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## Physician Profiles: Consumer Protection or Excessive Exposure?

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PHYSICIAN PROFILES:  
CONSUMER PROTECTION OR EXCESSIVE EXPOSURE?

*Ann Stewart*

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# PHYSICIAN PROFILES: CONSUMER PROTECTION OR EXCESSIVE EXPOSURE?

ANN STEWART\*

I. INTRODUCTION .....	957
II. THE INFORMED CONSENT RUBRIC .....	959
A. The Autonomy Justification .....	961
B. Autonomy and Economics .....	962
C. Physician Privacy v. Patient Autonomy: The Delicate Balance .....	963
D. Disclosure—The Nonfinancial Costs .....	966
E. Procedure Specific Data Disclosure.....	967
F. Fiduciary Obligations.....	968
III. ACCOUNTABILITY DOCTRINES.....	970
IV. MASSACHUSETTS PRACTICES .....	975
A. Factual Practitioner Data.....	976
B. Medical Malpractice Claims History.....	977
1. The Bovjberg and Petronis Study .....	979
C. Licensing Board and Hospital Disciplinary Actions.....	981
1. Regulation and the National Practitioner Data Bank.....	982
2. The Florida Example.....	985
3. Hospital Discipline—Disclosure as a Cure All?.....	987
D. Criminal Convictions.....	987
E. What Is Not in the Massachusetts Profiles and Why.....	988
V. WHAT DOES LEGISLATION LIKE THIS COST? .....	989
VI. CONCLUSION.....	990

## I. INTRODUCTION

The medical profession has segregated society into disparate groups including physicians, non-physician providers, health insurers, malpractice liability insurers, regulatory boards, attorneys, and patient-consumers. Each plays a distinct role, yet all are expected to assimilate into a manageable, profitable, and productive health care system. However, today's society seems unwilling to continue to accept the notion that doctor knows best, and that the patient is subordinate to the provider.<sup>1</sup> Consumers are demanding more information about physicians,<sup>2</sup> expansion of their legally protected rights,<sup>3</sup> and greater involvement in their own health care decisions.<sup>4</sup>

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\* The author thanks her mother, June, for her patience, support, and guidance. The author would also like to thank Ralph Artigliere, Tom Surgent, and those who contributed to the editing and publication of this Comment.

1. See Robert S. Adler, *Stalking the Rogue Physician: An Analysis of the Health Care Quality Improvement Act*, 28 AM. BUS. L.J. 683, 741 (1991) ("Society has reached a point where citizens no longer view the medical profession with an uncritical eye and unquestioning faith."); Esekiel J. Emanuel & Linda L. Emanuel, *Preserving Community in Health Care*, 22 J. HEALTH POL., POL'Y & L. 147, 148 (1997) ("No longer given free rein, physicians and hospitals are being asked to provide information and to justify their practices.").

2. See *State Increases Access to Physician Data*, 23 HEALTH LEGIS. & REG. WKLY. (Apr. 9, 1997), available in 1997 WL 8740264 [hereinafter *State Increases Access*]. Consumer-driven legislation has led to the disclosure of various types of information. In Ill-

With Massachusetts leading the way, several state legislatures are responding to consumer dissatisfaction by enacting bills aimed at increasing consumer access to physician-specific information in profile format.<sup>5</sup> Certainly, accurate information in comprehensible form would facilitate consumer comparison of physicians and allow patients to better assess treatment options. The weakness with much of the proposed, or even enacted, legislation is the erroneous impression that the data disclosed will adequately inform a consumer about a given physician. Misleading information is worse than no information.<sup>6</sup> In noble efforts to make physician data more consumer-friendly, several state legislatures have taken significant liberties with previously compiled physician information already in the public

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nois, a bill would require telephone hotlines to provide information about criminal convictions, disciplinary action, and license restrictions. See *id.* In Delaware, a bill would allow the Board of Medicine to subpoena previously privileged peer review and quality review records to enhance consumer complaint investigations. See *id.* Maryland previously prepared reports in response to written consumer requests that include information on all claims against a given physician, whether a payment was made or not. See *id.* However, physicians objected to legislation that would have allowed the public to obtain this information on the Internet. This legislation was shelved and an agreement was reached between physicians and the Maryland Medical Association that "only final adjudicated malpractice data" should be provided to consumers. *Id.*; see also Mass. Consumers Gain Access to MD Data, 13 *MED. MALPRACTICE L. & STRATEGY* 1 (1996) [hereinafter *Consumer Access*] ("[S]igns point toward more health care information being put in the hands of the public . . . [it is] 'an inexorable trend across the country.'" (quoting David B. Nash, Director of Health Policy and Clinical Outcomes at Thomas Jefferson University Hospital in Philadelphia)).

3. See 42 U.S.C. §§ 11131-11151 (Supp. 1995) (requiring certain entities to report malpractice disciplinary action and obligating hospitals to obtain such information); MASS. GEN. LAWS ch. 112, § 5 (1996) (requiring physicians to report biographical information for a physician profile, and requiring the Board to investigate complaints, hold hearings, take disciplinary action when appropriate, and establish a risk management unit to prevent future claims); FLA. STAT. § 455.5651 (1997) (requiring physicians to provide biographical information, including any criminal offenses or final disciplinary action against them, and requiring the Department of Health to compile information and submit it to the public); *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 480 (1990) (holding that the plaintiff stated a cause of action against his physician, as well as others, for their failure to disclose their personal interest, unrelated to plaintiff's health, in using plaintiff's cells in potentially lucrative medical research); *Hidding v. Williams*, 578 So. 2d 1192, 1198 (La. Ct. App. 1991) (holding a physician liable for malpractice for failing to obtain informed consent from the patient before surgery by failing to educate the patient on the risks associated with the procedure as well as the physician's alcohol abuse).

4. See discussion *infra* Part IV; see generally Emanuel & Emanuel, *supra* note 1; *Hidding*, 578 So. 2d at 1198 (holding that the patient had a right to know about the physician's alcohol abuse when deciding whether to have surgery).

5. See *State Increases Access*, *supra* note 2 (explaining that Florida, Delaware, Maryland, Vermont, Connecticut, California, Massachusetts, and New York all have pro-consumer laws in effect or under consideration).

6. See *infra* notes 174-78 and accompanying text (discussing the Entman study and its findings).

record by selectively publishing the information in formats that are not comprehensive.<sup>7</sup>

Accountability, informed consent, fiduciary duty, and basic supply and demand theory have been cited by various consumer advocates as reasons for the swell of disclosure-oriented legislation.<sup>8</sup> This Comment begins by exploring the interrelationship of provider-specific disclosure and these doctrines. Part II focuses on informed consent and patient autonomy, harm to the consumer by the disclosure of inaccurate or incomprehensive information, procedure specific data disclosure, and fiduciary obligations. Part III discusses holding physician's accountable through the complexities of government disclosure of provider-specific information. Part IV explores the risks and benefits associated with the disclosure requirement in Massachusetts. Studies and laws from other states, in particular Florida, are used in analyzing the Massachusetts law. Part V reveals the anticipated cost of the disclosure legislation enacted in Florida. Finally, this Comment concludes that consumers have a valid interest in being fully informed about those treating them, but that current disclosure schemes are inadequate to inform consumers because of the legal and medical complexities involved.

## II. THE INFORMED CONSENT RUBRIC

The medical field follows a doctrine unique in its existence, but hardly unique in its purpose. The doctrine of informed consent provides that valid patient-consumer consent to medical treatment requires that the patient-consumer be informed of all material information related to such care.<sup>9</sup> Traditionally, this has meant that health care providers must disclose the potential risks, benefits, side effects, details of treatment, and anticipated results involved with a particular treatment.<sup>10</sup>

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7. See Frances H. Miller, *Illuminating Patient Choice: Releasing Physician-Specific Data to the Public*, 8 *LOY. CONSUMER L. REP.* 125, 125 (1996).

8. See generally Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients From Their Physicians*, 55 *U. PITT. L. REV.* 291 (1994); Emanuel & Emanuel, *supra* note 1, at 148; Mark Fajfar, *An Economic Analysis of Informed Consent to Medical Care*, 80 *GEO. L.J.* 1941 (1992); Miller, *supra* note 7, at 125-26; Douglas Sharrott, *Note, Provider-Specific Quality-of-Care Data: A Proposal for Limited Mandatory Disclosure*, 58 *BROOK. L. REV.* 85 (1992).

9. See Fajfar, *supra* note 8, at 1941. In *Natanson v. Kline*, 350 P.2d 1093, 1106 (Kan. 1960), the Kansas Supreme Court launched the trend in treating failure to obtain consent to treatment as negligence. The court held that a physician must provide a patient with sufficient information to allow the patient to understand the treatment prior to consent to such treatment. See *id.*; see also Fajfar *supra* note 8, at 1943.

10. See *Hidding v. Williams*, 578 So. 2d 1192, 1194 (La. Ct. App. 1991) (stating that a physician is required to provide the patient with enough information to allow the patient to make an informed and intelligent decision about submitting to a proposed course of treatment); *Moore v. Regents of the Univ. of Cal.*, 793 P. 2d 479, 483 (1990) (stating that when obtaining informed consent, "a physician has a fiduciary duty to disclose all information

Some commentators argue that informed consent should extend beyond a doctor's mandatory disclosure of treatment information to include disclosure of provider-specific data.<sup>11</sup> Precisely what type of provider-specific data should be disclosed to patients to enhance informed consent is a tricky question. Some commentators argue for the release of outcome data,<sup>12</sup> while others believe that a patient is entitled to personal information about their doctor.<sup>13</sup> Advances in computer and communication technology further encourage the release of and increased access to various types of data on physicians and treatments.<sup>14</sup>

This section explores the relationship between informed consent, the recent trend toward the disclosure of provider-specific data, and potential problems that may arise. For example, patient autonomy, while potentially increased by disclosure, could easily be jeopardized if public disclosure is deemed to satisfy consent requirements. The burden would then be shifted away from the physician historically charged with providing information, and onto the patient to seek data that is in the public record. Moreover, a physician's privacy rights could be compromised if consumer advocates succeed in their efforts to know all, no matter how unrelated the information may be to the administration of health care. All of these potential problems stem from the erroneous premise that the more a consumer knows, the more valid consent to treatment will be.<sup>15</sup>

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material to the patient's decision"); Fajfar, *supra* note 8, at 1943 (arguing that treating patients without their consent violates the physician's fiduciary duty to patients and that patients have the "right to informed self-determination"); Miller, *supra* note 7, at 125 (stating that some would argue that the "informed consent doctrine should not be extended beyond a patient's right to information about the risks and benefits of recommended therapy"); Sharrott, *supra* note 8, at 85-87 (stating that physicians must respect patient autonomy in making decisions regarding the patient's course of medical treatment by providing the patient with enough information to make an informed decision).

