope that

this subcommittee hearing, will be able to expand on that. Thank you.

Mr. UPTON. Thank you, Mr. Green.

I note that Senator Wyden has an amendment on the floor at some point this morning. If we could try to do a better job, all of us, in limiting our opening remarks, I know it will make him a lot more comfortable.

Mr. Bryant?

Mr. GREEN. I could not be any shorter, Mr. Chairman.

Mr. UPTON. You did a good job. You get kudos, extra credit at the end of the day.

Mr. GREEN. Oh, okay. Thank you.

Panel four.

Mr. GREEN. I need that star.

Mr. BRYANT. Thank you, Mr. Chairman. Out of respect to the Senator, I know we have been asked to keep our opening statements short, and I know a lot has been said, but there are instances where people talk, and talk and talk in their opening statements and say things I think that have to be answered, and this whole issue of politics, and I realize I am in Washington, and I have not been up here as long as some people have been up here, but this is a good hearing. And there is an absolute necessity and need to have this type of discussion in Washington. And I think to attribute this to political motives and stick in somebody's eye I think lowers the level of this issue, brings this hearing down I think, and I hope that wasn't the intent. Because I think we have the potential in this hearing, based on the panels that I have seen, to really garner some outstanding information and some outstanding insight on this very important issue.

So to try to denigrate it and call this just a political act of retribution I think is unfair to this subcommittee and to the chairman of this subcommittee, and to the interests that will be discussed by this very qualified group of witnesses today.

This is the Information Age, not everything should be disclosed. There are good reasons a lot of times when you don't want disclosure. And I think that is what I welcome today and want to hear from people like the doctors. The hospital association, AHA, I think has made an excellent statement. I look forward to hearing more about their reasons that deal with the openness and continued validity, usefulness of peer review if you get into disclosing who is rating who and who is talking about who.

The issue of context I think is a very important issue, that any information, as Dr. Norwood's statement that Dr. Ganske read said, the sophistication level out there of people to understand this is a reality. Without discrediting anybody, that is a reality, and there has to be a context, in a way, put around this information to explain that.

I come from a background of representing doctors in malpractice cases, and I understand the issues of settlement, sometimes why you settle cases and sometimes why lawsuits are filed and frivolous lawsuits, together with some very meritorious lawsuits, I might add, that probably do need to have a public airing out there.

I think I want to commend those that have offered bills in this area and that will, I understand our subcommittee chairman has

a bill that he will offer, I think the more that we can debate this issue and get the right type of quality information out there for consumers to make those decisions, the better off we are.

I do want to commend what the State of Tennessee has done, my home State. It has, with the help of doctors, and hospitals, and consumers, come up with a balanced approach to this. In fact, I have a copy of such a listing of a doctor, who I understand we can use this and I would like to submit it for the record, that goes through the doctor and lists the academic background, and certifications, and the appointments and staff privileges, the disciplinarian actions, any criminal offenses, any liability claims, and this was, again, done with the cooperation of the medical profession and those on the other side. So it can be done, I think, in an effective way, and I will submit this for the record.

[The information referred to follows:]

Health Care Professions													
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<p>This practitioner currently participates in the following <i>TennCare</i> plans:</p> <p>BLUE CARE</p>					
<p>FINAL DISCIPLINARY ACTION</p> <p>None Reported</p>					
<p>CRIMINAL OFFENSES</p> <p>None Reported</p>					
<p>LIABILITY CLAIMS</p> <p>Some studies have shown that there is no significant correlation between malpractice history and a doctor's competence. At the same time, the Legislature believes that consumers should have access to malpractice information. In these profiles, the Department has given you information about both the malpractice history of the physician's specialty and the physician's history of payments. The Legislature has placed payment amounts into three statistical categories: below average, average, and above average. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high quality care by selecting a doctor based solely on malpractice history.</p> <p>When considering malpractice data, please keep in mind:</p> <ul style="list-style-type: none"> • Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares doctors only to the members of their specialty, not to all doctors, in order to make individual doctor's history more meaningful. • The incident causing the malpractice claim may have happened years before a payment is finally made. Sometimes, it takes a long time for a malpractice lawsuit to move through the legal system. • Some doctors work primarily with high risk patients. These doctors may have malpractice histories that are higher than average because they specialize in cases or patients who are at very high risk for problems. • Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the provider. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred. <p>You may wish to discuss information provided in this report, and malpractice generally, with your doctor. The Department can refer you to other articles on this subject.</p> <p>The Health Department started getting reports for claims paid after May, 1998.</p>					
<p>None Reported</p> <p>Settlements valued below \$75,000 are not included here.</p>					
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Mr. GREEN. I think one other issue I would like to hear some testimony on today, some explanation, because I do kind of like the State-by-State issue, although there is a Federal level, a Federal bill here that would Federalize a lot of this. And I am getting wound up here, so I will stop right now, in deference to our Senator, and yield back the balance of my time.

Mr. UPTON. Thank you.

The gentleman from California, Mr. Bilbray?

Mr. BILBRAY. Mr. Chairman, I appreciate the chance to participate in this hearing, and I thank you for calling it. Let me just say that being the last speaker here, listening to my colleagues on both sides of the aisle, I hope we keep this transcript. Because I think that we are not just talking about the consumer right to know when it comes to the choice of physician. I am hearing colleagues on both sides of the aisle discuss this issue in a manner that I don't hear them talking about consumer-to-right-know issues on many other aspects.

I think that there may be those that want to divert away from the substance of this by trying to bring politics into it. I think this is something that is an American issue. How do you have an informed consumer make the best decision possible? And we hear a lot about damages and about problems and trying to litigate reimbursement for damages done and by certain providers in many fields. And I think that, as any physician will tell you, is damage avoided is absolutely the best opportunity that we have as consumers and as providers. And if an informed populace out there can make the best decision of choosing a health care provider, then it may, in the long run, mean that we avoid a lot of the problems, and we don't have to talk about bringing in tort issues, trial lawyers and all of the other things that we talk about.

Let me just say, though, sincerely, that the issue of informed consumer has been abused in the past, and California is a good example. Those of you who ever visit California, that when you go walk into a five-star hotel, out on the front door of a five-star hotel is: "Warning. There are cancer-causing agents within this building," and that could be anything from the carpeting to the drapes. But the argument of give so much information that the more quantity somehow means that you will have a higher quality decision being made by the consumers not necessarily always pencilled out.

But I would just like to say on this one, I think we have got a perfect situation now to set a standard about consumer information that does not only apply to the choice of physician, but should apply to every other service the consumers in America want to make. And I would just ask Democrats and Republicans to consider the big picture. When you set a standard for the choice of physician, you darn well better be able to stand by that when people start talking about choosing other services and other products in America. And I think this hearing is great, not just for the health care issue, I think it is great for the consumer issue across the board.

I yield back, Mr. Chairman.

Mr. UPTON. Thank you, Mr. Bilbray.

Mr. Wyden, we are ready. Welcome back to the committee. We always found you to be a friend and fair adversary, and we are pre-

pared to listen to your opening statement, and then we will take questions.

**STATEMENT OF HON. RON WYDEN, A UNITED STATES
SENATOR FROM THE STATE OF OREGON**

Senator WYDEN. Mr. Chairman and colleagues, it is an honor to be invited to be back with so many friends. For 15 years, I had the privilege of working with almost all of you in this room on health care issues, the area in which I have specialized in the Congress. I believe when the members of this committee tackle an important issue in a bipartisan way, there is nobody in this country that does public policy better.

Now, today, you are looking at the question of opening the National Practitioner Data Bank to the public. I commend you for recognizing that to debate the matter of opening the Data Bank to the public, you must examine the entire Health Care Quality Improvement Act that created it. At a minimum, you are going to have to look at why the law was originally enacted, how our health care system has changed since the law's enactment and how or whether a number of amendments to the act should be enacted so that the law better meets the needs of patients and families.

I would like to touch briefly on these concerns. However, before I do, I want you to be aware of two concerns that are foremost on my mind. First, there is no logical argument for keeping information about proven flagrant cases of professional misconduct from the public. For the Federal Government not to disclose this important information in the Data Bank about physician misconduct simply doesn't pass the smell test.

Second, because the vast majority of physicians are talented, dedicated individuals who have never perpetrated flagrant, proven cases of misconduct, great care must be taken to ensure that these physicians do not have their reputations unfairly maligned in the effort to protect the public from the truly incompetent. That is why it is so important, as several of you have noted, that your work not be part of a political agenda, but instead be part of a bipartisan effort to update the act.

Having introduced legislation to accomplish these two objectives in both the House and the Senate—I did it in the House with our former colleague, Scott Klug, Republican from Wisconsin, and I have done it in the Senate with our colleague, Senator Olympia Snowe from Maine, I can tell you that I have firsthand evidence about how hard it will be to accomplish the two objectives that I have stated this morning.

I would like to spend just a few minutes telling you about a little bit of what went into the committee's consideration 14 years ago because I think it might make your job a little easier this morning. Fourteen years ago in Astoria, Oregon, when the physicians of a clinic reviewed a colleague's surgical competence, the doctor sued them. I reviewed that case in detail, and I decided that regardless of that Astoria doctor's guilt or innocence that to persuade physicians to come forward and prevent incompetent doctors from harming patients, there needs to be strong legal protection for good-faith physician peer review.

With the help of a Commerce Committee bipartisan trio, the late Ed Madigan, Tom Tauke and Henry Waxman, I drafted and was able to include in the Health Care Quality Improvement Act unprecedented protection for good-faith peer review. My prepared statement outlines that four-part test. But suffice it to say, I don't believe that there is a profession in America that now has such significant legal protection for physician peer review. In short, what we did is say that when physicians are doing peer review and they meet certain procedural protection, the presumption shifts that they have acted in good faith and anyone who challenges it must prove otherwise.

In return for those physician peer review rights that were part of the bill in 1986, I told our colleagues on this committee that it was only fair that provisions be included in the law to require that the medical profession assume new responsibilities to the public. There were rights with respect to peer review, and we felt it was important that there be responsibilities to the public in terms of National Practitioner Data Bank.

My specific concern in 1986 was, and it remains to this day, that the small number of physicians who are truly incompetent have a unique, almost extraordinary ability, to stay one step ahead of the disciplinary authorities. These are the physicians who voluntarily surrender their license just before it is about to be taken away. They jump from State to State so their record of incompetence does not catch up with them or they plea bargain with understaffed State medical boards so that the true nature of their incompetence doesn't show up in their records.

So because of these concerns, the committee created the National Practitioner Data Bank, in which various health care organizations were required to report to the Data Bank disciplinary actions taken against physicians and all settlements and verdicts in medical malpractice cases. Credentialing authorities were required to check the Data Bank prior to hiring a physician and regularly review the individual's record in the bank.

To enforce the law, the committee determined that if a credentialing body didn't comply with these provisions and a patient was harmed by an incompetent physician and a lawsuit was filed, the credentialing body would have imputed to them the knowledge that was in the Data Bank. Now, this law was passed almost 15 years ago, and I believe one of the first issues you should examine is how much the health care world has changed since the law was enacted. For example, in 1986, when we sat in this room, we didn't know much about the Internet. Today, there are 10,000 websites where you can get information about physicians. Millions of our citizens visit these sites regularly and certainly a significant number of these sites offer information of dubious quality. When we sat in this room, the Government hadn't created the Health Care Integrity and Protection Data Bank, which seeks to track fraud and it is accessible to different individuals than the National Practitioner Data Bank information is available to.

Since we sat in this room, several States have passed legislation providing the very sort of information to the public that would have generated enormous opposition had Congress included them in the Health Care Quality Improvement Act in 1986.

That is a little bit of the history, a little bit of what I think has changed in health care since we enacted the law in 1986. I will wrap up this morning by trying to outline what I think the most important issues are as you go about the effort to improve the act.

First, because there now is so much information about physicians from so many sources, the committee needs to decide what information is likely to be most helpful to patients and their families and how the Data Bank might be retooled to deliver it. The public is much hungrier for information today about health care quality than it was in 1986. The question is whether they are going to get it from sources that are accurate and objective. I want to see an amended Data Bank law help deliver meaningful, reliable and relevant information that assists patients and families in choosing their health care providers.

Second, I hope the committee will work on a bipartisan basis to update the law in several areas where it cries out for improvement. For example, the Data Bank ought to be required to receive reports on the denials of licensures, along with the revocations and suspensions of a medical license.

The committee should look at additional ways to ensure that bad doctors and others can't go from State to State because this remains a problem today. For example, the Data Bank's current information does not enable the Data Bank to report how many physicians have lost their license in one State and have received licenses in another. The committee ought to look at due process guarantees for doctors to assure that the Data Bank is not used as a threat to muzzle physicians who report concerns about patient care to appropriate authorities.

Third, I believe the committee needs to carefully study several issues that were controversial in 1986 and are just as controversial today. One of those areas is the use of malpractice information. The Data Bank does not currently receive a significant amount of information about malpractice settlements because of what is known as the corporate shield. Because of the corporate shield, physicians can settle suits under the corporation's name and not as an individual and escape being reported to the Data Bank. I believe that the corporate shield loophole ought to be closed, but I can tell you there will be a very vigorous debate in this committee as to whether a majority of our colleagues agree.

In addition, the committee needs to consider if malpractice data provides predicted information that is useful to consumers. Some of our colleagues have stated just because you say a doctor has five malpractice settlements doesn't mean that that individual is a bad physician. We need to do more work in the area of looking at what really is predictive.

Another area of study should be how to assure information in the Data Bank that is useful to licensing boards and consumers actually gets into the Data Bank. With nearly 60 percent of the hospitals having never made a report, we all know that the Data Bank today is not getting all of the relevant information it should. Certainly, hospitals doing their own internal reviews of quality of care need to be encouraged to provide information to the Data Bank.

Finally, a word about what sort of information should be made public. I was approached recently by a physician in Oregon, who

has one report of a malpractice settlement in the Data Bank. He was the physician in charge of a surgery in which a medical resident made a mistake. Yet because the surgeon was the one in charge, the malpractice settlement was made in his name. That information isn't predictive of whether the surgeon is good or bad. That is not going to help patients or families. We want to make sure that patients and families can get important information, such as when a significant diagnosis that a physician should have been able to make is missed and avoid the kinds of things that harm physicians who certainly haven't done anything wrong.

My last point is that I think you also have a major challenge in making sure that the National Practitioner Data Bank is coordinated with the efforts that are ongoing by the States and with the fraud Data Bank that Congressman Stupak was right to mention. Now, all of these reforms are going to require careful study, and it just can't be done through an abbreviated schedule and a slap-dash approach. I can tell you I personally spent many, many months negotiating with physician groups, patients, hospitals, licensing bodies and insurers before I even introduced the Health Care Quality Improvement Act. Then Chairman Henry Waxman spent many months, in addition, examining this issue at length in the subcommittee before it even came to the full committee. So I have got firsthand evidence that a rush job on issues this important can do more harm than good.

Mr. Chairman, I thank you for having me. The fact that you would reach out and want to know some of the history of what went on in this room almost 15 years ago seems to me to show your good faith in trying to tackle this in a bipartisan way. That is the way this committee does its work best, and I happen to believe that these are just about the best precincts in American politics when you work together on a bipartisan basis, and I look forward to having the chance to do that with you again.

Mr. UPTON. Well, thank you very much. Your staff has been calling frantically. I know that you are needed on the Senate floor, and I know that there are a number of members that have some questions for you, and I will let you make the call as to whether you need to go now or whether you would like to come back, and we will put you into the right order when we come back.

What is your—

Senator WYDEN. You are gracious as always. Why don't we take maybe a few minutes, and then I better shoot off to—

Mr. UPTON. Okay. Let me just yield to Chairman Bliley. We will try to do about 2 minutes per member. Is that okay?

Senator WYDEN. Yes, I think I have got 7 or 8 minutes maybe.

Chairman BLILEY. Thank you, Mr. Chairman. Good to see you again, Senator, having served with you for many years when you were in the House. I am sorry you saw fit to go over to the other body, but that is the way it goes.

I am not sure if you have had a chance to review the data in the National Practitioner Data Bank, but my committee staff demanded and received information from HHS. And I am shocked by some of this information.

I understand that approximately 200 doctors and dentists have 13 or more reports in the NPDB. In light of this, do you believe

the current system of doctor discipline adequately protects consumers from problem doctors?

Senator WYDEN. As I indicated in my prepared remarks, Chairman Bliley, I think that there are a number of areas where this law needs to be improved. I mean, there are something like 700,000 physicians in this country. I think there were close to 3,500 significant disciplinary actions taken against those physicians in 1998. These are actions taken by colleagues against colleagues. I think that kind of information and what I call proven flagrant violations ought to be made public, and we need to work together in a bipartisan way so as to do it to not injure the many, many physicians who, obviously, haven't come close to committing such a violation.

Chairman BLILEY. I couldn't agree more.

Thank you, Mr. Chairman. I don't want to abuse the time.

Mr. UPTON. Mr. Stupak?

Mr. STUPAK. Thank you, Mr. Chairman.

Senator, good to see you again, as always. Let me just ask you about three questions, and if you can respond, great.

Do we have an idea of the number of doctors we think that are presently practicing that, if scrutinized by competent peer review process, would be disallowed from practicing? Chairman Bliley mentioned these physicians that have 13 or more malpractice claims or malpractice cites against them. Where are the State licensing boards? Why is this being allowed to continue? Where is the breakdown here?

Senator WYDEN. I think you heard me mention, in response to Chairman Bliley's question, there are perhaps 700,000 doctors in this country. In 1998, there were close to 3,500 major disciplinary actions taken by colleagues against colleagues. The AMA on a regular basis cites a concern about a small percentage of the physicians in this country. Part of the problem, to respond to the additional part of your question, is I think a lot of these State medical boards are woefully understaffed. There are some that are very good. Congressman Bryant is proud of his in Tennessee. We are proud of ours in Oregon, but we have found, even in Oregon, that very often when you have one of these small number of incompetent people that they are extraordinarily slippery and evade the disciplinary authority.

Mr. STUPAK. But if we have this 5 percent that you claim, and they must be in the data base, then why isn't the data base being enforced and their licensing being removed or whatever remedy that should be delved out? Is it a lack of money? Is it moving from State to State, as you mentioned? What is it specifically? If we know the 5 percent, they are in the data base, how come we are not doing something about it?

Senator WYDEN. Well, I think, as I touched on and several of our colleagues, a number of reports aren't being filed at all. For example, I cited 60 percent of the hospitals haven't made a report at all. I think there are significant shortcomings with respect to reporting, No. 1. I think there are problems that I cited in my testimony with respect to matters like the corporate shield. We know that some physicians and medical groups seek to work out arrangements so that the final settlement comes in just under the terms that re-

quire reporting. I think most of the issues that I sought to examine in my testimony are the major shortcomings in the Data Bank as it exists today.

Mr. UPTON. Thank you.

Dr. Ganske?

Mr. GANSKE. Senator, welcome.

Senator WYDEN. Thank you.

Mr. GANSKE. I have actually practiced medicine in the State of Oregon. I did my general surgery training there, and Dr. Reardon will be testifying and he practices in Oregon. I can testify that the credentialing process in the State of Oregon is very rigorous and that the Oregon Board of Medical Registration is very thorough. I think you would agree with that, wouldn't you?

Senator WYDEN. That is why I mentioned we are very proud, Greg, of our process in Oregon. What we found recently—I want to highlight one case in Oregon—is that we had a situation in our State where disciplinary action was taken and, in effect, the person moved a short distance away to Washington State, and it took a long time before their questionable conduct caught up with them.

Mr. GANSKE. And let me just follow up by saying that in Oregon, in Iowa, in all of the States that I know of, when the Board of Medical Registration or the Board of Licensure makes a decision that is adverse to a physician, it is published on the front page of the Des Moines Register in Iowa, for example, so that the public is informed of those medical licensure decisions in which, for instance, a physician's license is revoked or they are put on suspension. So it is not a case that under the current situation, the public does not get the information from the Boards of Medical Registration; in fact, they do, and many times with front-page coverage.

Your point, though, was valid, and that is that the National Practitioner Data Bank was set up to provide help for other Boards of Medical Registration so that they can get the data. But my point would be this: The National Practitioner Data Bank was set up to provide a help to State boards of registration and licensure so that they can do their job with adequate information from physicians transferring from other States, and that was your point on that.

But it was not set up to be an open Data Bank, it was set up to give help to the boards of registration, such as Oregon, which are already doing a very good job in publicizing the misadventures of, as you put it, a small number of physicians. And so I appreciate the original intent of the bill. What I have problems with is moving from the National Practitioner Data Bank as an adjunct to the boards of registration and changing it totally in concept. I think it would be detrimental to the way the National Data Practitioner Bank is working.

And thank you, Mr. Chairman.

Senator WYDEN. Let me see if I can respond because I think Dr. Ganske raises a couple of thoughtful points.

First, there is no question that in a significant number of cases, in places where there is a vigorous press, when there has been an action taken to revoke a license, that will get out to the public, and that is helpful. However, I think as you are going to hear today and we have seen, there are a significant number of cases where that has not been the case, where these physicians who are truly incom-

petent have had, either through a voluntary surrender of a license or a plea bargain or something of this nature, been able to consistently stay ahead of these disciplinary authorities. And what it comes down to, for me, and I have said this to many, many physicians, I cannot think of one logical argument for not making public proven, flagrant cases of professional misconduct. I don't think you can stand up in a town hall meeting anywhere in this country and say that for proven, flagrant cases of professional misconduct, the public shouldn't have that information.

The question is, and this is why I agree with part of what you are saying is, how do we do that so that we act in concert with the State licensing boards? And that is critical. Second, how do we do it, given the dramatic changes in the health care world since this law was originally enacted? I have talked to many people who are close to the Board of Medical Examiners, and they have said, "You know the public is going to get this information somehow. They are going to get it off some website. They are going to get it from some press account."

I am concerned that unless we work in a bipartisan way, like I have tried to do with Scott Klug, and Olympia Snowe, and colleagues both in the House and Senate, to update this law and do it in a way that is fair to patients and families and to the vast majority of physicians who are dedicated and honorable, I think we are going to see the public look at a variety of other ways to get this information, and that will end up doing more harm than good.

Mr. UPTON. I know Ms. DeGrete has questions, and she has allowed me to go ahead of her.

A couple of things. I am going to ask my questions first and let you respond all at once. I know that the Data Bank, when it was set up, had six criteria. One of them was not criminal convictions. I would be interested to know the legislative history in terms of why that was not included.

You talked about the Data Bank not getting all of the relevant information, which I think is a concern by all of us here. And I do not know if you saw today's New York Times, but on the front page, there was a story, and I quote, the headline is, "Surgeon is Treated Wrong Side of Two Brains, Albany Says." And in the story it says, "While the State investigation did not conclude that Dr. Arbit's surgery caused the death of a Staten Island patient, it said that one other patient of his had died after a questionable procedure and that others had become disabled. In several instances, the State said the hospital did not report any of the medical errors, as it is required to do, and violated several provisions of to New York health laws."

I would be interested in what we can do. That law is on the books already, but obviously isn't being followed through, at least in one State, and I would sense that there are other States as well.

I, also, constructively, when a State denies a license, whether it is Des Moines, Oregon, Michigan, New York, I don't know whether that is always included in the Data Bank, and I believe that those State licensure boards ought to have access to that information. I have seen physicians in my own district whose licenses have been revoked in one State and only years later the same instances catch up with them and that license is pulled again, which shows that

there is some misinformation. I would like you to comment on that in the remaining 13 seconds that I have.

Senator WYDEN. Starting at the end, as I noted, Mr. Chairman, in my testimony, these denial of licenses, generally, are not reported. I definitely support receiving that. I think that is important information, just as suspension or revocation, as it relates to quality issues, that information should be reported as well.

With respect to why we didn't address criminal issues, this was a bill concerned with health care quality. And, of course, criminal issues are more the province of the Judiciary Committee. In an effort to focus on quality, we said let's look at rights which are protections for physicians doing good-faith peer review and let's look at responsibilities, which are requirements that you work with the Data Bank.

Finally, with respect to State law, one of the areas that you have to look at to update the law and to modernize it along the lines of what we have been talking about, is to examine how to integrate it with what is going on at the State level. I agree with Dr. Ganske that the States have got to have a very significant role in this. Many of the States are putting their information online which, in one sense, means they are vastly ahead of the Federal Government at this point, and I think that we ought to be looking thoroughly at why States aren't enforcing current law, in some instances. At this point we don't know much more about the New York case, other than what we read in the paper.

Put more broadly, we have to make sure that at the end of the day, we integrate this fraud Data Bank, the National Practitioner Data Bank, the efforts of the States, particularly the ones that are serving as a model, and that's why it is going to require some careful and bipartisan work to do the job right.

Mr. UPTON. Thank you.

Ms. DeGette.

Ms. DEGETTE. Thank you, Mr. Chairman. Thank you, Senator. Just a couple of questions.

First of all, I have been reading some evidence that not all entities that are required to report to the Data Bank are doing so. For example, in the last National Practitioner Data Bank Executive Committee meeting, it was reported more than 60 percent of all hospitals haven't ever filed an adverse action report to the Data Bank since 1990, and it is hard to believe that they wouldn't have something to report. So that would suggest a significant problem with underreporting. And I am wondering if you could comment on what the implications of underreporting are to the Data Bank.

Senator WYDEN. I am going to have to really zip out the door. Congresswoman, I touched on that 60-percent figure in my prepared remarks.

Ms. DEGETTE. Right.

Senator WYDEN. But I share your view. I think clearly, without that kind of involvement by the hospitals, their participation in a meaningful way, that is a significant limitation on our ability to address this issue in a responsible way. So I think you are on to a matter that I feel very strongly about, and I am anxious to work with you on.

Ms. DEGETTE. Thank you. I have got more, but I will let you go. Thanks, Senator.

Senator WYDEN. Mr. Chairman.

Mr. UPTON. I would just like to say we would like to keep the record open, and if you wouldn't mind answering written questions that we can make as part of the record, that would be terrific.

Senator WYDEN. I would be happy to. I look forward to working with all of you.

Mr. UPTON. Perhaps on the, we wish you good luck or bad luck, depending on whatever the amendment is in the Senate.

Our next panel will include Dr. Liana Gedz and Mr. Anderson Smart. And if they are there, if they would take seats I guess for a moment.

We have a longstanding tradition of taking testimony under oath. We waived that for Mr. Wyden as a former member of the committee. But under committee rules, do you have any objection to that procedure?

Ms. GEDZ. No.

Mr. UPTON. And, also, the committee rules allow you to have counsel, if you desire. Would you ask for counsel?

Ms. GEDZ. Yes.

Mr. UPTON. And could you state who that individual is, for the record.

Mr. McGRATH. Christopher T. McGrath of Sullivan, Papain, Block, McGrath & Cannavo, 55 Mineola Boulevard, Mineola, New York.

Mr. UPTON. Okay. And?

Ms. CRONIN. For Anderson Smart, Linda Cronin of Trager, Cronin & Byczek, 1983 Marcus Avenue, Lake Success, New York.

Mr. UPTON. That is very good.

If you would stand, all of you, and raise your right hand.

[Witnesses sworn.]

Mr. UPTON. You are now under oath, and we would like you take no more than about 5 minutes for your testimony. Your testimony will be made part of the record, as it was submitted, with unanimous consent.

And we will start with Dr. Gedz.

TESTIMONY OF LIANA GEDZ, ACCOMPANIED BY CHRISTOPHER T. McGRATH; AND ANDERSON SMART, ACCOMPANIED BY LINDA CRONIN

Ms. GEDZ. Mr. Chairman and committee members, my name is Liana Gedz, and I'm a Russian-born dentist, have graduated from New York University Dental School, and live and practice in New York City.

I am pleased to have the opportunity to testify today as you consider issues related to making the information currently in the National Practitioner Data Bank available to the public. I believe that availability of such information would give patients the chance to make an intelligent choice about who should be their health care provider before they place their health and well-being into the hands of a doctor or hospital. In the next few minutes, I would like to summarize what happened to me 6 months ago from the hands of a supposedly prominent and experienced OBGYN, Dr. Alan

Zarkin, in the supposedly reputable medical facility known as Beth Israel Medical Center.

Six months ago, I delivered a baby girl in Beth Israel Hospital by Caesarian section, emergency Caesarian section. After the completion of surgery, Dr. Alan Zarkin carved his initials on my abdomen. What happened to me is traumatizing enough. What was more devastating is that after Dr. Zarkin was suspended from Beth Israel Hospital, he was able to work as an OBGYN physician for 5 more months, performing complicated surgical procedures on unsuspecting patients. In Beth Israel's report to the New York State Health Department, Dr. Zarkin's actions were described as gross misconduct, without giving any details.

If the entire information would have been made available to the public through the National Practitioner Data Bank, I don't think Dr. Zarkin would be able to practice medicine any longer. The patients seeing Dr. Zarkin after me would have known of my horrific experience. Dr. Zarkin's attorney blamed his action on a frontal lobe disorder. As described in any medical textbook, frontal lobe disorder manifests itself in violent behavior. It is very, very dangerous to have a person like this allowed to hold a scalpel when you give him power over your body or your life on the operating table. The information in the National Practitioner Data Bank should be available not only to medical facilities, but also for every patient who needs to protect themselves from questionable doctors and facilities.

Another issue is whether hospitals fully comply with their statutory obligation to report to the National Practitioner Data Bank before hiring a doctor. The failure to do that would seriously undermine the ability of the Data Bank to protect the patient. Also, I truly believe we have a "white wall of silence": hospitals protect doctors, doctors protect their peers, and in all of this, crucial information is getting lost.

We, as the patient, are in a very vulnerable position not knowing if you are dead because God wanted to or because your doctor is insane. Please understand I am a doctor myself, and I am not attacking the medical profession. The United States has some of the most brilliant doctors and the most sophisticated medical facilities in the world. But lately, medicine has become more of a business with bottom lines, in detriment of patient care.

Now it is the time to let the public know and choose who will hold their life in their hands. We shouldn't make decisions blindly. We should be able to question and research. If I knew what I know now, Dr. Zarkin would never have been able to rob me of the experience of my daughter's birth. He would not be my doctor.

I hope that availability of information to the public will make sure that every man, woman and child, when they seek medical care, feels safe. I wish I had that information available to me. I should have—it should have been my right, as the patient, to have this information.

Thank you.

[The prepared statement of Liana Gedz follows:]

PREPARED STATEMENT OF LIANA GEDZ

Mr. Chairman and Committee Members: My name is Liana Gedz. I am a Russian born dentist, have graduated from New York University Dental School and live and practice in New York City.

I am pleased to have the opportunity to testify today as you consider issues related to making the information currently in the National Practitioner Databank available to the public. I believe that availability of such information would give patients the chance to make an intelligent choice about who should be their health care provider before they place their health and well being into the hands of a doctor or a hospital. In the next few minutes I would like to summarize what happened to me six months ago from the hands of a supposedly prominent and experienced OBGYN Dr. Alan Zarkin in the supposedly reputable medical institution known as Beth Israel Medical Center.

Six months ago I delivered a baby girl in Beth Israel Hospital by emergency caesarian. After the completion of the surgery Dr. Zarkin carved his initials on my abdomen. What happened to me is traumatizing enough, but what is more devastating is that after Dr. Zarkin was suspended from Beth Israel Hospital, he was able to work as an OBGYN physician for five (5) more months performing complicated surgical procedures on unsuspecting patients. In Beth Israel's report to the New York State Health Department, Dr. Zarkin's actions were described as "gross misconduct" without giving any details.

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Another issue is whether hospitals fully comply with their statutory obligation to report to the National Practitioner Databank before hiring a doctor. The failure to do that would seriously undermine the ability of this Databank to protect THE PATIENT. Also, I truly believe that we have a "white wall of silence", hospitals protect doctors, doctors protect their peers, and in all of this, crucial information is getting lost. We, as patients are in a very vulnerable position not knowing if you are dead because God wanted to or because your doctor is insane. Please understand I am a doctor myself and I am not attacking the medical profession. The United States has some of the most brilliant doctors and the most sophisticated medical facilities in the world, but lately medicine has become more of a business with bottom lines in detriment of the patient care. Now it is the time to let the public know and choose who will hold their life in their hands. We shouldn't make a decision blindly, but rather be able to question and research. If I knew what I know now, Dr. Zarkin would never have been able to rob me of the experience of my daughter's birth, he would not be my doctor. I hope that the availability of the information to the public will make sure that every man, woman, and child will be safe when they seek medical care. I wish I had that information available to me. It should have been my right as a patient to have it.

Mr. UPTON. Thank you very much.
Mr. Smart?

TESTIMONY OF ANDERSON SMART

Mr. SMART. Mr. Chairman and members of the committee, thank you for inviting me to appear before you today. My name is Anderson Smart, and I am a detective with the New York City Police Department.

Twenty-seven months ago, my wife Lisa, who was just 30 years old, died after undergoing routine surgery to remove a fibroid tumor. Her death was caused by negligent doctors who disregarded her basic right to be informed that they would, for the first time, be using a new machine; for allowing nurses into surgery who, like themselves, had never been trained on the proper use of this new

machine; and for allowing a salesman from Johnson and Johnson to actually participate in the surgery. Most egregious of all was the failure of these doctors to act upon the nurses' warnings that Lisa was literally drowning to death.

I am here today to address the issue of public access to the National Practitioner Data Bank. I am certain that if Lisa knew that her doctor's partner would be participating in the surgery, a doctor who was already on probation for professional misconduct and who had been sued several times for malpractice, she would have made a different, more informed choice of physicians.

Lisa and I knew each other since we were teenagers. We worked hard, had just purchased our first home and were going to start a family. We moved to a rural county far from our work so that we could enjoy nature. I was so proud of her when she started her career at Chase as a financial analyst. Her tragic death was a direct result of her doctor's negligence during what I—what should have been a simple, routine, outpatient procedure. Had Lisa been given access to the National Practitioner Data Bank, she would be alive today.

Lisa's ability to succeed in her career were basic qualities that she used in her own life. She was a perfectionist who would have certainly made use of the information in the National Practitioner Data Bank if it had been available to the public. In fact, Lisa was adamant that she did not wish to have her surgery in our hometown, choosing instead a physician affiliated with a hospital with an outstanding reputation for quality care. She was very frightened about this procedure, as this was her first hospitalization, and she was especially concerned about the use of anesthesia. Lisa, an avid reader, who regularly referred to the Internet and Consumer Digest for information, had, in fact, prior to the surgery, done exhaustive research on anesthesia. However, Lisa had no access to any relevant data concerning her physician, other than that he qualified under her health plan. Certainly, she was entitled to make an informed decision about who would be performing the surgery.

When Lisa died, I promised myself that I would do everything possible to make certain that Lisa did not die in vain and that her kind of senseless death would never happen again. In New York, we are supporting legislation named in honor of Lisa, which would provide patients access to relevant information about their medical providers. We are encouraged that the chairman of the New York State Health Committee is revisiting Lisa's Law and his position against the New York Bill.

Requiring practitioners and hospitals alike to be held responsible for reporting and consulting with the National Practitioner Data Bank is only the first step. Consumer access to this information is essential. Access to data will assist all patients in making informed decisions about their medical care. While the Government cannot protect us from all conceivable harm, public access to the National Practitioner Data Bank will certainly help us to help ourselves.

I want to thank the chairman for giving me the opportunity to tell my story and hope that he and the committee can find some way to prevent what happened to our family from ever happening again. I would like to thank you all.

[The prepared statement of Anderson Smart follows:]

PREPARED STATEMENT OF ANDERSON SMART

Mr. Chairman and members of the Committee, thank you for inviting me to appear before you today. My name is Anderson Smart, and I am a Detective with the New York City Police Department.

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I am here today to address the issue of Public Access to the National Practitioner Data Bank (NPDB). I am certain that if Lisa knew that her doctor's partner would be participating in the surgery—a doctor who was already on probation for professional misconduct and who had been sued several times for malpractice, she would have made a different, more informed choice of physicians. Lisa and I knew each other since we were teenagers. We worked hard, had just purchased our first home and were going to start a family. We moved to a rural county far from our work so that we could enjoy nature. I was so proud of Lisa when she started her career at Chase as a financial analyst. Her tragic death was a direct result of her doctor's negligence during what should have been a simple, routine, outpatient procedure. Had Lisa been given access to the National Practitioner Data Bank, she would be alive today.

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I want to thank the Chairman for giving me the opportunity to tell my story and hope that he and the Committee can find some way to prevent what happened to our family from ever happening again.

