

MEDIATING MED-MAL WITHOUT THE DATA BANK REPORTS

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I. EARLY MEDIATION: SOMETIMES STYMIED BY THE DATA BANK

Recent years have brought increasing recognition that errors and adverse outcomes in health care are far more common than was once supposed, that malfunctioning systems of care are far more likely than individual wrongdoers to be the source of such errors, and that improvements on the systems level require broad communication. Equally important, medical malpractice litigation has turned out to be a poor instrument for improving quality of care and patient safety. Pointing the Finger of Blame at individuals, litigation tends to discourage rather than facilitate the broad communication required for systems-level improvements.¹

Fortunately, a number of hospitals have begun to recognize that they can improve safety and quality by emphasizing honesty and accountability. Where investigation shows the institution has erred, these hospitals disclose the error to patients and families, with offers of apology and restitution where appropriate. As early as the 1980s a Veterans Administration hospital in Lexington, Kentucky initiated a program of "extreme honesty" and learned that doing the right thing could actually reduce overall malpractice costs substantially.² Other hospitals have followed suit, with impressive results. The University of Michigan Health System, for instance, instituted a program of disclosure with offer of compensation, and has seen major reductions in defense costs, malpractice payouts, rates of new claims, and time to resolution, even as it has been better able to help injured patients/families and

¹ This Article is based on a larger Article that discusses these points in greater detail. See Haavi Morreim, *Malpractice, Mediation, and Moral Hazard: the Virtues of Dodging the Data Bank*, forthcoming: Ohio State Journal on Dispute Resolution, v.27 #1, 2011; Edward A. Dauer & Leonard J. Marcus, *Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement*, 60 LAW & CONTEMP. PROBS. 185, 185 (1997).

² Steve S. Kraman & Ginny Hamm, *Risk Management: Extreme Honesty May be the Best Policy*, 131 ANNALS OF INTERNAL MED. 963, 963–67 (1999).

redirect resources toward improving quality.³ A number of other hospitals have similarly discovered they could do well by doing good.⁴

Early mediation has become a cornerstone of such early dispute resolution efforts.⁵ Unfortunately, physicians are often left on the sidelines in these settlements. Even where multiple parties to a suit can otherwise reach an agreement, physicians may feel impelled to litigate, at least partly because money paid on their behalf in a medical malpractice settlement must ordinarily be reported to the National Practitioner Data Bank (NPDB)—leaving a permanent black mark on their professional record. In contrast, physicians usually win if a case actually goes to trial. The math makes the decision appear obvious: why settle early and incur a life-long black mark when the physician can hold on for a highly-likely victory later on.⁶

³ Allen Kachalia et al., *Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program*, 153 ANNALS OF INTERNAL MED. 213, 213-214 (2010); Richard C. Boothman et al., *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, 2 J. HEALTH & LIFE SCI. LAW 125, 142 (2009).

⁴ Dale C. Hetzler, *Superordinate Claims Management: Resolution Focus from Day One*, 21 GA. ST. U. L. REV. 891, 894 (2005); Chris Stern Hyman, Carol B. Liebman, Clyde B. Schechter & William M. Sage, *Interest-Based Mediation of Medical Malpractice Lawsuits: A Route to Improved Patient Safety?*, 35 J. HEALTH POL., POL'Y & L. 797 (2010); Carol B. Liebman & Chris Stern Hyman, *MEDICAL ERROR DISCLOSURE, MEDIATION SKILLS, AND MALPRACTICE LITIGATION: A DEMONSTRATION PROJECT IN PENNSYLVANIA*, 53-56 (2005), available at http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/Medical_liability/LiebmanReport.pdf.

⁵ Florence Yee, *Mandatory Mediation: The Extra Dose Needed to Cure the Medical Malpractice Crisis*, 7 CARDOZO J. OF CONFLICT RESOL. 393, 405-423 (2006); Carol Liebman & Chris Hyman, *A Mediation Skills Model to Manage Disclosure of Errors: The Value of an Early, Interest-Based Mediation Model*, 23 HEALTH AFFAIRS 22, 24 (2004), available at <http://content.healthaffairs.org/cgi/reprint/23/4/22>.

⁶ In Tennessee in 2008, for instance, of 3154 med-mal claims closed in Tennessee in 2008, only 43, or 1.36%, were resolved through alternative dispute resolution, either mediation or arbitration. Of the 425 cases that were resolved through judgment, the defendants prevailed in 420, with

Notwithstanding this apparent dilemma, several options permit physicians to participate in a mediated settlement and still avoid a Data Bank report. Mediators who familiarize themselves with these options will be far better prepared to facilitate multiparty agreements in which hospitals, physicians, long-term care facilities and other parties can fully participate. After explaining the origin and purposes of the Data Bank, Part II arrays seven recognized avenues by which a report can be avoided.

Part III focuses more closely on one of these, namely the "pre-suit notification" period that many states mandate prior to filing a medical malpractice claim. This issue deserves special attention because important opportunities for mediating health care disputes arise when a presuit notice has been received. Arguably here, too, during the (typically) 60 or 90 days' period of advance notice a plaintiff must provide before formally filing suit, a monetary payment should not be deemed reportable.

II. NATIONAL PRACTITIONER DATA BANK

A. NPDB Origins and Physician Concerns

The NPDB was created as part of the Health Care Quality Improvement Act (HCQIA) of 1986.⁷ The Act aimed to reduce the incidence of actual malpractice⁸ and to "restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance."⁹ The Act's primary strategy was to ramp up hospital-based peer review, first by providing qualified

plaintiff taking nothing. *See* TENN. DEP'T OF COMMERCE & INS., MED. MALPRACTICE CLAIMS REPORT 2009, 4, 6 (Nov. 1, 2009); available at <http://www.tn.gov/commerce/insurance/documents/2009MedicalMalpracticeClaimsReport.pdf>

⁷ 42 U.S.C. 11101 et seq.

⁸ The Act was expressly not directed at the malpractice insurance crisis, but rather was directed at malpractice itself. *See* H.R. REP. NO. 99-903, September 26, 1986, *reprinted in* 1986 U.S.C.C.A.N. 6384, re. P.L. 99-660, at 6384.

⁹ 42 U.S.C. 11101(2).

immunity for those who participate in such review,¹⁰ and second by providing broader information on which to base such review. This expanded information base was to be accomplished by creating the NPDB to serve as a repository for data about adverse licensure actions,¹¹ adverse professional review actions undertaken, e.g., by hospitals¹² and, of particular importance here, medical malpractice payments.¹³ The trigger for a med-mal report is found in Section 11131(a):

Each entity (including an insurance company) which makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report . . . information respecting the payment and circumstances thereof.

Section 11151(7) then defines a "medical malpractice action or claim" as "a written claim or demand for payment based on a health care provider's furnishing (or failure to furnish) health care services, and includes the filing of a cause of action, based on the law of tort, brought in any court of any State or the United States seeking monetary damages." A failure to report under this provision subjects the violator to a civil money penalty.

¹⁰ Per 42 U.S. 11112(a), the " professional review action must be taken (1) in the reasonable belief that the action was in the furtherance of quality health care, (2) after a reasonable effort to obtain the facts of the matter, (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting" specified procedural requirements.

¹¹ 42 U.S.C. 11132.

¹² 42 U.S.C. 11133.

¹³ 42 U.S.C.11131. Of note, data collection extends to other practitioners in addition to physicians. Per 11151(8): "The term 'physician' means a doctor of medicine or osteopathy or a doctor of dental surgery or medical dentistry legally authorized to practice medicine and surgery or dentistry by a State (or any individual who, without authority holds himself or herself out to be so authorized)."

The NPDB is not just a dusty repository. Section 11135 requires hospitals to check the Data Bank when initially credentialing a physician and every two years thereafter. In the mid-1980s when HCQIA was enacted, most physicians maintained at least part of their practice in a hospital setting, hence hospitals were fairly well-positioned to identify and restrict poorly performing practitioners. If such a physician attempted to start over in a different location, his or her next hospital would quickly find out about the adverse prior history and either restrict that person's practice or refuse to provide credentials.