11. See Miller, *supra* note 7, at 125; Sharrott, *supra* note 8, at 86-88.

12. See Sharrott, *supra* note 8, at 87-91. Outcome data can be analyzed in two ways. First, the information can analyze and compare a physician's or hospital's services to the specific characteristics of the patient. Second, the information can analyze the "appropriateness of a given treatment to determine whether a particular procedure or diagnosis is overutilized or unnecessary." *Id.* at 87 n.6.

13. See Miller, *supra* note 7, at 125 (stating that patients choose a physician because of price and competence and because price is a diminishing factor with the growth of the managed care system, competence "constitutes the only other basis on which patients can make decisions about providers and treatment").

14. See Brian Kibble-Smith & Arthur W. Hafner, *The Effect of the Information Age on Physicians' Professional Liability*, 36 DEPAUL L. REV. 69, 80-85 (1986) (discussing on-line information relating to medical treatment); Sharrott, *supra* note 8, at 86-87 (discussing on-line information relating to physician and hospital care).

15. See *infra* section II.C (discussing the balance between physician privacy and patient autonomy).

### A. The Autonomy Justification

Patient autonomy is the cornerstone of informed consent.<sup>16</sup> The basic premise is that patients lack the specific medical knowledge necessary to assess treatment options. To alleviate the knowledge disparity between the patient and physician, the patient should receive all pertinent information to ensure that the choice to undergo the contemplated medical treatment is one the patient would make if all potential outcomes were known.<sup>17</sup> Unlike other services or products for which a consumer can exercise informed, independent judgment when deciding whether to make the purchase or not, the "purchase" of medical services is one frequently made on blind faith in the provider chosen. Patient ignorance of the qualifications of those providing medical care undermines personal autonomy by exacerbating the imbalance of power between the physician and the patient.<sup>18</sup> Thus, any decision to pursue medical treatment or therapy is uninformed to the extent that the patient does not know personal information which could affect a physician's ability to perform the medical services contemplated. In this scenario, alcohol or substance abuse problems, criminal convictions, and prior malpractice claims or prior bad outcomes not resulting in any legal action would theoretically be useful information for a patient considering medical treatment. The flaw in weighing heavily this type of information is that it can be misinterpreted or misunderstood in many of the forms in which it is currently available.<sup>19</sup> The translation of reality into print can often fall short in terms of accuracy and usefulness.

Those who advocate for the release of personal provider information as a means of ensuring patient-consumer autonomy cite increased provider competition and the radical changes in the health care system resulting from managed care as a justification for arming the patient-consumer with enhanced physician data.<sup>20</sup> No longer is it deemed sufficient for a patient to be told solely about the treat-

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16. Former New York Supreme Court Justice Benjamin Cardozo penned the premise of informed consent: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body." *Schloendorff v. Society of New York Hospital*, 105 N.E. 92, 93 (N.Y. 1914) (holding that lack of patient consent to surgery results in the intentional tort of battery); see also Fajfar, *supra* note 8, at 1943.

17. See Fajfar, *supra* note 8, at 1943; Miller, *supra* note 7, at 125; Sharrott, *supra* note 8, at 120.

18. See Bobinski, *supra* note 8, at 292; see also Miller, *supra* note 7, at 125 (arguing that consumer ignorance significantly "contributes to a patient's inability to evaluate medical judgment").

19. See Sharrott, *supra* note 8, at 119-20 (citing Mark V. Pauly, *The Public Policy Implications of Using Outcome Statistics*, 58 *BROOK. L. REV.* 35 (1992)).

20. See Miller, *supra* note 7, at 125 (citing Anthony Szczygiel, *Beyond Informed Consent*, 21 *OHIO N.U. L. REV.* 171 (1994)).

ment. The individual administering the treatment is also an indispensable variable in the risk-benefit analysis.<sup>21</sup>

### B. Autonomy and Economics

Supply and demand theory suggests that providing specific information could increase competition among providers, thereby increasing consumer choice and eventually raising the standards for health care providers.<sup>22</sup> The key to the competition justification, however, is that the patient-consumer must have the ability to shop for a provider.<sup>23</sup> In reality, managed health care alters the delivery of health care to such an extent that the patient is not the one who "shops" for a provider; the real health care consumer is often the insurer who creates a health care package that the patient ultimately purchases.<sup>24</sup> Problematically, choices among insurers are decreasing as employers limit the insurance available to their employees.<sup>25</sup> Thus, because the patient falls out of the provider-consumer loop, insurance companies are the entities that must evaluate the providers with whom they contract.<sup>26</sup>

Presuming, however, that a patient-consumer participates in a health plan where some provider choice remains, two variables affect competition in any market—price and quality.<sup>27</sup> Consumers typically buy the product or utilize the service when price and quality fall within a certain agreeable range.<sup>28</sup> In the typical fee-for-service health care regime, those who can pay the most receive the best care, and those who cannot pay as much frequently sacrifice quality. As managed care becomes more and more prevalent, the gap in available care will likely narrow, and patient-consumers will likely worry

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21. See *Hidding v. Williams*, 578 So. 2d 1192, 1194 (La. Ct. App. 1991); *Moore v. Regents of the Univ. of Calif.*, 793 P. 2d 479, 483 (1990); Miller, *supra* note 7, at 125; Sharrott, *supra* note 8, at 141.

22. See Emanuel & Emanuel, *supra* note 1, at 156. Emanuel & Emanuel have developed an economic model of accountability in which patients are consumers who shop for health care seeking a satisfactory combination of price and quality, and care providers are "economic producers trying to sell their services as the best product for the lowest price." *Id.* The interaction will induce the care providers "to maintain or even enhance quality." *Id.*

23. See Robin Elizabeth Margolis, *Dentists and Physicians Wiggling Out of National Practitioners' Data Bank?*, 10 *HEALTHSPAN* 25, 25 (1993).

24. See Emanuel & Emanuel, *supra* note 1, at 156.

25. See *id.* at 166; Marc A. Rodwin, *Managed Care and Consumer Protection: What Are the Issues?*, 26 *SETON HALL L. REV.* 1007, 1018 (1996) (pointing out that although many consumers prefer traditional insurance to managed care, "employers and third-party payers often do not offer it or make it affordable").

26. See Rodwin, *supra* note 25, at 1014 (arguing that this may lead to "shoddy treatment" by the managed care organization).

27. See Emanuel & Emanuel, *supra* note 1, at 156; see also Miller, *supra* note 7, at 126.

28. See Miller, *supra* note 7, at 126.



less about how much a provider's services cost because they will receive services as long as they pay their insurers' monthly premiums.<sup>29</sup> Insurers will bear the burden of contracting with the best physicians, and physicians will be compromised by the need to contract with insurers to maintain patient pools.<sup>30</sup>

The patients' ability to assess the quality of the physicians that contract with their insurers, however, will continue.<sup>31</sup> As a result, any deficiency in the provider information will impair a patient's ability to make an informed choice about the physicians available within any given health plan.<sup>32</sup> But if the supply and demand theory is a real component in the evolving health care delivery system, as some analysts believe, insurer competition and physician competition should weed out physicians that consumers presumably do not want, and the remaining "stable" of physicians should all be desirable providers.<sup>33</sup> Thus, the appreciable difference among providers should diminish, and the value of provider-specific data should also decline.

### C. Physician Privacy v. Patient Autonomy: The Delicate Balance

In opposition to the patient-consumer interest in personal provider information is the privacy interest of the physician.<sup>34</sup> The very fact that individual profiles of all physicians licensed in the United States are maintained by the federal government, but have not been accessible to the public at large for the past decade, suggests that valid reasons exist for controlling the amount and form of information the public receives about providers.<sup>35</sup> Much of the information

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29. See *id.*

30. See Emanuel & Emanuel, *supra* note 1, at 156.

31. See Miller, *supra* note 7, at 126.

32. See Sharrott, *supra* note 8, at 122 (citing usefulness of "timely, accurate, understandable and well-presented" provider-specific outcome data as a means of making more informed provider and treatment decisions).

33. See *id.* at n.22. Sharrott notes that:

Provider-specific data may also be used to detect and identify low-quality provider performance. From this the number of low quality providers may be reduced by the following methods: (1) the providers may modify and correct their procedures, practices, and skills so that their performance is enhanced to acceptable levels; (2) if uncorrectable, the provider's license to practice the procedure in question may be revoked; or (3) the low-quality provider is driven out of business by market forces.

*Id.* at 124 (emphasis added) (citations omitted). See John D. Butler, GM's View on Purchasing High-Quality Providers, 61 HOSP. 90 (1987) ("In the old market of few providers and minimal competition, most providers could be confident of their survival. In the new market, no such assurances exist.").

34. See Bobinski, *supra* note 8, at 291.

35. See Stephen S. Entman et al., The Relationship Between Malpractice Claims History and Subsequent Obstetric Care, 272 JAMA 1588, 1591 (1994); see also Fitzhugh Mulvan et al., The National Practitioner Data Bank: Report From the First Year, 268 JAMA 73, 78-79 (1992).

that is becoming available as the result of state legislation<sup>36</sup> is already public information available to curious patients.<sup>37</sup> However, the information that is available may be difficult for the lay person to discover<sup>38</sup> and thus some consumer advocates believe government compilation is not only beneficial but also necessary for enhancing the regulation of the medical profession.<sup>39</sup> A problem arises, however, when information is summarized or reduced to statistics; brevity then gives way to accuracy.

For example, in the April 1997 Florida Report on Physician Discipline and Malpractice, the Agency for Health Care Administration disclosed select information about closed medical malpractice claims.<sup>40</sup> Though the preface for the information, in chart form, explains that a malpractice suit or payment of a malpractice claim “does not necessarily mean a doctor is unsafe,”<sup>41</sup> the chart categorizes injuries into nine levels of severity.<sup>42</sup> The chart also designates the point in the legal process at which the claim was resolved.<sup>43</sup> Though a useful means of summarizing the information, the explanation of the designations chosen is less than exact. For instance, under the explanation of the “stage legal” classifications, the Florida Health Care Report reads:

STAGE LEGAL[:] Indicates at what point in the legal process the claim was resolved. Most medical malpractice claims settle before going to trial. If a claim is settled for nuisance value, this is probably more likely to happen early in the process, since this is when the insurer can save the most money in defense costs. Of course some significant cases settle early when the malpractice liability is very clear and the defendant and the insurer have little likelihood of successfully defending the suit. The later in the legal process the

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36. See *supra* note 2 and accompanying text; see also FLA. STAT. § 455.247 (1997); Miller, *supra* note 7, at 126 (citing MASS. GEN. LAWS ch. 112, § 5 (1997)).

37. See Consumer Access, *supra* note 2, at 1 (citing Mass. HB 5662 (1996) as providing data “that routinely is not available such as out-of-court settlements or the names of physicians whose hospital privileges have been revoked or restricted”). Though Massachusetts provides final decisions of hospital disciplinary bodies, pre-decision proceedings are confidential. See MASS. GEN. LAWS ch. 111, §§ 111, 204 (1997).

38. Much of the information is made public through court files, administrative hearings, and perhaps even licensing records. The average consumer may not have the general knowledge of the various agencies and courts to know where to look for the information or may not have ability to locate the data once there. Searching jury verdicts and court records can be a daunting task for someone unfamiliar with the legal system. Undoubtedly, other agency records would be equally as challenging to search for useful information.

