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REFERENCES

1. BRANDON AN, HILL DR. Selected list of books and journals for the small medical library. *Bull Med Libr Assoc* 1987 Apr;75:133-65.
2. BRANDON AN, HILL DR. Selected list of books and journals for the small medical library. *Bull Med Libr Assoc* 1995 Apr;83:151-75.
3. U.S. BUREAU OF LABOR STATISTICS. Consumer price index—Urban: March 1995. USDL press release USDL-95-123. Washington, DC: U.S. Dept. of Labor, 1995 Apr 12.
4. *IBID.*
5. U.S. BUREAU OF THE CENSUS. Statistical abstract of the United States 1992. 112th ed. Washington, D.C.: U.S. GPO, 1992.
6. FORTNEY LM, BASILE VA. Index Medicus price study. Vantage Point: EBSCO Subscription Services, 1994.
7. KRONENFELD MR, GABLE SH. Update on inflation of journal prices: medical journals, U.S. journals, and Brandon-Hill list journals. *Bull Med Libr Assoc* 1989 Jan;77(1):61-4.
8. PAUL H. Serials: higher prices vs. shrinking budgets. *Ser Libr* 1984 Win;9:3-12.
9. WHITE HS. Getting into this mess wasn't easy! it took a lot of effort on our part. *Tech Serv Q* 1990;8(2):1.

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The Health Care Quality Improvement Act of 1986 and the National Practitioner Data Bank: the controversy over practitioner privacy versus public access

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INTRODUCTION

During the 1970s and 1980s the substantial rise in the number of medical malpractice lawsuits created a situation often characterized as a "malpractice crisis" [1]. In fact, more medical malpractice suits were filed in the decade ending in 1987 than in "the entire previous history of American tort law" [2]. Claim frequency per 100 physicians rose at least 10% each year during this period, from 13.5 claims in 1982 to 17.2 in 1986 [3]. The Department of Health, Education and Welfare, in an early attempt to study this problem, established the Commission on Medical Malpractice in 1973 [4].

In an effort to address this malpractice "epidemic," Congressman Ron Wyden from Oregon introduced legislation that became The Health Care Quality Improvement Act of 1986 (HCQIA) [5]. The act was designed to address two long-standing, fundamental problems endemic to the community of physicians: a reluctance on the part of practitioners to engage in honest peer review of the errant few among their ranks, and the ability of incompetent practitioners to move from state to state without any record of previous negligence.

The act, signed into law by President Reagan on November 14, 1986, with "unusual dispatch" [6], granted limited immunity from damages to physicians and dentists engaging in peer review, and prohibited incompetent physicians and dentists from moving across state boundaries without disclosing information about previous negligent performance [7].

To accomplish the second provision, the act authorized the secretary of health and human services to establish the National Practitioner Data Bank, which would serve as a repository of information regarding the professional competence and conduct of doctors of medicine, doctors of osteopathy, and dentists [8].

A review of congressional hearings on the act suggests that the immunity provisions were the primary

impetus behind its passage. In fact, witnesses at the 1986 hearings supported the immunity provisions, but were divided concerning what a federal data bank should contain [9]. Ultimately, however, it was decided that a data bank was an essential part of the overall plan, because a major reason why physicians could move easily to other locations after committing malpractice was fear among hospital peer review members that the expelled physician would sue them and the hospital if a quiet, discrete departure were not negotiated as part of a "plea bargain" [10].

The data bank would serve to eliminate such plea bargaining and increase the severity of the consequences of expulsion. Congress believed that heightened immunity was needed, due to the real possibility that expelled physicians whose movements were restricted might be more inclined than ever to file antitrust actions against hospitals and peer review committees [11]. Thus, Congress envisioned the data bank as a tool for assuring that the information used by peer review boards would be accurate, complete, and uniformly available [12].

The data bank, however, has been a controversial, albeit essential, component of the act. Since the inception of the data bank on September 1, 1990, the American Medical Association (AMA) has voiced many concerns about the rules regarding the type of information to be reported to the bank as well as the confidentiality and integrity of that information. Although information in the data bank is exempt from disclosure to the general public under the Freedom of Information Act (FOIA), a campaign led by Ralph Nader's Public Citizen Health Research Group ("Public Citizen") has been lobbying aggressively to open it to the public. As might be expected, the AMA is fiercely opposed to public access to the data bank. Thus, the implementation of the data bank has led to a policy debate pitting the privacy rights of practitioners against consumers' "right to know."