Mr. UPTON. Thank you both very much. And, certainly, Mr. Smart, you kept your promise, and we hope that, just both of you, it is a very sad and tragic story, and I think it certainly tells us all that there is much needed reform. We need to do it on a bipartisan basis.

It seems as though, particularly Dr. Gedz, not only did the system break down in terms of where it is supposed to be, in light of today's front-page story in the New York Times as well, but as you heard from Mr. Wyden's questions and the dialog that went back on both sides of the aisle, Republicans and Democrats, I think that there can be some very constructive reform that moves forward. And by shedding light on some of those reforms in this morning's

hearings, perhaps we can work on legislation and look at a number of different proposals that are out there so that your cases will not ever happen again.

And your willingness to go public through this very painful and certainly personally private experience is a credit to you both for seeking changes. I know I speak for all members here in appreciation for the time that you are spending with us this morning.

And I just want to say, too, that I think most of us here will have some very tough questions later on for the panels that are coming later, as it pertains specifically to the examples that you raised this morning, and to seek a common bond where we can move together to make sure that it doesn't happen again. I think your statements speak in a very meaningful and full way, and I have no further questions at this point and would yield to my colleague from Michigan, Mr. Stupak.

Mr. STUPAK. Thank you, Mr. Chairman.

Dr. Gedz, you mentioned in your testimony that you believe that a "white wall of silence" exists regarding the protection of doctors, hospitals and other health care providers. Can you elaborate a little bit more what you mean by that term.

Ms. GEDZ. Well, in my particular case, as Dr. Zarkin, like I said in my testimony, after he was suspended from Beth Israel Hospital, only the New York State Department of Health was notified as gross misconduct, without any details. So he was able to get a job and actually practice and perform surgeries for 5 months, supposedly being insane. I believe, if doctors and nurses who were in this operating room would report it, hospital would report it in a different way.

Mr. STUPAK. "In a different way," what do you mean?

Ms. GEDZ. Just describe what he did to me. Just let—

Mr. STUPAK. Okay. But in this case here, it was reported to the New York State Medical Board?

Ms. GEDZ. Right, as gross misconduct. That doesn't give you any details. I mean, I don't think carving initials with a deadly weapon as a scalpel on the body who lays in front of you that's gross misconduct. That's a crime.

Mr. STUPAK. I don't disagree with you there. I guess what I'm trying to say is where did the system break down? If the New York Licensing Board found gross misconduct, was it not disseminated then within New York, not within the State, in the country? Where do you think the breakdown occurs? I guess no one can say what was done to you was appropriate or anything. I agree with you wholeheartedly there. What we're trying to find out where is the breakdown, in your estimation? You have mentioned this code of silence, you mentioned the doctor was disbarred by gross negligence. Then what happened? Where did it break down? That is what we are trying to get at.

Ms. GEDZ. Well, then everybody was quiet, and this is why his colleagues, who knew what happened, Dr. Saltzman is a chairman OBGYN, a former chairman OBGYN of Beth Israel Hospital, after the fact what Dr. Zarkin did to me, was trying to conduct business with the facility where Dr. Zarkin was medical director. I mean, how would you explain that?

Mr. STUPAK. I guess what I am trying to get at, and maybe I am missing—

Ms. GEDZ. I know what you are trying to get—

Mr. STUPAK. I am trying to say how do we correct that? How do you get the communication lines open? Just by throwing open the data base doesn't necessarily do that. There are some, I am sure, some physicians in there who, when cases are reviewed, we have heard a lot about 200 cases with 13 or more malpractices. How do you make sure that you are not punishing a doctor, while at the same time trying to protect the public? I mean—

Ms. GEDZ. Well, I think it could be two ways of doing this: One, if we see why doctors fail to police other doctors, maybe an independent organization should be established to police doctors. And another way is the National Practitioner Data Bank giving a patient the right to know this information and question the doctors.

Mr. STUPAK. Did you ever inquire of the New York Board as to why the doctor, after they found him responsible for gross negligence, why he was allowed to practice? Did the New York Licensing Board ever give you a reason?

Ms. GEDZ. No, I didn't.

Mr. STUPAK. Thank you.

Mr. SMART, basically the same kind of questions. It is my understanding that at least two doctors involved in your wife's case had previously had actions taken against them by the New York State Board of Medicine.

Mr. SMART. It was only one.

Mr. STUPAK. One?

Mr. SMART. Yeah.

Mr. STUPAK. What should New York have done differently, in your estimation?

I guess we are trying to figure out how does the system break down.

Mr. SMART. Personally, my wife's death was ruled as an accident. I knew something was wrong. I went to attorneys and told them what had happened. And when they started their own investigation, the hospital really didn't cooperate with them at all. They asked for information, they asked for documents. They were only sent maybe a total of 10 to 15 pages' worth of what happened on that particular day, and we all knew that there was more to it than what was received.

I think there was too much time, too much time allowed for these, the hospital and whoever else, to sort of get their story straight, and speak to their people and, you know, be prepared for when they interact with us.

The New York State Department of Health informed us maybe about approximately a year later that something was wrong, and they sat us down and told us exactly what happened in that operating room, and that's when we found out, indeed, what went wrong. We knew something was wrong all along, but we didn't know what it was. And I think that's where the breakdown is.

Mr. STUPAK. Did you ask them about the one physician then who has been involved with other problems? And did you ask whatever happened, how can this individual continue to practice if there's been problems?

Mr. SMART. They really didn't give a straightforward answer. They also were like, you know, "we really don't know."

Mr. STUPAK. This is the licensing board that is supposed to license the physicians; is that what you are telling me?

Mr. SMART. Yes. And that was the first time that I had heard of a Dr. Sklar. I have never—I have never heard of him before. When I went my wife to have the procedure done, I met the other doctors. I knew nothing of a Dr. Sklar. A year later I found out about a Dr. Sklar, and that was very disturbing to me.

Mr. STUPAK. Sure.

Mr. SMART. Knowing his background.

Mr. STUPAK. Thank you. Thank you both.

Mr. UPTON. Chairman Bliley?

Chairman BLILEY. Thank you.

Dr. Gedz, both you and your husband, as practicing dentists, can be reported to the National Practitioner Data Bank. Does this, in any way, change your belief that the National Practitioner Data Bank should be open to the public?

Ms. GEDZ. No, it doesn't change our opinion because as long as information is accurate and as long as—the most important thing is would a patient have a chance of knowing about my or my husband's prior record and make an intelligent decision if they wanted to be treated by me or my husband.

Chairman BLILEY. In your testimony, you referred to the "white wall of silence," in describing the medical profession failing to speak out against questionable doctors. Do you think that solely giving more information and resources to State licensing boards without giving consumers access will adequately protect consumers from problem doctors?

Ms. GEDZ. No. I believe it should be an independent organization or the public should know and be able to question doctors if they have any questions or make a choice if I wanted to be treated by the doctor.

Chairman BLILEY. Some have argued, Doctor, that consumers cannot understand this kind of information that is in the National Practitioner Data Bank. Do you think patients would be able to understand what is in the National Practitioner Data Bank and especially what Dr. Zarkin did to you?

Ms. GEDZ. Well, in Dr. Zarkin's case, it's pretty self-explanatory what he did to me. I think every person would understand what he did. And I don't think we should underestimate the intelligence of the public. But I agree that there should be some guidelines or in language what you put in the National Practitioner Data Bank. But, also, if a patient didn't understand something, at least they have a chance to question a doctor.

Chairman BLILEY. Thank you.

Mr. Smart, you indicated that your wife Lisa was an avid reader who regularly referred to the Internet and, in fact, did extensive research on anesthesia before her operation. Do you believe that if comparative information about doctors, like the National Practitioner Data Bank were available to her, she would have used that information to select a doctor?

Mr. SMART. Yes, I do.

Chairman BLILEY. Do you think that if she had known about Dr. Sklar's prior history in the National Practitioner Data Bank involving numerous malpractice payments, she would have ever agreed to be treated by him?

Mr. SMART. No, she wouldn't have.

Chairman BLILEY. Thank you both. Thank you very much.

Thank you, Mr. Chairman.

Mr. UPTON. Thank you.

Ms. DeGette?

Ms. DEGETTE. Thank you, Mr. Chairman. Thank you both for coming here to testify. I know it is hard, and I appreciate it because it helps us understand your perspective and what happened to you.

I got here a little bit late, but I read the materials, and what I am struck by, especially hearing your testimony, is how complex this issue is and how very little of a tip that we can actually handle on the Federal level. Because even if you opened up the Data Bank, I am not sure every patient would be as diligent as Dr. Gedz would or as your wife would have been, Mr. Smart. So I think we need to look at the Data Bank. But more importantly, perhaps, we need to look at the State entities that are taking disciplinary actions against bad doctors.

Both of these cases happened at Beth Israel; is that correct? I am wondering if either one of you could comment whether you think there is some fundamental problem with the way they are supervising their physicians there.

Mr. SMART. I think it's something that can happen at any hospital. It just so happened that it happened two times, actually, at Beth Israel. And I think peo—basically, if you have information on the background of a doctor, I think that's your choice whether or not you should go to that doctor.

What happened with this lady right here, I mean, and especially to hear it happening at another institution, I mean, that's very disturbing.

Ms. DEGETTE. Uh-huh. Doctor?

Ms. GEDZ. I believe it's a fundamental problem in Beth Israel Hospital because I spent 2½ months there on complete bed rest. And I was a witness of lack of knowledge of nurses, negligence of residents, and I made sure, as a doctor being there and knowing what's going on, that I complained on every single day and pointed to the problems. But what did I get in response? I basically was told if I'm not going to stop making waves, I'm going to be dismissed from the hospital.

Ms. DEGETTE. Mr. Smart, I have been told—and maybe I am wrong, let me know—that this doctor was provided by your HMO; is that correct? That came through your HMO?

Mr. SMART. Yes, by the primary care physician.

Ms. DEGETTE. And so is it your understanding that if the HMO didn't check out the qualifications of the doctor and just said, "Here, go do this procedure," did you know you would not be able to sue that HMO for that negligence?

Mr. SMART. I hold the HMO responsible as well.

Ms. DEGETTE. But did you know you can't sue them for negligently providing that doctor to you?

Mr. SMART. No, I didn't know that. That I didn't know.

Ms. DEGETTE. That is why we are trying to do a Patient's Bill of Rights.

Mr. SMART. Yeah, I didn't know that.

Ms. DEGETTE. Now, let me just ask you, Dr. Gedz, in particular, because I do think patients should be able to get more information from the Data Bank, but what I'm concerned about is how we make sure that the information in the Data Bank is accurate. For example, if someone gets a—if someone doesn't like the root canal you did on them and so they decide to manufacture some kind of complaint, how do we deal with that? How do we make sure that patients who are going on the Internet to get this information are actually getting accurate information? I think that that is the concern people have.

Ms. GEDZ. Well, I don't believe the National Practitioner Data Bank is made to be court, jury and executioner of a doctor. I believe information which you put there should be evaluated and only valid information should be put in the data.

Ms. DEGETTE. And who would evaluate that and make sure it was accurate? Let's say I have a doctor in Colorado who gets sued. The evidence of that lawsuit is going to go on the Data Bank, but who is going to evaluate that to see whether that is accurate or not?

Ms. GEDZ. Well, maybe we should establish an independent organization with a board of physicians and doctors who would be independent from a State to evaluate every case, and only cases with proven—proven would be put in the Data Bank.

Ms. DEGETTE. Thank you.

Mr. Chairman, let me just say I think we should get more NYU graduates here to testify in front of our committee. I am a graduate of NYU Law School myself.

Ms. GEDZ. Thank you.

Ms. DEGETTE. Thank you for coming.

Mr. UPTON. Dr. Ganske?

Mr. GANSKE. Thank you, Mr. Chairman. I thank both of our guests today.

Dr. Gedz, did you require any stitches for these initials?

Ms. GEDZ. No. Well, they shouldn't be placed because he went subcutaneous and now I have a healing by keloid.

Mr. GANSKE. So there was underlying fat exposed?

Ms. GEDZ. I saw the initials 2 days after. I wasn't aware what he did to me. I only found out 2 days after. When I saw it, the tissue was necrotized. So, but I know, when I asked people and when I saw the scar, I could tell it was subcutaneous.

Mr. GANSKE. So when you did see, when you saw the wound, was the skin completely cut through so that you could see fat underneath?

Ms. GEDZ. Well, what I could see, I could see necrotized tissue at that point. After 2 days, it was all gray and inflamed.

Mr. GANSKE. Now, clearly, there is litigation going on; is that right?

Ms. GEDZ. Yes.

Mr. GANSKE. Personal injury?

Ms. GEDZ. Litigation is concluded.

Mr. GANSKE. Yes. And will there be criminal charges?

Ms. GEDZ. He is criminally prosecuted, and I was subpoenaed by grand jury, and I give my testimony.

Mr. GANSKE. To the best of your knowledge, was there ever this type of behavior before by this physician?

Ms. GEDZ. Dr. Zarkin had, I believe, four former complaints against him—I don't think to the extent of what he did to me, but he had four former complaints.

Mr. GANSKE. Of what type, do you know?

Ms. GEDZ. I am not sure. I am not sure.

Mr. GANSKE. Well, it certainly is a bizarre thing. I was just amazed.

How long after this happened did this appear in the newspapers?

Ms. GEDZ. Five months after. I really wasn't craving publicity. I think it's a very private matter, and it's not really pleasurable to see your stomach plastered all over television and the newspapers, so—

Mr. GANSKE. Will you require reconstructive surgery?

Ms. GEDZ. Yes, I would have to have reconstructive surgery.

Mr. GANSKE. Like an abdominal plasty?

Ms. GEDZ. No. That would be a full-blown tummy tuck.

Mr. GANSKE. You would need a full-blown—

Ms. GEDZ. Yes.

Mr. GANSKE. Yes.

Ms. GEDZ. I would have to replace this piece of skin completely.

Mr. GANSKE. So how did you choose Dr. Zarkin?

Ms. GEDZ. Dr. Zarkin was recommended to me by a friend, and I went to see him after the loss of my first baby.

Mr. GANSKE. Are you in an HMO?

Ms. GEDZ. Yes, I have insurance.

Mr. GANSKE. Is it a Health Maintenance Organization?

Ms. GEDZ. Yes.

Mr. GANSKE. So you had to get an authorization from your HMO to go to Dr. Zarkin?

Ms. GEDZ. No, he was participating with the Blue Cross/Blue Shield.

Mr. GANSKE. He was a participant. So I guess I will ask the same question that Congresswoman DeGette said. Is your insurance through your employer?

Ms. GEDZ. No. I believe we purchased the insurance.

Mr. GANSKE. You hold an individual policy on your own.

Ms. GEDZ. Yes.

Mr. GANSKE. So, in that situation, you could hold the HMO responsible for having somebody on their staff that would do something like Dr. Zarkin. You could, but Mr. Smart could not.

Ms. GEDZ. Mr. Ganske; is that correct?

Mr. GANSKE. Uh-huh.

Ms. GEDZ. This lawsuit, it wasn't really about the settlements and money. It really was about, in the beginning, it was very embarrassing to me, and I felt completely violated with what he did to me. But in the end, right now, the only purpose of my speaking out and doing all of this publicity and TV shows is because if I can go to sleep and know that it's never going to happen to anybody again, because this is the purpose.

Mr. GANSKE. I guess what—

Ms. GEDZ. I didn't want to sue my insurance company.

Mr. GANSKE. I guess what my point would be is that it may or may not be that you would or would not have chosen Dr. Zarkin if the National Practitioner Data Bank were open because it may or may not have given data that would have made a difference to you in terms of who you chose.

Ms. GEDZ. But if I saw Dr. Zarkin's name in a National Practitioner Data Bank with four former complaints, it doesn't matter how small or big they were, and if I still was—he was recommended to me by a friend, at least I had a chance when I talked to Dr. Zarkin for the first time to ask him about that and expect an explanation why he's reported to the National Practitioner Data Bank and what were his actions.

Mr. GANSKE. Most obstetrician/gynecologists, because that's a high-risk area, over the course of a career very well may have four incidents reported against them, which may or may not have been any negligence on their part, but simply a settlement by an insurance company. So how would you distinguish that?

Ms. GEDZ. Mr. Ganske, every doctor, and being a doctor myself I can tell you, could make a mistake under pressure. But as long as there are no cover-ups and these mistakes are attended accordingly, this is what matters to the patient. Yes, I can do a bad root canal and, yes, I can maybe even extract the wrong tooth. But you know what matters is the patient, when he walks in and asks you for medical care, he wants to be good in the end. He wants to be well.

Mr. GANSKE. I understand.

Ms. GEDZ. So if I made a mistake, but I didn't try to cover it up, and I tried to fix it and tried to tell the patient, "You know what, because I did the bad root canal, let me fix it. Let me do this, this and that, and in the end you would function as you functioned or even better before you came to my office." So—

Mr. GANSKE. What I want to get at, and I don't think it is information you can give us, is along the lines of what Congressman Stupak was getting at, and that was that after this behavior which, as far as I know from everything you have said and I have read in the newspapers, is inexcusable happened, what I want to find out, and I think on the next panel we are going to have the hospital representatives on this, is after that happened, it must have been reported to the operating room Director of Personnel, it must have then gone up the administrative chain to committees, and then your point on this is that he was able to continue—I want to find out what happened to his privileges at that hospital and then I want to find out—

Ms. GEDZ. They were suspended.

Mr. GANSKE. They were suspended?

Ms. GEDZ. Yes.

Mr. GANSKE. Immediately?

Ms. GEDZ. I believe so.

Mr. GANSKE. As soon as they found out? Then what I want to find out is how should that information have been shared with any other hospitals where he had privileges? That is what I want to

find out. And I thank you very much for coming forward on this. And, Mr. Smart, I thank you also.

Mr. SMART. Thank you.

Mr. UPTON. Thank you.

Mr. Bryant?

Mr. BRYANT. Thank you, Mr. Chairman.

I apologize to this panel for having to step out, and I apologize to the subsequent panels when I step out again. Because all of us are on different schedules, as you can see people coming and going, and that is not to say this is not very important, but they schedule us in advance, and we have to do these kind of things.

I am going to try to get back because I still have those questions that I would like to ask or hear answered by the subsequent panels about why the current system we have is not working as well as it should and perhaps how we can improve it.

In listening to these two witnesses, I want to add my appreciation I think that has been certainly offered by everyone on this panel today for you coming forward and testifying.

Doctor, you certainly have, I think Dr. Ganske said, a bizarre situation, very unusual situation where, as I understand it, a doctor intentionally did something. And that, in my experience, that is really an unusual situation. And, Mr. Smart, you certainly have a case that, while not intentional, it appears to be some degree of negligence, a more traditional malpractice case, I would suppose, and certainly with tragic results.

I think, as I sit here and listen to this testimony developing and the statements developed, I kind of see two problems evolving: One is that we have a small percent—1, 2, 3 percent, maybe even 5 percent—of doctors who play the system, and they are able to do things and at the last minute move or plea bargain or whatever, and perhaps these are the ones that need to be completely out of the system, but because they are able to move, relocate, they stay in the system.

And I think clearly what we are talking about in legislation, whether it is at a State level or whether it is Federal legislation, the current State legislation needs to do a better job. Again, I asked the question in my opening statement, how can you do all of this stuff in one State and then just bounce over to another State and be recertified, and licensed and credentialed and those things? But that is really a small percentage, and it needs to be addressed.

But the bigger problem I think the legislation we are talking about would address is all of the other doctors and more the consumer learning about, Dr. Gedz, like you said, if you had seen the doctor and perhaps they had only had one black mark against them, you might not have gone to that doctor. And that is the bigger group out there. And how do we fairly have a system that does that, as I said in my statement, to put these black marks, if you will, or gray marks, if you will, in context so that the average person can understand and how do we do that fairly? Because I think we have to have a balanced system here. We certainly want informed consumers, informed patients. But on the other hand, we want to make sure that it is quality, valuable information that we are putting out there that people can understand and make that decision. I guess that is the bigger problem we are dealing with

here today. As opposed to the doctors that just bounce around from State to State that need to be out of the practice altogether, we are talking about the rest of the doctors that are out there that we are trying to pick and choose from to get quality medical care.

And, again, I would thank you for coming out today, both of you, and would yield back my time.

Mr. UPTON. Thank you.

To both of you I just want to say we have a number of subcommittees that are meeting today. So members are on multiple subcommittees. There is a very important issue on the House floor as well, so that is why members are coming in and out. I would like to say that, for those members that are not here or members that are still here, we may do some follow-up questions. We are going to leave the record open for all members and for all panels today.

But, again, we very much appreciate your openness and willingness to come and tell your story before us. It dramatically speaks for reform, to examine the facts in terms of why even the existing policy and law was not followed. And your statements today are, in fact, very, very helpful to all of us, and we appreciate your time, and it was well spent.

Thank you very much. You are formally excused.

Mr. SMART. Thank you, Mr. Chairman.

Mr. UPTON. The next panel includes the following: Ms. Nancy Sullivan, executive director of the Board of Registration in Medicine from the Commonwealth of Massachusetts; Ms. Barbara Neuman, president of the Administrators in Medicine, Board of Medical Practice, State of Vermont; Dr. Edward Loniewski, from Plymouth, Michigan, testifying on behalf of the American Osteopathic Association; Dr. Rodney Hochman, senior vice president and chief medical officer of Sentara Health System, testifying on behalf of the American Hospital Association; Dr. Tom Reardon, president of the American Medical Association; Dr. Robert Newman, president and CEO of Continuum Health Partners, testifying on behalf of Beth Israel Medical Center; Mr. Wayne Osten, director of the Division of Health Care Standards and Surveillance from the New York State Department of Health; and Mr. Larry Silver, Silver and Field, from Los Angeles, California.

We are going to try and keep strict time. And as you heard from the earlier panel, we have a longstanding tradition of taking testimony under oath. Do any of you have objection to that?

[No response.]

Mr. UPTON. Seeing none, we also allow folks that are testifying to be represented also by counsel. Do any of you want counsel to speak on your behalf?

[No response.]

Mr. UPTON. Seeing none, if you would all stand. Again, raise your right hand.

[Witnesses sworn.]

Mr. UPTON. You are now under oath, and we will start with Ms. Sullivan—Dr. Sullivan. Oh, I see. There are two Sullivans. That is right. We will start with Ms. Nancy Sullivan.

Mr. SULLIVAN. Actually, with me.

Mr. UPTON. Oh, actually, with you. Okay.

TESTIMONY OF MARY ANNA SULLIVAN, CHAIR; ACCOMPANIED BY NANCY ACHIN SULLIVAN, EXECUTIVE DIRECTOR, BOARD OF REGISTRATION IN MEDICINE, COMMONWEALTH OF MASSACHUSETTS; BARBARA NEUMAN, PRESIDENT, ADMINISTRATORS IN MEDICINE, BOARD OF MEDICAL PRACTICE, STATE OF VERMONT; EDWARD LONIEWSKI, ON BEHALF OF AMERICAN OSTEOPATHIC ASSOCIATION; RODNEY F. HOCHMAN, SENIOR VICE PRESIDENT AND CHIEF MEDICAL OFFICER, SENTARA HEALTH SYSTEM, ON BEHALF OF AMERICAN HOSPITAL ASSOCIATION; THOMAS R. REARDON, PRESIDENT, AMERICAN MEDICAL ASSOCIATION; ROBERT G. NEWMAN, PRESIDENT AND CEO, CONTINUUM HEALTH PARTNERS, INC., ON BEHALF OF BETH ISRAEL MEDICAL CENTER; WAYNE M. OSTEN, DIRECTOR, DIVISION OF HEALTH CARE STANDARDS AND SURVEILLANCE, NEW YORK STATE DEPARTMENT OF HEALTH; AND LAWRENCE SILVER, SILVER AND FIELD

Ms. MARY ANNA SULLIVAN. I'm Dr. Mary Anna Sullivan, chair of the Massachusetts Board of Registration in Medicine. On behalf of the members of the board, I thank you for giving us the opportunity to provide the subcommittee with information on the Massachusetts Physician Profiles Project.

Like many practicing physicians, I had concerns about the impact of increased disclosure of physician information on my profession, and we have certainly heard those concerns this morning. But Massachusetts was careful to respect due process and includes only adjudicated or settled malpractice suits or final disciplinary action as information on our profiles.

As Ms. Sullivan will describe in detail, malpractice information is carefully presented in context. It's not a perfect system, and we will continue to try to improve it, but our patients in Massachusetts would have had the information that Ms. Smart, at least, so tragically did not have. If a physician in Massachusetts has been disciplined by us or by his or her hospital or if he or she has paid on a malpractice claim, that information is available to our patients in Massachusetts.

I can assure you that this project has been a tool for positive change for health care in Massachusetts. And interestingly, the concerns of physicians have proved largely groundless. I am proud of our board's leadership positions on many of the complex issues facing all of us who care about quality health care in our Nation. Our Profiles Program is one example of this leadership.

Massachusetts also leads the Nation in another important area, error identification and prevention. Through our confidential and nondisciplinary Patient Care Assessment Program, we address the quality of the health care systems in which individual physicians practice.

Through our other activities, such as disciplinary actions and public information programs, we ensure the competence of our licensees and strengthen the decisionmaking processes for our patients. These approaches are not exclusionary. In fact, they can and should be part of an integrated approach to attaining health care quality. Our board has asked our executive director, Nancy Achin Sullivan, who oversaw the design of the Profiles Project in 1996,

to present the overview of the program, and we will both be happy to answer any questions from the committee at the end of her presentation.

[The prepared statement of Mary Anna Sullivan follows:]

PREPARED STATEMENT OF MARY ANNA SULLIVAN, CHAIR, MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE

I am Dr. Mary Anna Sullivan, Chair of the Massachusetts Board of Registration in Medicine. On behalf of the members of the Board, I thank you for giving us the opportunity to provide the subcommittee with information on the Massachusetts Physician Profiles Project. Like many practicing physicians, I had concerns about the impact of increased disclosure of physician information on my profession. I can assure you that this project has been a tool for positive change for health care in Massachusetts.

I am proud that the Massachusetts Board of Registration in Medicine has taken leadership positions on many of the complex issues facing all of us who care about the quality of health care in our nation. The Physician Profiles Program is one example of this leadership. Massachusetts also leads the nation in another important area: error identification and prevention. Through our confidential and non-disciplinary Patient Care Assessment program, we address the quality of the health care systems in which individual physicians practice. Through other activities, such as disciplinary actions and public information programs, we ensure the competence of our licensees and strengthen the decision-making processes of patients. These approaches are not exclusionary; in fact they can and should be part of an integrated approach to attaining health care quality. The Board has asked our Executive Director, Nancy Achin Sullivan, who oversaw the design and implementation of the Profiles Project in 1996, to present the overview of the program. We will both be happy to answer any questions from the Committee at the end of Ms. Achin Sullivan's presentation.

Mr. UPTON. Go ahead.

TESTIMONY OF NANCY ACHIN SULLIVAN

Ms. NANCY ACHIN SULLIVAN. Thank you, Mr. Chairman and members of the committee. My name is Nancy Achin Sullivan, and I am here to provide information to assist the subcommittee on its deliberations concerning public access to the National Practitioner Data Bank.

Dr. Sullivan and I are not here to advocate for any specific outcome of the legislation at the Federal level. Instead, I would like to talk about the genesis of the Profiles Project in Massachusetts, the common concerns at the Federal and State level, and the outcomes of the Massachusetts project, now entering its fourth year of operation.

I'm also here as a person whose personal experience with health care I think underscores the importance of informed patients. I have survived three separate battles with fairly advanced cancer because I had wonderful doctors who fought for my life. But I live, as I refer to it, under the sword of Damocles of not knowing how long—what my health status will be because my cancers were very advanced in the end because I was misdiagnosed. And those are the issues that face patients every day. And each morning I pass the cemetery near my home where I visit my sister, who died at age 32, leaving a 6-year-old orphan behind. She died of a brain tumor that went undiagnosed for years.

Part of the impetus behind this program in Massachusetts, and I think others like it, is the recognition that families should not live with that lingering doubt, "Did I do enough? Did I do every-

thing? Did I get every resource, including every information resource?"

My primary message about the Physician Profiles Program, and I hope the committee members will come away with this, is that it is not in Massachusetts seen as a tool to identify and punish bad doctors. Instead, it's an educational tool. It is not disciplinary in nature. The program's primary goal is to help patients find the right doctors for them and for their families. It's the responsibility of the State medical boards to remove bad doctors from practice. The existence of the public information program does not relegate that responsibility to the consumer. This is something different.

In November 1996, the Massachusetts Board unveiled the Physician Profiles Project in partnership with its lead sponsor, the Massachusetts Medical Society, the State legislature and the Governor. The Profiles Project was the first of its kind in any State and has since enabled millions of health care consumers to learn more about the physicians to whom they entrust their care. And I have supplied the committee with a breakdown of some of that information. Our recent numbers show that 4.9 million profiles have been accessed either through our website or through other educational tools we have for our consumers.

Prior to 1996, the Board collected a great deal of information about consumers. Some of it was available to the public, if requested; some was statutorily protected and was not disclosed. As public interest in health care has grown, the Board undertook a very long examination of what information was appropriate and how it could be presented to the public in a way that was organized and set in appropriate context to be useful.

And finding the balance between the appropriate and useful information for consumers in protecting physicians from unwarranted adverse effects is difficult, but difficult is not impossible. That's why we have leadership, and that's what I hoped that we have achieved in Massachusetts and that that will be the goal for whatever your—wherever your deliberations take you.

The medical community raised very reasonable issues, and we tried to measure for that: The fear that physicians would leave the State, reducing access to quality care; targeting of physicians who already had malpractice payments with frivolous lawsuits; and the possible chilling effect on peer-review reporting.

In Massachusetts, these concerns did not become reality. Since the inception of the Profiles Program, the number of licensed physicians has not decreased; in fact, it is steadily increasing, particularly in the area of young physicians coming to train in our State and stay in our State.

The decision to reveal the physician's malpractice history did cause the greatest concern and did really create the greatest challenge for us. The concerns raised included the issue of targeting doctors with frivolous suits. Another major concern was how to present the data in a context that accounted for differences among specialties, where we know that there would be different experiences expected. The malpractice data really very vividly demonstrates the need for context as the data is reported.

We resolved the issue by reporting only the malpractice payments, not pending suits; by demonstrating how the individual

record—physician's record compared to other physicians in the same specialty; and by categorizing the payments in terms of it falling at, above or below the average for that specific specialty. We believe in large, to a large degree, that does address some of the small nuisance suits, as I think many people consider the settlements because they do report as being substantially below the average.

Based on the Massachusetts' experience, it's strongly recommended that any Federal disclosure law be crafted in a manner that allows for this type of contextual information. Simply throwing out raw data is not going to be helpful. The committee may wish to establish levels of contextual setting that reflect not only difference in specialty, but regional differences. The statistical data support the general impression that the Physician Profiles Project has not changed the nature of malpractice in Massachusetts. In fact, our rate for malpractice payments has decreased since the release of the Physician Profiles Project. And, again, that information is included as an attachment for the committee.

In 1998, when the national rate was at 21.1 suits per thousand doctors, a decrease of 5.2 percent from the period before, the Massachusetts' rate had declined during the same period 12.4 percent. So we think that it has not had the effect for which we were very carefully measuring out of respect for our doctor community.

Other States with physician populations similar to ours had different results for the same period. New York's malpractice rate on that same measure increased. New Jersey, Connecticut and Rhode Island all had increases on that measure, and they didn't have disclosure laws.

And, again, the chilling effect on peer-review reporting has not materialized. Our Licensure and Clinical Privileges reports, as reported to the Data Bank, have remained constant in Massachusetts. They have maintained the same tight level as national changes in addition. And, again, that is included as an attachment for the committee.

The Physician Profiles Program in Massachusetts has been a tremendous success. The very reasonable fears voiced by organized medicine did not come true. The response from the public has been tremendous. Since Profiles was launched, nearly 4.9 million profiles have been given to the public through the website or through the call center. It has really become part of the culture of medicine in Massachusetts. Countless numbers of patients have been given the tools to have more helpful and rewarding discussions with their physicians because they had good information to stimulate that conversation. And, again, wherever your deliberations take you, I hope that is the outcome, that people have better information.

[The prepared statement of Nancy Achin Sullivan follows:]

PREPARED STATEMENT OF NANCY ACHIN SULLIVAN, EXECUTIVE DIRECTOR,
MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE

My name is Nancy Achin Sullivan. I am here today to provide information to assist the subcommittee on Oversight and Investigations deliberations concerning Public Access to the National Practitioner's Data Bank. Dr. Sullivan and I are not here to advocate for any specific outcome or legislation on the Federal level. Instead, I will share the genesis of the Massachusetts Physician Profiles Project; common concerns shared by both federal and state entities; and the outcomes of the Massachusetts Profiles Project, now entering its fourth year of operation.

I am also here as a person whose personal experience with health care underscores the importance of informed patients. I have survived three separate battles with cancer because I had wonderful doctors who fought for my life. I live beneath the sword of Damocles of being in remission with a cancer that would not have been so advanced had I not been misdiagnosed. Each morning I pass the cemetery near my home where I visit my sister who died of cancer at age 32 from a brain tumor that went undiagnosed for years by her doctor. Part of the impetus behind programs like the Massachusetts Physician Profiles is the recognition that families should not live with the lingering doubt about whether or not they utilized all resources available, including information resources, in obtaining treatment for a loved one.

I have one primary message about the Physician Profiles Program that I hope the Committee members will remember. The Physician Profiles Program is not designed to identify or to punish bad doctors. The Profiles Program is an educational tool; it is not disciplinary in nature. The Program's primary goal is to help patients find the right doctors for them and their families. It is the responsibility of state medical boards to remove bad doctors from practice. The existence of a public information program does not relegate a board's responsibility to consumers.

In November 1996, the Massachusetts Board of Registration in Medicine unveiled the Physician Profiles Project in partnership with the Massachusetts Medical Society, the state legislature, and the Governor. The Profiles Project was the first of its kind in any state in the nation, and has since enabled millions of health care consumers to learn more about their physicians to whom they entrust their care. Prior to 1996, the Board collected a great deal of information about physicians. Some of this information was available to the public, if requested. Other information was statutorily protected from disclosure, leaving health care consumers unable to access most of this information. As public interest in health care information grew, the Board undertook a long examination of how to respond to the public's need for information. The underlying challenge to starting a comprehensive information system such as the Profiles Project is to identify how much information should be disclosed to the public and how the information can be organized and placed into appropriate context to be both beneficial to the consumer and fair to the physician. (Attachment 1)

Finding the balance between appropriate and useful information for consumers and protecting physicians from unwarranted adverse information is difficult. The medical community raised reasonable issues of concern as the Profiles Program was being implemented. The concerns included :

- The fear that physicians would leave the state and reduce the number of high quality health care practitioners;
- Possible targeting of physicians with reported malpractice payments with frivolous lawsuits;
- A possible "chilling effect" on peer reporting of physicians if the action would appear on Profiles.

In Massachusetts, these concerns did not become reality. Since the inception of the Physician Profiles Program, the number of licensed physicians in Massachusetts has not decreased. In fact, the Commonwealth continues to attract thousands of the most talented young physicians in the nation through its world-renowned medical training programs.

The decision to reveal a physician's malpractice history caused the greatest concern for many doctors. The concerns raised included possible targeting of physicians who had malpractice payments with additional, frivolous suits. Another concern was how to present the data in a context that accounted for differences in expected malpractice history among various specialties. It is the malpractice data that most vividly demonstrates the need for context as the data is reported. The Massachusetts Board of Registration in Medicine resolved the issue by reporting only malpractice payments, not pending suits; by demonstrating how the individual physician's record compared to other physicians in the same specialty; and by categorizing the payment in terms of its falling at, above, or below the average for the specific specialty. Based on the Massachusetts experience, it is strongly recommended that any Federal disclosure law be crafted in a manner that allows this type of contextual information. The Committee may wish to establish levels of contextual setting that reflect not only differences among practice specialty, but also regional differences.

The statistical data support the general impression that the Physician Profiles Project has not changed the nature of malpractice payments in Massachusetts. In fact, the Massachusetts rate for malpractice payments has actually decreased since the release of the Physician Profiles Project in late 1996. The national average (payments per 1,000 physicians) in 1996 was 22.34. At the same time, the Massachusetts rate was 10.81. By 1998, the national average rate was 21.18, a decrease of 5.2%. In Massachusetts, the rate declined from 10.81 to 9.26%, a decrease of 12.36%.