39. See Miller, *supra* note 7, at 135.

40. See AGENCY FOR HEALTH CARE ADMIN., FLORIDA REPORT ON PHYSICIAN DISCIPLINE AND MALPRACTICE 167-90 (1997) [hereinafter FLORIDA HEALTH CARE REPORT] (stating that closed medical malpractice claims constitute claims that have been resolved either in court or through a settlement).

41. *Id.* at 167.

42. See *id.* at 170.

43. See *id.*

claim is settled, the more likely that the issues of fact or the law were closely contested.<sup>44</sup>

One can only guess what the average reader could draw from this explanation. An individual with a good grasp of the legal system or the insurance industry may understand that the point at which a case settles or closes may have little, if any, correlation to the merits of the case—especially in a state like Florida where medical malpractice insurers can settle claims without the consent of their clients.<sup>45</sup> A lay person may assume that the earlier the resolution, the worse the case must have been.<sup>46</sup> An astute reader of the Florida Health Care Report may, however, recognize that the stage level may be a useful indicator of how particular insurers handle claims, but not at all informative as to the potential level of care available.<sup>47</sup>

One school of thought takes the position that the mere existence of malpractice claims is a valuable indication of the quality of the doctor-patient relationship, and thus his ability to care for patients.<sup>48</sup> The correlation of prior claims with subsequent claims and changes in care has been the focus of several empirical studies.<sup>49</sup> Studies focusing on Florida physicians indicate “that even a single malpractice claim has predictive value as a harbinger of subsequent claims”<sup>50</sup> and thus would more fully inform the patient-consumer seeking a physician for future treatment. The researchers performing the Florida study concluded that previous claims, regardless of whether they resulted in a payment or not, were indicative of physicians with troubled relationships with their patients.<sup>51</sup> If these studies are accurate

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44. *Id.* at 169.

45. See Scott S. Thomas, *An Insurer's Right to Settle Versus Its Duty to Defend Non-meritorious Medical Malpractice Claims*, 16 *J. LEGAL MED.* 545, 550-55 (1995).

46. This is a real danger despite the language in the report indicating that both nuisance claims and significant claims often are settled early in the legal process. See *FLORIDA HEALTH CARE REPORT*, *supra* note 40, at 169-70.

47. For example, according to the report one physician faced three malpractice claims, each resulting from a death (severity code nine) and each resolved at legal stage four (“more than 90 days after suit filed and prior to or during the course of mandatory settlement”). The insurance policy limit was \$1 million. In 1991 the first claim was resolved for \$30,000, in April 1994 another claim was resolved for \$1 million, and in September 1995 the final claim was resolved for \$25,000. See *FLORIDA HEALTH CARE REPORT*, *supra* note 40, at 171. With identical outcomes and resolutions at the same stage, there is no way to determine the reason for the discrepancy in the indemnification. One might question the usefulness of this information, or at least this format, if the ultimate goal is to enhance a patient's knowledge about a particular physician so that the patient can make a more informed physician choice. In its current form, the only fact that a reader can determine is the amount of insurance this particular physician carries.

48. See Randall R. Bovjberg & Kenneth R. Petronis, *The Relationship Between Physicians' Malpractice Claims History and Later Claims: Does the Past Predict the Future?*, 272 *JAMA* 1421, 1425 (1994); Entman, *supra* note 35.

49. See Miller, *supra* note 7, at 127; see also Bovjberg & Petronis, *supra* note 48, at 1430.

50. Miller, *supra* note 7, at 127.

51. See Bovjberg & Petronis, *supra* note 48, at 1425.

in assessing the value of knowing prior claims, the question remains how much a consumer needs to know about the claim. It would appear that consumers would benefit from simply knowing of a previously filed case against a physician if prior claims are true indicators that a particular physician has poor interpersonal communication skills that affect quality of care.<sup>52</sup> However, simply revealing that a physician has had a claim filed against him or her does not mean that the claim was meritorious or that there was any malpractice.

#### D. Disclosure—The Nonfinancial Costs

Disclosure of prior claims is accompanied by significant costs such as unjust harm to the physician's reputation and consumer misreliance.<sup>53</sup> Inaccurate or complex data does not enhance consent, it merely muddies the waters of consumer choice. For example, the consumer who receives data revealing a prior malpractice claim filed against a given physician could accept that information as indicative of a low-quality provider. If, however, the claim never progressed past filing because it had no merit, the information could easily tarnish the physician's reputation. The consumer could be harmed in this scenario by possibly disregarding a provider who may be the best in the field, thereby compromising the quality of the treatment received, or by choosing another provider who is incompetent but has escaped claims for whatever reason. Though some commentators strongly disagree that harm to a physician's reputation and consumer misreliance are justifiable reasons for stifling provider-specific data,<sup>54</sup> it is essential to recognize that informed consent is only facili-

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52. Emphasis should, however, remain on quality of care rather than merely incompatible personas that lead to the filing of claims. See Entman, *supra* note 35, at 1588 (noting that the relationship between previously filed claims and future standard care may be valuable, but warning that "if the frequently sued physician does not practice standard medicine, but has, for example, poor interpersonal skills that promote claims, then the deterrent effect of the tort system may be targeting physicians because of their personalities and not the technical care they provide" (citations omitted)).

53. See Sharrott, *supra* note 8, at 126-31.

54. See *id.* (discounting the threat of unjust reputational harm by arguing: (1) that the only harm of "incorrect" provider choice based on publicly disclosed data is an economic loss that does not warrant a continued nondisclosure policy; (2) that physicians concerned with data complexity should contribute to making the data easier to comprehend rather than complaining of reputational harm that may be caused by inexact information; (3) that output data does not need to be complex, but rather can be simplified to provide a comparison of providers to the "average" or a ranking that is within the comprehension of the general public; and (4) that the very idea of withholding information is paternalistic and is contrary to public policy favoring government disclosure).

Sharrott admits that risk factors adversely affect the accuracy of provider statistics, but concludes that:

the data will always indicate that some providers are worse or better than they actually are, and in this sense, will always be unfair, either to the physician or the consumer. But is there a superior alternative? The haphazard qualitative

tated by the compilation and disclosure of accurate and comprehensive information.<sup>55</sup>

### E. Procedure Specific Data Disclosure

Another dimension of the informed consent issues associated with physician-specific information is the disclosure of procedure-specific data. Those who encourage access to such information claim procedure- or treatment-specific data will allow patients to assess the quality of care of a given physician (or even a facility) and also allow a consumer to determine whether a physician has sufficient experience with a specific treatment.<sup>56</sup> For instance, in the early 1990s the New York State Department of Health published a unique ranking of New York physicians based on open-heart-surgery-related mortality rates.<sup>57</sup> The rankings were reportedly risk-adjusted to more adequately rank the surgeons.<sup>58</sup> By reporting the number of surgeries performed, and the corresponding mortality rate, a patient-consumer could determine whether a particular physician performed a sufficient number of procedures with acceptable outcomes.<sup>59</sup>

The accuracy of such risk-adjusted statistics poses the most significant concern. The baseline problem with the medical profession, as well as the legal profession, is that the variables that must be calculated when providing treatment are infinite—as are the outcomes. If physicians face the possibility of being published and compared in rankings whenever they accept patients, there is a real risk that the rankings will result in greater defensive medicine and a decrease in the number of physicians willing to pioneer new techniques or to accept high-risk patients.<sup>60</sup> Outcome-specific provider data will only enhance informed consent if those who have the information are able

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methods now used by patients to select providers are just as unfair to both physicians and patients.

Id. at 130 (citations omitted).

55. Sharrott suggests that providers who are subject to a reasonableness standard in terms of preventing harm to their patients caused by medical malpractice should not demand perfection but merely reasonably accurate provider data. See *id.* This argument has limited appeal, especially to the physician who suffers a loss due to poor data representations.

56. See *id.* at 89.

57. See *id.*

58. See *id.* at nn.10-11. Risk adjustment theoretically permits physicians performing similar procedures to be compared equally by factoring out patient pre-treatment conditions such as degree of sickness or age. See *id.*

59. See *id.* at 88.

60. See *id.* at 94 (“There may be an increase in defensive medicine by providers, taking the form of an increased reluctance by providers to treat high-risk patients.” (citing Joyce A. Lanning & Stephen J. O’Connor, *The Health Care Quality Quagmire: Some Signposts*, 35 *HOSP. & HEALTH SERVICES ADMIN.* 39 (1990), and “criticizing HCFA’s attempt to provide consumers with a provider performance ‘scorecard’ since its punitive approach is more likely to result in greater defensive medicine and not better health outcomes”).

to rely on the data to make better choices. If the data fails to accurately account for severity and risk, or is statistically skewed, the rankings may misrepresent that one physician is “better” than another. The value of the data to the consumer would then be outweighed by the physician’s privacy interests and the community’s interest in preserving the health care options available.

#### F. Fiduciary Obligations

The degree to which a physician has a legal obligation to disclose information has been addressed by various courts across the nation. In *Moore v. Regents of the University of California*,<sup>61</sup> the California Supreme Court treated a physician’s failure to adequately disclose information as a breach of fiduciary duty, giving rise to the patient’s legal right to receive at least some personal information about his treating physician.<sup>62</sup> One year later, in *Hidding v. Williams*,<sup>63</sup> a Louisiana appellate court expanded that state’s Uniform Consent Statute<sup>64</sup> to include liability when a physician failed to disclose his chronic alcoholism.<sup>65</sup> The unifying theme in these decisions is that the physician has a fiduciary duty to reveal anything that could affect a patient’s decision about treatment. Though *Moore* and *Hidding* deal with the disclosure of information about conditions that may severely affect the judgment of the treating physicians, requiring a more extensive, “blanketing” form of disclosure as a legal duty has inherent flaws. The fact that the standard for informed consent varies from state to state demonstrates the most essential problem—there is no clear consensus. Who should decide what information will truly increase patient autonomy, and what information will infringe on a physician’s privacy rights (or possibly hindering much needed treatment for the patient) remains highly debatable.

In *Moore*, the patient received treatment for hairy-cell leukemia.<sup>66</sup> The bodily fluids that were removed from the patient’s body during the course of his treatment had significant financial value as research material and ultimately as a cell-line created from the patient’s T-lymphocytes.<sup>67</sup> The court concluded that the patient had a legally protected interest in being informed about his treatment which the physician violated by failing to disclose the “extent of his research and economic interests in *Moore*’s cells before obtaining consent to the medical procedures by which the cells were ex-

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61. 793 P.2d 479 (Cal. 1990).

62. See *id.* at 483.

63. 578 So. 2d 1192 (La. Ct. App. 1991).