Although construed as a public policy debate, this issue is particularly relevant to library and information professionals because it concerns the meaning of information, the beneficiaries of information, and the power struggle over who controls information. Public policy issues will increasingly be defined by legal precedents that will determine how information is to be governed.

THE NATIONAL PRACTITIONER DATA BANK

The AMA aggressively lobbied the White House to sign the HCQIA into law, despite the association's opposition to a federal data bank [13]. The AMA supported increased confidential peer review reporting to state medical boards, but argued that a national tracking system should be effected through one of two data banks already in existence. The AMA as-

serted that its Practitioner Masterfile or the Federation of State Medical Boards (FSMB) data bank would be better able to provide confidential treatment of such personal information than would the federal data bank [14].

Information on errant physician behavior contained in these data banks was never made available to quality-assurance or credentialing bodies on a regular basis [15]. For example, the FSMB's Board Action Data Bank maintains records on medical licensure and disciplinary actions taken by hospitals and professional societies. This information, however, is not tracked by any independent agency or group and thus is not readily accessible. Confounding the problem is the fact that, although many states have laws that mandate the reporting of malpractice claims to a state agency, such information may be used only within the state collecting it [16].

Defending these "private" data banks, physicians argued that professional credentialing and quality-assurance programs provided sufficient safeguards against patient injuries. Consumer advocacy groups and patient advocates disputed this assertion, claiming that peer-review boards and state licensing regulatory boards did not effectively monitor physician performance. Bolstering their argument, consumer groups and skeptics reviewed FSMB data that revealed that a general lack of vigilance by state boards resulted in too few licenses being revoked and great variation in actions taken across state lines [17].

The consumers' argument was supported by an investigation of the credential verification capabilities of state boards by the Office of the Inspector General of the U.S. Department of Health and Human Services, which found that board effectiveness in this area "might be seriously limited" [18]. The Office of the Inspector General further noted that numbers of license revocations, license suspensions, and probationations had remained relatively constant during a time when the number of U.S. physician was increasing by 15,000 to 20,000 per year [19].

Consumer groups and skeptics maintained that this lack of action was evidence of the failure of the peer review process. Medical professionals and hospital authorities rebutted the allegation, claiming that physicians feared reporting their errant peers because of the threat of legal liability.

The latter argument seemed to be substantiated by a successful antitrust suit brought by Dr. Timothy Patrick against an Oregon hospital and members of its peer review board, who had terminated his privileges [20]. Dr. Patrick alleged that his peers wanted him terminated because he was competing with them [21]. Although the award was later reversed by the U.S. Court of Appeals for the Ninth Circuit, the original ruling was believed to have had a "chilling effect" upon practitioners' willingness to assess their

negligent peers honestly [22]. Consumer advocacy groups directed public attention toward the spate of other high-profile cases in which negligent practitioners successfully moved from locale to locale to avoid professional sanctions taken against them [23, 24]. As noted earlier, when Congressman Wyden proposed the legislation that became the HCQIA, his primary intention was to protect and encourage physicians who might speak out against negligent colleagues, as evidenced by review of the hearings and their timing in relation to the Patrick case. In fact, the original version of the act (H.R. 5110) required immunity first and data collection as a secondary provision [25].

PRACTITIONER PRIVACY VERSUS THE PUBLIC'S RIGHT TO KNOW

The public policy debate pitting practitioner privacy against public access to the data bank is based on two perspectives—the practitioner's view, which advocates privacy rights, and the consumer rights view, which advocates the public's "right to know." In general, practitioners believe that the information in the data bank is of a personal, confidential nature and should not be subject to public scrutiny. Practitioners also feel that the information must be interpreted by professional medical entities, that it is "over the heads" of average lay people and therefore bound to be misunderstood by them.

Beyond practitioners' philosophical concern about the meaning of privacy, they harbor more pragmatic worries about the meaning of negligence and the integrity of the data bank. Many practitioners believe that a substantial number of the malpractice lawsuits filed are frivolous and as such do not reflect real negligence. Instead, they argue, the spate of claims during the past two decades may be attributed, at least in part, to the Medical Malpractice Trial Bar and its contingency fee arrangement, which encourages meritless claims by litigious patients. Many physicians attribute the insurance crisis in large part to overzealous and unethical attorneys who institute groundless suits in the hope of garnering large contingency fees [26]. Practitioners maintain that allowing public access to the data bank would be truly misleading and irresponsible.

