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Illuminating Patient Choice - Releasing Physician-Specific Data to the Public

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FEATURE ARTICLE

Illuminating Patient Choice

Releasing Physician-Specific Data To The Public

by Frances H. Miller

"Knowledge is power," Ethel Watts Mumford once quipped, "provided you have it about the right person."[1] Physicians all too often occupy critically important roles in patients' lives, but people have traditionally possessed very little factual information about their doctors. Patient ignorance of their physicians' qualifications reinforces the inherent and seemingly inevitable imbalance of power between them.[2] Significantly, it contributes to a patient's inability to evaluate medical judgment, and thus to weigh the true quality of physician-patient interaction. Such ignorance undermines personal autonomy, the theoretical linchpin of informed consent.[3]

Some would argue that informed consent doctrine should not be extended beyond a patient's right to information about the risks and benefits of recommended therapy, to satisfy doctors' mandatory duty of disclosing information.[4] However, recent cases such as the California Supreme Court decision in *Moore v. Regents of the University of California*[5] do just that, and are grounded on the broader fiduciary obligations that physicians owe to their dependent charges. *Moore* made clear that patients have the legal right to be told at least some personal information about their doctors when conflicts of financial interest are present, on the ground that such conflicts may be material to decisions about initiating or continuing therapy. A Louisiana court has gone even further in giving a patient a cause of action against a doctor for failure to disclose alcohol abuse, again using a materiality rationale.[6]

A patient's choice of a doctor matters greatly for personal autonomy reasons, whether or not formally analyzed as a right protected by informed consent doctrine, but it also carries increasing importance now that intensified competition characterizes our rapidly restructuring health care delivery system.[7] Aggressive health insurer competition for subscribers has been accompanied by escalating physician competitiveness for patients, and the country's well-documented oversupply of doctors merely fuels that rivalry.[8] If, as predicted, 20 percent of the nation's physicians will be superfluous in the year

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2000,[9] patients should soon have - at least according to basic supply and demand theory - even more substantial choice when selecting their doctors. The range of that potential choice is being narrowed dramatically by health insurers, however, as they become increasingly selective about the stables of "preferred" providers with whom they will contract.[10]

Competition in any market flourishes on the basis of only two variables: price and quality. Buyers tend to gravitate to sellers offering goods or services at the combination of price and quality that most nearly matches their personal preferences. However, once subscribers or their employers pay health insurance premiums, price drops out of the picture - or at least suffers diminished significance - as a determinant when subscribers thereafter select their doctors. Price also loses its significance as a factor insured patients consider when deciding whether to undergo specific medical treatment. Quality constitutes the only other basis on which patients can make decisions about providers and treatment, at least so long as competition functions as our basic mechanism for distributing health services. But patients must possess sufficient factual information to impart some measure of meaning to their choices if their decisions are to constitute anything more than a charade.[11]

The notion of informed choice means very little when the physician selection criteria generally available to a patient are limited to which doctors are associated with the patient's health plan; or at most, to a recommendation by a friend who has had a satisfactory experience with a particular physician. Convenience considerations such as geographical location and office hours may play a large part in an initial decision to establish a relationship with a practitioner, but these factors usually have little to do with the clinical quality of the chosen doctor's medical services. In reality, most patients know precious little about the skills of those they trust to treat them.[12]

Patient access to information about physician competence has always been controversial, primarily because of alleged lay difficulty in understanding sometimes complex and technical medical outcomes, which may be reported out of context or be strongly affected by individual patient variation.[13] This generalized objection has tended to sweep far too broadly, however, because much factual information important to patients about their doctors - for example educational qualifications, board certification, or even criminal conviction history - is not highly technical, and can be readily absorbed and understood by the average person. Moreover, much of it has already been collected under reasonably reliable circumstances in centralized data repositories, such as those maintained by state medical licensing boards and health insurers.[14]

In addition, since the end of the 1980s, the federal government has been compiling and maintaining individual dossiers on the nation's licensed physicians in the Congressionally-established National Practitioner Data Bank .[15] That database contains a variety of information related to the quality of physicians' practices, such as disciplinary actions against doctors by health care facilities and licensing authorities, as well as medical malpractice settlements and judgments against them. Patients are not currently permitted access to the federal database, but the Data Bank has received millions of inquiries from hospitals, licensing boards, medical malpractice and health insurers, physicians themselves, and other authorized parties[16] since it began making

information available.[17] Significantly, more than 80 percent of its inquiries thus far have come from health insurers.[18] In a time of physician oversupply and tighter cost containment controls, a doctor with a checkered history is presumably expendable to many managed care plans. At the very least, such a doctor will have to contend with awkward questions about clinical competence that Data Bank entries may raise.

Health insurers have been taking a more assertive role in evaluating the quality of care their participating physicians deliver for some time now. Some physicians argue that as a consequence patients have less need for access to potentially damaging information about their doctors - for example malpractice payout histories - which could be easily misunderstood by the lay public. Advocates of non-disclosure contend that some doctors would be unfairly prejudiced if malpractice payout histories were available to the public. For example, they reason that most patients lack a sophisticated understanding of the role some settlements play in reducing transaction costs once a colorable malpractice claim has been made, regardless of whether medical negligence was actually involved in the particular case.[19] Others counter that while an individual malpractice allegation may or may not have anything to do with the defendant's clinical competence on the occasion in question, it does say something about the quality of the doctor-patient relationship involved.[20] A recent empirical study corroborates that point by indicating that even a single malpractice claim has predictive value as a harbinger of subsequent claims; doctors who have trouble in their relations with patients tend to keep having troubled patient relationships.[21]