64. LA. REV. STAT. ANN. § 1299.40 (West 1997).

65. See *Hidding*, 578 So. 2d at 1196-97.

66. See *Moore*, 793 P.2d at 480.

67. See *id.* at 481.

tracted.”<sup>68</sup> After finding that informed consent extended beyond the disclosure of medical risks to include the failure to reveal a personal interest in the outcome, the court continued, “The scope of the physician’s communication to the patient must be measured by the patient’s need, and that need is whatever information is material to the decision.”<sup>69</sup> The rationale of the court focused on a patient’s right to be free of concerns that a physician’s judgment or skill could be clouded by economic interests or incentives.<sup>70</sup> Thus, the standard for disclosure in California requires a physician to disclose any health-related or extraneous interests that a reasonable patient would want to know prior to consenting to treatment.<sup>71</sup>

If a physician truly has a fiduciary duty to reveal all information that may be material to the patient, the current swell of disclosure legislation and the accompanying expenditures necessary to implement such programs raise additional questions. The first is whether states must necessarily become involved if physicians already have a duty to disclose.<sup>72</sup> Second, if state agencies compile and publish information, does that constitute notice sufficient to relieve a physician of the duty to disclose?<sup>73</sup> If so, a real possibility exists that patients will be even less informed because not everyone will access the public information available.

A comparison of the Hidding case and legislation recently enacted in Florida provides a good example of this conundrum.<sup>74</sup> In Hidding, a patient brought a malpractice action alleging that the physician failed to completely explain the risk of loss entailed in “loss of function of body organs.”<sup>75</sup> The court stated that the law of Louisiana required a physician “to advise a patient of any material consequence that would influence the decision of a reasonable person in the patient’s condition.”<sup>76</sup> The physician failed to disclose his chronic alcohol abuse, which the court determined vitiated the consent given by the patient “[b]ecause this condition create[d] a material risk associated with the surgeon’s ability to perform, which if disclosed would have obliged the patient to have elected another course of treatment.”<sup>77</sup> Subsequently, the Louisiana State Board of Medical Exam-

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68. *Id.* at 480.

69. *Id.* at 483 (quoting *Cobbs v. Grang*, 502 P.2d 1, 11 (Cal. 1972)).

70. *See id.* at 480.

71. *See id.* at 497.

72. *See generally id.* (discussing physicians’ fiduciary duty and the duty to disclose); *Hidding v. Williams*, 578 So. 2d 1192 (La. Ct. App. 1991) (discussing same).

73. *See Sharrott*, *supra* note 8, at 94 (suggesting that publishing data in the public record could satisfy disclosure requirements in the scope of informed consent).

74. *See Hidding*, 578 So. 2d at 1192; FLA. STAT. § 455.565-.5651 (1997).

75. *Hidding*, 578 So. 2d at 1196.

76. *Id.* at 1195 (emphasis added).

77. *Id.* at 1196; *see also Emanuel & Emanuel*, *supra* note 1, at 158.

iners suspended the physician's license for reasons related to his alcoholism.<sup>78</sup>

In 1997 Florida Senator Ginny Brown-Waite<sup>79</sup> introduced legislation to make information regarding physicians more accessible to health care consumers in a profile form by 1999.<sup>80</sup> The Brown-Waite Act does not require a physician, like the physician in Hidding, to reveal his or her alcoholism unless a criminal conviction or a disciplinary action related to the addiction had occurred.<sup>81</sup> The question is whether the legislation's exclusion of alcohol or drug dependency reflects on the materiality of that information. If the Legislature excluded the information because it is not considered valuable in a consumer's assessment of a potential physician, then is it logical for a court to impose a duty upon the physician to reveal such an addiction in the scope of informed consent? The omission of information relating to substance abuse or other character traits that have the potential to affect a physician's judgment may give those reading the physician profile a false sense of security. On the other hand, absent any criminal or disciplinary history, no foundation exists for concluding that such abuses are necessarily a threat to patients.

If informed consent is the justification for publishing physician profiles, the lines distinguishing a physician's fiduciary-like obligations to disclose material information, and the extent to which publication is sufficient notice for consent, need to be clarified. If a physician already has a legal duty to disclose, the investment of additional time and resources to compile already public information into a more manageable format for consumers may be a poor appropriation of public funds—the proverbial fleecing of taxpayers.

### III. ACCOUNTABILITY DOCTRINES

Informed consent is a legal mechanism that regulates physician behavior and makes doctors more accountable. Civil litigation, however, is not the only method for enforcing standards of care and ensuring that physicians abide by the social rules and scientific boundaries recognized by the general populous and the medical community. Any consumer can initiate a complaint against a physician, commencing an investigatory process into the alleged deviant behavior by filing a complaint with the Agency for Health Care Administration.<sup>82</sup> At times this may be the most effective means of holding physicians accountable; however, one recent evaluation of

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78. See Hidding, 578 So. 2d at 1196-97.

79. Repub., Brooksville.

80. See Fla. CS for SB 648 (1997) (codified at FLA. STAT. § 455.565-.5651 (1997)).

81. See *id.*

82. "Deviant" may mean the physician deviated from acceptable standards or is deviant in terms of misconduct.



the complaint process in Florida suggests that professional paternalism in the peer review process, combined with the internal administration of professional discipline, disadvantages the consumer who is forced to rely upon state agencies and boards to hold physicians accountable.<sup>83</sup> Thus, holding physicians accountable through means other than civil litigation may be achieved through increasing consumer access to physician information.

Some in the medical community believe that as managed care plans flood the health care scene, the present standard for accountability will be significantly altered.<sup>84</sup> For example, some believe that the professional model,<sup>85</sup> in which physicians self-regulate through their professional organizations and review boards, will be usurped by a model in which medical care is considered a commodity and patients are the consumers.<sup>86</sup> Viable alternatives to the professional model of accountability are the economic model<sup>87</sup> and the political model.<sup>88</sup> Accurate physician profiles are most effective in the economic model; consumers can then express their discontent by changing providers as a means of optimizing cost and quality.<sup>89</sup> In the political model, accountability is accomplished by consumer "voice votes" in public forums.<sup>90</sup> As medicine becomes more of a mar-

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83. Critics of the Board of Medicine peer review panels suggest that the Board is more interested in preserving its medical fraternity than ensuring the quality of care administered by the state's physicians. See Alan Judd, *Disciplining Doctors: Board Seems Inclined to Defend Physicians*, LAKELAND LEDGER, July 6, 1997, at A1.

84. See Emanuel & Emanuel, *supra* note 1, at 147. Accountability is the process by which a party justifies its actions and policies. Components of accountability include parties being held or holding others accountable, assessing domains and content areas, and procedures of evaluation. See *id.*

85. See *id.* at 152-53. In the professional model, health care is considered a professional service where, "Because the physician is primarily dedicated to the patient's well-being, the patient can be a trusting recipient of the physician's care, rather than a wary consumer in the marketplace." *Id.* at 153. Accountability in this model focuses primarily on physician competence and legal and ethical conduct. See *id.*

86. See *id.* at 156.

87. See *id.* In the economic model, "patients should be viewed as consumers who are shopping among managed care organizations for what they perceive to be the best combination of price and quality that satisfies their preferences . . . . [H]ealth care is properly viewed as a commodity; it is subject to supply and demand based upon price and perceived quality." *Id.*; see also discussion *infra* Part IV.

88. See Emmanuel & Emmanuel, *supra* note 1, at 158. In the political model, health care is a community service rather than a market commodity. Patients and physicians are part of the health system, as opposed to the economic model where patients are consumers and physicians are essentially the goods. See *id.*

89. See *id.*

90. See *id.* (citing A. HIRSCHIMAN, *EXIT, VOICE, AND LOYALTY: RESPONSES TO DECLINES IN FIRMS, ORGANIZATIONS, AND STATES* (Harvard Univ. Press 1970)); Rodwin, *supra* note 25, at 1013-14.

ket good, physician profiles could become the equivalent of nutritional labels for doctors.<sup>91</sup>

Accountability as a justification for the publication of provider-specific information emphasizes an aspect of disclosure that both correlates with and contradicts the informed consent rationale. The two doctrines correlate to the extent that making information available to the public makes physician conduct and character more visible. However, publication as a means of increasing the accountability of providers, as well as managed care plans, relies on the patient-consumer actively seeking information and then processing and relying on that data to make choices about providers and plans. Only if the patient-consumer uses the data to choose the providers that deliver the best quality of care for the best price, will providers then become accountable for the conduct that may be reflected in a physician profile.

For example, in the traditional model—the professional model—of accountability, physicians go about their business and, for the most part, only have to answer to their peers or a discontented patient that files a claim in court.<sup>92</sup> As recent exposés on peer review boards suggest, consumers are increasingly skeptical of intra-professional standards for accountability.<sup>93</sup> Presently, a lay perception exists that

91. The weakness of this analogy is in the idea that data could simply be printed out, like a nutrition label, and the health care customer would know what he or she was buying in a physician. See Emanuel & Emanuel, *supra* note 1, at 168.

92. See *id.* at 151-52. For a general discussion of consumer fraud legislation as another means of redressing grievances against health care providers, see Lee Ann Bundren, *State Consumer Fraud Legislation Applied to the Health Care Industry*, 16 J. LEGAL MED. 133 (1995).

93. See Judd, *supra* note 83, at A1.

“The Board of Medicine has operated for a number of years within a professional cocoon,” said Doug Cook, director of the state Agency for Health Care Administration, which prosecutes cases before the board. “We’ve tried to bring more aggressive consumer representation, and we’ve begun to sensitize the board.” But he said: “In many cases, it is the ‘distinguished professional’ versus the aggrieved consumer. And it is the ‘distinguished professional’ who prevails.”

The three-part exposé by Alan Judd was accompanied by a reader’s poll that discusses the skepticism of the average consumer as well as the potentially irrational reliance a consumer may place on accessible data that could be misinterpreted. The poll posed this question: “Do you think patients should have access to records of investigations or complaints against doctors?” Of 40 respondents, 95% said yes and 5% said no. The responses speak for themselves:

Yes, the American Medical Association is a corrupt organization . . . Yes, they say that only doctors can bury their mistakes . . . Yes, the doctor has my life in his hands . . . Yes, doctors have been killing patients for way too long. It is about time someone watches these people . . . Yes, doctors always protect their own . . . Yes, there are way too many incompetent doctors that are only motivated by greed . . . Yes, doctors think they are God. Nay, complaints that have resulted in disciplinary action should be open to the public . . . Yes, and we should have a better balanced committee. This committee of all doctors is ridiculous . . . Yes, the medical industry is protecting killers . . . Yes, the patient should know a physician’s professional history. The patient pays for quality

peer review is shrouded in secrecy<sup>94</sup> which enables the physicians to escape accountability at a cost to the consumer who must rely on the profession to regulate itself.<sup>95</sup>

Contrasting with the professional model is the economic model. In the economic model, consumers are purchasers who use physician profiles to comparison shop for providers. Relying on basic supply and demand theory, the physicians with the most desirable cost and quality will be chosen most often by consumers. Those that are selected less will be forced to either clean up their acts, if the profiles reveal criminal or disciplinary problems, or attempt to increase their quality of care, if malpractice claims are the reason they are slighted by the health care consumer.

