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# The National Practitioner Data Bank

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## I. Background

The National Practitioner Data Bank (NPDB) was established through the Health Care Quality Improvement Act of 1986.<sup>1</sup> Congress enacted this legislation to improve the quality of health care, restrict the ability of incompetent physicians to move from state to state without disclosing their incompetence, and encourage protected peer review.<sup>2</sup> This is done by encouraging state licensing boards, professional societies, hospitals, and other health care entities to identify and discipline those who engage in unprofessional behavior.<sup>3</sup> Thus, the purpose of the NPDB is to collect and release certain information relating to the professional conduct and competence of physicians, dentists, and other health care providers.<sup>4</sup> In other words, the NPDB is a flagging system intended to facilitate a comprehensive review of health care practitioners' professional credentials.<sup>5</sup> A sister data bank of the NPDB, the Healthcare Integrity and Protection Data Bank (HIPDB), collects and disseminates similar information, including health care-related civil judgments, criminal convictions, and injunctions.<sup>6</sup> The NPDB and HIPDB are implemented by the Division of Practitioner Data Banks of the Bureau of Health Professions, which is part of the Health Resources and Services Administration in the Department of Health and Human Services.<sup>7</sup> As of 2003, the NPDB had over 344,500 records and had processed over 32 million queries into these records.<sup>8</sup> With an average of almost 20,000 new reports each year, the NPDB will, by the end of 2005, have a number of reports equivalent to half the number of physicians in the United States.<sup>9</sup>

### A. Mandatory Reporting & Querying

The Department of Health and Human Services describes the NPDB as the central repository of information about: (1) malpractice payments made for the benefit of physicians, dentists, and other health care practitioners, (2) licensure actions taken by state medical boards and state boards of dentistry against physicians and dentists, (3) professional review actions against physicians and dentists—primarily taken by hospitals, health maintenance organizations, group practices, and professional societies, (4) actions taken by the Drug Enforcement Administration, and (5) Medicare and Medicaid Exclusions.<sup>10</sup>

The regulations that govern the NPDB, set out in 45 C.F.R. Part 60, establish minimum reporting requirements that apply to hospitals, health care entities, boards of medical examiners, professional societies, other health care providers that take adverse licensure actions, and entities that make payments as a result of medical malpractice actions, including insurance companies.<sup>11</sup> Each of these entities must report to the NPDB

any action taken to reduce, restrict, suspend, revoke, or deny clinical privileges or membership in the respective entity.<sup>12</sup> This applies to any professional review activity which takes place to determine or modify the scope or conditions of a physician's privileges or membership.<sup>13</sup> For example, a professional review action could be as simple as a hospital's recommendation that a surgeon obtain second opinions before conducting elective surgery and obtain assistance from an assistant surgeon.<sup>14</sup> As of 1997, the NPDB also includes information regarding practitioners who have been declared ineligible from participating in Medicare or Medicaid.<sup>15</sup> The reporting entities are also responsible for revising their own reports for any errors or omissions.<sup>16</sup> The Secretary of the Department of Health and Human Services may impose sanctions on an entity for failing to report required incidents to the NPDB.<sup>17</sup>

Every hospital must query the NPDB when a health care practitioner applies for a position on its medical staff or for clinical privileges at the hospital.<sup>18</sup> The hospital must then re-query the health care practitioner every two years.<sup>19</sup> The information gathered from the NPDB is confidential and can only be used for the limited purposes for which it was disclosed.<sup>20</sup> Accordingly, any person who violates the confidentiality of NPDB information is subject to a monetary civil penalty for each violation.<sup>21</sup> In addition, federal statutes provide criminal penalties for individuals who knowingly and willfully report to or query the NPDB under false pretenses, or otherwise fraudulently gain access to NPDB information.<sup>22</sup>

The general public may not request information from the NPDB that identifies a particular practitioner.<sup>23</sup> However, a plaintiff's attorney may query the NPDB for information on a particular practitioner against whom the attorney has filed a medical malpractice action if the plaintiff can determine through discovery that the hospital at which the practitioner practiced did not query the NPDB regarding the practitioner.<sup>24</sup> Defense attorneys are not allowed to access the NPDB, but the defendant practitioner may request information concerning him to see which incidents, if any, have been reported to the NPDB.<sup>25</sup> While advocacy groups have led successful efforts to gain access to state data banks, these groups have failed to gain access to the NPDB.<sup>26</sup> A bill was introduced to Congress in 2000 to allow easier public access to the NPDB, but it was not passed into law.<sup>27</sup> However, plaintiff's lawyers are still advocating opening the NPDB to the public.<sup>28</sup>

