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## Physician, Heal Thyself: Because the Cure, the Health Care Quality Improvement Act, May be Worse Than the Disease

Kathleen L. Blaner

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## COMMENTS

### PHYSICIAN, HEAL THYSELF: BECAUSE THE CURE, THE HEALTH CARE QUALITY IMPROVEMENT ACT, MAY BE WORSE THAN THE DISEASE<sup>1</sup>

Incompetent physicians must be identified and then must either improve their performance or be removed from practice.<sup>2</sup>

When a physician harms a patient through professional incompetence<sup>3</sup> or engages in unprofessional conduct,<sup>4</sup> a peer review group<sup>5</sup> at the facility

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1. Cf. S. GROSS, OF FOXES AND HEN HOUSES: LICENSING AND THE HEALTH PROFESSIONS 3 (1984). The author suggests that professional licensing groups cause more problems with professional licensure than they resolve or prevent. *Id.*

2. Waxman, *Medical Malpractice and Quality of Care*, 316 NEW ENG. J. MED. 943, 944 (1987).

3. See generally *Franz v. Board of Medical Quality Assurance*, 31 Cal. 3d 124, 642 P.2d 792, 181 Cal. Rptr. 732 (1982) (physician failed to adequately supervise inexperienced physician in surgery); *State Bd. of Medical Examiners v. Rogers*, 387 So. 2d 937 (Fla. 1980) (physician used inappropriate treatment for arteriosclerosis); *In re Johnston*, 99 Wash. 2d 466, 663 P.2d 457 (1983) (physician used natural remedies instead of standard medical treatment).

4. Unprofessional conduct for a physician may include: making obscene phone calls, *Ewing v. State Bd. of Medical Examiners*, 290 S.C. 89, 348 S.E.2d 361 (1986); intimidating opposition witnesses in a malpractice case, *McDonnell v. Commission on Medical Discipline*, 301 Md. 426, 483 A.2d 76 (1984); possessing unregistered submachine guns, *Raymond v. Board of Registration in Medicine*, 387 Mass. 708, 443 N.E.2d 391 (1982); sexually abusing patients, *In re Polk*, 90 N.J. 550, 449 A.2d 7 (1982); and evading taxes, *Board of Medical Examiners v. Steward*, 203 Md. 574, 102 A.2d 248 (1954).

In most cases, licensing laws permit licensure boards to take disciplinary action against a physician guilty of criminal conduct. Such licensure board action supplements any criminal charges brought by law enforcement agencies. *Withrow v. Larkin*, 421 U.S. 35, 37 (1975); *Arthurs v. Board of Registration in Medicine*, 383 Mass. 299, 418 N.E.2d 1236 (1981) (physician prescribed controlled substances for illegal purposes); *Board of Medical Examiners v. Potter*, 99 Nev. 162, 659 P.2d 868 (1983) (physician convicted of mail fraud); *Story v. State*, 721 P.2d 1020 (Wyo.) (physician abused patients sexually), *cert. denied*, 107 S. Ct. 459 (1986).

5. Traditionally, physicians use a method of self-regulation called peer review to evaluate the type and quality of care that other physicians provide to patients. The premise behind peer review is a belief that only a peer (someone with similar professional training) can effectively judge the ability of another in the same profession. When a peer review group disciplines a physician, the disciplinary action affects the physician's medical practice only at the facility the peer review group represents. Most other professions also use peer review to ensure a mini-

where the physician practices, or the state board of medical examiners that issued the physician's medical license,<sup>6</sup> may take disciplinary action against the physician.<sup>7</sup> A disciplinary action may have only a limited effect on a physician because an individual disciplinary group has limited jurisdiction; a peer review group governs a physician's practice only in the hospital or clinic where the group sits,<sup>8</sup> and a licensure board acts as an arm of the government only in the state where the board sits.<sup>9</sup>

If the disciplined physician has privileges at another hospital or a license to practice in another state, which often is the case, the physician may continue to practice medicine with impunity.<sup>10</sup> Thus, the physician can continue to harm patients in other facilities and states.<sup>11</sup>

When a state medical board or peer review group<sup>12</sup> takes disciplinary action against an allegedly incompetent physician, or a physician who may

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num level of competency within the profession. See S. GROSS, *supra* note 1, at 68-89; Dolin, *Antitrust Law Versus Peer Review*, 313 NEW ENG. J. MED. 1156 (1985). But see R. DERBYSHIRE, *MEDICAL LICENSURE AND DISCIPLINE IN THE UNITED STATES* 13 (1969).

6. Before a physician can practice medicine in a state, the physician must obtain a medical license from a state agency composed of physicians, generally called a state board of medical examiners [hereinafter licensure board]. F. GRAD & N. MARTI, *PHYSICIANS' LICENSURE AND DISCIPLINE: THE LEGAL AND PROFESSIONAL REGULATION OF MEDICAL PRACTICE* 54-55 (1979). See generally OFFICE OF INSPECTOR GENERAL, DEP'T OF HEALTH AND HUMAN SERVICES, *MEDICAL LICENSURE AND DISCIPLINE: AN OVERVIEW* (1986) [hereinafter *MEDICAL LICENSURE AND DISCIPLINE*].

7. Peer review groups may discipline a physician by issuing a letter of reprimand, restricting the physician's privileges, suspending the physician's ability to use the facility for a fixed period of time, or revoking the physician's privileges at that facility altogether. See FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC., *A GUIDE TO THE ESSENTIALS OF A MODERN MEDICAL PRACTICE ACT* 14 (1985) [hereinafter *GUIDE TO MEDICAL PRACTICE*]. However, licensure boards are the ultimate peer review groups because they control a physician's ability to practice medicine throughout an entire state. See R. DERBYSHIRE, *supra* note 5, at 76-90; F. GRAD & N. MARTI, *supra* note 6, at 26-29; see, e.g., *Withrow*, 421 U.S. at 37 (listing the types of disciplinary actions the Wisconsin statute governing physicians provides).

8. H.R. REP. NO. 903, 99th Cong., 2d Sess. 2-3, reprinted in 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6385.

9. *Dent v. West Virginia*, 129 U.S. 114, 122 (1889).

10. H.R. REP. NO. 903, *supra* note 8, at 2-3, reprinted in 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6384-86.

11. Newspapers have chronicled incidents where physicians removed from practice in one facility or community because of their incompetence have surfaced in another, only to repeat the damage that caused the initial censure. See, e.g., *Out-of-State Move Averts Discipline*, Wash. Post, Jan. 10, 1988, at A17, col. 1; *Army Had Evidence on Doctor Accused of Sodomy*, Wash. Post, Dec. 7, 1985, at D1, col. 1; *Doctor Sued 14 Times But No State Hearing*, Chi. Tribune, May 10, 1982, at 1, col. 1; *9 Deaths Studied in Doctor's Case*, N.Y. Times, Dec. 3, 1967, at 60, col. 3.

12. When text in this Comment applies equally to both state licensure boards and peer review groups at health care facilities, this Comment will use the term "disciplinary groups."

have breached professional standards of conduct,<sup>13</sup> the physician frequently challenges the action in court.<sup>14</sup> While the litigation proceeds, courts generally permit the physician to continue treating patients.<sup>15</sup> Thus, the disciplinary action appears futile to the disciplinary group because the incompetent<sup>16</sup> physician continues to treat, and possibly harm, patients.<sup>17</sup> To make matters worse, the disciplinary group finds itself embroiled in expensive<sup>18</sup> and time-consuming<sup>19</sup> litigation because of the disciplinary action. Consequently, disciplinary groups often are reluctant to sanction incompetent physicians,<sup>20</sup> a phenomenon referred to as the "brotherhood of silence."<sup>21</sup>

13. See R. DERBYSHIRE, *supra* note 5, at 76-90.

14. See Dolin, *supra* note 5, at 1156; Iglehart, *Health Policy Report: Congress Moves to Bolster Peer Review: The Health Care Quality Improvement Act of 1986*, 316 NEW ENG. J. MED. 960 (1987).

15. See R. DERBYSHIRE, *supra* note 5, at 92; F. GRAD & N. MARTI, *supra* note 6, at 47-48.

16. This Comment concerns both physicians who are incompetent and those who have engaged in unprofessional conduct. To avoid repetition, this Comment uses the term "incompetent" to describe both types of physicians.

17. *E.g.*, Board of Medical Examiners v. Rogers, 387 So. 2d 937, 940 (Fla. 1980) (licensure board ordered physician to stop using questionable treatment; reviewing court quashed order); Board of Medical Examiners v. Potter, 99 Nev. 162, 164, 659 P.2d 868, 870 (1983) (per curiam) (licensure board suspended physician's license after physician's second felony conviction; reviewing court reinstated physician's license finding board decision not supported by sufficient evidence); *In re Polk*, 90 N.J. 550, 559-60, 449 A.2d 7, 11-12 (1982) (licensure board suspended license after finding the physician sexually abused juvenile patients; reviewing court reversed suspension to consider standard of proof).

18. In an unpublished decision, the United States District Court for the District of Oregon awarded approximately \$2.2 million in damages in an antitrust suit brought by a physician disciplined by a peer review group. The United States Court of Appeals for the Ninth Circuit reversed the district court, and the Supreme Court reversed the Ninth Circuit. Patrick v. Burget, 800 F.2d 1498 (9th Cir. 1986), *rev'd.*, 108 S. Ct. 1658 (1988).

19. Although it is not unusual for a physician who brings suit against a licensure board or peer review group to spend four or five years before the courts trying to reverse the disciplinary action, *e.g.*, Patrick, 800 F.2d at 1498 (dispute started in 1981 and lasted until 1988); Board of Medical Examiners v. Potter, 99 Nev. 162, 659 P.2d 869 (1983) (dispute lasted six years); *In re Johnston*, 99 Wash. 466, 663 P.2d 457 (1983) (dispute lasted seven years), Dr. Ronald E. Clark, a general practitioner in Michigan, managed to stretch Michigan's efforts to revoke his medical license from February 1956 to July 1968. R. DERBYSHIRE, *supra* note 5, at 98-100. During this period, at least nine of his patients died from apparent malpractice. *Id.* After his assistant's suspicious death, the police chased Dr. Clark with bloodhounds for 12 hours in snow and five degree weather. *Id.* The Michigan courts found Dr. Clark guilty of manslaughter and sent him to prison. *Id.*

20. See H.R. REP. NO. 903, *supra* note 8, at 2-3, reprinted in 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6384-86; F. GRAD & N. MARTI, *supra* note 6, at 38-39; Dolin, *supra* note 5, at 1156.

21. F. GRAD & N. MARTI, *supra* note 6, at 38-39, 114-15. *But see Medical Malpractice: Hearings on H.R. 5110 Before the Subcomm. on Health and the Environment of the House Comm. on Energy and Commerce*, 99th Cong., 2d Sess. 436 (1986) [hereinafter *Medical Mal-*

Congress intends to end this "brotherhood of silence" with the Health Care Quality Improvement Act of 1986 (the Act).<sup>22</sup> The Act encourages physicians to police their ranks by granting disciplinary groups extensive immunity from liability.<sup>23</sup> The Act also establishes a computer network linking state disciplinary groups to a national data bank that will trace and report most disciplinary actions taken against physicians,<sup>24</sup> as well as all malpractice payments that insurance companies or individual physicians make.<sup>25</sup>

The Act makes several fundamental changes in law. It introduces the federal government into physician licensing, an area that the states have governed exclusively.<sup>26</sup> The Act creates a unique data bank, that the Department of Health and Human Services (DHHS) will administer, to serve as a federal conduit for states to exchange information about disciplined physicians.<sup>27</sup> The Act grants immunity to disciplinary groups from almost all traditional causes of action a physician might bring against these groups, leaving the physician with little opportunity to seek redress for improper or erroneous disciplinary actions.<sup>28</sup> Finally, the Act establishes no

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*practice Hearings*] (statement of Raymond Scalettar, M.D., Board of Trustees, American Medical Association).

22. Pub. L. No. 99-660, §§ 401-432, 100 Stat. 3784 (1986) (codified at 42 U.S.C.A. §§ 11,101-11,152 (West Supp. 1988)), amended by Pub. L. No. 100-177, § 402, 101 Stat. 986, 1007 (1987) (to be codified at 42 U.S.C. § 11,137) [hereinafter the Act]. Some provisions of the Act apply to other health professionals as well as to physicians. This Comment examines the Act only as it applies to physicians.

23. *Id.* §§ 11,111-11,112.

24. *Id.* §§ 11,132-11,137.

25. *Id.* § 11,131.

26. MEDICAL LICENSURE AND DISCIPLINE, *supra* note 6, at 21.

27. The data bank the Act creates may be unique because the bank serves no distinct federal program. Congress created the data bank solely to ensure that states communicate with each other when they discipline physicians. H.R. REP. NO. 903, *supra* note 8, at 2-3, reprinted in 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6384-86. Most other federal data banks directly support some federal program, even if states or other organizations also use them. See, e.g., Reporters Comm. for Freedom of the Press v. United States, 816 F.2d 730, 732 & nn.1-2, 733 & nn.3-4 (D.C. Cir. 1987) (describing the Federal Bureau of Investigation record systems and their uses), cert. granted, 108 S. Ct. 1467 (1988) (No. 87-1379); Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93, § 5, 101 Stat. 680, 689 (1987) (to be codified in scattered sections of 42 U.S.C.) (requiring states to report individuals convicted of Medicare or Medicaid fraud to the Department of Health and Human Services (DHHS)).

28. The Act specifically bars suits in which physicians seek damages from a licensure board or peer review group. 42 U.S.C.A. § 11,111. A physician may seek injunctive or declaratory relief, H.R. REP. NO. 903, *supra* note 8, at 9, reprinted in 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6391. These actions will not provide much relief because the Act creates a strong presumption that the disciplinary group acts properly when it takes action and thus decreases the likelihood that the physician will succeed on the merits. "This immunity is not contingent on the propriety of the behavior of the peer review body." Iglehart, *supra* note 14,

safeguards for the DHHS to follow to protect the accuracy of the information in the data bank.<sup>29</sup>

This Comment examines the development and effectiveness of physician licensure and disciplinary processes in order to identify the reasons Congress adopted the Act, intervening in an area historically governed by the states. It reviews the ways in which the federal government uses computers as regulatory tools, and how the Act requires the DHHS to use computers to accomplish the Act's objectives. It discusses the legislative process Congress followed, pointing out that, in theory, the Act fairly addresses the problems Congress identified while drafting the Act. This Comment finds that Congress paid too little attention to how the Act may harm physicians, and that some provisions of the Act may violate the constitutional rights of physicians without promoting the Act's objectives. The Comment suggests ways Congress or the DHHS could eliminate these harms. This Comment concludes that the Act has the potential to reduce the number of incompetent physicians, and consequently, the harm they inflict on their patients, but that Congress did not go far enough to ensure that outcome.<sup>30</sup>

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at 962. Physicians still may bring suits against disciplinary groups for civil rights violations under 42 U.S.C. §§ 1981, 2000e (1982). 42 U.S.C.A. § 11,111.