The Massachusetts decline in the rate of malpractice payments was 2.4 times greater than the national decline.

Other states with physician populations similar to that of Massachusetts had very different results for the same period. For example, New York's malpractice rate rose from 26.94 to 28.99, an increase of 7.6%. New Jersey, Connecticut and Rhode Island all had increases in the rate of malpractice payments reported by the NPDB during the period, yet these states had no disclosure laws in place. (Attachment 2)

The feared "chilling effect" on peer reporting has not materialized in Massachusetts. Licensure and Clinical Privileges reports about physicians have remained constant in Massachusetts. In 1997 and 1998 the number of reports from physician peers and/or facilities remained 3.09 reports per thousand Massachusetts physicians. From 1996 to 1997, the national reporting rate for this measure decreased from 7.04 per 1,000 physicians to 6.35. This was consistent with the Massachusetts decline for the same period from 3.71 to 3.09. (Attachment 3)

The Massachusetts Physician Profiles Project has been a tremendous success. The reasonable fears voiced by organized medicine did not come true. The response from the public has been tremendous. Since the Profiles Project was launched in November 1996, nearly 4.9 million Profiles have been given to consumers through the Board's website or through its call center. It has become part of the culture of progressive health care in Massachusetts. Countless numbers of patients in Massachusetts have been given the tools to have more helpful and rewarding discussions with their physicians because they had good information to stimulate that conversation.

ATTACHMENT 1.

Information Included on the Massachusetts Physician Profiles Program

By logging onto www.massmedboard.org or by calling the Board's toll-free number, 1-800-377-0550, users can have access to timely data on a physician's:

- business and professional demographics;
- education and training;
- hospital affiliations;
- insurance plans that are accepted;
- paid malpractice claims;
- hospital discipline;
- Board disciplinary actions (if any);
- criminal history (if any).

The Profile does not include:

- the number of suits filed against a physician;
- information about hospital or physician complications;
- patient mortality rates;
- malpractice dollar awards.

The Massachusetts Physician Profiles Project has become a popular consumer product of the Massachusetts Board of Registration in Medicine. In its first year alone, web site activity indicated that there were over 1,600,000 hits. Currently, the Profiles system operates at over 3,000,000 hits per year.

ATTACHMENT 2

Rate of Malpractice Payments for Massachusetts and Selected States.

Malpractice Payment Reports per 1,000 Physicians, by State

(National Practitioner Data Bank, 1994-98)

State	1994		1995		1996		1997		1998	
	Rate	Adjusted Rate	Rate	Adjusted Rate	Rate	Adjusted Rate	Rate	Adjusted Rate	Rate	Adjusted Rate
CA	24.47	24.47	19.45	19.40	22.74	22.70	23.67	22.97	19.26	18.84
CT	12.42	12.42	14.19	14.19	11.23	11.23	12.92	12.75	13.01	12.84
FL	26.37	26.27	26.96	26.87	32.70	32.52	34.11	32.07	31.87	30.30
ME	14.53	14.53	12.79	12.79	12.56	12.18	15.99	15.54	12.94	12.58
MD	11.60	11.50	11.38	11.33	12.00	12.00	12.00	11.37	13.11	12.64
MA	11.18	11.18	9.90	9.90	10.81	10.81	9.20	8.66	9.53	9.26
MI	53.19	53.14	50.85	50.80	32.40	32.40	31.58	30.40	35.84	34.76
NH	32.52	32.52	21.12	20.72	27.38	27.38	19.77	18.62	22.05	21.18
NJ	26.96	26.87	23.51	23.28	23.12	23.08	20.56	19.64	25.77	25.05
NY	32.26	32.18	25.55	25.52	27.00	26.94	27.94	26.98	29.66	28.99
OHIO	25.23	25.15	25.42	25.34	26.93	26.86	24.65	23.73	16.55	16.11

Rate of Malpractice Payments for Massachusetts and Selected States.—Continued

Malpractice Payment Reports per 1,000 Physicians, by State
(National Practitioner Data Bank, 1994-98)

State	1994		1995		1996		1997		1998	
	Rate	Adjusted Rate								
PA	37.93	28.19	38.29	28.89	42.82	28.87	41.33	27.14	34.86	22.16
RI	19.02	17.61	19.25	18.92	19.00	19.00	27.38	25.38	23.51	22.32
TX	30.70	30.61	28.11	28.01	28.58	28.55	24.36	22.83	26.03	25.04
DC	13.61	13.61	10.23	10.23	17.66	17.66	15.67	16.69	21.64	23.42
Total	24.80	23.91	21.87	21.06	23.42	22.34	22.85	20.90	21.83	21.18

Source: NPDB

ATTACHMENT 3

Malpractice Payment and Licensure and Clinical Privileges Reports per 1,000 Physicians, by State, Last Five Years

(National Practitioner Data Bank, 1994-98)

	MedMal	L & P						
CONN	11.23	4.81	12.75	4.75	12.84	4.66	12.69	4.98
MASS	10.81	3.71	8.66	3.09	9.26	3.09	9.96	3.60
MICHIGAN	32.40	10.58	30.40	8.45	34.76	10.72	40.30	9.05
NEW YORK	26.94	5.68	26.98	5.87	28.99	6.64	28.13	5.680
HIO	26.86	10.81	23.73	8.11	16.11	11.63	23.46	10.29
PENN	28.87	5.19	27.14	6.01	22.16	3.88	27.05	4.57
RI	19.00	9.02	25.38	6.73	22.32	8.26	20.71	7.47
VERMONT	17.00	6.68	20.80	12.13	28.31	6.93	21.31	9.43
TOTAL	22.34	7.04	20.90	6.35	21.18	6.53	21.90	6.56

This table includes only disclosable reports in the NPDB as of December 31, 1998. The rates for 1994 through 1997 may differ from those shown in previous Annual Reports because of modifications and voided reports. Modified reports are counted in the year of modification.

Data on the number of physicians: For 1994: The number of physicians is the number of "total physicians" less the number of physicians listed as inactive or "address unknown" as of January 1, 1994 from Table D-7 of the American Medical Association's Physician Characteristics and Distribution in the U.S., 1995-96 edition. For 1995: The number of physicians is the number of "total physicians" less the number of physicians listed as "inactive" or "address unknown" as of December 31, 1995 from Table D-7 of the American Medical Association's Physician Characteristics and Distribution in the U.S., 1996-1997 edition. For 1996: The number of physicians is the number of "total physicians" less the number of physicians listed as "inactive" or address unknown as of Dec. 31, 1996 from Table E-7 of the American Medical Association's Physician Characteristics and Distribution in the U.S., 1997-98 edition. For 1997-1998: The number of physicians is the number of "total physicians" less the number of physicians listed as "inactive" or "address unknown" as of Dec. 31, 1997 from Table E-7 of the American Medical Association's Physician Characteristics and Distribution in the U.S., 1999 edition.

Mr. UPTON. Thank you very much.

Ms. Neuman? And we will let you get that mike close to you as well. There is a little warning light. I don't know, I have not been on that side of the table, but on this side it has a little—do you see it? That comes with a minute to go.

TESTIMONY OF BARBARA NEUMAN

Ms. NEUMAN. Mr. Chairman and distinguished members of the subcommittee, I am Barbara Neuman, president of the Administrators in Medicine, the national organization for State Medical and Osteopathic Board Executive Directors. I want to thank you today for holding this hearing on this very important consumer access issue.

As a founder of the Administrators in Medicine's free online DocFinder, I have seen firsthand the benefits of consumer access to physician information. DocFinder is a centralized website of States providing physician information for consumers in an easily searchable format. DocFinder has been extremely popular with consumers, receiving millions of hits since it was launched in 1996.

One reason for its popularity is that DocFinder has helped provide basic information to consumers in managed care plans, many of whom are handed a list of doctors and told to make a decision with little more information than name, address and specialty.

DocFinder information comes directly from the 18 State medical and osteopathic boards on the site and includes States with physician profile laws, such as Massachusetts. Physician profile laws provide medical malpractice, criminal conviction, hospital discipline and board disciplinary action information to the public. Eleven States have passed various versions of the profile law.

During the past 2 years, our organization has been active in assisting State boards in the implementation of physician profile laws by holding annual meetings of the profile States, including those with pending legislation. The inability of the public to access the National Practitioner Data Bank has required State medical boards to "reinvent the wheel" in implementation of profile laws. Except for criminal conviction information, the major data components to implement a physician profile law are contained in the National Practitioner Data Bank. But since the information is not public, States are faced with no other choice but to collect the information all over again at great expense.

I believe a strong State and Federal partnership can be forged to improve public information available about all physicians. State medical board data bases in the DocFinder contain information about all State licensees. The National Practitioner Data Bank contains reported information about certain physicians. In fact, the administrator of HRSA noted that most doctors never wind up in the National Practitioner Data Bank. Expanding consumer access to the National Practitioner Data Bank's single national clearinghouse would make it harder for problem physicians to move undetected from one State to another because both data bases, the State medical board data bases in the DocFinder and the National Practitioner Data Bank, would be working together.

It is my opinion, based on 16 years' experience as a medical board executive director, that the National Practitioner Data Bank should be open to the public. I believe that consumers have a right to this information to make informed choices about their health care. We have now had experience with disclosing this kind of information to consumers in the profile States. The data provided in the testimony of the Massachusetts Board indicates that the issues of concerns raised by the medical community have not come to pass, including the issue of greatest concern—malpractice history. But as with profile information, the National Practitioner Data Bank information should be put into context to help consumers understand the data. Calling on the expertise of the profile States to assist in this process would make sense.

I also believe that the National Practitioner Data Bank should be expanded to include records of criminal convictions and that information relating to these criminal convictions should be made available to the public. The information also will help State medical boards, health plans and hospitals currently lacking this information.

The legislation which led to the creation of the National Practitioner Data Bank was enacted because Congress believed that the

increasing occurrence of medical malpractice litigation and the need to improve quality of medical care had become nationwide problems that warranted greater efforts that any individual State could undertake. As we move to improve patient safety and reduce medical errors nationwide by discouraging secrecy, I believe it is time to remove the secrecy surrounding the National Practitioner Data Bank and to allow informed consumer access to the information. It has been my experience that secrecy protects the bad doctors, not the good ones.

Thank you for this opportunity to testify, and I would be happy to answer any questions.

[The prepared statement of Barbara Neuman follows:]

PREPARED STATEMENT OF BARBARA NEUMAN, PRESIDENT, ADMINISTRATORS IN MEDICINE

Mr. Chairman and Distinguished Members of the Subcommittee: I am Barbara Neuman, President of the Administrators in Medicine, the National Organization for State Medical and Osteopathic Board Executive Directors. I want to thank you for holding this hearing on this very important consumer access issue.

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DocFinder information comes directly from the 18 state medical and osteopathic boards on the site and includes states with physician profile laws such as Massachusetts. Physician profile laws provide medical malpractice, criminal conviction, hospital discipline and board disciplinary action information to the public. Eleven states have passed various versions of a profile law.

During the past two years, our organization has been active in assisting state boards in the implementation of physician profile laws by holding annual meetings of the profile states including those with pending legislation. The inability of the public to access the National Practitioner Data Bank has required state medical boards to "reinvent the wheel" in the implementation of profile laws. Except for criminal conviction information, the major data components to implement a profile law are contained in the National Practitioner Data Bank but since the information is not public, states are faced with no other choice but to collect the information all over again at great expense.

I believe a strong state and federal partnership can be forged to improve the public information available about all physicians. State medical board databases in the DocFinder contain information about all state licensees. The National Practitioner Data Bank contains reported information about certain physicians. In fact the Director of HRSA noted that most doctors never wind up in the National Practitioner Data Bank. Expanding consumer access to the National Practitioner Data Bank's single national clearinghouse would make it harder for problem physicians to move undetected from one state to another because both databases—the state medical board databases in the DocFinder and the National Practitioner Data Bank would be working together.

It is my opinion based on sixteen years experience as a Medical Board Executive Director that the National Practitioner Data Bank should be open to the public. I believe that consumers have a right to this information to make an informed choice about their health care. We have now had experience with disclosing this kind of information to consumers in the profile states. The data provided in the testimony of Massachusetts Board indicates that the issues of concern raised by the medical community have not come to pass including the issue of greatest concern—malpractice history. But as with profile law information, the National Practitioner Data Bank information should be put into context to help consumers understand the data. Calling on the expertise of the profile states to assist in this process would make sense.

I also believe that the National Practitioner Data Bank should be expanded to include records of criminal convictions and that information relating to these criminal

convictions should be made available to the public. This information also will help state medical boards, health plans and hospitals currently lacking this information.

The legislation which led to the creation of the National Practitioner Data Bank was enacted because Congress believed that the increasing occurrence of medical malpractice litigation and the need to improve the quality of medical care had become nationwide problems that warranted greater efforts than any individual state could undertake. As we move to improve patient safety and reduce medical errors nationwide by discouraging secrecy, I believe it is time to remove the secrecy surrounding the National Practitioner Data Bank and to allow informed consumer access to the information. It has been my experience that secrecy protects the bad doctors, not the good ones.

Thank you for this opportunity to testify. I would be happy to answer any questions.

Mr. UPTON. Extra credit for not using the full 5 minutes.

Ms. NEUMAN. Thank you.

Mr. UPTON. Dr. Loniewski, you are going to have to say it for me.

Mr. LONIEWSKI. Loniewski.

Mr. UPTON. Loniewski, got it. Thank you.

TESTIMONY OF EDWARD LONIEWSKI

Mr. LONIEWSKI. Chairman Upton and members of the committee, my name is Edward A. Loniewski, D.O. I am a retired orthopedic surgeon, which by the way is also a high-risk specialty, from the State of Michigan and a past president of the American Osteopathic Association. I am also a board member of the National Practitioner Data Bank Executive Committee. On behalf of the 44,000 osteopathic physicians represented by the American Osteopathic Association nationwide, I appreciate the opportunity to testify on the issue of the National Practitioner Data Bank.

A full discussion of the AOA's positions is found in my prepared remarks, but I will just highlight a few for you today.

The AOA opposes the National Practitioner Data Bank and any attempt to make the information in that bank public in its current form because the information included within it regarding malpractice settlements and adverse actions can be misleading. The use of such misleading information by hospitals and insurers is damaging physicians' careers. While the intent is to track the negligent practitioner, the information that is currently housed in the Data Bank is often not appropriate for that purpose. Although the AOA opposes the current National Practitioner Data Bank, the Association does not oppose a Federal Data Bank that is open to the public if the information accurately reflects the negligence of the practitioner. As I will state later in my testimony, these practitioners can be identified through true peer review.

The NPDB places much emphasis on medical malpractice. When a medical malpractice payment is made on behalf of a practitioner, payment information must be reported to the Data Bank. In many cases, a malpractice settlement or judgment simply is not a good barometer for quality of care. Recent studies have shown that among malpractice claims, the severity of the patient's disability, not the occurrence of the adverse event or an adverse event due to negligence, was predictive of payment to the plaintiff.

In addition, malpractice claims studies show that between a half and two-thirds of the claims were brought with no apparent indication of negligence. Oftentimes a physician's malpractice insurer will

settle the case, not because the practitioner is guilty of malpractice, but to avoid the even greater expenses of taking a suit to court.

The harm created by the misleading entry concerning your malpractice settlement is very real. Whenever a doctor applies for a position or clinical privileges on a hospital medical staff at any hospital staff in the United States, that hospital is legally required to request information concerning the physician from the Data Bank and thus will learn of the settlement and consider it in connection with his or her application. As such, a physician's ability to secure positions at other hospitals in the United States is severely damaged.

State medical and dental boards, hospitals, professional societies and other health care entities must report certain adverse actions related to the practitioner's professional competence or conduct. While a physician has a right to rebut the information in the Data Bank, it is not sufficient to correct the damage that it causes. A small-town New Mexico physician White House was reported to the Data Bank after her obstetrical privileges were revoked reported that she could not relocate because of the Data Bank report. The physician sued those responsible for making the Data Bank report and won a favorable verdict. The court found that the physician suffered impairment of reputation and standing in the community when she applied for privileges at a new hospital and had to explain why her privileges had been revoked by the hospital which reported her to the Data Bank. The court also noted, "An opportunity for rebuttal seldom suffices to undo harm of defamatory falsehoods."

In conclusion, to summarize, the AOA opposes the National Practitioner Data Bank as it currently functions because the information included within it regarding malpractice settlements and adverse actions can be misleading and is damaging to careers of good, competent physicians. However, the AOA is not opposed to having a Federal Data Bank that is open to the public if, and I repeat, only if the information accurately reflects the negligence of the practitioner. These practitioners can be identified through true peer review. To wit, when a professional organization, licensing board or true peer review organization comprised of physicians of the same specialty have ruled that a practitioner has been negligent in his or her performance of patient care, the public has a right to know. But I emphasize that before any information is made public, it must pass the true test of true peer review.

Thank you for this opportunity to testify before this committee.
[The prepared statement of Edward Loniewski follows:]

PREPARED STATEMENT OF EDWARD A. LONIEWSKI ON BEHALF OF THE AMERICAN
OSTEOPATHIC ASSOCIATION

Introduction

Chairman Upton and Members of the Committee, my name is Edward A. Loniewski, D.O. I am a retired orthopedic surgeon from the State of Michigan and the past president of the American Osteopathic Association. I am also a board member of the National Practitioner Data Bank Executive Committee. On behalf of the 44,000 osteopathic physicians represented by the American Osteopathic Association (AOA) nationwide, I appreciate the opportunity to testify on the issue of the National Practitioner Data Bank.

The AOA is the national professional organization for osteopathic physicians who number over 44,000 in the United States. In addition, the AOA is the recognized

accrediting authority for colleges of osteopathic medicine, osteopathic postdoctoral training programs and osteopathic continuing medical education.

Osteopathic medicine is one of two distinct branches of medical practice in the United States. While allopathic physicians (MD) comprise the majority of the nation's physician workforce, osteopathic physicians (DO) comprise more than five percent of the physicians practicing in the United States. Significantly, D.O.s represent more than 15 percent of the physicians practicing in communities of less than 10,000 and 18 percent of physicians serving communities of 2,500 or less.

AOA's Position

The AOA opposes the National Practitioner Data Bank and any attempt to make the information in that data bank public in its current form because the information included within it regarding malpractice settlements and adverse actions can be misleading. The use of such misleading information by hospitals and insurers is damaging physicians' careers. While the intent is to track the negligent practitioners, the information that is currently housed in the data bank is often not appropriate for that purpose. The problems I will highlight today include:

- Medical Malpractice and Adverse Action Data
- Practitioner's Right to Recourse
- Corporate Shield

Although the AOA opposes the current National Practitioner Data Bank, the Association does not oppose a federal data bank that is open to the public if the information accurately reflects the negligence of the practitioner. As I will state later in my testimony, these practitioners can be best identified through true peer review.

Background of National Practitioner Data Bank

The National Practitioner Data Bank (NPDB) was established through Title IV of the Health Care Quality Improvement Act of 1986, as amended. The intent of the law was to improve the quality of health care. The purpose was to encourage hospitals, state licensing boards and other health care entities including professional societies to identify and discipline those who engage in unprofessional behavior and then restrict the ability of incompetent physicians, dentists and other health care practitioners to move from state to state without disclosure or discovery of previous damaging or incompetent performance.

The NPDB is supposed to act as a clearinghouse of information. Its records include data relating to medical malpractice settlements and judgements as well as adverse actions taken against the licenses, clinical privileges and professional society memberships of physicians, dentists, and other licensed practitioners. The Data Bank also contains information regarding practitioners who have been declared ineligible to participate in Medicare and/or certain other state health care plans under the Social Security Act.

Practitioners may not submit changes to reports. The practitioner must contact the reporting entity to request corrections if there are any inaccuracies. A practitioner may add a statement to the report and/or dispute either the factual accuracy or whether the report was submitted in accordance with NPDB reporting requirements. The practitioner may also request that the Secretary of Health and Human Services review the issues, if the practitioner and reporting entity cannot resolve the issues in dispute.

The NPDB is a resource for state licensing boards, hospitals and other health care entities in conducting investigations into the qualifications of practitioners they seek to license or hire or to whom they wish to grant membership or clinical privileges. The Data Bank information should be considered with other relevant information in evaluating a practitioner's credentials.

Flaws Within NPDB

The NPDB places much emphasis on medical malpractice. When a medical malpractice payment is made on behalf of a practitioner, payment information must be reported to the Data Bank. However, settlement of a medical malpractice claim may occur for a variety of reasons that do not reflect negatively on the competence or conduct of the practitioner. In many cases, a physician's malpractice insurer will settle the case—not because the practitioner is guilty of malpractice—but to avoid the even greater expenses of taking the suit to court. Sometimes this is even done without the consent of or notice to the physician.

For example, the AOA and Kansas Association of Osteopathic Medicine recently filed a brief of Amici Curiae in the Kansas Court of Appeals on behalf of an osteopathic physician licensed to practice in the State of Kansas (Miller v. Sloan, Listrom, et al, District Case # 95-CV-328). This lawsuit concerned the settlement of a medical malpractice claim by an insurer without the physician's knowledge or

consent. In accordance with federal laws and regulations, the settlement then was reported to the National Practitioner Data Bank, where the report now stands as a permanent part of the physician's record.

Because a malpractice settlement was made without the physician's knowledge or consent, he had no opportunity to contest the settlement, deny his liability or explain to the NPDB his belief that he did nothing wrong when treating the patient. In fact, the doctor only learned of the settlement through the National Practitioner Data Bank, where the report has become a permanent scar on the doctor's record.

The harm created by the misleading entry concerning a malpractice settlement is very real. Now, whenever this doctor applies for a position or clinical privileges on a hospital's medical staff—at any hospital staff in the United States—that hospital is *legally required* to request information concerning the physician from the Data Bank and, thus, will learn of the settlement and consider it in connection with his application. As such, the physician's ability to secure positions at other hospitals in Kansas and elsewhere in the United States has been severely damaged.

In many cases, a malpractice settlement or judgement simply is not a good barometer for quality of care. A study published in *The New England Journal of Medicine* (December 26, 1996—Vol. 335, No. 26) showed that among the malpractice claims, "the severity of the patient's disability, not the occurrence of an adverse event or an adverse event due to negligence, was predictive of payment to the plaintiff."

The *Rand Health Law Issue Paper* of July 1999 (*A Flood of Litigation? Predicting the Consequences of Changing Legal Remedies Available to ERISA Beneficiaries*; Carole Roan Gresenz, Deborah R. Hensler, David M. Studdert, Bonnie Dombey-Moore, Nicholas M. Pace, *A Rand Health Law Issue Paper*, July 1999) stated that several studies have reviewed medical malpractice claims files to determine the relative frequency of appropriate and inappropriate suits (Harvard, 1990; Cheney et al., 1989; Farber and White, 1991; McNulty, 1989) and found that between half and two-thirds of claims are brought with no apparent indication of negligence.

Adverse Actions

State medical and dental boards must report certain disciplinary actions, related to professional competence or conduct taken against the licenses of physicians or dentists, including revocation, suspension, censure, reprimand, probation and surrender.

Hospitals and other eligible health care entities must report professional review actions that may restrict or revoke a practitioner's clinical privileges due to issues related to conduct or competence. Professional societies are also required to report specific information when any professional review action due to professional competence or conduct adversely affects the membership of the practitioner.

One small-town New Mexico physician who was reported to the Data Bank after her obstetrical privileges were revoked reported that she could not relocate because of the Data Bank report. Notably, that physician sued those responsible for making the Data Bank report on a number of theories, including defamation, and obtained a favorable jury verdict. On appeal, the court found that sufficient evidence was presented for a jury to have concluded the physician suffered impairment of reputation and standing in the community, when she applied for privileges at a new hospital and had to explain why her privileges had been revoked by the hospital which reported her to the Data Bank. Significantly, though the physician was ultimately granted privileges at the new hospital, the Court did not feel that the physician's damage claim was undermined since: "an opportunity for rebuttal seldom suffices to undo harm [sic] of defamatory falsehood."

Corporate Shield

Another problem that has arisen is what is termed the "corporate shield." This refers to those instances where an individual health care practitioner's name is removed from a case, usually during the settlement process, and replaced with some corporate entity. When this occurs, even though a settlement was made, no report is filed to the NPDB. Removing a person's name for the sole purpose of hiding that individual is illegal under the original statute under which the NPDB was created (the Health Quality Improvement Act of 1986).

To address this issue, the Health Resources and Services Administration (HRSA) published a proposed rule on Christmas Eve, December 24, 1998. HRSA defines the goal of the proposed change to be "to prevent the evasion of Data Bank medical malpractice reporting requirements." The proposed rule describes instances "in which a plaintiff in a malpractice action has agreed to dismiss a defendant health care practitioner from a proceeding, leaving or substituting a hospital or other corporate entity as defendant, at least in part for the purpose of allowing the practitioner to avoid having to report on a malpractice payment made on his or her behalf sub-

mitted to the Data Bank." In this circumstance, this "corporate shield" allows for no report to be filed with NPDB.

The AOA does not disagree with HRSA that this "evasion of the reporting requirement" is wrong. However, the remedy that HRSA proposes is equally wrong. It contains numerous factual, legal, and practical shortcomings. Among the problems are:

1. Failure to make any effort to create a factual record to document the existence and scope, if any, of the so-called "corporate shield" problem.

According to HRSA, the Department of Health and Human Services (DHHS) is aware of efforts to evade the reporting requirements, especially with respect to self-insured entities. However, no effort was made to document this assertion. As a member of the NPDB Executive Committee, I participate regularly in the Committee meetings. Audit results, studies, or other evidence of the existence or extent of the "corporate shield" problem were not reported during any of the meetings I attended.

2. Lack of statutory authority to expand the reporting requirements beyond those set forth in the Health Care Quality Improvement Act.

HRSA's plan would expand the reporting requirement beyond the name of "any physician or licensed health care practitioner for whose benefit the payment was made," which is provided for by Congress in the Health Care Quality Improvement Act. In place of this narrow mandate, the proposed rule would make it the "responsibility of the payer, during the course of its review of the merits of the claim, to identify *any* practitioner whose professional conduct was at issue in that malpractice action or claim that resulted in a payment, and report that practitioner to the Data Bank." [emphasis added] This rule far exceeds the statutory authority delegated by Congress.

3. Imposition of substantial administrative burdens and costs on health care providers and their insurers which will ultimately be passed on to health care consumers.

The requirement that the payer identify any practitioners whose conduct was at issue would impose investigative and claim costs far beyond those currently incurred by insurers in processing medical malpractice claims. The proposal would require the payer to identify each health care entity with which the practitioner is affiliated. This would include any managed care organization, group practice, clinic, medical society or other group that provides health care services and engages in a peer review process. In addition the payor would also have to identify all practitioners who might be involved in the claim.

If this requirement were imposed, a significant administrative burden would be added to those already in existence for the payer. Cost of health care and medical liability insurance would undoubtedly increase, and ultimately be passed onto the consumer.

4. Lack of fairness and due process involved in reporting practitioners.

Serious fairness and due process concerns are raised by the requirement that payers report any practitioner whose conduct was at issue, regardless of whether or not that practitioner was actually named in the claim. Attention must be given to the adverse impact a report to the Data Bank may have on a health care provider's career and reputation.

The American Osteopathic Association, along with a large number of other organizations, brought this issue to the attention of the DHHS General Counsel, Harriet S. Rabb, and HRSA Administrator, Claude E. Fox, M.D., M.P.H. at a September 29, 1999 meeting. Dr. Fox said that HRSA would withdraw the Dec. 24, 1998 NPDB proposal. However, to date no withdrawal notice has been published in the *Federal Register*, so the proposal has yet to be formally withdrawn.

Conclusion

To summarize, the AOA opposes the National Practitioner Data Bank as it currently functions because the information included within it regarding malpractice settlements and adverse actions can be misleading. The use of such misleading information by hospitals and insurers is damaging physicians' careers. However, the AOA is not opposed to having a federal Data Bank that is open to the public if the information accurately reflects the negligence of the practitioner. These practitioners can be identified through true peer review, to-wit: when a professional organization, licensing board or true peer review organization (comprised of physicians of same specialty) has ruled that a practitioner has been negligent in his/her performance of patient care, the public has a right to know. But I emphasize that before any information is made public, it must pass the true test of peer review.

The National Practitioner Data Bank has serious flaws, which make it inadequate for the purpose it is meant to fulfill. I encourage each of you to carefully consider the issues presented today.

Americans have a right to the best medical care possible and physicians have a right to be treated fairly when under review by government agencies, review boards, hospitals and their peers.

Thank you for the opportunity to testify today. The AOA stands ready to participate in a bipartisan effort to develop a data bank that will truly protect the quality of patient care.

Mr. UPTON. Thank you very much.

Is it pronounced Dr. Hochman?

Mr. HOCHMAN. Hochman.

Mr. UPTON. Hochman. Great. Terrific.

TESTIMONY OF RODNEY F. HOCHMAN

Mr. HOCHMAN. Thank you, Mr. Chairman. I think you have a complete text of our comments, and I will try to keep my remarks in the 5-minute timeframe.

Mr. Chairman, I am Dr. Rodney Hochman, chief medical officer and senior vice president of Sentara Health Care in Norfolk, Virginia, and a board-certified internist and rheumatologist. I am here, today, on behalf of the American Hospital Association's nearly 5,000 hospitals, health systems, networks and other health care providers. We are pleased to have the opportunity to testify on the issue of public access to the National Practitioner Data Bank.

Sentara Health Care is not-for-profit health system which serves more than 2 million residents in Southeastern Virginia and Northeastern North Carolina. We operate more than 70 care-giving sites, including six hospitals, with more than 1,800 beds. More than 2,000 physicians are members of our hospital medical staffs.

As Sentara's chief medical officer, one of my roles is to ensure our staff provides high-quality services and that our credentialing and peer-review processes are effective. Nothing is more important than the safety of our patients. At Sentara, like most hospitals and health systems across the United States, we conduct an exhaustive background check on our medical staff before a physician is allowed to treat a patient in our facility. We inquire about a physician's educational, personal, professional background, malpractice history and any career gaps. We conduct primary source verification. We inquire about past performance and quality issues at each hospital at which the physician has had privileges, and we also query the National Practitioner Data Bank, an essential step in our credentialing process. The book which our physicians need to complete before they can be members of our staff is here, and we conduct that exhaustive review.

Hospitals take seriously their legal obligation to query the Data Bank. At Sentara, we use the information to supplement our credentialing activities and as a possible indication if there is a problem. Let me say we firmly believe that consumers deserve to have useful information that will assist them in selecting a practitioner.

Congress specifically created the Data Bank as a tool for health care professionals. Its primary purpose is to alert health care facilities, licensing boards and professional societies to the possibility of incompetent or dangerous performance by a health care practitioner. The Data Bank, as currently configured by Congress, was not designed as a resource for consumers. However, consumers have a legitimate interest in knowing that the people who provide

their care are competent. In fact, the AHA agrees that some information in the Data Bank could be useful to consumers. For example, the public disclosure regarding licensure actions and criminal convictions, which are not currently included in the Data Bank, would be valuable to consumers.

At the same time, malpractice information must be put in the proper context before it's released to the public. As presently configured, the Data Bank does not differentiate between payments made in situations involving substandard care and payments made for a variety of other reasons, such as to eliminate the defense of a frivolous or nonmeritorious claim or to minimize the cost of litigation.

In many cases, settlement payments are made by the insurer without the consent of the physician being sued. In fact, the statute that created the Data Bank argues against making malpractice reports public, cautioning that a settlement does not necessarily indicate that malpractice occurred. In today's litigious society, numerous malpractice settlements result from frivolous claims. While we're willing to discuss the concept of public disclosure of large malpractice awards clearly related to quality, we must ensure that only claims that reflect clear quality of care concerns are publicly available.

Congress promised confidentiality when it created the National Practitioner Data Bank. Complete disclosure of the Data Bank's contents to the public could cause caregivers to be less forthcoming about their own mistakes and less likely to express concerns about the competence of their peers. The confidentiality of the peer review process allows practitioners to candidly discuss the qualifications of their peers. Hospitals depend on the peer review process to ensure that practitioners are capable. We must do nothing that would be detrimental to the peer review process. Peer review is one of the most important tools, but not the only tool, for the assurance of quality care, and confidentiality of peer review and activities is essential.

Mr. Chairman, the AHA looks forward to working with Congress to develop the appropriate approach for determining the future use of the National Practitioner Data Bank, including which information can be useful to consumers.

Thank you.

[The prepared statement of Rodney F. Hochman follows:]

PREPARED STATEMENT OF RODNEY HOCHMAN, CHIEF MEDICAL OFFICER AND SENIOR VICE PRESIDENT, SENTARA HEALTHCARE, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, I am Rodney Hochman, M.D., chief medical officer and senior vice president of Sentara Healthcare in Norfolk, Virginia. I am here today on behalf of the American Hospital Association's (AHA) nearly 5,000 hospital, health system, network, and other health care provider members. We are pleased to have the opportunity to testify on the issue of public access to the National Practitioner Data Bank.

Sentara Healthcare is a not-for-profit health system, which serves more than 2 million residents in southeastern Virginia and northeastern North Carolina. We operate more than 70 caregiving sites, including six hospitals with a total of more than 1,800 beds. Sentara Healthcare employs more than 180 physicians representing 20 medical specialties and subspecialties. Our hospitals provided care for more than 250,000 outpatient and emergency department visits and close to 65,000

hospital admissions in 1999. More than 2,000 physicians are members of our hospitals' medical staffs.

I am a board-certified internist and rheumatologist. As Sentara's chief medical officer, I am responsible for the clinical effectiveness programs, physician integration efforts, and medical management issues for its six-hospital system and 300,000 member HMO. One of my roles is to work with our hospitals' medical staffs to ensure their credentialing and peer review processes are effective. Twelve employed physicians, functioning as medical directors under my direction, facilitate and monitor these processes across Sentara. I also participate as an ex-officio member of our board's Medical Affairs Committee, which is responsible for the quality of care provided in our hospitals.

The AHA supports the goals of the Health Care Quality Improvement Act, under which the National Practitioner Data Bank was created. The act recognizes the importance of encouraging and supporting effective professional peer review to help protect consumers from incompetent or dangerous performance by practitioners. The AHA and its members engage in a range of activities that help hospitals and health systems deliver the highest quality care. One of the most important of these being the peer review and quality assurance activities that occur every day in hospitals across the country.

PEER REVIEW ACTIVITIES

At Sentara, like most hospitals and health systems across the United States, we conduct exhaustive background checks on our medical staff before a physician is allowed to treat patients at our facilities.

Initially, physicians applying for hospital privileges are subject to an intense screening process. The credentialing application inquires about a physician's educational, personal, and professional background, malpractice history and any career gaps. We then conduct primary source verification. For example, we verify with the physician's medical school that he did indeed graduate; we check with the Board of Medical Specialties that he is a board-certified physician, and we confirm with the state licensing board that he is in fact licensed by the Commonwealth of Virginia to practice medicine. We inquire about past performance on quality issues at each hospital at which the physician has had privileges, and we also query the National Practitioner Data Bank.

The National Practitioner Data Bank contains information on medical malpractice payments, adverse licensure actions, adverse actions taken by physician professional societies, and suspension of hospital privileges for more than 30 days. Hospitals by law are mandated to query the data bank. At Sentara, we use the information to supplement our other credentialing activities, and as a *possible* indication that there is a problem.

Sentara uses a three-tier screening process. First, our Credentialing Committee, which consists of 12 physicians from many different specialties, reviews a physician's complete credentialing application. Next, the Credentialing Committee's recommendation is forwarded to the Medical Executive Committee, which consists of 15 physicians including the officers of the medical staffs and the chiefs of each clinical department. Final approval or denial is made by our board's Medical Affairs Committee.

Physicians are subject to re-credentialing every two years. At that time, physicians formally attest to whether anything has changed since the initial credentialing process. The department's quality improvement chairman assesses this information along with the physician's quality assurance profile for the previous two years and makes a recommendation to the department chairman. We also query the National Practitioner Data Bank and state licensing board for reports of any adverse actions. The department chair makes a recommendation to the Credentials Committee. The Credentialing Committee reviews all information and makes a recommendation to the Medical Executive Committee, and the Medical Affairs Committee makes a final decision.