## **B. Qualified Immunity**

The hospital peer review participants that join in taking action against a health care practitioner enjoy qualified immunity.<sup>29</sup> Any person who takes part in a peer review action cannot be held liable for providing information regarding the health care practitioner unless the information provided is false and the person knew it was false.<sup>30</sup> The Secretary of the Department of Health and Human Services may conduct an investigation if it believes that a health care entity has failed to report.<sup>31</sup> If the entity still fails to report after it is given an opportunity to correct its noncompliance, the entity will lose its immunity for three years.<sup>32</sup>

Courts have held that hospitals are immune, as a matter of law, from reporting peer review information to the NPDB because hospitals are required to make such reports, as long as the report was made without knowledge of the falsity of any information contained in the report.<sup>33</sup> Health care entities that report to the NPDB rely on this immunity whenever physicians bring defamation suits against the reporting entity.<sup>34</sup> Furthermore, courts have also held that reporting a physician to the NPDB does not violate a physician's substantive due process rights, even if the report inflicts a "stigma on the reputation of [the physician] causing that [physician] hardship in obtaining employment...."<sup>35</sup> However, the reporting entity may not necessarily be granted immunity if it conducts a cursory review of only a few files before filing a false report<sup>36</sup> or takes too long in correcting a false report.<sup>37</sup>

### C. Challenging NPDB Reports

The Department of Health and Human Services mails a copy of any report filed in the NPDB to the health care practitioner the report concerns.<sup>38</sup> Since 1994, the NPDB has allowed practitioners to submit a statement, limited to 2000 words, to be included with the report that expresses their views about the report.<sup>39</sup> If a health care practitioner believes that information reported to the NPDB is inaccurate, he may dispute the accuracy of the information.<sup>40</sup> Before the practitioner may dispute the report, he must first attempt to resolve the dispute with the entity that reported the incident.<sup>41</sup> If this does not reconcile the practitioner's situation, he must object to the report in writing to the Secretary of the Department of Health and Human Services within 60 days from the date the report was originally mailed to the practitioner and request that the report be noted as "disputed" for those who query the report.<sup>42</sup> The Secretary will then hold a hearing to determine the accuracy of the information in the report.<sup>43</sup> As of 2003, there have been over 1,600 requests for Secretarial Review, with about 16 percent resulting in a corrected, changed, or voided report.<sup>44</sup>

However, Secretarial Reviews are limited to the accuracy and appropriateness of reporting.<sup>45</sup> The review does not address the underlying decision to make a malpractice payment or take an adverse action.<sup>46</sup> This means that the review does not include a review of the merits of a medical malpractice claim or the basis for an adverse action.<sup>47</sup> Thus, the reviews are limited to factual accuracy and whether the report was properly submitted in accordance with the NPDB reporting requirements.<sup>48</sup> This may explain the 45 percent decrease in requests for Secretarial Review from 2002 to 2003.<sup>49</sup> Even though this review is extremely limited, courts have held that this is a health care practitioner's sole remedy by which to challenge an NPDB report that concerns him.<sup>50</sup> Furthermore, most courts have held that a health care practitioner must exhaust all of these administrative procedures for challenging an NPDB report before filing a lawsuit to seek relief.<sup>51</sup>

The Department of Health and Human Services notes that the settlement of a medical malpractice claim may occur for a variety of reasons that do not necessarily indicate that medical malpractice has occurred.<sup>52</sup> Accordingly, the Department has said that a payment made in settlement "shall not be construed as a presumption that medical

malpractice has occurred.”<sup>53</sup> The Department goes on to say that the NPDB report on such a payment should only alert the reader that there “may” be an issue with the practitioner’s competence.<sup>54</sup>