29. The Act allows the Secretary of the DHHS to develop procedures that physicians can use to challenge the accuracy of information contained in the data bank. 42 U.S.C.A. § 11,136. In the proposed regulation, the DHHS assumes limited responsibility in this area. "The Secretary proposes minimal involvement in the resolution of disputed information, leaving this to the individual practitioner and the entity submitting the disputed report." National Data Bank for Adverse Information on Physicians and Health Care Practitioners, 53 Fed. Reg. 9264, 9267 (1988) (to be codified at 42 C.F.R. § 60.13) (proposed Mar. 21, 1988). This proposed policy is at odds with the Privacy Act, 5 U.S.C. § 552a (1982 & Supp. IV 1986), which requires federal agencies to ensure the accuracy of information kept in their records. A federal official who violates the Privacy Act faces criminal penalties. *Id.* § 552a(i). The DHHS has published notice of the Privacy Act system of records in which it will keep information reported to the data bank, acknowledging that the Privacy Act controls recordkeeping practices related to the data bank. New System of Records, 52 Fed. Reg. 34,721, 34,722 (1987). Consequently, the DHHS has conflicting rules.

The proposed regulation also conflicts with some federal court decisions. The United States Court of Appeals for the District of Columbia Circuit refused to let the Federal Bureau of Investigation deny responsibility for the accuracy of records it keeps in the National Crime Information Center. The court said that "if the FBI has the authority to collect and disseminate inaccurate criminal information about private individuals without making reasonable efforts to safeguard the accuracy of the information, it would in effect have the authority to libel those individuals." *Tarlton v. Saxbe*, 507 F.2d 1116, 1122 (D.C. Cir. 1974). Thus, the proposed regulation adopts a position that probably will not survive judicial scrutiny.

30. This Comment does not address all of the issues the Act raises. The Comment does not examine how the Act affects federal-state government relationships, or analyze the Act's impact on state relationships with physicians. The Act does raise significant issues in these areas. If the Act proves effective, Congress could impose similar oversight on other professions with similar disciplinary problems. *Cf.* Weber, "Still in Good Standing": *The Crisis in*

## I. REGULATING PUBLIC HEALTH AND SAFETY BY COMPUTER: HOW IT EVOLVED

### A. *Regulating Physician Competence and Conduct*

#### 1. *An Historical Overview of Physician Licensing*

States regulate medicine through their historic police powers.<sup>31</sup> As early as 1760, colonies created boards of medical examiners to evaluate individuals seeking to practice medicine and to issue licenses to those individuals the boards found qualified.<sup>32</sup> States appointed respected physicians to serve on these boards, believing that only those who actually studied and practiced medicine could judge whether others were competent to safely provide medical care to patients.<sup>33</sup> In the 1889 case of *Dent v. West Virginia*,<sup>34</sup> the United States Supreme Court validated the authority of these boards to set standards and control the practice of medicine within a state.<sup>35</sup>

At first, licensing boards acted to keep unlicensed individuals, referred to as "quacks,"<sup>36</sup> from calling themselves physicians and practicing medicine.<sup>37</sup> However, once these first boards found an individual qualified to practice medicine, they rarely subjected the individual to further professional review because few accurate measures existed of what was and was not good medicine.<sup>38</sup> In the mid-1800's, physicians formed professional societies and developed additional professional standards.<sup>39</sup> Boards used these standards

*Attorney Discipline*, A.B.A. J., Nov. 1, 1987, at 58 (describing problems in the disciplinary system applicable to lawyers).

31. "No precise limits have been placed upon the police power of a State, and yet it is clear that legislation which simply defines the qualifications of one who attempts to practice medicine is a proper exercise of that power." *Hawker v. New York*, 170 U.S. 189, 192-93 (1898).

32. R. DERBYSHIRE, *supra* note 5, at 3, 9.

33. *Id.* at 4, 13, 32-44. But see OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, DEP'T OF HEALTH, EDUCATION, AND WELFARE, REPORT ON LICENSURE AND RELATED HEALTH PERSONNEL CREDENTIALING 2 (1971) [hereinafter REPORT ON LICENSURE], in which a federal work group concluded that "licensure may mean only that licensed practitioners meet standards set by their own profession; it does not necessarily mean that the State has evaluated the profession's standards and has approved these standards as being valuable to society."

34. 129 U.S. 114 (1889).

35. *Id.*

36. R. DERBYSHIRE, *supra* note 5, at 6.

37. See S. GROSS, *supra* note 1, at 58. See generally R. DERBYSHIRE, *supra* note 5, at 1-12.

38. See R. DERBYSHIRE, *supra* note 5, at 1-12; S. GROSS, *supra* note 1, at 52-59.

39. Physicians formed state medical societies as early as 1830. The American Medical Association (AMA) was formed in 1847 to create nationally recognized academic standards for physicians. S. GROSS, *supra* note 1, at 56-59. State licensing boards banded together in 1891 to form the Confederation of State Medical Examining and Licensing Boards, which later

to monitor physician competence, and began to discipline licensed physicians who violated the standards.<sup>40</sup> From the late 1800's until today, medical licensure board responsibilities have changed very little.<sup>41</sup> Their two major responsibilities are issuing licenses to practice medicine and disciplining licensees.<sup>42</sup>

## 2. Licensure Boards and Physician Discipline

Generally, licensure boards discipline physicians for conduct described as harmful to public health<sup>43</sup> or involving moral turpitude.<sup>44</sup> These broad criteria merely serve as a base upon which individual state boards freely embellish.<sup>45</sup> Even today, one state disciplines conduct that another state does not.<sup>46</sup> Because the federal government has played no role in physician li-

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became the Federation of State Medical Boards (FSMB), the dominant professional group in the area of physician licensing today. FEDERATION OF STATE MEDICAL BOARDS, FSMB HANDBOOK 1-3 (1987). See generally R. DERBYSHIRE, *supra* note 5, at 6-9.

40. See, e.g., *Hawker v. New York*, 170 U.S. 189 (1898) (the Supreme Court upheld New York's authority to revoke the license of a physician after a New York court had convicted the physician of a felony).

41. F. GRAD & N. MARTI, *supra* note 6, at 1 (physician licensure and discipline system has been in place for 150 years). Compare *Hawker*, 170 U.S. at 189 (where the Supreme Court held that licensure boards had the authority to discipline physicians as well as to issue medical licenses) with MEDICAL LICENSURE AND DISCIPLINE, *supra* note 6, at 1 (which defines the primary responsibilities of a licensure board as licensing and disciplining physicians).

42. F. GRAD & N. MARTI, *supra* note 6, at 1.

43. See, e.g., *Withrow v. Larkin*, 421 U.S. 35 (1975) (Wisconsin statute authorized the licensure board to hold hearings to decide whether a physician's conduct was "inimical" to the public health); see also *Aitchison v. State*, 204 Md. 538, 544, 105 A.2d 495, 498 ("[N]o person has an absolute vested right to practice medicine, but only a conditional right which is subordinate to the police power of the State to protect and preserve the public health."), *cert. denied*, 348 U.S. 880 (1954); cf. *Schware v. Board of Bar Examiners*, 353 U.S. 232, 239 n.5 (1957) ("Certainly the practice of law is not a matter of the State's grace.") (citing *Ex parte Garland*, 71 U.S. (4 Wall.) 333, 379 (1867)).

44. *Hawker*, 170 U.S. at 189 (plaintiff challenged the New York law that conditioned the right to practice medicine upon the state's finding that the physician was of good character).

45. F. GRAD & N. MARTI, *supra* note 6, at 26-27. The professional societies, such as the FSMB, established minimum educational standards for physicians to help states evaluate physician competence. All of the state licensure boards have adopted these standards. *Medicare and Medicaid Patient and Program Protection Act of 1984: Joint Hearings on H.R. 5989 Before the Subcomm. on Health of the House Comm. on Ways and Means and the Subcomm. on Health and the Environment of the House Comm. on Energy and Commerce*, 98th Cong., 2d Sess. 55 (1984) [hereinafter *Hearings*] (statement of Bryant L. Galusha, M.D., Executive Vice President, Federation of State Medical Boards of the United States).

46. Compare *McDonnell v. Commission on Medical Discipline*, 301 Md. 426, 483 A.2d 76 (1984) (Maryland statute describes conduct that is subject to disciplinary action by medical licensure board to include only acts directly related to a physician's medical skills) with *Raymond v. Board of Registration in Medicine*, 387 Mass. 708, 443 N.E.2d 391 (1982) (Massachusetts law permits licensure board to discipline a physician for conduct unrelated to the physician's medical skills, such as storing unregistered submachine guns).



censing, each state has had complete sovereignty to decide what standards physicians must meet to obtain and keep licenses in that state.<sup>47</sup>

Because medical licensing boards are administrative arms of the state, courts defer to licensure board decisions just as they defer to any other state administrative agency.<sup>48</sup> Courts also defer to licensure boards because the boards, comprised of physicians, possess specialized knowledge.<sup>49</sup> In almost all cases, courts uphold board actions if they are based on substantial evidence<sup>50</sup> and are not arbitrary or capricious.<sup>51</sup>

Despite what appears to be broad authority to act under state law and the great deference state courts give board decisions, licensure boards generally take few disciplinary actions.<sup>52</sup> Various groups have criticized licensure boards publicly over time, arguing that boards have not acted quickly enough to discipline physicians who appear to the public to be woefully incompetent or even criminally culpable.<sup>53</sup>

Even when licensure boards take disciplinary action, critics attack boards as self-serving.<sup>54</sup> Some physicians have successfully overcome disciplinary actions by proving that a board acted to eliminate competition among physi-

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47. F. GRAD & N. MARTI, *supra* note 6, at 10.

48. *Id.* at 177-90; *see, e.g.,* Reetz v. Michigan, 188 U.S. 505 (1903) (licensure board is an administrative agency of the state with full governmental powers).

49. Dent v. West Virginia, 129 U.S. 114, 122-23 (1889).

50. While courts generally review licensure board actions to determine whether they are supported by substantial evidence, *see, e.g.,* Boggs v. State Bd. of Medical Examiners, 288 S.C. 144, 146-47, 341 S.E.2d 635, 636 (1986); Story v. State Bd. of Medical Examiners, 721 P.2d 1013, 1017 (Wyo. 1986), statutes governing licensure board action may require the licensure board to reach a decision based on clear and convincing evidence. *See, e.g.,* Story, 721 P.2d at 1014; Fallon v. State Bd. of Medical Examiners, 441 P.2d 322, 326 (Wyo. 1968); F. GRAD & N. MARTI, *supra* note 6, at 178-88. *But see* Steadman v. SEC, 450 U.S. 91, 96, 102 (1981) (licensure board may revoke a license based on a preponderance of the evidence standard). For a discussion of whether the due process clause requires medical licensure boards to use a standard of proof higher than the preponderance of the evidence, *see In re Polk*, 90 N.J. 550, 560-62, 449 A.2d 7, 12-13 (1982).

51. *See, e.g.,* Dent, 129 U.S. at 124; R. DERBYSHIRE, *supra* note 5, at 92-93.

52. State licensure boards are remarkably understaffed and underfunded, considering the importance of their job. Boards are comprised of physicians asked to act as judges, and consequently, the physicians are uncomfortable in that role. F. GRAD & N. MARTI, *supra* note 6, at 38-39. Because boards are sued often, they often are reluctant to act. *Id.* at 139-40. Boards must find that a physician has acted improperly, a task made difficult by disagreement among physicians as to what is and is not proper medical practice. R. DERBYSHIRE, *supra* note 5, at 13.

53. REPORT ON LICENSURE, *supra* note 33, at 2; MEDICAL LICENSURE AND DISCIPLINE, *supra* note 6, at 12; *see also* Waxman, *supra* note 2, at 943-44; *Doctors Rarely Lose Licenses*, Wash. Post, Jan. 10, 1988, at A1, col. 1.

54. H.R. REP. NO. 903, *supra* note 8, at 15, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6398-99; F. GRAD & N. MARTI, *supra* note 6, at 115; S. GROSS, *supra* note 1, at 13; *see also* Waxman, *supra* note 2, at 943.

cians,<sup>55</sup> or to preclude physician extenders, like physician assistants and nurse practitioners,<sup>56</sup> from providing routine health care services that at one time only physicians could provide.<sup>57</sup> Public interest groups and members of state and federal legislatures also have criticized licensure boards for agreeing to take no disciplinary action in return for a promise from a substandard physician that he or she will leave the state and never practice medicine there again, a bargain referred to as the "brotherhood of silence."<sup>58</sup>

### 3. Peer Review Groups, Professional Societies, and Physician Discipline

Most physicians need more than a state license to practice medicine. To properly treat patients, physicians need hospitals and the many services available only in hospitals. Before a physician can use a particular hospital, a peer review group at the hospital must grant the physician privileges.<sup>59</sup> As the physician provides medical care to a patient in hospital facilities, a peer review group at the hospital monitors the physician's performance.<sup>60</sup> If the physician fails to comply with hospital policy or procedure, provides substandard care, or engages in unprofessional conduct, the peer review group may investigate the problem and discipline the physician.<sup>61</sup> Thus, physicians must answer to both licensure boards and peer review groups.

Many states<sup>62</sup> and professional organizations, such as the American Medical Association (AMA)<sup>63</sup> and the Federation of State Medical Boards

55. *Patrick v. Burget*, 108 S. Ct. 1658 (1988), *rev'g*, 800 F.2d 1498 (9th Cir. 1986); *see also Waxman*, *supra* note 2, at 943.

56. REPORT ON LICENSURE, *supra* note 33, at app. B; *see also Waxman*, *supra* note 2, at 943.

57. *See, e.g., United States v. Composite State Bd. of Medical Examiners*, 656 F.2d 131 (5th Cir. 1981); *cf. GUIDE TO MEDICAL PRACTICE*, *supra* note 7, at 28-29 (describing the role of physician assistants and physician supervision of their activities).