Practitioners also fear that a rising number of false reports will be included in the data bank, particularly in light of the 1990 Omnibus Budget Reconciliation Act (OBRA) Amendment, which requires states to report "any negative action or finding" by "any peer review or private accreditation entity" [27]. This amendment expands the original concept of the data bank as a clearinghouse or system of red flags "to an all inclusive library with operational requirements that would be exceptionally hard to manage" [28]. It

is not clear what the nebulous phrase "negative action" means, but if construed broadly, the term could "include a confidential letter from a state medical board to a physician noting an improper prescription on one occasion" [29].

Finally, the stance of practitioners against an openly accessible data bank is based on the belief that much of the information it contains is not relevant to professional competence [30]. For example, they fear that items such as tardy licensing fee payments may be included.

The public advocacy groups frame their argument in favor of open access to the data bank in the context of public health risks. Generally, they claim that errant physicians are not uncommon, and that the public therefore has a right to know about them. Public Citizen is perhaps the undisputed leader in this arena. There are, however, many more health care and patient advocacy groups. The New York-based National Center for Patients' Rights, Ethical Treatment in Health Care, and Massachusetts Public Interest Research Group are just a few of those making headlines [31, 32]. Such groups stage rallies and publicize alarming stories and statistics about negligent professional behavior. Clearly, they argue, the public's right to know about the many shocking cases of gross negligence and who is responsible for them supersedes the case for the personal privacy of physicians.

ISSUE ANALYSIS

The debate surrounding the National Practitioner Data Bank is an especially difficult one. Should the issue of practitioner malpractice be framed in the context of public health risks, or should the information in the data bank be treated in the same manner as is sensitive, personal information? The matter is complicated because a policy decision cannot be based only upon a neat equation balancing privacy and access. As with many controversial debates, the two camps harbor fundamentally different perspectives on the meaning and validity of the substantive issues. In this case, the practitioners and the citizens' rights groups hold opposing views on the meaning of the malpractice crisis. In other words, their vested interests preclude them from engaging in any unbiased discussion of the meaning of privacy.

Negligence

To identify and implement sound public policy in this area, it is necessary to reconcile the conflicting opinions held by practitioners and citizens' rights groups with respect to the incidence of negligence. The first step is to determine what constitutes medical malpractice.

A search of the professional medical literature re-

veals many articles written by practitioners advising their peers how to avoid malpractice lawsuits [33, 34]. Because the general consensus among medical professionals is that the malpractice "crisis" has been invented and orchestrated by adversarial forces (lawyers), much of the information shared in the articles states or implies that the physician must be vigilant about spotting the "litigious patient" [35].

There is much evidence, however, that the malpractice "crisis" is not entirely the result of greedy lawyers and a litigious public. Contrary to what the pundits claim, it is not "easy" to win a malpractice lawsuit. According to Harvey Wachsman, a former neurosurgeon who specializes in malpractice law and is author of the text *American Law of Medical Malpractice*, the law protects practitioners from frivolous claims. Wachsman explains that successful malpractice claims are not the result of honest errors in judgment but true cases of gross negligence that never should have occurred. He states that the AMA, which is adept at conducting surveys, neglected to compile statistics that would show "that approximately 70 percent of all malpractice lawsuits involve the type of slip-up that would be obvious to even a first year medical student" [36]. He maintains that these lawsuits stem from a failure by the physician to do one or more of the following: be present when needed, take an adequate medical history, or perform an adequate examination [37].

Although lobbyists for the medical profession suggest that malpractice litigation is a recent phenomenon, lawsuits against negligent physicians first became prevalent in the 1830s and 1840s. Many of the fundamental guidelines governing malpractice law date back to English common law of the eighteenth century. William Blackstone's *Commentaries*, for example, provided a foundation for legal arguments that would develop into American case law on the subject. Blackstone defined malpractice as some harm to a patient's "vigor or constitution" resulting from the "neglect or unskillful management of a physician, surgeon, or apothecary" [38].