This spectre of subsequent hospitals circumscribing a physician's medical practice, based on NPDB filings, has caused physicians considerable concern. Even a one-dollar payout must be reported, and that payment will never disappear unless the Secretary of DHHS removes the information as inaccurate or not reportable.¹⁴ As noted by Metzloff *et al.* in their study of mediation in North Carolina:

Evidence from our study reveals that the Data Bank's reporting requirement is in fact a major issue in many malpractice cases. The Data Bank was a significant issue in twenty-five percent of the cases in which a defendant doctor subject to the reporting requirement was involved (eight of thirty-two cases). In fact, this percentage significantly understates the importance of the Data Bank issue. In several of the cases, liability was clear, and, predictably, the Data Bank was not a concern. In nearly fifty percent of the cases in which liability was an issue, the Data Bank was expressly referenced (eight of seventeen cases). In each of these cases, the affected doctor discussed the Data Bank as a major issue in the settlement of the case.

¹⁴ "The Secretary [of DHHS] reviews disputed reports only for accuracy of factual information and to ensure that the information was required to be reported." U.S. DEPT OF HHS, HEALTH RESOURCES AND SERVICES ADMINISTRATION NATIONAL PRACTITIONER DATA BANK GUIDEBOOK, Publication No. HRSA-95-255, September 2001 at F-3, *available at* <http://www.npdb-hipdb.hrsa.gov/resources/NPDBGuidebook.pdf> (hereinafter, "NPDB_Guidebook"); *Straznicky v. Desert Springs Hosp.*, 642 F. Supp. 2d 1238, 1245 (D. Nevada 2009).

Often, the doctor spoke personally to the mediator about the impact of the Data Bank.¹⁵

Not surprisingly, shortly after the NPDB began collecting data in 1990, physicians became considerably less willing to settle cases, expressly because of Data Bank concerns.¹⁶ To be sure, the Act emphasizes that an NPDB med-mal entry does not necessarily betoken actual malpractice.¹⁷ Nevertheless, the damage can be real.¹⁸

¹⁵ Thomas B. Metzloff, Ralph A. Peeples & Catherine T. Harris, *Empirical Perspectives on Mediation and Malpractice*, 60 LAW & CONTEMP. PROBS. 107, 148 (1997). The report will follow the physician for the rest of his or her career.

¹⁶ See Teresa M. Waters et al., *Impact of the National Practitioner Data Bank on Resolution of Malpractice Claims*, 40 INQUIRY 283, 290 (2003); Lawrence E. Smarr, *A Comparative Assessment of the PIAA Data Sharing Project and the National Practitioner Data Bank: Policy, Purpose, and Application*, 60 LAW & CONTEMP. PROBS., 59, 71 (1997). See also Michelle M. Mello & Thomas H. Gallagher, *Malpractice Reform—Opportunities for Leadership by Health Care Institutions and Liability Insurers*, 362 NEW ENG. J. MED. 1353, 1255 (2010).

¹⁷ "In interpreting information reported under this subchapter, a payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred." 42 U.S.C. 11137(d). See also 45 C.F.R 60.7(d).

¹⁸ As noted by Dale Hetzler when describing his efforts to mediate comprehensive agreements at Children's Healthcare of Atlanta:

When a case involves physicians, great concern surrounds the advisability of settlement when liability is not clear.

Unreconcilable expert opinions may make it unclear whether a jury would hold a physician responsible at trial. With their professional reputations at stake, physicians are appropriately cautious about using this approach. Until the government aligns the system of regulating the practice of medicine and reporting the resolutions of claims with the interest-based claims resolution process of disclosure and system improvement, comprehensive progress is not likely.

Dale C. Hetzler, *Superordinate Claims Management: Resolution Focus from Day One*, 21 GA. ST. U. L. REV. 891, 905 (2005).

See also Florence Yee, *Mandatory Mediation: The Extra Dose Needed to Cure the Medical Malpractice Crisis*, 7 CARDOZO J. OF CONFLICT RESOL. 393, 430-31 (2006). Yee notes that the fears concern not just removal of existing privileges, but an

In *Chudacoff v. Univ. Med. Ctr. of S. Nev.*,¹⁹ for instance, a university physician's privileges were suspended when he complained to his department chair about residents' inadequate skill levels and offered recommendations for improvement. The Medical Executive Committee responded by suspending his privileges and ordering him to undergo drug testing and various physical and mental examinations. The university president then terminated his employment because his privileges had been suspended. Shortly thereafter, "other health care facilities notified Chudacoff that his privileges had been denied or revoked because of the information listed on the NPDB."²⁰

As the District of Nevada court observed in finding that the hospital had not observed the procedural requisites of due process:

The private interest at stake here is the ability to practice medicine at a particular location. The interest extends further, however, in that a suspension of privileges at one hospital, when reported to the NPDB, could limit a physician's ability to practice anywhere in the country. The amount of process must accord sufficient respect for a professional's life and livelihood.

In *Doe v. Community Medical Center*,²¹ the Montana Supreme Court similarly held

we agree that Dr. Doe has demonstrated a likelihood of irreparable harm if CMC [Community Medical Center] is allowed to report his suspension prior to the resolution of the underlying merits of this case. ... [T]he fact is that a ringing bell cannot be unringed. An erroneous report announcing to all interested parties that a physician is being investigated or suspended ... has the potential for

inability to gain privileges at new sites, or to gain entry to managed care organizations. *Id.* at 430 n. 180.

¹⁹ 609 F.Supp.2d 1163 (D.Nev. 2009).

²⁰ *Id.* at 1166.

²¹ 21 P.3d 651 (Mont. 2008).

immediate harm as well as permanent harm, even if later retracted.²²

B. Legal Options for Avoiding NPDB Reports

Although the Data Bank thus poses a significant deterrent to early resolution, physicians can in fact settle early and avoid a Data Bank report via a number of mechanisms. Mediators and attorney advocates need to be aware of them.

1. Provider pays out of pocket

Per HCQIA, insurers and other entities who pay settlements or judgments on physicians' behalf must report that payment to the Data Bank.²³ Although initially DHHS guidelines required that any payment made by a "person or entity" must be reported, this statutory interpretation was rejected by the D.C. Circuit Court of Appeal in 1993. In *American Dental Ass'n v. Shalala*²⁴ a dentist who had paid a malpractice claim out of pocket was reported to the Data Bank. His efforts to remove that report were unsuccessful, and the District Court agreed with DHHS that any payment made by a person or entity must be reported to the NPDB.

The Circuit Court reversed, however, based on careful statutory analysis. If Congress' intent is clear, the court observed, there is no need to carry the analysis further.²⁵ In this case Congress was quite clear. The HCQIA

²² 221 P.3d 651, 661 (Mont. 2008). As Dr. Doe pointed out to the court, "since hospitals must consult the NPDB every time a physician applies for clinical privileges or is placed on staff, that he could be denied privileges by a hospital on the basis of the information contained in the revised Report, which would result in yet another NPDB entry which would 'reflect unfavorably upon him.'" *Id.* at 127. *See also* Cole v. St. James Healthcare, 199 P.3d 810 (Mont. 2008).

²³ "Each entity (including an insurance company) which makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report . . . information respecting the payment and circumstances thereof." 42 U.S.C. 11131(a).

²⁴ 3 F.3d 445 (D.C.Cir. 1993).