Besides this aspect of the formal peer review process, we have ongoing quality improvement (QI) activities designed to flag possible quality of care problems. For example, at Sentara the following situations automatically initiate a QI review: a death; a return to the OR within 48 hours; a return to ICU; and re-admissions for certain diseases. In addition, patient complaints and incident reports, which can be initiated by any staff member, are reviewed. As part of the QI review process, a QI nurse investigates the incident/complaint and files a report with the department's QI Committee, and the physician has an opportunity to present his case. The department QI Committee reviews these cases and forwards appropriate ones to the hospital QI Committee. If the hospital QI Committee identifies a quality concern,

the case is sent to the Medical Executive Committee for review and possible corrective action. Records for such cases are kept in the physician's QI file and reviewed at the time of re-credentialing.

Hospitals actively monitor the quality of patient care and services. Every health care organization must ensure that its workforce, including all clinical staff affiliated with the organization, is competent, adequately credentialed and trained. As you can see, querying the National Practitioner Data Bank is an essential step in the credentialing and QI process. However, it is only one part of the equation.

OPENING THE DATA BANK

Consumers have a legitimate interest in knowing that the people who provide their care are competent. But completely opening up the data bank to public scrutiny would do much more harm than good for two reasons. First, public disclosure of the data bank's contents, as presently configured, would undermine the confidentiality of the peer review process in hospitals across America—thus impeding the data bank's goal of promoting quality care.

Congress promised confidentiality when it created the National Practitioner Data Bank. The normal tensions created by peer review would be significantly heightened if reports were available to the public. And complete disclosure of the data bank's contents to the public could cause caregivers to be less forthcoming about their own mistakes and less likely to report errors made by their peers.

The threat of public access to adverse credentialing decisions in the data bank will force mistakes underground, and hospitals and practitioners would lose the opportunity to analyze what went wrong and make the necessary changes to ensure that the mistakes do not happen again. Of course, the real losers are the public who would benefit the most from improved quality of care that comes from quality assurance activities.

Second, the data bank, as it is currently configured, is not designed to be a tool for consumers. Congress created the National Practitioner Data Bank to be a resource for health care professionals. One fear is that consumers would misinterpret settlement reports. In fact, the statute that created the data bank argues against making its reports public. The statute cautions that a settlement does not necessarily indicate that malpractice occurred. For a consumer trying to evaluate a potential caregiver, knowing only that a settlement occurred could be misleading. It could cause serious consequences for a practitioner and unnecessarily undermine public confidence in the hospital.

As presently structured, the data bank does not differentiate between payments made in situations involving substandard care and payments made for a variety of other reasons, such as to eliminate defense of a frivolous or nonmeritorious claim, or to minimize the cost of litigation. There is no minimum threshold for reporting amounts paid in relation to malpractice claims or litigation.

REPORTING PHYSICIANS TO THE DATA BANK

Hospitals take seriously their legal reporting obligations to the data bank. The AHA is not aware of any data which documents that hospitals are not meeting these obligations. Questions about potential noncompliance appear to be based on anecdotal information and studies that use the *level* of hospital reporting to suggest that NPDB requirements are not being met. A recent study by the Journal of the American Medical Association (JAMA) raised concerns about the rate of reporting. However, the JAMA study measures current reporting against what appears to have been, at best, projections of future reporting at the time the National Practitioner Data Bank was created. While a few hospitals have been noted as not reporting to the data bank, that does not mean they are not effectively overseeing health care practitioners.

Restriction and loss of a physician's hospital privileges is a serious action. Hospitals usually suspend a doctor's clinical privileges only as a last resort, after they've tried alternative interventions, such as the use of supervision, requiring medical education, and short-term limitations on privileges.

CONCLUSION

Hospitals are accountable for the care within their facility and bear legal responsibility. We are committed to the delivery of high quality care to the communities we serve. Peer review is an important tool for the assurance of quality care, and confidentiality of peer review activities is essential.

The data bank's primary purpose is to serve as a "flagging" system for health care facilities, licensing boards, and professional societies. The purpose is to alert these

agencies to the possibility of incompetent/dangerous performance by a health care practitioner. The data bank was not designed as a public tool.

The public deserves to have information that is meaningful and could help them make better decisions about their health care.

Opening the National Practitioner Data Bank, as presently configured, to the public would not only breach the promise of confidentiality under which the data bank was created and reports are submitted, but public disclosure, as the data is currently configured, would not provide the consumer with valid or practical information.

Consumers would be better served by reforms that foster an environment promoting candor. Candor is absolutely critical if we are to be truly successful in identifying and learning what makes the health care system safer. We need to create a non-punitive culture that will encourage people to participate in peer review—the frontline protection for health care quality.

Mr. UPTON. Thank you very much.

Dr. Reardon, welcome back.

TESTIMONY OF THOMAS R. REARDON

Mr. REARDON. Good morning, Mr. Chairman and members of the committee. My name is Thomas R. Reardon, M.D. I am a general practice physician from Portland, Oregon, and currently serve as the president of the American Medical Association. On behalf of our 300,000 physician and medical student members, I appreciate the opportunity to testify today on the National Practitioner Data Bank.

Safeguarding the millions of patients in our expansive American health care system is one of the AMA's highest priorities. We need to ensure that patients have access to accurate and relevant information to help them choose among health insurance plans, physicians and other health care providers. We believe that the best approach to meet patients' needs is to enhance the State-based systems already in place.

State agencies and some private-sector organizations are at the forefront of providing consumers with relevant information on health care providers and are taking appropriate steps to rid the health care system of negligent and incompetent providers. Congress can assist by supporting these efforts.

Prominent commissions, institutes and other health care leaders that have studied ways to improve the quality and safety of health care have concluded that simply opening the National Practitioner Data Bank and disseminating raw, unsynthesized legal data would not improve the quality and safety of health care for patients. For example, the recent IOM report on health system errors discussed, but did not recommend, opening up the NPDB.

And in 1998, the President's Health Care Quality Commission, on which I had the privilege of serving, released its report on consumer protection and health care quality. The commission considered and then rejected a recommendation to open the Data Bank as a method to improve patient quality and safety.

We agree the NPDB was designed for a specific and limited purpose and does not contain information about the overall qualifications of physicians and other health care providers. The licensing and regulation of physicians and other health care providers has always been in the purview of States, and the AMA strongly agrees that this should remain the case.

State medical boards are in the best position to assess accurate data on physicians and revoke or suspend medical licenses to protect patients. They are uniquely positioned, both historically and practically, as the primary source of information about the physicians that they regulate. In fact, with the advent of the Internet, States have taken the lead in developing physician profiling systems. For example, over 30 States have recently initiated action to provide consumers with information about physicians and other health care providers. Further, consumers in 25 States now have Internet access to key information about physicians licensed in those States, and in another nine States plan to have the programs in place by the end of the 2000 legislative session.

The Federation of State Licensing Boards, a private-sector entity, has recognized the advances at the State level and is providing important assistance to the development of State-based profiling systems. In April 1999, the FSMB established the Special Committee on Physician Profiling. This committee is reviewing the current physician profiling information available to the public and determining what information is most helpful. We understand that the FSMB will release the Special Committee's report within the next month. To our knowledge, this report will include the most comprehensive and up-to-date information on physician profiling available. Thus, we strongly recommend that Congress consult with the FSMB on their findings and recommendations.

The well-balanced and complete information that States and the FSMB are working to give to patients stands in stark contrast to the National Practitioner Data Bank. Roughly, three-quarters of the reports in the NPDB pertain to medical malpractice settlements. Unfortunately, this NPDB system for collecting medical liability settlements is fundamentally flawed and an exceedingly inaccurate measure of the competence of a physician or other health care provider. Some of our Nation's best physicians are involved in settlements, yet the NPDB data does not reflect their high level of competence.

Further, it has found that malpractice claims infrequently correlate with findings of negligent care. A New England Journal study—of Medicine—study indicates that only about one in five settlements resulted from negligent medical care. Thus, reports to the National Practitioner Data Bank on malpractice claims provide an incomplete and misleading indicator of a physician's competence or quality.

In conclusion, opening the Data Bank would not solve the problem of weeding out negligent or incompetent physicians and other health care providers. We recommend that Congress consult the Federation of State Medical Boards on its forthcoming report and support State medical boards in their efforts to provide the most relevant information to consumers.

I thank you for the opportunity to testify.

[The prepared statement of Thomas R. Reardon follows:]

PREPARED STATEMENT THOMAS R. REARDON, PRESIDENT, AMERICAN MEDICAL
ASSOCIATION

Good morning, Mr. Chairman and members of the Committee, my name is Thomas R. Reardon, MD. I am a general practice physician from Portland, Oregon, and currently serve as President of the American Medical Association (AMA). On behalf

of our 300,000 physician and medical student members, I appreciate having the opportunity to testify on the National Practitioner Data Bank (NPDB).

The AMA commends the Committee for addressing issues surrounding the safeguarding of the millions of patients in our expansive American healthcare system. As you know, this system continues to undergo dramatic change, and with this change there is a pressing need to ensure that patients have the best information available to help them choose among the many competing physicians and other health care professionals seeking the privilege to treat.

The AMA is strongly committed to the objective of improving patient safety and protecting patients from preventable harm caused by incompetent or unethical practitioners. In fact, beyond the initiatives that we outlined for this committee in our February 9, 2000, statement for the Record on the Institute of Medicine (IOM) Report, the AMA regularly reviews its membership master file and reports to the NPDB those physicians we expel for reasons relating to peer reviewed breaches of quality of care and patient safety.

As we search together for ways to best safeguard patients, we must continue to question whether disseminating to the public raw, unsynthesized data from existing Federal repositories would improve the quality of health care for patients. Or, instead, do we need to advocate for other private sector or State-based mechanisms that would provide the public with relevant, reliable, verified, accurate, and contextual information? In our opinion, we need to perfect mechanisms already in place that hold the best chance of meeting patients needs. This is the view of opinion leaders in health care and finds its firm basis in the Congressional intent and history surrounding the NPDB.

On February 9, 2000, the House Commerce Subcommittee on Health and Environment, the Subcommittee on Oversight & Investigations, and the Committee on Veterans' Affairs Subcommittee on Health held a joint hearing on the IOM Report on health system errors. At this hearing a Majority member of this Subcommittee posed the question to the entire third panel of witnesses of whether the NPDB should be expanded beyond its intended purpose. The entire panel responded in the negative. The panel was comprised of such health care experts as Dennis O'Leary, MD, Joint Commission on Accreditation of Healthcare Organizations; William Golden, MD, American Health Quality Association; Michael Langberg, MD, Cedars-Sinai Health System; Daniel Perry, Alliance for Aging Research; and Mary Foley, RN, American Nurses Association.

These views echo what Congress intended when it designed the NPDB: Congress did not design the NPDB to disseminate information at large. In fact, the House Committee on Energy and Commerce (now the Commerce Committee) emphasized this view in its Committee Report on the Health Care Quality Improvement Act of 1986 (HCQIA) (Rept. 99-903), which created the NPDB. For example, in discussing malpractice settlement data the Committee Report stated that the Committee was "confident that those authorized under the bill to gain access to this information will have the awareness and sensitivity to use it responsibly" (p.14). Further, the Committee stated that "it is essential to collect and disseminate these data to those in the health care community who make judgments about the competence and professional conduct of health care practitioners" (p. 13). These statements are as true today as they were then.

The NPDB was established as a flagging mechanism to improve the quality of health care by encouraging state licensing boards, hospitals, and professional societies to identify and discipline physicians who lacked the requisite competency and high ethical standards required for patient care. At the time there was concern that States did not have the resources to advance quality of care initiatives. The NPDB was also intended to prevent physicians who lost their license in one State from moving to another State without disclosing disciplinary actions taken against them.

The AMA supports the goal of preventing physicians from moving State to State or hospital to hospital without disclosure of adverse peer reviewed actions taken against them. We respectfully disagree, however, that the NPDB is the appropriate mechanism by which information on physicians and other health care providers should be disseminated beyond its intended purpose. Opening the NPDB would not solve the problem of weeding out bad physicians and other health care providers from the health care system.

Since the establishment of the NPDB, Congress has consistently recognized that only medical credentialing and licensing entities have the resources and expertise needed to evaluate NPDB reports and analyze how the reports reflect the competency of health care professionals. In addition, public disclosure of the NPDB data was discussed at length in the 1986 and subsequent debates on the NPDB, including the 1995 debate during the Senate Labor & Human Resources Committee's mark-up of the Health Care Liability Reform and Quality Assurance Act of 1995 (S.

454). After extensive deliberation in each debate, greater dissemination of the NPDB's data was rejected.

There are other influential commissions and institutes that have studied ways to improve the quality and safety of health care and have come to the same conclusion. It was a personal honor and privilege for me to serve on the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry that in 1998 considered, then rejected a recommendation to open the NPDB. I can assure you that this matter was thoroughly discussed by the Commission, with the Commission's 1998 report stating that the "current systems to reduce or prevent errors in the provision of health care services tend to focus too much on individual practitioners and not enough on system problems" (p. 155). Additionally, the Commission recommended that steps be taken to improve error reporting and focus on determining the causes of error. Similarly, the recent IOM Report on health system errors discussed but did not recommend opening the NPDB.

The AMA agrees with the above cited opinion leaders, Congressional drafters of the NPDB legislation, the President's Quality Commission, and the IOM Report that the NPDB was designed for a limited purpose and is not the mechanism upon which to provide patients with the information about the overall qualifications of physicians. The licensing of physicians and other health care providers has always been within the purview of the States, and the AMA strongly agrees that this should remain the case. We see no value in Federal programs outside the context of State-based licensing and state medical boards.

In fact, a Federal response is probably unnecessary because the States are far ahead of Washington in addressing these concerns and have made tremendous advances in the last few years in developing profiling systems. For example, over 30 States have recently responded to public interest for information about physicians and other health care practitioners. In the last two legislative sessions, 12 States have enacted laws that mandate the provision to consumers of information about physicians who practice medicine within those States.

Supplementing these actions by State legislatures, state medical licensing boards are recognizing profiles as a significant resource for consumers and have elected to address the profiling issue voluntarily. To date, 16 state medical boards have put in place physician profile mechanisms that are accessible directly by consumers. These efforts address local needs and are established by the regulatory body that controls medical practices. With the advent of the Internet, consumers in 25 States now have Internet access to key information about physicians licensed in those States, and another 9 States plan to have their programs in place by the end of the 2000 legislative session.

Historically, States tracked physician information related to education, training, licensure status, disciplinary actions by state medical boards and hospitals, and criminal offenses. Recently, however, State-based physician profile programs have begun expanding to include no-contest pleas, pending complaints, medical malpractice data, malpractice comparison, instances of "derogatory information," and "findings of unprofessional conduct."

State medical boards are an important gateway to this provider profiling information. At the State level, medical boards are able to access accurate data and can take affirmative action through the control of medical licenses and have authority to enforce disciplinary actions on medical practitioners. They are uniquely positioned—both historically and practically—as the primary source of information about the physicians they regulate.

We are encouraged by the recent activities of the Federation of State Medical Boards (FSMB) to assist in the development of State-based profiling systems. It is our understanding that the FSMB will soon release a report on the findings and recommendations of its Special Committee on Physician Profiling. This Committee was established in April 1999 to review the current physician profiling information available to the public and determine what information is most helpful. To our knowledge, the Special Committee's report will include the most comprehensive and up-to-date information on physician profiling available. Thus, we strongly recommend that Congress consult with the FSMB on their findings and recommendations.

The well balanced and complete information that States and the FSMB are working to give to patients stands in stark contrast to the NPDB, which is administered by the Health Resources and Services Administration. In its Operations Summary of November 1999, HRSA showed that roughly three-quarters of the reports in the NPDB pertained to so-called "Medical Malpractice" settlements.

Unfortunately, this NPDB system for collecting medical liability settlements and verdicts is fatally flawed and an exceedingly inaccurate measure of the competence of a physician. Inclusion of malpractice settlement data in the NPDB does not indi-

cate that a physician has provided substandard care. Even some of our nation's finest physicians who specialize in high-risk cases are involved in settlements.

Malpractice claims seldom correlate with findings of negligent care in the medical record. Thus, reports made to the NPDB on paid malpractice claims provide, at best, an incomplete and haphazard indicator of a practitioner's competence or quality. The HCQIA acknowledges that malpractice payments do not indicate that malpractice has occurred. Section 427(d) states:

Interpretation of Information.—In interpreting information reported under this part, a payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred.

The Department of Defense and the Department of Veterans Affairs recognize the serious problems with correlating lawsuits with physicians' competence or negligence. Under the DOD and VA health systems, physicians are not reported to the NPDB when a claim is settled on their behalf unless a panel of peers found negligence or incompetence. Representatives of the DOD and VA told the AMA that the correlation of settled claims and actual negligence is about 30%. This is somewhat similar to a study published in the New England Journal of Medicine indicating that only 23.8% of claims closed with an indemnity payment resulted from negligent medical care. (see, 335 New Eng. J. Med. 1963 (1996)).

In addition, the NPDB makes no adjustment for high-risk patients or cutting-edge medical procedures. Each day many people would die or become severely incapacitated if it were not for the high-risk medical procedures of dedicated and very capable physicians. High-risk obstetrics, open-heart surgery, and neurological surgery to relieve the effects of Parkinson's Disease are just a few examples of commonly used high-risk procedures. Only the most highly qualified and competent physicians are willing to perform such high-risk procedures that offer the only hope for relief of debilitating symptoms or life-threatening conditions. The NPDB information is flawed and misleading because it does not adjust for the risks involved in these procedures. Unrestricted public access would lead to unfair scrutiny of some of our nation's most talented physicians.

Also, advances in medicine are made only by utilizing new procedures and drugs. Someday these "cutting-edge" procedures will be as common as yesterday's new innovations. But, for the same reasons as above, these pioneering physicians could be unfairly evaluated by a systematic release of gross settlement results.

Further obscuring the relevance of malpractice claims data in the NPDB is the fact that many cases are settled without the consent of the physician. Many insurers disallow "consent to settle" clauses in their contracts with physicians. In fact, some States actually prohibit "consent to settle" clauses. Without this clause, the insurer can disregard the physician's right to defend him or herself on the merits. Such decisions are purely economic and do not take into consideration the quality of medical care. Nevertheless, the settlement and physician are reported to the NPDB.

Conclusion

Improving patient safety and protecting patients from preventable harm caused by incompetent or unethical health care practitioners are issues strongly supported by the AMA. We are encouraged that many states and the FSMB are developing systems to provide relevant information on their licensed health care providers. We respectfully disagree, however, that the NPDB is a mechanism by which information on physicians and other health care providers should be disseminated beyond its intended purpose. Other state-based systems are currently being developed and deserve deferential consideration. We believe that Congress should consult with the FSMB regarding its forthcoming report on state-based profiling systems.

We appreciate the opportunity to discuss this matter before the Subcommittee and would be pleased to answer any questions.

Mr. UPTON. Thank you very much, as well.

Dr. Newman?

TESTIMONY OF ROBERT G. NEWMAN

Mr. NEWMAN. Thank you very much, Chairman Upton. I do have two somewhat embarrassing acknowledgements to make at the very outset. First, for reasons that I really can't explain, the resume which I submitted along with my testimony failed to mention that I am a graduate of New York University.

I hope you will convey to the Congresswoman my apologies for that.

Mr. UPTON. She will be back, sir.

Mr. NEWMAN. Second, after having spent endless hours trying to squeeze into four or five pages a clear, concise summary of my views on this very important subject, I see, in today's New York Times, a letter to the editor by a Ms. Wittkin of Yonkers, which in one brief sentence really says it all. Ms. Wittkin, in this letter to the editor in today's newspaper says, "All patients should have access to the taxpayer-financed National Practitioner Data Bank and any other doctor-specific information that can be culled from State medical board records." That, in essence, Chairman Upton, members of the committee, summarizes my view on the issue before you today.

The law that currently demands that every single hospital query the Data Bank to get information which will obviously be considered of great help in making a decision who should have staff appointment, that that same data is not available to the consuming public for making decisions in terms of the provider to take care of their own health care needs and the health care needs of their family members seems paradoxical and probably also patronizing.

Furthermore, I believe that there is no dichotomy of interest here between the consuming public and the providers. Certainly, in New York there is a very, almost universally known commercial which goes, "An educated consumer is our best customer." What applies to suits and other haberdashery items I think very definitely also applies to the health care field. I think the patient that has the most possible access to information about his or her illness, about the medical treatment that is contemplated and about the provider is the patient that the providers are going to be able to most be in a position to help.

At the same time, I think it would be wrong not to acknowledge the limitations that will continue to exist no matter how much data is made available, no matter how freely, to the consuming public. And one of the limitations is that there simply is no way to protect ourselves against totally unanticipated, random, unpredictable, erratic actions. And this is a truism in our society, whether we are talking about the workplace, whether we are talking about, and there's tragic evidence of this almost every day, whether we're talking about the schools of our country, and it's true when we're talking about health care institutions.

I do have a couple of very specific recommendations that I would urge you to consider with regard to the Data Bank and its increased usefulness. Currently, there is no requirement, no requirement, that any health care provider organization, other than hospitals, to query the Data Bank prior to hiring or giving an appointment to a physician. There is no requirement that ambulatory surgery centers or community neighborhood health centers or any other type of health care provider entity query the Data Bank. And, again, that seems paradoxical.

Second, and this goes to the heart of a question that was repeatedly heard this morning, there is no requirement imposed on State licensure agencies that they query the Data Bank before making the decision whether to grant a license to practice or whether to renew a license to practice. That is a type of paradox that, to me, makes absolutely no sense whatsoever, and certainly should be cor-

rectable very, very easily, and I truly can't imagine how anybody would take exception to that kind of a change.

The final suggestion, in terms of considering how to improve access to the public, making access to the public a reality, is that you and your congressional colleagues not allow the best to become the enemy of the good. I think if we discuss how to address every conceivable, conceivable concern with regard to data release, I think we will be debating this point for the next 50 years. I think we have some very excellent models—Massachusetts being one. I think we should implement it on a national scale and then we should all work together to perfect it in the future.

Finally, I do want to express in this very public forum, on my own behalf and on behalf of the entire Beth Israel Medical Center, which I represent, the very sincere condolences to Mr. Smart and our very great regrets for the experience of Dr. Gedz.

I also want to come back to a comment, and this will be my last comment, that Congressman Dingell made regarding the good name and the reputations of practitioners. I'm sure the Congressman will agree with me that those who do not earn that reputation and good name that we need feel no sympathy for them whatsoever. But I think I would be remiss if I didn't point out that at Beth Israel Medical Center, and I believe the same thing is true at other institutions, the overwhelming majority of practitioners are of the highest quality, the most competent, the most dedicated. And speaking for Beth Israel Medical Center, I truly believe that their good name and their reputation is very richly deserved and places them among the very best medical staffs at any hospital anywhere in the United States.

Thank you.

[The prepared statement of Robert G. Newman follows:]

PREPARED STATEMENT OF ROBERT G. NEWMAN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, CONTINUUM HEALTH PARTNERS, INC.

It is a privilege to testify before this Committee on the subject of Public Access to the National Practitioner Data Bank: What Consumers Should Know About Their Doctors. My own views can be summarized very simply: although there are valid concerns about specific procedural aspects. I strongly support the right of all individuals to obtain any and all information contained in the National Practitioner Data Bank (NPDB).

The law demands that hospitals and other health care entities query the NPDB when screening applicants for a medical staff appointment or when granting, adding to or expanding clinical privileges, and biennially for existing staff members. Obviously, this legal mandate reflects the premise that NPDB data are of great importance in determining whom an institution should authorize to provide services in its facilities. And yet, paradoxically, members of the public are expressly forbidden from receiving that same information to help decide on the health care providers to whom they will entrust their very lives.

This prohibition seems to be a vestige of an earlier era, when patients were not expected to play an active role in all aspects of their health care. It was rare for patients to challenge the medical care regimen that was contemplated, let alone the credentials and the disciplinary and malpractice records of their providers. Even in the eleven years since the final regulations governing the NPDB were promulgated, access to data via the Internet and other communications breakthroughs has risen dramatically, along with the assumption that this is a right and not a privilege. Our society has undergone a veritable transformation in its demand for detailed information regarding those who seek to serve be they aspirants for political office or health care professionals. This is not a demand that is to be denied! Nor, I believe, should it be.

I am convinced that open access to the files of the NPDB is good for all concerned. The utility of universal access to NPDB records, however, will be directly propor-

tional to the accuracy, comprehensiveness and currency of the data. There is a need for close and ongoing communication among all concerned parties, who must share a common commitment to perfecting the system of data collection and dissemination despite (indeed, because of) the reality that perfection can never be achieved. The point to be stressed is that the essential characteristics of a meaningful and useful data bank are equally relevant to all: practitioners, health care organizations, professional societies, State agencies and other currently authorized recipients of NPDB information, as well as the general public. In other words, there is no dichotomy of interests!

To those concerned about possible adverse effects of making practitioner information readily available to the public, reassurance can be derived from the experience in those areas where these data already are accessible. Massachusetts, for example, provides unrestricted, free, on-line information via the Internet with regard to every licensed physician in the State, including:¹

- Education and training, specialty certification, honors and awards
- Malpractice history—number of payments made in the past ten years, whether the dollar amount of each was above average, average or below average compared to all payments by specialists in the field, and the number and percent of these specialists who made one or more malpractice payments in this time period.
- Disciplinary actions—criminal convictions, hospital disciplinary actions and/or final disciplinary actions by the State Board of Registration in the past ten years.

To my knowledge, there is nothing to suggest that unfettered public access to the Massachusetts practitioner data base has had any negative impact on physicians or patients with respect to satisfaction, malpractice experience, or quality of care.

A final, critical caveat: Any advocate of open access to NPDB records must acknowledge that there are limits to the benefits to be derived from such access; it would be disingenuous to imply otherwise. Specifically, it will not be possible in the future, just as it has not been possible in the past, to provide protection against random, irrational acts. This truism applies to society in general, in every setting, private as well as public, in schools, the workplace and, of course, in health care settings—hospitals, nursing homes, private practitioner offices, etc.

A recent, widely publicized occurrence at my own hospital, Beth Israel Medical Center, is illustrative. An obstetrician, Dr. Allan Zarkin, carved his initials in the abdomen of a patient following a Cesarean section. The NPDB file on this physician, queried as a required part of the biennial reappointment process in 1999, confirmed that he had never been reported for disciplinary action by any hospital or state agency; his malpractice history consisted of one settlement, in 1994, with respect to a case that occurred in 1987. Also as part of the reappointment process, a medical and mental assessment of Dr. Zarkin was received from an internist, not associated with Beth Israel, which had no positive findings. Earlier, in November, 1998, an episode of verbal abuse by Dr. Zarkin was the subject of a meeting with Beth Israel's Medical Director, the Chairman of Obstetrics and Gynecology and the Chief of the Division of Obstetrics. While no disciplinary action was considered warranted, he was required to receive both a medical and a psychiatric assessment. The former was provided by the Director of Employee Health Services and was negative. As for the psychiatric evaluation, it was carried out by a psychiatrist with no connection to Beth Israel, and the file contains two written assessments. These reports are dated December 31, 1998, and February 4, 1999, and each states that Dr. Zarkin was "fully fit for duty" and "poses no threat to patients."

The egregious act of Dr. Zarkin is a sobering reminder that public access to NPDB data is not a panacea that will provide 100% protection either to patients or the institution in which they seek care. Nevertheless, just as the ability to query the NPDB data base is an important element for hospitals in their consideration of appointment and reappointments of medical staff, so too will it be helpful to patients in selecting their personal care-givers.

Thank you for the opportunity to testify. I shall be pleased to try to respond to questions the Committee may have.

Mr. UPTON. Thank you.
Mr. Osten?

¹ Massachusetts Board of Registration in Medicine, www.massmedboard.org

TESTIMONY OF WAYNE M. OSTEN

Mr. OSTEN. Thank you. Good afternoon. My name is Wayne Osten. I'm the director of the Office of Health Systems Management for the New York State Health Department. Chairman Upton, Chairman Bliley, Congressman Dingell, thank you for inviting me to speak with you today.

I am speaking to you on behalf of the New York State Commissioner of Health, Antonia Novello. My responsibilities in the New York State Health Department include oversight of the physician medical conduct program, as well as activities related to the regulatory oversight and quality improvement of all hospitals, clinics, dialysis programs and ambulance services in New York State.

Governor Pataki, Commissioner Novello and the New York State Health Department are committed to providing information to consumers that they can use to make decisions about their health care. New York, in fact, is a leader in the Nation and its efforts to reduce medical errors and to provide information to consumers on quality of care provided by physicians, hospitals and managed care plans.

New York State was the first State in the Nation to have a mandatory incident reporting system. This system known as NYPORTS has been improved since Governor Pataki took office by providing clear criteria about what kinds of adverse incidents health care facilities need to report to our Department.

In addition, New York is currently collecting incident reports online, reducing paperwork. Currently, New York's incident reporting system receives over 20,000 incident reports a year from hospitals, clinics and ambulatory surgery centers. We work with these facilities to make sure that corrective action is taken to prevent these incidents from occurring in the future.

Last week, at the direction of Governor Pataki, Commissioner Novello sent a letter to every administrator in New York State in which she reminded them of the importance of prompt reporting of adverse event incidents to New York's incident reporting system. Dr. Novello warned hospital administrators that the Department will publicly sanction those facilities that fail to promptly and accurately report incidents that result in patient death, injury or potential injury. I believe, Congressmen, the New York Times report of our investigation at Staten Island Hospital gives ample testimony to our commitment to that promise.

New York's Professional Medical Conduct Program is also recognized as a national leader in taking action to protect patients from physicians who commit misconduct, fraud, abuse and incompetence. During 1999, the Office of Professional Medical Conduct of the State Health Department took 356 disciplinary actions against physicians, including nearly 200 actions that involve revocation or surrender of a physician's license to practice medicine.

Information on disciplinary actions involving physicians has been published on the Department's website since 1995. The site, the website located at www.health.state.ny.us receives, on average, two hits every minute of every day of the year.

Just last week, the New York State Health Department released its fifth annual report on the performance of managed care plans. Our nationally recognized QARR Reports, which stands for Quality

Assurance Reporting Requirements, provides information on the performance of both commercial and Medicaid managed care plans in a variety of performance areas.

And New York led the Nation in providing consumers with critical information on the quality of care provided by cardiac surgeons and cardiac centers across New York State. This information is updated annually so that consumers can make better health care decisions.

We believe that consumers have the right to information about credentials, track record, experience of health care providers that is complete, accurate and easy to use. With comprehensive improvement, the National Practitioner Data Bank could be a useful source of information for consumers. In its current state, however, this Data Bank could provide consumers with a false sense of security and could actually cause patient harm.

There, from our perspective, are three major problems with the National Practitioner Data Bank. First, the data is not complete, and therefore it is not accurate; second, the data is not made available in a timely manner; and, third, the Data Bank system is difficult to use.

As you know, the Federal law requires that hospitals report to the Data Bank disciplinary actions involving the suspension of hospital privileges of a physician for 30 days or longer. The data in the National Practitioner Data Bank is not complete because, simply said, the reporting requirement is not being enforced.

The U.S. Department of Health and Human Services which oversees the Data Bank recently reported, as you have already heard, that approximately 66 percent of all hospitals in the Nation have never reported a physician disciplinary action to the Data Bank. It's highly unlikely that since the implementation of the Data Bank in 1990, that 66 percent of the hospitals in this Nation have never suspended a physician's hospital privileges. Under these circumstances, a consumer using the system might see no disciplinary action listed for a certain physician when, in reality, the physician may have been involved in one or more disciplinary actions.

The information in the National Practitioner Data Bank also lacks completeness because there are loopholes that hospitals use to circumvent the reporting requirement. As I mentioned, the law requires hospitals to report suspensions of a physician's privileges when the suspension is 30 days or longer. Rather than report a suspension to the Data Bank and expose the hospital and physician to bad publicity, hospitals frequently suspend a physician's hospital privileges for less than 30 days.

I see my time is up. Let me just conclude, in my report, my written comments, I talk about the other concerns with the Data Bank. Let me conclude by saying we want to emphasize that consumers deserve complete and accurate information that they can use to make informed decisions about their health care. With substantial improvements, the National Practitioner Data Bank can be one tool that consumers can use to ensure they receive high-quality care. Perhaps the Department of Health and Human Services should look to States like New York that are leading the way in making physician discipline information available to customers.

We, in New York, stand ready to work with the Federal Government in making the data base—the Data Bank the best it can be. And with that, I will conclude my remarks.

[The prepared statement of Wayne M. Osten follows:]

PREPARED STATEMENT OF WAYNE M. OSTEN, DIRECTOR, OFFICE OF HEALTH SYSTEMS MANAGEMENT, NEW YORK STATE DEPARTMENT OF HEALTH

Good afternoon. I am Wayne Osten, director of the Office of Health Systems Management for the New York State Department of Health. Chairman Upton, Chairman Biley, and Congressman Dingell, thank you for inviting me to speak with you today.

I am speaking to you today on behalf of New York State Commissioner of Health Antonia Novello. My responsibilities in the New York State Health Department include oversight of the physician medical conduct program as well as activities related to regulatory oversight and quality improvement at all hospitals, clinics, dialysis programs, and ambulance services in New York State.

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Currently, New York's incident reporting system receives over 20,000 incident reports a year from hospitals, clinics, and ambulatory surgery centers. We work with these facilities to make sure that corrective action is taken to prevent these incidents from occurring in the future.

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New York's Professional Medical Conduct Program is also recognized as a national leader in taking action to protect patients from physicians who commit misconduct, fraud, abuse, and incompetence. During 1999, the Office of Professional Medical Conduct of the New York State Health Department took 356 disciplinary actions against physicians, including nearly 200 actions that involved the revocation or surrender of a physician's license to practice.

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And New York led the nation in providing consumers with critical information on the quality of care provided by cardiac surgeons and cardiac centers across the state. This information is updated annually so that consumers can make better health care decisions.

We believe that consumers have the right to information about the credentials, track record, and experience of health care providers that is complete, accurate, and easy to use. With comprehensive improvement, the National Practitioner Data Bank could be a useful source of information for consumers. In its current state, however, this data bank could provide consumers with a false sense of security and could actually cause patient harm.

There are three major problems with the National Practitioner Data Bank. First, the data is not complete, and therefore is not accurate. Second, the data is not made available in a timely manner. Third, the data bank system is difficult to use.

Lack of Completeness

As you know, federal law requires that hospitals report to the data bank disciplinary actions involving the suspension of hospital privileges of a physician for 30 days or longer. The data in the National Practitioner Data Bank is not complete because this reporting requirement is not being enforced. The U.S. Department of Health and Human Services, which oversees the Data Bank, reported recently that approximately 66 percent of all hospitals in the nation have never reported a physician disciplinary action to the data bank. It is highly unlikely, that since the implementation of this data bank in 1990, 66 percent of the hospitals in this nation have never suspended a physician's hospital privileges. Under these circumstances, a consumer using the system might see no disciplinary actions listed for a certain physician when, in reality, the physician may have been involved in a disciplinary action.

The information in the National Practitioner Data Bank also lacks completeness because there are loopholes that hospitals use to circumvent the reporting requirement. As I mentioned, the law currently requires hospitals to report the suspension of a physician's hospital privileges when the suspension is 30 days or longer. Rather than report a suspension to the Data Bank and expose the hospital and physician to potential bad publicity, hospitals frequently suspend a physician's hospital privileges for less than 30 days or impose a lesser disciplinary action.

In New York, we have seen cases in which a hospital suspended a physician's privileges for four weeks—or 28 days—in cases in which the physician caused serious patient harm. Such a suspension is not reportable to the National Practitioner Data Bank. While this avoids the federal reporting, New York State reporting is still mandated and would result in both hospital and physician investigations and appropriate disciplinary actions. Hospitals also may take lower level disciplinary actions against physicians, such as fining them or requiring them to perform community service, and these actions are not required to be reported in the Data Bank.

In contrast, New York State requires that all disciplinary actions taken by hospitals against physicians are reportable to the New York State Board for Professional Medical Conduct.

Lack of Timeliness

Another problem with the National Practitioner Data Bank is that information about physicians doesn't get on the system in a timely manner. New York's medical conduct program immediately reports to the Data Bank all physician disciplinary actions it takes in New York State, and this information is posted immediately. But we know anecdotally that some hospitals have had difficulty getting information into the system at the time they report it because of alleged system break-downs.