Modern malpractice law is based on this concept of negligence. Negligence law is part of that body of law referred to as torts. Under all tort theories, liability is imposed on the basis of fault. All medical malpractice action is based on the allegation that "the patient, who claims injury, was owed some duty by the physician, and that the duty was breached, resulting in injury" [39]. American courts have broken down negligence into four basic principles and developed long-standing decisions in the case law. The result is a system whereby the plaintiff (patient) must prove four essential elements to obtain a judgment of negligence; all of these elements must be present for negligence to have taken place.

Often overlooked in the malpractice debate is the

vast number of patients who, although victimized by doctors, never sue. In fact, a Harvard University study reported in the *New England Journal of Medicine* revealed that as few as 3,000 lawsuits resulted from the 27,000 injuries caused by negligence in one year [40]. According to the study, "eight times as many patients suffer an injury from medical negligence as there are malpractice claims" and "there are about sixteen times as many patients who suffer an injury from negligence as there are persons who receive compensation through the tort system." The report refers to additional studies estimating that "only one in ten instances of malpractice results in litigation" [41].

Other studies show that state medical boards do not adequately discipline negligent doctors. Public Citizen, for instance, revealed that the 3,034 disciplinary actions taken by state medical boards in 1991 were "a pittance" compared to the 150,000 to 300,000 Americans injured or killed each year in hospitals at the hands of incompetent M.D.s [42].

Privacy

The concept of privacy is central to the debate over the data bank. Historically, commentators have failed to agree on an acceptable definition of privacy because they focused on its philosophical or moral dimension, which suggests multiple definitions [43]. Thus, the evolution of privacy law has allowed for four or five distinct "species" of legal rights. In "One Hundred Years of Privacy," Gormley argues that the concept of legal privacy is driven by events of history: "What constitutes an engine of privacy in the year 1890 is not necessarily the same thing which formulates a societal notion of privacy in the United States in 1939, or 1968, or 1973" [44].

The concept of privacy is certainly related to the era in which it is applied. Privacy, like democracy, is not a static concept. Although Supreme Court Justices Warren and Brandeis' definition of privacy as simply "the right to be left alone" is still relevant, Gormley maintains that we must ask, "with respect to what?" Each generation of Americans' privacy is defined a little differently from that of earlier generations.

Certainly, the dawn of the electronic age has forced Americans to rethink the definition of privacy. Records and data that once were isolated and static bits of information stored in a warehouse or office are now part of a vast online network. As an individual interacts with a state, that state can amass a considerable amount of information about that individual. There is very little statutory or case law that prevents states from sharing this information. Although all states have passed laws limiting the availability of certain records, "no two states have adopted the same standards of confidentiality or the same procedural safeguards" [45]. At the federal level, the only major

law governing the release of personal records by the government is the Privacy Act of 1974 [46]. The net result of the lack of uniform privacy laws is a struggle to set precedents with each new "age" of privacy.

The controversial debate over whether the National Practitioner Data Bank should be open to the public has created a quagmire for policy makers. Although the data bank is exempt from the public access mandates of the FOIA, support for eliminating this exemption is growing. Further complicating the matter is the fact that states are free to enact laws that would allow the release of data bank information even though it is exempt from the FOIA.

Because there are no hard and fast rules governing privacy, policy decisions regarding open access to the data bank must be made with an eye toward balancing the rights of both groups, without totally compromising the stated goals of the policy.

EVALUATION OF POLICY OPTIONS

Congress is unlikely to authorize public access to the National Practitioner Data Bank in the foreseeable future, because confidentiality was a crucial factor in formulating the HCQIA. Courts have indeed tended to side with practitioners on this issue: In June 1993, New York State's highest court ruled that "the state must keep its disciplinary proceedings against doctors secret unless it finds them guilty of misconduct" [47]. Although the precedent in New York prevents information regarding a pending disciplinary decision from being disclosed—the data bank will only include actions already settled or taken—the point is that the privacy of the practitioner is given priority over public access. A similar case is pending in California [48]. The consumer advocacy lobby is, however, fairly powerful; Public Citizen has a representative on the data bank's executive committee [49].