²⁵ *Id.* at 446.

reveals unmistakably that Congress did not intend to encompass any individual doctor or dentist as an 'entity' that must report to the National Practitioner Data Bank. The Act does not define 'entity,' but the term as used in the Act refers uniformly to groups and organizations. . . . [A]ll of the textual evidence points in one direction: Congress did not intend the term 'entity' to encompass individual practitioners. . . . We find great significance in the fact that Congress chose to use only the term "entity" in setting out the requirement to report malpractice payments.²⁶

The Secretary of DHHS subsequently revised its guidelines and now states quite clearly that payments out of pocket do not require any report.²⁷

2. Waiver of debt or refund of payment; loss adjustment expenses

A physician who forgives a patient's debt or refunds a prior payment need not report to the Data Bank. "A waiver of a debt is not considered a payment and should not be reported to the NPDB. For example, if a patient has an adverse reaction to an injection and is willing to accept a waiver of fee as settlement, that waiver is not reportable to the NPDB."²⁸

²⁶ *Id.* at 446-47.

²⁷ "Individual subjects are not required to report payments they make for their own benefit to the NPDB. On August 27, 1993, the Circuit Court of Appeals for the District of Columbia held that . . . the NPDB regulation requiring each 'person or entity' that makes a medical malpractice payment was invalid, insofar as it required individuals to report such payments. . . . [I]f a practitioner or other person, rather than a professional corporation or other business entity, makes a medical malpractice payment out of personal funds, the payment is not reportable." NPDB Guidebook at E-10. *See also* NPDB Guidebook at E-16: "Payment is made based only on oral demands. No report is required."

²⁸ NPDB Guidebook at E-12. *See also* 45 C.F.R 60.7: "For purposes of this section, the waiver of an outstanding debt is not construed as a 'payment' and is not required to be reported." However: "If a refund of a practitioner's fee is made by an entity (including solo incorporated

In a similar fashion, loss adjustment expenses (LAEs) such as attorney fees, expert witness fees, and copying fees need not be reported unless they are actually made part of a medical malpractice payment.²⁹

3. Oral or other nonwritten communication of demand for payment

The key trigger requiring a report for a medical malpractice payment is "a written claim or demand for payment based on a health care provider's furnishing (or failure to furnish) health care services"³⁰ If a plaintiff or her attorney makes claim or demand for payment in a nonwritten form, such as by telephone or by direct person-to-person conversation, any money paid to settle that claim need not be reported.³¹ DHHS' NPDB Guidebook clarifies:

A refund of a fee is reportable only if it results from a **written** complaint or claim demanding monetary payment for damages. . . .³²

DHHS removes any lingering doubt in its question/answer examples:

"If a patient makes an oral demand for a refund for services, is the resulting payment reportable to the NPDB?"

"No. Only payments resulting from written demands are reportable to the NPDB. Even if the practitioner transmits the

practitioner), that payment is reportable to the NPDB." NPDB Guidebook at E-12.

²⁹ *Id.* at E-12. See also *Id.* at E-31:

"Question 15: "If there is no medical malpractice payment and Loss Adjustment Expenses (LAEs) are paid in order to release or dismiss a healthcare practitioner from a medical malpractice suit, should the LAE be reported?"

"Answer: "No. If LAEs are not included in the medical malpractice payment, then they should not be reported to the NPDB."

³⁰ 42 U.S.C. 11151(7).

³¹ NPDB Guidebook at E-12.

³² NPDB Guidebook at E-12 (emphasis in original).

demand in writing to the medical malpractice payer, the payment is not reportable if the patient's only demand was oral. However, if a subsequent written claim or demand is received from the patient and results in a payment, that payment is reportable."³³

Plaintiffs who wish to pursue a claim by oral notification must of course be mindful about statutes of limitation, lest they be caught in failed oral negotiations after the statute has run.

4. Contractual agreement or statutory mandate for pre-suit mediation

Some institutions, such as Drexel University College of Medicine, invite patients to sign a voluntary mediation agreement.³⁴ By statute, South Carolina requires mediation prior to filing a medical malpractice claim.³⁵ West Virginia does not

³³ NPDB Guidebook at E-31, Question 10.

³⁴ Florence Yee, *Mandatory Mediation: The Extra Dose Needed to Cure the Medical Malpractice Crisis*, 7 CARDOZO J. OF CONFLICT RESOL. 393, 442 n. 233 (2006); Christopher Guadagnino, Malpractice Mediation Poised to Expand, PHYSICIAN'S NEWS DIGEST, Apr. 2004, <http://www.physiciansnews.com/cover/404.html>.

To view the mediation agreement patients are invited to sign, see <http://www.drexelmed.edu/documents/mediation/mediationagreement.pdf>. To view the pamphlet accompanying that agreement, see http://www.drexelmed.edu/portals/1/NewMediationPatientBooklet-CHI_final_2_setp09_3_.pdf. (Drexel Mediation Home Page available at <http://www.drexelmed.edu/home/mediation.aspx>.)

³⁵ S.C. CODE ANN. § 15-79-125(C): "Within ninety days and no later than one hundred twenty days from the service of the Notice of Intent to File Suit, the parties shall participate in a mediation conference unless an extension for no more than sixty days is granted by the court based upon a finding of good cause.". Of note, this mediation mandate accompanies a requirement that potential plaintiffs file a notice of intent to file a suit and an expert affidavit, after which parties may subpoena relevant documents.

See also S.C. CODE ANN. § 15-79-120: "At any time before a medical malpractice action is brought to trial, the parties shall participate in mediation. . . . Parties may also agree to participate in binding arbitration, nonbinding arbitration, early neutral evaluation, or other forms of alternative dispute resolution." This latter version, unlike § 15-79-125, envisions a mediation taking place after, rather than before, the

mandate that parties mediate, pre-suit, but does provide defendants with the option of requiring the plaintiff to mediate, once they have received pre-suit notification of plaintiff's intent to sue. A physician electing to do so thereby places a demand for pre-suit mediation.³⁶

In these cases where a written demand asks, not for payment of money, but simply for a voluntary conversation whose usual purpose is to avoid litigation, the plain language of the statute or contract suggests that an NPDB report is not required. That is, a written demand to *discuss* does not constitute a written demand for *payment*. If a settlement ensues, plain language further would imply that the money was not paid in response to a written claim or demand for payment.

5. High-low agreements

In some cases, parties wishing to limit risk will make an agreement prior to trial, that whatever the jury outcome, money will be paid within agreed parameters. Where the defendant practitioner prevails, she will not be reported even though money is paid. Per the NPDB Guidebook:

A 'high-low' agreement, a contractual agreement between a plaintiff and a defendant's insurer, defines the parameters of a payment the plaintiff may receive after a trial or arbitration proceeding. If the finder of fact returns a defense verdict, the defendant's insurer agrees to pay the "low end" amount to the plaintiff. If the finder of fact returns a verdict for the plaintiff and against the defendant, the defendant's insurer agrees to pay the 'high end' amount to the plaintiff.

patient has actually filed suit. As discussed below in Part III, pre-trial settlement should not be confused with pre-suit settlement.

³⁶ "Upon receipt of the *notice* of claim or of the screening certificate of merit, if the claimant is proceeding pursuant to the provisions of subsection (d) of this section, the health care provider is entitled to pre-litigation mediation before a qualified mediator upon written demand to the claimant." W. VA. CODE, § 55-7B-6(f). Pre-suit resolution will be discussed further in Part III, *infra*.

A payment made at the low end of a high/low agreement that is in place prior to a verdict or an arbitration decision would not be reportable to the NPDB **only** if the fact-finder rules in favor of the defendant and assigns **no liability to the defendant practitioner**. . . . *Note: in order for the low-end payment to be exempted from the reporting requirements, the fact finder must have made a determination regarding liability at the trial or arbitration proceeding.*³⁷

6. Corporate shield

A well-recognized but somewhat more controversial avenue for resolving a medical malpractice claim without necessitating a Data Bank report has been dubbed the "corporate shield." The NPDB Guidebook makes clear that [1] where an entity such as a hospital or clinic makes a payment in a suit that does not identify an individual practitioner, no Data Bank report is required³⁸ and [2] where a practitioner is dismissed from a lawsuit prior to the settlement or judgment, no report need be made.³⁹

³⁷ NPDB Guidebook at E-13 (emphasis in original). Additional guidance available at E-13.