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During 1994 in Massachusetts a well-publicized series of media "exposés" spotlighted a few allegedly egregious quality of care deficiencies involving some physicians licensed in the Commonwealth, and charged that regulatory authorities and hospitals had been too lenient in dealing with the targeted offenders.[22] Fairly or unfairly, this notoriety reinforced a long-standing public perception that the Board of Registration in Medicine (composed of five doctors and two lay members),[23] which licenses and disciplines physicians might at times be unduly solicitous of physician interests. Partially in response, but also because of a general sense that the prior policy of non-disclosure had outlived its usefulness in the current managed care environment, Massachusetts' Secretary of Consumer Affairs appointed an Advisory Committee on Public Disclosure of Physician Information.[24] The Committee was charged with considering "what information [currently held by the Board] to disclose and the most effective means for disclosing it."[25]

The Advisory Committee thus began its work under clear direction that fuller public disclosure of Board-held information[26] would be desirable. Information currently in the Board's possession covers a broad range of categories and comes from a variety of sources, including phy-

sician self-reporting on licensure and re-licensure applications.[27] It also includes statutorily mandated reporting from courts about malpractice tribunal findings,[28] court judgments,[29] and certain criminal convictions.[30] In addition the Board receives legislatively mandated reports from malpractice insurers about closed malpractice claims,[31] from hospitals and other health care facilities about disciplinary actions,[32] and from professional medical associations about their physician discipline.[33] The Secretary directed the Advisory Committee to determine exactly *which* information in the Board's possession should be disclosed, in what manner, and with what protections.

The Committee accordingly began its work with a presumption in favor of disclosure, and it quickly adopted the following two working principles:

1) "All *reliable* information in the Board's possession that could be helpful to the public in choosing doctors should be released, unless there is a compelling public policy reason for keeping it confidential, and

2) Judgments and other dispositions regarding a physician's competency which result from adversarial or due process proceedings, provide reasonably reliable information."[34]

After extensive public hearings and comment, review of the relevant literature, statistics, and other licensing authority and data bank experience, and after having received information and analysis from many other expert sources on all sides of the relevant issues, the Advisory Committee recommended that the Board release four broad categories of physician-specific information. These four categories are discussed in Part II of this article. Most of this information is currently held in the Board's own data repository, and the Advisory Committee specified safeguards which should accompany disclosure to minimize both potential misunderstandings and any unduly prejudicial impact conveyed by some potentially damaging information.[35]

II. Physician information to be disclosed to the public

The Advisory Committee recommended that the Board of Registration in Medicine compile and disseminate - in user-friendly format - Physician Profiles containing the four categories of information.[36] The vast majority of suggested entries relate to non-controversial "hard" factual data in the first category, which includes general information about physician education, training, specialty credentialing, employment and achievements. Only the potentially damaging information in the other three categories, which are concerned with: 1) malpractice claims history; 2) criminal convictions; and 3) licensing and hospital disciplinary sanctions, presented difficult disclosure issues. However, more than two-thirds of the physicians licensed in Massachusetts will have no entries at all in any of these categories.[37] A suggested format for the physician profile was set forth by the Advisory Committee as follows in Figure 1:

A: Education and training

Premedical and medical education,[38] plus postgraduate clinical training,[39] are structural building blocks underlying the quality of care a doctor can deliver. These constitute the basic

Physician Profile Format

- Name
- Office phone number(s) and address(es)
- Nature of practice (group practice, solo practice, hospital staff)
- Number of years in practice
- Medical license status
- Premedical and medical schools, years attended and degrees awarded
- Postgraduate training
- Specialty
- American Specialty Board certification and recertification, and eligibility for certification.
- Current employment, including faculty appointments
- Health care facilities where physician holds privileges
- Plans in which physician is a provider
- Refereed journal articles and book chapters
- Honors and awards
- Board or hospital disciplinary findings
- Criminal convictions
- Malpractice summary (compared with norm for specialty)

Figure 1

"positive" factual information about physician competency. If patient self-determination means anything, fundamental common sense dictates that patients should be entitled to know, for example, whether physicians holding themselves out as specialists have at least gone through the graduate training programs appropriate to qualify them to perform up to the standard for the specialty. Doctors often hang their diplomas and post-graduate training certificates on their office walls, but not all do, and some have multiple offices which may not each display those credentials. Moreover, patients often never even set foot in the offices of certain facility-based specialists, such as radiologists and anesthesiologists. Thus while this core factual information about a doctor's professional training is theoretically available to patients, it is not uniformly available in easy-to-access ways that facilitate comparison. As the practice of telemedicine over long distances gains wider acceptance by the professional and patient communities, the problem will only intensify.[40] The Advisory Committee therefore recommended that the Board compile this information in standardized physician profile format, and make it easily accessible to the public to facilitate patient choice among doctors. This was the easy part of the Advisory Committee's task.

B: Medical malpractice claims history

A great deal of physician apprehension surrounds release of medical malpractice claims history statistics.[41] Doctors fear that patients will misinterpret raw claims data, which may or may not indicate problems involving clinical competence in particular cases. Although all major empirical studies show that most instances of chart-demonstrated medical malpractice never result in negligence claims,[42] the studies also reveal that some claims are indeed filed in cases where the record fails to demonstrate that the defendant doctor departed from customary standards of care.[43] Although most physicians have never had a single malpractice allegation made against them in their entire professional lives, all are understandably vulnerable to "there but for

the grace of God go I" professional anxieties. Some doctors may thus feel reluctant to advocate a precedent that they fear - however unfoundedly - could somehow be used (unfairly?) against them in the future.

This professional apprehension must be weighed against the information value of a doctor's malpractice claims history to patients. Since the major studies all show that only 10 - 12 percent of chart-demonstrated medical negligence results in any claims at all,[44] at some point, allegations of physician malpractice *do* indicate problems; if not with pure clinical competence, at least with the quality of doctor-patient interaction.[45] For example, a patient prepared to endure the long-term aggravation and uncertainties associated with filing a malpractice action is usually a person very unhappy about either the unanticipated unfortunate results of medical care, or the medical and emotional costs of iatrogenic injury.[46] If the particular result was a known complication of a recommended procedure, a doctor warning the patient in advance about the risk is less likely to be the target of patient anger should that complication in fact materialize. The patient may not be pleased with the outcome, but cannot claim ignorance that an unhappy result was possible.[47] The knowledgeable patient may thus feel morally or even legally constrained from filing a malpractice lawsuit, regardless of whether the doctor actually provided sufficient information to meet the legal requirements of an informed consent.

