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August 19, 2020

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health and Human Services
200 Independence Ave. SW
Washington, D.C. 20201

Thomas J. Engels
Administrator
Health Resources and Services Administration
U.S. Department of Health and Human Services
5600 Fishers Lane
Rockville, MD 20857

RE: Enhancing the Specificity and Thoroughness of the National Practitioner Data Bank (NPDB), Increasing Reporting of Sexually Abusive and Problematic Physicians and Other Health Care Practitioners, and Opening the NPDB to the Public

Dear Secretary Azar and Mr. Engels:

Public Citizen, a national nonprofit consumer advocacy organization with more than 500,000 members and supporters nationwide — respectfully urges you to implement six recommendations concerning the National Practitioner Data Bank (NPDB) to protect the public from sexually abusive physicians and other health care practitioners. These recommendations were made in our recent comprehensive report, titled “15-Year Summary of Sexual Misconduct by U.S. Physicians Reported to the National Practitioner Data Bank, 2003 — 2017: In-Depth, Updated Evidence on White Coat Betrayal.”¹

The recommendations are the following:

- (1) Add “patient sexual abuse” as a new basis for action or specific malpractice-act-or-omission allegation in all NPDB reports that would apply to any conduct that involves any sexual contact between physicians or other health care practitioners and their patients or any behaviors or remarks of a sexual nature by physicians or other health care

¹ AbuDagga A, Carome A, Wolfe S, Oshel R. 15-year summary of sexual misconduct by U.S. physicians reported to the National Practitioner Data Bank, 2003 — 2017. In-depth, updated evidence on white coat betrayal. May 26, 2020. <https://www.citizen.org/wp-content/uploads/2523.pdf?eType=EmailBlastContent&eld=cfae6104-8c44-4f07-87b5-f78353346c47>. Accessed August 19, 2020.

practitioners toward their patients.² For all forms of sexual misconduct not involving patients, change the current “sexual misconduct” basis for action or specific malpractice-act-or-omission allegation to “sexual misconduct not involving patients.”

- (2) Establish and enforce requirements for reporting entities to always specify “sexual abuse of patients” as a basis for action or specific malpractice allegation in all reports of conduct that involve *any* sexual contact between physicians or other health care practitioners and their patients or any behaviors or remarks of a sexual nature by physicians or other health care practitioners toward their patients. Similarly, require NPDB reporting entities to specify “sexual misconduct not involving patients” as a basis for action or specific malpractice-act-or-omission allegation in all reports of sexual misconduct not involving patients.
- (3) For all NPDB reports that include “sexual abuse of patients” or “sexual misconduct not involving patients” as a basis for action or specific malpractice allegation, require the reporting entities to provide in the narrative descriptions key specific details regarding the physician’s or other health care practitioner’s sexual abuse of patients or sexual misconduct not involving patients, as applicable.
- (4) Require reporting entities to always include the most specific available basis-for-action or malpractice-act-or-omission codes, as applicable, in *all* NPDB reports and to submit complete and detailed narrative descriptions for all NPDB reports.
- (5) Seek legal authority that would allow the Health Resources and Services Administration’s (HRSA’s) Division of Practitioner Data Bank (DPDB) to investigate compliance with NPDB reporting requirements by state medical boards, health care organizations, malpractice insurers, and other entities and to take enforcement actions against noncompliant entities.
- (6) Seek legal authority to make individually identifiable information in the NPDB publicly available to consumers because the benefits of doing so far outweigh the harms to individual physicians or physician interest groups.

About our recent report

Our report provides an in-depth analysis of public and restricted NPDB data for all physicians with sexual-misconduct–related adverse licensing, clinical-privileges, and malpractice-payment reports.³ We found that that only 1,354 physicians — 0.2% of U.S. physicians — had sexual-misconduct–related licensing, clinical privileges, or malpractice-payment NPDB reports from January 2003 through December 2017. This is an alarmingly low proportion compared with that for physicians who self-reported engaging in this unethical behavior in survey studies. For example, an anonymous random national survey of physician members of the American Medical

² We also are sending letters to each state medical board requesting that they replace the term “sexual misconduct” with “sexual abuse of patients” in their laws and policies when the abuse involves patients.

³ Department of Health and Human Services, Health Resources and Services Administration. NPDB guidebook. October 2018. <https://www.npdb.hrsa.gov/resources/NPDBGuidebook.pdf>. Accessed August 19, 2020.

Association showed that 3.4% of the respondents reported a history of personal sexual contact (genital-genital, oral-genital, or anal-genital) with one or more patients.⁴

Our report illustrated several practices through which the largely self-regulated medical profession (through both state medical boards and medical peer-review committees in health care organizations) fails to curtail the problem of sexually abusive physicians. Particularly, state medical boards and medical peer-review committees in health care organizations too often deal leniently with such physicians. Disturbingly, we found that 510 (38%) of the 1,354 physicians with sexual-misconduct reports continued to hold active licenses and clinical privileges in the states where they were disciplined or had malpractice-payment reports. We also discovered that out of the 317 physicians who had clinical-privileges actions or malpractice-payment reports because of sexual misconduct, 221 (70%) were not disciplined by any state medical board for their harmful behavior.