³⁸ "A payment made as a result of a suit or claim solely against an entity (for example, a hospital, clinic, or group practice) and that does not identify an individual practitioner is not reportable under the NPDB's current regulations." NPDB Guidebook at E-8.

In order for a particular physician, dentist, or other health care practitioner to be named in an MMPR submitted to the NPDB, the practitioner must be named in both the written complaint or claim demanding monetary payment for damages and the settlement release or final adjudication, if any. Practitioners named in the release, but not in the written demand or as defendants in the lawsuit, are not reportable to the NPDB. A practitioner named in the written complaint or claim who is subsequently dismissed from the lawsuit and not named in the settlement release is not reportable to the NPDB.

NPDB Guidebook at E-11.

³⁹ "A payment made to settle a medical malpractice claim or action is not reportable to the NPDB if the defendant health care practitioner is dismissed from the lawsuit **prior** to the settlement or judgment. However, if the dismissal results **from a condition in the settlement or release**, then the payment is reportable. In the first instance, there is no

In essence, "[t]he corporate shield refers to the situation where the medical corporation for which the doctor works is named in the suit, and the doctor is either not originally named or is released specifically for the purpose of avoiding a report to the NPDB. There is evidence that some insurers will 'cut a deal' with the plaintiff's attorney to dismiss the doctor from the suit and let the payment be made entirely on behalf of the corporation, hospital, or other entity."⁴⁰ By the mid-1990s somewhere around 50 percent of otherwise-required NPDB reports were thought to be diverted via the corporate shield.⁴¹

DHHS has long recognized this phenomenon and, over time, has considered whether to limit its use.⁴² A GAO study in 2000 expressly acknowledges DHHS's ambivalence, given that a significant change in these rules could "interfere with settlement negotiations between the insurer and the claimant."⁴³

payment for the benefit of the health care practitioner because the individual has been dismissed from the action **independently** of the settlement or release. In the latter instance, if the practitioner is dismissed from the lawsuit **in consideration** of the payment being made in settlement of the lawsuit, the payment can only be construed as a payment for the benefit of the health care practitioner and must be reported to the NPDB." (emphasis in original) NPDB Guidebook at E-12.

⁴⁰ Lawrence E. Smarr, *A Comparative Assessment of the PIAA Data Sharing Project and the National Practitioner Data Bank: Policy, Purpose, and Application*, 60 LAW & CONTEMP. PROBS., 59, 67 (1997).

⁴¹ *Id.*

⁴² John F. Bales, *Medical Malpractice Developments*, in PRACTICING LAW INSTITUTE, COMMERCIAL LAW AND PRACTICE COURSE HANDBOOK SERIES, PLI Order No. A4-4455, September-October, 1994, Health Care Reform Law Institute; 700 PLI/Comm 563, 625-26 (1994).

⁴³ Per the GAO report:

Soon after NPDB began operating in 1990, HRSA officials became aware that under the data bank's regulations, some practitioners, who may have committed malpractice, were not being reported because of what has become known as the "corporate shield." NPDB regulations require that only the practitioners named in final malpractice settlements be reported to the data bank. The corporate shield occurs when individuals filing malpractice claims remove the practitioner's name from the claim, leaving only the hospital or another corporate entity

identified as the responsible party. When this happens, no report is submitted to NPDB. HRSA officials believe that practitioners who have committed malpractice use the corporate shield to avoid being reported. However, they have not been able to quantify the extent to which the corporate shield is used for such purposes. In addition, the agency has not found a means of successfully addressing this issue in a way that would also have the support of industry representatives on NPDB's Executive Committee, who could facilitate compliance by persuading member organizations to adopt this policy change.

In December 1998, HRSA proposed changing NPDB's malpractice payment reporting regulations. The proposal would have required that insurers report all practitioners for whose benefit a payment is made, including those practitioners who might not have been named in the final settlement or even in the initial malpractice claim. The health care industry—including those organizations on NPDB's Executive Committee—overwhelmingly opposed the proposal, arguing that it would interfere with settlement negotiations between the insurer and the claimant. The industry also argued that reporting all initially named practitioners would deny due process to those not found liable by the court. HRSA subsequently withdrew the proposal and initiated other strategies to solve this problem while working to gain NPDB Executive Committee support for a change in medical malpractice reporting requirements."

U.S. GEN. ACCOUNTING OFFICE, REPORT TO THE CHAIRMAN, SUBCOMM. ON NAT'L ECON. GROWTH, NATURAL RES. AND REGULATORY AFFAIRS, COMM. ON GOV'T REFORM, HOUSE OF REPRESENTATIVES, NAT'L PRACTITIONER DATA BANK: MAJOR IMPROVEMENTS ARE NEEDED TO ENHANCE DATA BANK'S RELIABILITY GAO-01-130, at 11 (2000), *available at* <http://www.gao.gov/new.items/d01130.pdf>.

See also U.S. DEP'T OF HEALTH AND HUMAN SERVS., HEALTH RES. AND SERVS. ADMIN., BUREAU OF HEALTH PROFESSIONS, DIV. OF PRACTITIONER DATA BANKS, NAT'L PRACTITIONER DATA BANK: 2005 ANNUAL REPORT at 30, *available at* <http://www.npdb-hipdb.hrsa.gov/resources/reports/2005NPDBAnnualReport.pdf> (hereinafter "NPDB 2005 Annual Report"). *See also* U.S. DEP'T OF HEALTH AND HUMAN SERVS., HEALTH RESOURCES AND SERVS. ADMIN., BUREAU OF HEALTH PROFESSIONS, DIV. OF PRACTITIONER DATA BANKS, NAT'L PRACTITIONER DATA BANK: 2006 ANNUAL REPORT, at 34, *available at* <http://www.npdb-hipdb.hrsa.gov/resources/reports/2006NPDBAnnualReport.pdf> (hereinafter "NPDB 2006 Annual Report").

Notwithstanding such controversy regarding the Corporate Shield, it has proved to be an important asset in efforts to promote early dispute resolution and to focus on injured patients' and families' needs while emphasizing broad communication that can improve safety and quality of care.⁴⁴ The University of Michigan Health System (UMHS) avowedly uses the corporate shield, and its settlements are generally in the institution's name. UMHS is a staff-model institution in which physicians are employees rather than independent contractors, hence "reporting of individual caregivers in medical malpractice claims in the National Practitioner Data Bank is rare. However, full claims histories are maintained and reported for each involved caregiver, as required."⁴⁵ In other words, even though UMHS rarely reports medical malpractice payments, it still actively reports adverse actions on a provider's privileges or credentials to the NPDB.

The "moral hazard" issues that arise when providers systematically avoid the Data Bank are discussed elsewhere.⁴⁶ Suffice it here to say that rapid changes in the current health care market make possible a significantly greater use of the corporate shield, with the emergence of Accountable Care Organizations, bundled payment arrangements, hospital purchases of physician practices, and other structures that may make it more attractive and appropriate for hospitals and other entities to provide "enterprise liability."⁴⁷ To the extent that corporate shield remains

⁴⁴ UMHS tries to emphasize "honesty and transparency with patients and staff, regardless of whether events resulted from error, and encourages staff to enlist risk management in the disclosure process." Allen Kachalia et al., *Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program*, 153 ANNALS OF INTERNAL MED. 213, 214 (2010).

⁴⁵ *Id.* at 214.

⁴⁶ See Haavi Morreim, *Malpractice, Mediation, and Moral Hazard: the Virtues of Dodging the Data Bank*, forthcoming: Ohio State Journal on Dispute Resolution, v.27 #1, 2011.

⁴⁷ Mark C. Shields, Jankaj H. Patel, Martin Manning & Lee Sacks, *A Model for Integrating Independent Physicians into Accountable Care Organizations*, 30 HEALTH AFFAIRS 1 (2011); Thomas L. Greaney, Anna D. Sinaiko & Meredith B. Rosenthal, *Accountable Care Organizations—The Fork in the Road*, 263 NEW ENG. J. MED. e1 (2011); *Patients' Role in Accountable Care Organizations*, 363 NEW ENG. J.

permissible, and to the extent it becomes increasingly utilized by complex provider structures, physicians can find expanding opportunities to participate in early mediation of health care disputes without incurring a permanent black mark in the Data Bank.