#### **D. Snapshot of the NPDB in 2003**

The Department of Health and Human Services published its last report regarding the NPDB in 2003. The report compiled data collected from September 1, 1990 to December 31, 2003.<sup>55</sup> As of 2003, nearly three-quarters (72.7 percent) of all reports in the NPDB concerned medical malpractice payments.<sup>56</sup> This has resulted in over 344,500 medical malpractice payments and adverse action reports concerning over 205,000 practitioners.<sup>57</sup> Almost nine out of ten reports (85 percent) were original reports.<sup>58</sup> Correction reports and revision reports made up the remaining 15 percent.<sup>59</sup> In the same year, the NPDB had a query match rate of over one in ten.<sup>60</sup>

Almost 14 percent of queries in 2003 showed that the practitioner had a reported medical malpractice payment or adverse action on record in the NPDB.<sup>61</sup> This was higher than the cumulative match rate of 11.2 percent.<sup>62</sup> This year’s payment allocations were typical, with physicians responsible for four out of every five (80.4 percent) medical malpractice payment reports.<sup>63</sup> This correlates with the statistic that 11 percent of physicians reported were responsible for half of all malpractice dollars paid from 1990 to 2003.<sup>64</sup> Nurses only accounted for one out of 50 (1.8 percent) malpractice payment reports.<sup>65</sup> Most of the queries were voluntary, with managed care organizations making almost half of those queries.<sup>66</sup>

### **II. Accuracy of the NPDB**

There have been numerous studies that call into question the accuracy of the information found in the NPDB. For example, even the Department of Health and Human Service’s 2003 Annual Report recognized that the use of the “corporate shield” may “mask the extent of substandard care and diminish [the] NPDB’s usefulness as a flagging system.”<sup>67</sup> The corporate shield occurs when attorneys arrange for the name of a health care organization to be substituted for the name of the practitioner when medical malpractice payments are arranged.<sup>68</sup> Under current NPDB regulations, a report is not filed if a practitioner is named in the claim but not the settlement.<sup>69</sup> The Department said that the extent of how often this loophole is used “cannot be measured with available data.”<sup>70</sup>

This was not the only situation where the 2003 report noted discrepancies in reporting procedures. Another example occurs when the federal government is sued. Under the Federal Tort Claims Act, the government, not the physician, is named in the lawsuit when malpractice is alleged concerning a federal practitioner.<sup>71</sup> Another problem is that both the Department of Defense and Department of Veterans Affairs use a complex process to determine whether to report the medical malpractice payment.<sup>72</sup> Yet another instance of reporting discrepancies occurs when hospitals fail to report incidents that occur within the bounds of a residency program.<sup>73</sup> The report pointed out that a

common misperception exists that, since residents are under the direction of a supervising physician, residents by definition are not responsible for the care provided and, thus, not subject to NPDB reporting.<sup>74</sup> These discrepancies in reporting can also be seen in the fact that, as of 2003, over 53 percent of the hospitals that were currently in “active” registered status had never submitted a single clinical privileges action report.<sup>75</sup> These statistics varied from state to state, ranging from 26.7 percent of hospitals in Rhode Island not reporting to 79.3 percent in South Dakota.<sup>76</sup>

### A. General Accounting Office Reports

The United States General Accounting Office (GAO) has released two publications detailing the insufficiencies and inaccuracies with the NPDB. In 1993, the GAO released *Health Information Systems: National Practitioner Data Bank Continues to Experience Problems*.<sup>77</sup> This was a follow up to a 1990 review that evaluated the development of the NPDB and reported that the Department of Health and Human Services had not effectively managed the project.<sup>78</sup> The GAO performed the 1993 review “because of continuing concerns about management of the data bank.”<sup>79</sup> Specifically, hospitals and physicians had expressed concerns over the data bank’s timeliness in responding to requested information, the security of data, and increasing user fees.<sup>80</sup> After finishing its study of the NPDB, the GAO concluded that the Department of Health and Human Service’s management of the data bank “has allowed weaknesses that undermine achievement of a timely, secure, and cost-efficient operation.”<sup>81</sup> The report noted that, due to insufficient internal controls, organizations had received sensitive practitioner data to which they were not entitled.<sup>82</sup> The GAO said that the mishandling of sensitive data could “seriously undermine the integrity of the data bank.”<sup>83</sup> Furthermore, a lack of internal monitoring had led to system processing deficiencies and inaccurate documentation.<sup>84</sup> The report also found that a private company hired to provide technical oversight did not perform any on-site examinations of the system.<sup>85</sup> Overall, the GAO’s report said that these faults raised serious concerns about the NPDB’s management.<sup>86</sup>