The Advisory Committee decided for several reasons that malpractice *claims* are not on their own sufficiently reliable indicators of questionable physician competence to warrant public disclosure. Therefore the Committee recommended that only those claims which have matured after adversary proceedings to settlements, awards, or judgments in favor of patients be made available to the public. Raw data on claims closed with some payment to malpractice plaintiffs can indeed be highly misleading, because those unfamiliar with malpractice litigation may be unaware that non-meritorious claims are sometimes settled just to get rid of the litigation costs associated with contesting them. For this reason, the Advisory Committee recommended that malpractice payments - including settlements - be separated into broad categories representing small, medium, and large awards, rather than reported in specific dollar amounts.

These reports of malpractice payments to malpractice plaintiffs should be accompanied by a statement drawing attention to the fact that a small award may well represent a nuisance settlement in a case where physician negligence was not at all clear, or even entirely absent. A larger settlement, however, may indicate a great deal about the seriousness of the injury and the strength of the plaintiff's evidence of defendant's negligence. The Advisory Committee also recommended that all malpractice payments, whether they be settlements, arbitration awards, or jury verdicts, be reported in a format which compares the subject doctor's payout history with that of other physicians in the same specialty. In that way patients will be able to evaluate the malpractice payment experience of, for example, a surgeon, against the significantly higher and more frequent experience of other surgeons, rather than possibly being misled by comparing it with the lower and less frequent payments made on malpractice claims against *all* doctors.

C. Licensing Board and hospital disciplinary actions[48]

States impose licensing sanctions against physicians as a remedy of last resort to protect the public, to send deterrent messages to the profession, and to reprimand physicians deemed to have engaged in sub-standard practice. Final licensing board decisions are usually a matter of public record, available to anyone upon request. Some Board disciplinary proceedings receive widespread media coverage in addition, particularly when sensational facts have been alleged.[49] The Advisory Committee thus believed there was no legitimate reason not to include final Board disciplinary actions on Board-generated physician profiles.

The final decisions in hospital disciplinary proceedings were another matter entirely. To begin with, Massachusetts law at the time the Advisory Committee was deliberating required the Board of Registration in Medicine to keep hospital disciplinary actions reported to it pursuant to statute confidential, except as might be necessary for the Board to use them in its own disciplinary proceedings against the licensee.[50] Releasing those reports to the public would thus require statutory change, except as the parties themselves might choose to release them.

The Massachusetts legislature had previously been persuaded that hospitals would engage in full and frank discussion,[51] culminating in vigorous self-regulation, if the confidentiality of institutional disciplinary actions were assured. Improving the quality of hospital-based care has always been considered especially important, because the vast majority of all U.S. medical malpractice actions have involved allegations of negligence occurring within hospital walls.[52] Many legislatures have sought to improve the overall quality of care by decreasing the stigma of hospital sanctions against doctors, with whom institutional peer reviewers often have had long-standing professional and personal relationships that might color the reviewers' willingness to impose discipline.

This confidentiality theory was attractive, but the results of confidentiality have been less so. Both national and state statistics comparing reported hospital disciplinary actions with state licensing board sanctions indicate that most hospitals have been far less than aggressive in carrying out their responsibilities for peer review. For example, a 1995 report by the U.S. Department of Health and Human Services Inspector General found that about 75 percent of the nation's hospitals failed to report *any* adverse decisions to the National Practitioner Data Bank, as required by statute, for the first three and one-quarter years of its existence.[53] Moreover, the Massachusetts experience was not even average; the Commonwealth's hospitals reported only 1.7 sanctions per 1,000 licensed beds, giving the state a rank of 37th in the country on the scale of physician discipline.

During the same three-year time period that the country's hospitals were reporting only about 1,000 sanctions a year to the National Practitioner Data Bank, state licensing boards - never known as bastions of aggressive enforcement themselves - were taking disciplinary action against approximately 8,000 doctors per year. Although some of the differential is undoubtedly accounted for by licensure sanctions for physician misconduct occurring outside of the hospital setting, the wide discrepancy raises questions about how seriously the country's hospitals have been taking their responsibility for ensuring the

quality of patient care by monitoring and disciplining staff member performance. For example, Massachusetts' 128 hospitals reported an average of only 37.5 sanctions per year to the Board of Registration in Medicine during the three-year period covered by the Inspector General's report, and most hospitals in the Commonwealth consistently reported no disciplinary actions whatsoever.[54]

Whatever the reason, the discrepancy between reported hospital disciplinary actions and state licensure penalties indicates that when a hospital actually *does* sanction a physician, the doctor's transgression is probably fairly clear and reasonably serious. The Advisory Committee thus decided after considerable deliberation that the policy of complete confidentiality did not seem to be achieving the intended result of more rigorous hospital oversight and discipline. The Committee determined that given this apparent failure of confidentiality protection to stimulate better peer review, there was no longer any justification for withholding from patients information about those few final Massachusetts hospital decisions which actually did sanction errant doctors.[55]

D. Criminal convictions[56]

A doctor's conviction of a felony or serious misdemeanor indicates that a jury has found the defendant guilty of a significant offense against the public order. This raises an issue of moral character in the minds of many people. Some contend that if the particular crime is not directly related to the practice of medicine, patients can claim no unique right to possess that information, and thus medical licensing authorities should not be in the business of providing it to the public. Criminal convictions are considered relevant to the medical licensing function itself, however, and doctors can lose their licenses as a result of criminal activity,[57] even when not directly connected with medical practice.[58]

To protect the public safety, courts are usually required to report physician convictions of serious crimes to licensing boards, and doctors are usually required to self-report them on licensure and re-licensure applications.[59] If licensing boards find a doctor's criminal activity relevant to their dealings with physicians, should patients who must trust those same doctors in much more intimate ways be kept in the dark? Most patients would say that moral character affects their willingness to trust, and that criminal behavior illuminates character.