7. Pre-suit notification period

Finally, a number of states now mandate that before a plaintiff is permitted to file a medical malpractice claim, he or she must provide advance notification to the defendant(s). Although these notices must generally be in writing and may require considerable specificity, arguably they do not constitute a "written claim or demand for payment," but rather, simply a written alert that in the future there will likely be such a claim. If so, then settlements made during this period should also be deemed non-reportable. These statutes are the focus of the Part III.

III. PRE-SUIT NOTIFICATION STATUTES AND NPDB REPORTS

A. Statute characteristics

In recent years a number of states have enacted legislation requiring plaintiffs to provide defendants with advance notice of their intent to file a medical malpractice claim. West Virginia

MED. 2583 (2011); Paul R. DeMuro, *Community Physicians Participating in Accountable Care Organizations through Clinical Integration*, 22 THE HEALTH LAWYER 13 (2010). See also, e.g., Jeroen N. Struijs & Caroline A Baan, *Integrating Care Through Bundled Payments—Lessons from the Netherlands*, 364 NEW ENG. J. MED. 990 (2011); William M. Sage, *Enterprise Liability and the Emerging Managed Health Care System*, 60 LAW & CONTEMP PROBS. 159 (1997); William M. Sage & JM Jorling, *A World That Won't Stand Still: Enterprise Liability by Private Contract*, 43 DEPAUL LAW REV. 1007 (1994); Avery Johnson, *The Model of the Future? The Health-Care Law Promoted Accountable-Care Organizations. But It's Hard to Know What They Are*, WALL ST. J., March 28, 2011, available at <http://online.wsj.com/article/SB10001424052748703300904576178213570447994.html>.

requires 30 days' notice,⁴⁸ for instance, while Tennessee, Texas, and Mississippi each require 60 days.⁴⁹ States requiring 90 days include Utah, Florida, California, and the District of Columbia.⁵⁰ Somewhat indirectly, Louisiana⁵¹ and South Carolina⁵² also require 90 days. Michigan provides the longest pre-suit notice period, at 182 days.⁵³ Three states have either repealed pre-suit notice⁵⁴ or have seen it judicially overturned.⁵⁵

These statutes share the same basic purposes: "to promote settlement without the need for formal litigation and reduce the cost of medical malpractice litigation while still providing compensation for meritorious medical malpractice claims that might otherwise be precluded from recovery because of litigation

⁴⁸ W. VA. CODE, § 55-7B-6(b); provider may be entitled to pre-litigation mediation upon written demand to claimant: 55-7B-6(f).

⁴⁹ TENN. CODE ANN. § 29-26-121(a)(1); TEX. CIV. PRAC. & REM. § 74.05(a); MISS. CODE ANN. § 15-1-36.

⁵⁰ UTAH CODE ANN. 1953 § 78B-3-412; FLA. STAT. ANN. § 766.106(2), (3)(a); CAL. CIV. PROC. CODE § 364(a); D.C. CODE § 16-2802.

⁵¹ LA. REV. STAT. ANN. 40:1299.47(A)(1)(a), (2)(a), (B)(1); (medical malpractice claims must begin with request for review panel, which then suspends for 90 days the time within which suit must be filed).

⁵² S.C. CODE ANN. § 15-79-125; (requiring notice of intent to be followed by mediation in 90-120 days; suit may not be filed until after mediator determines impasse exists or mediation should end, within 60 days thereafter).

⁵³ MICH. COMP. LAWS ANN. § 600.2912b.

⁵⁴ VA. CODE ANN. § 8.01-581.2 (*repealed by statute*); *see Harris v. DiMattina*, 462 S.E.2d 338 (Va. 1995).

⁵⁵ In Washington, RCW 7.70.100(1) (2006) was ruled unconstitutional as a violation of separation of powers, per *Waples v. Yi*, 234 P. 3d 187 (Wash. 2010); *but see Waples v. Yi*, 234 P.3d 192 (Wash. 2010) (Johnson, J., dissenting). In New Hampshire, N.H. REV. STAT. § 507-C:5 was ruled unconstitutional as violating equal protection, in *Carson v. Maurer*, 424 A.2d 825 (N.H. 1980).

Several courts expressly uphold the constitutionality of pre-suit notification statutes are *Neal v. Oakwood Hosp. Corp.*, 575 N.W.2d 68, 76 (Mich.App. 1997); *Thomas v. Warden*, 999 So. 2d 842, 847 (Miss. 2008); *Wimley v. Reid*, 991 So. 2d 135, 137-38 (Miss. 2008); *Pearlstein v. Malunney*, 500 So.2d 585, 586 (Fla.App. 1986), *rev. denied*, 511 So.2d 299 (Fla. 1987).

costs."⁵⁶ "The purpose of an intent to sue notice is to give the parties an opportunity to discuss, and hopefully to resolve, the potential claim before they become locked into a lawsuit."⁵⁷

At this point the question arises whether payments an insurer makes on a physician's behalf during this pre-suit period must be reported to the Data Bank. If such payments must be reported just as though the plaintiff has formally filed suit, these statutes' objectives will be largely eviscerated. If physicians still need to avoid a permanent NPDB "black mark" at this early point, then they will still have the same motivation to avoid settling and to hold out for victory at trial.

B. Insurer Concerns

As it happens, some medical malpractice insurers do report a settlement made during this pre-suit period. There are several reasons.

First, some of these statutes require a fair amount of information to be provided with the pre-suit notice of intent, so that the notice looks quite a bit like a filed claim. South Carolina, for instance, requires that the pre-suit notice "must name all adverse parties as defendants, must contain a short and plain statement of the facts showing that the party filing the **notice** is entitled to relief, must be signed by the plaintiff or by his attorney, and must include any standard interrogatories or similar disclosures required by the South Carolina Rules of Civil Procedure."⁵⁸ The notice must ordinarily be in writing and must be delivered in specified

⁵⁶ Neal v. Oakwood Hosp. Corp., 575 N.W.2d 68, 71, 75 (Mich.App. 1997); more recently, see also DeCosta v. Gossage, 782 NW 2d 734 (Mich. 2010).

⁵⁷ Behrens v. Raleigh Hills Hosp., Inc., 675 P.2d 1179, 1183 (Utah 1983). See also Jenkins v. Marvel, 683 F. Supp. 2d 626, 639 (E.D. Tenn. 2010); Hinchman v. Gillette, 618 S.E.2d 387 (W.Va. 2005); Solimando v. International Medical Centers, 544 So.2d 1031, 1034 (Fla.App. 1989); Weinstock v. Groth, 629 So.2d 835 (Fla.1993); Hill v. Russell, 247 S.W.3d 356, 360 (Tex.App.2008); Schepps v. Presbyterian Hosp. of Dallas, 652 S.W.2d 934, 938 (Tex. 1983).

⁵⁸ S.C. CODE ANN. § 15-79-125(A).

ways.⁵⁹ Michigan, similarly, requires that the notice state numerous details:⁶⁰

The trigger mandating a report to the Data Bank is, after all, a "written claim or demand for payment ..."⁶¹ If these notices must be written, and if in all this detail they can be interpreted as a demand for payment, then insurers may infer it is best to be on the "safe" side, and report any pre-suit settlement payment.

Second, and again analogous to litigation, some states require that informal discovery take place following such pre-suit notice. Florida, for instance, requires that "[u]pon receipt by a prospective defendant of a notice of claim, the parties shall make discoverable information available without formal discovery. Failure to do so is grounds for dismissal of claims or defenses

⁵⁹ West Virginia requires certified mail, return receipt requested. W. VA. CODE § 55-7B-6(b). Tennessee requires written notice to each prospective defendant and requires that it be mailed both to the provider's current business address and to the address listed with the state's department of health. TENN. CODE ANN. § 29-26-121(a)(1); TENN. CODE ANN. § 29-26-121(a)(3)(B). *See also, e.g.*, MICH. COMP. LAWS. ANN. § 600.2912b(2); UTAH CODE ANN. § 78B-3-412(3); FLA. STAT. ANN. § 766.106(2)(a); TEX. CIV. PRAC. & REM. § 74.051(a).