58. H.R. REP. NO. 903, *supra* note 8, at 3, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6385. The State of Pennsylvania promised not to take disciplinary action against a physician if the physician promised to leave the state and never practice there again, provided the physician promised to enter public service with the Indian Health Service or some other federal program. The United States Public Health Service, which provides personnel to the Indian Health Service, was chagrined when the physician applied for a job and submitted the Pennsylvania agreement with his application. Interview with Bruce Immerman, Senior Health Services Officer, Division of Commissioned Personnel, Office of the Surgeon General, United States Public Health Service (Nov. 25, 1987).

59. F. GRAD & N. MARTI, *supra* note 6, at 201-11.

60. *See, e.g., Dolin*, *supra* note 5, at 1156.

61. *Id.*; *see, e.g., Patrick v. Burget*, 800 F.2d 1498 (1986), *rev'd*, 108 S. Ct. 1658 (1988).

62. MEDICAL LICENSURE AND DISCIPLINE, *supra* note 6, at 14-15; *see, e.g., Stronger Rules on Disciplining Doctors Sought*, Wash. Post, Jan. 11, 1988, at A7, col. 1.

63. *See Medical Malpractice Hearings*, *supra* note 21, at 430-46 (statement of Raymond Scalettar, M.D.).

(FSMB),<sup>64</sup> have attempted to make it easier for disciplinary groups to identify and discipline physicians who fall below acceptable professional standards.<sup>65</sup> As part of this effort, both the AMA and the FSMB have established data banks containing information about licensure and disciplinary actions taken against physicians.<sup>66</sup> However, neither the AMA nor the FSMB has the authority to force disciplinary groups to submit information to the data banks. Consequently, the information in the data banks is incomplete,<sup>67</sup> allowing some incompetent physicians to remain unreported.

Although the shortcomings of the physician disciplinary process are significant,<sup>68</sup> the process seems more effective today than at any time in the past. The actual number of disciplinary actions licensure boards take has increased by over 500% in the past twenty years.<sup>69</sup> State legislatures have enlarged the scope of authority licensure boards have to take disciplinary actions, and have funneled more revenue into state disciplinary processes.<sup>70</sup> The professional societies in the medical community remain committed to improving the quality of physicians in practice, and seem optimistic that the medical community will resolve the remaining problems on its own.<sup>71</sup>

### B. *The Federal Government Develops Data Banks*

Federal use of computers to monitor areas of federal concern is not new.<sup>72</sup> By 1974, the government had computerized 86% of all its records.<sup>73</sup> Government agencies initially computerized records because computers made

64. See *Hearings*, *supra* note 45, at 53-56 (statement of Bryant L. Galusha, M.D.).

65. MEDICAL LICENSURE AND DISCIPLINE, *supra* note 6, at 12.

66. *Hearings*, *supra* note 45, at 54-55 (statement of Bryant L. Galusha, M.D.); *Medical Malpractice Hearings*, *supra* note 21, at 430, 433-35 (statement of Raymond Scalettar, M.D.).

67. MEDICAL LICENSURE AND DISCIPLINE, *supra* note 6, at 16-17; H.R. REP. NO. 903, *supra* note 8, at 17, reprinted in 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6399-400.

68. R. DERBYSHIRE, *supra* note 5, at 76-90; F. GRAD & N. MARTI, *supra* note 6, at 38-39, 115-40; REPORT ON LICENSURE, *supra* note 33, at 31-33.

69. Between 1963 and 1967, licensure boards disciplined an average of 234.5 physicians a year. R. DERBYSHIRE, *supra* note 5, at 77. In 1984, 520,700 physicians practiced medicine and licensure boards disciplined 1,381 of them. MEDICAL LICENSURE AND DISCIPLINE, *supra* note 6, at 12. In fiscal year 1987, the State of Maryland had 1,245 disciplinary actions pending, but took formal action in only 11 cases. See *Panel Regulating Md. Doctors Seldom Acts to Revoke Licenses*, Wash. Post, Jan. 10, 1988, at A16, col. 1.

70. F. GRAD & N. MARTI, *supra* note 6, at 4-5; MEDICAL LICENSURE AND DISCIPLINE, *supra* note 6, at 14-15.

71. *Medical Malpractice Hearings*, *supra* note 21, at 443 (statement of Raymond Scalettar, M.D.); *Hearings*, *supra* note 45, at 55-56 (statement of Bryant L. Galusha, M.D.).

72. Congress considered creating a single computer network in the mid-1960's for the entire federal government, but decided against it. Instead, each federal agency developed its own computer system. Shattuck, *In the Shadow of 1984: National Identification Systems, Computer-Matching, and Privacy in the United States*, 35 HASTINGS L.J. 991, 996 (1984).

73. STAFF OF SUBCOMM. ON CONSTITUTIONAL RIGHTS OF THE SENATE COMM. ON THE

collecting and maintaining large quantities of information more efficient and less expensive.<sup>74</sup> As computer technology developed, record collection and maintenance led to record sharing.<sup>75</sup> Record sharing encouraged record matching, also referred to as computer matching.<sup>76</sup> The government uses computer matching for oversight purposes,<sup>77</sup> and to detect fraud and abuse in benefit programs.<sup>78</sup> Thus, computers have become a regulatory tool that is more efficient and less expensive than traditional methods of regulation.<sup>79</sup>

Congress has expressed concern that federal recordkeeping by computer allows the government to intrude into private lives.<sup>80</sup> Given the enormous scope of federal records, an individual or organization that misuses information in a federal record system has the potential to harm most of the Ameri-

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JUDICIARY, 93D CONG., 2D SESS., FEDERAL DATA BANKS AND CONSTITUTIONAL RIGHTS: SUMMARY AND CONCLUSIONS 33-35 (Comm. Print 1974).

74. In 1972, computers could store the equivalent of 20 pages of personal information on every person in the United States and could retrieve an individual record in 30 seconds. COMMITTEE ON GOVERNMENT OPERATIONS, UNITED STATES SENATE, AND COMMITTEE ON GOVERNMENT OPERATIONS, HOUSE OF REPRESENTATIVES, 94TH CONG., 2D SESS., LEGISLATIVE HISTORY OF THE PRIVACY ACT OF 1974, SOURCE BOOK ON PRIVACY 835 (1976).

75. See Shattuck, *supra* note 72, at 993; see, e.g., Child Support Enforcement Program; Provision of Services in Interstate IV-D Cases, 53 Fed. Reg. 5246 (1988) (to be codified at 45 C.F.R. pts. 301-03, 305) (creating central registry for information concerning parents who fail to keep up child support).

76. Shattuck, *supra* note 72, at 996. The Privacy Act of 1974, 5 U.S.C. § 552a(b) & (m) (1982 & Supp. IV 1986), authorizes federal agencies to conduct computer matches. The Office of Management and Budget issued guidelines for federal agencies to use when planning computer matching programs. Revised Supplemental Guidance for Conducting Matching Programs, 47 Fed. Reg. 21,656 (1982).

77. See, e.g., *Whalen v. Roe*, 429 U.S. 589 (1977) (New York statute requires oversight of the narcotic prescriptions physicians write); see also Matching Program—HHS Physician Records/Federation of State Medical Boards of the United States, Inc. Disciplinary Records, Notification of Matching Program, 50 Fed. Reg. 48,133 (1985) [hereinafter Matching Program] (federal agency matched lists of federal physicians against the FSMB Disciplinary Data Bank to learn whether state medical boards had disciplined the physicians for activities performed outside the scope of the physicians' federal duties).

78. See, e.g., Computer Matching Programs—United States Department of Agriculture and United States Postal Service Personnel in Missouri Participating in United States Department of Agriculture Programs and Cross-State March [sic] of Food Stamp Program Participants in Illinois and Kansas, 52 Fed. Reg. 47,738 (1987); Computer Matching Program—Postal Service/California State Employment Development Department, 52 Fed. Reg. 35,010 (1987).

79. “[Computer matching] is the Federal Government’s most cost-effective tool for verification or investigation in the prevention of and detection of fraud, waste, and abuse.” *Bowen v. Roy*, 476 U.S. 693, 711 (1986) (citing 7 THE PRESIDENT’S PRIVATE SECTOR SURVEY ON COST CONTROL, MANAGEMENT OFFICE SELECTED ISSUES—INFORMATION GAP IN THE FEDERAL GOVERNMENT 90 (1984) (commonly referred to as the Grace Commission Report)).

80. Shattuck, *supra* note 72, at 987-89.

can population.<sup>81</sup> To prevent such misuse, Congress enacted safeguards that federal agencies must follow to protect the integrity of these records.<sup>82</sup> With these safeguards in place, Congress continues to establish new information-collection activities and to authorize more computer oversight.<sup>83</sup>

Despite the safeguards Congress created, individuals identified in computerized government records have experienced a variety of troubles, some serious, that simple exchanges of records can generate.<sup>84</sup> Congress cannot adequately protect individuals identified in government records from the types of harm these exchanges may cause,<sup>85</sup> because the harm generally is not caused by deliberate abuse or misuse of records. The harm is caused by

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81. In 1974, Congress heard testimony that the government and private organizations keep between 10 and 20 files on the average American. Project, *Government Information and the Rights of Citizens*, 73 MICH. L. REV. 971, 1224 (1975) (citing *Records Maintained by Government Agencies: Hearings on H.R. 9527 and Related Bills Before a Subcomm. of the House Comm. on Government Operations*, 92d Cong., 2d Sess. 22 (1972) (statement of Rep. Patten)).

82. At the close of the first session of the 100th Congress, the Senate passed the Computer Security Act of 1987, Pub. L. No. 100-235, 101 Stat. 1724 (1987) (to be codified in scattered sections of 15 & 40 U.S.C.), which the House of Representatives had passed earlier in the year. Under this law, the National Bureau of Standards must develop computer security measures for government-wide implementation. *Id.* § 3(2)(d)(4). Government agencies must use the new system for records that contain "sensitive information," defined as "any information, the loss, misuse, or unauthorized access to or modification of which could adversely affect the national interest or the conduct of Federal programs, or the privacy to which individuals are entitled." *Id.*; see also Peck, *Extending the Constitutional Right to Privacy in the New Technological Age*, 12 HOFSTRA L. REV. 893, 897 n.27 (1984); Shattuck, *supra* note 72, at 996-98.

83. In addition to establishing the national data bank in the Act, Congress recently authorized more computer-assisted oversight to help detect fraud and abuse in the Medicare and Medicaid Patient and Program Protection Act, Pub. L. No. 100-93, § 5, 101 Stat. 680, 689 (to be codified in scattered sections of 42 U.S.C.). The Senate passed legislation to facilitate computer matching and create additional safeguards for records used or created in the matching process. Computer Matching and Privacy Protection Act of 1987, S. 496, 100th Cong., 1st Sess., 133 CONG. REC. S7042 (daily ed. May 21, 1987). At the time of publication, the House of Representatives had not yet considered the Senate bill.

84. In *Bowen v. Roy*, 476 U.S. 693 (1986), the Social Security Administration terminated food stamps and welfare benefits it paid on behalf of a child because the child had no social security number due to her parents' belief that such a number would rob her of her spirituality. *Id.* at 696. This is a striking case because the Court found that the government's interest in the efficient operation of its programs outweighed the child's interest in adhering to her religious beliefs. *Id.* at 699-700. Ultimately, the Social Security Administration assigned the child a number and used that number to process the child's claims, even though the child and her parents refused to use the number when applying for benefits. *Id.* at 701 n.7.

In *15,844 Welfare Recipients v. King*, 474 F. Supp. 1374 (D. Mass. 1979), the Massachusetts Department of Public Welfare conducted a computer match of records about individuals receiving welfare and state employment records to identify people who had become ineligible for welfare because of employment. *Id.* at 1381. The district court upheld Massachusetts' use of computer matching for this purpose, despite testimony from experts that people living at the poverty level move in and out of employment status with such rapidity that information gained from a computer match at a fixed point in time is unreliable. *Id.* at 1382-83.

85. See generally Gerety, *Redefining Privacy*, 12 HARV. C.R.-C.L. L. REV. 233 (1977).

everyday errors and mistakes that even the most careful people make.<sup>86</sup> As computers transmit information further from the original source of the information, the accuracy of the information becomes more difficult to verify.<sup>87</sup> Ultimately, federal decisionmakers may determine an individual's entitlement to basic necessities, such as food stamps or Medicare, based on erroneous information obtained from computerized records about which the individual knows nothing.<sup>88</sup>

Public interest groups, corporations, and private citizens have petitioned the courts for protection from government record collection, maintenance, and dissemination.<sup>89</sup> In *California Bankers Association v. Shultz*,<sup>90</sup> these groups united to challenge the constitutionality of the recordkeeping and reporting requirements of the Bank Secrecy Act.<sup>91</sup> Although the plaintiffs alleged ten separate constitutional violations, the Supreme Court decided that none of the allegations had sufficient merit for the Court to strike down any provision of the Bank Secrecy Act.<sup>92</sup> Although the Court has said on more than one occasion that the scope of records the government keeps on private individuals gives the government the potential to invade individual rights,<sup>93</sup> the Court has not struck down any statute creating computerized recordkeeping schemes.<sup>94</sup>

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86. See, e.g., *id.* at 287-89.

87. The Privacy Act of 1974, in recognition of the errors that occur when information is transmitted from one record to another, requires federal agencies to gather information from the individual to whom information pertains whenever possible. 5 U.S.C. § 552a(e)(2) (1982 & Supp. IV 1986).

88. See Gerety, *supra* note 85, at 287-88.

89. See, e.g., *Whalen v. Roe*, 429 U.S. 589, 595 (1977) (plaintiffs were private individuals); *California Bankers Ass'n v. Shultz*, 416 U.S. 21, 41 (1974) (plaintiffs included the American Civil Liberties Union, the California Bankers Association, and private customers of banks in California); see also *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 752 (1986) (plaintiffs were physicians subject to state law requiring physicians to report abortions); *Buckley v. Valeo*, 424 U.S. 1, 7-8 (1976) (plaintiffs were candidates for public office subject to the Federal Elections Campaign Act of 1971).

90. 416 U.S. 21 (1974).

91. Pub. L. No. 91-508, 84 Stat. 1114 (1970) (codified as amended in scattered sections of 12 & 31 U.S.C.).

92. The plaintiffs alleged that the Bank Secrecy Act was an unreasonable search and seizure, that it compelled self-incrimination, that it violated rights of free speech and freedom of association, and that it denied them due process. *California Bankers Ass'n*, 416 U.S. at 41.