Criminal conviction information is already in the public domain, since criminal trials are almost always public prosecutions. Patients thus can secure conviction information about doctors as a matter of right if only they know where to look. Unfortunately, however, information about the criminal convictions of specific physicians is hard for the ordinary patient to come by, short of fortuitous media notoriety or laborious poring over often obscure court records. Even if a doctor's criminal conviction were unrelated to the practice of medicine in the narrow sense, in that it did not involve activity *directly* connected with clinical treatment, patients may well consider it relevant in deciding whom to trust about their own medical care. Respect for patient self-determination mandates that conclusion, particularly since the doctor can claim no countervailing right of privacy.[60] Trust is a time-honored core ingredient of the doctor-patient relationship.[61]

For example, a patient might rationally

choose not to be treated by a doctor convicted of a crime involving physical violence, such as domestic abuse, reasoning that patients are often physically and emotionally dependent - and correspondingly especially vulnerable - in their doctors' care. Thus a doctor's assault conviction might bear on a patient's willingness to be treated by that particular physician. A patient might also feel strongly about not going to a practitioner convicted of criminal activity more closely related to medical practice, yet less directly connected to physical violence. Accordingly, a patient might quite reasonably choose to shun a physician convicted of fabricating medical research data, or of fraud involving Medicare, Medicaid or other health insurance payments. In that way the patient could avoid being used as an instrument of any future fraud.

A patient's reasons for choosing to avoid - or seek out - a doctor convicted of a particular crime need not be "rational," however, in the sense that others would find the underlying conduct relevant in choosing their own physicians. For example, a doctor convicted of certain acts of civil disobedience, such as refusal to serve in active combat or having engaged in other political protest, might repel some patients yet at the same time attract others. Presumably some patients, or those anxious to have a particular doctor's specialized skills, would find whatever negative impact such a conviction might carry outweighed by other reasons for preferring that practitioner, so long as the physician retains a license to practice medicine. But respect for patient autonomy - and the fiduciary duties of doctors in the context of their inherently unequal relationship - would honor that preference.

All physicians convicted of crimes have already had their days in court, where relevant defenses could be raised. Juries of their peers have nonetheless found the defendants guilty of offenses against the public order; that is the common denominator of all convictions. Criminal convictions are *not* considered private information entitled to protection from disclosure. Their status is that of public records, unless for some overriding reason the conviction has been sealed. If the defendant doctor's activity was serious enough to warrant public prosecution, and ultimately resulted in a conviction, then there seems little justification for not making the fact of that conviction more easily available to patients. They have no choice but to trust that those they choose as care providers will place patient welfare and safety above peccadillo or personal interest. A doctor's character is a critical element of that trust.

II. What information did the Advisory Committee decline to recommend be collected by the Board or included in patient-accessible physician profiles?

The Advisory Committee considered an extremely broad range of issues, including whether the Board of Registration in Medicine ought to be collecting certain data not yet required to be reported to it, such as information about the reimbursement incentives under certain managed care plans that might color physician recommendations for treatment.[62] It declined to recommend at this stage that such potentially controversial information be reported to the board, so obviously it could not be made available to patients on physicians' profiles. The Committee adhered to its guiding principles, that all reliable information in its possession be made available to patients, and that *final decisions ar-*

rived at after an adversary process constituted reasonably reliable information.[63]

A. Criminal and malpractice claims

Although some would argue that both criminal and malpractice *claims* against a physician carry some information value for patients, the Advisory Committee believed that when no final resolution of a claim or criminal charge has occurred, whatever informational value it might carry is far outweighed by considerations of fairness to the accused doctor. Indeed, a patient upset about an unavoidably bad medical result might be irrationally driven to file a malpractice claim, or to press a criminal charge, with no factual justification or realistic hope of success.[64] Alternatively, an angry person might simply seek to injure the reputation of a doctor with whom he or she had a dispute unrelated to medical practice at all. Since bare claims and charges have not been carried through the adversarial process to final resolution, the Advisory Committee did not find them sufficiently reliable indicators of physician quality or character to warrant their disclosure on Board-generated profiles available to patients.

B. Chemical dependency information

The Advisory Committee grappled seriously with the question of whether information in the Board's possession concerning a doctor's chemical dependency should be released to patients, and finally decided against it.[65] The Committee ultimately reasoned that so long as the afflicted doctor was enrolled in and living up to the requirements of a Board-approved comprehensive treatment and monitoring program,[66] the doctor's confidentiality interest in personal medical information outweighed any patient interest in discovering potentially inflammatory details concerning the practitioner's medical condition. Presumably some patients would choose not to be treated by a chemically dependent doctor.[67] However, after extensive deliberation the Advisory Committee decided that so long as the Board of Registration in Medicine remained persuaded that patient care was not jeopardized by permitting the doctor to continue practicing medicine, patient preferences would have to yield to the doctor's own right as a patient to have confidential medical information protected from public discovery.[68] The Committee did set forth recommendations designed to ensure that the Board continue to guarantee the appropriate level of public safety, however. Among these was a recommendation that if the dependent doctor resumed the use of alcohol or drugs, or violated "any other material condition" of the agreed-upon rehabilitation program, and failed to self-report, the Board institute an automatic disciplinary hearing which could result in de-licensure.

C. Outcomes data

Both the State of New York and the Commonwealth of Pennsylvania have compiled and released certain physician-specific data about patient outcomes to the public.[69] The Advisory Committee recognized the information value of an outcomes yardstick for measuring clinical performance, and mortality and unexpected complications rates such as those used in New York and Pennsylvania might well constitute such a measuring device. However, the Committee also recognized the difficulties of developing an information format sophisticated enough to account

for variations such as differential patient age and health status mix, yet accessible enough for the public to understand readily.[70] It also recognized that outcomes measurements are easier to calculate for procedure-based specialties than for primarily cognitive practitioners, and might thus give a skewed picture about where quality problems exist among the specialties. On balance, the Advisory Committee did not believe that current outcomes measures convey sufficiently reliable information about the quality of physician performance to warrant recommending their collection by the Board or their release to the public on physician profiles.