Theoretically, all health care providers could become more accountable in terms of training and continuing involvement in health care advancements if health care consumers rely on and shop based upon the data regarding education and publication.<sup>96</sup> For instance, knowledge that a particular physician was foreign-educated rather than educated in the United States or educated in the specific state in which the patient seeks a provider could affect a patient's confidence in the type or quality of care that the physician provides. Physicians may feel the pressure to obtain the most prestigious education or to become more involved in research and publications if it becomes evident that this type of information has an impact on physician choice.

While increased emphasis on educational pursuits and continuing contribution to medical developments could increase accountability,

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care and should know, without a doubt, that it will be received . . . No, where does freedom end and slander begin? . . . No, patients, like members of the press, are not capable of determining both sides of the story. They can not make a proper assessment of a physician's actions.

Alan Judd, *Disciplining Doctors: Accused Doctors Continue to Practice*, LAKELAND LEDGER, July 8, 1997, at B1.

94. See Kathleen L. Blaner, *Physician, Heal Thyself: Because the Cure, the Health Care Quality Improvement Act, May Be Worse Than the Disease*, 37 CATH. U. L. REV. 1073, 1076 (1988) (referring to the Health Care Quality Improvement Act as Congress's attempt to "end this 'brotherhood of silence'").

95. The data used to support this premise, in criticizing both the legal and medical professions, are based on the action or discipline ultimately administered in response to consumer complaints. For example, one legal reform group claimed that for the year 1988, less than 2% of the more than 70,000 complaints levied against attorneys resulted in public discipline, 90% were dismissed, and 8% resulted in non-public action. Similarly in California in 1986, 8574 attorney complaints were received. Of those, only 192 attorneys had formal charges against them, and only 185 eventually received sanction. See Linda Morton, *Finding a Suitable Lawyer: Why Consumers Can't Always Get What They Want and What the Legal Profession Should Do About It*, 25 U.C. DAVIS L. REV. 283, 305-06 (1992). Likewise, in 1996 the Florida Board of Medicine received 8000 complaints about physicians but ultimately punished only 191. The Board dismissed 90% of the cases it reviewed (only 1800 of the 8000 were reviewed; the remainder were presumably dismissed for a complete lack of reviewable conduct.) See Judd, *supra* note 83, at A1.

96. See Miller, *supra* note 7, at 128-29.

this pressure could compromise commitment to actual practice, thereby reducing quality of care and constricting the pool of accessible providers. In terms of accountability, this is a negative consequence of increased disclosure if consumers inaccurately equate certain education or research contributions with the quality of care available from a given provider.

The linchpin to increased accountability resulting from physician profiles is the accuracy and understanding of the information.<sup>97</sup> Undoubtedly, some of the biographical data proposed in legislation such as Florida's Brown-Waite Act speaks for itself.<sup>98</sup> Disciplinary action<sup>99</sup> and information relating to liability actions or criminal convictions could easily fall prey to misinterpretation. Profiles as accountability tools will backfire if the information provided is not carefully presented to the consumers.

97. See Emanuel & Emanuel, *supra* note 1, at 151; Miller, *supra* note 7, at 130; Rodwin, *supra* note 25, at 1018; Sharrott, *supra* note 8, at 92-93.

98. See FLA. STAT. § 455.565-5651 (1997). Information such as the name of the physician's medical school and the date of graduation is easily interpreted. Currently, Florida requires practitioners to furnish the following biographical data: the name of each medical school that the applicant for licensure has attended, including the dates of attendance and the date of graduation as well as a description of all graduate medical education completed by the applicant; the name of each hospital at which the applicant has privileges; the address at which the applicant will primarily conduct his or her practice; any certification the applicant has received from a specialty board; the first year the practitioner practiced; current appointments to medical school faculty and any responsibility for graduate medical training in the previous 10 years; any criminal offense for which there was a finding of guilt whether adjudication was withheld or not (including any offense to which there was a guilty or *nolo contendere* plea—all crimes that would be a felony or a misdemeanor in Florida); and any final disciplinary action taken within the previous 10 years by the agency regulating the profession that the applicant has been licensed to practice (including resignation from or renewal of medical staff membership or the restriction of privileges at a licensed hospital, health maintenance organization, prepaid health clinic, ambulatory surgical center, or nursing home) taken in lieu of or in settlement of a pending disciplinary case related to competence or character. See *id.*

Comparatively, Massachusetts requires disclosure of the following biographical data: name; office phone numbers(s) and address(es); the nature of the practice (group practice, solo practice, hospital staff); the number of years in practice; medical license status; pre-medical and medical schools, including the years attended and the degrees awarded; post-graduate training; specialty; American Specialty Board certification, recertification, and eligibility for certification; current employment, including faculty appointments; health care facilities where the physician holds privileges; plans in which the physician is a provider; referred journal articles and book chapters; honors and awards; board or hospital disciplinary findings; criminal convictions; and malpractice summary (compared with norm for specialty). See MASS. GEN. LAWS ch. 112, § 5 (1997); see also Miller, *supra* note 7, at Appendix.

99. See Blaner, *supra* note 94, at 1095-96. Blaner argues that a report filed with the National Practitioners Data Bank:

destroys a physician's right to be presumed innocent . . . [I]t will blemish the physician's professional reputation as long as the information remains in the data bank. Because the Act requires all facilities at which a physician practices to check the data bank routinely, a physician has little hope that the medical community will forget a mistake the physician made early in his or her career.

*Id.* (citations omitted).

Much of the data contained in the existing and proposed profiles is already public information that can be attained through consumer research. While such research may be tedious and challenging for the average consumer, it is least likely to be misinterpreted in its original context. For instance, court files can be viewed by anyone requesting access, and transcriptions of disciplinary hearings are available upon request.<sup>100</sup> Consumers have the opportunity to read the facts and decide for themselves whether the physician is one from whom they wish to seek care. At a minimum, profiles that do abbreviate practitioner data on claims, discipline, and convictions should provide links and references to sources of more detailed information.

#### IV. MASSACHUSETTS PRACTICES

As of November 1996, consumers can retrieve the profiles of up to ten Massachusetts physicians per call on a toll-free phone line.<sup>101</sup> The impetus of the Massachusetts data bank was a 1994 media revelation of reported "extreme physician negligence and malfeasance"<sup>102</sup> that had been handled too leniently by the hospitals and licensing authorities charged with regulating the medical profession. Responding to public skepticism that physician self-regulation results in patient-consumer concerns yielding to physician interests, the Massachusetts Secretary of Consumer Affairs appointed an Advisory Committee on Public Disclosure of Physician Information.<sup>103</sup>

The Committee's inquiry had two premises: first, that all reliable information in the Board of Registration in Medicine's possession helpful to the public in choosing doctors should be released, unless a compelling public policy reason exists for keeping it confidential; and second, that "[j]udgments and other dispositions regarding a physician's competency which result from adversarial or due process proceedings, provide reasonably reliable information."<sup>104</sup> The Committee concluded that four types of information should be compiled in a consumer-comprehensible format and made easily accessible: factual practitioner data, medical malpractice claims history, licensing board and hospital disciplinary actions, and criminal convictions.<sup>105</sup> The means of dissemination included the above-noted toll-free request

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100. See FLORIDA HEALTH CARE REPORT, *supra* note 40, at inside front cover.

101. See State Increases Access, *supra* note 2.

102. *Id.*

103. See Miller, *supra* note 7, at 127. The Committee's objective was to determine what and in what form data in possession of the Board of Registration in Medicine would tend to equalize the patient-physician relationship, increase accountability, and allow patient-consumers to make more informed choices about their health care.

104. *Id.* (citing MASSACHUSETTS ADVISORY COMM. ON PUBLIC DISCLOSURE OF PHYSICIAN INFO., FINAL REPORT (1995)) [hereinafter MASSACHUSETTS REPORT].

105. See MASS. GEN. LAWS. ch. 112, § 5 (1997); see also Miller, *supra* note 7, at 127.

line,<sup>106</sup> posting the information on the Internet<sup>107</sup> and publication on CD-ROM to be maintained in public libraries.<sup>108</sup>

The bill initially proposed in the Massachusetts legislature called for the release of "raw outcomes data," including all complaints no matter how resolved."<sup>109</sup> After passing through both houses, the Governor vetoed the bill.<sup>110</sup> Although its initial response was adamant opposition to the release of provider data,<sup>111</sup> the Legislature's ease in passing the early version of the profile bill, the strength of the consumer skepticism of the medical profession, led to the medical community tempering its opposition and sponsoring its own compromise bill.<sup>112</sup> This compromise bill was enacted into law.<sup>113</sup>

### A. Factual Practitioner Data

The first category of information contained in the profiles is biographical data that a physician can supplement with information on "publications, awards and other honors, training and specialty certification and length of practice."<sup>114</sup> The education and medical training information consists of "basic 'positive' factual information about physician competency."<sup>115</sup> The Committee recognized that physicians often display diplomas and specialty and training certificates; however, limited consumer access to such information does not facilitate easy comparison.<sup>116</sup> As a means of enhancing patient autonomy, the

106. See *State Increases Access*, supra note 2 ("An initial barrage of 700-1000 calls a day nearly overwhelmed the system; however, by spring, calls leveled off to around 200 per day. Consumers can request up to 10 physician reports at a time, to be mailed or facsimiled the same day.")

107. See *Consumer Access*, supra note 2, at 2.

108. See Massachusetts Board of Registration in Medicine (visited April 2, 1998) <[http://www.docboard.org/ma/ma\\_home.htm](http://www.docboard.org/ma/ma_home.htm)>.

109. *State Increases Access*, supra note 2 (quoting Massachusetts Medical Society President Joseph Heyman).

110. See *id.*

111. See *Consumer Access*, supra note 2, at 2-3.

Naturally, the Massachusetts medical community is critical of the bill. Arguments against it include that malpractice data do not reflect the quality of care, as physicians who take on higher-risk care will have the highest rates of malpractice judgments; that in cases involving HMOs, physicians may not be named as defendants, while independent practitioners do not have that advantage; that insurers often urge physicians to settle, rather than engage in costly litigation; and even that erroneous information might inadvertently be published.