93. *Whalen*, 429 U.S. at 605-06; *California Bankers Ass'n*, 416 U.S. at 78-79 (Powell, J., dissenting); *United States v. United States Dist. Court*, 407 U.S. 297, 311-13 (1972).

94. In *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747 (1986), the Court affirmed the unconstitutionality of a Pennsylvania statute requiring physicians to report information about women who obtained abortions. The statute made these records available for public inspection and copying. *Id.* at 766. The statute did not provide for computer maintenance or transmission of these records. However, *Thornburgh* may be of critical importance in determining how the Court would treat a recordkeeping scheme like that

Lower federal courts have held that, in some instances, government information collection and dissemination activities have exceeded the governmental interest the records were collected to promote.<sup>95</sup> However, these instances are rare. Courts are more likely to find that the information needs of the government outweigh the interests of an individual.<sup>96</sup>

### C. Medical Licensure Actions Form a Federal Data Bank

#### 1. Professional Society Oversight of Physician Discipline

Computers have greatly enhanced the ability of the professional societies to collect and disseminate disciplinary information.<sup>97</sup> The FSMB computerized its disciplinary information in the early 1980's with the help of a contract from the DHHS.<sup>98</sup> By 1984, FSMB's computerized disciplinary data bank could verify the credentials of an applicant for a medical license in one minute and five seconds.<sup>99</sup> The AMA started collecting and disseminating similar information more recently as an adjunct to its comprehensive computer file on medical school graduates, called the physician Masterfile.<sup>100</sup> Both the FSMB and the AMA generate monthly computer reports of disciplinary actions and disseminate the reports to state licensure boards.<sup>101</sup>

The AMA and the FSMB obtain the information for their data banks from state licensure boards, and assume no responsibility for the accuracy of the information they report each month.<sup>102</sup> Thus, the information in these data banks is only as accurate and complete as the information state licen-

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which the Act creates, because *Thornburgh* indicates a willingness on the part of the Court to prohibit government recordkeeping concerning fundamental rights in general, not only first amendment rights. See generally *California Bankers Ass'n*, 416 U.S. at 85-91 (Douglas, J., dissenting); *NAACP v. Alabama*, 357 U.S. 449 (1958); *Lovell v. Griffin*, 303 U.S. 444 (1938).

95. See, e.g., *Utz v. Cullinane*, 520 F.2d 467 (D.C. Cir. 1975); *Menard v. Saxbe*, 498 F.2d 1017 (D.C. Cir. 1974).

96. *Bowen v. Roy*, 476 U.S. 693, 699-700 (1986); *Whalen*, 429 U.S. at 598; *Buckley v. Valeo*, 424 U.S. 1, 80-81 (1976). But see *Thornburgh*, 476 U.S. at 766; *Utz*, 520 F.2d at 481-82.

97. *Hearings, supra* note 45, at 54-55 (statement of Bryant L. Galusha, M.D.).

98. FEDERATION OF STATE MEDICAL BOARDS, PHYSICIAN DISCIPLINARY DATA BANK (1986) [hereinafter FSMB DATA BANK].

99. *Hearings, supra* note 45, at 55 (statement of Bryant L. Galusha, M.D.).

100. *Medical Malpractice Hearings, supra* note 21, at 434 (statement of Raymond Scalettar, M.D.).

101. *Id.* at 443 (statement of Raymond Scalettar, M.D.); *Hearings, supra* note 45, at 55 (statement of Bryant L. Galusha, M.D.).

102. For example, the FSMB offers this disclaimer with regard to its data bank:

The data contained in the Bank are a direct reflection of the completeness and accuracy of the actions reported to it. Therefore, despite the significant quality control measures employed, the Federation makes no representations or warranties, either express or implied, as to the accuracy of the information reported and assumes no responsibility for errors or omissions that may be contained therein.

FSMB DATA BANK, *supra* note 98.

sure boards provide. At times, the state boards provide incomplete, misleading, and incorrect information.<sup>103</sup> Further, neither the AMA nor the FSMB has the authority to force state boards to submit information to private data banks, so states unwilling to participate might provide no information.<sup>104</sup>

## 2. Federal Intervention Into Physician Discipline

The federal government had little reason to become involved in medical licensure until recently because in 1920 the Supreme Court held, in *Johnson v. Maryland*,<sup>105</sup> that states could not impose licensure or other requirements on individuals engaged in federal work.<sup>106</sup> Consequently, federal physicians did not need state licenses, and the federal government itself had no licensing scheme.

The federal government acquired a vested interest in physician licensing when Congress created the Medicare and Medicaid programs in the early 1960's.<sup>107</sup> As the number of federal dollars going to state-licensed physicians increased to twenty-five percent of the total spent on health care in the United States,<sup>108</sup> the federal government's interest in physician licensing and

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103. The United States Public Health Service (PHS) has had bad luck with the data it has obtained from computer matches. The first computer match, *see* Matching Program, *supra* note 77, resulted in three "hits" (a "hit" is a match between records in two computer systems), and all three hits were erroneous or misleading. *Cf. infra* note 165 (erroneous computer match concerning a nurse). In one case, the licensure board reported only its own action to the data bank. It did not report that the United States government challenged the board action as an effort by the state to keep physician assistants from practicing in the state. Nor did it report that the Georgia court reversed the Board on remand from the United States Court of Appeals for the Fifth Circuit, *United States v. Composite State Bd. of Medical Examiners*, 656 F.2d 131 (5th Cir. 1981), restoring the physician's license. *United States v. Composite State Bd. of Medical Examiners*, No. C 79-1943 A (N.D. Ga. June 10, 1983); Letter from Assistant Surgeon General James H. Eagen, Deputy Director, Office of Personnel Management, United States Public Health Service, to Dr. Bryant L. Galusha, M.D., Executive Director, FSMB (Jan. 28, 1986) (informing the FSMB of erroneous match). In the second match, the disciplinary board legitimately disciplined the physician, but failed to clarify the reason for the discipline in its report to the FSMB data bank. The PHS investigated further and found that the physician himself had not violated state law. *In re Fort Help*, No. D-2109, California Bd. of Medical Quality Assurance (Mar. 23, 1979). Instead, the board had disciplined the physician for the actions of the staff at a clinic where he donated his time. *Id.* at 7. The staff billed the state for care the physician provided at the clinic, although the physician told the staff not to bill his time. *Id.* at 6.

104. H.R. REP. NO. 903, *supra* note 8, at 1-2, reprinted in 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6384-85; MEDICAL LICENSURE AND DISCIPLINE, *supra* note 6, at 18. *See generally* Medical Malpractice Hearings, *supra* note 21, at 457-61 (statement of Raymond Scalettar, M.D.).

105. 254 U.S. 51 (1920).

106. *Id.* at 57.

107. F. GRAD & N. MARTI, *supra* note 6, at 2-3; MEDICAL LICENSURE AND DISCIPLINE, *supra* note 6, at 21.

108. MEDICAL LICENSURE AND DISCIPLINE, *supra* note 6, at 21.



the quality of medical care paid for by federal dollars increased. This interest fostered numerous federal studies of licensure boards and medical practice,<sup>109</sup> describing the inadequacies of the licensure and disciplinary processes.<sup>110</sup> The problems these studies revealed, and the potential Congress recognized in the private disciplinary data banks, apparently led Congress to conclude that the time was ripe for federal intervention.<sup>111</sup>

### 3. *The Congressional Solution*

Congress had a variety of issues to contend with as it tried to find a way to reduce the number of incompetent physicians and the amount of harm they inflict. First, Congress had to find a way for the federal government to become involved in physician discipline without preempting the states' historic sovereignty to issue medical licenses and discipline their licensees.<sup>112</sup> Congress had no comparable concern about peer review groups at hospitals and other medical facilities because these groups are not part of state governments, raising no conflict in federal-state relationships.<sup>113</sup> Thus, Congress decided to impose precise disciplinary procedures and reporting requirements on peer review groups, while it imposed only general reporting requirements on state licensure boards.<sup>114</sup>

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109. *See id.*; DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, CREDENTIALING HEALTH MANPOWER (1977) (Appendix III lists 10 reports that the Department of Health, Education, and Welfare (now DHHS) prepared between June 1971 and July 1977). In addition, the DHHS awarded several grants to health licensure specialists, who prepared additional reports. Even Congress authorized a number of studies to be carried out by the General Accounting Office. *See Medical Malpractice Hearings, supra* note 21, at 422-23 (statement of Raymond Scalettar, M.D.); MEDICAL LICENSURE AND DISCIPLINE, *supra* note 6, at 21.

110. MEDICAL LICENSURE AND DISCIPLINE, *supra* note 6, at 21.

111. H.R. REP. NO. 903, *supra* note 8, at 1-2, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6384-85. As early as 1984, the General Accounting Office recommended that Congress create a national data bank concerning disciplined physicians in order to protect Medicare and Medicaid. *Medical Malpractice Hearings, supra* note 21, at 422-23 (statement of Raymond Scalettar, M.D.). A variety of groups from the private sector and individuals from within the government itself testified that the data bank was needed badly. *Id.* at 374-75 (statement of the Washington Business Group on Health), 383-85 (statement of the FSMB), 461 (discussion between Rep. Wyden and Ross N. Rubin of the AMA Division of Legislative Activities).

112. *See supra* notes 43-47 and accompanying text.

113. *See, e.g.,* Patrick v. Burget, 800 F.2d 1498, 1502 (9th Cir. 1986), *rev'd*, 108 S. Ct. 1658 (1988) (hospital peer review group composed of partners of hospital and associated clinic). Another reason Congress was not concerned with peer review in hospitals and clinics stems from Medicare and Medicaid. In order to receive reimbursement from the federal government for care furnished to Medicare and Medicaid patients, the health care facility must meet certain federal standards of care. F. GRAD & N. MARTI, *supra* note 6, at 208-11.

114. *Compare* 42 U.S.C.A. §§ 11,112, 11,133, 11,135 (imposing detailed hearing procedures on peer review groups, requiring hospitals and clinics to report disciplinary actions to state licensing boards, and requiring hospitals to verify credentials of physicians prior to grant-

Next, Congress needed to improve the quality and frequency of peer review.<sup>115</sup> Because peer review groups and experts on peer review identified fear of being sued as the greatest deterrent to vigorous peer review, Congress drafted a plan giving sweeping immunity to peer review actions.<sup>116</sup> Several federal agencies strongly opposed giving immunity to peer review groups because these groups had tried to hide antitrust activity under the guise of disciplinary action in the past.<sup>117</sup> Congress also tied the immunity to a requirement that peer review groups report their disciplinary actions to state licensure boards.<sup>118</sup>

Finally, Congress had to implement this comprehensive oversight program without significantly increasing the federal deficit.<sup>119</sup> Because Congress had great success with computer oversight in the past,<sup>120</sup> and because the professional societies already had fully operational data banks identifying disciplined physicians,<sup>121</sup> Congress chose to build its oversight program around computers. Congress permitted the DHHS, the agency charged with operating the new program, to operate the data bank by contracting with the private sector.<sup>122</sup>

With the data bank, Congress crafted a law that addressed almost all of the problems that critics of the physician disciplinary process had raised, without creating a massive new federal bureaucracy, and without overtly interfering with the historic police power of the states. Although both the AMA and the FSMB touted disciplinary data banks as the best method of identifying and restricting substandard physicians, they both strongly opposed Congress' plan to create a federal data bank, urging Congress to leave the data banks to the private sector.<sup>123</sup> Other professional societies favored

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ing privileges) *with id.* § 11,132 (requiring licensure boards to report disciplinary actions to the DHHS) *and id.* § 11,137 (giving licensure boards discretion to verify credentials prior to issuing a license to a physician).

115. See *supra* note 52 and accompanying text.

116. 42 U.S.C.A. § 11,111.

117. Iglehart, *supra* note 14, at 961.

118. The AMA objected to tying peer review group immunity to the reporting requirement. *Medical Malpractice Hearings, supra* note 21, at 439 (statement of Raymond Scalettar, M.D.).

119. The Congressional Budget Office estimated that if the DHHS implemented the program itself, start-up costs for the proposed data bank would reach \$30 million in the first year and \$10 million each successive year for ongoing operations. H.R. REP. NO. 903, *supra* note 8, at 4-5, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6387.

120. See *supra* notes 72-79 and accompanying text.

121. See *supra* notes 97-101 and accompanying text.

122. 42 U.S.C.A. § 11,134(b).

123. In congressional hearings, representatives of the AMA and FSMB offered these justifications for keeping the data banks in the private sector:

The [data collection] activity should not reside at HHS, as the track record at HHS

creating a federal data bank.<sup>124</sup> All of the professional societies praised the provision of the Act that granted immunity to peer review groups.<sup>125</sup> The praise may have been fostered by a \$2.2 million judgment the United States District Court for the District of Oregon entered against a peer review group, when a jury found that the group's disciplinary action was antitrust activity in disguise.<sup>126</sup>

## II. OVERVIEW OF THE HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986

### A. Congressional Findings

Congress specifically found that states alone could neither effectively reduce malpractice nor reduce the number of incompetent physicians in practice. Congress also found that peer review processes could solve the problems that substandard physicians cause, provided that peer review proved effective. To make peer review effective, Congress eliminated the threat of liability hanging over peer review organizations.<sup>127</sup>

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does not instill confidence that a system established by HHS would operate properly. . . . HHS collection and release of information on physician Medicare payments proved to be a disaster. . . . [Other] information, widely publicized in the media, was highly misleading and it may have damaged permanently the reputations of competent providers.

*Medical Malpractice Hearings*, *supra* note 21, at 441-42 (statement of Raymond Scalettar, M.D.); *see also* Iglehart, *supra* note 14, at 961.

Without strong and compelling cause it appears unnecessary and needlessly intrusive to implement a [federal] program which would interfere with the authority and responsibility which has been traditionally within the purview of the various states. . . .

In fact, I would suggest that the states may well view such an action as the Federal Government's first step into the field of medical licensure.

*Hearings*, *supra* note 45, at 55 (statement of Bryant L. Galusha, M.D.).

124. *Medical Malpractice Hearings*, *supra* note 21, at 461 (statement of Raymond Scalettar, M.D.); Iglehart, *supra* note 14, at 960-61.

125. Iglehart, *supra* note 14, at 960-61.

126. *Patrick v. Burget*, 800 F.2d 1498 (9th Cir. 1986), *rev'd*, 108 S. Ct. 1658 (1988) (holding the state-action doctrine does not immunize hospital peer review actions from antitrust liability because there is no active state supervision).