Based on the findings of our report, we generated several recommendations to address sexual abuse by physicians in the U.S. Several of our recommendations relate to the NPDB: how to enhance the quality of reports and increase reporting of sexual abuse of patients by physicians. Because these recommendations are generally applicable to other health care practitioners, we expanded their scope to all health care practitioners, not just physicians.

Recommendation 1: Add “patient sexual abuse” as a new basis for action or specific malpractice-act-or-omission allegation in all NPDB reports that would apply to any conduct that involves any sexual contact between physicians or other health care practitioners and their patients or any behaviors or remarks of a sexual nature by physicians or other health care practitioners toward their patients. For all forms of sexual misconduct not involving patients, change the current “sexual misconduct” basis for action or specific malpractice-act-or-omission allegation to “sexual misconduct not involving patients.”

The current NPDB codebook indicates that all submitted reports should contain basis-for-action codes (in the case of adverse-action reports) or specific malpractice-act-or-omission allegation codes (in the case of malpractice-payment reports) that accurately represent the reportable action or allegation.⁵ “Sexual misconduct” is the only code that pertains to physical sexual contact, sexual relations, and behaviors or remarks of a sexual nature directed toward patients or others.

We propose adding “sexual abuse of patients” as a new basis for action or specific malpractice-act-or-omission allegation in all NPDB reports that would apply to any conduct that involves any sexual contact between physicians or other health care practitioners and their patients or any behaviors or remarks of a sexual nature by physicians or other health care practitioners toward their patients. “Sexual abuse” is the term increasingly used by the international community, such as the government of Ontario, Canada⁶ and the Medical Council of New Zealand,⁷ when

⁴ Bayer T, Coverdale J, Chiang E. A national survey of physicians' behaviors regarding sexual contact with patients. *South Med J.* 1996;89(10):977-982.

⁵ Department of Health and Human Services, Health Resources and Services Administration. NPDB guidebook. October 2018. <https://www.npdb.hrsa.gov/resources/NPDBGuidebook.pdf>. Accessed August 19, 2020.

⁶ Government of Ontario. Regulated Health Professions Act, 1991, S.O. 1991, c. 18. (Currency date: January 1, 2020). <https://www.ontario.ca/laws/statute/91r18/v6>. Accessed August 19, 2020.

referring to any physician sexual contact or relations, or any behaviors or remarks of a sexual nature by a physician toward a patient because of the breach of trust and exploitative nature of such actions.⁸ In fact, “sexual misconduct” or any characterization that does not involve the term “sexual abuse” fails to connote the seriousness and profound unethical nature of physical sexual contact or relations and sexual interactions between physicians or other health care practitioners and their patients.

For all forms of sexual misconduct not involving patients, we propose changing the current “sexual misconduct” basis for action or specific malpractice-act-or-omission allegation to “sexual misconduct not involving patients.”

We believe that having these two new codes (“sexual abuse of patients” and “sexual misconduct not involving patients”) will enable reporting entities to provide the most accurate information in their NPDB reports. Note that reporting entities can include up to five bases for action in adverse action reports and up to two specific malpractice-act-or-omission allegations in malpractice-payment reports.

Recommendation 2: Establish and enforce requirements for reporting entities to always specify “sexual abuse of patients” as a basis for action or specific malpractice allegation in all reports of conduct that involve *any* sexual contact between physicians or other health care practitioners and their patients or any behaviors or remarks of a sexual nature by physicians or other health care practitioners toward their patients. Similarly, require NPDB reporting entities to specify “sexual misconduct not involving patients” as a basis for action or specific malpractice-act-or-omission allegation in all reports of sexual misconduct not involving patients.

The NPDB guidebook clearly recommends the use of basis-for-action or specific malpractice-act-or-omission allegation codes that accurately denote the reportable action or allegation in NPDB reports. It also instructs that the “other” code should be used only if there are no codes that match the actual basis for action or malpractice-act-or-omission allegation. Yet, the current NPDB regulations do not preclude reporting entities from using any nonspecific codes rather than the current specific sexual misconduct code.