In 2000, the GAO released another report concerning the NPDB entitled *National Practitioner Data Bank: Major Improvements Are Needed to Enhance Data Bank’s Reliability*.<sup>87</sup> This report began by noting that “[b]ecause NPDB information can affect a practitioner’s reputation and livelihood, the integrity of the data bank’s information has been of great concern.”<sup>88</sup> This concern arose because “[s]ince its beginning in 1990, questions have arisen about NPDB’s operational efficiency and effectiveness.”<sup>89</sup> This report found that, even though the Department of Health and Human Services “has long been concerned that underreporting weakens [the] NPDB’s reliability, steps for addressing such issues are not part of the agency’s strategic plan.”<sup>90</sup> This has resulted in an unsuccessful attempt to quantify or minimize underreporting.<sup>91</sup> The report also criticized the Department for focusing on the underreporting of malpractice payments when studies have shown that the underreporting of clinical privilege restrictions was a more pressing issue.<sup>92</sup> This issue is especially relevant because “[i]ndustry experts also agree, pointing out that disciplinary actions taken by health care providers and states are better indicators of professional competence than medical malpractice.”<sup>93</sup> The GAO said that the Department’s officials acknowledged that the agency had not been successful in

encouraging compliance with clinical privilege reporting requirements.<sup>94</sup> In addition, even though the Department had been focused on the underreporting of malpractice payments, “it has not been able to determine the magnitude of the problem despite many years of effort.”<sup>95</sup> The GAO said one cause of this was that the Department had “not yet identified or fined any organizations for failing to report the required information” during the NPDB’s entire existence.<sup>96</sup>

The 2000 report also questioned the quality of reported information.<sup>97</sup> For example, the report noted that the data in medical malpractice reports, which represents about 80 percent of NPDB data, generally did not meet the Department’s criteria for completeness.<sup>98</sup> The GAO pointed out that over 95 percent of the medical malpractice reports it reviewed did not note whether the standard of patient care had been considered when the claim was settled or adjudicated.<sup>99</sup> Furthermore, nearly 30 percent of the reviewed malpractice payment reports contained patient and practitioner names in violation of NPDB reporting instructions.<sup>100</sup> However, the Department’s officials said that they “were aware of the problem but had not found a cost-effective method for removing names.”<sup>101</sup>

The 2000 report also found that 30 percent of the state licensure actions were submitted late and 11 percent contained inaccurate or misleading information on the severity or number or times practitioners had been disciplined.<sup>102</sup> A common problem was duplicate submissions that made it appear that twice the number of actions against a practitioner had been taken.<sup>103</sup> There was also inaccurate information in about one-third of the clinical privilege restriction reports the GAO reviewed.<sup>104</sup> The report found that the Department had not implemented a requirement enacted 13 years prior to collect disciplinary actions taken against nurse and other health care practitioners.<sup>105</sup> The GAO also noted the “corporate shield” problem, which is echoed in the NPDB’s 2003 Annual Report that noted the Department had still been unable to address the problem.<sup>106</sup>

Importantly, the 2000 report concluded that practitioners had difficulty getting wrongly reported information corrected.<sup>107</sup> However, the Department’s officials said that the “NPDB’s practitioner notification and dispute resolution process adequately addresses individual concerns while maintaining the data bank’s integrity.”<sup>108</sup> The GAO disagreed, saying that “our analysis of reports submitted to the data bank and the results of our queries for information on particular practitioners suggest that these controls have not prevented erroneous information from remaining in the data bank once it is reported.”<sup>109</sup> As an anecdote, the GAO found a practitioner who had disputed a report and supplied evidence of its error.<sup>110</sup> Even though the state that reported the practitioner reported the mistake to the NPDB, the inaccurate information had not been expunged.<sup>111</sup> The GAO noted that this was of particular concern to the practitioner “because this was the only information the NPDB had on this individual.”<sup>112</sup>