⁶⁰ MICH. COMP. LAWS. ANN. § 600.2912b(4). The requirements include:

- “(a) The factual basis for the claim.
- (b) The applicable standard of practice or care alleged by the claimant.
- (c) The manner in which it is claimed that the applicable standard of practice or care was breached by the health professional or health facility.
- (d) The alleged action that should have been taken to achieve compliance with the alleged standard of practice or care.
- (e) The manner in which it is alleged the breach of the standard of practice or care was the proximate cause of the injury claimed in the **notice**.
- (f) The names of all health professionals and health facilities the claimant is notifying under this section in relation to the claim.”

⁶¹ 42 U.S.C. 11151(7).

ultimately asserted."⁶² Potential litigants may then obtain unsworn statements, medical records, documents and things, mental and physical examinations, and the like.⁶³

Third, insurers point out that once the presuit notice is issued and the parties express interest in mediation, parties may well exchange written proposals to establish a "ballpark" prior to the actual mediation. Perhaps these should be construed as written demands, an insurer might suppose.

Fourth, actual notice letters from plaintiff attorneys sometimes—perhaps commonly—move quickly from the language of "potential claim" to the language of "claim." See Figures 1, 2, and 3. If the attorney herself calls it a claim, then insurers may infer that perhaps it really is a claim and must be treated as such, for NPDB reporting purposes.

Dear [REDACTED]

I am the attorney representing [REDACTED] and [REDACTED] next of kin. Through me and my firm, [REDACTED] is asserting a potential claim for medical malpractice against your professional corporation. This claim arises out of care provided by employees, shareholders, members, and/or agents, of [REDACTED], and by other individuals acting on behalf of [REDACTED]

Figure 1: "potential claim" becomes "claim"

⁶² LA. STAT. ANN. § 766.106(6)(a).

⁶³ *Id.* at (6)(b).

Dear [REDACTED]

I am the attorney representing [REDACTED] the legal representative of [REDACTED] [REDACTED]. Through me and my firm, [REDACTED] is asserting a potential claim for medical malpractice against you. This claim arises out of care provided by you to your patient [REDACTED], at [REDACTED] on or about [REDACTED].

Figure 2: "potential claim" becomes "claim"

Dear [REDACTED]

I am the attorney representing the surviving family members of [REDACTED] [REDACTED]. Through me and my firm, the family members are asserting a potential claim for medical malpractice against you. This claim arises out of care provided by you to your patient, [REDACTED] at the home municipal known as [REDACTED] on or about [REDACTED].

Figure 3: "potential claim" becomes "claim"

The answer to this last concern seems obvious: plaintiff attorneys should consistently speak only of "potential claims" and never use "claim" without an appropriate qualifier such as "potential" or "possible." Even with this fix, however, we must still consider insurers' other three concerns, namely, that these notices are in writing, that they may feature elements that strongly resemble a classic medical malpractice claim, and that written monetary proposals may be exchanged before and during mediation.

C. Data Bank Report: Arguably Not Required During Pre-Suit Notification Period

Several arguments suggest that, notwithstanding the superficial resemblance between a filed malpractice suit (clearly a "written claim or demand for payment") and a pre-suit notice, a monetary payout made during the pre-suit notice period does not require a Data Bank report.

First we must look to the plain language of the federal statute and to the plain language of the various state statutes. Plain language figured prominently in the only appellate case reasonably on point. In *American Dental Ass'n v. Shalala*,⁶⁴ the D.C. Circuit Court invoked an extensive plain-language analysis to find that an "entity" does not encompass a "person" and conclude that a practitioner need not report out-of-pocket payments to the Data Bank. Per the court, the HCQIA

reveals unmistakably that Congress did not intend to encompass any individual doctor or dentist as an 'entity' that must report to the National Practitioner Data Bank. The Act does not define 'entity,' but the term as used in the Act refers uniformly to groups and organizations. ... [A]ll of the textual evidence points in one direction: Congress did not intend the term 'entity' to encompass individual practitioners.⁶⁵

Five years later the District of D.C. court likewise undertook careful analysis of the statute's plain language regarding what counts as and "investigation" by an "institution," to conclude that a Data Bank report should not have been made in a case where senior members of a surgery department began monitoring a surgeon's performance.⁶⁶

⁶⁴ 3 F.3d 445 (D.C.Cir. 1993).

⁶⁵ *Id.* at 446-47.

⁶⁶ *Simpkins v. Shalala*, 999 F.Supp. 106 (D.D.C.1998). Somewhat in contrast, a Kentucky court found that, under a significantly different fact pattern, a bona fide investigation had been commenced by an institution, thereby requiring a Data Bank report. *See Omar v. Jewish Hospital Healthcare Serv's*, 153 S.W.3d 845 (Ky.App. 2005).

Here, HCQIA's language requires that an entity such as an insurer file a report when it "makes payment . . . in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim."⁶⁷ A "medical malpractice action or claim," in turn, is a "written claim or demand for payment based on a health care provider's furnishing (or failure to furnish) health care services . . ."⁶⁸ Thus, we must parse carefully the words "written claim or demand for payment." As noted above, DHHS already recognizes that the statute must be read precisely as it is written, even as it concedes, e.g., that an *oral* claim or demand for payment will not trigger a Data Bank report,⁶⁹ because it is not "written." Accordingly, our question is whether a pre-suit notice constitutes a "written claim or demand for payment."

A brief review of the relevant state statutes suggests that these notices do not. Although written, these notices are not a "claim or demand *for payment*." Rather, they are a notification about a potential, future claim. Michigan, for instance, mandates that "a person shall not commence an action alleging medical malpractice against a health professional . . . unless the person has given . . . written notice under this section not less than 182 days *before the action is commenced*."⁷⁰ In other words, a written claim or demand for payment can not be made unless the prior notice has first been satisfied. Tennessee emphasizes that this notice describes a "potential claim"⁷¹ and expressly states that the notice must be provided "before the filing of a complaint."⁷² Plain language says that a "potential" claim is merely a possibility of a future claim—not an actual present demand, and that a notice that must be sent *before* a complaint can be filed can not, itself, be that

⁶⁷ 42 U.S.C. 11131(a).

⁶⁸ 42 U.S.C. 11151(7).

⁶⁹ "Payment is made based only on oral demands. No report is required" NPDB Guidebook at E-16.

⁷⁰ MICH. COMP. LAWS. ANN. § 600.2912b(1) (emphasis added).

⁷¹ TENN. CODE ANN. § 29-26-121(a)(1): "Any person, or that person's authorized agent, asserting a **potential claim** for medical malpractice shall give written notice of the potential claim to each health care provider that will be a named defendant at least sixty (60) days **before the filing of a complaint** based upon medical malpractice in any court of this state" (emphasis added).

⁷² *Id.*

complaint or demand. Texas' statute provides similar wording.⁷³ Mississippi and California both use the comparable language of "prior written notice" or "prior notice of the intention."⁷⁴ A notice that exists *prior to* a claim does not, itself, be that claim.

Indeed, a number of states have expressly dubbed their required pre-suit notification a "condition precedent" to filing a claim. Again, plain language suggests that a condition precedent to a filed claim can not, itself, be such a filed claim. Thus, the Mississippi Supreme Court held in *Wimley v. Reid*⁷⁵ that "pre-suit requirements are clearly within the purview of the Legislature, and do not encroach upon this Court's rule-making responsibility. Indeed, we consistently have held that the Legislature has authority to establish presuit requirements as a condition precedent to filing particular kinds of lawsuits."⁷⁶ Similarly, the Florida Supreme Court has held that "[t]imely written notice of intent to initiate litigation is a condition precedent to maintaining a medical malpractice action."⁷⁷

⁷³ TEX. CIV. PRAC. & REM. § 74.05(a): "Any person or his authorized agent asserting a health care liability claim shall give written notice of such claim . . . to each physician or health care provider against whom such claim is being made at least 60 days **before the filing of a suit** in any court of this state based upon a health care liability claim" (emphasis added).