*Id.*

112. See Mass. HB 5662 (1996) (codified at MASS. GEN. LAWS ch. 112, § 5 (1997)). Massachusetts House Bill 5662 was signed into law by Governor William Weld on August 9, 1996. See *id.*

113. See *State Increases Access*, supra note 2.

114. See MASS. GEN. LAWS ch. 112, § 5(q) (1997); see also *Consumer Access*, supra note 2, at 3.

115. Miller, supra note 7, at 128-34.

116. See *id.* at 129.

Committee recommended that the profiles create a uniform presentation of such data so consumers can shop for physicians that have the background they find desirable.<sup>117</sup> The other categories of information, especially the method of presentation, spawned greater concern and apprehension in the medical community.<sup>118</sup>

### B. Medical Malpractice Claims History

The original bill included all complaints no matter how resolved.<sup>119</sup> The obvious problem with this proposal is that a filed claim definitively indicates little more than the fact that a patient, dissatisfied for whatever reason,<sup>120</sup> was able to find a willing attorney to initiate litigation.<sup>121</sup> Recent studies on the effects of prior claims on quality of care and malpractice suggest that the mere fact that a plaintiff files a claim may be indicative of a poor physician-patient relationship.<sup>122</sup> As such, there may be some consumer value in knowing whether prior claims were initiated against a particular provider.<sup>123</sup> However, this value should be carefully balanced against the harm that such vague reporting of claims could do to the professional reputation of the physician.<sup>124</sup> This concern may be evidenced by the fact that the Massachusetts law reveals malpractice payments classified in general categories of above average, average, and below average without disclosing the actual amounts paid.<sup>125</sup> An accompanying disclaimer warns consumers that settlements may be unrelated to the issue of professional competence.<sup>126</sup> The profile also provides statistical data for physicians in the particular field allowing for a comparison between a given physician and the percentage of those in the same field who have also paid claims.<sup>127</sup>

Though restricting the profile data to paid claims history is a vast improvement on the original profile proposal, there are some inherent problems that remain unresolved by the categorization provided for in the final bill. For example, replacing dollar amounts with broad classifications fails to adequately represent the cause of a claim. Consider two physicians with vastly different insurance policy

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117. See *id.*

118. See *State Increases Access*, *supra* note 2; see also Miller, *supra* note 7, at 127-29.

119. See *State Increases Access*, *supra* note 2.

120. Dissatisfied patients include those who have suffered malpractice and have a legitimate claim, as well as those who have suffered no injury but file a claim.

121. See *supra* note 111 (discussing problems related to malpractice data).

122. See Entman et al., *supra* note 35, at 1588.

123. See Miller, *supra* note 7, at 127.

124. See Sharrott, *supra* note 8, at 126-27 (arguing this could lead to financial loss, ruined careers, and hospital closings).

125. See MASS. GEN. LAWS ch. 112, § 5(f) (1997); see also *State Increases Access*, *supra* note 2.

126. See MASS. GEN. LAWS ch. 112, § 5(f) (1997).

127. See *State Increases Access*, *supra* note 2.

limits, doctor one at \$1 million and doctor two at \$200,000. Doctor one has a nuisance claim that his insurance company is willing to settle for \$200,000 because the complexity of the claim would result in litigation costs well in excess of that amount. Plaintiff one accepts the settlement offer. Doctor two has a claim with clear negligence, but he is only one of several defendants, and his insurance company offers to settle for the amount of the policy limit early to avoid incurring the expense of litigation. Plaintiff two accepts, knowing that the other defendants have some liability as well. Both doctors pay the same amount; the question is, how they will be classified? They could both fall into the same category because the amount paid was the same. They may fall in different categories because the payment in proportion to the amount of insurance coverage was vastly different (25% as opposed to 100%). They may also fall into different categories because the classification is based on the average amounts paid for certain types of injuries or by certain types of physicians. With so many possible grounds for determining whether a payment is considered “average,” it is unlikely that such categorization will provide accurate or truly informative data for consumers. The complexity of medical malpractice—from the physician-insurer relationship<sup>128</sup> to the actual legal issues—are barely comprehensible to the physicians themselves, not to mention the general consumer who would be using naked claims data to make provider choices.

One powerful argument in support of classified disclosure of the medical malpractice claims can be found in the results of several studies that reveal only one tenth of medical negligence results in any claim at all.<sup>129</sup> At least one well-known study, analyzing Florida practices,<sup>130</sup> found a significant correlation between past claims and the likelihood of future claims.<sup>131</sup>

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128. See *id.* (discussing hidden insurance related issues); see also Thomas, *supra* note 45, at 583 (discussing the rights of insurers, insured physicians, and the potential tension that arises when reporting requirements tarnish a physician’s reputation). The article concludes that courts have a responsibility to protect the insurers’ and physicians’ rights while protecting the rights of the patients-consumers.

129. See, e.g., Miller, *supra* note 7, at 133.

130. See Bovjberg & Petronis, *supra* note 48, at 1421.

131. See *id.* at 1423; but see Entman et al., *supra* note 35, at 1588.

Conclusions.-No relationship was found between prior malpractice claims experience and the technical quality of practice by Florida obstetricians. Strategies that attempt to identify physicians at risk for future clinical errors by using data on prior malpractice claims (such as the National Practitioner Data Bank) may be misjudging the likelihood that substandard clinical care will be provided by physicians with prior claims.



### 1. The Bovjberg and Petronis Study

The Bovjberg and Petronis study analyzed the effect of negative claim history on future decisions by physicians,<sup>132</sup> the likelihood of disciplinary action against physicians with bad claims,<sup>133</sup> and the relationship between claims and the actual quality of care given by physicians with negative claim history.<sup>134</sup> The data sources for the study were the Florida Medical Professional Liability Insurance Claims file<sup>135</sup> and the American Medical Association's Physician Masterfile.<sup>136</sup> The researchers made several conclusions with implications concerning the accuracy and usefulness of prior claims history, some of which would support the profiles<sup>137</sup> and some of which reveal the potential flaws of such disclosure.<sup>138</sup>

As an initial matter, the researchers noted that malpractice claims on the whole are "relatively rare in the life of a physician, even in Florida, a very litigious state."<sup>139</sup> Of the 8247 physicians included in the study 59.2% faced non-consequential claims (that is, where the claimant never made a demand for payment or the insurer never expended funds for investigation or litigation) during the nine-year focus period for the study.<sup>140</sup> Of the remaining physicians, 13.4% had a single paid claim,<sup>141</sup> 7.2% had multiple paid claims, and 20.2% faced no claims at all.<sup>142</sup> Physicians facing no claims, as opposed to non-consequential claims, declined during the study period causing the researchers to speculate that either incident reporting increased in accuracy or patients became more litigious.<sup>143</sup> The litigiousness conclusion was cited as the best explanation for another finding—a rise in the number of claims per physician, per year.<sup>144</sup>

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132. See Bovjberg & Petronis, *supra* note 48, at 1421.

133. See *id.*

134. See *id.*

135. See *id.* at 1422. The Florida Medical Professional Liability Insurance Claims file is a state-maintained archive with information on all medical liability claims closed in Florida. This file is the compilation of data submitted, by law, by all Florida insurers and self-insurers concerning all claims filed, regardless of whether any payment was demanded or paid. The file, however, excludes physicians who have had no claims filed against them. See *id.*

136. This file contains "descriptive and demographic information about all physicians" and includes data on physicians without a claims history. *Id.*

137. See *id.* at 1425.

138. See *id.* at 1421.

139. *Id.* at 1424.

140. See *id.* The study examined claims from 1975-1983.

141. See *id.* at 1425.

142. See *id.*

143. See *id.*

144. See *id.* A physician-year is a full calendar year in which a physician practices and is exposed to potential claims of malpractice.

Though Massachusetts aborted its initial plan to disclose all claims filed,<sup>145</sup> this data is instructive as to the misrepresentation caused by such disclosure. If the physicians in the Bovjberg and Petronis study were subject to the disclosure standards first issued in Massachusetts, only 20.2% of the physicians would have escaped publication of a claims history despite the fact that 79.4% of the physicians faced only non-consequential claims, or faced no claims at all.<sup>146</sup> Even if the mere filing of a claim has some consumer value, it seems difficult to justify tarnishing a physician's professional reputation by disclosing claims that never involved demands or expenditure of funds by the physician's insurer.

The study also concluded that there is predictive power in malpractice claims.<sup>147</sup> Regardless of size or frequency of prior claims, "having any baseline claims at all puts a physician at substantially higher risk of having subsequent claims of all categories."<sup>148</sup> This should not, however, alter the above conclusion that disclosure of non-consequential claims is more harmful than helpful to the general consumer. Non-consequential claims are not reliable indicators of poor quality of care or poor physician-patient relationships.<sup>149</sup> In fact, non-consequential claims, if they have any informative value, are only indicative of the increasing litigiousness of patients.<sup>150</sup> Though some advocates steadfastly believe any information is better than no information,<sup>151</sup> the medical field is one of such complexity that states should proceed cautiously in allowing consumers to place value on claims that neither the courts, nor insurers, would give credence.

The third segment of the study focused on the usefulness of prior claims given the determined predictive power of claim history.<sup>152</sup> Interestingly, this analysis never mentions the potential use of such information by patient-consumers. Rather, the study emphasized the potential use for insurers and as a means for "quality monitoring"<sup>153</sup> by peer review boards. There are two plausible explanations for excluding consumer interests. The first is the timing of the study. The Bovjberg and Petronis results were published in 1994, two years

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145. See Miller, *supra* note 7, at 133-34; State Increases Access, *supra* note 2.

146. Massachusetts' original, but not enacted, standard was the publication of any physician with any claims history, so only 20.2% of the physicians in the Florida study would have fit the no-claim requirement even though an additional 59.2% had claims which fell in the non-consequential claims category. See Bovjberg & Petronis, *supra* note 48, at 1425.

147. See Bovjberg & Petronis, *supra* note 48, at 1425.

148. *Id.*

149. See *id.*

150. See *id.*

151. See, e.g., Miller, *supra* note 7, at 133.

152. See Bovjberg & Petronis, *supra* note 48, at 1425.

153. *Id.* The study concedes that the "use of claims history [by patients] is more controversial." *Id.*

prior to the onslaught of consumer-driven legislation to publish such information. Second, the questions that seemed to be the impetus for the study itself stemmed from the value of the National Practitioner Data Bank,<sup>154</sup> a source unavailable to the public at large, as a gauge for medical quality and future problems.<sup>155</sup>

Bovjberg and Petronis concluded that claims history is a useful tool for medical malpractice insurers as a means for experience rating potential insureds and as a basis for determining insurability.<sup>156</sup> This is not a problematic conclusion in terms of physician profiles because the issues involved in disclosing to an insurer that will ultimately provide coverage are vastly different than the issues involved in disclosing to a consumer who has little concept of the triangular relationship between physicians, their insurers, and patients-consumers. The researchers ultimately concluded that:

this analysis does not address the dollar cost of reporting compliance, nor does it seek to look behind the bald fact of claims outcomes to any estimate of true merit. Claims history is not a measure of technical medical competence and is certainly no measure of the value of a physician to society. However, it does indicate a measurable cost—the fiscal and emotional costs of resolving the malpractice claim. The predictive information inherent in claims, even small claims, could be used to reduce these costs.<sup>157</sup>

The conclusions about the use of claims history to regulate the medical profession are more directly related to the issues, especially the accountability issues, raised by provider-specific data disclosure legislation.<sup>158</sup> As suggested above, prior claims predict health-care-related costs which, as with all products, will eventually be passed on to the health care consumer.<sup>159</sup> Publication, however, is not the best means for reducing or eliminating these costs. Better regulation within the profession and changes in the legal approach to malpractice claims would be more effective, as they would treat the problem at the source.