III. Conclusion

Massachusetts is scheduled some time in 1996 to become the first state in the country where the licensing authority provides consumers with standardized profiles on the physicians licensed to practice medicine in the Commonwealth. These profiles are designed to contain reliable, material information to help patients better evaluate the quality of service rendered by those they choose to treat them. The information these profiles contain will illuminate similarities and differences among physicians, and thus should enhance the quality of patient decisions about the doctors to whom they entrust their medical care.[71]

Appendix

Advisory Committee On Public Disclosure Of Physician Information April, 1995

Summary of recommendations

The following is a summary of the recommendations made in the body of this report.

Physician-specific information to be released

Medical malpractice as a matter of public policy:

The Committee believes that reliable medical malpractice information about a physician should be made available to the public. Specifically, the Committee recommends that the Board isclose to the public the following:

1) all medical malpractice court judgments and amounts;
2) all medical malpractice arbitration awards and amounts; and
3) all medical malpractice insurance settlements and amounts.

Dispositions should not be reported in specific dollar amounts; rather, they should be reported in at least three graduated categories suggesting the level of significance of the award or settlement [e.g., 1) minor, 2) medium, and 3) major].

Medical malpractice information should be reported fairly and in context by comparing physicians within their particular specialties.

Pending malpractice claims should not be disclosed to the public. Unlike judgments or settlements that survive tests of adversarial or due process proceedings, complaints are mere accusations and standing alone are not reliable indicators of substandard care. These should be left to the Board to investigate as a function of its licensing and disciplinary responsibilities.

To implement the above, we recommend:

A) The Board's regulations be amended to release the above medical malpractice information: 1) received from physicians on their license applications; and 2) received from insurance companies.

B) The Board meet with the Chief Administrative Judge of the Trial Court to establish effective procedures to ensure that courts report all medical malpractice dispositions to the Board as required by statute.

Hospitals and health care facility reporting

Disciplinary actions as a matter of public policy

The Committee believes that final disciplinary actions taken against physicians by hospitals and other health care facilities should be made available to the public. Specifically, the Committee recommends that the Board disclose to the public the following:

All final disciplinary actions taken against physicians by hospitals and other health care facilities, including, but not limited to, denial, restriction or revocation of staff privileges due to incompetence or other just cause.

Need for oversight as a matter of public policy

To maintain an effective system for hospitals and other health care facilities to monitor and address adverse events, the Committee believes that the peer review process should remain confidential to the extent that deliberations should not be disclosed to the public. We do, however, recommend:

1) hospitals and other health care facilities be required to report all dispositions in professional conduct cases whether or not there is a final determination that a disciplinary action be taken;

2) hospitals and other health care facilities be required to report all incidents of "significant maloccurrences" whether or not harm results, including actions taken to prevent recurrence; and

3) the Board be granted authority on a confidential basis to inspect internal documents of hospitals and other health care facilities to verify the accuracy and completeness of their disciplinary and incident reports.

To implement the above, we recommend:

Mass. Gen. L. ch. 111, § 53 be amended to allow the Board to disclose to the public information contained in hospital and other health care facility final disciplinary action reports.

The Board's regulations be amended to permit disclosure of formation regarding final disciplinary actions taken against a physician reported by the physician on his/her license applications.

Criminal charges and convictions as a matter of public policy

The Committee believes that information regarding a physician's criminal convictions of serious charges should be made available to the public. Specifically, the Committee recommends that the Board collect and disclose to the public the following:

1) all convictions of felonies during the past ten years; and

2) all convictions of serious misdemeanors (e.g., assault and battery, larceny, etc.) during the past ten years.

Convictions shall include *nolo contendere* pleas and cases where sufficient facts of guilt have been found and the matter has been continued without a finding (entered without a finding of guilt).

The above convictions shall be disclosed whether or not they are related to the practice of medicine.

To implement the above, we recommend:

Mass. Gen. L. ch. 221, § 26 be amended to require courts to report to the Board all convictions of felonies and misdemeanors whether or not related to the practice of medicine.

The Board's regulations be amended to release information concerning the above criminal convictions received from physicians on their licensing applications.

Physician chemical dependency as a matter of public policy

The committee believes that information concerning a physician's chemical dependency that is not the subject of disciplinary action should be confidential provided that the physician is successfully undergoing or has successfully completed a Board-approved treatment program and continues to maintain his/her sobriety. In order to guarantee public safety:

1) the Board should conduct an annual review of all approved treatment programs with respect to their efficacy in monitoring and enforcing physician compliance;

2) attendance at required AA meetings should be monitored in accordance with current practices accepted by the AA community;

3) the Board and /or PHS should conduct an assessment and make written findings concerning whether it is safe for the physician to practice without limitation during the initial stages of recovery, or whether some restrictions should be imposed until the physician demonstrates a

sufficient track record of sobriety; and

4) if the physician-patient resumes the use of alcohol or drugs or violates any other material condition of the program, the Board should conduct an immediate disciplinary hearing to determine whether restriction on the physician's practice of medicine would be imposed. The only exception to an automatic disciplinary hearing would be if any infraction or "slippage" was self-reported by the doctor and the doctor agreed: a) to enter more intensive treatment, such as an in-patient program; and b) to sign a voluntary agreement for appropriate medical practice restrictions.

In addition, we recommend the following:

Medical education and post-graduate training

The Board should disseminate factual data about a physician's education and training background to the public in an effective manner.

The Board should treat records detailing academic and training performance prior to licensure as confidential. However, the Board should disclose information about a physician's failure to complete a residency training program, where the physician has been expelled, suspended, or invited to take a leave of absence due to competency or character concerns, under circumstances where procedural due process was afforded the physician.

Employment and credentialing

Physician-specific employment and credentialing history of his or her practice of medicine should be released in published form. (See section entitled "Creation of Physician Profiles").