NPDB regulations should be revised to explicitly prohibit the use of such nonspecific codes in NPDB reports whenever a specific basis-for-action or malpractice-act-or-omission allegation code appropriately matches the physician’s or other health care practitioner’s conduct described in the NPDB report. Our report documents numerous examples of reports in which reporting entities opted to use the “other” or nonspecific codes (such as “unprofessional conduct,” “conduct evidencing moral unfitness,” “conduct evidencing ethical unfitness,” “other unprofessional conduct,” and “violation of federal or state statutes, regulations, or rules”) in lieu of “sexual misconduct” when the narrative descriptions of these reports clearly indicated that the

⁷ Medical Council of New Zealand. Sexual boundaries in the doctor-patient relationship. November 2018. <https://www.mcnz.org.nz/assets/standards/3f49ba8048/Sexual-boundaries-in-the-doctor-patient-relationship.pdf>. Accessed August 19, 2020.

⁸ AbuDagga A, Carome M, Wolfe SM. Time to end physician sexual abuse of patients: Calling the U.S. medical community to action. *J Gen Intern Med*. 2019;34(7):1330-1333.

named physician had engaged in sexual abuse against patients or sexual misconduct involving others. We also observed that many of the physicians with sexual-misconduct-related reports had prior or subsequent licensing or clinical-privileges reports with these similarly vague codes, which may indicate avoidance of the specific sexual-misconduct basis code.

We believe such practices were done deliberately to conceal sexual abuse and sexual misconduct because reporting entities can capitulate to pressures from sexually abusive physicians and their legal representatives to circumvent the clear declaration of this unethical behavior in NPDB reports. As an attorney who represented sexually abusive physicians argued, “as long as [the negotiated basis-for-action code] is accurate, there may be several ways of reporting something.”⁹

Recommendation 3: For all NPDB reports that include “sexual abuse of patients” or “sexual misconduct not involving patients” as a basis for action or specific malpractice allegation, require the reporting entities to provide in the narrative descriptions key specific details regarding the physician’s or other health care practitioner’s sexual abuse of patients or sexual misconduct not involving patients, as applicable.

The current NPDB submission system permits reporting entities to provide a qualitative narrative description for each report. This narrative description, which can be up to 4,000 characters, is an extremely important measure for providing future queriers with additional essential information. For licensing and clinical-privileges reports, the narrative description is supposed to include details about the type of disciplinary actions taken against the physician who was named in the report, the specific acts or omissions upon which these actions were based, and the circumstances that led to the actions. For malpractice-payment reports, the narrative description is supposed to include a description of the alleged acts or omissions and injuries upon which the malpractice payment was based and any conditions (including the terms of payment).

However, the de-identified narrative descriptions from sexual-misconduct-related reports provided to us for research purposes showed great variability in the completeness of information. We also found that some physicians had just one NPDB sexual-misconduct-related report, but the redacted narrative descriptions of the reports showed that these physicians had multiple victims or had a history or a pattern of sexually abusing patients or of sexual misconduct involving others.

Therefore, we propose that the NPDB guidebook and submission system should be revised to require all reporting entities to provide key specific details in the narrative descriptions about the grounds of adverse action or malpractice payment, and any current or past circumstances pertaining to sexual abuse of patients or sexual misconduct involving others.

It is critical that such information be included in the narrative description of each report because doing so will maximize the benefit of the NPDB to future queriers and researchers. This is particularly important given that state laws do not mandate health care organizations or other

⁹ Ernsthausen J. Why a national tracking system doesn’t show the extent of physician sexual misconduct. July 6, 2016. http://doctors.ajc.com/sex_abuse_national_database/?ecmp=doctorssexabuse_microsite_nav. Accessed August 19, 2020.

entities to disclose that one of their former physicians engaged in sexual abuse of patients or sexual misconduct not involving patients to potential future employers of that physician. Therefore, without such a disclosure mandate, health care organizations may fear being sued by such formerly employed or credentialed physicians for invasion of privacy if they release such information to potential future employers of those physicians.

Including this information in the narrative descriptions of the NPDB reports will also be valuable to researchers who are interested in extracting information about the victims and contextual factors related to sexual abuse by health care practitioners.

Recommendation 4: Require reporting entities to always include the most specific available basis-for-action or malpractice-act-or-omission codes, as applicable, in *all* NPDB reports and to submit complete and detailed narrative descriptions for *all* NPDB reports.

From our long experience working with NPDB data, we believe that the issues described under recommendations 2 and 3 regarding the common use of nonspecific basis-for-action or malpractice-act-or-omission codes and the frequently incomplete information in the narrative descriptions of reports are general problems that apply to all types of NPDB reports, not just those that pertain to sexual abuse or sexual misconduct. Therefore, it is critical that the DPDB always require the use of the most specific available basis-for-action or malpractice-act-or-omission codes for all reports. These requirements should be reflected in the NPDB guidebook and submission system.

The DPDB should determine that reports are “legally insufficient” and not in compliance with NPDB reporting requirements if they include a nonspecific or “other” code or if they do not include complete narrative descriptions as described under recommendations 2 and 3. In the event of noncompliance with either of these two requirements, the DPDB should ask the reporting entities to “correct” these reports by providing the most specific applicable codes and key specific details in the narrative descriptions of NPDB reports on the basis that such reports are “legally insufficient.”