## **B. Office of Inspector General Reports**

The Department of Health and Human Services has conducted its own studies of the NPDB through its Office of Inspector General (OIG). In 1992, the OIG published

*National Practitioner Data Bank: Malpractice Reporting Requirements.*<sup>113</sup> This report recognized that some organizations have called for imposing a reporting floor—perhaps \$30,000 or \$50,000.<sup>114</sup> The rationale behind this argument is that lower payments most likely represent “the efforts of practitioners or insurers to settle ‘nuisance suits,’ are not evidence of actual malpractice, and present an unnecessary burden for reporters.”<sup>115</sup> Furthermore, several insurers told the OIG that a floor would make practitioners more receptive to settling small claims.<sup>116</sup> The report said that a \$50,000 reporting floor would reduce the number of malpractice payment reports sent to the NPDB by almost half.<sup>117</sup> A \$30,000 floor would eliminate 38 percent of the reports.<sup>118</sup> However, the OIG concluded that a reporting floor should not be imposed because it could lead to distortion and misrepresentation in the settlement process such as settling for one dollar less than the reporting amount or spreading large settlements over many practitioners to fall below the reporting requirement.<sup>119</sup> It is relevant to note that the OIG said that this was not a “definitive recommendation” due to the limited scope of its inspection and the need for additional information on small payments and the overall distribution of malpractice payment amounts.<sup>120</sup>

In 1995, the OIG published a report that found similar unwillingness of over half the hospitals in the country to comply with the NPDB reporting requirements as seen in the OIG’s 2000 report.<sup>121</sup> In 1997, the OIG published a report that found that the Drug Enforcement Administration (DEA) was not reporting practitioners who voluntarily gave up their Controlled Substance Act registration number at the threat of having it revoked or suspended.<sup>122</sup> This report found that the DEA was actually sanctioning three times the amount of practitioners as it was reporting.<sup>123</sup> In 1999, the OIG published a report that said “[t]here are indications that hospitals may not be complying with the reporting requirements” of the NPDB.<sup>124</sup> The data behind this study showed that about 67 percent of hospitals never reported an adverse action from September 1990 to September 1998.<sup>125</sup> The report cited a national conference of major medical and health organizations in October 1996 that reached a consensus that the number of reports in the NPDB “is unreasonably low compared with what would be expected if hospitals pursued disciplinary actions aggressively and reported all such actions.”<sup>126</sup> The OIG cited another study of reports to state data banks that found a deterioration in the cooperation between hospitals and the agency where they sent their reports.<sup>127</sup> The study raised a concern that hospitals were “not fully reporting adverse peer review actions to appropriate governmental agencies and stronger laws are needed.”<sup>128</sup> Finally, in 2001, the OIG released a study that found that 84 percent of managed care organizations had never reported an adverse action.<sup>129</sup> The same study found that many managed care organizations devoted little focus to clinical oversight and relied on hospitals, physician practice groups, and state licensure boards to conduct quality monitoring of practitioners.<sup>130</sup> The study concluded by noting the limitations on these “downstream entities” that the managed care organizations rely upon.<sup>131</sup>

### III. Conclusion

While the National Practitioner Data Bank has been successful at amassing an enormous amount of information regarding physicians and other health care practitioners, various studies have shown that problems such as underreporting, over-reporting, and inaccurate reporting call into question the reliability of the data bank as a true depiction of a physician's competence.

The studies cited herein display the difficulties in challenging an inaccurate report. Additionally, if reports of medical malpractice payments have no information regarding the standard of care or the reason for settlement, a physician who has defended nothing but frivolous lawsuits will still turn up in the "bad doctor" data bank. Therefore, physicians will be more likely to pay the extravagant costs of litigating every matter to a jury decision just to avoid having to report a miniscule settlement of a frivolous lawsuit.

The process of complying with the Health Care Quality Improvement Act of 1986 is complex and challenging for all involved. It is a process that will probably always be criticized and never completely perfected.

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<sup>1</sup> 45 C.F.R. § 60.1 (2005) (citing Health Care Quality Improvement Act of 1986, Pub. L. 99-660 (codified as amended at 42 U.S.C. § 11101 *et. seq.*)); 54 Fed. Reg. 42,722 (Oct. 17, 1989).

<sup>2</sup> 42 U.S.C. § 11101 (2004).