The Board should disclose any restrictions on a physician's license or privileges, such as:

1) the surrender of a physician's medical license or privileges in any state whether or not voluntary, if considered by the licensing or privilege-granting entity to be a disciplinary action;

2) a physician's resignation from practice in a particular state or from a medical staff if the resignation is considered a disciplinary action, or if it was offered to avoid investigation or disciplinary action;

3) the denial of a medical license in any state for any reason; and

4) restrictions on or denial of participation or enrollment because of issues related to competency or character in a system where a third party pays all or part of a patient's bill.

Methods of release

Creation of physician profiles

The Committee believes that to release adverse information (e.g., a negative malpractice history) in isolation would tend to magnify and exaggerate the importance of an adverse event in what

may be an otherwise unblemished career of accomplishments. Therefore, the Committee recommends that the Board create a "Physician Profile" containing essential information about a physician's education, training, employment and character. This type of format will provide the patient community with a ready reference to a particular doctor. Below is a sample of the type of information that should be included in the profile:

- Name
- Office phone number(s) and address(es)
- Nature of practice (group practice, solo practice, hospital staff)
- Number of years in practice
- Medical license status
- Premedical and medical schools, years attended and degrees awarded
- Postgraduate training
- Specialty
- American Specialty Board certification and recertification, and eligibility for certification.
- Current employment, including faculty appointments
- Health care facilities where physician holds privileges
- Plans in which physician is a provider
- Refereed journal articles and book chapters
- Honors and awards
- Board or hospital disciplinary findings
- Criminal convictions
- Malpractice summary (compared with norm for specialty)

Accurate information

In disclosing information to the public, the Board is obligated to take all steps necessary to assure that the information which it releases to the public about individual physicians is accurate and complete. The Board should provide the individual physician with an advance copy (a galley) of any information intended to be published so that the physician has an opportunity to correct factual inaccuracies.

Interpreting the data

To insure that the information disclosed is reported in a fair manner, the Board should provide explanations and interpretations of the information being released, e.g.,

1) medical malpractice information should be released in specialty comparison format;
2) data concerning settlement of malpractice claims should be discussed in light of current tort system realities of settlement practice; and
3) specialty certification procedures should be explained.

Consumer outreach

The Board should become an active and strong voice for consumer protection in the health care field. Its mission should include a commitment to an education and outreach program for consumers on general issues of health care delivery.

Consumer advocacy

The Board should develop vehicles to inform consumers about its operations and information it has available to them, so that the Board's services and the information it retains can be routinely utilized.

The Board should be accountable to the public for its performance and should make public information documenting the way it has done its job.

Board's resources and commitment

Resources

We recommend that the responsibilities delegated to the Board should not go as "unfunded mandates." Therefore, any proposed budget should consider the staffing, technical support, and information systems necessary to achieve the important and attainable goals outlined in the Committee's report.

Commitment

The Board believes that tools and funding alone, although essential, will not bring about the strong leadership needed to protect the public interest. These must be accompanied by a firm commitment on the part of the Board to enforce the standards that will provide maximum protection to the public.

Looking to the future: outcome measurements

The Committee believes that one of the bottom lines in judging a medical practitioner's or a hospital's performance lies in comparing their ability to reduce rates of mortality and unexpected complications. Therefore, the Committee recommends that a commission be appointed to formulate recommendations for developing working models to measure an compare mortality rates, complication rates and other performance outcomes of hospitals, and among doctors in selected specialties.

E N D N O T E S

[1] WEBSTER'S NEW WORLD DICTIONARY OF QUOTABLE DEFINITIONS 307 (2d ed. 1988).

[2] *See* Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients from Their Physicians*, 55 U. PITT. L. REV 291 (1994); Jeffrey A. Potts, *Moore v. Regents of the University of California: Expanded Disclosure, Limited Property Rights*, 86 Nw. U. L. REV 453 (1992).

[3] Jay Katz, THE SILENT WORLD OF DOCTOR AND PATIENT 130-64 (1984) (note particularly Chapter 6: *Respecting Autonomy: The Obligation for Conversation*); *see also* Ruth R. Faden & Tom L. Beauchamp, A HISTORY AND THEORY OF INFORMED CONSENT 235-73 (1986).

[4] L.H.Glantz et al., *Risky Business: Setting Health Policy for HIV-Infected Health Care Professionals*, 70 MILBANK QTRLY No. 1, 43 (1992).

[5] 793 P. 2d 479 (Cal. 1990) (discussing physician financial conflict of interest with patient welfare). *See also* Arato v. Avedon, 23 Cal. Rptr. 2d 131 (Cal. Ct. App. 1993) (failure to disclose dismal prognosis of patient's disease gave false signal that prompt estate planning was not imperative); *rev'd*, 839, P.2d 983 (1994). Current debate centers on whether providers should disclose reimbursement incentives created by managed care insurers which might affect treatment recommendations. For background see, Steffie Woolhandler and David Himmelstein, *Extreme Risk - The New Corporate Proposition for Physicians*, 333 NEW ENG. J. MED. 1706 (1995) (editorial comment on managed care contract gag orders).

[6] Hidding v. Williams, 578 So. 2d 1192 (La.Ct.App., (5th Cir.) 1991).

[7] Anthony Szczygiel, *Beyond Informed Consent*, 21 OHIO N. U. L. REV. 171 (1994).

[8] *Oversupply of Specialist Physicians Said to Need Regulatory, Market Fixes*, 3 Health Care Pol'y Rep. 34 d30, (August 21, 1995); *American College of Surgeons Meet to Discuss the Problem of Oversupply*, 2 Health Care Pol'y Rep. 41 d40, (October 17, 1994).

[9] Esther B. Fein, *Medical Schools Are Urged to Cut Admissions by 20%*, N.Y. TIMES, Nov. 17, 1995, at 2 (reporting on recent findings of the Pew Foundation Commission).