Not Consumer-Friendly

Based on our experience in using the system, the National Practitioner Data Bank in its current form would be difficult for consumers to use. To extract information from the system, the user must input very precise language and be fluent in using and understanding the technical language and terms used by the system. At the New York State Health Department, we have had to provide extensive training to our staff who use the system and interpret the information in the Data Bank.

Again, we want to emphasize that consumers deserve complete and accurate information that they can use to make informed decisions about their health care. With substantial improvements, the National Practitioner Data Bank can be one tool that consumers can use to ensure that they receive high quality care.

Perhaps the Department of Health and Human Services should look to states like New York that are leading the way in making physician discipline information available to consumers. We in New York stand ready to assist the federal government in making the Data Bank the best it can be. It will take resources, however, to improve the data bank. In New York, Governor Pataki has committed both additional manpower and money to make our information available. The federal government will have to do this as well.

Thank you for allowing me to speak with you today on this very important issue, and I will be happy to answer your questions.

Mr. UPTON. Thank you very much.

Mr. Silver?

TESTIMONY OF LAWRENCE SILVER

Mr. SILVER. Thank you, Chairman Upton, and thank you for inviting me to appear here today. I have presented, and I understand it is going to be included in the record, 34 pages of documents with

legal citations. And with your leave, I will not repeat those portions. But I would like to try to, in my formal remarks, answer questions both you and Mr. Stupak, as well as Dr. Ganske, have asked other witnesses, since I do have some views on that.

To that end, I have had a varied career in the last 30 years. As a lawyer, I have prosecuted physicians, as part of the Pennsylvania Department of Justice, in connection with their licensure matters; I have represented hospitals and advised hospitals about how to conduct peer reviews against physicians; and for a period of time, represented physicians who were subject to peer review proceedings. It is accurate that this lawyer has been on all sides of those issues, and so that you are aware, I represent no physician involved in any litigation at current. I've been busy with others of my clients.

Frankly, the issue is an interesting one. In California, we find it of some concern, accusations brought against physicians by the licensing agency are made public in the front page of the paper, not the Des Moines paper, but certainly in the L.A. Times. The conclusion of a licensure proceeding is made public, peer-review proceedings are not made public, and I'd like to get to those. But that information is already available to the public and certainly available on any website.

The problem that you face, the problem that Congressman Dingell and others have raised, is the problem with peer review proceedings. And peer review started out, as you know, as a collegial educatory experience with no due process procedures, ways to help other physicians improve their medical care. That's no longer the case. That is not what it's about. That's not how it is practiced in the field. The problem that you have is that peer review proceedings, starting out with this historical collegial educatory function, have ended up being utilized sometimes properly to get rid of bad docs, but other times for highly competitive reasons, colleague against colleague. There's no difference in the economics and sometimes in the political area where colleagues against colleagues have different and sometimes very hostile views.

I have reported in my remarks representing a physician who was called into an administrator's office and said, an OBGYN, "You either bring your good insurance patients to this hospital and take your Medicaid patients to the hospital down the street or we'll commence a peer review proceeding," and had a document in the hand which showed that the doctor, over 20 years of practice, hadn't dotted every "T" or crossed every—done the other way around.

I have represented physicians in various States who have had similar types of economic matters raised in a peer review proceeding where the violation of peer review conduct was trivial, but nevertheless in violation of hospital codes. Indeed, in Tennessee, I have represented Dr. Reid. Dr. Reid was a physician, an oncologist employed by the hospital in Oak Ridge—

Mr. UPTON. Keep going. You will hear a couple buzzers.

Mr. SILVER. [continuing] the hospital in Oak Ridge. He found virulent cancers, cancers of unusual nature, cancers that had substantial amount of difficulty and unusual natures. He tried to investigate where the cause of these cancers were, and as a result, offended the political outrage and created the outrage of the local

business community which supported the hospital, which commenced peer review proceedings against him—peer review proceedings which had no semblance of due process. He lost, I lost, that peer review proceeding. The judicial review in Tennessee, although certainly better than other States, was not sufficient to overturn that decision. And as a result, Dr. Reid has suffered perhaps because of his own intense feelings about the cancers that he observed in this community which, as you know, produces high qualities of radiation—high levels of radiation, has suffered economically for years as a consequence. And his name is not only on there once, but on there twice on the National Data Bank because we lost these cases.

What you need to be very concerned about is the iconoclastic physician, the physician who has something new or different to say, the physician who condemns the community for not taking sufficient action to protect cancer patients, reminding us always of the case in which a physician was excoriated, kicked out of the medical society, removed from the staff, and had he been in the United States rather than Austria, he would be on the National Data Bank. His name was Dr. Semmelweis, and he came up with the outrageous proposal, 100 years ago, that physicians before they do surgery, wash their hands. He would be on your Data Bank because he was subject to peer review proceedings, and he was actually drummed out of the medical society.

I represented, unfortunately, Mr. Upton and Mr. Stupak, physicians in Michigan, not in Iowa, but I have the same to say for Iowa, Dr. Ganske. Michigan joins ten other States as being the worst States in terms of representing a physician. I have no basis to challenge what the hospital does. I can't call witnesses, I can't cross-examine witnesses, I can't subpoena witnesses, and at times I've been excluded from the proceedings. At times, the panel has gotten evidence that I was not permitted to share. I was not allowed to see the evidence against my own client. And do you know what judicial relief the States of Alabama, Arkansas, Iowa, Michigan, Nevada, Oklahoma, South Carolina, Virginia, Washington and Wisconsin—my alma mater—provide? None. Indeed, the last lawyer that I know who brought an action in Michigan seeking either damages or judicial review of the actions of the peer review panel was sanctioned for bringing a frivolous lawsuit because Michigan law is clear—Iowa is clear, Wisconsin law is clear—you cannot bring such a proceeding.

Consequently, my physician, who in Michigan had what I will call, and if you want more elaboration, I will certainly be able to answer the questions, had what I considered to be a trivial problem, is now in the National Bank and I could do nothing. My critical witness promised to come, but later declined to come because that witness was told, I was told, that had she come, she would have been subject to peer review proceedings herself.

So in terms of the panoply and, frankly, there are many more cases and individual cases, which I'd be happy to discuss with you or with staff, which indicates that the peer review process can and sometimes is used for improper purposes. And the immunity which you have provided to encourage this area precludes lawyers from

vindicating those. I have set forth in the formal remarks the deficiencies in peer review.

Do I believe, frankly, that you ought to be able to report and to publicize the existence of health care providers who provide deficient care? Clearly, but only after you assure that you're doing your job and providing that information fairly, honorably and after full and complete due process that we all know and at least have a belief that is correct.

I quote from an opinion, and very briefly, from an opinion of Judge Cook of Oklahoma in a peer review case which he dismissed, by the way, because of certain immunities, "This litigation was the Court's first exposure to hospital peer review process. The Court was shocked to discover the physician's career can be, and in this instance has been, destroyed by patent—through patently improper proceedings. Peer review, as it is presently practiced—"

Mr. SILVER. Somebody doesn't like what I'm saying.

Mr. UPTON. Mr. Silver, I regret to say you're over your 5 minutes by 3 minutes.

Mr. SILVER. Let me finish this sentence.

Mr. UPTON. Go ahead and finish, and then we are going to need to depart from because those buzzers means we have votes on the floor. So go ahead.

Mr. SILVER. [continuing] "is presently practiced is fundamentally flawed," and the judge continues.

In terms, I would like, just if I may, answer two questions. One, I tell you in California, in the Beth Israel cases, at least certainly the first case, 6 weeks would not have elapsed. The district attorney or the attorney general would have been in court, perfectly properly, with a temporary restraining order to enjoy our initiating doctor's practice.

And in terms of the other proceeding, which is I think, and I think it's proper to say that it is bizarre, and I'm not entirely sure, by the way, you ought to enact national legislation in terms of response to a singular bizarre and almost insane incident. But the other proceeding would be a—a more difficult proceeding in terms of a prompt response, but certainly would have been done, and certainly the information about prior activities would have been available.

I do have some additional comments and would wait, I guess, until you return, if you are going to do that, to ask questions of this panel.

[The prepared statement of Lawrence Silver follows:]

PREPARED STATEMENT OF LAWRENCE SILVER, ATTORNEY AT LAW

Mr. Chairman, Mr. Upton and Ranking Minority Member, Mr. Klink: I want to thank the Committee for the opportunity to discuss possible amendments to certain provisions of the Health Care Quality Improvements Act of 1986 (AHCQIA"). As I understand it, these amendments would provide for posting of information regarding physicians whose names are kept in National Practitioner Databank.

I have been an attorney for over 30 years. During the early 70's I was the head of the civil litigation section for the Pennsylvania Department of Justice, in which capacity I supervised actions brought against the licenses of physicians for improper conduct and practice. After moving to California in 1976, I spent several years representing hospitals in "peer review" proceedings against physicians. Since then, I have represented numerous physicians in peer review proceedings and in actions brought by the California Medical Board against physician's licenses. I argued one of the few peer review cases taken for review before the Supreme Court of the

United States, *Summit Health v. Pinhas*, 500 U.S. 322, 111 S.Ct. 1842, 114 L.Ed.2d 366 (1991).

The proposal to provide to the general public the information contained in the national database, previously limited to hospitals and others involved in the delivery of health care, presents troublesome issues of basic fairness. There are both practical and legal reasons why this is true.

There is a crucial assumption which underlies this proposal to publish the names of physicians: that the result of the peer review was fair and accurate. I would like to suggest to you that this assumption is *not* valid; that there are inadequate protections in place to assure fair and just results; and that the Secretary has no means of confirming the fairness of the result even though posting the results suggests to the contrary. This Congress must be very careful not to permit the creation of a "black list" unless it can be certain that results were achieved based upon a factual and legal determination by an independent finder of fact after a hearing where full due process protection has been granted to any physician charged.¹

Many of the protections I will suggest are based upon my experience in handling peer review cases. To make the suggestions concrete, I will discuss some individual cases which I believe will be informative to the Committee. I have handled cases from a number of states, but I will discuss cases from Tennessee, Michigan, and California.

First, however, I want to discuss a case which you may not have heard anything about. It involves an unusual physician. This physician was, as many physicians are, an independent person concerned about the care of his patients. He proposed a new procedure at his local hospital. His proposed procedure was a departure from the then existing standard of care. He proposed the procedure hopeful that it might save lives. His colleagues disagreed; they thought he was deranged and incompetent. They excluded him from the local medical societies. His colleagues commenced, in effect, a peer review proceeding and he was barred from hospitals.

Had there been a Databank in the 1800's, Dr. Ignaz Semmelweis would have been in it. His reputation would have been further besmirched by the posting of this information on the internet. Dr. Semmelweis's suggestion, for which he was effectively hounded out of the practice of medicine, was that before physicians engage in surgery, in order to avoid infections in their patients, they should wash their hands.

The story of Dr. Semmelweis exemplifies one major problem with peer review, one at the heart of the *Pinhas* case which I argued: iconoclastic physicians with good, but different, ideas frequently don't get along with their fellow practitioners. Peer review has been and is being used to silence those who are different.

You are undoubtedly aware that the Norman Rockwell image of the physician making a house call no longer represents medicine as it is practiced in the United States today. The practice of medicine has become a business, a big business. That business is controlled by hospitals which are concerned about the "bottom line", including length of stay issues; it is controlled by insurance companies which may veto proposed treatment of patients; it is controlled by HMO's, big business which may resist expensive treatments recommended by iconoclasts—imagine how much time and money could be saved if surgeons didn't need to scrub!²

I have represented a highly competent obstetrician who was called into the administrator's office in one of the two hospitals in which he primarily practiced. He was told, "Either you stop putting your Medicaid patients in this hospital—take them down the street to the other hospital and just bring us your 'good insurance' patients—or I will commence peer review proceedings against you." The administrator held up a draft of charges for peer review proceedings—a list of 2 or 3 cases in which, over approximately 20 years of the practice, this obstetrician may have not have dotted all the i's or crossed all the t's. Fortunately, this case arose before

¹ There is no assurance that the physicians who are already in the Databank are properly there. Any decision to post the names should be prospective only, based upon the criteria which I have set forth below.

² During preliminary discussions with members of this Committee's staff, I was asked why a physician wrongfully excluded from the hospital cannot sue for wrongful discharge, or make a complaint before the National Labor Relations Board. I agreed that a physician employee of an HMO who has a significant disagreement with the HMO may very well have a breach or contract or some other claim against an HMO which wrongfully discharges him. However, the HMO, realizing that, may cause a peer review proceeding against the physician, causing his removal from the hospital, and making him ineligible to practice with the HMO. This effectuates a discharge without, in fact, discharging or causing the discharge. Since physicians are not "employees" of a hospital, they have no claim against the hospital for "wrongful discharge", nor any complaint which they may file with the National Labor Relations Board. In addition, because of the immunities provided by HCQIA, such physicians may not have any claim against anybody who participated in the peer review proceedings.

HCQIA and was "resolved" when the hospital recognized that such peer review proceedings would violate federal and state law and would result in a civil suit—an action which would not be possible today because of the immunity which HCQIA provides.

You may have heard of the peer review case involving Dr. William Reid, an oncologist, who blew the whistle in Oak Ridge, Tennessee regarding cancers that he found in greater frequency, and of greater virulence, than in the normal population. Dr. Reid had the courage, although perhaps foolish courage and disregard for his own career, to bring these cancer problems to public attention, after efforts at private focus had failed.

The hospital in Oak Ridge, and its peer reviewers, brought numerous charges against Dr. Reid. Although Dr. Reid's diagnosis, care, and treatment were fully supported by experts and, indeed, the only other oncologist on the staff of the hospital, Dr. Reid lost that peer review and had his name sent to the Databank. This report necessarily implied poor quality care by Dr. Reid, yet the Medical Board in Tennessee never moved against Dr. Reid's license and had no basis to do so. It is now abundantly clear that those peer review proceedings were designed to silence Dr. Reid.

A hospital staff is a very small place. Think of a hospital as a marketplace—it is where physicians go to perform their services. Each physician in a department is in direct competition with the others. If one physician can get another excluded, that can have a direct economic benefit. Surgeons—or oncologists—without staff privileges are effectively barred from practicing their profession. Let me give you an example of how the lack of due process protections can contribute to abuse of the system for economic motives.

Another doctor who is in the Databank resides in Michigan. He is an ophthalmologist. He was one of the innovators of cataract surgery in Michigan many years ago. As he grew older, he secured a fellowship to become more familiar with and proficient in newer techniques of cataract surgery. His economic competitors jumped on this and accused him of being outdated and incompetent. They did not succeed. So far so good; but then they brought another charge against him based upon a technicality.

He was subject to a peer review proceeding and lost and was removed from the hospital staff. The hearing was a star chamber proceeding. I asked the chief of the department to come and testify; I could not subpoena witnesses or their documents. The Chief assured us of an appearance. I listed the Chief as a witness. The Chief did not appear. Later we learned that the Hospital threatened that if the Chief appeared, peer review proceedings would be commenced against the Chief also.

At this point I can hear you insisting that there must be a civil remedy for this. Wrong. Michigan law, like that of 9 other states, *allows no judicial review whatsoever of peer review*. This ophthalmologist thus had no remedy available under state law to challenge the lack of due process. Could he have sued under Federal law? I can tell you from personal experience that an antitrust claim is enormously difficult to prove, even without the procedural hurdle that HCQIA imposes by forcing the physician to prove that he did *not* receive due process.

This case would be tragic enough if it stopped here, but it didn't. This doctor applied to other hospitals. The other hospitals said that they would need the record of the original peer review. However, when I produced the record and certified that it was full, accurate and complete, they refused to consider it and said that the record—the transcripts, exhibits, motions and rulings—had to come from the first hospital. The first hospital absolutely refused to provide it because "peer review" proceedings were confidential and it would be a violation of the confidentiality requirements to send on the "official" record. Michigan courts refused even to enforce the production of this record. As a result, this physician was effectively precluded from practicing ophthalmology at any hospital and has been forced into economic retirement. In a nation that does not have enough physicians of experience and competence this is not only a tragedy for him but for all of us.

Judicial supervision of peer review proceedings throughout the United States is very uneven. There are, as I said, 10 states that permit no judicial review of hospital activities. As far as state law is concerned, the hospital need not provide the physician with any due process whatsoever, any notice of charges, any hearing, or any power to defend himself. A physician's only hope in those states is that the peer review violate some substantive federal law. She can then hope to sustain her burden of proving that HCQIA's immunity provisions do not apply, such that she can actually litigate her substantive case.

Fifteen other states provide for judicial review only to determine whether the hospital complied with its own bylaws. If those bylaws do not provide for a hearing in which evidence can be compelled, if those bylaws do not provide for an impartial

hearing officer, if those bylaws do not permit attorneys to appear on even the cross-examination of witnesses, it is of no interest to those courts.

The National Databank depends for its accuracy upon the vagaries of the laws of 50 different states. The Secretary lacks the authority and the resources to assure due process in the reported cases. If state law *does* not protect due process, and if the Secretary *cannot*, then Congress will have created a system ripe for injustice.

It is essential, if you are going to provide information to the public, that the following fundamentals of due process be available for *every* reported physician:

1. The hearing officer(s) should be impartial. I can tell you, as a former hospital lawyer, that it was the custom in California to select as a hearing officer another attorney who regularly represented hospitals and was "reliable" in his or her rulings. The physician had no say in the selection of the hearing officer. Also, we advised the hospital's administrator to "select" hospital friendly physicians to sit on peer review panels.

You must insure against "hometown justice" by ensuring that the hearing officer be as completely impartial as an arbitrator. It is essential that the affected physician have a role in the selection of the hearing officer; if the parties cannot agree, the court of local jurisdiction can select the hearing officer. There are enough retired judges and lawyers with considerable experience who can perform this role, as they do every day.

2. The medical members of the peer review panel must also be independent. They should not be staff members at the hospital or even practice in the same market area if they have the same speciality as the accused.

3. It is essential that the physician be able to subpoena both testimony and documentary evidence to the hearing. The hospital effectively has subpoena power because it already has all the records and because it can tell physicians that failure to participate in peer review proceedings at the hospital's request would be a violation of the hospital bylaws, subjecting them to peer review proceedings. The playing field is now unequal—the physicians have no power to compel testimony which they otherwise need, as in the case of the Michigan doctor which I described above.

4. The physician should have the right of discovery, that is, the right to obtain evidence reasonably in advance of the hearing.

5. The physician needs the right to have counsel present the case and cross-examine witnesses. It is ridiculous, in this day and age, for a physician to have to do this herself.

6. There should be reasonable statute of limitations for charges.

7. The physician should have the right, for his/her own benefit, to waive any confidentiality protection.

8. Lastly, the physician should have a right of judicial review. The state that accepts the benefits of HCQIA should provide judicial review, preferably *de novo*, but certainly no less than a substantial evidence review. This means that a full record must be available both in court and in subsequent peer review proceedings. Obviously no report should be made to the Databank, or posted, until all proceedings are final.

I have presented these protections as essential for practical economic reasons, but they are also necessary in order to meet legal standards of due process.

Congress enacted HCQIA in an effort to prevent "bad doctors" from moving from hospital to hospital, state to state. 42 U.S.C. § 11101(2); House Report 99-903, Energy & Commerce Comm., 1986 U.S. Code Cong. & Admin. News, pp. 6384-5. The statute consists of two parts. In the first part, Congress provided an incentive for hospitals to grant certain due process protections to physicians who become subject to hospital peer review proceedings. The incentive is a blanket immunity against all actions, state or federal, arising out of the peer review action. 42 U.S.C. § 11111(a)(1). Neither HCQIA nor any other federal statute *requires* hospitals to provide such due process protections; the only incentive is the reward of immunity if the hospital provides the "adequate notice and hearing" defined in 42 U.S.C. § 11112.

The second half of HCQIA establishes a national system for reporting actions against physicians. Malpractice insurers, state licensing boards, hospitals, and professional medical societies are all required to report to the Secretary any adverse action against a physician. 42 U.S.C. §§ 11131-34.

Professional societies and state licensing boards may request information from the Data Bank. Hospitals alone have the *obligation* to obtain such information, an obligation which arises (1) whenever they screen applicants for medical staff appointments or grant clinical privileges, and (2) every two years for those physicians already on the medical staff. 42 U.S.C. § 11135(a); 1986 U.S. Code Cong. & Admin. News, *supra*, at 6393-5. Hospitals which fail to obtain the information as required

are presumed to have knowledge of that information for purposes of medical malpractice actions. 42 U.S.C. § 11135(b).³

The Secretary's regulations give physicians a very limited ability to challenge hospital's report to the Data Bank. The Secretary does hold the report for 30 days before entering the information into the Data Bank, thereby providing an opportunity for corrections. However, there are significant substantive limitations on the ability to correct any report:

"A practitioner may dispute (1) the factual accuracy of reported information or (2) whether a report was filed in accordance with the Data Bank's reporting requirements, including the eligibility of an entity to report to the Data Bank. **The dispute process is not an avenue to protest a decision by an insurer to settle a claim or to appeal the underlying reasons of an adverse action affecting a practitioner's clinical privileges, license, or professional society membership. Disputes of this nature will be rejected if a practitioner requests review by the Secretary of HHS.**

Neither the merits of a medical malpractice claim nor the appropriateness of or basis for an adverse action may be disputed."

Four aspects of this system affect the due process issues. **First**, the Secretary does not provide any procedural or substantive due process protections to any physician prior to any adverse action. HCQIA makes no provision for such a hearing by the Secretary; that function, traditionally, rests with the local medical board, hospital, or professional society. The entire system assumes that the only hearing will take place there. **Second**, the Secretary does not know if any particular physician received any procedural due process protections during the course of the hearing which led to the adverse action. **Third**, the Secretary does not know what, if any, standards were applied by the hospital in taking adverse action against the physician, so does not know if the decision was arbitrary or capricious.⁴ **Fourth**, the Secretary provides no mechanism for the affected physician to challenge the propriety of the report for reasons such as the failure to receive procedural due process or the arbitrary or capricious nature of the decision.

These failures of due process affect a fundamental right. In *Meyer v. Nebraska*, 262 U.S. 390, 399, 43 S.Ct. 625, 626 (1923), the Supreme Court defined "liberty" to include "the right of the individual...to engage in any of the common occupations of life." Numerous other cases have reinforced this fundamental principle. See, e.g., *Greene v. McElroy*, 360 U.S. 474, 492, 79 S.Ct. 1400, 1411 ("[T]he right to hold specific private employment and to follow a chosen profession free from unreasonable governmental interference comes within the 'liberty' and 'property' concepts of the Fifth Amendment...") and *Truax v. Raich*, 239 U.S. 33, 41, 36 S.Ct. 7, 10 (1915) ("It requires no argument to show that the right to work for a living in the common occupations of the community is of the very essence of the personal freedom and opportunity that it was the purpose of the [14th] Amendment to secure.")

These protected interests include the right to practice such professions as law or medicine. "A state cannot exclude a person from the practice of law or from any other occupation in a manner...that contravenes the Due Process...Clause..." *Schware v. Board of Bar Examiners*, 353 U.S. 232, 238-9, 77 S.Ct. 752, 756 (1957). See also *State Board of Medical Examiners v. Friedman*, 150 Tenn. 152, 263 S.W.2d 75 (1924); *Margaret S. v. Treen*, 597 F.Supp. 636, 674 (E.D. La. 1984) (physician-liberty interest); *Poe v. Charlotte Memorial Hosp., Inc.*, 374 F.Supp. 1302, 1312 (W.D.N.C. 1974) (physician-property right); *Yashon v. Hunt*, 825 F.2d 1016, 1022 n. 2 (6th Cir. 1987). The Data Bank is intended to and does infringe on these protected interests.

The Supreme Court's decision in *Wisconsin v. Constantineau*, 400 U.S. 433, 91 S.Ct. 507 (1971), examined a state regulation similar to the HCQIA data bank. Wisconsin passed a statute which provided that certain designated persons could forbid the sale or gift of intoxicating liquors to individuals who exposed themselves or their families to "want" or became dangerous to the peace of the community. The police chief in one city "posted" a notice in all retail liquor outlets in that city forbidding the sale of liquor to Grace Constantineau for one year. Although the Supreme Court had no doubt that states had the power to deal with the evils described in the Wisconsin statute, and noted that the police power of states over liquors was extremely broad, it did not hesitate to rule that statute unconstitutional:

³Hospitals may become liable for negligent failure to screen medical staff members. *Darling v. Charleston Community Memorial Hospital*, 211 N.E.2d 253 (Ill. 1965), cert. denied, 383 U.S. 946 (1966).

⁴The "substantive" aspect of the due process clause protects against arbitrary or capricious actions. *Gutzwiller v. Fenik*, 860 F.2d 1317, 1328 (6th Cir. 1988).

"Where a person's good name, reputation, honor, or integrity is at stake because of what the government is doing to him, notice and an opportunity to be heard are essential. 'Posting' under the Wisconsin Act may to some be merely the mark of illness, to others it is a stigma, an official branding of a person. The label is a degrading one. Under the Wisconsin Act, a resident of Hartford is given no process at all. This appellee was not afforded a chance to defend herself. She may have been the victim of an official's caprice. Only when the whole proceedings leading to the pinning of an unsavory label on a person are aired can oppressive results be prevented." 400 U.S. at 437, 91 S.Ct. at 510.

Government conduct becomes actionable whenever it denies "a person collateral credentials or privileges practically necessary for pursuing an occupation..." *Phillips v. Vandygriff*, 711 F.2d 1217, 1223 (5th Cir. 1983), *pet. for reh.*, 724 F.2d 490 (1984). Although denial of staff privileges at one hospital may alone suffice to raise this protected interest, *Id.*, the denial of staff privileges at one hospital forecloses an entire range of employment opportunities for physicians.

The Data Bank affects not just one physician but physicians generally. Its impact derives from the importance of hospital staff privileges to the practice of certain medical specialties. Surgeons and other specialists must have access to the equipment and trained support staff of a hospital. Those with staff privileges can practice their specialty, those without them cannot. *Dolan & Ralston, Hospital Admitting Privileges And The Sherman Act*, 18 Houston L.Rev. 707, 713 (May 1981). Congress was well aware of this when it passed HCQIA: "For most physicians..., perhaps the most severe disciplinary action next to the loss of their license is the loss of clinical privileges at a hospital." 1986 U.S. Code Cong. & Admin. News, *supra*, at 6401.

Physicians know this fact of life as well as anyone. Most physicians—surgeons, ophthalmologists, anesthesiologists, oncologists, obstetricians, gynecologists, and others—simply *must* have access to hospital facilities to practice medicine. For physicians and many others, a hospital is the marketplace in which they provide medical services. *Peer review controls their access to that marketplace*.

Before the passage of HCQIA, a physician denied access to one hospital might find another marketplace (hospital) in which to provide services. Congress established the Data Bank specifically to control this: "The reporting system in this legislation would virtually end the ability of incompetent doctors to skip from one jurisdiction to another." 1986 U.S. Code Cong. & Admin. News, *supra*, at 6384-5; 42 U.S.C. § 11101(2).

HCQIA accomplishes this goal by (1) requiring peer review for all physicians at all hospitals, 42 U.S.C. § 11135(a), (2) keeping track of any adverse action in the Data Bank, (3) passing along the adverse information to other hospitals, and (4) penalizing those hospitals which fail to obtain information. The unspoken but obvious implication is that hospitals should remove such physicians from their staffs or deny them access in the first place.

As Congress no doubt knew, the law already provides a substantial incentive for hospitals to do just that. The decision in *Darling v. Charleston Memorial Community Hospital*, *supra*, imposed liability on a hospital for negligence in screening its staff physicians. "[I]mposing the duty of care upon a hospital should have the 'prophylactic' effect of supplying the hospital with a greater incentive to assure the competence of its medical staff and the quality of medical care rendered within its walls." *Elam v. College Park Hospital*, 132 Cal.App.3d 332, 345, 183 Cal.Rptr. 156, 164 (1982); 42 U.S.C. § 11135(b). The widespread adoption of this principle, *Id.* at 346, 183 Cal.Rptr. at 164-5, means that the Data Bank sows its tares on a field already fertile.

Even before HCQIA, the harmful impact of an adverse peer review was well known:

"Although there may be more than one hospital in the relevant geographic market, excluding a physician from one hospital often leads to exclusion from other hospitals. Moreover, exclusion by one hospital may lead to disciplinary investigation by local medical boards and thus further impede an excluded physician's ability to practice medicine." *Drexel, The Antitrust Implications of the Denial of Hospital Staff Privileges*, 36 U. Miami L. Rev. 207, 231 (Jan. 1982) (footnotes omitted).

"The consequences of an adverse finding in the medical peer review process may be very significant to the physician who is censured. The curtailment or denial of clinical privileges can destroy the physician's ability to practice and earn a living." *Darricades, Medical Peer Review: How is it Protected by the Health Care Quality Improvement Act of 1986*, 18 J. Contemp. L. 263, 271 (1992), footnote omitted.

"For physicians, the staff privileges granted or confirmed by review committees are crucial to their professional survival: 'A physician without privileges is

a physician without patients.'... This denial is particularly catastrophic for surgeons who rely extensively on hospitals for operating facilities and support personnel.

... A privilege denial or revocation may have an even greater impact on a physicians' efforts to practice in the future. Not only is his reputation damaged, but subsequent privilege applications invariably force the physician to detail previous privilege denials or revocations, resulting in further denials." Comment, *Patrick v. Burget: Has The Death Knell Sounded For State Action Immunity In Peer Review Antitrust Suits?*, 51 U. Pitt. L. Rev. 463, 468 (1990), footnotes omitted.

In 1991, before the Data Bank went into operation, Howard L. Lang, then President-elect of the California Medical Association, pointed out that the Data Bank "raised the stakes" for physicians:

"It is clear, therefore, that the courts have understood that membership on a medical staff is essential to almost every physician and that without hospital privileges, a physician loses the opportunity to practice the medical profession to the fullest extent.

Indeed, the stigma of revocation or denial of privileges can ruin a physician's career. With the implementation of the National Practitioner Data Bank, the stakes are raised even higher, as every physician's record will follow him or her to other communities. If the privilege denial is unjustified or unrelated to the physician's competence, therefore, that individual will be unfairly labeled. With dissemination of this information to health maintenance organizations, preferred provider organizations, state licensing agencies, and medical staffs, the physician may be unable to practice medicine anywhere. Besides destroying the physician's reputation and livelihood, an unfair privilege decision may deprive the community of a qualified physician." Lang, *Economic Credentialing—Why It Must Be Stopped*, 5 The Medical Staff Counselor 19, 22-23 (No. 2, Spring 1991), footnote omitted.

Since the practice of medicine is a protected liberty or property interest, and since the Data Bank imposes a stigma which seriously infringes on those rights, it remains only to ask: Did the physicians who were reported to the Data Bank have an opportunity to refute the allegations made against them that was consistent with due process? The answer to this inquiry requires consideration of several possibilities.

One possibility is that HCQIA requires that accused physicians receive a certain minimum level of due process prior to reporting. HCQIA does, in fact, specify certain due process protections for peer review hearings. If hospitals do provide such protections, then they receive immunity from liability for their conduct of the peer review proceeding. 42 U.S.C. Section 11111. However, those protections are not mandatory; HCQIA provides a carrot but no stick. No portion of the statute actually requires hospitals to provide these or any other elements of a fair hearing.

It is equally clear that the Department of Health and Human Services does not itself provide any hearing to the accused physician. This implies no criticism of the Department—the statute never intended for HHS to undertake this obligation. Instead, the Department serves only as a repository and distributor of information obtained from the local medical board, hospital, or professional society.

Nor does the Secretary provide the affected physician with any right to challenge a data bank entry on the basis that the peer review hearing lacked due process fundamentals. As is clear from the challenge procedure described above, the Secretary reports only the fact of a professional review action and does not judge the validity of the accusation or the fairness of the hearing.

Because the Department does not itself provide a fair hearing and makes no judgment regarding the adequacy of the procedures followed, it has no way of knowing whether or not the physician actually did receive the rudiments of due process. The Secretary simply records the information without knowing either the basis for the professional review action or the procedures which led to it.⁵

⁵I have limited my discussion to peer review cases, but the Data Bank also "posts" physicians for settlements of malpractice cases. 42 U.S.C. § 11131. As Congress recognized, "any number of considerations other than the merits of a claim can affect the size and frequency of malpractice payments. The sympathy generated by the severity of an injury, the attractiveness of a claimant, the skill of a claimant's attorney, the demands of a busy medical practice and the unpredictability of juries can all lead health care practitioners to settle cases...with respect to medical services that meet or exceed accepted standards of medical care." 1986 U.S. Code Cong. & Admin. News, *supra*, at 6396. The insurance company may even make a business decision to settle over the protests of the physician. In all these cases the physician receives no process at all, yet "posted" she will be.

Though all 50 states differ in the specifics of their treatment of private hospital peer review, they tend to fall into several general categories. By examining these categories this Committee will see that state laws do not protect physicians in private hospital peer review hearings, so the Secretary cannot rely on them to justify the Data Bank.

(1) **States which refuse to protect the physician.** Ten states—Alabama, Arkansas, Iowa, Michigan, Nevada, Oklahoma, South Carolina, Virginia, Washington, and Wisconsin—refuse to permit their courts to review a hospital's actions.

Mr. UPTON. I might just say, for those members, and we will pass the word on the floor, those buzzers meant we have a number of recorded votes on the floor. So at this point, we will recess and come back for questions from us at 1:45.

[Brief recess.]

Mr. UPTON. Well, I appreciate everybody coming back promptly. I am told, as I left the House floor, that we are expecting one more vote about 3 o'clock. So we will see how things go. And at this point, again, I want to reiterate my thanks for all of you coming to Washington, most of you, I think, for submitting your testimony on time so we were able to review it last night and prepare some questions.

And I am going to be pretty tight on this gavel, including on me, as we start this round of 5-minute questions. We will probably go maybe two rounds at least, maybe a third, depending on how many members come back.

For me, I have a lot of questions, and it was a delight to talk to a number of you during the little break and almost wish that we could all sit at that table and just raise our hand and ask a lot of questions.

First of all, Ms. Neuman, I would like to have a little dialog of walking through the procedure of what a physician does to get licensed, and I want to raise a couple of points. One, as you walk me through this, what do you do with multiple licenses and folks that may, in fact, get disbarred, I guess you would say, in one State, while they have another license in another, which would then allow them to continue?

And I use a little bit of some anecdotal evidence on my part. But I knew a physician in my district, no longer my district. It is not in Bart's either. But he, in fact, was disbarred by the State of Michigan a couple of years ago. And lo and behold, I found evidence to show that he had practiced in Virginia for a number of years before that and had been disbarred there. And somehow, and I would like to ask my own Michigan people, and I intend to do that, how does this individual, how did he get through the clearing process to allow that to happen? That is No. 1.

No. 2, when they lose their license, does that get into the Data Bank at all? And what tools do you have to check other States and to make sure they are appropriate? And what do you do, as we heard with the awful example a little bit earlier this morning, of a hospital that doesn't report really what happened? The term "gross misconduct" bad enough term on its own for sure, but the carving of one's initials into somebody is more than that. And without that detail, what red flags would a State have in terms of really checking into the information that was submitted? In other words, the information that is there is only as good as those that submit it. And when you read about that particular physician who

still went on and began to practice, when you see today's story allegedly—what do you do when you find providers or hospitals that don't, in fact, report individuals and they continue? How does that all fit together? Go ahead.

Ms. NEUMAN. Okay. I'll start out with the first question that you asked me about the licensure process and how we prevent a doctor from getting licensed in another State after he's been disciplined in the earlier State. What we do is that we, as the application comes in, we do our own verifications of licensure on that individual. We also query the Data Bank, we query our own Data Bank of the Federation of State Medical Boards to make sure that the doctor has not been disciplined. We ask a number of questions on the application form, and those all go, in a State like mine, to something called the Licensing Committee of the Board, and in some States they are called Credentialing Committees or whatever of the board.

But one of the most important things that we do as boards is to check the Data Bank to make sure that the doctor has not been disciplined when that application is coming in. So at that point, what the board's option is is to deny license. And what we see in those cases is the doctor will bring his lawyer in, and we will start the process up again of just reviewing all of the material, and they will submit all of their material from that other State where they were licensed and were disciplined, and the board reviews that.

In most cases, you have a better option of stopping that doctor from practicing in your State at the licensure level than—and being able to take action, rather than having to do a piggyback on an existing licensee. So we do review the material, we do look at it. And hopefully in a case like that, where a doctor has been revoked or suspended in another State, as it has been in my State, we deny the license of that doctor so that he cannot continue to move.