<sup>3</sup> United States Dep't of Health & Human Servs., Health Res. & Servs. Admin., *Fact Sheet on the National Practitioner Data Bank 1* (Oct. 11, 2001), available at <http://www.npdb-hipdb.com/factsheet.html>.

<sup>4</sup> 45 C.F.R. § 60.1.

<sup>5</sup> *Fact Sheet on the National Practitioner Data Bank* at 1.

<sup>6</sup> United States Dep't of Health & Human Servs., Health Res. & Servs. Admin., *Fact Sheet on the Healthcare Integrity and Protection Data Bank 1* (Nov. 4, 2003), available at <http://www.npdb-hipdb.com/factsheet.html>. This data bank was created in 1996. It also functions as an information clearing house and was created specifically to combat fraud and abuse in health care insurance and delivery. The HIPDB contains information on adverse actions taken against all healthcare practitioners, as opposed to primarily physicians and dentists in the NPDB, but the types of reportable adverse actions are more limited. For further information, see 45 C.F.R. § 61 (2005); <http://www.npdb-hipdb.com/hipdb.html>.

<sup>7</sup> United States Dep't of Health & Human Servs., Health Res. & Servs. Admin., *National Practitioner Data Bank 2003 Annual Report 5*, available at <http://www.npdb-hipdb.com/annualrpt.html>.

<sup>8</sup> *Id.* at 36, 47.

<sup>9</sup> See *id.*; Dennis Cauchon, *Medical Miscalculation Creates Doctor Shortage*, USA Today, March 2, 2005 ("[t]he nation now has about 800,000 active physicians").

<sup>10</sup> *National Practitioner Data Bank 2003 Annual Report* at 6.

<sup>11</sup> 45 C.F.R. §§ 60.2., 60.7.

<sup>12</sup> *Id.* § 60.3.

<sup>13</sup> *Id.* § 60.3.

<sup>14</sup> *Azmat v. Shalala*, 186 F. Supp. 2d 744 (W.D. Ky. 2001), *aff'd*, 49 Fed. Appx. 521 (6<sup>th</sup> Cir. 2002).

<sup>15</sup> *Fact Sheet on the National Practitioner Data Bank* at 1; *National Practitioner Data Bank 2003 Annual Report* at 27.

<sup>16</sup> 45 C.F.R. § 60.6.

<sup>17</sup> See, e.g., 42 U.S.C. §§ 11131(c), 11132(c), 11133(c); 45 C.F.R. §§ 60.7(c), 60.8(c), 60.9(c).



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<sup>18</sup> 42 U.S.C. § 1135; 45 C.F.R. § 60.10.

<sup>19</sup> *Id.*

<sup>20</sup> 42 U.S.C. § 11137(b)(1); 45 C.F.R. § 60.13(a).

<sup>21</sup> 42 U.S.C. § 11137(b)(2); 45 C.F.R. § 60.13(b).

<sup>22</sup> *National Practitioner Data Bank 2003 Annual Report* at 9.

<sup>23</sup> United States Dep't of Health & Human Servs., Health Res. & Servs. Admin., *Fact Sheet on Reporting 1* (Jan. 31, 2005), available at <http://www.npdb-hipdb.com/factsheet.html>; *National Practitioner Data Bank 2003 Annual Report* at 1.

<sup>24</sup> United States Dep't of Health & Human Servs., Health Res. & Servs. Admin., *Fact Sheet for Attorneys 2* (Oct. 11, 2001), available at <http://www.npdb-hipdb.com/factsheet.html>.

<sup>25</sup> *See id.*; 45 C.F.R. § 60.11(2)

<sup>26</sup> Kristen Hallam, *Next Target: National Practitioner Data Bank*, *Modern Healthcare* Vol. 30 (2000).

<sup>27</sup> *See id.*

<sup>28</sup> *See, e.g.,* Jim Girards, *An Argument for Opening the National Practitioner Data Bank*, 16 *Tex. Lawyer* Vol. No. 31 (2000).

<sup>29</sup> *See* 45 U.S.C. § 11111(a).

<sup>30</sup> *Id.*

<sup>31</sup> 42 U.S.C. § 11111(b).