[10] Physicians have fought back against the competition spawned by selective contracting by lobbying for "any willing provider" legislation on the state level, which requires health insurers to contract with any licensed physician who meets the plan's minimum qualifications. *Cf.* Robert S. McDonough, Note, *ERISA Preemption of State Mandated Provider Laws*, 1985 DUKE L.J. 1194; *State 'Anti-Managed Care' Laws Threatened by Federal Reform Bills*, 3 Health L. Rep. D-20 (Jan. 20, 1994).

[11] *See generally infra* notes 3-4.

[12] Physicians have traditionally been "dedicated first and foremost to serving the needs of their patients," 273 JAMA 330 (1995).

[13] Douglas Sharrott, Note, *Provider-Specific Quality-of-Care Data: A Proposal for Mandatory Disclosure*, 58 BROOKLYN L. REV. 85 (1992).

[14] *See, e.g.*, Mass. Gen. L. ch. 112, §5 (1995).

[15] *See* THE QUALITY OF MEDICAL CARE: INFORMATION FOR CONSUMERS, U.S. OFFICE OF TECHNOLOGY ASSESSMENT (1988) (discussing the National Practitioner Data Bank established pursuant to Health Care Quality Improvement Act of 1986, 42 U.S.C. §§11131-11137 (1995)) [hereinafter HCQA]. *See also*, BARRY R. FURROW, *QUALITY CONTROL IN HEALTH CARE: DEVELOPMENTS IN THE LAW OF MEDICAL MALPRACTICE*, 173, 185 (1993). For general background see Reams, THE HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986: A LEGISLATIVE HISTORY OF PUB.L. 99-660 (1990).

[16] HCQA § 11137.

[17] Malpractice insurers rely on a doctor's malpractice claims history when evaluating insurability and experience-rating premiums. Randall R. Bovbjerg and Kenneth R. Petronis, *The Relationship Between Physicians' Malpractice Claims History and Later Claims*, 272 JAMA 1421, 1425 (1994).

[18] *Report*, at 8. *See also*, NATIONAL PRACTITIONER DATA BANK, 1994 ANNUAL REPORT (1995); Mullan et al., *The National Practitioner Data Bank: Report from the First Year*, 268 JAMA 73 (1992).

[19] *Cf.* Frank A. Sloan et al., *Medical Malpractice Experience of Physicians: Predictable or Haphazard?*, 262 JAMA 3291 (1989).

[20] Hickson et al., *Obstetricians' Prior Malpractice Claims and Patients' Satisfaction with Care*, 272 JAMA 1583 (1994) (obstetrical patients are statistically more likely to complain about the interpersonal skills of physicians sued frequently, even if the complaining patient herself never filed a claim).

[21] Bovbjerg and Petronis, *supra* note 18, at 1425 (having *any* claims, regardless of whether large or small, or whether ultimately resulting in any payment to the claimant, "puts a physician at substantially higher risk of having subsequent claims" of *all* categories).

[22] Gerard O'Neill, et al., *Malpractice in Massachusetts*, BOSTON GLOBE, Oct. 2, 1994, at 1. A parallel newspaper series purported to document serious quality of care deficiencies among some Massachusetts hospitals. Dolores Kong, *Spotlight: High Hospital Death Rates: Study Finds 10 Facilities with Above-Average Mortality*, BOSTON GLOBE, Oct. 3, 1994, at 1.

[23] Registration of Physicians and Surgeons, Mass. Gen. L. ch. 112, § 5 (1995).

[24] *See supra* note 1 (setting forth the composition of the three-member Advisory Committee.

[25] *Report*, at 1.

[26] Mass. Gen. L. ch. 112, § 5 (1995).

[27] Mass. Gen. L. ch. 112, § 5 (1995), (the Medical Malpractice Act of 1986, created a Data Repository at the Board of Registration of Medicine, where most of this data is stored.)

[28] Mass. Gen. L. ch. 231 § 60B.

[29] Mass. Gen. L. ch. 231 § 60B.

[30] Mass. Gen. L. ch. 221 § 26.

[31] Mass. Gen. L. ch. 112 § 5C

[32] Mass. Gen. L. ch. 231 § 53B; 243 C.M.R. 3.02.

[33] Mass. Gen. L. ch. 112, § 5B.

[34] *Report*, at 4 (emphasis added).

[35] Both the Massachusetts Medical Association and the Massachusetts Hospital Association immediately supported the Committee's final recommendations, as did Massachusetts Public Interest Research Group, the major local public interest entity responding to the Committee's request for input to its deliberations. Delores Kong, *Public Has Right to Files on Doctors, Panel Says*, BOSTON GLOBE, May 3, 1995, at 25; Dolores Kong, *Medical Society Urges Access to Information*, BOSTON GLOBE, April 7, 1995, at 27.

[36] The format suggested to the board is designed to facilitate online access to physician data, as well as mass publication in handbook form.

[37] Information provided by Penelope Wells, General Counsel to the Massachusetts Board of Registration in Medicine.

[38] This includes schools attended and dates of attendance.

[39] This includes internships, residencies and postgraduate fellowships.

[40] Daniel McCarthy, Note, *The Virtual Health Economy: Telemedicine and the Supply of Physicians in Rural America*, 21 AM. J. OF LAW & MED. 111 (1995); Douglas A. Perednia and Ace Allen, *Telemedicine Technology and Clinical Applications*, 273 J. AM. MED.ASS'N 483 (1995). For general background see, Douglas D. Bradham et al., *The Information Superhighway and Telemedicine: Application, Status and Issues*, 30 WAKE FOREST L. REV. 145 (1995).

[41] For an excellent overview of what we do and do not know about physician malpractice, surveying the current literature, see RANDALL R. BOVBJERG, MEDICAL MALPRACTICE: PROBLEMS & REFORMS, THE URBAN INSTITUTE (1995).

[42] *See, e.g.*, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK, The Report of the Harvard Medical Practice Study to the State of New York (1990). *See also* Paul C. Weiler et al., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION AND PATIENT COMPENSATION (1993) (summarizing many publications); DON HARPER MILLS, REPORT ON THE MEDICAL INSURANCE FEASIBILITY STUDY (1987).