Now, the bigger problem is when you have a doctor who has been disciplined in one State who takes off and moves to another State. There are due process, even in the licensure denial process, there are due process—there's due process afforded the physician during that process. You can, as we recommended to—and I've done in my State, which is to pass a law that would allow the boards to automatically piggyback on serious disciplinary actions, and we would encourage other State boards to do that. The process is long if you don't have that power to automatically piggyback on a disciplinary action on another State, by another State, and so it's very important that State boards look at passing laws that provide for this automatic suspension or automatic piggyback of a suspension or revocation in another State. That's another way that you can address dealing with physicians who are moving.

And I agree with many of the comments made here today, that doctors in trouble very often move very quickly. And if they have multiple licenses, which many of them do, each State has to take the action. And that's what you're facing. The time period, and one of the reasons why we want—that I feel that the Data Bank should be open is that that information would be instantly available to all consumers. Even with the individual data bases, they are only data bases for those States. By having this national clearinghouse open

with this information, consumers could then get that information immediately.

Mr. UPTON. And the Data Bank today doesn't list, isn't required to list, if they actually lost their license; is that not correct?

Ms. NEUMAN. Oh, absolutely, they are required to, if they've revoked—

Mr. UPTON. They are.

Ms. NEUMAN. Yes. So that's what's so important about having this information available because, just because of the due process that's afforded the doctor, it takes a while for a State board to take action and piggyback on that action unless they have, like they have in my State, this automatic piggyback provision of their statute.

Mr. UPTON. Do you want to ask 5 minutes and then come back?

We are going to recess. I know, actually, that Dr. Ganske went over to vote. So when he comes back, so stay tuned, he can start, and then we will go to Mr. Stupak.

[Brief recess.]

Mr. UPTON. I apologize for the delay. I thought Dr. Ganske was on the way back so I allowed myself to get grabbed by a couple of people who wanted to chat about a variety of different things and I also finally got something to eat today. So, a quick sandwich.

Mr. Stupak?

Mr. STUPAK. Thank you, Mr. Chairman.

You know, throughout the testimony today we have heard about peer panel review and how that should be the determining factor of what is made available to the public. But after listening to Mr. Silver I guess I see a different aspect here where you see political, economic and procedural safeguards not being part of peer review panels and actually that could actually be abused and maybe people who should not then go into the national data base would be in the national data base.

Mr. Silver, I would like to ask you a little bit more, give us a little bit more specific example. You had mentioned—and I remember you being before this committee before on the investigative work of Dr. Reid, I believe it was—he was looking into the nuclear workers who were possibly exposed or showing unusual patterns of disease in connection with the work at Oakridge facility in Tennessee. Can you briefly summarize what took place in that case and how the national data base was used as a punitive tool against that doctor?

Mr. SILVER. Yes. Dr. Reid is an oncologist and treats people who have, among other things, cancer. And he observed having been a member of the staff of the hospital and he having a separate position of being employed through a subsidiary of the hospital a variety of things that in his experience and in his private practice, in his residencies had not observed. He observed cancers occurring with greater frequency than occurred in the general population. He observed cancers in people—prostate cancers is one that sticks in my mind—in men much younger than we ordinarily experience those types of cancers. He had four cases of a bizarre and unusual kind of cancer that in his entire career up to that point had only seen one. He had four active cases.

And as a result he has tried to find out what is causing these cancers? And because when he used traditional, by-the-book medications or chemo or radiation, the cancers were much more virulent. So, he was not treating by the book. Now, that is really important. I will come back to that in a second.

As a result, he frankly is a very idealistic kind of person and may not be as politically astute as others, tried privately to find out what was going on and then when that failed, tried publicly. That may have been a fatal mistake for his career and probably was.

The public accusation against the company town and against the factory led to a peer review proceeding against three physicians who were part of that hospital group, selected by the hospital. And as a result, it was determined by that panel after we had had the 10 days of hearings that his practice, even though supported by experts and even though supported by the only other oncologist on staff, that he engaged in practice which was different than the standard of care. And he said, you bet you I engage in practice different than the standard of care because I had like a lady down our road here who has had four different types of virulent cancers, you need to save her, you need to do what you have to do.

They found that that practice violated the standard of care in Oakridge and he was on the national data base. As a result, by the way the record in that case is at least 4-to-5 feet thick. The record in that case is a few sentences in the national data base and as a result, as far as I know, he has been unable to get on the staff of any other hospital because he has been determined to have practiced in disagreement to the ordinary standard of care.

Mr. STUPAK. Well, if this doctor did not get back on to practice, then how could those doctors that were from our other witnesses we heard just before your panel, how do they continue practicing after they do gross negligence and things like that?

Mr. SILVER. Well, first of all, there is the National Data Bank and as I was speaking to Congressman Upton during the break my experience is, for example, the piggyback is—I had a doctor who did suffer a licensure action. There was some action taken against his license in California. Within 30 days, New York suspended him like that, revoked his license like that because he had violated the standard of New York and that is he was eliminated from another licensure.

California requires, Jersey requires, New York requires that when you apply and in your reapplication that you list all the States in which you are licensed and if any action against that license is taken, at least, California notifies all the other licensure States.

Mr. STUPAK. Well, then is it fair to ask—do the different States do it differently? I mean in New York here there is—when Dr. Getz there, Dr. Zarkin, who went on to go into, I think, two other businesses after that, just like that hospital went on to two others with Mr. Smart. He had no idea that this doctor was Dr. Sklar, or Sklar was even going to operate on his wife.

I mean even though there is patterns of gross negligence, every State doing it differently? Is there a need then for the Federal Government to step in and say, if the States aren't doing it properly

we have to do it? And then after we come to some final disposition then we end up putting that open to the public?

Mr. SILVER. Well, if we were to establish a national rule you would, in effect, have the Congress tell the States how to operate their own systems. I do not think there is anything bad necessarily with piggybacking. The doctor in my case got substantially due process in California and was then reported to New York and terminated in New York. That later gets changed by the way after an appeal.

But at least in my practice, in the States in which I have practiced, I have not found that to be a problem. And even if you listen carefully to the testimony, they have a piggyback statute, which is what it is called, and down in one, down in all.

And as I said, in my opening remarks, at least in California, had this doctor who carved his initials in the patient, there would have been a temporary restraining order and proceeding very promptly in California.

Mr. STUPAK. Well, but in New York he went onto another business and I guess I asked the question earlier, what is breaking down here?

Mr. SILVER. Right.

Mr. STUPAK. I guess I am still without an answer. I am sure the Chairman can find other witnesses who would have just as grievous stories as the other two people we heard here today.

Mr. SILVER. Well, I don't know what broke down. I can tell you in California, and I think in New York as well, that you could stop the other doctor—you said other businesses, I think he went to another hospital where he was already a member of the staff. No. I disagree, and I must say that the white wall of silence I think is flipped. I have had a doctor who has been encouraged to resign from one hospital and collegially the other doctors on staff let that information get out to the other hospitals in the community and usually there is a domino effect without due process in which he is asked to resign.

And, in fact, I find that the informal method is much more brutal than sometimes the formal method.

Mr. UPTON. Thank you.

Dr. Ganske.

Mr. GANSKE. It is hard to keep your train of thought when you get called back and forth like we have. And I thank you all for your patience because it is getting a little later in the afternoon.

My understanding is that denials of licensure are not reported to the Data Bank. So, Dr. Reardon, what do you think about that?

Mr. REARDON. Thank you, Dr. Ganske.

No. We would support the denials of licensure should be reported to the Data Bank. It is my understanding at the present time, though, that a denial of licensure or a removal of a license is shared through the Federation of State Medical Boards with all the other Medical Boards. They send out a monthly newsletter so that the information is available at that level.

Mr. UPTON. If I might just freeze the time and just—this was a question that I asked Ms. Neuman before, at least that is the question I had thought that I had asked. And you indicated that they are reported on the Data Bank; is that not correct?

Ms. NEUMAN. The denials of licensure are not reported in the Data Bank but they are reported to the Federation of State Medical Boards' Data Bank. That was just recent though because within the last, oh, I will say within the last 5 years, because our board had to put a resolution into the Federation to encourage State Boards to report denials of licensure because our State had been burned by an applicant who applied to our State and in our investigation we found out that he had been denied in other jurisdictions and there was not a place to get that information.

I would certainly support that the National Practitioner Data Bank be collecting that information. It is very important information for the States to have.

Mr. UPTON. I am going to yield back my time here to Mr. Ganske.

Mr. GANSKE. All right. What about denials of privileges? Should that be reported to the National Data Bank, Dr. Reardon?

Mr. REARDON. Here, again, I think Dr. Ganske, it depends on what the denial of privileges is for. If the denial of privilege is a denial over substandard care, certainly. If the denial of privilege is over an administrative issue, for example, probably one of the most common reasons I have seen physicians lose their privileges at my hospital is they don't sign their charts on time and that has nothing to do with the quality of care they are providing to a patient. It is an administrative issue within the hospital. But we would certainly support if a physician is practicing substandard care, poor quality of care, then, yes, that should be reported.

Mr. GANSKE. Is there anyone on the panel that would disagree with that?

Mr. NEWMAN. No, sir. If I might though, there is a distinction between denial of privileges and rescinding privileges.

Mr. GANSKE. Right.

Mr. NEWMAN. Rescinding generally is for cause of some kind. Denial could simply be a determination that there isn't sufficient experience, training, what have you. So, there is a real distinction there. But rescinding privileges, I am in full agreement, that they should be reported.

Mr. GANSKE. Okay. Dr. Hochman, you are testifying on behalf of the American Hospital Association. One of the criticisms that we heard earlier was that our hospitals are not reporting reportable events to the National Practitioner Data Bank, which is a problem not in terms of opening it up but just in terms of whether current law is working properly.

Can you comment on that? Is that true? What is being done to remedy that?

Mr. HOCHMAN. Well, let me take it in three issues. One, there are a whole bunch of activities that go on in the hospitals today that fall before something is reported. Hospitals will take actions against physicians revealing cases, monitoring their performance, that will not make it to a Data Bank but will occur inside the processes that occur in a hospital, since there are a lot of activities as it relates to the quality performance that go on.

The second, the 30-day rule is kind of an arbitrary rule that was set up, and I guess there is some question whether someone has passed the 30-day suspension, that gets reported; less than 30 days

doesn't get reported; that, to me, raises some question whether that criteria was appropriate or not. And then the third that has to be looked at and one of the things that we want to look at, is there a greater incidence of less than 30-day suspensions that are out there; is that being used?

From personal experience, it isn't. And generally in the institutions where I have worked when we decide to suspend someone it is not like in the NHL where we take someone out for a week or 2; it is either we decide to suspend someone or not. So, to me it may be that when the criteria were established the whole concept of something 30 days or not that may be flawed and that may need to be looked at.

We also need to look at whether, indeed, when we look across the country at hospitals, whether shorter revocations or suspensions of licensure or credentialing are being used by hospitals. We think not in what we have seen but we need to look at that.

Mr. GANSKE. Okay. Dr. Newman, your representing Beth Israel and I apologize if I am asking a question that has been asked before when I was not here. But we had a prior testifier today talk about an incident that occurred at Beth Israel. And she said that this doctor was immediately suspended. Now, then what happened? Did Beth Israel then report that immediately to somebody? What was the mechanism for that?

Mr. NEWMAN. Sir, the suspension did occur as Dr. Gedz testified. A report was submitted to the State Office of Professional Medical Conduct and also to the National Data Bank. I think that the fact that this physician was able subsequently to apparently continue working in some capacity in what I understand is an ambulatory facility reflects two problems. One is a problem clearly at Beth Israel Medical Center. We had believed unequivocally—it was a wrong belief in retrospect—that gross misconduct—and I believe the chairman asked this earlier—that gross misconduct was a sufficient red flag. It clearly was not in retrospect and I can only assure you that that is a term that we will never again use in reporting anything at Beth Israel. We will be explicit in excruciating details spelling out exactly what the nature of the misconduct was.

The other aspect of the problem and I think this, again was in part a response to the member from Tennessee's question earlier on and that is that not being a hospital and this facility was not a hospital, there is—

Mr. GANSKE. That he was subsequently practicing in?

Mr. NEWMAN. That he was subsequently, as I understand it, employed by, there is no requirement—and again it seems paradoxical and inexplicable to me—there is no requirement that that facility would query the National Data Bank. They may, and if they do they will get the access, but there is no requirement. So, I think two things to learn from this very, very regrettable experience is No. 1, that institutions should be explicit; and No. 2, that there should be a requirement that any health care entity query the Data Bank for the information that is there. It just seems silly not to utilize it.

Mr. GANSKE. Well, let me if I may have unanimous consent for 1 additional minute?

Mr. UPTON. Hearing none, go ahead.

Mr. GANSKE. Okay. So, this gentleman loses his privileges at your hospital and you report it to the National Data Bank and you also reported it to the State Board of licensure?

Mr. NEWMAN. Yes. There was an oversight on our part. We reported it to the State Health Department. We viewed this egregious incident as being an incident of medical misconduct, so, we reported it to the Office of Professional Medical Conduct. It was subsequently pointed out to us as criticism, which we fully accept, that we should also have reported that incident to the Office of Health Systems Management of the State. But we did, in fact, report to both, but I didn't want you to think that we were fully in compliance, because we were not.

Mr. GANSKE. If you had done that was it then that State Department's responsibility? How would anyone know where this physician would have multiple privileges so that those institutions could get the knowledge that this incident happened? Who is responsible for that?

Mr. NEWMAN. First of all, my understanding is and I might be wrong, but my understanding is that he did not at that time, at the time of his suspension, have privileges anywhere else. We have instituted within Beth Israel a standard practice now—

Mr. GANSKE. But how would you know that? Do you know where all your physicians have privileges?

Mr. NEWMAN. We know because there is a requirement. Again, we can't protect ourselves against out-and-out falsehoods, but there is a requirement at reappointment time and at initial application time that every applicant or member of the staff indicate every other facility and we have adopted, in response to this issue, a practice which is routine that we will immediately, at our initiative without being asked, let everybody know.

But if there were a requirement that the other entities, nonhospital entities, query the National Data Bank, again, maybe gross misconduct wouldn't have been a sufficient flag, but they would have seen this is somebody who was terminated from the staff and it would have given them a clue that this is a problem physician.

Mr. GANSKE. If that physician is applying for new privileges?

Mr. NEWMAN. That's right, that's right.

Mr. GANSKE. And, Dr. Hochman, would it be generalized hospital procedures similar to those around the country such as Beth Israel, for hospitals to be required to have an idea of all the other facilities that a physician would have privileges at so that if a physician goes off the deep end and you have taken away his privileges you can then notify these other facilities?

Mr. HOCHMAN. A couple of things. We do keep a listing of where all physicians have their privileges. We also require that every 2 years they have to get recertified so that the issue of whether it is new or not is there. And then when an action is taken that is immediately reported.

Now, where some of the things, where some of the gaps that I think some of you have been highlighting is some physicians are very adept at moving around, having multiple privileges and there are issues of what our reporting procedures are. So, if we report to the State, we report to the National Data Bank there are poten-

tially holes that the other places where a physician has privileges may not know. That there is a potential there.

The other thing is that not every system has an exhaustive way of reviewing all the records and kind of going through in detail and that's another potential where, if the institutions like health clinics don't do that, there are really potentials for a physician to slip in there under that.

Mr. GANSKE. Thank you.

Mr. UPTON. The gentleman's time has expired but we are going to have another round.

Mr. Dingell.

Mr. DINGELL. Mr. Chairman, I thank you.

I would like to welcome Dr. Loniewski and an old friend, Dr. Reardon.

I have several questions, first, for Dr. Reardon, two in number. Doctor, you mentioned that lawsuits are frequently settled by an insurer without the physician's consent. Again, a similar question: What are the implications of this fact on the discussion of whether we should open the Data Bank to the public on that kind of matter?

Mr. REARDON. Thank you, Congressman Dingell. And I think the issue is oftentimes suits are filed. There sometimes is an agreement with the insurance company in the contract that they can settle a suit which they consider a nuisance suit rather than go through the court process and defend that. It is a very low settlement. That then becomes a matter of record on the physician, the physician has no choice. The physician may want to defend that and, so, he can then maintain his integrity. So, that is one of our concerns about the accuracy and the reliability and the validity of the information on the Data Bank.

Mr. DINGELL. Dr. Reardon, one of the sections in your testimony mentions that the NPDB does not make any adjustment for high-risk procedures. Tell us about the implications of this fact as to whether it relates to our opening or not opening the Data Bank to the public on this matter?

Mr. REARDON. Well, Congressman Dingell, I think our concern is that there are many high—there are high-risk practices, neurosurgery, orthopedic surgery, obstetrics. There are also many high-risk procedures which are not often done, maybe not done frequently or done by a few physicians that we need those physicians there to do those procedures, to have them available so when a patient is critically ill that someone will take that risk. There is not always the best outcome on some of these high-risk procedures or high-risk practices.

The physicians do their best job, provide high-quality care and, yet, the outcome may not be optimum. And, so, there is a lawsuit. If you have these continually released by the Data Bank which does not reflect on the quality of care, the concern is will physicians continue to make themselves available to do the high-risk type of practice and the high-risk procedures.

Mr. DINGELL. Thank you, Doctor.

Now, ladies and gentlemen of the panel, I am going to have to ask you to respond as quickly as you can because I have two questions for each of you. And we will start at your left and my right,

with Mr. Silver, and what are the primary weaknesses regarding data in the National Practitioner Data Bank? Are there other weaknesses and, if so, how do these matters affect the usefulness of the Data Bank? Starting with you, Mr. Silver.

Mr. SILVER. The States under which the information is achieved in peer review proceedings, in my judgment as my prepared remarks I think prove, do not conform to even the most basic due process; and, as a result, you are having a determination made without the adequacy of protections that we all, as Americans, grow to love. And, as a result, good doctors, high-risk doctors, doctors who may do things a bit differently end up in the Data Bank unnecessarily.

That's not to say that there aren't docs who ought not be there because I think there are. But you end up with doctors like Dr. Reid and others who do these kinds of things who will be discouraged from doing them in the future.

Mr. DINGELL. Next panel member, please?

Mr. OSTEN. Basically it's in my testimony. I think the biggest weaknesses are that the system is not accurate, it is not complete. If you have two-thirds of the hospitals in this country not reporting, you really don't have a Data Bank.

Mr. DINGELL. Dr. Hochman?

Mr. HOCHMAN. I certainly agree completely with what Mr. Osten said by way of a weakness. I think the other weaknesses I have already alluded to. One is that there is no mandate that nonhospital health care entities query the data registry and I think that that absolutely should be done. And I think that there is no—and I know there is no mandate that State licensure agencies query the National Data Bank before issuing or renewing licenses.

And those are presumably problems that could be corrected immediately.

Mr. DINGELL. Thank you. Dr. Reardon?

Mr. REARDON. Thank you. I was—I have two comments. One is the lack of access in the Data Bank by say licensing boards. I think that is critical. And, second, one of our greatest concerns is the malpractice settlements which do not reflect quality of care or competency. As I pointed out in my testimony when peer reviewed only 1-in-5 settlements were really true negligence.

Mr. DINGELL. Thank you, doctor.

Next panel member?

Mr. HOCHMAN. I would echo some of those comments. Just the information that is there is information without knowledge and it doesn't have information that really relates to quality of care, particularly around the medical malpractice issue.

Mr. DINGELL. Thank you.

Dr. Loniewski?

Mr. LONIEWSKI. Yes. Rather than repeating everything that has been said, there are too little other areas that I come up sitting at the—on an executive committee as well—that seem to be disturbing to me. And one is the permanency of the record, itself. Once a physician is in the record, he stays there forever.

No. 2, we also, I think, which is unfair and nobody has brought this up, and that is that we do have at hospitals, interns and residents, that many times are mentioned through a—in a malpractice

suit and then included in the Bank. Unfortunately, many times because they are acting as a delegate of the attending it is not their actions there but for some reason they—the hospital will end up settling that case and to get them out they will just settle it and keep them involved with it. The resident doesn't even know about it until later on when he applies for privileges, finds out, hey, you've been mentioned in three cases, while you were a resident and really when they were not really directly responsible for the care of that patient.

Mr. DINGELL. Thank you, doctor.

Dr. Sullivan?

Ms. NEUMAN. I am Ms. Neuman, but I can tell you that—

Mr. DINGELL. I am sorry.

Ms. NEUMAN. That is all right.

Mr. DINGELL. I see the name Sullivan there. You have my apologies.

Ms. NEUMAN. I think there are two areas, criminal convictions and license denial actions, that should be included in the Data Bank to encourage the State Boards to query the Data Bank. I met with some HRSA officials a couple of—a few years ago about making it free for State Boards to query since their staffs, we all in our States spend our staff time compiling the information to go into the Data Bank. We should be able to query it for free and that would help our Boards considerably.

Mr. DINGELL. Thank you.

Ms. Sullivan, if you, please?

Ms. SULLIVAN. Thank you.

I will save time and say that I believe that Ms. Neuman has expressed the same concerns that the Massachusetts Board has.

Mr. DINGELL. Thank you all.

Mr. Chairman, I have one more question to ask the entire panel and I would ask unanimous consent that they be permitted to respond, if you please?

Mr. UPTON. Go ahead.

Mr. DINGELL. Ladies and gentlemen of the panel, we have now discussed what we feel in a quick way are the concerns we have with regard to the usefulness of the Data Bank and how it is affected by the weaknesses which have been identified.

Let us now address what you would suggest to make this National Practitioner Data Bank a useful public tool to inform the public of problems that might exist with regard to particular physicians, which would impair the kind of care or put the patient at higher risk or—and what should be done to assure that the system is fair, not only to the patient who does need the information but also to the physician so that the physician is not hurt.

So, ladies and gentlemen, if you would, please, tell us what changes you think need to be made with considerable specificity and in a short time because of our time limit, starting with you, Mr. Silver, if you please?

Mr. SILVER. Well, thank you, again, Congressman.

I have set forth specific amendments, lines and words, that I think ought to be contained in the National Data Bank to make the changes necessary to make it fair but it seems to me that if you are going to provide the public with information about physicians

and malpractice actions, you might also include about other health care providers, including hospitals as well, and to make sure that the public is adequately and fully aware. But, last, I think all of the people who may be listed on the Data Bank ought to have a chance before the Secretary, who now has no discretion, the Secretary must report as it is reported to her, whatever it is. It seems to me that if the hospital—I have had one case where the hospital reported a different result, different grounds than were actually determined—there be some basis upon which you can, as against the Secretary, get a hearing to have a modification of the report if it is false or inaccurate.

Mr. DINGELL. Mr. Osten, if you please?

Mr. OSTEN. I think the key is in enforcing the requirements to assure that you are getting accurate reporting and whether that you charge HRSA or HCFA as a condition of Medicare participation, that hospitals are surveyed and if they are found not to be complying with the reporting conditions that sanctions be imposed to assure that reporting is carried out. And I think that should be part of the standard Medicare survey process.

Mr. DINGELL. Thank you.

Dr. Newman?

Mr. NEWMAN. Congressman, the question is of such fundamental importance and so complex that my suggestion would be that all of the various parties some now have the opportunity to address that specific issue and I'm not just talking about providers—hospitals, medical associations, State agencies—I am also talking about patient advocacy groups, consumer advocacy groups, because Heaven knows, they are a very, very interested party. I think the only way to come up with a maximally optimally useful Data Bank is to get the input of all of these parties.

Mr. DINGELL. Thank you.

Dr. Reardon?

Mr. REARDON. Thank you.

I think that some of these things have already been mentioned and I think they enforce the requirements of the Data Bank, I think the State Boards ought to have to inquire in the Data Bank before they relicense, reporting of criminal actions would certainly be there, but I think that one of the important things to do would be do a peer review of malpractice actions. For example, the Department of Defense and the VA do not report malpractice actions before peer reviewing and they have found like the "New England Journal" article that very few malpractice actions are true negligence. And I just finally, our concern is that I think the States are way ahead of the Data Bank in developing their Internet access and their profiling and we ultimately would rather see it go in that direction.

Mr. DINGELL. Thank you.

Dr. Hochman?

Mr. HOCHMAN. I would take the opinion that the NPDB, the way it was constructed, is really there for a different reason and I would advocate that we look at a different format for consumer reporting for patients. Looking at what some of the States have done and looking at more of that format as a more adequate way to provide information to the consumer.

Mr. DINGELL. Thank you.

Dr. Loniewski?

Mr. LONIEWSKI. Yes. As I mentioned in my testimony, I think the best way to have the public access to a bank of this nature would be to get true peer review, and I still stand with that and I agree with what Dr. Reardon has been saying as well.

Mr. DINGELL. Nothing goes in that without appropriate peer review?

Mr. LONIEWSKI. That is correct. Appropriate true peer review by specialist against specialist and physician against physician rather than having a general practitioner trying to review my orthopedic cases. It would have to be an orthopod looking at another orthopod.

Mr. DINGELL. Would you suggest that the proceeding be formal and that there be opportunity to cross-examine and things of that nature?

Mr. LONIEWSKI. Oh, yes, I believe so. Physician should have due process as well. And I mean be well represented and be able to present his case or her case to that peer review panel and then they can make a decision from there whether it was within a normal standard of care and that good quality care was afforded or not. And if not, I think that patient should be—that physician should be reported.

Mr. DINGELL. Thank you, Doctor.

Ms. Neuman?

Ms. NEUMAN. Yes. I think that the information that is provided to consumers from the National Practitioner Data Bank should be put into context as our State Boards have done or our profile laws and I think that that will go a long way to helping the consumer understand the information. We certainly have had good experience in the profile States in releasing this information to the public without a problem. And the good thing about opening the National Practitioner Data Bank is that it would cover all States, it would be a national clearinghouse and that's why I think the States should work with the Federal Government in order for that to happen.

Mr. DINGELL. Ms. Sullivan, if you please?

Ms. SULLIVAN. Yes. I, once again, echo the importance of context. But one fact that we found in developing profiles may be helpful to you as you think about this. We actually used a consumer research company to test different versions of the product to see what was meaningful for consumers. When we presented the malpractice information without the contextual data setting and the disclaimer information, the consumer focused on that to the exclusion of other information. When we then adjusted the product to have the information of malpractice placed in context, it became far less important in the weighted view of the consumer of it. So, I think that—but the one very consistent finding with every consumer focus group was that the exclusion of the information invalidated the entire process for the consumer. That they felt very strongly information needed to be there in order to have a sense that the product was truthful and full.

Mr. DINGELL. Thank you.

Mr. Chairman, thank you for the patient and fair way in which you have conducted these hearings. I have concluded with my questions.

Mr. UPTON. Thank you. Mr. Bryant?

Mr. BRYANT. Thank you, Mr. Chairman.

Ms. Sullivan, you may have touched on the answer to this question but you might want to expand. I would like you to answer the question from your experience in Massachusetts and Mr. Osten, maybe you can answer it, too, from your experience in New York and then after both of you answer, my 5 minutes will be winding up, but I would like to have Dr. Hochman speak on behalf of the Hospital Association in response or comment, and also Dr. Reardon, on behalf of the AMA, in response to the question.

The question is in essence, do you think that the information in the Data Bank should be placed in context to provide consumers nationwide with the same kinds of useful information that I assume both of you have used in your State systems?

And, again, if you can elaborate on the context. I think you mentioned a disclaimer and a couple of other things. But that is a real concern I have in that whatever we put out there to the general public that undue influence and so forth might not be put on one thing or the other and how can you put it in a proper context?

Ms. SULLIVAN. I think that the issue is very valid and what the research that we did with a third party firm that does this for a living that even the consumer understood that it was not only not fair but not helpful when it was not presented in a way that was in context.

That the consumer is very educated and understood that there were frivolous, nuisance cases and when something was reported at being substantially at the low average that they really to some degree dismissed that in their considerations. I am never—I am always pleasantly surprised by the brilliance of the American people and as people become more and more attuned to using complex information through the Internet, I think that the educated consumer does use the information well.

So, I think that we—you can craft a piece of legislation that addresses those concerns in a meaningful way. We think it is important to look at specialty to show what other doctors in that specialty have in terms of overall history, what percent of them have any malpractice payments and to look at the payments in terms of each suit, whether it is above-average, an outlier statistically, either above or below the average.

Mr. BRYANT. So comparisons with other doctors?

Ms. SULLIVAN. Within that specialty, yes.

Mr. BRYANT. Explanation of high-risk, those kind of issues?

Ms. SULLIVAN. Right. And the other issue that I would say with that and I think to some degree there is a sense that I have heard today that there is no review process for the mid-mal payments. On our report we do not in any way make reference to open investigations of discipline, we do not make any reference to pending malpractice cases. We only look at payments.

And I think that we have to respect that there is a process that is called a malpractice jury. I think to disrespect the jury process and say that that is not a vetted review of the case, I think may

fly in the face of some common sense with what goes on with the constituents.

Mr. OSTEN. I guess we have some concerns about the malpractice information for the concerns you have heard today about the information in there. But I think the ultimate litmus test is if you were the patient, would you want that information? And I know applying that litmus test for myself, yeah, I would want that information, including knowing their concerns with the malpractice part of that.

If the information is complete and accurate I would want that information if I was a patient and if it is a system that is maintained by the Federal Government then people should have a right to that and make their own judgment as to their use of the information.

Mr. HOCHMAN. You know, I think from our standpoint, what we would like to see—the context issue is incredibly important to us. We have reviewed quality data that is out there on the Net and it is amazing what you see. It is all over the board. And what I had hoped we would do here would be to take a rational approach at looking at really reviewing what information is being put out there, how helpful is it to the consumer, particularly as it relates to the medical malpractice issue.

A lot of the frivolous suits that are out there that get reported really could hurt a physician unnecessarily. If I look at our own experience, when we credential a physician in the process, when we get the Data Bank information and we look at it, I got to tell you the synthesis of that, we automatically can exclude or include based on our previous knowledge.

And it took us, on the hospital side, a long time to get used to the Data Bank information and understand how to use it. So, that is something that we haven't talked about but it has taken us a while, when we look at that data to really interpret, oh, this is an OBGYN physician, I may expect a different profile on this specialist with this suit. So, as we move toward the consumer reporting, I would hope that we try to exercise some of that and take care with that not to throw out a lot of information that then doesn't inform or educate the consumer any more than they are today.

Mr. REARDON. Thank you, Congressman.

I wouldn't disagree with, I think, with anything that has been said. I think the information should be placed in context. Now, how we do that through a peer review process, I think, is the right way to do it. I guess I am struck at the moment that we are struggling to try and correct a system that is just not a good system and is not working. And I will come back to my testimony and say I think the States are way ahead of Rockville, Maryland, and HRSA, in the Data Bank. They already, 30 States are putting the information out, good information, a wide-range of information, education, board certification, where they practice, also information on malpractice in some States, as well as disciplinary actions.

So, I think as we wrestle with this, I think what we need to look at is how do we get the best, most accurate, meaningful, valid information to the patients? And at the moment, I would say that I look at this as the States are doing this and they are far ahead of us. And I would hope that as you look at this as a committee, and as Congress looks at this that you would look to strengthen what

is already going on in the States and that we work very well with that.

I think that is the best way to get the information to the patient.

Mr. UPTON. Thank you, Mr. Bryant.

We are going to start a second round of questions and I am going to apologize in a few minutes as I have a meeting that I need to be at and I intend to return. I will return I just don't know whether you will be here or not.

And Dr. Ganske is going to take the gavel after I finish my questions but before I yield to Mr. Stupak, who I know has another round as well. But I want to say a couple of things. I have learned a lot, not only in this hearing, but in preparing for it. Particularly, I want to thank our staff, who for a number of weeks we have done a lot of good things and though we have some conflicts of opinion I know that we are all on the same page: We want the system to work better and sadly, not only us but, others, have exposed what I think are a number of major flaws in the system as it works or maybe doesn't work today.

None of us ever want to see the nightmare that our first two witnesses on panel two experienced in any State. And I guess as I have sat down with my chief medical officers in my district and looked at what they see, look at the review that they undertake, though I have not sat down with my State licensing board—Ms. Neuman, you are sort of in that catbird seat speaking for all the States—but my hospitals, my providers look at it every 2 years, they have to. And I have two large hospitals in the center part of my district and they, in fact, have over 600 physicians and they review them by pediatrics, they look at different divisions.

Do the State licensing boards do any type of periodic review or is it once you get your license you are there until it is taken away?

Ms. NEUMAN. Review of the Data Bank?

Mr. UPTON. Correct.

Ms. NEUMAN. Yes. The State boards look at the Data Bank when they open a case, like in our case—

Mr. UPTON. But is there an automatic review as my hospitals do? It is like you are up for pediatrics this week and next week it is the OBGYNs? I mean is there—

Ms. NEUMAN. No.

Mr. UPTON. So, unless something is flagged or a case is presented it is just autopilot?

Ms. NEUMAN. We do it in the initial licensure process and then when an investigation is opened. But it is not done routinely on renewal and that would be comparable to what the hospital does. Now, as I said earlier, one of the reasons why I went to meet with HRSA is that we need to encourage that these inquiries can be done at no charge. Right now we—

Mr. UPTON. I understand.

Ms. NEUMAN. [continuing] pay \$4 to do that and for a State of like Nancy's with 27,000 physicians times \$4, you would have to put a chunk of your budget, which in many of the States they are struggling with under-funding to begin with, to, to do that. So, I think that if the States are putting their staff time into reporting to the Data Bank there should be some consideration of the—

Mr. UPTON. And I know that the reviews of my providers it is usually about a \$250-or-so charge that they pass along to the physician to undertake that every 2 years as well.

Mr. Osten, I am concerned about under-reporting and I want to go more than just New York, whether it is the "New York Times" today or the case that we saw with Beth Israel, too, just grossly inadequate versus the real details of it. I mean this is, again, as I looked at the field that someone can type in, it is unlimited. It is on the computer. You know, it is not limited to 20 characters. You know, it can be pages long. And I just—has the State of New York learned something from what happened in the widely publicized cases?

Mr. OSTEN. Yes.

Mr. UPTON. I mean including this one today? I mean you have fined the hospital but, you know, one of the things that this particular—and I don't know if you are aware of this particular case, but—

Mr. OSTEN. I am quite aware of it.

Mr. UPTON. [continuing] apparently this doctor had been fired from Sloan Kettering, and the State gave him a 1-year probation but he quickly found work at Staten Island University Hospital. I know that is a relative term; I don't know if it is 1 month or 13 months, but it doesn't sound good.

Mr. OSTEN. What had happened—and let me give you some background. We did the initial investigation at Sloan Kettering and it was a combination of issues, both the physician as well as system failures on the hospital part. We sanctioned the hospital, the physician was put on probation for a year, sanction for that. That was on the department's Website and it was widely publicized at the time.

Staten Island Hospital fully was aware of the background, did their appropriate credentials check, checked with us, checked with Sloan Kettering, and made the decision to award him privileges.

Mr. UPTON. Was it post—was it within that year cycle that he was suspended?

Mr. OSTEN. After the—

Mr. UPTON. Or was it after—

Mr. OSTEN. It was after the Sloan Kettering event, which happened in 1995. We took action at that point so he was during that 1 year suspended. Staten Island knew that and it was on our Website for the public to see and still is on our Website. They chose to grant him privileges despite that background.

Mr. UPTON. Yes. Thank you. I need to move to my 3 o'clock meeting. I could stay on this for a long time but I am going to yield to Mr. Stupak.

Mr. STUPAK. Thank you, Mr. Chairman.

Mr. Osten, does the State of New York, does it maintain a State Data Bank that the public can access?

Mr. OSTEN. Yes. Every physician action that we have taken during, for the past 10 years, is on the Department's Website. And people, as I have said, we are getting a hit on the Website—

Mr. STUPAK. Do you have a way to know if the public accesses this Website?

Mr. OSTEN. As I said, we get a hit, two hits every minute of every day. So, the public is using the Website. And using it, we think, frequently and appropriately.

Mr. STUPAK. So, would the prior—you know, we had those cases earlier today from Beth Israel—would those incidents have been on that Website about those physicians?

Mr. OSTEN. In the first Beth Israel case, the case involving Lisa Smart, the one physician, her primary surgeon had never had any disciplinary actions taken. His record as far as we were concerned was clean. So, if they had checked—

Mr. STUPAK. Right. But there was another physician.

Mr. OSTEN. There was another physician who was on the Website, Dr. Sklar, for a previous enforcement action that we had taken against him. I think the problem in that case is that Ms. Smart didn't know that he was going to be assisting in the surgery so they never, you know, used the Website to check on his background.