<sup>32</sup> *Id.*

<sup>33</sup> *See, e.g.,* *Brown v. Presbyterian Healthcare Servs.*, 101 F.3d 1324, 1334 (10<sup>th</sup> Cir. 1996), *cert. denied* 520 U.S. 1181; *Lee v. Hosp. Auth.*, 353 F. Supp 2d 1255 (M.D. Ga. 2004), *aff'd*, 397 F.3d 1327 (11<sup>th</sup> Cir. 2005).

<sup>34</sup> *Brown*, 101 F.3d at 1334; *Bryan v. James E. Holmes Reg'l Med. Ctr.*, 33 F.3d 1318, 1321, 1334 (11<sup>th</sup> Cir. 1994), *cert. denied* 514 U.S. 1019.

<sup>35</sup> *See Randall v. United States*, 30 F.3d 518, 522 (4<sup>th</sup> Cir. 1994), *cert. denied* 514 U.S. 1107.

<sup>36</sup> *See Brown*, 101 F.3d at 1334.

<sup>37</sup> *See Wuchenich v. Shenandoah Mem'l Hosp.*, 215 F.3d 1324, 2000 U.S. App. LEXIS 11557 (4<sup>th</sup> Cir. 2000).

<sup>38</sup> 45 C.F.R. § 60.14(a) (2005).

<sup>39</sup> *National Practitioner Data Bank 2003 Annual Report* at 10.

<sup>40</sup> *Id.*

<sup>41</sup> *See id.* § 60.14(b)(3).

<sup>42</sup> *See id.* § 60.14 (b)(1).

<sup>43</sup> *Id.* § 60.14(c)(2).

<sup>44</sup> *National Practitioner Data Bank 2003 Annual Report* at 4, 43.

<sup>45</sup> *Id.* at 41.

<sup>46</sup> *Id.*

<sup>47</sup> *Id.*

<sup>48</sup> *Id.*

<sup>49</sup> *Id.* at 42.

<sup>50</sup> *See, e.g.,* *Brown v. Med. Coll.*, 79 F. Supp. 2d 840 (N.D. Ohio 1999); *Simpkins v. Shalala*, 999 F. Supp. 106 (D.C. 1998).

<sup>51</sup> *See, e.g.,* *Bigman v. Med. Liab. Mut. Ins. Co.*, 1996 U.S. Dist. LEXIS 1949 (S.D.N.Y. 1996), *but see* *Rogers v. Columbia/HCA*, 961 F. Supp 960, 965 (W.D. La. 1997) (holding that courts should apply the doctrine of primary jurisdiction instead of exhaustion of administrative remedies).

<sup>52</sup> *Fact Sheet on the National Practitioner Data Bank* at 1.

<sup>53</sup> *Id.*

<sup>54</sup> *Id.*

<sup>55</sup> *See National Practitioner Data Bank 2003 Annual Report* at 34.

<sup>56</sup> *Id.* at 1, 17.

<sup>57</sup> *Id.*

<sup>58</sup> *Id.*

<sup>59</sup> *Id.*

<sup>60</sup> *Id.*

<sup>61</sup> *Id.* at 2, 19.

