COUNTERPOINT

International Practitioner Data Bank: False Premise, False Promise

M. R. YESSIAN

U.S. Department of Health and Human Services, Boston, Massachusetts, USA

In 1984, the US General Accounting Office issued a report pointing out that physicians who lost their licence to practice in one state were continuing to practice in another [1]. In 1986, a federal court issued a ruling that physicians carrying out peer review activities in an Oregon medical clinic violated antitrust laws [2]. Both actions triggered calls for congressional action. Consumer advocates urged that patients be better protected from incompetent or unscrupulous doctors. Medical professionals urged that physicians conducting peer review be granted greater legal protection:

The National Practitioner Data Bank (NPDB) emerged from these developments. In 1986, the US Congress gave physicians the peer review liability protections they sought, but as a quid pro quo called for the establishment of the NPDB. The data bank began operation in September 1990. After some early implementation problems, it has functioned in an efficient manner and proven to be useful.

Hospitals, which are required by Federal law to query the NPDB as part of their credentials verification process, seldom obtain information of which they were unaware. Yet, they tend to find it useful: as a means of confirming information, as a way of encouraging applicants for staff positions to be honest and complete in reporting any prior adverse or malpractice actions involving them, and, occasionally, as a source of new information [3,4].

As the quantity of information in the NPDB has increased over the years, it has become an increasingly valuable central source of information for organizations employing health care professionals. Managed care organizations, even though they are not required to query the Data Bank, now account for the majority of enquiries being made to it. Consumer advocates argue that consumers should also have access to the NPDB to help them make more informed choices about the physicians they choose in the turbulent health care marketplace of the late 1990s.

But among physicians, the very notion of this central clearinghouse of information has continued as a major irritant. A past president of a state medical association certainly echoed the views of many of his colleagues when he said about the NPDB: “I’d like it to just disappear. Let’s put it somewhere beyond the reach of fiber optics” [5]. The American Medical Association could not agree more, as it continues to call for its dissolution [6].

Enter Drs Israeli and Altholz with their call for an international data bank modelled on the American one. As a rationale, they present the same basic concern that gave rise to the NPDB. They do not dwell on the phenomenon of bad doctors banished in one jurisdiction and continuing to practice in another, but they do stress the need, in an increasingly global economy, to protect patients and organizations “from the increasing risks in today’s medical environment.”

Their concern and their search for a way to address it are certainly important and timely. But I submit that the vehicle they propose is flawed in both its premise — that the NPDB serves as a relevant reference point for the kind of international data bank they outline — and in its promise — that such an entity could be effective in addressing their concern.

First, the premise. In a number of significant respects, the international data bank they propose bears little resemblance to the NPDB. The following are of particular note:

— They call for an organization that will establish guidelines and standards for medical care. This idea may be of value, but it has nothing to do with what the NPDB was established to do or with what it does. Further, the authors’ reference in this regard to the Federation of State Medical Board and its guide to state medical practice acts is also misleading. This guide provides a useful reference for regulatory matters concerning
licensure and discipline, but addresses only tangentially the elements of medical care.

— They call for an organization that will provide information on and contribute to the development of standards on the education, licensure, and work experience of medical practitioners. The NPDB does not serve as this kind of repository of information. It is a source of disciplinary action information. Physicians with no malpractice actions or adverse actions will not even appear in the NPDB. For those who are included, there is no profile of the physician's work history or education.

— They call for an organization that will serve as an impartial monitoring system, that “would facilitate the use of international standards instead of personal opinions”. The NPDB does not even monitor hospital compliance with the reporting or querying requirements, let alone with the standards used in medical care. The Joint Commission for the Accreditation of Health Care Organizations monitors most hospitals in the United States to determine adherence to its accreditation standards, but in doing so gives little attention to NPDB requirements. The minimal oversight concerning compliance with NPDB laws may have something to do with the fact that in the first 6 years of its operation about two-thirds of the hospitals in the US have not reported a single adverse action to the NPDB [7].

Thus, the precedent of the NPDB offers little support for the kind of international organization the authors set forth. But even in its own right, the promise of such an organization is limited. Basically, this is attributable to what I would call structural overload. The authors expect far too much of any such organization, be it part of the World Health Organization, a professional trade association, or some free-standing entity. The costs and complexities of establishing, operating and gaining sufficient buy-in for the informational, standard-setting body they delineate would be far-reaching and almost certainly counterproductive, especially as one considers matters of accuracy, uniformity and completeness of information. This would be so in the context of a single nation. It would be far more so across nations, as different cultures and customs add complexity.

Beyond that, the promise of this organization would be undermined by what appears to be an unrealistic linking of quality assurance and continuous quality improvement objectives. The authors suggest that quality assurance efforts intended to ensure that certain minimum standards of practice are maintained (with sanctions imposed on aberrants) would serve to increase overall standards of care. Yet, continuous quality improvement efforts typically do not focus on minimums or outliers or sanctions, but rather on the collection and dissemination of practice-related data, with the assumption that this process in itself will raise standards.

My critique notwithstanding, the authors should be applauded for calling attention to the need for some kind of international action on matters concerning medical credentialing and standard-setting. The growth of information technology, the reduction of trade barriers and many associated developments add a sense of urgency to such action. Although the international governing body they urge is not likely to trigger such action, perhaps an international group that defines its role as a catalyst could achieve some success.

For one thing, it could highlight the importance of having medical licensure and disciplinary bodies in different countries disclose more information about practitioners in their jurisdictions. A start in this direction has already occurred with the recent convening of two international conferences on medical registration. But there is a long way to go, as most licensure bodies still view themselves far more as self-regulatory bodies representing their profession than as consumer protection entities accountable to the public [8]. A catalyst group might suggest to participants at these conferences that more of them should follow the model of the Massachusetts medical licensure board, which makes available to the public profile information (including disciplinary and malpractice actions) on all physicians licensed in the state. That information, in fact, is available on the Internet, thereby giving individuals all over the world access to it.

A catalyst group could also seek to expedite the dissemination and discussion of information concerning medical practice guidelines and standards. For the most part, it would seem that medical and academic organizations would be the most appropriate forums for this kind of interaction. But given the rapid changes occurring in the health care field, it would also be important to look to other broader forums that include insurers, payers, regulators, and consumers.

In short then, Drs Israeli and Altholz direct our thoughts to some key issues that must be addressed in the years ahead. But the organizational mechanism they propose for addressing them would not be up to the job, nor would it be able to draw much guidance or legitimacy from the NPDB.

Note: The views expressed in this commentary are those of the author and do not necessarily represent those of the Office of Inspector General or the Department of Health and Human Services.

REFERENCES
1. General Accounting Office, Expanded federal authority needed to protect Medicare and Medicaid patients from health care practitioners who lose their licenses. May 1990.
2. Patrick v. Burget, 800 F. 2d 1498 (9th Cir. 1986).