Mr. STUPAK. Right.

Mr. OSTEN. But the information was on the Website regarding Dr. Sklar.

Mr. STUPAK. So, the primary physician—

Mr. OSTEN. Had a clean record at that point.

Mr. STUPAK. But did he perform the surgery? I mean he was assisted by another—

Mr. OSTEN. He performed the surgery, the bulk of the surgery. Dr. Sklar assisted but it was Dr. Klinger who was her primary surgeon.

Mr. STUPAK. Hmm. All right. You know, Mr. Smart indicated it took him over a year to find out that information. Wouldn't that be available?

Mr. OSTEN. I mean I just in terms of background, that was an extremely complex case. The hospital did report it. We, as, you know, we did an initial investigation looking at the records and the complete story about what happened with Lisa Smart only came about after the New York City Medical Examiner identified some discrepancies in the medical record. That then caused us to do an intensive investigation where we interviewed dozens of people, re-interviewed them several times until we could get to the bottom line. When we found that bottom line we issued a very detailed report of our findings.

Mr. STUPAK. Could you and, maybe Dr. Newman, could you since we have those two cases here and there has been a lot of interest in it today, could you give us a full accounting of what broke down and what lessons were learned from those two cases?

Mr. NEWMAN. Well, I think with regard—

Mr. STUPAK. I mean in writing. I don't mean for you to do it today?

Mr. NEWMAN. Oh, yes, sure.

Mr. STUPAK. If you would just provide to us in writing. Other members have asked questions, we talked about it on the floor and we can get it all to the other members then.

Mr. NEWMAN. Absolutely.

Mr. STUPAK. Because I think we need to learn what broke down. I know I have asked that question a number of times today; I am still trying to figure out what went wrong.

Mr. OSTEN. I would be happy to do that.

Mr. NEWMAN. And I might just say that with regard to the Zarkin case, my written testimony does address that but I will be happy to go into more detail and I shall.

[The following was received for the record:]

CONTINUUM HEALTH PARTNERS, INC.
NEW YORK, NY 10019
March 14, 2000

The Honorable BART STUPAK
Congressional Subcommittee on Oversight and Investigations
U.S. House of Representatives
2348 Rayburn House Office Building
Washington, D.C. 20515

DEAR CONGRESSMAN STUPAK: I wish to thank you, Chairman Upton and the other members of the Subcommittee on Oversight and Investigations, for the opportunity to testify in support of public access to the National Practitioner Data Bank (NPDB).

As I stated in my written testimony, an effective NPDB is important to hospitals in appointing and re-appointing medical staff, and it would be extremely helpful to healthcare organizations, as well as to patients. In addition, I also strongly support pending New York State legislation that would provide all New Yorkers access to information on licensed practitioners in the State, similar to the successful program in effect in Massachusetts. Mr. Anderson Smart, who gave such compelling testimony at the hearing, is a leading advocate for this legislation; at the hearing, I expressed to him my support for his efforts.

In response to your request, I wish to share with you and the other members of the Subcommittee some of the steps Beth Israel Medical Center has taken recently to enhance further the safe and effective care of all its patients.

With regard to the tragic death of Ms. Smart, Beth Israel has accepted its responsibility for failing to ensure compliance with its longstanding policies. (Ms. Smart died from excessive fluid intake, resulting in cardiac arrest, during a hysteroscopic procedure with a piece of equipment that had not been fully approved.) The physicians involved in the case were dismissed from the medical staff and reported to the New York State Department of Health and the NPDB. Beth Israel's plan of correction, submitted to and approved by the New York State Department of Health, included the following steps:

- New procedures were implemented to monitor more effectively intrauterine fluid during hysteroscopic procedures.
- Documentation on the approval of new equipment, and staff training in the use of new equipment, was strengthened. In addition, a new policy was implemented to advise patients when new equipment is intended for use for the first time during a surgical procedure.
- More stringent documentation of patient approval on professional and non-professional visitors to the operating room suite was implemented.

In the other case, involving Dr. Liana Gedz, upon learning of Dr. Allan Zarkin's outrageous act (carving his initials into the patient's abdomen), we promptly suspended his privileges. We reported the incident to the New York State Department of Health (DOH)-Office of Professional Medical Conduct, and to the NPDB. We cooperated fully in the DOH's investigation, as well as in an investigation by the Manhattan District Attorney's Office, which is ongoing.

Several weeks ago, we submitted our plan of correction to the State Department of Health. It includes the following policy and procedure changes and enhancements:

- Explicit language will be used in all communications to the Department of Health and other governing agencies regarding reportable incidents, and more stringent follow-up procedures were implemented with regard to submitted reports/letters (e.g., to ensure the reports have been received and to seek assurances that they are being investigated).
- The process for reporting and investigating any complaint of inappropriate physician actions and behavior was strengthened.

- Proactive notification by the Medical Center to other facilities where physicians/providers are known to practice, of any significant privilege adjustments/terminations, was enacted.

As I testified, there was nothing in Dr. Zarkin's files at the Medical Center, at the National Practitioner Data Bank or, as far as I know, in the files of the State Health Department that gave the slightest hint that he would pose a risk to any patient. This was an irrational, random, egregious and unpredictable act.

I hope this additional information is helpful. If there is any further information that you require, please do not hesitate to contact me. In the meantime, I look forward to working with you and your colleagues to provide every citizen in this country with the opportunity to learn as much as possible about their healthcare providers.

Sincerely,

ROBERT G. NEWMAN, MD

Mr. STUPAK. Thanks.

I mentioned in my opening statement the HIPTB reporting that we do and it hasn't come up much. We talked about the Federal data base but the HIPTB; is that something we could look at as a model to set up a system for reporting that the public could have access to? There are some safeguards. You have to have State and Federal determinations and nothing is reported until there is a final determination. Is that something we should look at, Dr. Loniewski or Dr. Hochman or Dr. Reardon or any other doctors?

Mr. LONIEWSKI. Well, HIPTB, my understanding is really that they are looking at other areas as well and that the access is a little different. The original rules that were written which have been held up because of they became really inappropriate to try to work with in any way, so, really we don't know where they are going with it. At this time for me to say that it is good to look at or something, I just think it is just too broad the way it was originally written to be an effective type or bank.

Mr. STUPAK. Well, it has a data base of final adverse actions taken against health care providers, suppliers, and practitioners. Final adverse actions include: One, civil judgments against the health care providers, supplier or practitioner in a State or Federal court. Two, Federal or State criminal convictions against a health care provider, supplier or practitioner. Three, actions by State or Federal agencies responsible for the licensing and certification of the health care providers, practitioners. Four, exclusion of health care provider, supplier or practitioner from participation in Federal health care programs, and last but not least, any other adjudication, actions or decisions that the Secretary establishes by regulation. I know the last one is sort of a catchall.

But it seems like in each one of these four areas there is a final action, there is some final conclusion, not just an accusation or a peer review based upon political or whatever other reasons. That is what you are looking before the public would have access, isn't it? Some final action which would be termination?

Mr. LONIEWSKI. The final action but worthwhile final action. They didn't identify things like civil actions. One of the questions they asked at the NPDB was, well, are you talking about if my dog bit my neighbor am I going to be placed in that Data Bank because there was a civil suit against me? And that is the broadness that I felt had to be further refined.

Mr. STUPAK. Yes. Each one needs to indicate as their health care provider, supplier, practitioner related to the delivery of health care.

Mr. LONIEWSKI. Okay. Well, if it is with health care then we can go for it.

Mr. STUPAK. Anyone else care to comment on that?

Ms. Sullivan?

Ms. SULLIVAN. Thank you. That is what we do in Massachusetts and we actually have under the criminal conviction component of ours language that says felony and serious misdemeanors and we also have a list of what we consider to be serious. So, that people know what the apples and oranges issues are. So, I think it is a good model to look at.

Mr. STUPAK. But you wouldn't post it until after, like the final appeal is done and things like that?

Ms. SULLIVAN. That is correct. It is only final actions that we post.

Mr. STUPAK. Okay. Dr. Newman?

Mr. NEWMAN. Yes. I certainly am all for fairness in terms of wanting to wait until the process is totally exhausted. But in contrast to some of the amazing, to me, amazing stories that Mr. Silver described from other States, New York State, to its great credit, has a very, very elaborate but also very time-consuming due process afforded to anybody whose privileges in a hospital are curtailed or terminated. That process, which involves not only an internal procedure within the hospital, but then goes to the Public Health Council of New York and then goes to the judiciary, if I am not mistaken, that can take many, many months or even years. So, I think when, if you are fortunate—well, for New Yorkers, who are fortunate enough to have such a very, very fine system of due process, the consumer should not pay the price of having to wait two or three or whatever, however many years before a Dr. Zarkin, let us say, has exhausted the remedies.

Mr. STUPAK. How does Massachusetts get around that then so they didn't have to wait 2 or 3 years?

Ms. SULLIVAN. In terms of a hospital disciplinary action?

Mr. STUPAK. Sure.

Ms. SULLIVAN. We do wait for the final report from the hospital. We, of course, encourage quick action. It has not been a big issue with us and we certainly think that the hospitals have acted in good faith at all times. We do have substantial due process rights also. But I think the fairness issue for the doctor does rise within the institution to resolve the issue quickly and fairly.

Mr. NEWMAN. Could I just add just so I didn't mislead anybody.

Mr. STUPAK. Sure.

Mr. NEWMAN. Certainly despite that lag that can exist before final adjudication, Beth Israel Medical Center, in these cases and just as a matter of routine, notifies the State and notifies the Data Bank when the decision is made to take action rather than waiting. I didn't want anybody to think that we waited 2 years before we—

Mr. STUPAK. Well, thanks, Dr. Newman.

And thanks again for agreeing to get that stuff to me in writing on the Smart case and the other Doctor Gedz case.

Mr. GANSKE [presiding]. The Chair will recognize Mr. Strickland from Ohio for 5 minutes.

Mr. STRICKLAND. Thank you, Mr. Chairman.

Mr. Chairman, I will not take my 5 minutes. I apologize for not being here more today. I have been tied up with other matters. But this is an incredibly important issue. I thank you all for your testimony and I promise you that I will consider it very, very carefully and I yield back the balance of my time.

Mr. GANSKE. Well, then the Chair will recognize himself.

We are coming to the end unless Mr. Stupak wants some additional time.

The sense that I am getting from this panel is that the data that is in the Data Bank that is given to, for instance, hospitals, boards of medical registration, et cetera, is useful but it requires some interpretation. That the raw data is not that easy sometimes to understand. For instance, I think there has been a reference to, as I made earlier, on the specialty specific profiles. Because you may have physicians, for instance, doing high-risk procedures or there may be a higher incidence of complications, higher incidence of queries, et cetera, and, so, after a while when you are looking at that data you begin to get a feel for what is out of bounds and what is way beyond the norm. But a norm for an OBGYN may be significantly different than a norm for a dermatologist. Is the panel in unanimous agreement on that? And let it be recorded as, yeses, across-the-board.

Dr. Newman?

Mr. NEWMAN. Yes. I would just point out, first of all, I am not only a fan of New York, I am also a fan of Massachusetts. And Massachusetts has currently available to anybody who wants access through the Internet, a listing of every single licensed practitioner. It lists not only the number of malpractice settlements, but it also categorizes the payments as being above-average, average or below-average. It also gives—and, you know, I just found all this out in the last few weeks in preparing for this testimony—but it also gives to that specialty the proportion of all doctors who have had one or more settlements. So, I think it doesn't take a tremendous amount of background and knowledge to be able to derive some general conclusions from those data. And, so, I think we have a very excellent model to build upon and that is the Massachusetts model.

And maybe there are others, I just happened to be very familiar with that.

Mr. GANSKE. All right. And the general sense that I have had from this panel on another area is that there are some inequities and possibly inaccuracies in the data, in the raw data that don't place some of that data into context. And, Mr. Silver, you have been quite eloquent on describing how, for instance, there is a need for better due process in terms of the data as it is in the Data Bank.

Is that a fair statement? Does the Board agree with that?

Ms. SULLIVAN. Again, my—and I don't mean this in any critical way from the previous testimony—but sort of anecdotally when I keep hearing that the issue is that there is not enough reporting and, thus, the—without full information what there is there maybe

skewed, as I have said to one of your staff members, I am somehow remembered of the old story of the man—the person who has killed both his parents and then goes before the judge begging for leniency, because he is an orphan. I think that there is a partnership between the medical boards and the hospitals and practitioners to fully report. Because not only is it the right thing to do for the practice of medicine, not only is it the right thing to do for the law, it gives the fuller, more robust data base that gives the context even more meaning. So, there is a good reason for it.

Mr. GANSKE. Okay. So, we are in agreement that the data in there is useful; we are in agreement that there needs to be corrections in how that data is valid and how it is reported.

I have another question. It is this: A week or so ago this committee held hearings on medical errors. And we had a similar panel before us and there was unanimous agreement on that panel, all across-the-board, from people representing all sorts of different organizations, that if you are going to get reporting of data that there needs to be protections in terms of confidentiality or you could see the reverse happen—you would have less reporting.

And I am concerned that if we were to open up the Data Bank as it is now, when there are in my opinion flaws in the way it is reported, would you then exacerbate rather than improve the problem of getting the information that you need to the medical licensing boards and others that need it?

Dr. Reardon, do you have any comment on that?

Mr. REARDON. Thank you, Congressman Ganske.

I do, yes. I have been sitting there thinking as you have been outlining some of the, I think, testimony and I put down a comment here and maybe it is not correct, but I said, I almost think this system is broken. And we have a system that was set up initially for the profession to use as they did the recredentialing and they did their licensing but not a system that was initially set up to provide information to the public. I think what we are struggling with today is how are we going to correct the system, repair the system so that it becomes information that will be usable for public consumption or it would be good, reliable, valid data so the public could have this to make good decisions?

And I will come back. In some ways I think the Data Bank is redundant. And I am going to come back to what I have said earlier, I think the States are doing a great job. They are innovative. We have the Federation of State Medical Boards, that has a committee who will report soon with some recommendations for all States. You have 30 States already doing this. They have Websites up, I think in 23 States and 7-to-10 more coming up.

I would hope, as you look at this, again, you would look at how do you support what is going on out there in the private sector which in my view are the States, and how can we build on that? Massachusetts has been complemented for what they have done, Tennessee has a good program, Oregon is getting a program, Texas has something that is working well and helping the public. But I think as you wrestle with this, Congressman, as you look at this and say, is the Data Bank fixable? Is it repairable? Can we make it over so it will provide the valid that that people need or is there

another mechanism which in my view would be working with the State Boards?

Mr. GANSKE. All right, well, let's talk about another mechanism. We've got Ms. Sullivan, who is Executive Director of the Board of Medical Registration in Massachusetts; and Ms. Neuman, who is a Director of the Board of Medical Practice in Vermont. Tell me about what the executive directors of the Boards of Medical Registration are doing across the country in terms of their Executive Directors Association, to make sure that when a deficient practitioner moves to another State that the State gets the information to make sure that we just don't have people hop-skipping around?

Ms. NEUMAN. Well, one of the things that our organization has is we have established a committee called the Golden Rule Committee, which is to look at to make sure as the Golden Rule is, do unto others as you would like them unto you, and to make sure that States are communicating with each other, improving our State statutes so that we can exchange investigative information. A lot of the times that, for example, in a State like ours, there will be a situation where the doctor will be investigating the doctor and the States will take off to another State.

And right now, in most States, some States can share investigative information and some can't, but we need to be able to start that process early in the process when there is a problem physician.

We have had physicians in my State, where on a license denial situation, they have fought us all the way up to the Supreme Court because they wanted to withdraw their license so it wouldn't be reported anywhere and we fought that. In a lot of States the energy it takes and the staff resources it takes when a doctor tells you, well, I'm leaving, don't worry, I won't practice here, is—there are a lot of—it takes a lot of effort.

And in our State, we fought that up to the Supreme Court and we won the case, but it is very—I think some of the stories you heard today and the reason why I feel so strongly about the Data Bank being opened is that having that information in one central source—and I agree with Dr. Reardon that we need to have the States work also together—but having all of that information and having the States work with that and having that available, once that doctor starts moving, the consumer, as it was portrayed in these cases, would have that information immediately. We could put it in context and they would know that. Because as Nancy pointed out, the due process that is afforded doctors in this process absolutely causes time delays in the Board's taking actions.

I encourage Boards to look at using the summary suspension process. That is an immediate suspension. Nancy has started doing it more. In the early 1980's I got criticized by the Medical Society for taking too many summary suspensions and what I did is I provided them a list and summary of those cases. I said, you think we're taking too many? Why don't I summarize those cases for you. And I did and I didn't hear anything back after I—well, oftentimes what I will tell people when they criticize us is that take a look at the actual action, take a look at the facts, take a look at the conclusions of law that the Board came up with in order to issue that disciplinary action.

Mr. GANSKE. But let me just interrupt for a minute. There have been some—this is not exactly along the lines of what this hearing is about—but there have been some who have suggested that we move to a national registration, a national licensing board. I personally don't feel that that is the best way to move.

Would you give us your opinion on that?

Ms. NEUMAN. I do not believe that there should be national licensure.

Mr. GANSKE. And why?

Ms. NEUMAN. I believe that the States, that is in the States' purview to license their doctors to issue set standards for who they should license and by having a national standard there would—I really believe that it would not protect the public.

How would you handle disciplinary actions on a national level? We, even though the States get criticized for how quickly they act on a doctor's license, there is no way that I would have confidence that a Federal licensure system would be able to act any quicker than the State Boards are considering the due process that is afforded the doctor.

Mr. GANSKE. I can imagine if that were the situation, Mr. Silver, that you would have quite a problem in determining how to resolve disputes where you have variations in care regionally.

Mr. SILVER. Well, I'm not necessarily sure that a national licensing system shouldn't be considered. Clearly, standards of practice ought to be in the local community and not necessarily national.

I just comment that you don't want to throw out—we have been using a lot of sort of afternoon expressions—the baby with the bathwater. Summary suspension is just brutal. And a physician can have a patient in the hospital and needing care and summary suspension comes down, he can't even discharge the patient, he can't do anything. And it is just a brutal thing. And to suggest that in our system of Government that we would prefer that than to yield to due process, I think does not give our tested institutions a great deal of respect.

There are ways in which you can effectuate a prompt disposition but to use that as a substitute for due process I think is incorrect. But leaving that aside, you will have, you do have even currently issues of what is the proper scope of review and what is the proper standard to meet? And I think frankly what I will consider, if I may be so bold, is your seminar approach that we have just used for the last several minutes that we really do come back to Dr. Reardon's suggestion and that is that the National Data Bank is flawed and I think you ought to do something about correcting it for the purposes which it was to achieve.

Mr. GANSKE. Hmm-hmm.

Mr. SILVER. But I really think that what we have evolved here is that it is not transmutable to accomplish the other goal of public information and consequently don't release information in a flawed Data Bank. Create, if you wish, a national system, modeled on the Massachusetts or other basis, and that rather than tinker with the system, see if there is a real need, in light of the States' individual choices, but if you have a system that is clunking because of deficiencies that it has don't ask it to do more than it can't do already.

Mr. GANSKE. I appreciate your comment.

And I recognize Mr. Stupak.

Mr. STUPAK. If I may just for all our panelists, those who testified before and those who are with us now, the reason why it may appear like we are tinkering, we are the Oversight Investigation Committee. We don't have legislative authority. When the Chairman said that he wanted this investigated for whatever reason, whether it was because of patient bill of rights or whatever reason, this is the only vehicle that we had.

I think most of us up here if we were going to design a system or the public right to know—and we believe they have a right to know of the quality of the health care professionals they are dealing with—it would be different than this national data base. But that is the only thing that we have before us because we are Oversight and Investigation so we are oversighting that.

That is the reason why and the Chairman said we will do this and that's the reason why we are doing this hearing all day. But we would do a much different, I think, system, I think that would be fair to say, Greg.

Mr. GANSKE. And reclaiming my time, I think it would be an appropriate topic of a discussion for the Health and Environment Subcommittee, to which I am also a member, to look at a way to improve consumer education and to seriously look at some of the methods that the various States have already started in doing.

And, so, that will conclude our hearing today. I thank you all very much for coming.

[Whereupon, at 3:27 p.m., the subcommittee was adjourned.]

ASSESSING THE OPERATION OF THE NATIONAL PRACTITIONER DATA BANK

THURSDAY, MARCH 16, 2000

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:08 a.m., in room 2322, Rayburn House Office Building, Hon. Fred Upton, (chairman) presiding.

Members present: Representatives Upton, Bilbray, Ganske, Bryant, Bliley (ex officio), Stupak, and Green.

Staff present: Charles Symington, majority counsel; Amy Davidge, legislative clerk; and Chris Knauer, minority investigator.

Mr. UPTON. Good morning everyone. I know as usual there are a number of subcommittees meeting this morning. The House just went into session. I don't think we expect a vote for a little while. I know that Chairman Bliley is expected to be here, my colleagues Mr. Ganske, Mr. Whitfield, Mr. Bryant are on the way, and I know that Mr. Stupak from the great State of Michigan is also on his way, but I thought that we would start in any regard and would make, if no one would object, just a unanimous consent request that all members of the subcommittee will be able to put into the record their full statement, if in fact they don't get here by the time that I am finished with mine.

So with that, welcome to today's Oversight and Investigations Subcommittee hearing on assessing the operation of the National Practitioner Data Bank.

We are going to hear from Mr. Tom Croft, Director of the Division of Quality Assurance of the Health Resources and Services Administration. He oversees the administration of the National Practitioner Data Bank, and I am looking forward to discussing ways in which we can make the Data Bank a more effective tool in the improvement of health care quality across the country.

The National Practitioner Data Bank was created by Congress in 1986 in response to several factors—the increasing occurrence of medical malpractice litigation and the need to improve the quality of medical care by increasing the willingness of physicians to participate in the diligent peer review programs. The Data Bank law does this by shielding physicians from liability from antitrust and private damage suits when they are engaged in peer review. By creating a nationwide flagging system, the Bank was designed to address the problem of physicians who lose their licenses or face

other discipline in one State simply moving to another State to practice.

This hearing is particularly timely and important in light of the recent release of the Institute of Medicine's report, "To Err is Human." This report came to the startling conclusion that anywhere from 44,000 to 98,000 people die every year as a result of medical errors caused largely by failures or glitches in systems of care. The report notes that more people die from medical errors in a given year than from motor vehicle accidents, AIDS, or breast cancer. Clearly we need to strengthen all of the resources at our disposal to improve health care quality, and the Data Bank is one of the most important of these resources.

Several months ago in preparation for our hearings on the National Practitioner Data Bank I asked several hospitals in my district to arrange a demonstration of just how they use the Data Bank in their credentialing process, and after the demonstration, which was most informative, I had the opportunity to talk in some depth with the credentialing staff and the chief medical officers of the hospitals about their front-line experiences with this Bank.

It was certainly an interesting day for me and my staff and I look forward to discussing the issues that they raised with Mr. Croft.

I will get into specific issues in our question period, but let me just raise one general concern that the credentialing staff had, the fact that the Data Bank was not entirely online yet and the time that it took to receive the response to a query. My staff followed up yesterday to see how things were going now, and we received an excellent report.

In the words of the lead credentialing staffer, Bronson Hospital in Kalamazoo, Michigan, "The Bank has come a long way. It is now online and the response times are between 4 and 6 hours." She noted that it is quite user friendly and that the Bank is working on a system to allow hospitals to send in batch requests rather than having to query for each doctor individually, and I would note that they usually have about 600 that they do over—each of my two hospitals there—over a 2-year span.

In the words of the Chief Medical Officer at Borgess Hospital in Kalamazoo, the credentialing process has been greatly improved by the creation of the Data Bank and "Borgess has profited"—in his words.

So I want to commend you, Mr. Croft, for the progress that you have made in honing this important tool for improving the quality of care and I also want to thank you for the courtesy that you extended to Jane Williams on my staff when she was arranging for the demonstration.

With that, I will yield to my colleague from Iowa, Dr. Ganske.

Mr. GANSKE. I thank you, Mr. Chairman. I appreciate your being here, Mr. Croft.

I have looked over your testimony and I know that you are going to be talking about this, but I think there is one paragraph that is particularly significant and that is that you say, "Nothing in the Data Bank's information is intended to produce an independent determination about the competency of an individual practitioner. It is rather intended to supplement a comprehensive and careful pro-

fessional peer review. It is noteworthy," you continue to say, "that the vast majority of practitioners who have reports listed in the Data Bank have only one, and that is almost always a malpractice payment report. It is impossible and unfair to conclude from a single malpractice payment report alone or even in some cases from numerous malpractice payment reports anything substantive about the competence of that practitioner. To do so would be a disservice to all parties involved."

Mr. Croft, I will be asking you to expand upon this statement because I think it is crucial when we look at the attempts by some to open up the Practitioner Bank for uses for which it was just not intended. I appreciate your being here today and I look forward to your further testimony.

I yield back, Mr. Chairman.

Mr. UPTON. Thank you. Mr. Stupak.

Mr. STUPAK. Mr. Chairman, I will be brief. You know this is our second hearing we have had on this and the question has been whether we should or should not open up the National Data Bank for public review of information that really has not been designed for public scrutiny but rather to help out health professionals in the way they license and review credentials of physicians and others.

Last time we brought up issues of under-reporting, the technicalities of the Data Bank, what may or may not be appropriate, and of course there is always the concern that maybe this whole issue has come up because many of the health care professionals supported a real Patient Bill of Rights that passed earlier.

Whatever the reasons are, I think we have to proceed cautiously. I think you have to have a National Practitioner Data Bank that hospitals and other health care professionals can access in a technology and a terminology that they use for their licensing requirements. If you want to put forth some kind of a national bank to profile all physicians and health care facilities and rate them, that should be completely different from this National Data Bank, the Practitioner Data Bank, so I would look forward to this hearing here today, and see what HHS and others have to say today, but I think if we are really serious about having more public awareness of health care professionals, then I think it is incumbent upon us, the U.S. Congress, to put forth a system that is designed for public input, easy public access, and not to rely upon something called the National Practitioner Data Bank, which was not intended for the purpose in which it is being looked at as maybe to provide information to the public because it was set up for a different purpose.

If we are going to set one up for public knowledge, then let's set one up for public knowledge and not use this National Data Bank.

Mr. UPTON. Thank you. Mr. Bilbray.

Mr. BILBRAY. I have no comments.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. TOM BLILEY, CHAIRMAN, COMMITTEE ON COMMERCE

Chairman Upton, thank you for holding this hearing which continues the Committee's examination of the National Practitioner Data Bank. I believe consumers need greater access to quality information about their doctors. So this hearing is important. I would also like to welcome Tom Croft, the Director of the Division of Quality Assurance at the Health Resources and Services Administration, and express my re-

gret that Administrator Fox was unavailable to attend today's hearing on this very important topic.

The purpose of today's hearing is to examine the operation of the NPDB and determine whether this closed system, which denies consumers access to important information about doctors, is doing an adequate job of protecting these same consumers. Congress, when it established the NPDB, intended to protect patients from incompetent doctors. Based on the testimony that we heard at the hearing before this Subcommittee two weeks ago from Dr. Liana Gedz and Anderson Smart, I have serious questions about whether this goal is being met.

I am also troubled by the information the Committee has reviewed relating to hospitals. Approximately sixty two percent of hospitals registered with the NPDB have never reported a disciplinary action against a doctor. In fact, the Health Resources and Services Administration has estimated that approximately 4,000 hospitals have never made a single such report. Also disturbing is the fact that over the decade that HHS has operated the Data Bank, only two hospitals have ever even been warned about their failures to report clinical privilege actions to the NPDB. I have serious concerns with hospitals reporting of valuable information to the NPDB and HHS enforcement of those requirements.

Following our first hearing, there have been several accounts in the press, detailing other serious allegations involving problem doctors. I have here a stack of articles and editorials from around the country, all expressing their support for the idea of increasing the public's access to comparative information about their doctors. According to a recent poll, ninety six percent of the Americans polled want more comparative information about their doctors and hospitals, and most believe that currently they do not have access to such information. I think this should change.

Despite public support for empowering patients, the American Medical Association and others continue to fight to keep this information from the public. In fact, the AMA's official position on this issue continues to be that the NPDB should be abolished and that no one should have access to the important information in the NPDB.

All Americans deserve to have basic, accurate information about their doctor and hospital. I believe that now is the time for the Washington-based special interest groups to stop treating this information as "restricted." As patients learn more about information that the Federal government already collects in the NPDB, their demand for such comparative information about their health care providers will only increase.

Today's hearing will evaluate how the Data Bank is currently administered, and will identify improvements to the system. Questions relating to the validity and accuracy of the data in the NPDB were raised at our last hearing, which have been used to justify continuing to prevent the public from obtaining this information. Today's hearing will hopefully explain what HHS is doing to insure that the data in the NPDB is accurate and reliable. I firmly believe that problems with the Data Bank, if they exist at all, can be corrected, rather than keeping this information locked away from the public.

I would like to again thank Chairman Upton for holding today's important hearing and I look forward to Mr. Croft's testimony.

PREPARED STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM
THE STATE OF TEXAS

Thank you, Mr. Chairman. I would like to welcome our witness to this hearing today. I appreciate the fact that he has come to help clarify some of the many questions that we have about the National Practitioner Data Bank.

We would all like patients to have as much information about doctors as possible, so that they might be able to make informed and intelligent decisions about their health care.

However, we must ensure that such information is provided in a fair and accurate manner. Simply dumping raw, sometimes inaccurate data on patients will not improve their quality of care. We must focus on how to improve reporting and accuracy to the existing data bank before we go releasing information that could mislead the public or give false impressions about the competency or incompetency of doctors.

Again, thank you for holding this hearing and I look forward to the testimony of the witness.

Mr. UPTON. Okay. Mr. Croft, as you may know, we have a long-standing tradition of taking testimony under oath. Do you have any problem with that?

Mr. CROFT. No, sir.

Mr. UPTON. And committee rules also allow you to have counsel if you so desire. Do you have a desire to have counsel?

Mr. CROFT. Not at the moment, sir.

Mr. UPTON. Okay. If you do, please come to me. If you would stand and raise your right hand.

[Witness sworn.]

Mr. UPTON. You are now under oath. We appreciate your sending up your statement in advance so that we could review that. It is part of the record in its entirety and if you could limit your remarks to about 5 minutes, that would be terrific, and the time is now yours. Welcome.

TESTIMONY OF TOM CROFT, DIRECTOR, DIVISION OF QUALITY ASSURANCE, HEALTH RESOURCES AND SERVICES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. CROFT. Thank you, Mr. Chairman. I want to begin by thanking you for your kind remarks. I am glad to hear that things are going well and it validates what my staff and the staff of our contractors have been telling us as well. I also want to thank you for the opportunity to come here today and talk to you about these important issues.

The National Practitioner Data Bank as you mentioned was created in response to the requirements of the Health Care Quality Improvement Act of 1986 and began operation in September 1990 under the most difficult of circumstances. Funding and staffing issues, opposition from many practitioner organizations and frankly an operating system in need of updating were major obstacles to its success. We believe we have overcome these problems now, at least most of them, and primarily by moving away from a paper-driven system which often could not respond in 30 days to a request for information and now a typical response is 2 to 3 hours.

Today, because of our commitment to customer service and continuous quality improvement, the National Practitioner Data Bank plays a vital role in the important process of practitioner credentialing. It provides verification of sensitive adverse information about practitioners in an efficient and reliable manner, while, at the same time, maintaining the security and confidentiality required by law.

At the beginning of the year the National Practitioner Data Bank held nearly 228,000 disclosable records concerning more than 146,000 practitioners of which more than 100,000 are physicians. In 1999 the Data Bank responded to nearly 3.5 million requests for searches of the data base, more than four times the number in 1991, the first full year of operation. Those requests resulted in actual disclosures, or "hits," at the rate of about 3.5 per minute during a normal business day. The Data Bank's ability to respond quickly and accurately, and for a relatively modest fee, and I might add here, Mr. Chairman, contrary to what you heard at the other hearing, this is not a taxpayer funded system. This is entirely funded by fees including my salaries and those of my staff.

In any event, it has not only fueled the Data Bank's success but has made it a model for other government data collection and disclosure efforts.

It is fair to say that the significant growth and success of the Data Bank can be attributed in large part to our efforts to improve the systems which support the Data Bank. However, there is room for improvement in other areas as well. We are refocusing our efforts on improving the practical usefulness of the information in the Data Bank, particularly our efforts to collect information on all actions and malpractice payments which should be reported.

For example, certain industry sources told us in 1990 that we should expect hospitals to report more than 1,000 disciplinary actions every month, yet fewer than 1,000 are reported in a year. After almost 10 years, more than half of all hospitals have never reported a disciplinary action to the Data Bank.

In a 1995 report on this subject the Inspector General of the Department of Health and Human Services cited several reasons which might explain this underreporting, but because of the confidentiality accorded peer review records in hospitals, none could be substantiated conclusively. As a result of that OIG report, a forum of industry leaders was held in Chicago in 1996, at which there was general agreement that underreporting is an unfortunate reality. However, the continuing absence of wholly reliable data makes it more difficult to assess the extent of the problem so that useful solutions can be formulated.

Accordingly, the Health Resources and Services Administration (HRSA) will soon contract with an accounting firm to help us devise, and execute, a plan for auditing hospital records so that required data can be efficiently collected and analyzed.

The Department is also considering a recommendation by the Inspector General to seek a legislative change which would provide for monetary penalties in instances where hospitals had demonstrably failed to report reportable actions.

Another important issue that has been raised by Congressman Bliley concerns disclosing Data Bank information to the public. As you know, the Secretary, in her response to Mr. Bliley on this subject said, and I quote, "The issue of disclosing to the public information contained in the NPDB is complex. On one hand, I agree with your assertion that consumers need more information in order to make educated decisions regarding the medical professionals whose treatment they may wish to seek. On the other hand...there are privacy concerns regarding broad public disclosure of potentially incomplete negative information."

In fact, Mr. Chairman, the statute and the regulations under which NPDB operates are very clear. In the nearly 10 years of our management diligence has been exercised to ensure the confidentiality mandated by the law. You have previously heard testimony on various sides of this multi-faceted issue from earlier witnesses. HRSA would only caution that any changes in the law be carefully considered and further debated, with due attention to what may be significant privacy implications, before being enacted.

Without a doubt, there are legitimate arguments on both sides of opening up NPDB which ought to be considered. However, it is

my opinion as the Data Bank manager that the key is not in the data itself, but in how it is used.

Currently, for example, when a practitioner applies for employment or for admitting privileges, the hospital asks the practitioner for a complete practice history including any malpractice payments or adverse actions. A query of the Data Bank then verifies the information about malpractice payments and adverse actions for the hospital, or it discloses information to the hospital which the practitioner may have failed to include in the application.

In either case it ensures that the practitioner cannot move from place to place in the hope of escaping a checkered past. That is precisely the purpose of the Act.

Nothing in the Data Bank's information, on the other hand, is intended to produce an independent determination about the competency of an individual practitioner.

Since Dr. Ganske has already read this for me, I think I will skip that part of my statement down the point—and I think this is important for me to say—that at the same time, it is easy to understand the public's frustration with the lack of entirely accurate and unbiased information, particularly when some licensing authorities are slow to act in the face of practitioners' histories of poor and occasional shoddy medical practices. I will be glad to expand on that as we get into the questions and answers.

In conclusion, Mr. Chairman, I believe that by almost any account the National Practitioner Data Bank has been a success. However, there is room for improvement, to which we remain committed. To a great degree, the Data Bank's successful beginning is due to the Congress. We welcome your suggestions for better service and will work closely with you on these.

Mr. Chairman, this concludes my remarks. I will be glad to address your questions.

[The prepared statement of Tom Croft follows:]

PREPARED STATEMENT OF THOMAS CROFT, DIRECTOR, DIVISION OF QUALITY ASSURANCE, BUREAU OF HEALTH PROFESSIONS, HEALTH RESOURCES AND SERVICES ADMINISTRATION

Mr. Chairman, I am Thomas Croft, Director of the Division of Quality Assurance in the Bureau of Health Professions, Health Resources and Services Administration. The Division oversees the operation of the National Practitioner Data Bank. I appreciate the opportunity to speak with you today about the Data Bank and the important issues you have raised.