127. 42 U.S.C.A. § 11,101. Congress passed the Act with amazing speed and no obvious attempts to reconcile strongly conflicting views. Iglehart, *supra* note 14, at 960-61. Congress appropriated the data bank concept developed by the FSMB and the AMA even though both groups hoped their respective data banks would dominate the profession. *See Medical Malpractice Hearings*, *supra* note 21, at 458 (statement of Ross N. Rubin); *Hearings*, *supra* note 45, at 53-56 (statement of Bryant L. Galusha, M.D.). Further, Congress enacted the Act with no formal comments from the DHHS. This is a curious fact, because Congress charged the DHHS with running the data bank. H.R. REP. NO. 903, *supra* note 8, at 22, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6405; *see also* Iglehart, *supra* note 14, at 960-63.

### B. Promoting Peer Review

Part A of the Act eliminates many of the deterrents to more effective and aggressive peer review of physician competence and conduct. It provides immunity under federal and state law from damage suits against peer review groups and individuals acting in support of these groups,<sup>128</sup> preserving only civil rights actions.<sup>129</sup> The Act also precludes antitrust actions against peer review organizations unless the United States or a state attorney general brings the action.<sup>130</sup> Because courts have found that peer review groups have used peer review to restrain competition, the Act also prohibits physicians in direct economic competition with the physician facing discipline from sitting on the peer review group.<sup>131</sup>

The grant of immunity in the Act is conditioned on two factors. First, a peer review group must provide sufficient due process protections to a physician subjected to peer review action. The Act specifically details the procedures Congress deemed to be appropriate due process, and creates a rebuttable presumption that the peer review group met the due process requirements even if the group did not follow the procedures in the Act.<sup>132</sup> Second, the peer review group must take the disciplinary action in the reasonable belief that the action will further quality health care.<sup>133</sup>

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128. 42 U.S.C.A. § 11,111. The Act extends immunity to witnesses who appear before the group, private investigators, and most importantly, other physicians who may have worked with the suspect physician in the past and who could have been aware of the suspect physician's deficiencies.

129. *Id.* The legislative history indicates that the immunity provisions do not bar physicians from seeking injunctions or declaratory relief against peer review groups who propose disciplinary actions. See *supra* note 28.

130. 42 U.S.C.A. § 11,111(a). The \$2.2 million antitrust judgment of the United States District Court for the District of Oregon in *Patrick v. Burget*, 800 F.2d 1498 (9th Cir. 1986), *rev'd*, 108 S. Ct. 1658 (1988), horrified the medical profession generally because it resulted from a routine peer review action. Dolin, *supra* note 5, at 1156-57. This provision of the Act may be what the medical community wanted most from Congress. See *Medical Malpractice Hearings*, *supra* note 21, at 437-39 (statement of Raymond Scalettar, M.D.); Iglehart, *supra* note 14, at 960-63.

131. 42 U.S.C.A. § 11,112. While this provision of the Act aims at ensuring that peer groups do not engage in anticompetitive activity, see H.R. REP. NO. 903, *supra* note 8, at 2-3, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6385, it arguably may undermine the effectiveness of the peer review process in areas with relatively small numbers of physicians. The theory behind peer review is that only someone with comparable training and experience is capable of judging a professional, like a physician. See *supra* note 5. Thus, if someone is a true peer, that person is by definition in competition to provide medical services identical to those of the physician he or she must evaluate. *Id.* Peer review groups may be forced to hire physicians from other cities to sit on disciplinary panels in order to comply with the terms of the Act and also provide meaningful review.

132. 42 U.S.C.A. § 11,112.

133. *Id.*

The Act gives peer review groups immunity and flexibility to summarily suspend a physician's hospital or clinic privileges for up to fourteen days when the physician poses an imminent danger to the health of his or her patients.<sup>134</sup> However, the peer review group must restore the physician's privileges at the end of the fourteen days, or when the physician no longer poses an imminent danger to patients, regardless of whether the peer review group has completed its investigation and deliberations concerning formal disciplinary action.<sup>135</sup>

Part A also conditions the peer review group's immunity on faithful reporting of disciplinary actions to the national data bank.<sup>136</sup> It further requires the DHHS to investigate failures to report disciplinary actions. If the DHHS finds that a peer review group failed to report to the data bank, the Act requires the DHHS to publish the name of the group in the Federal Register, and the group loses immunity under the Act for three years.<sup>137</sup>

### C. Reporting Disciplinary Information

Part B of the Act requires a variety of individuals and organizations to report disciplinary actions, as well as malpractice payments and settlements, to both state licensure boards and the national data bank.<sup>138</sup> The Act establishes a different trigger for reporting by each type of individual or organization required to report. Insurance companies and physicians must report all money paid in settlement of malpractice claims or judgments, regardless of the amount, although the Act precludes any presumption of malpractice from such a report.<sup>139</sup>

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134. *Id.* § 11,112(c). Because a truly incompetent physician can kill, peer review groups must have the power to act immediately when they perceive such a threat.

135. *Id.*

136. *Id.* § 11,111(b). The AMA and the FSMB strongly objected to any ties between immunity and reporting under the Act. See *Medical Malpractice Hearings*, *supra* note 21, at 429 (statement of Raymond Scalettar, M.D.); *Hearings*, *supra* note 45, at 55 (statement of Bryant L. Galusha, M.D.). If both groups believed that the only way to stop incompetent physicians was through the use of a computer network similar to their own respective data banks, it seems they should have favored some sanction that would ensure reporting. Their protests create the impression that of the two parts of the Act, the immunity provision was the more important to them.

137. 42 U.S.C.A. § 11,111(b).

138. Insurance companies and physicians must report malpractice payments directly to the data bank and to the state licensure board in the state where the plaintiff brings the claim. 42 U.S.C.A. §§ 11,131(a), 11,134. Peer review groups need report only to state licensure boards. *Id.* § 11,133. Medical licensure boards must report directly to the data bank. *Id.* § 11,132.

139. *Id.* §§ 11,131, 11,137(d). Congress decided not to set a dollar threshold for reports of malpractice payments because Congress believed that a physician who made many small malpractice payments over a short period of time might deserve scrutiny. H.R. REP. NO. 903, *supra* note 8, at 13-14, reprinted in 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6396.

Health care facilities must report any disciplinary action resulting from a peer review process if it affects a physician's privileges<sup>140</sup> to practice for more than thirty days. Health care facilities also must report to licensure boards whenever a physician surrenders his or her privileges while under investigation or in exchange for an agreement from the facility to forego an investigation.<sup>141</sup> The Act requires state licensure boards to report to the national data bank any type of disciplinary action they take, from a verbal reprimand to actual revocation of the physician's license.<sup>142</sup>

All individuals and organizations required to report disciplinary actions under part B face sanctions if they fail to report.<sup>143</sup> If an insurance company or individual physician fails to report a payment made to settle a malpractice claim or judgment, regardless of the amount, the DHHS may impose a \$10,000 civil penalty on the physician or insurance company.<sup>144</sup> If a health care facility fails to report a disciplinary action, the Act makes the facility ineligible for the immunity granted by part A of the Act.<sup>145</sup> If a state licensure board fails to report any action affecting a physician's license status, the DHHS will designate another organization to report to the data bank in place of the licensure board.<sup>146</sup>

Part B of the Act also requires health care facilities to check the information in the data bank before issuing privileges to practice at that facility to physicians who initially apply for privileges, and to recertify the licensure status of each physician already with privileges every two years thereafter.<sup>147</sup> If a facility fails to inquire, a court will deem the facility to have known any adverse information it could have learned had it checked with the data

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140. The Act defines "privileges" as follows: "'[C]linical privileges' includes privileges, membership on the medical staff, and the other circumstances pertaining to the furnishing of medical care under which a physician or other licensed health care practitioner is permitted to furnish such care by a health care entity." 42 U.S.C.A. § 11,151(3).

141. *Id.* § 11,133.

142. *Id.* § 11,132.

143. *Id.* §§ 11,131(c), 11,132(b), 11,133(c).

144. *Id.* § 11,131(c).

145. *Id.* § 11,133(c).

146. *Id.* § 11,132(b). The effect of this last sanction is unclear. The Act permits the DHHS to exclude a state licensure board from the system and to replace it with another organization. *Id.* § 11,133(c)(2). However, states, in almost all cases, have only one organization capable of generally evaluating physicians and taking disciplinary action. The FSMB and the AMA are the only alternative sources for information about disciplinary actions, and both are fed information from the licensure boards. This section of the Act seems to have the most significant preemptive effect on state law of any provision in the Act, but the effect merely excludes the licensure board from the data bank without interfering with the board's authority to license and discipline physicians. *Id.*

147. *Id.* § 11,135.

bank.<sup>148</sup> If a facility relies on information obtained from the data bank, the Act absolves the facility from liability for its reliance on that data unless the facility knew the information obtained was false.<sup>149</sup> Medical licensure boards may obtain information from the data bank at their discretion.<sup>150</sup>

### III. PHYSICIANS UNDER ATTACK: WHERE DOES IT HURT?

During the legislative process, Congress focused almost exclusively on the effect of the Act on licensure boards and peer review groups.<sup>151</sup> Congress, as well as the witnesses who testified before it and the federal agencies reporting to it, spent little time studying the effect of the Act on individual physicians. Yet the Act may have a very serious impact on individual physicians, and in some cases may strip a physician of his or her ability to practice medicine.

#### A. Legislative AIDS (*Acquired Immunity Deficiency Syndrome*)

Because disciplinary groups often take punitive action against physicians for improper reasons,<sup>152</sup> physicians can expect these groups to continue acting in response to improper motives. Due to the Act, physicians have lost much of their ability to defend themselves against improper peer review actions. Like victims of the disease AIDS,<sup>153</sup> physicians could become defenseless prey to opportunistic and destructive peer review groups.

Under the Act, a physician may still bring an action against a peer review group for damages in tort or under antitrust laws, but only if the physician can first rebut the Act's presumption that a disciplinary group's action is, more likely than not, reasonably related to the furtherance of quality health

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148. *Id.* § 11,135(b). Hospitals may need to keep complete records of all data bank inquiries to ensure that they can prove they checked the data bank before allowing the physician to practice at the hospital or clinic. Otherwise, hospitals face almost certain liability for any harm the physician commits in the facility.

149. *Id.* § 11,135(c).

150. *Id.* § 11,137. Had Congress required state boards to check the data bank before issuing a license, it would have interfered directly with the licensure process itself, as established by the state legislature in the state's medical practice act. Such a requirement could have resulted in a de facto federal licensure standard, preempting differing state standards.

151. The legislative history of the Act, H.R. REP. NO. 903, *supra* note 8, at 2-3, reprinted in 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6384-86; the testimony of the two major professional associations, *Medical Malpractice Hearings*, *supra* note 21 (statement of Raymond Scalettar, M.D.) and *Hearings*, *supra* note 45 (statement of Bryant L. Galusha, M.D.); and the articles in professional journals, such as Iglehart, *supra* note 14, concentrate on peer review groups and the disciplinary process.

152. See *supra* notes 54-58 and accompanying text.

153. Acquired Immune Deficiency Syndrome (AIDS) attacks the body's immune system, leaving the body unable to defend itself against invading viruses that human antibodies normally could overcome. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, SURGEON GENERAL'S REPORT ON ACQUIRED IMMUNE DEFICIENCY SYNDROME 10 (1986).

care.<sup>154</sup> Because medicine is not an exact science, physicians usually have several options from which to choose when treating a patient.<sup>155</sup> As long as a disciplinary group can use the wisdom of hindsight to assert that a physician should have used method *B* instead of method *A*, the group's action is reasonably related to furthering quality health care. If the physician can overcome the initial presumption, he or she can go forward with the suit, but must prevail on the merits to receive any relief. In the past, physicians prevailed against disciplinary groups only in approximately twenty-nine percent of the cases brought.<sup>156</sup>

While the Act may not affect the number of physicians who prevail on the merits, it will reduce substantially the number of physicians able to reach the merits, or willing to risk paying the disciplinary group's legal expenses if the physician loses.<sup>157</sup> Disciplinary groups should be less reluctant to take disciplinary actions, as Congress intended, because of their newly acquired federal immunity. However, more vigorous peer review under the Act will be costly to individual physicians, because the threshold at which a disciplinary group is immunized is so low that even when a disciplinary group acts for improper reasons, it probably will be able to show that its actions were in some way related to furthering quality health care.

#### *B. Extending the Life of a Physician's Reputation*

Although the Act's immunity provisions for disciplinary groups make it difficult for a physician to obtain relief from improper disciplinary action, a physician can overcome them. Consequently, part A of the Act provides some hope for superficial recovery of a physician's reputation. If a physician prevails against a disciplinary group, the physician collects his or her damages, has his or her professional disabilities officially removed, and continues practicing medicine. Part B, however, provides no hope of recovery for the physician's professional life.

Part B of the Act creates a presumption that medical licensure boards and health care facilities must monitor a physician reported to the data bank either because the physician did something wrong, or because the physician *may* have done something wrong.<sup>158</sup> Thus, a report to the data bank de-

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154. 42 U.S.C.A. § 11,112.

155. Cf. F. GRAD & N. MARTI, *supra* note 6, at 2 (the greater range of choices available to physicians today makes it difficult for physicians to know what choice is the best); MEDICAL LICENSURE AND DISCIPLINE, *supra* note 6, at 14 (there is "considerable variation among physicians themselves about what constitutes acceptable practice in many facets of medicine").

156. R. DERBYSHIRE, *supra* note 5, at 94.

157. 42 U.S.C.A. § 11,113.

158. The section of the Act that requires insurance companies and physicians to report



stroys a physician's right to be presumed innocent.<sup>159</sup> While losing the presumption of innocence may not rise to the level of being guilty, it will blemish the physician's professional reputation as long as the information remains in the data bank.<sup>160</sup> 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.

Like most professionals, physicians rely on their reputations to foster the success of their practice.<sup>161</sup> Colleagues and patients refer others to the physician for medical care because of the physician's reputation.<sup>162</sup> These referrals perpetuate more referrals, but only if the physician's reputation remains positive. Thus, a physician's reputation is second in value only to the physician's medical license.

When a board disciplines a physician, or when a patient sues the physician, claiming malpractice, the physician's reputation must suffer some effect. If either action results in a report about the physician in the data bank, the physician's reputation is frozen in the computer's memory chips. As a result, a physician may experience a wide variety of difficulties. Colleagues may lose respect for the physician, patients may turn to other physicians, income may fall, or peer review groups may deny the physician privileges at various facilities.<sup>163</sup>

As time passes, the physician will not know whether the information in the data bank is stifling career advancement and causing other losses, or whether his or her present performance causes any current problems. As more time passes, the relevancy of the disciplinary action to the physician's current skills and performance lessens. Yet, the physician's reputation is held captive in the data bank and follows the physician everywhere he or she

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payments made to settle malpractice claims carries with it a presumption that the payment does not mean that the physician actually committed malpractice. *Id.* § 11,137(d).