In creating policy governing the data bank, a pragmatic approach is essential. To that end, several important questions must be asked. First, is the malpractice problem, as reflected in the high rate of lawsuits brought to court in recent years, as severe and widespread as the consumer advocates claim? Second, is practitioner negligence as pervasive as critics charge? Information gleaned from the medical and legal literature appears to support the charge that the bulk of medical malpractice litigation is not reflective of frivolous claims. Moreover, many serious incidents seem to go unreported, supporting the view that negligence of this magnitude is not confined to a few "bad apples," as the medical profession insists.

The question of the validity of malpractice claims is crucial to policy formulation. If it could be ascertained that most of these claims were in fact unwarranted, then it would be unconscionable to allow such

information to be released. The purpose of the data bank itself would be questionable, in that the information contained therein would be founded on baseless claims; but this does not appear to be the case.

Having determined that the scope and magnitude of the malpractice crisis is real, the next question is: Should the general public be given access to the data bank? Consumer rights advocates have framed the issue in the context of a public health crisis, and in so doing have raised the level of anxiety about practitioner competence and added a feeling of urgency to the perceived need for public access. The problem of across-the-board negligence is certainly a serious cause for concern; however, it is not entirely clear that malpractice has reached the level of a true threat to public health. In order to prove that it has, more compelling evidence in the form of statistics and studies would have to be brought forth. Taking all of this into consideration, a case can be made for limited public access to the data bank: At this time, the need to protect the public against errant practitioners is evident. Disclosure of information about a dangerous practitioner is not an invasion of privacy if that information is defined narrowly in the context of professional competency. Care must be taken, however, to minimize the potential for harming the reputations of practitioners by including misleading information in the data bank.

Before a new policy can be developed, certain problematic rules and regulations now in place need to be addressed. Four problems are evident. First, the HCQIA lacks a crucial component: There is no provision mandating that a negligent practitioner be retrained or reeducated [50]. Given the thrust of the act, it is surprising that this problem was not addressed. Because approximately half of all medical knowledge becomes outdated every ten years [51], a doctor who has not taken postgraduate courses since leaving medical school in the 1950s or 1960s is very out of touch. Even though the AMA sponsors many continuing education courses every year, physicians are not required to take any. Some form of compulsory postgraduate training would be an effective prophylactic measure against incompetent physicians who continue to practice.

Second, physicians are concerned that much of the information gathered by the data bank has nothing to do with professional competence. The OBRA Amendment of 1990 mandates that state medical boards report "any negative action or finding" to the data bank. This mandate could lead to a flood of irrelevant information coming into the data bank; the net effect would be a dilution of its value [52].

Third, the reporting provision mandates that any malpractice payment, regardless of how small, must be recorded in the data bank. To address the opinion of physicians that making malpractice payments

should not be construed as synonymous with committing malpractice, the following provision was added to the act: "A payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred" [53]. Although Congress heard testimony that most small settlement payments reflect nuisance claims (it is often cheaper for doctors to settle rather than incur the expense of a trial), a decision was made not to except small claims "because of the feeling that a significant number of small payments may, notwithstanding the sums involved, represent truly meritorious claims" [54].

Fourth, malpractice payments need be reported only if "pursuant to a written demand" [55]. Thus, oral demands that result in payment need not be reported. Some attorneys simply encourage plaintiffs' attorneys to discuss a settlement before putting it in writing, "thus avoiding a physician's disincentive to settle because of reporting fears" [56].

Although there is a case for public access to the data bank, such a case cannot be considered unless the above reporting problems are addressed and rectified. Only a well-maintained data bank should be open to the public; and the National Practitioner Data Bank is not well-maintained. Clearly, it must be governed by much stricter rules than now exist regarding the reporting of information by health care entities. The terms of the OBRA amendment, in particular, are very unclear with respect to reporting, and must be clarified to prevent superfluous, irrelevant information from being added to the data bank.

Finally, loopholes that allow practitioners to evade being reported to the data bank are patently unfair. There is evidence that evasive settlement tactics are increasing because physicians fear being reported to the data bank. This practice undermines its integrity.

CONCLUSION

Although many of the logistical concerns associated with public access to the data bank can be mitigated by stricter regulation of the information it contains, a more fundamental problem remains. The controversy over practitioner privacy versus public access to the data bank is predicated on a philosophical concern over the meaning of information itself, particularly in the context of electronic databases. The arrival of the "information society" has changed the way in which information is perceived, processed, and accessed. The concept of privacy, which is in part defined by one's ability to control the information released about oneself, has inevitably been challenged.