[43] *Id.*

[44] *See* Bovbjerg and Petronis, *supra* note 42, at 2.

[45] *See* Bovbjerg and Petronis, *supra* note 18.

[46] *Cf.* LaRae Huycke and Mark Huycke, *Characteristics of Potential Plaintiffs in Malpractice Litigation*, 120 Annals of Int. Med. 792 (1994); Gerald B. Hickson et al., *Factors That Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 JAMA 1359 (1992); Marlynn L. May and David B. Stengel, *Who Sues Their Doctors? How Patients Handle Medical Grievances*, 24 LAW & SOC. REV. No. 4, 105 (1990).

[47] If the patient gave informed consent, and the procedure was not negligently performed, recovery of financial damages is unlikely.

[48] Mass. Gen. L. ch. 111 §53-B.

[49] *See, e.g.*, Gary S. Chafetz and Morris E. Chafetz, OBSESSION: THE BIZARRE RELATIONSHIP BETWEEN A PROMINENT BOSTON PSYCHIATRIST AND HER SUICIDAL PATIENT (1994); Eileen McNamara, SEX, SUICIDE AND THE HARVARD PSYCHIATRIST (1994).

[50] Mass. Gen. L. ch. 111, § 53B.

[51] The *proceedings* of hospital disciplinary bodies, however, remain confidential. *See* Mass. Gen. L. ch. 111, §§ 111, 204.

[52] According a recent report compiled by the Urban Institute, 70-80% of medical malpractice claims allege negligent hospital care. RANDALL R. BOVBJERG, *MEDICAL MALPRACTICE: PROBLEMS & REFORMS*, 6 (1995).

[53] *See Report*, note 17.

[54] *See Report*, at 14.

[55] Furthermore, the Advisory Committee decided it was time to throw more light on the hospital disciplinary process in general. It therefore recommended changes in existing law so as 1) to require hospitals to report *all* dispositions in professional conduct cases, whether or not a disciplinary finding is made, 2) to report all "significant maloccurrences," whether or not patient harm results, and 3) to inspect internal documents of health care facilities to verify the completeness and accurancy of their disciplinary and incident reports. *Report*, at 18.

[56] This category includes guilty pleas, and could be expanded without doing violence to the fairness concept by picking up nolo pleas, and cases where sufficient facts of guilt have been found and the matter has been continued without a finding.

[57] *See, e.g.*, People v. Kevorkian, 534 N.W. 2d 172 (Mich. App. 1995).

[58] Raymond v. Board of Reg. in Med., 443 N.E. 2d 391 (Mass. 1982) (physician's conviction of possession of unregistered submachine gun reasonably called into question his fitness to practice medicine).

[59] *See, e.g.*, MASS.GEN.L. ch. 112, § 2 (g); Bovbjerg and Petronis *supra* note 18.

[60] Paul v. Davis, 424 U.S. 693 (1976) (doctor's failure to disclose financial conflicts of interest can give rise to a cause of action for breach of informed consent).

[61] Moore v. Regents of Univ. of Cal., 793 P. 2d 479 (1990). *Cf.* K.A.C. v. Benson, 527 N.W. 2d 553 (Mass. 1995) (undisclosed, miniscule risk involved in HIV positive exposure, which did not materialize in harm in patient who later tested negative for the virus, leaves patient no claim against physician for negligent failure to disclose); *In re* Milton S. Hershey Med. Ctr. of Pa. State Univ., 595 A. 2d 1290 (Pa. Super. 1991) (hospital allowed to reveal identity of HIV positive doctor who exposed patient to virus during invasive procedure).

[62] *See* Woolhandler and Himmelstein, *supra*, note 5.

[63] *See supra* text accompanying note 34.

[64] *See generally* David J. Sokol, *The Current Status of Medical Malpractice Countersuits*, 10 AM. J. OF LAW & MED. 439 (1985).

[65] *Cf., Hidding*, note 6.

[66] Mass. Gen. L. ch 112, § F requires providers to report doctors reasonably believed to be chemically dependent to the Board. Doctors are also urged to self-report chemical dependency, and to enter Board-approved treatment and monitoring programs. Disciplinary hearings cen be avoided if the Board and the dependent doctor come to one of three forms of agreement. For a description of the differences among these agreements, *Report*, at 20-21.

[67] *Cf.*, B. Kantrowitz, *Doctors with AIDS: The Right to Know*, NEWSWEEK, July 1, 1991 at 48 (reporting that more than 90% of Americans believe health care workers should disclose HIV status to patients); Barbara Gerbert et al., *HIV-Infected Health Care Professionals: Public Opinion About Testing, Disclosing and Switching*, 153 ARCHIVES INT. MED. 313 (1993) (74% of Americans would switch from infected surgeon, but only 37% from infected gatekeeper physician).

[68] *But see* Phillip L. McIntosh, *When the Surgeon Has HIV: What to Tell Patients About the Risk of Exposure and the Risk of Transmission*, note 11, forthcoming in 44 KAN. L. REV. 1 (1996) summarizing HIV-infected physician cases.

[69] If the violation were self-reported and the doctor agreed to enter more intensive treatment, or voluntarily signed an agreement appropriately limiting his or her practice, then the automatic disciplinary hearing could be avoided. *Report*, at 23. Recommendations were generally consistent with current board practice.

[70] Elisabeth Bumiller, *Death Rankings Shake N.Y. Cardiac Surgeons*, N.Y. TIMES, Sept. 6, 1995, at 1.

[71] Claude E. Welch and P.L. Grover, *An Overview of Quality Assurance, Medical Care 29* (Supp.8) AS8-AS28 (1991).

[72] As of publication, bills more or less embodying the appended recommendations of the Advisory Committee on Public Disclosure of Physician Information have passed both Houses of the Massachusetts legislature, and the Governor has announced that he will sign the final statute as soon as certain legislative procedural formalities have been completed.