⁷⁴ MISS. CODE ANN. § 15-1-36(15) "No action based upon the health care provider's professional negligence may be begun unless the defendant has been given at least sixty (60) days' **prior written notice of the intention to begin the action**" (emphasis added).

CAL. CIV. PROC. CODE § 364 (a) "No action based upon the health care provider's professional negligence may be commenced unless the defendant has been given at least 90 days' **prior** notice of the **intention** to commence the action" (emphasis added).

⁷⁵ 991 So. 2d 135 (Miss. 2008). *See also* Thomas v. Warden, 999 So. 2d 842, 847 (Miss. 2008)

⁷⁶ *Id.* at 139.

⁷⁷ Patry v. Capps, 633 So.2d 9, 11 (Fla. 1994). *See also* Neal v. Oakwood Hosp. Corp., 575 N.W.2d 68, 74 (Mich.App. 1997); Foil v. Ballinger, 601 P.2d 144, 146 (Utah, 1979); Ingersoll v. Hoffman, 589 So.2d 223, 224-25 (Fla. 1991); Hospital Corp. of America v. Lindberg, 571 So.2d 446, 448 (Fla. 1990).

Additionally, some states have expressly stated that a pre-suit notice is not equivalent to a malpractice complaint. Per the Utah Supreme Court:

A notice of intent to sue, as required by U.C.A., 1953, § 78-14-8, is not intended to be the equivalent of a complaint and need not contain every allegation and claim set forth in the complaint. The purpose of an intent to sue notice is to give the parties an opportunity to discuss, and hopefully to resolve, the potential claim before they become locked into a lawsuit. Although the notice must include “specific allegations of misconduct on the part of the prospective defendant,” that requirement does not need to meet the standards required to state a claim for relief in a complaint. The parties need to give only general notice of an intent to sue and of the injuries then known and not a statement of legal theories.⁷⁸

Likewise, Florida has expressly stated that the informal discovery of pre-suit negotiations must be assured confidentiality, so as to distinguish these exchanges of information from the formal discovery of a medical malpractice action.⁷⁹ As Louisiana requires all malpractice claims initially to be presented to a medical review panel for prelitigation screening, Louisiana statute stipulates that this request can not be reported to the state licensing board or any other supervisory body—whereas actual malpractice claims do require such reporting.⁸⁰

⁷⁸ Behrens v. Raleigh Hills Hosp., Inc., 675 P.2d 1179, 1183 (Utah 1983) (§ 78-14-8 now renumbered as § 78B-3-412 by Laws 2008, c. 3, § 718, eff. Feb. 7, 2008).

⁷⁹ "In order to distinguish non-meritorious negligence claims at the earliest point, a free and open exchange of information during the presuit screening process is necessary and this is more likely to occur if parties are assured confidentiality of information. For all of these reasons, the legislature distinguished between informal and formal discovery in a medical malpractice action, *see* § 766.106(6), Fla. Stat. (2007), and made it clear that information obtained during presuit screening is confidential and not subject to formal discovery." *Variety Children's Hosp. v. Boice*, 27 So. 3d 788, 790 (Fla. Dist. Ct. App. 2010).

⁸⁰ "The filing of a request for review by a medical review panel as provided for in this Section shall not be reportable by any health care

These specifications regarding confidentiality also extend to mediations. Although mediations commonly involve written pre-mediation statements that may, indeed, feature proposed settlement terms, and although intra-mediation negotiations will likewise bandy numbers about, these statements should not be deemed a written claim or demand for payment under the statute. First, mediation by nature does not feature a "demand" in the relevant sense. Parties of course make proposals but, because any resolution is completely voluntary, they do not constitute the kind of "claim" or "demand" contemplated by HCQIA.

Second, strong confidentiality provisions generally protect mediation. Tennessee, for instance, mandates a thorough-going confidentiality in its Supreme Court Rule 31: "Rule 31 Neutrals shall preserve and maintain the confidentiality of all information obtained during Rule 31 ADR Proceedings and shall not divulge information obtained by them during the course of Rule 31 ADR Proceedings without the consent of the parties, except as otherwise may be required by law."⁸¹ Mediation confidentiality is also

provider, the Louisiana Patient's Compensation Fund, or any other entity to the Louisiana State Board of Medical Examiners, to any licensing authority, committee, or board of any other state, or to any credentialing or similar agency, committee, or board of any clinic, hospital, health insurer, or managed care company." LA. REV. STAT. ANN. 40:1299.47(A)(1)(a).

⁸¹ TENN. SUP. CT. R. 31 Section 10(d). *See also* TENN. SUP. CT. R. 31 Appendix A, Section 7: **Confidentiality**

"(a) Required

A Neutral shall preserve and maintain the confidentiality of all dispute resolution proceedings except where required by law to disclose information.

(b) When Disclosure Permitted

A Neutral conducting a Rule 31 Mediation shall keep confidential from the other parties any information obtained in individual caucuses unless the party to the caucus permits disclosure.

(c) Records

A Neutral shall maintain confidentiality in storing or disposing of records and shall render anonymous all identifying information when materials are used for research, training, or statistical compilations."

See also Ala.Code of Ethics for **Mediators** Std. 6: " (a)

Confidentiality. A **mediator** shall preserve and maintain the **confidentiality** of all **mediation** proceedings except where required by

protected in federal rules of court.⁸²

Although such protections often feature the caveat permitting disclosure if "otherwise . . . required by law," at no point does HCQIA require such a disclosure. HCQIA's definition of a "medical malpractice action or claim" "includes the filing of a cause of action, based on the law of tort, brought in any court of any State or the United States seeking monetary damages."⁸³ Similarly, the Code of Federal Regulations states such a malpractice claim "includes the filing of a cause of action based on the law of tort, brought in any State or Federal Court or other adjudicative body."⁸⁴ The emphasis on formal filings with

law to disclose information gathered during the **mediation**."

See also O.R.S. § 36.262: " (1) All memoranda, work products and other materials contained in the case files of a **mediator** or **mediation** service are **confidential**. Any communication made in, or in connection with, the **mediation** which relates to the controversy being **mediated**, whether made to the **mediator** or a party, or to any other person if made at a **mediation** session, is **confidential**. However, a **mediated** agreement shall not be **confidential** unless the parties otherwise agree in writing. (2) **Confidential** materials and communications are not subject to disclosure in any judicial or administrative proceeding except: (a) When all parties to the **mediation** agree, in writing, to waive the **confidentiality**; (b) In a subsequent action between the **mediator** and a party to the **mediation** for damages arising out of the **mediation**; or (c) Statements, memoranda, materials and other tangible evidence, otherwise subject to discovery, that were not prepared specifically for use in and actually used in the **mediation**."

⁸² *See, e.g.,* U.S. Dist. Ct. Rules N.D. Cal., ADR L.R. 6-12: " (a) **Confidential Treatment**. Except as provided in subdivision (b) of this local rule, this court, the **mediator**, all counsel and parties, and any other persons attending the **mediation** shall treat as "confidential information" the contents of the written **Mediation** Statements, anything that happened or was said, any position taken, and any view of the merits of the case expressed by any participant in connection with any **mediation**. "Confidential information" shall not be: (1) disclosed to anyone not involved in the litigation; (2) disclosed to the assigned judge; or (3) used for any purpose, including impeachment, in any pending or future proceeding in this court."

See also Federal Rules of Evidence Rule 408: offers of compromise are not admissible.

⁸³ 42 U.S.C. 11151(7).