The debate surrounding the National Practitioner Data Bank is representative of many policy issues concerning electronic data. The controversy regard-

ing public access to electronic data banks in general, and concern about the release of information deemed confidential, will continue to be an underlying theme in many public policy debates. The concept of information in this age of electronic data will increasingly be politicized, as advocacy groups assert their rights to data.

Consequently, the spheres of public policy and information management will continue to merge. Many public policy issues will be defined by the way in which policies toward information storage and access are conceptualized and ultimately formalized. The meaning of personal privacy in the context of a consumer-oriented society and its emphasis upon public access to information on demand will continue to be a pivotal issue in future public policy debates.

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REFERENCES

1. WASCHMAN H, PEGALIS SE. American law of medical malpractice. 2 vols. Rochester: Lawyers Cooperative, 1980.
2. RYZEN E. The National Practitioner Data Bank. *J Leg Med* 1992;13:409-62.
3. *IBID.*, 411.
4. WASCHMAN, *op. cit.*, 4.
5. RYZEN, *op. cit.*, 412.
6. *IBID.*, 415.
7. LOMBARADO TROSTORFF D. Implementation of the Health Care Quality Improvement Act and the future of peer review. *Med Staff Couns* 1990 Spr;4(2): 23-30.
8. RYZEN, *op. cit.*, 412.
9. *IBID.*, 413.
10. *IBID.*, 414.
11. *IBID.*, 414.
12. MULLAN F, POLITZER RM, LEWIS CT. The National Practitioner Data Bank: report from the first year. *JAMA* 1992 Jul 1;268(1):73-9.
13. RYZEN, *op. cit.*, 414.
14. *IBID.*, 415.
15. MULLAN, *op. cit.*, 73.
16. *IBID.*, 73.
17. *IBID.*, 73.
18. *IBID.*, 73.
19. *IBID.*, 73.
20. RYZEN, *op. cit.*, 411.
21. MULLAN, *op. cit.*, 73.
22. RYZEN, *op. cit.*, 411.
23. KONG D. State is flunked on policing of doctors. *Boston Globe* 1992 Feb 6: Metro Section, 21.
24. KONG D. Rally urges faster action on complaints against doctors. *Boston Globe* 1992 May 8: Metro Section, 66.
25. RYZEN, *op. cit.*, 413.

26. WASCHMAN H. Lethal medicine: the epidemic of medical malpractice in America. New York: Holt, 1993.
27. RYZEN, op. cit., 418.
28. IBID., 421.
29. IBID., 421.
30. IBID., 428.
31. KONG, op. cit., 21.
32. KONG, op. cit., 66.
33. CHARLES S. The doctor-patient relationship and medical malpractice litigation. *Bull Menn Clin* 1993;57(2):195-207.
34. KRAUSHUR M. Recognizing and managing the litigious patient. *Surv Ophthalmol* 1992;37(1): 54-6.
35. IBID., 55.
36. WASCHMAN, 1993, op. cit., 24.
37. IBID., 24.
38. IBID., 57.
39. WOOD CL. Historical perspectives on law, medical malpractice, and the concept of negligence. *Emerg Med Clin North Am* 1993;11(4): 819-931.
40. WASCHMAN, 1993, op. cit., 54.
41. IBID., 55.
42. CONDES R. Medical boards found lax on doctor discipline. *Trial* 1993 Apr:87-8.
43. GORMLEY K. One hundred years of privacy. *Wis Law Rev* 1992:1335-442.
44. IBID., 1342.
45. GOLDSTEIN B. Confidentiality and dissemination of personal information: an examination of state laws governing data protection. *Emory Law J* 1992;41(4):1185-280.
46. IBID., 1195.
47. DAO J. Court protects identity of doctors under disciplinary review. *New York Times* 1993 June 16: B6.
48. FELDSENTHAL E. Disciplinary data should stay secret, doctor group says. *Wall St J* 1993 Nov 5:B3.
49. RYZEN, op. cit., 460.
50. WALZER R, MILITMORE JD. Mandated supervision, monitoring, and therapy of disciplined health care professionals. *J Leg Med* 1993;14(4):565-96.
51. WASCHMAN, 1980, op. cit., 20.
52. RYZEN, op. cit., 429.
54. IBID., 429.
55. IBID., 436.
56. IBID., 439.

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