159. *Cf.* Shattuck, *supra* note 72, at 1002 ("Computer-matching can turn the presumption of innocence into a presumption of guilt.").

160. The Act does not fix the period of time for which records must remain in the national data bank. The DHHS published its intent to keep information in the data bank throughout the life of the physician, plus 15 years. *New System of Records*, 52 Fed. Reg. 34,721, 34,724 (1987). DHHS arrived at this time period because medical imposters often attempt to assume the identity and credentials of deceased physicians. *See* R. DERBYSHIRE, *supra* note 5, at 105-11.

161. F. GRAD & N. MARTI, *supra* note 6, at 197-98.

162. *See, e.g.*, Patrick v. Burget, 800 F.2d 1498, 1502 (9th Cir. 1986), *rev'd*, 108 S. Ct. 1658 (1988) (describing how physicians at the hospital where Patrick worked referred patients to other hospitals instead of to Patrick, even when Patrick was physically at the hospital).

163. *Cf.* Gerety, *supra* note 85, at 287 (describing potential problems arising from automated information used to approve mortgages or hire job applicants).

seeks to practice medicine.<sup>164</sup>

Part B of the Act creates the possibility of a more frightening scenario if a board erroneously reports to the data bank a physician whom it has not disciplined. If a licensure board report to the data bank includes a typographical error, for example, the reversal of two digits in a medical license number, a physician could suffer the same harm as a physician the licensure board has disciplined.<sup>165</sup> However, in such a case, the innocent physician probably would not know that a board had reported him or her to the data bank.<sup>166</sup>

Once a report harms a physician's reputation, there is no cure. Even if the physician were to win a monetary judgment against the government or a disciplinary group for its error, and even if a court ordered the government to delete the damaging information from the data bank and to contact every organization to which the government released the damaging information, these actions would not make the physician whole. People who simply heard about the physician's problems by word-of-mouth would not receive official retractions the government might issue. Despite the amazing capabilities of modern computers, they are no match for gossip, innuendo, and rumor.<sup>167</sup>

#### IV. PHYSICIANS ON THE ATTACK

The Act brings two of the most powerful forces in our society, the federal government and physicians, into open and direct conflict.<sup>168</sup> It injects the federal government into a realm historically governed by the states.<sup>169</sup> It places physicians under a federal spotlight intended to facilitate actions that

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164. See, e.g., 42 U.S.C.A. §§ 11,135, 11,137.

165. For example, the National Council of State Boards of Nursing issued its October 1987 disciplinary report identifying Sarah Jane Smith, license number 14,286, as the subject of a disciplinary action in Colorado. Letter from Karen D. Brumley, Program Administrator, Board of Nursing, State of Colorado, to Bruce Immerman, United States Public Health Service (Nov. 25, 1987). The agency that employs Ms. Smith full-time contacted the Colorado state board for more information. *Id.* The Board responded that Sarah Jane Smith had never been licensed in Colorado, that the license number reported belonged to Linda Mary Brown, whose license was suspended in 1986, not October 1987, and that Colorado had issued a license to a Sarah Stafford Smith, but no disciplinary action was ever taken against her. *Id.* The Board concluded its letter by questioning the legitimacy of its own report. The names in this footnote have been changed to protect the nurses' privacy.

166. *Cf.* Letter from Bruce Immerman, United States Public Health Service, to nurse erroneously identified in disciplinary action report (Dec. 18, 1987) (nurse identified in disciplinary report because of error in recording her license number).

167. See Gerety, *supra* note 85, at 287.

168. See Iglehart, *supra* note 14, at 964.

169. See *supra* text accompanying notes 31-42.

would deprive them of their livelihood.<sup>170</sup> The Act seeks to accomplish these goals by a controversial method—sharing derogatory information through a federal computer.<sup>171</sup>

Because a physician's ability to practice medicine freely is of great value, the government should take actions that will impair a physician's ability to practice medicine only when necessary to vindicate a more important interest or right,<sup>172</sup> and only after providing the physician with due process of law.<sup>173</sup> When drafting the Act, Congress should have asked whether a particular provision of the Act promotes the government's interest in protecting public health and safety to a degree that outweighs the physician's interest in his or her unimpaired ability to practice medicine.<sup>174</sup>

Congress apparently failed to perform this balancing test. As a result, several provisions of the Act seem to infringe on individual rights protected by the Constitution, such as equal protection of the law,<sup>175</sup> freedom from unreasonable government searches and seizures,<sup>176</sup> personal privacy free of governmental intrusion,<sup>177</sup> and due process of law prior to governmental deprivation of life, liberty, or property.<sup>178</sup> Because individual physicians have much to lose and little to gain from the Act, physicians probably will challenge the constitutionality of the Act itself, in addition to challenging disciplinary actions taken against them. While Congress may have the

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170. 42 U.S.C.A. § 11,101; see also Waxman, *supra* note 2, at 943.

171. See *supra* text accompanying notes 84-88.

172. Courts have used this reasoning in other contexts. See, e.g., *United States v. Salerno*, 107 S. Ct. 2095, 2103 (1987) (community safety outweighs the liberty interest of a criminal suspect denied bail pending trial); *Bowen v. Roy*, 476 U.S. 693, 699-700 (1986) (the government's interest in efficient operation of its welfare programs outweighs a beneficiary's interest in not obtaining a social security number because of religious beliefs); *Whalen v. Roe*, 429 U.S. 589, 602 (1977) (vital interest in reducing illegal narcotic traffic outweighs privacy interest of patient for whom narcotics are prescribed); see also L. TRIBE, *AMERICAN CONSTITUTIONAL LAW* § 15-17, at 969 (1978) ("[W]here exposure of potentially derogatory information about an individual serves a significant governmental purpose, such exposure is not automatically unconstitutional. The key point to note is that a valid and sufficient governmental purpose may not be presumed lightly . . .").

173. Because a license to practice medicine has been described as a property right, *Dent v. West Virginia*, 129 U.S. 114, 121-22 (1889), the government must provide procedural due process before it impairs that right. *Salerno*, 107 S. Ct. at 2101.

174. See, e.g., *Salerno*, 107 S. Ct. at 2102-03 (the government's interest in protecting the public from dangerous criminals outweighs a criminal's interest in liberty).

175. U.S. CONST. amend. V.

176. U.S. CONST. amend. IV.

177. The exact source of the right to privacy has not been finally decided, but Justice Douglas, in *Griswold v. Connecticut*, 381 U.S. 479 (1965), found privacy rights emanating from the first, third, fourth, fifth, and ninth, amendments, *id.* at 483-85; see also Peck, *supra* note 82, at 902-03.

178. U.S. CONST. amend. V.

power to preclude causes of action at common law<sup>179</sup> or created by statute,<sup>180</sup> the Supreme Court has never permitted Congress to bar all suits challenging the constitutionality of an act.<sup>181</sup>

Constitutional analysis of a statute starts with a presumption that an act of Congress regulating public health and safety is constitutional,<sup>182</sup> and continues with a valuation of the interest the statute advances.<sup>183</sup> The interest allegedly injured by the statute, or a specific provision of the statute, determines the burden the physician must overcome to defeat the challenged provisions of the statute.<sup>184</sup>

### A. Equal Protection Analysis

The equal protection clause of the Constitution ensures that when a government treats similarly situated individuals differently, the government has

179. See, e.g., *San Diego Bldg. Trades Council v. Garmon*, 359 U.S. 236 (1959).

180. *United States v. Locke*, 471 U.S. 84, 104-10 (1985) (Congress can legislate to deny substantive rights to further legitimate legislative objectives); see also *Patrick v. Burget*, 108 S. Ct. 1658, 1665 n.8 (1988) (referring to immunity provisions of the Health Care Quality Improvement Act), *rev'g*, 800 F.2d 1498 (9th Cir. 1986).

181. See *Barlett v. Bowen*, 816 F.2d 695, 704-07 (D.C. Cir. 1987); see also U.S. CONST. art. VI, cl. 2.

182. "[S]tatutes come to us clothed with the authority of Congress and attended by a correspondingly heavy presumption of constitutionality." *Shapiro v. Thompson*, 394 U.S. 618, 676 (1969) (Harlan, J., dissenting); see also *Duke Power Co. v. Carolina Env'tl. Study Group, Inc.*, 438 U.S. 59, 83 (1978); *City of New Orleans v. Dukes*, 427 U.S. 297, 303 (1976).

183. The government's interest in a legislative objective can range from plausible, *United States R.R. Retirement Bd. v. Fritz*, 449 U.S. 166, 179 (1980), to compelling, *United States v. Salerno*, 107 S. Ct. 2095, 2102-03 (1987). The government's interest in regulating public health and safety leans toward compelling. See, e.g., *Salerno*, 107 S. Ct. at 2102 ("[G]overnment's regulatory interest in community safety can . . . outweigh an individual's liberty interest."); *Bowen v. Roy*, 476 U.S. 693, 732 (1986) (O'Connor, J., concurring in part and dissenting in part) (government's interest in stopping fraud and abuse of welfare is compelling); *Whalen v. Roe*, 429 U.S. 589, 598 (1977) (government's interest in controlling illegal distribution of narcotics is vital). Consequently, the governmental interest the Act advances should be considered compelling. However, if a specific provision of the Act fails to promote public health and safety, and some do fail, as discussed *infra* at text accompanying notes 185-95, then the physician's burden in challenging that provision of the Act will decrease.

184. The government's interest can override every individual right, including a fundamental right such as the right to life, provided the governmental interest being promoted is sufficiently compelling. See *Furman v. Georgia*, 408 U.S. 238, 342-59 (1972) (Marshall, J., concurring) (examining the validity of possible legislative purposes for capital punishment). If the Act tangibly harms some fundamental right of the physician, a reviewing court will give strict scrutiny to the means by which the Act accomplishes its objectives. *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965); *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942). If the Act harms some interest that is less than a fundamental right, the value of that interest to the physician will determine the level of deference the Court gives to the specific provision of the Act the physician is challenging. See, e.g., *supra* note 183, cases and accompanying discussion.

a legitimate reason for doing so.<sup>185</sup> If no legitimate reason for the disparate treatment exists, the government may not impose the discriminatory treatment. On its face, the Act appears to treat physicians, and all other health professionals subject to state licensure,<sup>186</sup> the same. However, certain provisions of the Act are discriminatory when applied.<sup>187</sup>

A physician could argue that section 11,132 of the Act, which requires licensure boards to report every disciplinary action they take to the data bank,<sup>188</sup> violates the equal protection clause. Because one state may discipline conduct that another state may not,<sup>189</sup> two physicians who have engaged in the same conduct, but who are licensed by different states, will not be treated alike under the Act. The public, however, has an equal interest in learning about both physicians.

If State *A* routinely places all physicians with drug abuse problems on probation,<sup>190</sup> but State *B* takes no action in a similar case, only the licensure board in State *A* will report the physician to the data bank. Thus, only the physician in State *A* will suffer the harm that may flow from being labeled a drug abuser in a data bank that his or her professional community routinely checks.

This disparate treatment perpetuates and exacerbates the problem Congress hoped to eliminate with the Act. Under section 11,132, physicians in State *B* are free to go from state to state because no information about their drug abuse exists in the data bank. The data bank will report physicians from State *A* to states like *B*, even though states like *B* are not interested in the report because they do not impose sanctions on physicians for drug

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185. See, e.g., *City of Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432 (1985) (government had no legitimate interest in forbidding mentally retarded individuals from living in the neighborhood).

186. 42 U.S.C.A. § 11,115(c).

187. Under current equal protection analysis, a physician could attack the facial validity of the statute, as well as its validity as applied. See generally J. NOWAK, R. ROTUNDA & J. YOUNG, *CONSTITUTIONAL LAW* § 14.2 (3d ed. 1986) [hereinafter J. NOWAK]. Attacks on facial validity are extraordinarily difficult to make because the physician would need to show that the Act would not be valid under any set of circumstances. *Salerno*, 107 S. Ct. at 2100. An attack on a specific provision of the Act, as the government applies it to the physician, would be easier to maintain because the physician would need to show only that a provision has no rational relationship to the Act's objectives. See, e.g., *Whalen*, 429 U.S. at 597.

188. 42 U.S.C.A. § 11,132.

189. F. GRAD & N. MARTI, *supra* note 6, at 26-27.

190. The state of Maryland conducts a rehabilitation program for impaired physicians, aimed at helping physicians overcome problems amenable to treatment, like drug abuse. See *Commission Sometimes Takes Years to Act in Incompetence Cases*, Wash. Post, Jan. 11, 1988, at A6, col. 2. Under the program, Maryland has allowed physicians who abuse drugs to keep their licenses to practice medicine, but places these physicians in a probationary status. See *Rehabilitation at Work: Dr. Coombs*, Wash. Post, Jan. 11, 1988, at A6, col. 1.

abuse. By deferring to state disciplinary standards, section 11,132 also could cause the migration of substandard physicians into states that have relaxed disciplinary standards, and that consequently make few reports to the data bank.<sup>191</sup> Once licensure boards realize how seriously a report to the data bank may affect a physician's career, boards may become even more reluctant to take disciplinary actions,<sup>192</sup> particularly those actions triggered by minor violations of professional standards. Boards may prefer to take an "all or nothing" approach to discipline once reporting is required. None of these results furthers Congress' objectives.

The reporting requirements imposed on licensing boards are significantly overbroad and underinclusive.<sup>193</sup> Congress could use means that are more closely tailored to achieving the Act's objectives and at the same time avoid the inequities that section 11,132 imposes on physicians. For example, Congress could require reports from licensure boards only when the boards take disciplinary action to restrict, suspend, or revoke a physician's license for more than thirty days. This standard is comparable to the reporting requirements imposed on health care facilities under section 11,133.<sup>194</sup> Congress could also draft a list of the types of physician incompetence and misconduct that boards must report in all cases. This would ensure a uniform level of protection against incompetency throughout the entire country.<sup>195</sup>

### B. Unreasonable Search and Seizure

While the equal protection clause protects groups of citizens from dis-

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191. A physician could argue that the Act creates an impermissible burden on the right to travel, *Shapiro v. Thompson*, 394 U.S. 618 (1969), because once the data bank starts reporting a physician's disciplinary record, he or she may not be able to obtain a license or privileges in another state. Consequently, the physician might be forced to remain in the state that took the disciplinary action and be denied an opportunity to move elsewhere for a new beginning. Because the Supreme Court has considered the right to travel as fundamental in some cases, abridgment of this right might trigger strict scrutiny analysis. *Id.* However, Congress specifically intended to impair the right to travel to prevent substandard physicians from evading discipline by moving to another state. H.R. REP. NO. 903, *supra* note 8, at 2-3, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6384-86. Thus, a right to travel challenge would be almost identical to an attack on the facial validity of the statute because a reviewing court would need to find Congress' objectives unconstitutional before the physician could prevail. *See generally* J. NOWAK, *supra* note 187, §§ 14.2, 14.38.