### C. Licensing Board and Hospital Disciplinary Actions

The third category of information the Massachusetts Advisory Committee deemed appropriate for profile disclosure is disciplinary actions against physicians.<sup>160</sup> As opposed to the above discussion in which prior malpractice claims histories were analyzed as indicators

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154. See discussion *infra* Part V.C.1.

155. See generally Blaner, *supra* note 94.

156. See Bovjberg & Petronis, *supra* note 48, at 1425.

157. *Id.* at 1426.

158. See *supra* Part III.

159. See Bovjberg & Petronis, *supra* note 48, at 1426.

160. See Miller, *supra* note 7, at 131; see also MASS. GEN. LAWS ch. 112, § 5 (1997).

of potential problems that could eventually lead to medical board action, the types of data disclosed within this category are final decisions that affect a physician's ability to practice. While some believe prior claims can be used to forewarn consumers that a physician may not deliver the quality of care desired,<sup>161</sup> board action would seem to be the most valuable type of information available. After all, disciplinary action is usually administered by a physician's peers,<sup>162</sup> individuals with the specialized knowledge of the practices and procedures within a given field. Malpractice claims, however, involve patients, insurers, lawyers, and jurors who are likely to know nothing about medicine but are nonetheless placed in a position to evaluate a physician's behavior. Certainly, if one believes prior claims history is valuable to the consumer, disciplinary action would be invaluable in physician selection.

As with claims histories, however, the disclosure of licensing board and hospital disciplinary action is wrought with problems. Disclosure of licensing board decisions, which are generally a matter of public record, is not as problematic as is the process by which such discipline is handed down.<sup>163</sup> The public attention in Massachusetts, which spawned the legislative drive to publish information<sup>164</sup> in an effort to make peer reviews more accountable, certainly suggests that, if anything, licensing boards are too lenient.

### 1. Regulation and the National Practitioner Data Bank

Some background on the National Practitioner Data Bank (NPDB) is helpful in understanding the role of provider data in

161. See Miller, *supra* note 7, at 127.

162. For example, in Florida, the Board of Medicine, which serves as "the state agency responsible for protecting Florida consumers from incompetent, dangerous and predatory doctors," has 15 seats, 12 of which are held by physicians. Judd, *supra* note 83, at A1.

163. Among the most disturbing factors in the administration of discipline is the length and seemingly inconsistent treatment of cases. For instance, of the cases before the Florida Board of Medicine that closed in 1996, the average time that elapsed from the filing of a consumer complaint to final resolution by the Board was 27.1 months. See *id.*

The resolution of a disciplinary complaint is a three-step process in Florida. When a complaint is lodged against a physician, the complaint is reviewed by the AHCA to determine whether the allegations, if proven, amount to an actionable violation of the standard of care within the state. Of the 1996 closed cases, this first step took 6.4 months. See Judd, *supra* note 93, at B1.

Probable cause review is the second step. Cases alleging inadequate care are turned over to medical experts for review. Those cases involving substandard care and cases involving physician misconduct are then reviewed by a probable cause panel charged with determining whether formal charges should be brought against a physician. This phase took an average of 9.5 months. See *id.*

If the probable cause panel finds a violation, the AHCA files formal charges against the physician. The Board of Medicine then takes the case and makes a final determination of disciplinary action against the physician. This step averaged 11.2 months. See *id.*

164. See *supra* text accompanying notes 101-13.

“quality monitoring” or professional regulation of physicians.<sup>165</sup> The NPDB is the product of the Health Care Quality Improvement Act of 1986 (HCQIA),<sup>166</sup> federal legislation that sought to insulate peer review from legal intrusions.<sup>167</sup> The NPDB was created as a repository for three types of information, one of which was paid malpractice claims. To fulfill the goal of the HCQIA, the data in the NPDB “are only available to bolster peer review and the actions of licensing boards; allowance of discovery in subsequent malpractice cases was eliminated by amendment, and data are not available to the public.”<sup>168</sup> HCQIA specifically admonishes peer reviewers accessing the information that malpractice payments should not raise even a presumption that malpractice occurred simply because a claim was filed.<sup>169</sup> If such cautious language is necessary to remind a physician’s own peers that claims do not necessarily correlate with a breach of the standard of care or even undesirable quality of care, it would seem that a consumer without the specialized medical and legal knowledge would be less capable of fully appreciating the significance of such a history. Accordingly, the disclaimers aimed at consumers by both Massachusetts<sup>170</sup> and Florida<sup>171</sup> in their public profiles closely parallel the language of the HCQIA.<sup>172</sup>

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165. See Bovjberg & Petronis, *supra* note 48, at 1425.

166. 42 U.S.C. §§ 11101-11152 (1994); see also Thomas, *supra* note 45, at 563-64. The NPDB faced opposition similar to that faced by state compiled profiles, which was the concern of Congress, and which resulted in the HCQIA “weeding out incompetent and unprofessional physicians who change their practice locations after losing privileges at hospitals where the offending conduct occurred.” *Id.* at 564 (citation omitted). The medical community, via the American Medical Association, despite opposing the NPDB, lobbied for the HCQIA on the premise “that a national system of malpractice payment reporting would create a huge amount of complex and misleading information. They cited the variability in payments based on nuisance value, costs of litigation, specialty, jury sympathy to plaintiffs, and other factors.” *Id.* (citation omitted); see also Margolis, *supra* note 23, at 25 (“While the general public regarded the Data Bank as a positive initiative, it was initially viewed by health care professionals with near-panic, because they feared that its existence would encourage an onslaught of frivolous malpractice litigation against competent practitioners.”)

167. See Thomas, *supra* note 45, at 563-64.

168. Bovjberg & Petronis, *supra* note 48, at 1425.

169. See *id.*

170. VI. Malpractice Information

Some studies have shown that there is no significant correlation between malpractice history and a doctor’s competence. At the same time, the Board believes that consumers should have access to malpractice information. In these profiles, the Board has given you information about both the malpractice history of the physician’s specialty and the physician’s history of payments. The Board 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.

When considering malpractice data, please keep in mind:

\* Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares doctors

Another example from Florida helps illustrate problems that may arise with the Massachusetts legislation. One study of Florida obstetricians (Entman study) with malpractice claims histories examined the usefulness of "bad-apple" monitoring systems such as the NPDB<sup>173</sup> in identifying physicians at risk for future errors in their medical practice.<sup>174</sup> The Entman study concluded that using such data as a professional monitoring device "may be misjudging the likelihood that substandard clinical care will be provided by physicians with prior claims"<sup>175</sup> and that despite the public interest aims of the NPDB, "this study suggests its data may not reliably identify physicians likely to make errors."<sup>176</sup> The Entman study tested the hypothesis that peer review of current practice can distinguish between physicians based on their prior claims.<sup>177</sup> Using three types of tests, researchers were unable to link prior claims experience with

only to the members of their specialty, not to all doctors, in order to make individual doctor's history more meaningful.

\* This report reflects data for the last 10 years of a doctor's practice. For doctors practicing less than 10 years, the data covers their total years of practice. You should take into account how long the doctor has been in practice when considering malpractice averages.

\* 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 physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

You may wish to discuss information provided in this report, and malpractice generally, with your doctor. The Board can refer you to other articles on this subject.

Massachusetts Board of Registration, *supra* note 108.

171. See FLA. STAT. § 455.5651(4) (1997).

If information relating to a liability action is included in a practitioner's practitioner profile, the profile must also include the following statement: "Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred."

*Id.*

172. See 42 U.S.C. § 11137(d) (1994) ("In interpreting information reported under this subchapter, a payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred.")

173. Entman et al., *supra* note 35, at 1590. The study was commissioned to investigate the link between prior malpractice claims and future claims. The study focused on obstetricians practicing between 1977 and 1983 in Florida, a particularly litigious state. See *id.*

174. See *id.*

175. *Id.* at 1588.

176. *Id.* at 1591.

177. See *id.* at 1588.

the technical quality of care or current practice of the Florida physicians when reviewers were unaware of the prior history.<sup>178</sup>

## 2. The Florida Example

It does not take more than one week of practice in a law firm specializing in medical malpractice defense in the state of Florida to recognize the inequity of disciplinary action administered by the state agency charged with regulating the medical profession. The Florida Report on Physician Discipline and Malpractice, published by the Agency for Health Care Administration in April 1997,<sup>179</sup> has four sections: physician discipline,<sup>180</sup> administrative complaints,<sup>181</sup> emergency actions,<sup>182</sup> and closed medical malpractice claims.<sup>183</sup> While it would be hard to argue that accurate information in each of these categories can be anything but helpful in the move toward improving health care, allowing health care consumers to make better choices, and improving the review systems already in place, the fact remains that much of the information available is incomplete and misleading. Sections one through three of the Report disclose disciplinary action in uniform language that describes in legal terms the alleged violation.<sup>184</sup> As the Report admits, however, two physicians found guilty of very different violations may have the same description under the "Terms of Final Order" section of the Report.<sup>185</sup>

If the goal of physician profiles is to adequately inform consumers of their potential physician choices by listing generic charges and resolutions, including instances in which the physician neither ad-

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178. See *id.*

179. See FLORIDA HEALTH CARE REPORT, *supra* note 40, at title page.

180. According to the Florida Health Care Report, disciplinary charges are "based on Florida law, which identifies nearly 40 grounds on which a doctor can be disciplined." *Id.* at 5. The Florida Board of Medicine is the oversight board for all licensing and administrative procedures for medical doctors (similar boards exist for osteopaths, chiropractors, and dentists). Sanctions for violating the rules and laws regulating Florida physicians can range from assignments of continuing education and fines to license revocation. See *id.* at 5-6.

181. Administrative complaints against all health care providers in Florida are investigated by the Agency for Health Care Administration (AHCA). Administrative complaints are consumer complaints filed with the agency, which are only mere accusations that initiate investigation. These complaints are, however, public record, making them little different than a non-meritorious malpractice claim. The report lists recent complaints that have resulted in disciplinary action. See *id.* at 6.

182. Emergency actions are responses by AHCA to consumer complaints that reveal a physician may be an immediate threat to public health or safety. AHCA will issue an immediate suspension or restriction of the physician's license; meanwhile AHCA can proceed with its normal investigation or discipline. The number of emergency actions tripled in Florida from 1995 to 1996 for a total of 41 actions in 1996. See *id.* AHCA attributes the increase to Florida's "aggressive action against a very small number of unsafe physicians." *Id.* at 2.