The National Practitioner Data Bank was created in response to the requirements of the Health Care Quality Improvement Act of 1986 and began operation in September 1990 under the most difficult of circumstances. Funding and staffing issues, opposition from many practitioner organizations and an operating system in need of updating were major obstacles to its success. We believe we have overcome these problems, moving from a paper-driven system which often could not respond in 30 days, to a fully electronic system which typically responds in 2 hours.

Today, because of our commitment to customer service and continuous quality improvement, the National Practitioner Data Bank plays a vital role in the important process of practitioner credentialing. It provides verification of sensitive adverse information about practitioners in an efficient and reliable manner, while, at the same time, maintaining the security and confidentiality required by law.

At the beginning of the year the National Practitioner Data Bank held nearly 228,000 disclosable records concerning more than 146,000 practitioners of which more than 100,000 are physicians. In 1999 the Data Bank responded to nearly 3.5 million requests for searches of the data base, more than four times the number in 1991. Those requests resulted in actual disclosures, or "hits," at the rate of about 3.5 per minute during a normal business day. The Data Bank's ability to respond

quickly and accurately, and for a relatively modest fee, has not only fueled its success but has made it a model for other government data collection and disclosure efforts.

It is fair to say that the significant growth and success of the Data Bank can be attributed in large part to our efforts to improve the systems which support the Data Bank. However, there is room for improvement in other areas as well. We are refocusing our efforts on improving the practical usefulness of the information in the Data Bank, particularly our efforts to collect information on all actions and malpractice payments which should be reported. For example, certain industry sources told us in 1990 that we should expect hospitals to report more than 1,000 disciplinary actions every month, yet fewer than 1,000 are reported in a year. After almost ten years, more than half of all hospitals have never reported a disciplinary action.

In a 1995 report on this subject the Inspector General of the Department of Health and Human Services cited several reasons which might explain this under-reporting, but because of the confidentiality accorded peer review records in hospitals, none could be substantiated conclusively. As a result of that OIG report, a forum of industry leaders was held in Chicago in 1996, at which there was general agreement that underreporting is an unfortunate reality. However, the continuing absence of wholly reliable data makes it more difficult to assess the extent of the problem so that useful solutions can be formulated.

Accordingly, the Health Resources and Services Administration (HRSA) will soon contract with an accounting firm to help us devise, and execute, a plan for auditing hospital records so that required data can be efficiently collected and analyzed. The Department is also considering a recommendation by the Inspector General to seek a legislative change which would provide for monetary penalties in instances where hospitals had demonstrably failed to report reportable actions.

Another important issue raised by Congressman Biley concerns disclosing Data Bank information to the public. As you know, the Secretary, in her response to Mr. Biley on this subject said: "The issue of disclosing to the public information contained in the NPDB is complex. On one hand, I agree with your assertion that consumers need more information in order to make educated decisions regarding the medical professionals whose treatment they may wish to seek. On the other hand, . . . there are privacy concerns regarding broad public disclosure of potentially incomplete negative information."

In fact, Mr. Chairman, the statute and the regulations under which NPDB operates are very clear. In the nearly ten years of HRSA management diligence has been exercised to ensure the confidentiality mandated by the law. You have previously heard testimony on various sides of this multi-faceted issue from earlier witnesses. HRSA would only caution that any changes in the law be carefully considered and further debated, with due attention to what may be significant privacy implications, before being enacted. Without a doubt, there are legitimate arguments on both sides of opening up NPDB which ought to be considered. However, it is the data bank managers' opinion that the key is not in the data itself, but in how it is used. Currently, for example, when a practitioner applies for employment or for admitting privileges, the hospital asks the practitioner for a complete practice history including any malpractice payments or adverse actions. A query of the Data Bank then verifies the information about malpractice payments and adverse actions for the hospital, or it discloses information to the hospital which the practitioner may have failed to include in the application.

In either case it ensures that the practitioner can not move from place to place in the hope of escaping a checkered past. That is precisely the purpose of the Act.

Nothing in the Data Bank's information, on the other hand, is intended to produce an independent determination about the competency of an individual practitioner. It rather is intended to supplement a comprehensive and careful professional peer review. It is noteworthy that the vast majority of practitioners who have reports listed in the Data Bank have only one and that is almost always a malpractice payment report. It is impossible and unfair to conclude from a single malpractice payment report alone, or even in some cases from numerous malpractice payment reports, anything substantive about the competence of a practitioner. To do so would be a disservice to all parties involved. At the same time, it is easy to understand the public's frustration with the lack of entirely accurate and unbiased information, particularly when some licensing authorities are slow to act in the face of practitioners' histories of poor and occasionally shoddy medical practices.

In conclusion, Mr. Chairman, I believe that by almost any account the National Practitioner Data Bank has been a success. However, there is room for improvement, to which we remain committed. To a great degree, the Data Bank's successful beginning is due to the Congress. We welcome your suggestions for better service

and will work closely with you on these. Mr. Chairman, this concludes my remarks. I am happy to address your questions.

Mr. UPTON. Well, thank you very much.

The regular order is that we now proceed to the questions and we will limit members' questions and answers to 5 minutes and we may go a round or two to get those questions in.

We will start off with the chairman of the full committee, Mr. Bliley.

Chairman BLILEY. Thank you, Mr. Chairman.

Mr. CROFT, in 1993 in the Clinton health care bill, the administration proposed opening the National Practitioner Data Bank to the public. Why has the administration changed its view and it has now taken a neutral position on the same issue?

Mr. CROFT. Mr. Chairman, that proposal as I recall was a part of a much larger proposal to make some significant changes in the way we deal with malpractice and malpractice complaints and I am certainly not an expert on that, but I—

Chairman BLILEY. Well, I understand that, but what has changed since 1993 to cause the administration to change its position?

Mr. CROFT. Well, the administration as far as I know is no longer proposing that comprehensive approach.

Chairman BLILEY. I understand that, but this was a small part of that comprehensive thing and so, you know, I was just curious as to why they would change.

Are you aware of any inaccurate or any invalid data in the NPDB?

Mr. CROFT. I am aware that occasionally there will be some errors in the presentation of the data by the reporter. When those come to our attention we make every effort to get those corrected.

Chairman BLILEY. It is my understanding, Mr. Croft, that approximately 4,000 hospitals in the United States have not filed a single clinical privileges report to the Data Bank since its inception a decade ago. What are you doing to address this issue?

Mr. CROFT. I mentioned a couple of things in my statement, Mr. Chairman, and I think the most important part of that is that we are preparing to make an effort to look at those hospital records that will be made and can be made available to us to start to document where we see the problems.

Chairman BLILEY. My committee staff has discovered that only two, two hospitals have ever been warned by HHS for failing to comply with the NPDB reporting requirements.

Shouldn't—I mean this is pretty shocking—I mean shouldn't HHS be doing more to investigate and discipline hospitals that fail to report?

Mr. CROFT. Our policy has been to respond, Mr. Chairman, to any allegations or any charges that are brought to our attention, but as I said in my statement we are now at a point where we think we can be more proactive in trying to discover—

Chairman BLILEY. I hope so. Mr. Croft, in spite of your statements to the contrary, doctors are escaping their checkered past by moving from place to place, in this hearing before the subcommittee 2 weeks ago we heard testimony of this. Why is it that the NPDB is failing to prevent this?

Mr. CROFT. The National Practitioner Data Bank, Mr. Chairman, collects information from various sources and we depend on those sources of course to provide us with the information on the actions they take. If there are no actions or if malpractice claims don't end in payments being made, then under the law those actions don't get reported.

Chairman BLILEY. Well, you know, we have found that doctors with more than 20 reports to the NPDB continue to practice in communities like Atlanta, Houston, Phoenix, and New York City. How does this come about? I mean—

Mr. CROFT. Well, as you know, Mr. Chairman, our job really here is to carry out the law. It is to collect information and provide it to the licensing boards and to the hospital who conduct peer review. It is not our role nor do we have a mandate really to begin making findings or decisions about the competency of practitioners in taking action. We simply don't have that role.

Chairman BLILEY. Well, thank you, Mr. Chairman, and Mr. Croft, would you be willing to respond in writing to additional questions, should I have any?

Mr. CROFT. Yes, sir.

Chairman BLILEY. Thank you very much. Thank you, Mr. Chairman.

Mr. UPTON. Thank you, Mr. Chairman. I would just have another unanimous consent request that all members of the subcommittee may have an opportunity to respond or further query Mr. Croft with questions in writing when the hearing is completed.

Mr. Stupak.

Mr. STUPAK. Thank you. Mr. Croft, based upon the last questions you had, why would you want a data base open to the public if 60 percent of the hospitals are not reporting or are underreporting? That would not be a very reliable factor then, would it?

Mr. CROFT. Mr. Stupak, as I mentioned before, we have got a law here that we are trying to administer, and the law really doesn't allow for that kind of release of information. In fact, the information is crafted specifically to be a part of a comprehensive peer review—

Mr. STUPAK. Sure, but the reason why we are here is some people propose that we should open a national data base, but in theory if 60 percent of the hospitals are not reporting it would not be a very accurate indication then of the skills of the physician.

Mr. CROFT. Well, it may simply be a reflection that those hospitals are not disciplining practitioners—

Mr. STUPAK. True, but in theory then the National Data Bank would not be a good source of information for the quality of information and actually could possibly produce some false negatives, would it not?

Mr. CROFT. If I understand your question, sir, there are responses to queries, positive responses to queries about 12 or 13 percent of the time, so if there is no information in the Data Bank on a particular practitioner, obviously there would be a negative response.

Mr. STUPAK. You said that the money comes from fees, user fees, right?

Mr. CROFT. That is correct.

Mr. STUPAK. At our last hearing some witnesses said that they thought it would be helpful if the States had free access to the Data Base. What are your thoughts on this? I know that the National Practitioner Data Base is a user fee system, but if we really want to encourage States to query, do you think that waiving these user fees for States would be a good idea? What are your thoughts on this?

Mr. CROFT. Mr. Stupak, my own personal view is that the cost ought to follow the demand, and I think we have done a very good job of doing that including recently starting to charge practitioners for their own self-queries. I certainly would not be opposed to trying that idea to see if it worked.

I do know, on the other hand, that many State boards already get the information by having the practitioners self-query and that seems to work well for them.

Mr. STUPAK. The Practitioner Data Base is a reporting system that is used, correct? You don't have an enforcement powers on a physician's license, do you?

Mr. CROFT. No, No, we do not.

Mr. STUPAK. That is left to the States, is it not?

Mr. CROFT. That is correct.

Mr. STUPAK. So if a person really wanted to know about a physician, a place or a hospital they could actually look to the State boards, could they not, who do the licensing and enforcing of the medical practice in their States?

Mr. CROFT. They should be able to.

Mr. STUPAK. Okay. And your board, your National Practitioner Data Bank doesn't do enforcement of licensing or sanctions against doctors who may have had difficulty?

Mr. CROFT. That is correct.

Mr. STUPAK. Okay. The chairman asked you about the 1993 Clinton health care, and your response was while the National Data Base was mentioned in there it was part of a more comprehensive approach. That comprehensive approach included certain criteria to evaluate a provider and health care. It did not say, if you know, did it say just open up the National Data Base and that could be our evaluation of health care and health care centers and providers as to their qualifications and that? There was a much more comprehensive approach to it in the Clinton health care plan, was there not?

Mr. CROFT. That is my recollection, yes, sir.

Mr. STUPAK. In this proposal that is current—I should not say proposal but the idea before this committee, why we are doing oversight and investigation, is there anything else—I mean what we are looking at is whether or not we should use the National Practitioner Data Base and open it up to the public. Is there any other comprehensive support mechanism before we open it up in this proposal?

Mr. CROFT. I am not sure I understand the question, sir.

Mr. STUPAK. Well, in national health care, with the President's plan we at least had a comprehensive approach. What we have before us is just the stark proposal to open up this National Practitioner Data Base, correct?

Mr. CROFT. That is correct.

Mr. STUPAK. There is nothing there to support it. There is no evaluation. There is no criteria on the National Data Base what should or should not be given to the public—just throw the whole thing open and let the public make up their own mind.

Mr. CROFT. I am not aware of anything.

Mr. STUPAK. Okay, thank you.

Mr. UPTON. Thank you. It is my understanding that under current law the hospital is obligated to report the doctor's conduct to the Data Bank. Correct?

Mr. CROFT. When they take an adverse—

Mr. UPTON. An adverse action, and at our hearing 2 weeks ago we had, you are familiar with the case of Dr. Zarkin in New York carved his initials into the abdomen of his patient and under questioning the hospital, all that they reported to the Data Bank was gross misconduct as I recall—

Mr. CROFT. To the State authorities.

Mr. UPTON. [continuing] or to the State authorities was gross misconduct. They didn't actually indicate the details of that case.

Did they play by the rules in that situation? Should they not have reported the full disclosure of what happened?

Mr. CROFT. If I recall correctly, Mr. Chairman, that was a report to the State and, frankly, I don't know what the State requirements are specifically for that explanation.

Mr. UPTON. See, what happened was he resigned and then sort of skirted the reporting of that to the Data Bank. Is that not a problem that maybe should be dealt with?

Mr. CROFT. Generally speaking, resignations when the practitioner is being investigated or being threatened with some sort of disciplinary action, that surrender is supposed to be reported.

Mr. UPTON. When someone loses a license, it is my understanding that under current laws State medical boards are required to report revocations and suspensions of licenses but not when they deny someone a license.

Would it not strengthen the Data Bank if that was an added requirement?

Mr. CROFT. You are speaking of denial of initial licensure applications. Denials of renewals are reportable and yes, I believe it would strengthen the Data Bank.

Mr. UPTON. We had a situation in my State. A physician lost his license. I do not believe that he was authorized to practice under a hospital setting, but in fact we found out later on, after he lost his Michigan license, and it was for, as I recall, for dealing drugs, that he had lost his license in the State of Virginia for exactly the same reason.

In my view, if that had been reported, though I do not know again the details of whether he actually practiced at a hospital in Virginia, but it seems to me that there ought to be a system where the State of Michigan or any State ought to be able to have some record that they could query as to whether an individual lost their license under a situation like that.

Mr. CROFT. They can now, sir, query the National Practitioner Data Bank. That information should be there.

Mr. UPTON. So the States when they revoke a license, they—regardless of whether they practice in a hospital setting or not, they enter that into the Data Bank?

Mr. CROFT. Yes, that is correct, Mr. Chairman.

Mr. UPTON. Okay. The Health Insurance Portability and Accountability Act provided for the creation of a second Federal Data Bank, the Health Care Integrity and Protection Data Bank, which provides a repository of information about health care practitioners who have been convicted of certain crimes.

I understand that you are responsible for administering that Data Bank as well.

What types of crimes must be reported to that Data Bank?

Mr. CROFT. The crimes must be health care related. In other words, if the practitioner were convicted of let's say drunken driving, that would not necessarily be reported unless the particular jurisdiction believed that it was somehow related to the provision of health care.

Mr. UPTON. What about something like sexual assault, rape, murder? Are those crimes included?

Mr. CROFT. If they are related to patient care.

Mr. UPTON. Well, okay. Do you think that perhaps that ought to be expanded, a serious crime of that nature, if it is not related to patient care ought to be reported as well?

Mr. CROFT. As I understand it, Mr. Chairman, this Data Bank attempted to focus its attention on health care related matters. We certainly haven't studied the issue of what impact other kinds of actions like this might have on the usefulness of the data, but I would say generally speaking for investigators I suppose more information is always better.

Mr. UPTON. Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman, and I ask unanimous consent to place a statement into the record.

Mr. Croft, since 1993 has there been any statutory changes in the National Practitioner Data Bank?

Mr. CROFT. No, sir.

Mr. GREEN. Outside of the expansion, as the chairman mentioned, to other data you are supposed to correct. This is not a question, but this committee considered the President's health care plan in 1993 and 1994 and I don't remember it ever coming up for a vote. I don't remember if opening the Data Bank was going to be that positive a thing in 1993 or 1994 to my colleagues. I was not on this committee but I know it was considered, but I guess if it was great in 1993 and 1994 it is good for 1999 and 2000.

Some of the primary weaknesses I see after our hearing last week of NPDB is that the reporting criteria oftentimes—in fact, I think looking at the minutes from the last National Practitioner Data Bank Executive Committee meeting, a range of concerns regarding the Data Bank were evident and could I get your reaction?

For example, it was reported that more than 60 percent of all hospitals had never filed an adverse action report to the Data Bank since 1990, is that correct?

Mr. CROFT. That is correct.

Mr. GREEN. And it suggests there is a significant problem of underreporting, is that correct?

Mr. CROFT. That is correct. Yes, sir.

Mr. GREEN. What are the implications if 60 percent of all the hospitals never filed a single report, either that or in those hospitals there are a lot of great things happening—why is it happening at those hospitals who are not filing those reports?

Mr. CROFT. The Inspector General in her report in 1995 suggested there were three reasons—one, simply that they are not taking disciplinary actions; a second one being that perhaps many or all the actions they are taking do not approach the threshold for reporting to the National Practitioner Data Bank; or possibly they are taking actions that ought to be reported and they are not, for whatever reason.

Mr. GREEN. What do you think we need to do on a statutory basis to increase that reporting?

Mr. CROFT. I think there are a couple of things that could be done.

One might be to provide stronger sanctions.

Mr. GREEN. Could you do that or could the board do that now?

Mr. CROFT. No, it could not. There is a sanction in the statute for failure to report and it is loss of immunity. Of course, any time an action is not reported there is no immunity anyway, but that and making it possible, more possible for us to work with the hospitals in terms of how they are carrying out their peer review and professional review responsibilities might make it easier to get those actions reported.

Mr. GREEN. Okay, so it would take action by Congress to be able to give you that authority?

Mr. CROFT. I believe it would, yes.

Mr. GREEN. What are your thoughts about the corporate shield problem relating to the NPDB? How pervasive is that problem—and again, does it take Congressional action to correct it?

Mr. CROFT. Well, as you know, Mr. Green, we have attempted to correct it through regulation, through changing our regulations. That has had a bumpy road, to say the least.

I do believe that there is underreporting of malpractice because of the so-called corporate shield. Data is obviously hard to come by to support that, but certainly in the discussions we have had with many folks in the industry and responses we have had from letters to insurers who tell us that they insure the organization rather than the individual practitioner and therefore do not believe that they need to report those things at least buttress the perception that there are malpractice payments that are not being reported.

I think we in our efforts to help the insurers identify the payments that should be reported probably produced or created an opportunity for the so-called corporate shield to apply as well, but—well, I will stop with that.

Mr. GREEN. Thank you.

Mr. UPTON. Thank you. Dr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman. It's no secret that I oppose opening the National Practitioner Data Bank.

I think it should be disclosed that I practiced medicine for 18 years. I have never been sued, I have never settled. I have never had any legal proceedings at all.

But, you know what? I don't know what's in my Data Bank. And, so, Mr. Croft, I need to get the address of where I should write.

How much does it cost, by the way, for an inquiry?

Mr. CROFT. The cost of a query of the National Practitioner Data Bank is \$10, sir.

Mr. GANSKE. Okay, I'll get that information, just to see if I'm listed on anything or not.

In your statement you say it is impossible and unfair to conclude from a single malpractice payment report alone, or even in some cases, from numerous malpractice payment reports, anything substantive about the competence of the practitioner. Can you expand on that for us?

Mr. CROFT. Yes, sir, I can. First of all, more than 70 percent of the practitioners who have reports in the Data Bank have only one.

And, generally speaking, that is a medical malpractice payment, and it deals with one incident in the life of, or in the practice history of the particular practitioner.

Mr. GANSKE. Is that a settlement?

Mr. CROFT. Most often, it is.

Mr. GANSKE. What percent, do you think?

Mr. CROFT. Ninety-seven percent of the time, it is.

Mr. GANSKE. Ninety-seven percent of the time, it's a settlement?

Mr. CROFT. It's a settlement, and I might add, with no admission of liability.

Mr. GANSKE. Okay, and so you say that doesn't indicate anything about the competence of the practitioner?

Mr. CROFT. I was going to also add that, generally, that is a matter which took place at least 4 or 5 years earlier, if not longer.

And so, yes, I would say that one incident doesn't make a practitioner incompetent.

Mr. GANSKE. So if 70 percent of the people that are listed have one incident, and 97 percent of those incidents are settlements, can you speak to the committee about what a settlement means?

Mr. CROFT. Let me answer it this way, sir, by starting—I'm certainly no—I'm not an attorney and I'm not an expert in the matters of settlement.

Mr. GANSKE. You run the thing, so what does it mean to you?

Mr. CROFT. But as I read the reports that are made to the Data Bank, there's a whole range of possibilities, everything from settling a case that perhaps the practitioner knew that he or she would lose if it went to court, to those that are settled because the amounts of money are so small that it's not worth litigating.

Mr. GANSKE. Do they list the amounts in the Data Bank?

Mr. CROFT. Yes.

Mr. GANSKE. So, of those settlements, can you give us some idea of what the average settlement amount is for, or what the mean amount is for?

Mr. CROFT. I think we have that, and if not, I'll certainly provide it for the record. I don't know it off the top of my head.

Mr. GANSKE. What percent of the settlements involve the doctor and what percent involve health plans only, or do you have that?

Mr. CROFT. We don't collect payment information against the entity, or the health plan, only where there's a practitioner that's named.

Mr. GANSKE. But it is fair to say that a sizable percent of those settlements were decisions that were made by the insurance company, simply because for cost-effectiveness purposes, they just didn't want to pay for litigation? Do you agree with that?

Mr. CROFT. I apologize, but—

Mr. GANSKE. Is it fair to say that a sizable percentage of those settlements were because the insurance company decided to settle, rather than just simply expend more money on litigation, and as a matter of cost/benefit analysis, they decided it would be cheaper for them to settle, rather than to fight a spurious case?

Mr. CROFT. On the—generally, speaking, the reporter doesn't tell us that. Sometimes they do, but it's rare. Generally they rely on the claim filed by the patient for the information that goes into the narrative description.

Mr. GANSKE. Isn't it true, though, that, generally speaking, if it's a really egregious case of malpractice, that the settlement sum is going to be a larger sum, rather than one of these smaller, \$5,000, \$10,000, \$20,000 settlements?

Mr. CROFT. It's probably true that that's the general bias, however, I can tell you that I have seen reports of incidents that look pretty egregious, where the amounts are fairly small, and vice versa.

I have seen some big settlements where at least from the description, it doesn't necessarily seem all that egregious.

Mr. GANSKE. How much data do you get on those settlements? I mean, is it like a paragraph or a page? Or is it a full legal brief?

Mr. CROFT. It's certainly not the latter. It generally is about a paragraph description.

Mr. GANSKE. A paragraph?

Mr. CROFT. Yes.

Mr. GANSKE. To sometimes describe some very complicated circumstances.

Mr. CROFT. I suppose you could say that, yes.

Mr. GANSKE. Which would make your point then that this data ought to be taken and looked at more thoroughly by the peer review panels that are making the determination on credentialing?

In other words, that you're providing the function that they get information, say a hospital credentialing board, that they get information that, in fact, the physician that applied for credentials, actually told them that they had a settlement. Then they look into the details of what that means; is that correct?

Mr. CROFT. That was certainly the intention, we believe.

Mr. GANSKE. How good a job do you think you're doing in getting that information to hospitals that are in the process of credentialing?

Mr. CROFT. As I mentioned in my statement—

Mr. GANSKE. Do you think you're covering 100 percent of physicians seeking credentialing? Ninety percent? Do you have a way of knowing that?

Mr. CROFT. Let me answer it this way: I believe that hospitals are following the law, and they querying their practitioners when they should be querying.

We've had virtually no allegations to the contrary. And particularly, for instance, the use of the plaintiff's attorney query, I think

we've maybe had half a dozen in 10 years use that, and as yet, it's turned up nothing.

So, I think that, yes, hospitals are querying.

Mr. GANSKE. If a physician writes in and gets his report from you, and sees that there is a mistake or an error, what is the procedure for getting that corrected?

Mr. CROFT. First of all, the Data Bank sends a copy of the report to the practitioner at the time it's filed with the Data Bank. That notification document includes all of the instructions and information about how the practitioner can dispute that report.

The information that comes in a self-query, in response to self-query, does not include that kind of information, and if that's the first time the practitioner has heard about it, then the practitioner should call our help line and get all the necessary paperwork.

Mr. GANSKE. Is it true that a practitioner, if he sees an egregious mistake, cannot get you to remove it, but has to go to the reporting agency that has reported to you, to get them to retract it, but that they are under no obligation to do that?

Mr. CROFT. That's the first step in the process, Doctor, and the statute does require that the reporting entity correct information when it is wrong. And, in fact, even those cases that come to the Secretary, many times when we find there is an error, we will instruct the entity to correct it.

Mr. GANSKE. Do they always comply? Is there any enforcement that they comply?

Mr. CROFT. I don't recall any incidents when they haven't.

Mr. GANSKE. Thank you. Thank you, Mr. Chairman.

Mr. UPTON. Mr. Stupak.

Mr. STUPAK. Thank you, Mr. Chairman. During our last hearing, Dr. Harkman remarked in his testimony that the National Practitioner Data Bank was never intended to be used as a consumer tool. Do you believe this to be true?

Mr. CROFT. Yes.

Mr. STUPAK. Why do you say that?

Mr. CROFT. Well, because the statute is very clear about the purpose and about who has access.

Mr. STUPAK. Well, if we wanted to make the National Practitioner Data Bank useful as a public tool, what specific changes would be needed to be made in order to make this into a public tool that the public could use with some degree of confidence to get accurate information about a doctor or a medical care facility?

Would the data base need to be totally retooled, redone, or could we just make some adjustments to achieve these objectives?

Mr. CROFT. Well, Mr. Stupak, I think there are several ways you could go about that. For one, you could—we could talk about perhaps joining forces with States and other jurisdictions that already have other data.

Certainly I would strongly suggest that having this data out there by itself is risky because that wasn't the purpose for it. Frankly, anytime you try to use something for a different reason than it was originally intended, you're always running some kind of risk.

But I would say it has to be taken in context with other information that may be available about the practitioner.

Mr. STUPAK. In your testimony you state, and I won't quote, but in your testimony you state that you have previously heard testimony on various sides of this multifaceted issue from earlier witnesses. HRSA would only caution that any changes in the law be carefully considered and further debated with due attention to what may be significant privacy implications before being enacted.

Would you elaborate further on specific issues that should be taken into account when considering opening the Data Bank and what the pitfalls might be?

Mr. CROFT. I think what we were specifically referring to there is that there are certain data elements in these reports which are subject to the Privacy Act, the Social Security Number, for instance, and that if any of this information is going to be revealed, there ought to be close attention paid to that data, and perhaps purging it from the record.

Mr. STUPAK. At the last hearing, the chairman mentioned, Chairman Bliley mentioned that an individual had around 300, give or take, reports in the National Practitioner Data Bank, and I believe that was a doctor.

Mr. CROFT. A dentist.

Mr. STUPAK. A dentist. Could you elaborate on that? Does that mean this was a bad dentist? What, exactly—how do you put that in context? Wasn't this really he gave them something that made the kids' teeth turn color, so everyone wrote into it?

Mr. CROFT. Not in this case. There was a physician or is a physician with many, many reports where that is the case. Tetracycline was prescribed and turned teeth brown.

In the case of the dentist, my review of the records suggest many, many claims for different reasons. A lot of them were about faulty crowns and that sort of thing.

But this was certainly not a case where there was essentially one problem that may have caused some minor harm.

Mr. STUPAK. So that's 300 of them, though, in this one dentist here with the bad crowns or something like that, you said?

Mr. CROFT. Well, 290-some were malpractice for the faulty crowns and other work that the dentist had done. There are some licensure actions.

Mr. STUPAK. So in this case, on the 297, it's not the responsibility of the National Practitioner Data Bank to take away this person's license. Would the State be responsible for doing that?

Mr. CROFT. That's correct.

Mr. STUPAK. Did they ever remove that license?

Mr. CROFT. Yes, they did.

Mr. STUPAK. Okay, was that it your urging or the urging of others?

Mr. CROFT. It was probably at the urging of others.

Mr. STUPAK. I didn't mean you, specifically.

Mr. CROFT. Hopefully they checked with us about this information.

Mr. STUPAK. Right. Thanks.

Mr. UPTON. Thank you. When I sat down with my Chief Medical Officer and had a demonstration of how the Data Bank works and we had the consent of a physician that was there with us as we

looked into his own file, we had a long discussion that morning in terms of pluses and minuses, constructive changes.

One of the things that I heard was that hospitals are always required to report when they deny privileges, but, in fact, they have had a number of cases when physician has applied for a staff position, and the physician has voluntarily withdrawn their name or their application.

They sort of flag it, you know, that you may not want to see this done to fruition, and the physician says, okay, get the message.

Sometimes they go to another town, another State, who knows where, but my CMO suggested that we require hospitals, in fact, to report voluntary withdrawals. Do you think that's a good idea?

Mr. CROFT. I believe it would be, yes.

Mr. UPTON. Now, we've talked about some good ideas that are out there on the table, whether it's reporting of sexual abuse cases or whatever, 30 days, corporate shields, referenced here. You're not—as I understand it, you're not able to do any of that.

You know, here's a good idea, we're going to proceed on this. You need legislation to do that; is that correct?

Mr. CROFT. That's correct, Mr. Chairman, they are all very specific.

Mr. UPTON. Well, something that this committee, I'll bet, would appreciate, is, as you think about this at night in the next couple of weeks, we're raising, I think, some pretty good questions.

But if you'd like to share specifically some other things in addition to your testimony that we might proceed in a constructive route, we sure might appreciate that.

I know that I have had some discussions with the chairman. I'm not prepared at this point to drop a bill or anything like that. I want to work with the chairman, but I do think there are some constructive changes that I have picked up from my local medical community, and work in closer harmony with our State licensing boards. I have some meetings and maybe my colleague from Michigan, Mr. Stupak, would like probably that it will happen back in Michigan.

But I really want to walk through some of the conversations that I've had and see what might help them as we look for continued quality care physicians in our home State.

And to make this system work in a stronger fashion, that, in fact, the few bad docs that are out there, in fact, don't continue to practice in areas where they really shouldn't participate. I mean, I know, as I have sat down with my physician community, 99.99, probably a couple more 9s are there for the right reason. They have the quality personnel to help them, and they want to do the job right.

But we're going to find every now and then, some others that should have been weeded out a long time before, and, in fact, because of some of the lurches that are in the system, are able to avoid having their license removed.

I think that we can come up with a little better system, and your thoughts in that degree, participation, as we perhaps move forward on a legislative process, I know would be appreciated by all members of the committee.

Mr. CROFT. We would be pleased to.

Mr. UPTON. Terrific. Mr. Green?

Mr. GREEN. Thank you, Mr. Chairman, and if the subcommittee jurisdiction on the legislation moves forward I would hope we would have some statutory changes before we do anything and see how that works.

Mr. CROFT, some witnesses have suggested that some of the data in the NPDB cannot readily be used to determine doctor quality. Do you have any thoughts on that matter?

Mr. CROFT. Mr. Green, as we discussed earlier, certainly taking one malpractice payment report in isolation is probably not a reliable way to make a determination about a practitioner's competence.

I do believe that taking all the information together that a peer review committee has at its disposal probably is usually sufficient to make a reasonable determination.

Mr. GREEN. Do you think whether it is the agency or the Bank or this Congress that enough study has been done on exactly should be done with regard to giving the public access to the Data Bank or do you think we should spend more time studying it?

Mr. CROFT. I think we ought to be very deliberate.

Mr. GREEN. One of the concerns I have, and I know it has been asked in different ways, is because of the lack of reporting, for example, take a fictitious "Dr. Green" or "Hospital Green" and if this was available and I contacted the Data Bank and it showed there was no information on it, today would I be able to rely on that as a patient or as an employer that is looking at a list of physicians that may be on the list that my insurance carrier gives me? Could I rely that there is no reports in the Data Bank if it was public?

Mr. CROFT. I am not sure I understand your question, sir.

Mr. GREEN. Okay. I guess the concern about the false negatives—

Mr. CROFT. Right.

Mr. GREEN. [continuing] if I was an employer who has a contract with XYZ Company and I want to check the physicians or the providers, the hospitals that are on my list, and if this bill was passed that our chairman has, could I in good confidence—

Mr. UPTON. I just want to note I don't have a bill yet.

Mr. GREEN. No, the chairman of the full committee has the bill—and I contacted you if that bill passed, would I have a comfort level under current information to say that since no one is listed there that I should have that physician or that hospital or that facility on that list?

Mr. CROFT. Well, the information there certainly does not attempt to make any sort of determination about the competency of the practitioner or any facility or entity that he or she may work for, and if there is no information there, that equally is not a determination about the competency of the practitioner.

Mr. GREEN. Particularly in light that 60 percent of all hospitals have never filed an adverse report.

Mr. Croft, at our last meeting Dr. Hotchman at American Hospital Association mentioned in his testimony that one of the reasons that we should not completely open the NPDB is because it ultimately would lead to further reduction of data reporting.

In his testimony he says, "Public disclosure of Data Bank contents as presently configured would undermine the confidentiality of the peer review process in hospitals across America, thus impeding the Data Bank's goal of promoting health care.

Congress promised confidentiality when it created a National Practitioner Data Bank and the normal tensions created by peer review would be significantly heightened if reports were available to the public and complete disclosure of the Data Bank's contents to the public could cause caregivers to be less forthcoming about their mistakes and less likely to report errors made by their peers."

Now what are your reactions to that statement and do you think Dr. Hotchman reports that opening the Data Bank to the public could actually lead to a further reduction in data reported?

Mr. CROFT. Mr. Green, I do not know whether that is true or not. We certainly have not studied the issue to find out, but that is a big concern.

Let me answer the question more directly this way, and I use this very often when I am speaking to groups about the Data Bank. Practically every question that I get about reporting is how can I avoid it, and practically every question I get about querying is how can I get more information. Very often they come from the same place.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. UPTON. Thank you. Dr. Ganske.

Mr. GANSKE. I will try to be brief, Mr. Chairman. I know we have a vote on.

At the previous hearing I mentioned a concern about the reporting for physicians who practice high risk procedures. I was one of those physicians, a plastic and reconstructive surgeon. I did major cranial faces cases, some of them lasting 10-12 hours, free flaps, all sorts of complicated procedures where, you know, if one little blood vessel doesn't stay open the whole thing fails.

As I said, I was fortunate that I have never had a lawsuit, but Mr. Bliley mentioned that there are some practitioners in the Data Bank who have had around 20 reports. I can easily envision that some of the best physicians in this country, particularly those at academic centers, over a 20-, 30-, 40-year course of practice could have 20 settlements.

Would you care to comment and amplify your comment in your testimony that goes back to that question, to an uninformed observer, what does simply the mere reporting of those procedures mean? Can they have any context?

I think, quite frankly, there are probably a lot of this Nation's best physicians that probably have some multiple entries into this Data Bank that could be misinterpreted. Would you care to comment on that, Mr. Croft?

Mr. CROFT. What I was referring to, doctor, was—and I think we talked about one already, the pediatrician who prescribed tetracycline to infants back in the 1960's only to learn that that caused staining of the permanent teeth of the children later.

Mr. GANSKE. Ex post facto.

Mr. CROFT. Yes.

Mr. GANSKE. Yes.

Mr. CROFT. And because, I assume because there haven't been any other payments or incidents lately that have been recorded that that pediatrician now knows better and otherwise is probably a competent practitioner, but I should be clear about that.

That is not a determination that I am expected to make, nor am I planning to do that.

There is another practitioner with multiple reports of malpractice because he failed to send employees home from a factor that had a chemical explosion problem. I cannot tell from the Data Bank report frankly whether the practitioner did anything wrong at all, but the fact is that there are 177 or whatever the number is reports that came from this one incident—

Mr. GANSKE. And your point being that that would be terribly unfair to those practitioners to open that up to public consumption when there is no context for them to make in terms of determining whether this was truly a poor practice or not?

Mr. CROFT. As I said, I think it would be unfair to judge that this practitioner was incompetent because of that one incident.

Mr. GANSKE. I thank you very much. Thank you, Mr. Chairman.

Mr. UPTON. Well, Mr. Croft, we appreciate your testimony. As you have heard from these buzzers, we have a vote that doesn't have a lot of time left, so we are going to adjourn this hearing.

We look forward to hearing from you in the future in terms of your thoughts and ideas and appreciate very much your time this morning.

Thank you.

Mr. CROFT. Thank you, Mr. Chairman.

[Whereupon, at 11:16 a.m., the subcommittee was adjourned.]