192. *Cf.* F. GRAD & N. MARTI, *supra* note 6, at 139-40 (physicians reluctant to report substandard conduct to state licensure board due to fear that punishment of colleague, such as suspension or revocation of license, may be disproportionately severe).

193. *See* J. NOWAK, *supra* note 187, § 14.2.

194. *See* 42 U.S.C.A. § 11,133.

195. Experts on physician licensing and discipline have recommended uniform standards throughout the country, and Congress has considered several legislative proposals to create uniform standards. F. GRAD & N. MARTI, *supra* note 6, at 8-9, 110-12.

criminy government practices, the fourth amendment's proscription of unreasonable searches and seizures protects the individual from certain types of governmental intrusion.<sup>196</sup> The Act requires a variety of intrusions into the personal affairs of physicians and requires the seizure of information that physicians would prefer to keep hidden.

The Supreme Court analyzes cases dealing with violations of the fourth amendment under the standard set forth in *Katz v. United States*.<sup>197</sup> According to *Katz*, government action implicates the fourth amendment only when the government invades an area in which someone has a reasonable expectation of privacy.<sup>198</sup> A person has a reasonable expectation of privacy when the person has a subjective expectation of privacy and when society in general would consider that expectation reasonable.<sup>199</sup>

The Act requires health care facilities and licensure boards to report information about disciplinary actions and malpractice settlements to the data bank. This information is not related to a physician's private life, but rather to his or her public profession. Under the *Katz* analysis, a physician would have a difficult time arguing that the public as a whole believes that the physician has a privacy expectation in information concerning his or her ability to practice medicine upon members of the public.<sup>200</sup> Current fourth amendment jurisprudence would not recognize a fourth amendment issue in the provisions of the Act.<sup>201</sup>

The Supreme Court has said that the fourth amendment prohibition against unreasonable searches and seizures protects people, not property.<sup>202</sup> However, a review of the Court's cases shows that in almost every case, unless there is some tangible property involved, the Court usually will not recognize any fourth amendment interest.<sup>203</sup> Some legal scholars suggest that the scope of the fourth amendment must be broad enough to protect

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196. U.S. CONST. amend. IV.

197. 389 U.S. 347 (1967).

198. *Id.* at 351.

199. *Id.* at 351-52.

200. *Cf. Gerety, supra* note 85, at 257-60. "[M]ost of us have very little power or expectation of power over the opinions and impressions others may form of us. Every affront to our dignity in that outer world, while felt, even keenly, in our inner world, is not a legally cognizable assault upon our private selves." *Id.* at 259-60.

201. *See New Jersey v. T.L.O.*, 469 U.S. 325, 341 nn.6-7 (1985) (schools can search personal property of students to ensure compliance with school rules); *see also Whalen v. Roe*, 429 U.S. 589, 604 n.32 (1977) (fourth amendment has never been extended to protect against computer oversight).

202. *Katz*, 389 U.S. at 351-52.

203. *See, e.g., United States v. Dionisio*, 410 U.S. 1 (1973) (no fourth amendment interest in voice or face); *United States v. Mara*, 410 U.S. 19 (1973) (no fourth amendment interest in handwriting).

intangible property, such as a person's reputation.<sup>204</sup>

The seizure of a physician's reputation that the Act requires differs from traditional fourth amendment problems because when the government seizes a physician's reputation under the Act, the seizure continues as long as the derogatory information remains in the national data bank. What may be a reasonable seizure when it is a discrete event with a beginning and an end, should become unreasonable when the seizure continues through time without any opportunity for the physician to recover what the government seized.<sup>205</sup> As government relies more and more on the almost perfect memories of computers, both Congress and the Court should have ample opportunity to consider exactly at what point in time the fourth amendment begins to afford protection.<sup>206</sup>

### C. Fundamental Right to Privacy

Courts and legal scholars frequently debate whether the Constitution contains a fundamental right of privacy.<sup>207</sup> This Comment assumes that such a right exists and that it is fundamental.<sup>208</sup> Government recordkeeping about a physician's professional competence should not implicate any general privacy interest. However, most cases<sup>209</sup> and commentaries<sup>210</sup> that concern government recordkeeping and government use of computers discuss the government's potential to invade individual privacy through these activities.

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204. See Peck, *supra* note 82, at 906-07; Shattuck, *supra* note 72, at 1002.

205. Cf. Gerety, *supra* note 85, at 288.

The threat of misuse becomes as permanent as the records themselves. The risks . . . multiply not simply because of the heightened possibility of unconsented reproduction and distribution at any given time, but also because those possibilities, however reduced by regulation, now extend indefinitely through time. Such a chronic and enduring risk must count as itself an injury.

*Id.*

206. See Peck, *supra* note 82, at 911-12.

207. See Gerety, *supra* note 85, at 239 n.25.

208. See, e.g., *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965) (right to privacy implied in Bill of Rights); *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting) (privacy is the "most comprehensive of rights"). See generally Warren & Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193 (1890).

209. See, e.g., *Whalen v. Roe*, 429 U.S. 589, 605-07 (1977) (computerized records could violate privacy rights); *California Bankers Ass'n v. Shultz*, 416 U.S. 21, 78-99 (1974) (Powell, Douglas, Brennan, Marshall, JJ., dissenting separately) (dissenters express concern over ease of governmental intrusion into privacy); *Utz v. Cullinane*, 520 F.2d 467, 476 (D.C. Cir. 1975) (government records of arrests implicate right to privacy); *Tarlton v. Saxbe*, 507 F.2d 1116, 1124 (D.C. Cir. 1974) (police records have potential to violate personal privacy).

210. See generally Gerety, *supra* note 85; Peck, *supra* note 82; Shattuck, *supra* note 72; Simitis, *Reviewing Privacy in an Information Society*, 135 U. PA. L. REV. 707 (1987); Note, *Formalism, Legal Realism, and Constitutionally Protected Privacy Under the Fourth and Fifth Amendments*, 90 HARV. L. REV. 945 (1977).



The Act gives a physician some privacy interest in the information collected and disseminated by the data bank. It provides that information in the data bank is confidential and that the government shall not disclose it, except as required under the Act or as authorized under state law.<sup>211</sup> This provision provides little privacy because most states have freedom of information laws that may require disciplinary groups to disclose information obtained under the Act.<sup>212</sup>

As time passes and the wrongful act that resulted in the physician being reported to the data bank becomes more remote, the physician should develop a privacy interest in the data bank information because the governmental and public interest in the information about the wrongful act decreases.<sup>213</sup> An act that occurred when a physician just finished residency training may not be relevant after the same physician has practiced for thirty years without any other blemish on his or her record. Further, as the physician proves his or her value to society over time, the physician earns the right to his or her current reputation without reference to a past mistake. Yet, as long as the information remains in the data bank, the data bank will report that information to every facility that considers extending privileges to the physician,<sup>214</sup> and to every facility conducting the biannual credential check that the Act requires.<sup>215</sup>

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211. 42 U.S.C.A. § 11,137(b).

212. Project, *supra* note 81, at 1163 n.1169 (1975); *see also* F. GRAD & N. MARTI, *supra* note 6, at 164-66.

One commentator on professional licensure asserts that licensure boards have been ineffective at self-regulation because disciplinary actions are unknown to the public. *See* S. GROSS, *supra* note 1, at 80-81. If the public knew the real level of a physician's professional competence, the commentator suggests, marketplace dynamics would cause consumers to stop using less competent physicians in favor of those with high competency ratings. *Id.* Under this theory, recognizing a privacy interest in physician's professional competence would defeat Congress' purpose in enacting the Act.

213. *See, e.g., California Bankers Ass'n*, 416 U.S. at 79 (Powell, J., concurring) ("At some point, governmental intrusion upon these areas would implicate legitimate expectations of privacy."). *But see* Reporters Comm. for Freedom of the Press v. United States, 816 F.2d 730, 741 (D.C. Cir. 1987) ("Nor can we say that an older public record has lost its public interest . . ."), *cert. granted*, 108 S. Ct. 1467 (1988) (No. 87-1379); *cf. Michelson v. United States*, 335 U.S. 469, 482 (1949) (An arrest can "even enhance the standing of the one who mends his way and lives it down."); Bazelon, *Probing Privacy*, 12 GONZ. L. REV. 587, 589 (1977) ("[O]ur secrets concern weaknesses that we dare not reveal to a competitive world, . . . past deeds that bear no relevance to present conduct, or desires that a judgmental and hypocritical public may condemn.").

214. Section 11,135 of the Act requires all health care facilities to check with the national data bank to see if it contains derogatory information concerning a physician who has applied to the facility for privileges. 42 U.S.C.A. § 11,135.

215. Once a facility grants privileges to a physician, the facility must verify the physician's licensure status every two years for as long as the physician has privileges. *Id.*

With the Act, Congress created a computer network that is almost identical to computer networks it created to detect and prevent criminal activity.<sup>216</sup> The Federal Bureau of Investigation (FBI) operates several of these networks.<sup>217</sup> All federal and state law enforcement agencies report criminal activity to, and obtain similar information from, these networks. Individuals with records in the FBI network challenged its constitutionality shortly after it was created, in *Menard v. Saxbe*,<sup>218</sup> *Tarlton v. Saxbe*,<sup>219</sup> and *Utz v. Cullinane*.<sup>220</sup> The United States Court of Appeals for the District of Columbia Circuit heard all three cases and generally upheld the constitutionality of the FBI network. However, the court in *Cullinane* expressed doubts about the constitutionality of the FBI network when it contained records about individuals who had been arrested but not yet convicted, and those who courts had exonerated of earlier convictions.<sup>221</sup> Because these two groups of individuals were presumptively innocent, the court said the FBI could not identify them as criminals in its computer network.<sup>222</sup> However, the court decided the case on other grounds, rendering the doubts expressed about the constitutionality of the computer network dicta.<sup>223</sup>

The government's interest in maintaining information about criminal activity is far greater than its interest in a physician's disciplinary records.<sup>224</sup> However, Congress has created a computer surveillance system for physicians that is almost identical to the one Congress established for criminals, in that both computer systems track their subjects for life.<sup>225</sup> Courts have recognized that a criminal record can stigmatize an individual.<sup>226</sup> Under the Act, a physician may face similar stigmatization. In both cases, the stigma

216. See *Reporters Comm. for Freedom of the Press*, 816 F.2d at 732 & nn. 1-2, 733 & nn. 3-4; Bank Secrecy Act, Pub. L. No. 91-508, §§ 121-129, 84 Stat. 1114 (1970) (codified as amended at scattered sections of 12 & 31 U.S.C.); Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93, § 5, 101 Stat. 680, 689 (to be codified in scattered sections of 42 U.S.C.).

217. For a description of how the FBI uses the information it collects on criminal activity, see *Reporters Comm. for Freedom of the Press*, 816 F.2d at 733 n.3.

218. 498 F.2d 1017 (D.C. Cir. 1974).

219. 507 F.2d 1116 (D.C. Cir. 1974).

220. 520 F.2d 467 (D.C. Cir. 1975).

221. *Id.* at 478.

222. *Id.*

223. *Id.* at 483.

224. *But see In re Ruffalo*, 390 U.S. 544, 551 (1968) (license revocation proceeding is of a quasi-criminal nature).

225. Compare *Reporters Comm. for Freedom of the Press v. United States*, 816 F.2d 730, 732-33, 738-42 (D.C. Cir. 1987), cert. granted, 108 S. Ct. 1467 (1988) (No. 87-1379) with *National Data Bank for Adverse Information on Physicians and Health Care Practitioners*, 53 Fed. Reg. 9264 (1988) (to be codified at 45 C.F.R. § 60.13) (proposed Mar. 21, 1988) (specifying no time period for which DHHS will keep the records).

226. See, e.g., *Michelson v. United States*, 335 U.S. 469, 482 (1948) (arrest record can

can have profound effects on an individual.<sup>227</sup>

In certain circumstances, courts permit an individual to have his or her criminal record expunged.<sup>228</sup> Congress should provide this same opportunity to a physician whose conduct shows that he or she is not likely to repeat the conduct that resulted in the disciplinary action. Because the Act does not specify how long the data bank must keep individual disciplinary records, the regulations implementing the Act could permit removal of the record. Because the value of the record diminishes over time, at a certain point in time a physician should be able to ask the DHHS to expunge the disciplinary record. Even if the government's interest in protecting public health makes it unwise to completely eliminate a record, the government could remove the record to an inactive file and simply stop disseminating the record routinely during the credential checks.

#### D. Due Process Analysis

##### 1. When Due Process is Due

A physician's license to practice medicine is a constitutionally protected property interest.<sup>229</sup> A physician's reputation may be a liberty interest meriting similar protections.<sup>230</sup> A disciplinary group that reports a physician to the data bank arguably affects both the physician's property and liberty interests. Before the government can impair or deprive the physician of these interests, the government must provide the physician with an opportunity to be heard.<sup>231</sup>

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cause variety of problems for record subject); *Menard v. Mitchell*, 430 F.2d 486, 491 n.24 (D.C. Cir. 1970) (arrest record blemishes individual's reputation).

227. Cf. Gerety, *supra* note 85, at 287-88 (describing the effects of computer errors on everyday activities).

228. See *Sullivan v. Murphy*, 478 F.2d 938, 968-73 (D.C. Cir.) (people caught in mass arrest during demonstration seek to have arrest record expunged), *cert. denied*, 414 U.S. 880 (1973); *United States v. McLeod*, 385 F.2d 734 (5th Cir. 1967) (civil rights workers' arrest is harassment); *Hughes v. Rizzo*, 282 F. Supp. 881 (E.D. Pa. 1968) (police arrested hippies to harass them).

229. *Hawker v. New York*, 170 U.S. 189, 191 (1898).

