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the previously noted period took disciplinary actions against about 8,000 physicians while hospitals reported about 3,100 practitioners to the Data Bank.

There are a number of possible explanations for the minimal levels of hospital reporting. One is that some hospitals may be circumventing the Data Bank reporting requirements by deliberately taking adverse actions that fall below the reporting threshold. Another is that hospitals, in accord with the continuous quality improvement principles, may be deemphasizing or even avoiding entirely adverse actions against poorly performing practitioners. Still another is that some reportable actions may not in fact be reported to the Data Bank. Given the little that is known about what happens inside the "black box" of hospital quality assurance programs, it is extremely difficult to assess the significance of any of these possible explanations. But each warrants investigation.

One conclusion about which there can be little doubt is that the very existence of the Data bank will continue to be controversial. Even if tensions concerning usefulness, impact, accuracy, timeliness, and the like are defused, pressures to open up access to the Data Bank will almost certainly keep the Data Bank in the spotlight as a "hot-button" issue. And as advances in information and medical technology move us toward what The Economist concludes will soon become a patient-driven health care system (*6*), these pressures to open up the Data Bank are unlikely to abate.

In this environment, it is vital that considerations of the Data Bank be grounded in objective realities on how it is functioning. Identifying those realities will not necessarily settle differences in perspectives and expectations of the Data Bank, but it could contribute to more intelligent decision making and public policy concerning it. Oshel, Croft, and Rodak make a useful contribution toward that end.

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U.S. Public Health Service
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JFK Federal Building
Boston, MA 02203

Telephone: 617-565-1442
FAX: 617-565-4260

Internet: PHR@PHSBOS.SSW.DHHS.GOV

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