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- <sup>62</sup> *Id.* at 2.
- <sup>63</sup> *Id.* at 34.
- <sup>64</sup> *Id.* at 3.
- <sup>65</sup> *Id.* at 20.
- <sup>66</sup> *Id.* at 2.
- <sup>67</sup> *Id.* at 25.
- <sup>68</sup> *Id.*
- <sup>69</sup> *Id.*
- <sup>70</sup> *Id.*
- <sup>71</sup> *Id.*
- <sup>72</sup> *See id.*
- <sup>73</sup> *Id.*
- <sup>74</sup> *Id.* at 26.
- <sup>75</sup> *Id.* at 4, 30.
- <sup>76</sup> *Id.* at 40.
- <sup>77</sup> United States General Accounting Office, Report to the Secretary of Health and Human Services, *Health Information Systems: National Practitioner Data Bank Continues to Experience Problems* (1993), available at <http://www.gao.gov/docsearch/abstract.php?rptno=IMTEC-93-1>.
- <sup>78</sup> *Id.* at 9-10.
- <sup>79</sup> *Id.* at 11.
- <sup>80</sup> *Id.* (Letter from Frank W. Reilly, Director of Human Resources Information Systems to Donna E. Shalala, Secretary of Health & Human Services (Jan. 29, 1993)).
- <sup>81</sup> *Id.* at 2.
- <sup>82</sup> *Id.* at 3, 14.
- <sup>83</sup> *Id.* at 21.
- <sup>84</sup> *Id.* at 3, 20.
- <sup>85</sup> *Id.* at 24.
- <sup>86</sup> *Id.* at 29-30.
- <sup>87</sup> United States General Accounting Office, Report to the Chairman, Subcommittee on National Economic Growth, Natural Resources and Regulatory Affairs, Committee on Government Reform, House of Representatives, *National Practitioner Data Bank: Major Improvements Are Needed to Enhance Data Bank's Reliability* (2000), available at <http://www.gao.gov/docsearch/abstract.php?rptno=GAO-01-130>.
- <sup>88</sup> *Id.* at 3.
- <sup>89</sup> *Id.*
- <sup>90</sup> *Id.* at 4.
- <sup>91</sup> *Id.*
- <sup>92</sup> *Id.* at 4, 10.
- <sup>93</sup> *Id.* at 4.
- <sup>94</sup> *Id.* at 13.
- <sup>95</sup> *Id.* at 10.
- <sup>96</sup> *Id.*
- <sup>97</sup> *See id.* at 16.
- <sup>98</sup> *Id.* at 5, 16, 20.
- <sup>99</sup> *Id.*
- <sup>100</sup> *Id.*
- <sup>101</sup> *Id.*
- <sup>102</sup> *Id.*
- <sup>103</sup> *Id.*
- <sup>104</sup> *Id.*
- <sup>105</sup> *Id.* at 14.
- <sup>106</sup> *Id.* at 11; *National Practitioner Data Bank 2003 Annual Report* at 4
- <sup>107</sup> *National Practitioner Data Bank: Major Improvements Are Needed to Enhance Data Bank's Reliability* at 16, 20.
- <sup>108</sup> *Id.* at 16.
- <sup>109</sup> *Id.* at 25.

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<sup>110</sup> *Id.* at 25-26.

<sup>111</sup> *Id.*

<sup>112</sup> *Id.* at 26.

<sup>113</sup> United States Dep't of Health & Human Servs., Officer of Inspector General, *National Practitioner Data Bank: Malpractice Reporting Requirements* (April 1992), available at <http://oig.hhs.gov/oei/ntor.html>.

<sup>114</sup> *Id.* at 5-6.

<sup>115</sup> *Id.* at i.

<sup>116</sup> *Id.* at 5-6.

<sup>117</sup> *Id.*

<sup>118</sup> *Id.*

<sup>119</sup> *Id.* at 7-8.

<sup>120</sup> *Id.* at iii.

<sup>121</sup> United States Dep't of Health & Human Servs., Officer of Inspector General, *Hospital Reporting to the National Practitioner Data Bank* 3-4 (February 1995), available at <http://oig.hhs.gov/oei/ntor.html>.

<sup>122</sup> United States Dep't of Health and Human Servs., Officer of Inspector General, *Drug Enforcement Administration Reporting to the National Practitioner Data Bank* 3-4 (March 1997), available at <http://oig.hhs.gov/oei/ntor.html>.

<sup>123</sup> *Id.*

<sup>124</sup> United States Dep't of Health & Human Servs., Officer of Inspector General, *Legislative Recommendation to Improve Hospital Reporting to the National Practitioner Data Bank* (Letter from June Gibbs Brown, Inspector General, to Claude Earl Fox, Administrator of Health Resources & Services Administration (July 21, 1999), available at <http://oig.hhs.gov/oei/ntor.html>.

<sup>125</sup> *Id.*

<sup>126</sup> *Id.*

<sup>127</sup> *Id.*

<sup>128</sup> *Id.*

<sup>129</sup> United States Dep't of Health & Human Servs., Officer of Inspector General, *Managed Care Organization Nonreporting to the National Practitioner Data Bank: A Signal for Broader Concern* 4 (May 2001), available at <http://oig.hhs.gov/oei/ntor.html>.

<sup>130</sup> *Id.* at 6-7.

<sup>131</sup> *Id.* at 8-9.