183. See *id.* at 7.

184. See *id.* at 23.

185. See *id.*

mits nor denies the charges, they fail this goal.<sup>186</sup> A nutritional label would be deficient in its purpose if it merely stated “carbohydrates-yes, sugars-yes, caffeine-no.” Similarly, a physician profile that merely sketches the charges against a physician may sufficiently deter a consumer but the reality may be that the physician opted to pay a fine or submitted to continuing education rather than undergo further review by the Board.<sup>187</sup>

One particular case found in the emergency actions section poignantly highlights the void of information provided by the summaries used in the Report. The Report lists Dr. Ernesto Pinzon-Reyes as receiving “[e]mergency suspension of license based upon a finding of committing gross malpractice.”<sup>188</sup> This action was taken in October 1996.<sup>189</sup> On June 26, 1997, a jury acquitted Dr. Pinzon-Reyes of first-degree murder charges based on the very same set of facts that gave rise to the emergency action.<sup>190</sup> The acquittal did not prevent the Board from proceeding with disciplinary action. In fact, six months after he was acquitted, the Board of Medicine convened and voted 7-6 to allow Dr. Pinzon-Reyes to resume the practice of medicine.<sup>191</sup> In the next edition of the Report, Dr. Pinzon-Reyes will find himself listed in section one, which lists those physicians who have been disciplined by the board.

This excerpt does illustrate what little information is really conveyed in this publication. The point is not that information is bad—the point is that incomplete or misleading information is bad. Consumers are not the only concern; physicians have reputational interests that need to be preserved. If physicians know they will be misrepresented by incomplete data, the possibility exists that doctors who practice in high-risk specialties or who take on high-risk patients will either suffer from the disclosures or will withdraw from those practices.<sup>192</sup> Medicine is a field in which experimentation is sometimes the only option, and new procedures and technologies are necessary for progress.

186. See e.g., *id.* at 153-60 (listing, in chart form, the names of physicians who have complaints filed against them and the violations the physicians allegedly committed).

187. See *id.*, at 1-24; Judd, *supra* note 83, at A1; Alan Judd, *Disciplining Doctors: Secrecy Shrouds Doctor's Case*, *LAKE LAND LEDGER*, July 7, 1997, at A1; Judd, *supra* note 93, at B1.

188. *FLORIDA HEALTH CARE REPORT*, *supra* note 42, at 165.

189. See *id.*

190. See *State v. Pinzon Reyes*, No. CF 96-00666A-XX, (Fla. 10th Cir. Ct. 1997) (disposition memorandum).

191. See Paulo Lima, *Doctor Wins Back License*, *TAMPA TRIB.*, Dec. 7, 1997, at 1. The Board found Dr. Pinzon-Reyes guilty of records violations and voted to suspend his license for two years with credit for time served and a “stay” for the remaining 10 months of the suspension. He was permitted to see patients again as soon as the Board’s decision was officially filed. Dr. Pinzon-Reyes was also required to perform 100 hours of community service.

192. See Sharrott, *supra* note 8, at 94-95.



### 3. Hospital Discipline—Disclosure as a Cure All?

At the time the Committee was determining what information should be disclosed in physician profiles, a statute in Massachusetts required hospital disciplinary reviews and actions to remain essentially confidential.<sup>193</sup> The law protecting such information was implemented in an effort to insulate reviews and to encourage “full and frank” interaction.<sup>194</sup> The Committee analyzed the effectiveness of the confidentiality law and determined that it had not increased the effectiveness of intra-hospital discipline as expected.<sup>195</sup>

Relying on a 1995 report by the Inspector General of the U.S. Department of Health and Human Services, the Committee determined that a significant discrepancy existed between hospital-leveled disciplinary action and state licensing board action.<sup>196</sup> Nationwide, only one out of every eight actions taken by a state board also resulted in hospital discipline that was reported to the NPDB.<sup>197</sup> The Committee decided the confidentiality of hospital actions failed to stimulate better peer review within the hospital setting, and thus patients should have access to information regarding hospital sanctions.<sup>198</sup>

### D. Criminal Convictions

The final category of information approved by the Massachusetts Advisory Committee for profile disclosure was convictions for felonies or misdemeanors.<sup>199</sup> Such convictions are already a matter of public record and would seem to stand little chance of misinterpretation. The only anti-disclosure argument that can seriously be proffered for convictions is that certain crimes may not be relevant to medical practice or to a physician’s fitness to treat patients. This argument is generally a weak defense because all crimes derogate public order and the law. While publication may be damning, the physician-patient relationship is significantly based on trust.<sup>200</sup> Convicted physicians had their day in court and most likely were convicted by lay persons similarly situated to the consumers that may use physician

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193. See MASS. GEN. LAWS ch. 111, § § 111, 204 (1995); see also Miller, *supra* note 7, at 131. The Board of Registration in Medicine was allowed access to hospital disciplinary actions for use in the Board’s own proceedings against physicians. The current law deems final disciplinary proceedings against physicians to be public record. See MASS. GEN. LAWS ch. 112, § 5(d) (1997).

194. See *id.*

195. See Miller, *supra* note 7, at 131.

196. See *id.*

197. See *id.* Hospitals are required by statute to report any adverse decisions to the NPDB. During the first three and one-quarter years of NPDB operation, only 25% of the nation’s hospitals made reports to the Data Bank.

198. See *id.* at 131-32.

199. See MASS. GEN. LAWS ch. 112, § 5(a) (1997).

200. See Miller, *supra* note 7, at 126.

profiles. Certainly, if a jury analyzed the facts of the crime and found the physician guilty, a consumer may be similarly inclined to doubt the willingness of a provider to stay within the bounds when practicing medicine.

#### E. What Is Not in the Massachusetts Profiles and Why

Several types of information failed to pass Committee scrutiny, ironically for many of the same reasons articulated above. Malpractice claims<sup>201</sup> and criminal charges prior to final resolution are excluded because the

informational value [they] might carry is far outweighed by considerations of fairness to the accused doctor. Indeed, a patient upset about an unavoidably bad medical result might be irrationally driven to file a malpractice claim, or to press a criminal charge, with no factual justification or realistic hope of success.<sup>202</sup>

The Committee also recognized that claims without final resolution are unreliable indicators of physician quality and character.<sup>203</sup>

Physician confidentiality interests outweighed consumer interests on the issue of substance dependency, as long as the addicted physician participates in a Board of Medicine approved treatment program.<sup>204</sup> The Committee juxtaposed a physician's dependency with any other patient's right to have confidential medical records, and concluded that physicians' rights as patients eclipse consumer protection.<sup>205</sup>

Finally, provider-specific outcome data failed to make the final cut for profile disclosure in Massachusetts,<sup>206</sup> though New York<sup>207</sup> and Pennsylvania<sup>208</sup> found certain outcome data valuable for purposes of consumer evaluation. The Committee's reluctance to undertake development of an outcome database reflected its concern over when the "current outcomes measures convey sufficiently reliable information about the quality of physician performance to warrant recommending their collection by the Board or their release to the public on physician profiles."<sup>209</sup> This laudable concern was, perhaps, not properly considered when the Massachusetts Advisory Committee—as

201. See *supra* Part V.B..

202. Miller, *supra* note 7, at 134.

203. See *id.*

204. See *id.*

205. See *id.*

206. See *id.* at 135.

207. See N.Y. PUB. HEALTH LAW § 2804-b (c)(i) (McKinney 1997); see also Miller, *supra* note 7, at 134.

208. See 18 PA. CONS. STAT. § 3214 (a)–(i) (1997); see also Miller, *supra* note 7, at 134.

209. Miller, *supra* note 7, at 135.

well as the legislatures and agencies of several of the states<sup>210</sup>—contemplated consumer-oriented physician profiles.

#### V. WHAT DOES LEGISLATION LIKE THIS COST?

Several states have Internet access to physician data.<sup>211</sup> Others operate toll-free phone lines,<sup>212</sup> provide copy and facsimile service for requesting consumers,<sup>213</sup> and generate entire publications<sup>214</sup> of all intrastate data. Providing such information involves the staffing of phone lines, integration of information systems, and extensive clerical and publishing expenses. Compilation and integration of the information, and especially verification, add to the expense of profiles. These are superfluous expenditures to make data that is, for the most part, already public and available somewhere to a patient truly interested in discovering it.

In preparation for the most recent Florida measure to increase consumer access to physician data, the Florida Senate prepared a Staff Analysis and Economic Impact Statement for Senate Bill 948, Physician Profiles.<sup>215</sup> Operation and staff expenses for the toll-free hotline will result in costs of \$250,185 per year.<sup>216</sup> The legislation would require AHCA to modify investigatory and referral mechanisms with anticipated costs totaling \$5,619,700 for 1997-98 and \$6,872,669 for 1998-99 based on 18,000 provider complaints per year.<sup>217</sup> The Department of Health is anticipated to incur total costs to implement the legislation of \$1,680,396 for the 1997-99 period.<sup>218</sup>

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210. See *State Increases Access*, supra note 2.

211. Massachusetts and Arizona currently provide Internet access. See Massachusetts Board of Registration in Medicine (visited Apr. 2, 1998) <[http://www.docboard.org/ma/ma\\_home.htm](http://www.docboard.org/ma/ma_home.htm)>; Arizona State Board of Medical Examiners (visited Apr. 2, 1998) <<http://www.docboard.org/az/df/azsearch.htm>>. Florida temporarily had a site, and the Brown-Waite legislation calls for a permanent one by 1999.

212. See *State Increases Access*, supra note 2.

213. See *id.*

214. For example, Florida's Report on Physician Discipline and Malpractice is a 194-page publication available for \$10 via mail.

215. See Fla. S. Comm. on Health Care, SB 948 (1997) Staff Analysis (Mar. 18, 1997) (on file with comm.).

216. See *id.* at 13. These expenses are calculated for fiscal years 1997-98 and 1998-99.

217. See *id.* at 14. Expenses for fiscal year 1997-98 are broken down as follows: non-recurring costs of \$465,198, salaries and benefits of \$2,500,422 for 89 full-time employees, and expenses of \$2,654,080. The 1998-99 expenses are anticipated as follows: salaries and benefits of \$3,333,896, and expenses of \$3,538,773.

218. See *id.* The "fiscal impact" for 1997-99 consists of \$754,826 in costs for data verification, \$489,173 in costs for data entry, \$436,397 in expenses (including project analysts) to make the profiles accessible via the Internet. Data verification will require 17 OPS staff positions and five and one-half full-time staff positions. Data entry will require 32 OPS staff positions and two full-time positions.

## VI. CONCLUSION

It is said that knowledge is power. Certainly, there are tremendous benefits in knowing more about those who provide health care. Consent can be enhanced and providers can be held more accountable, and hopefully the quality of health can be increased. Disclosing data does not, however, automatically impart on those who read it the ability to properly apply the information to positive ends. Information about malpractice and the discipline of physicians needs to be carefully presented to benefit the consumer without inadvertently damaging the physician. Ranking and scaling the severity of injuries or misconduct fail in this regard. A simple indication that there indeed has been a malpractice claim or disciplinary action, and providing references so that the interested consumer can find thorough information on a given physician, are the best means of informing consumers without causing unnecessary harm.

Health care is a dynamic and rapidly evolving sector of society that receives a tremendous amount of attention. There is a need to enhance the information available; however, the recent disclosure legislation is a leap by lawmakers without an adequate foundation. Better agency regulation and more thorough and consistent professional standards need to be implemented to ensure positive growth in medicine. This is, after all, the information age. The information provided should be the most accurate and comprehensive available, not mere tidbits of data that may lead to greater apprehension and tension among the plethora of health care players.