230. Cf. *Codd v. Velger*, 429 U.S. 624, 631-37 (1977) (Stevens, J., dissenting) (employee dismissed after attempting to commit suicide alleged his liberty interest in his reputation was violated when his former employer disclosed information about the suicide attempt without providing the employee with notice); *Wisconsin v. Constantineau*, 400 U.S. 433, 437 (1971) (plaintiff's liberty interest in his reputation was violated when the police department distributed a leaflet to merchants identifying him as a drunk driver without providing an opportunity for a hearing). *But see Paul v. Davis*, 424 U.S. 693, 701-02 (1976) (reputation alone does not constitute a liberty interest deserving protection under the due process clause).

231. *Utz v. Cullinane*, 520 F.2d 467, 480-81 (D.C. Cir. 1975) ("Due process obligates the government to accord an individual the opportunity to disprove potentially damaging allegations before it disseminates information that might be used to his detriment.").

Several provisions of the Act require a licensure board or peer review group to report a physician to the data bank when the physician has not had an opportunity to be heard because the physician surrendered his or her license voluntarily.<sup>232</sup> The physician is not entitled to procedural due process regarding the voluntary surrender of privileges or a license. Only government action triggers the right to due process.<sup>233</sup> However, if the licensure board or peer review group reports that the physician surrendered his or her privileges or license, the report itself could trigger a right to due process.<sup>234</sup> If the report contains allegations about the physician's competence or professional conduct, it could unfairly impair the physician's ability to continue practicing medicine because the allegations have not been proved and the physician has had no hearing.<sup>235</sup>

Even if a physician succeeds in a procedural due process challenge to this type of report, the challenge will only buy time and an opportunity for a hearing. If the physician fails to prevail on the merits, the licensure board or peer review group must report the physician to the data bank, which will disseminate the information.<sup>236</sup>

The disciplinary group that reports to the data bank might avoid a successful procedural due process challenge if the group limits its report to a factual statement that the physician surrendered his or her privileges or license on a particular date. The disciplinary group also could adopt a policy that in all cases, including a surrender of privileges or license, the group will

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232. 42 U.S.C.A. §§ 11,132(a)(1)(B), 11,133(a)(1)(B). Congress intended these provisions of the Act to keep physicians from "plea bargaining" with peer review groups and licensure boards in a brotherhood of silence. See *supra* note 21 and accompanying text. However, a physician may surrender his or her privileges voluntarily in response to improper pressure from the peer review group, or because of a belief that the peer review group is incapable of conducting an objective hearing. *Patrick v. Burget*, 800 F.2d 1498, 1504 (9th Cir. 1986), *rev'd*, 108 S. Ct. 1658 (1988).

233. See, e.g., *Codd*, 429 U.S. at 627-28; *Constantineau*, 400 U.S. at 437.

234. "The legality of government's program for . . . dissemination might independently violate a constitutional norm such as that of procedural due process even where no objection exists to the way in which the information was obtained or retained by government." L. TRIBE, *supra* note 172, § 15-17, at 972.

235. If the Act results in fewer physicians voluntarily surrendering their licenses, and instead, fighting the board action, licensure boards might find themselves completely overwhelmed with work. MEDICAL LICENSURE AND DISCIPLINE, *supra* note 6, at i. However, this is a gamble Congress decided to take. H.R. REP. NO. 903, *supra* note 8, at 18, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6400-01.

236. "[I]f the hearing mandated by the Due Process Clause is to serve any useful purpose, there must be some factual dispute between the employer and a discharged employee which has some significant bearing on the employee's reputation." *Codd*, 429 U.S. at 627. *But see id.* at 631 (Stevens, J., dissenting) ("I am not persuaded that a person who claims to have been 'stigmatized' by the State without being afforded due process need allege that the charge against him was false in order to state a cause of action.").

conduct a hearing prior to any reporting. The physician would then have an opportunity to formally present his or her position. The licensure board or peer review group could report both the physician's version of the incident and its own, without making any formal findings or conclusions. Facilities or groups that subsequently obtain the information from the data bank could conduct whatever further investigation they deem appropriate.

When an insurance company or physician reports a malpractice settlement to the data bank, no hearing is provided. In fact, no one could provide any semblance of an objective hearing unless the physician litigated the claim in a court. Presumably, the reason the physician or insurance company settled the claim was to avoid going to court. Yet the Act forces the physician or insurance company to choose between the expense and risk of litigation, the only hope of complete vindication, and settlement with a report to the data bank. Although the Act states that the settlement report creates no presumption of malpractice,<sup>237</sup> the report must have some significance or reporting it to the data bank becomes meaningless and irrational. Such law-making cannot stand.<sup>238</sup>

Congress believed that malpractice settlement information might serve as a warning that a physician might suffer competency problems.<sup>239</sup> The report casts a shadow on the physician's reputation by identifying him or her as someone who needs to be watched. The physician must suffer some harm to his or her reputation as a result of the report. Because a physician has no opportunity to challenge a settlement report through a hearing, the settlement reporting provision of the Act may violate the physician's due process rights.<sup>240</sup>

## 2. *When No Due Process is Due*

Until a right or entitlement that the due process clause protects has attached, a physician has no right to protect.<sup>241</sup> Consequently, even due process cannot protect a physician when a board refuses to grant the physician a license or when a health care facility refuses to grant the physician privileges in the first place. Thus, a physician cannot invoke the due process clause when a licensure board or peer review group refuses to grant the physician a

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237. 42 U.S.C.A. § 11,137(d).

238. See J. NOWAK, *supra* note 187, § 3.3.

239. H.R. REP. NO. 903, *supra* note 8, at 13-14, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6396.

240. Cf. Shattuck, *supra* note 72, at 1004 (to the extent that "hits" in a computer match have no hearing prior to government action based on the match, the "hits" have been denied due process).

241. Board of Regents v. Roth, 408 U.S. 564 (1972).

license or privileges based on a report received from the data bank about prior misconduct or malpractice settlements, even if the conduct reported took place years ago.

A licensure board or health care facility will be reluctant to admit a physician with a "record" into the organization because of the potential liability the board or facility assumes if the physician's performance is substandard.<sup>242</sup> Even though the Act requires the board or facility to offer the physician a hearing in this situation,<sup>243</sup> the immunity provisions of the Act render the hearing meaningless because they bar the physician from challenging an unfavorable or unfair decision as long as the peer review group can claim it acted to further quality health care.<sup>244</sup> The Act does not address situations where a peer review group acts with a variety of motives, as long as one motive is to further quality health care.<sup>245</sup>

This aspect of the Act is the most troublesome because peer review groups and licensure boards can use the Act with impunity to deny a physician a license or privileges. In this situation, the group that took the initial disciplinary action may have discovered that the physician's conduct did not warrant revoking the physician's license, but the action ultimately could have that effect if another peer review group uses the first action to deny the physician a license or privileges to practice.

## V. THE PROGNOSIS

Unlike most people, computers never forget.<sup>246</sup> While no one claims the Constitution contains a right to be forgiven,<sup>247</sup> the Constitution does contain provisions that elevate liberty and create a presumption of innocence.<sup>248</sup> The Act tarnishes both values because it holds a physician to a past mistake and routinely reminds the health care community that the physician is, or might be, guilty of the conduct that resulted in the information contained in the data bank.

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242. F. GRAD & N. MARTI, *supra* note 6, at 200-01.

243. 42 U.S.C.A. § 11,151(10) defines professional review activity to include a decision to grant clinical privileges.

244. A physician can still bring an action for discrimination against the peer review group under the Civil Rights Acts, 42 U.S.C. §§ 1981, 2000e (1982). 42 U.S.C.A. § 11,111(a)(1).

245. "This immunity is not contingent on the propriety of the behavior of the peer review body." Iglehart, *supra* note 14, at 962.

246. "Records are mechanical memories not subject to the erosions of forgetfulness and the promise of eventual obliteration." Gerety, *supra* note 85, at 288.

247. *Cf.* Reporters Comm. for Freedom of the Press v. United States, 816 F.2d 730, 739 (D.C. Cir. 1987), *cert. granted*, 108 S. Ct. 1467 (1988) (No. 87-1379).

248. "[P]eople in the United States are not forced to bear a continuous burden of demonstrating to the government that they are innocent of wrongdoing." Shattuck, *supra* note 72, at 1002.

If the reputation and livelihood of a physician with a drug abuse problem is measured against the life of a child who dies due to the physician's drug abuse, few would give much weight to the physician. To the extent that the government has the ability to prevent incompetent physicians from inflicting harm on their patients and the general public, the government must do so by the most effective means available. If the most effective means are regulation and surveillance by computer, the government should take advantage of those means.<sup>249</sup> The Act's objectives and the use of computers to help meet these objectives are laudable in theory. Unfortunately, the Act does not properly apply the theory.

Congress gave insufficient thought to actual operation of the Act. Many provisions of the Act will not accomplish the goals Congress set, although these provisions, particularly the data bank part B creates, may harm some physicians seriously.<sup>250</sup> While Congress may ask physicians to bear legitimate burdens imposed by the Act, many of the Act's reporting requirements impose burdens without providing any offsetting benefits.<sup>251</sup> The information collected through these provisions often has no clear meaning.<sup>252</sup> Therefore, imposing these burdens on physicians without any noticeable benefits seems fundamentally unfair.

The provision of the Act that mandates the reporting of malpractice information perpetuates the mistaken but common belief that physicians can practice mistake-free medicine. Medicine has not yet reached a point where it can guarantee results or be risk-free.<sup>253</sup> If Congress imposes such drastic oversight on physicians for results they often cannot control, Congress creates a standard of care far above what the medical community can meet, another fundamentally unfair result of the Act.<sup>254</sup>

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249. *United States v. United States Dist. Court*, 407 U.S. 297, 312 (1972).

250. *See supra* notes 152-67 and accompanying text.

251. If a section of the Act fails to accomplish Congress' objectives, that section provides no benefit to the public to offset the harm it may impose on the physician. For example, the lack of a uniform national standard for licensure board reports, discussed *supra* in notes 188-92 and accompanying text, allows incompetent physicians from states with relaxed disciplinary rules to practice with impunity. The malpractice settlement reports, discussed *supra* in notes 237-40 and accompanying text, by definition may not be interpreted to mean what they say, 42 U.S.C.A. § 11,137(d), so they too impose a burden without an offsetting benefit.

252. 42 U.S.C.A. § 11,137(d); *see also supra* notes 237-40 and accompanying text.

253. "[M]edicine . . . requires decisions that are often as much matters of judgment as of science." Editorial, *Beyond Tort Reform*, 257 J. A.M.A. 827 (1987); MEDICAL LICENSURE AND DISCIPLINE, *supra* note 6, at 14; *Commission Sometimes Takes Years to Act in Incompetence Cases*, Wash. Post, Jan. 11, 1988, at A6, col. 1.

254. If physicians, the medical community, medical professional societies, and medical licensure boards disagree among themselves over everything from proper treatment methods to disciplinary procedures, *see sources cited supra* note 253, the Act's immunity provision, 42 U.S.C.A. § 11,111, mandatory reporting of disciplinary actions, *id.* §§ 11,132-11,133, and

Experts have questioned the effectiveness and objectivity of state licensure boards for a long time.<sup>255</sup> Licensure boards contribute to many problems associated with physician incompetency and discipline.<sup>256</sup> Yet, Congress took no action to improve licensure board functions. Congress changed the law to encourage these boards to do more of what they do, not to encourage them to do it better.<sup>257</sup> Although Congress can claim it did not intend to preempt state laws governing how licensure boards issue licenses and discipline physicians,<sup>258</sup> but Congress already has interfered by mandating federal oversight of licensure board activities.<sup>259</sup> Having done so, Congress should have focused more attention on setting uniform standards for boards to follow when they discipline physicians. If conduct in one state merits sounding a nationwide alert, that same conduct committed in other states is equally objectionable and licensure boards should report it.

## VI. CONCLUSION

Physician licensing boards and peer review groups are sometimes similar to the incompetent physicians they try to discipline. From time to time they do a good job, but they often are ineffective. Critics say they always have been. Congress must have concluded as much, *sub silentio*, when it decided to invade an area that states have dominated exclusively. However, Congress erred by not going far enough. By deferring to state standards of what physician conduct is subject to disciplinary action, Congress crippled the success of its own initiative and perpetuated the inadequacies of the state systems in a federal computer. If the problems incompetent physicians cause are compelling enough to warrant some invasion of state sovereignty,

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\$10,000 fines for failing to report malpractice settlements, *id.* § 11,131(c), could create chaotic conditions for physicians attempting to practice medicine consistent with what they learned in medical school.

255. F. GRAD & N. MARTI, *supra* note 6, at 1.

256. *See supra* notes 52-58 and accompanying text.

257. With their new immunity from most suits, 42 U.S.C.A. § 11,111, disciplinary boards should take more disciplinary actions if they previously failed to act because they feared triggering lawsuits. *Delays Plague System Regulating Physicians*, Wash. Post, Jan. 11, 1988, at A7, col. 5. However, the Act does not affect state standards used to issue licenses, *see supra* note 33, nor does it provide more funding or staff to help the already overloaded boards thoroughly develop cases presented to them. These are also critical problems facing disciplinary groups. *See supra* note 52.

258. *See supra* notes 112-14, 150.

259. The Act affects licensure boards in many ways. It requires boards to report disciplinary actions to the DHHS, 42 U.S.C.A. § 11,133, provides significant immunity to board members involved in board actions, *id.* § 11,111, and imposes sanctions on boards that fail to report disciplinary actions, *id.* § 11,132(d).



and they may be, then Congress should have set its own standards to tell states what physician conduct is unacceptable in all cases.

Computer regulation is exceptionally effective. Use of computers to identify and track physicians who truly are substandard or incompetent will be cost-effective and, barring power failure, reliable. Unfortunately, computers are only as accurate as the information that they contain. In light of the problems within the various disciplinary groups, the groups will not always report accurate information. Innocent physicians may suffer serious harm under the Act, either because they cannot obtain relief from improper disciplinary action due to the immunity provisions of the Act, or because they fall victim to erroneous data in the national data bank.

Congress should modify the Act to eliminate the inconsistencies and inequities. If Congress makes the modifications necessary to avoid constitutional conflict and protect innocent physicians, the Act will have the impact that Congress intended. If Congress makes these changes, a substandard physician will find it very difficult to evade disciplinary action, because computers do not forget and computers do not compromise.

*Kathleen L. Blaner\**

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\* The author was an employee of Department of Health and Human Services at the time this Comment was written. The opinions expressed in this article are solely those of the author and in no way represent or reflect the official views of the DHHS or its employees.