Recommendation 5: Seek legal authority that would allow HRSA’s DPDB to investigate compliance with NPDB reporting requirements by state medical boards, health care organizations, malpractice insurers, and other entities and to take enforcement actions against noncompliant entities.

The NPDB plays a central role in ensuring patient safety by providing the most comprehensive, reliable information concerning the malpractice-payment and disciplinary history of physicians and other health care practitioners. To ensure that the information available to NPDB queriers is complete and accurate, the DPDB must have the authority to investigate compliance with NPDB reporting requirements by reporting entities and to take enforcement action when such investigations uncover noncompliance.

To our knowledge, due to this lack of authority, the DPDB has never been able to investigate or take enforcement action against any hospital or other health care organization for failing to report physicians (due to sexual misconduct or any other offenses) to the NPDB since the launch of the

database in 1990. Granting the DPDB this authority also will result in additional insight for improving the NPDB reporting processes to ensure all relevant information is included.

Recommendation 6: Seek legal authority to make individually identifiable information in the NPDB publicly available to consumers because the benefits of doing so far outweigh the harms to individual physicians or physician interest groups.

We continue to call for opening the NPDB to the public¹⁰ because failing to do so will only protect the minority of U.S. physicians with NPDB reports from the scrutiny of their own patients and others. Making the NPDB publicly available is especially important because, as we discuss in our report, state medical boards are not always aware of the disciplinary actions taken by other entities against physicians because they fail to query the NPDB. In fact, an investigation by *MedPage Today* and the *Milwaukee Journal Sentinel* showed that in 2017, 30 state medical boards queried the NPDB fewer than 100 times and that 13 boards failed to query the database at all, according to the search records at HRSA.¹¹ As of mid-2019, only nine state medical boards have subscribed more than 500 of their physicians for the continuous query feature of the NPDB,¹² which sends automatic email notifications about disciplinary actions involving individual physicians within 24 hours of receipt of new reports for them. Six states and the District of Columbia enrolled fewer than 15 physicians in the continuous NPDB query and the remaining 35 states did not enroll any of their physicians in this feature. Although medical boards may be checking information about physicians from the Federation of State Medical Boards' (FSMB's) physician data center, which is provided free of charge for board members, the FSMB data do not include information regarding clinical-privileges actions or malpractice payments. The investigation by *MedPage Today* and the *Milwaukee Journal Sentinel* found that at least 500 physicians who were disciplined by state medical boards for sexual misconduct and other reasons from 2011 to 2016 were practicing under different licenses in other states, mostly due to lapses in querying the NPDB.¹³

Additionally, currently available public information about problematic physicians, such as those on state medical board websites, are incomplete, unclear, hard to find, or generally do not include information from other states or sources (such as clinical-privileges actions or malpractice payments).¹⁴ Therefore, the best way to prevent all problematic physicians and other

¹⁰ Wolfe SM. Congress should open the National Practitioner Data Bank to all. *Public Heal Rep.* 1995;110(4):378-379.

¹¹ Wynn M, Fauber J. NPDB records often ignored in docs' licensing. *Milwaukee Journal Sentinel/MedPage Today.* March 7, 2018. <https://www.medpagetoday.com/special-reports/states-of-disgrace/71600>. Accessed August 19, 2020.

¹² Marso A. This tool can help state medical boards spot problem doctors. Why do so few use it? *The Kansas City Star.* June 21, 2019. <https://www.kansascity.com/news/business/health-care/article231444518.html>. Accessed August 19, 2020.

¹³ Fauber J, Wynn M, Fiore K. Prescription for secrecy: Is your doctor banned from practicing in other states? State licensing system keeps patients in the dark. *Milwaukee Journal Sentinel/MedPage Today.* February 28, 2018. <https://projects.jsonline.com/news/2018/2/28/is-your-doctor-banned-from-practicing-in-other-states.html>. Accessed August 19, 2020.

¹⁴ Cronin C, McGiffert L, Henry S. Seeking doctor information online: A survey and ranking of state medical and osteopathic board websites in 2015. March 29, 2016.

health care practitioners from “slipping through the cracks” and potentially harming other patients is to put all NPDB information in the hands of consumers.

Conclusion

We hope that you will implement our proposed recommendations in order to enhance the utility of the NPDB and better protect patients from sexually abusive and other dangerous or incompetent physicians and health care practitioners who move across state lines to seek new jobs and to prevent them from inflicting further public harm.

If you have any questions about this letter or the above recommendations, please contact Azza AbuDagga at (202) 588-7732 or at aabudagga@citizen.org.

Sincerely,



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cc: David Loewenstein, Director, DPDB, HRSA