⁸⁴ 45 CFR 60.3.

adjudicative bodies lends further credence to the conclusion that private mediation negotiations will not be deemed written claims or demands for Data Bank reporting purposes.

In sum, there appears to be no good argument that a pre-suit notice of intent to file a claim should, itself, be treated as a written claim or demand for purposes of Data Bank reporting.

Plain language suggests that such notices should not be construed as a "written claim or demand for payment." They are not a demand for payment at all. They are simply a written note indicating that a demand for payment may—or may not—be forthcoming. Moreover, the notice itself does not demand payment of any kind. It simply outlines some features of the demand that might or might not eventually be made, thereby permitting parties a relatively detailed picture of the issues they may wish to resolve early. Even pre-mediation statements that include a numerical proposal for settlement should not be deemed a written claim or demand, partly because these constitute a proposal rather than a "demand" and partly because the confidentiality protecting these statements places them outside the reach of the HCQIA.

Finally, the very purpose of these statutes is substantially defeated if the early resolution they seek to achieve is thwarted by a mistaken belief that pre-suit monetary exchanges must be reported to the Data Bank. The physicians whose participation is often essential to broad-based resolution of an adverse event would largely be chilled. Even more importantly, the nonmonetary goals and quality improvement that can be addressed through early, nonlitigious communication will likewise be thwarted.

D. Caveats: Dismissal, Abatement, and Voluntary Nonsuit

If the foregoing arguments are correct, and medical malpractice insurers should not report settlement payments made during the period of pre-suit notification, several special situations require attention. When a plaintiff files suit without providing the required pre-suit notice, the court has a choice. It can dismiss the suit with prejudice, it can dismiss the suit without prejudice, or it

can abate the claim and require that parties simply wait out the pre-suit period before proceeding with litigation. The plaintiff has an additional choice: take a voluntary non-suit, which may or may not be followed by a proper pre-suit notice and subsequent filed claim. Plaintiffs also can voluntarily non-suit even a properly noticed suit.

Courts' approaches to these choices vary considerably. Texas, for instance, grants abatement on the ground that outright dismissal is too harsh a consequence:

allowing tolling when a plaintiff sends notice without the authorization form gives the health care provider fair warning of an imminent claim and then allows the provider to obtain an abatement for negotiations and evaluation of the claim. We will not read an overly strict and unfounded requirement into section 74.051 when the plain language of the statute provides us with an unambiguous and reasonable meaning.⁸⁵

Where a opting for abatement thus permits a prematurely filed malpractice claim to continue to exist, simply postponing its effectiveness, then plain language suggests that there *is* a "written claim or demand for payment" on the table, and that any settlement reached during the time of abatement must be reported to the Data Bank. That is, because the plaintiff has filed a bona fide malpractice suit and the court is merely delaying litigation activity for the required 60 days, any settlement would arguably count as payment in response to that demand.

In contrast, many other states dismiss an inappropriately filed claim.⁸⁶ The Florida Court of Appeal expressly rejected abatement, holding that "we cannot simply abate what is, for all

⁸⁵ Hill v. Russell, 247 S.W.3d 356, 360 (Tex.App. 2008). *See also* Schepps v. Presbyterian Hosp. of Dallas, 652 S.W.2d 934, 938 (Tex. 1983).

⁸⁶ Tennessee statutorily dismisses with prejudice any medical malpractice suit that lacks a related prerequisite, namely a certificate of good faith. TENN. CODE ANN. 29-26-122(c).

intents and purposes, a nonexistent lawsuit."⁸⁷ Similarly, the Mississippi Supreme Court found that a suit filed without proper pre-suit notification is "not lawfully filed, and it is of no legal effect."⁸⁸ These courts thus make clear that no filed claim exists. Other courts provide similar analyses.⁸⁹

In these cases plain language would suggest that, where a court has declared that no claim exists, then if parties settle before any genuine malpractice claim is made, the monetary payment will not be reportable. After all, although an "entity" is paying, it is not paying to settle a "medical malpractice action or claim,"⁹⁰ i.e., a "written claim or demand for payment."⁹¹ There is no claim before the court, once it is dismissed and declared to have been a nonentity all along.

Arguably a similar response applies to plaintiff's voluntary nonsuit, or a dismissal with leave to amend and re-file. The Supreme Court of Florida, for instance, permits re-filing:

⁸⁷ Pearlstein v. Malunney, 500 So.2d 585, 587 (Fla.App. 1986), rev. denied, 511 So.2d 299 (Fla. 1987) [Pearlstein I]

⁸⁸ Thomas v. Warden, 999 So. 2d 842, 846 (Miss. 2008).

⁸⁹ Pitalo v. GPCH-GP, Inc., 933 So.2d 927, 929 (Miss.2006): Plaintiff's failure to send notice at any time "is an inexcusable deviation from the Legislature's requirements for process and notice under Miss. CodeAnn. 15-1-36(15), and such failure warrants dismissal of her claim."

South Miami Hospital v. Perez, 38 So. 3d 809 (Fla. 3d DCA 2010): "Because the respondent's claim is essentially a medical negligence action, she was required to comply with the presuit notice and other requirements of chapter 766, Florida Statutes. Having failed to do so, the amended complaint should have been dismissed."

Neal v. Oakwood Hosp. Corp., 575 N.W.2d 68, 75 (Mich.App. 1997): "This Court must follow the rule of law established by a prior published decision of this Court. MCR 7.215(H). Thus, in light of *Morrison*, we conclude that we are required to hold that dismissal without prejudice was the appropriate remedy for plaintiff's noncompliance with § 2912b(1) in this case."

See also Bush v. Shabahang, 772 NW 2d 272 (Mich. 2009) (dismissing case, but without prejudice); Hospital Corp. of America v. Lindberg, 571 So.2d 446, 449 (Fla. 1990) (dismissal with leave to amend).

⁹⁰ 42 U.S.C. 11131(a).

⁹¹ 42 U.S.C. 11151(7).

We therefore hold that, in medical malpractice actions, if a presuit notice is served at the same time as a complaint is filed, the complaint is subject to dismissal with leave to amend. The plaintiff may subsequently file an amended complaint asserting compliance with the presuit notice and screening requirements of section 768.57 and the presuit investigation and certification requirements of section 768.495(1). We note, however, that counsel for the defendants will be entitled to fees and costs resulting from the premature filing of the lawsuit, and such fees could be assessed against the plaintiff. Further, willful noncompliance with the presuit screening process can still result in dismissal of claims or defenses, as provided in section 768.57(3)(a).⁹²

Here, as just above, so long as the suit does not currently exist, then even if it may re-appear at some point in the future, any payment made during the interim period is not a payment made to settle a written claim or demand. During that period there simply is no written claim or demand.

IV. CONCLUSION

Litigators and mediators who practice actively in the realm of medical malpractice experience a major, ongoing hurdle. Even if all parties to a complex suit are amenable to resolution, physicians are often reluctant to participate. Unlike hospitals, nursing homes, nurses, or any other parties, the physicians stands to pay dearly with a permanent Data Bank report, even where such a physician would otherwise like very much to resolve the matter

⁹² Hospital Corp. of America v. Lindberg, 571 So.2d 446, 449 (Fla. 1990). See also Davis v. Mound View Health Care, Inc., 640 S.E.2d 91, 95-96 (W. Va. 2006): "The Rules do not specifically provide such a presumption where an action is involuntarily dismissed upon a defendant's motion for a plaintiff's failure to comply with statutory pre-filing notice requirements. The specification as to whether a dismissal is with or without prejudice is significant. Where a dismissal is without prejudice, our savings statute, W. Va.Code § 55-2-18 may be utilized to permit the re-filing of a medical malpractice action involuntarily dismissed for failure to comply with the mandates of W. Va.Code § 55-7B-6 because such dismissal would not be a dismissal on the merits."

early. However, mediators should be aware that a number of opportunities are available to achieve an early resolution that embraces physicians, without requiring a Data Bank report. These should be explored carefully and used wherever appropriate.