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Policy Forum

The National Practitioner Data Bank: Promoting Safety and Quality

The National Practitioner Data Bank attempts to help maintain a level of quality and safety assurance by providing data on the clinical competence of physicians.

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The National Practitioner Data Bank (NPDB) was established under the Health Care Quality Improvement Act of 1986 and began data collection September 1, 1990 [1]. The NPDB's goal is to improve medical care quality and safety by providing information that is useful in assessing the professional competence of health care practitioners. The NPDB receives and stores information on adverse disciplinary actions against physicians and payments made on physicians' behalves as a result of settled claims or judgments. Hospitals must query the NPDB when practitioners apply for admitting privileges and biannually thereafter. Other health care organizations, such as medical groups and preferred provider organizations, may query the NPDB concerning practitioners over whom they exercise significant professional control as part of their quality improvement program. The NPDB is explicitly not available to the public.

The NPDB is consistent with an individual responsibility (some might say "bad apples") approach to quality improvement and safety assurance. Its reports alert health care organizations that an individual practitioner has been the subject of disciplinary action or a claim and, hence, might have provided poor quality or unsafe care; thus, the reports serve as a double-check on information provided directly by the physician. The health care organization then decides whether the NPDB information warrants an investigation and, potentially, limits the physician's clinical privileges. While some have questioned the quality of the information contained in the NPDB [2,3], our studies suggest that the data are accurate and relatively complete [4].

Several reports from the Institute of Medicine [5,6] and other literature [7] eschew the individual responsibility approach to quality and safety assurance in favor of a systems approach that emphasizes the complex character of health care delivery. This approach recognizes that the delivery of any medical service involves many individuals, communicating countless pieces of information, invoking various decision-making tools, and using different technologies in communication, assessment, and treatment. This complex set of individuals, institutions, and interactions makes up the system of health care that has ultimate responsibility for delivering a service. Problems in care delivery, including problems with quality or safety are, thus, a systemic problem rather than an individual issue. Assigning blame for an error or lapse in quality to an individual is not only inconsistent with this view of health care delivery, it is detrimental to improvement because it makes individuals reluctant to share information about problems or near misses.

Is the NPDB and its requirements for reporting and querying, then, an antiquated mechanism that is no longer necessary in view of our more "enlightened" systems approach to quality and safety? We believe that the NPDB alone could not achieve acceptable levels of quality and safety, but it continues to play an important role in this arena even as other approaches are implemented. First of all, our fragmented set of health care institutions and individuals is not a "system," and its constituent parts often fail or refuse to communicate effectively, causing important information to be lost or unavailable at the time and place when it is needed. The NPDB provides a uniform structure for one set of the

information that might be helpful in improving medical care.

Moreover, despite the systematic structure of health care delivery, systems are made up of individuals. Periodically one of those individuals is the problem. Perhaps that individual lacks adequate skills or suffers from a substance abuse or mental health problem. It is the responsibility of the health care system to detect this and take appropriate remedial action. In such cases, the NPDB provides other components of the health care system access to relevant history about clinicians.

Our recent findings also suggest the NPDB may have a positive, though indirect, effect on quality and safety through the reduction of settlements in frivolous lawsuits [8]. The NPDB imposes a "nonmonetary" cost on physicians who settle medical malpractice lawsuits out of court because it establishes a centralized record that many consider damaging to their reputation—even though identical or even more detailed information is required by hospitals during their credentialing processes. We found evidence that this reputation effect may have reduced physician willingness to settle lawsuits, especially the sort they previously settled for convenience or financial exigency [8]. When fewer questionable claims receive compensation, the "specificity" of the tort system is enhanced. This may attenuate the unfortunate side effects of an unspecific tort system—defensive medicine and skyrocketing malpractice premiums. Since defensive medicine, by definition, represents unnecessary health care services, any reduction will improve quality and safety of health care. Likewise, since rapid increases in malpractice premiums may compromise access to care in certain geographic locations or for certain populations, containing those premiums through reduced compensation for questionable claims has positive consequences for ensuring quality and safety.

Critics of the NPDB's role in quality and safety assurance assert that while the Data Bank provides information that may be potentially useful, regulations do not stipulate how or when the information must be used. The absence of regulations for mandatory use opens up the possibility that many organizations may be complying with reporting and querying requirements without making optimal use of the data. We note that even the best system cannot improve quality and safety if it is not used. Moreover, even if only some organizations find it useful and only a few medical errors are thereby avoided, the NPDB is of value. In fact, our recent studies show that many organizations do find the NPDB system useful [4].

Would the NPDB play an even greater role in quality improvement and safety assurance if it were open to the public? That is, would giving patients access to information outweigh the reputation "costs" to practitioners? Congress prevented public disclosure out of concern that it would make physicians and health care organizations reluctant to provide information to the NPDB. We are increasingly aware, however, that patients are an important component of our health care system, especially in assuring quality and safety. The experience in several states that do provide public access to physician malpractice reports demonstrates that sharing information with consumers can improve patient satisfaction and informed decision making and provide an additional layer in our Swiss cheese detection system with no demonstrated adverse consequences.

The Health Care Quality Improvement Act is an example of federal legislation aimed at improving patient safety. The NPDB is a crucial component of the legislation and has a positive effect on patient safety. It provides an important balance to the systems-based reform approach to patient safety improvement by recognizing that there is an element of personal responsibility in protecting patients by providing a tool for encouraging physician accountability.

References

1. Health Care Quality Improvement Act of 1986, Pub L No 99-660, 100 Stat 3784 (codified as amended at 42 USC sec (11101-11152).
2. US General Accounting Office. *National Practitioner Data Bank: Major Improvements Needed to Enhance Data Bank's Reliability*. Washington, DC: GAO Report GAO-01-130; November 2000. Google Scholar
3. Office of Inspector General. *Managed Care Organization Nonreporting to the National Practitioner Data Bank.*

Washington, DC: DHHS OIG Report OEI-01-99-00690; May 2001.
4. Waters TM, Parsons J, Warnecke R, Almagor O, Budetti PP. How useful is the information provided by the National Practitioner Data Bank? *Jt Comm J Qual Saf*. 2003;29:416-424.
View Article PubMed Google Scholar
5. Kohn LT, Corrigan JM, Donaldson MS, eds; Committee on Quality of Health Care in America, Institute of Medicine. *To Err is Human: Building a Safer Health System*. Washington DC: National Academies Press; 2000.
6. Institute of Medicine, Committee on Quality of Health Care in America. *Crossing the Quality Chasm: a New Health System for the 21st Century*. Washington DC: National Academy Press; 2001.
Google Scholar
7. Brennan T, Berwick D. *New Rules: Regulation, Markets, and the Quality of American Health Care*. San Francisco: Jossey-Bass; 1995.
Google Scholar
8. Waters TM, Studdert DM, Brennan TA, et al. Impact of the National Practitioner Data Bank on resolution of malpractice claims. *Inquiry*. 2003;40:283-294.
View Article PubMed Google Scholar

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