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The National Practitioner Data Bank

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In 1986, the Health Care Quality Improvement Act (HCQIA) went into effect. A section of this law established the National Practitioner Data Bank (NPDB) which was a repository for reporting adverse actions of health care providers. The NPDB was formed because Congress was under the impression that the quality of medical care in America was decreasing; they viewed this as a national problem. To address this issue, Congress wanted to encourage physicians to participate in meaningful peer review. What better way could there be than to have doctors discuss cases which had bad results and then learn from each other's mistakes?

Prior to this law, any adverse action taken against a physician was not available to an outside review. As a result, it was not unusual for a physician with bad results to go to a different practice location, often in another state, and get a new license and start a new practice without having to account for his previous record.

Peer review is a good way to improve care. However, the reporting requirement of the law had a chilling effect for any meaningful review. Any settlement or judgment paid on a malpractice claim could subject the physician, or other health care provider involved in the case, to being reported to this National Practitioner Data Bank and to state licensing boards. These reports could negatively impact the practitioner's ability to maintain his credentials and privileges at his current place of practice and his ability to seek work at another location.

The intent of Congress in setting up the NPDB was to restrict the ability of incompetent practitioners from moving from state to state without having to disclose their previous malpractice payments and other adverse actions e.g., loss or restrictions on a license, loss of privileges, or loss of professional society memberships. The NPDB was a clearinghouse to collect and release

information that was believed to be related to professional conduct and competence. This data would be available to entities involved in granting, or denying, credentials and privileges to health care providers and to the appropriate licensing boards of the various states.

The NPDB would function as an alert system. The information it contained was limited but it was intended to lead to further inquiry into a listed practitioner's licensure, malpractice history, less than professional behavior, and professional society membership actions. The burden of the further inquiry was on the hospitals, licensing boards, and other health care entities to make final hiring, credentialing, and licensure decisions.

Under this law, reports must be submitted to the NPDB if a malpractice settlement or judgment payment is made for the benefit of a licensed physician; this includes residents and interns. Payments may be made for the benefit of medical and dental students, but these will not be reported to the NPDB. Payments made for the benefit of deceased practitioners are reported because a fraudulent practitioner could assume the identity of the dead person; this reporting would help identify these individuals.

There is a dispute process available to the practitioner who has been reported but this process cannot be used to protest a payment or to appeal the underlying reasons for the reporting. It can only be used to dispute the factual accuracy of the report or claim the report was not submitted in accordance with the NPDB requirements. This written statement would be available to those entities allowed access to the NPDB reports.

Since a report to the NPDB can have significant detrimental consequences for the practitioner, it is not surprising that most are willing to defend the case through the legal process up to and including a trial. According to an article in the New England Journal of Medicine, only 2 percent of patients injured by negligent care in a hospital file malpractice claims. (New England Journal of Medicine, Vol. 324, 1991 (370-6)) The elderly and the poor are even less likely to sue. (Medical error: What do we know? What do we do? Jossey-Bass 2002) If a malpractice case makes it to trial, there is a high likelihood, about 90%, for a defense verdict.

In a study of negligence cases in 2008 by the American Medical Association, they found that 65% of claims were dropped, dismissed, or withdrawn prior to trial. Settlements occurred in 27.5% of cases and only 5% were resolved at trial. Of the cases that made it to trial, the physician defendants won 90% of the time. (Carol K. Kane, Medical Liability Claim Frequency: A 2007-2008 Snapshot of Physicians)

With these kinds of statistics, it makes sense for the defendant to fight, even if he was negligent. The defendant's goal is to keep from being reported to the NPDB.

Unfortunately, a malpractice payment may not be an accurate measure of the quality of a particular provider. It is hard to predict what a jury may do and too often they rely on the quality of the lawyers, the predilections of the judge, and the sympathetic nature of the plaintiff. If the payment is not related to a breach of the "standard of care," then the black mark of a listing in the NPDB may not accomplish what the law was meant to do; identify the poor practitioner. Even the very best provider can have a bad result on occasion; this bad result can lead to an NPDB report even if no malpractice occurred.

It is the threat of a NPDB report which prevents the open discussion, fact-finding, and broad based analysis and problem solving which was the intent of the meaningful peer-review of the HCQIA. Perhaps it is time to do away with the reporting provisions of this law and focus on meaningful performance evaluations of our health care providers. Since the NPDB is a barrier to meaningful peer-review, it should be repealed.

New requirements for performance measures as a means of getting paid under Medicare and Medicaid may be a better way to assess the quality of our providers.

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