ing physicians and dentists under isolated scrutiny. In theory, the quality of the ancillary staff in the entity would have some bearing on liability or other actions sustained by physicians. And, in reality, there is little or no correlation between adverse action and medical malpractice payment reports.

The NPDB is having other unanticipated adverse effects. In 1993, the Physicians Insurers Association of America stated that 97 percent of their companies reported that physicians are less willing to settle claims as a result of the NPDB. Of malpractice reports, 21 percent of the payments were made for claims that were considered clearly defensible by the insurer, and presumably there are episodes of malpractice that never result in any action. Hospitals suspect a negative impact of the Data Bank on peer review actions. Also, 5 percent of hospitals report that the match reports were incomplete.

Although at the end of 1994 adverse actions represented 17.4 percent of the reports, slightly more than 6.6 percent of these were for modification of a previous adverse action report and actually were not adverse to the practitioner involved. Medical society reports are sparse mainly because adverse peer reviews occurring in facilities are already reported, and these societies have no influence over those who are not members.

Of perhaps greater significance is the $9.9 million in query fees paid to the bank in 1994 to say nothing of the indirect costs of compiling and submitting queries. Given all of these concerns, one has to wonder what really is the value of the Data Bank?

Without question, the changes in America's health care system include the imperative for useful information on the quality and competence of practitioners and entities providing care. Despite great attention to this imperative, no one yet has found an equitable, user-friendly, efficient manner for this documentation. The collection of massive amounts of data is seductive, but does it produce useful knowledge? Illustrative is the ill-fated attempt of the Health Care Financing Administration to disseminate hospital mortality rates as a measure of hospital quality. It was soon realized that such data were not useful or indicative, and the process was discontinued. The same may be said of the Data Bank as it now operates.

The authors make a strong case for the use of the Data Bank for research purposes, yet repeatedly they emphasize that the material must be interpreted with caution. It may be the bank does provide opportunities for research, but to date there is little evidence of useable knowledge being produced, and the recitation of numbers, while impressive, has not been very productive, nor is there any evidence that this is necessarily a unique data set. In an environment of cost constraint and the need for better measures of competence, it is difficult to justify the continuance of this expensive and seemingly flawed data repository.

Government's role should be to set the standards to which the profession should be held accountable, leaving it to the profession and those it serves to decide how close the practitioner or entity approaches those standards. There is a difference between data and knowledge. The National Practitioner Data Bank has yet to demonstrate that it can bridge that gap.

Reference

1. National Practitioner Data Bank guidebook. Public Health Service, Rockville, MD, October 1994.

Congress Should Open the National Practitioner Data Bank to All

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As we approach the fifth anniversary of the operation of the National Practioner Data Bank (NPDB), the main threat to this source of information about physicians is the desire of the American Medical Association (AMA)—in the face of possible public access—to get rid of it.

At its meeting in the summer of 1993, the AMA House of Delegates passed a resolution stating, "Resolved, that the American Medical Association . . . call for the dissolution of the National Practitioner Data Bank."

Just as the AMA's implicit threat not to support the 1986 legislation that established the NPDB succeeded in getting specific language included forbidding disclosure of records to patients or

physicians (other than the physician's own), the latest AMA threats have prevented any consideration of legislation to allow full public access. Now, as then, the AMA seems to want to protect the minority of American physicians about whom there is data in the NPDB from the scrutiny of their own patients and other physicians.

Despite NPDB-bashing by the AMA, which has said, among other criticisms, that the NPDB does not provide "useful" information to those who query it, two recent reports by the Inspector General of the Department of Health and Human Services document the usefulness of the Data Bank to two of its major consumers, hospitals—which are required by law to query it—and managed care organizations such as Health Maintenance Organizations (*1,2*).

In the most recent 2-year period studied, hospitals, in the process of their legally-mandated queries to the data bank on new attending physicians and periodic review of existing staff, had 89,430 "matches," instances in which the NPDB report to the hospital contained information on a physician. Based on a sample of these matches, there were an estimated 1,520 instances in the 2 years involving hundreds of physicians and affecting thousands of patients, in which the information obtained from the NPDB had an impact on a hospital's credentialing decision concerning an individual physician.

The Inspector General's report concluded by stating, "Finally, it is important to recognize that the very existence of the Data Bank may deter some unfit practitioners from even applying to hospitals for practice privileges and may encourage other practitioners to be more forthcoming in the applications they submit for hospital privileges." This latter point refers to the shrinking epidemic of doctors, thrown off the staff of one hospital, sneaking their way into another hospital in a different part of the country, previously secure in the low probability of the second hospital finding out about what happened in the first hospital.

It is true that only a small fraction of the reports in which there was a match had an impact on a hospital credentialing decision. But this must be placed in the context that hospitals make a grossly inadequate number of adverse credentialing decisions against physicians. Seventy-five percent of U.S. hospitals never—in the first 3 years and 4 months the data bank had been in operation—reported even one physician to it because of a credentialing action (*3*). But the NPDP's worth also can be seen in the finding that 85 percent of the reports of matches received by hospitals were found to be useful, and 28 percent, in the period from early 1992 to early 1994, provided information previously unknown to the hospitals' staffs. Similar usefulness was found in the study of matches in reports to managed care organizations like HMOs.

As more information about more physicians is entered into the Data Bank, its usefulness can only increase. The main problem with the NPDB, however, is neither the accuracy nor the usefulness of the data but the unconscionable secrecy whereby this Federal repository of important information about American physicians is kept from American patients and other physicians.

Although the AMA's agenda calls for abolition of the Data Bank for the phony reason that it is not useful, the real AMA objection is to the Bank being opened up. Rep. Ron Wyden of Oregon and others have proposed partial accessibility by providing data on fewer than half the physicians in it. The Congress should provide full accessibility, opening up all of the information in the Data Bank to everyone. Only in this way will the full potential of this important new source of information be realized.

References

1. National Practitioner Data Bank reports to hospitals: their usefulness and impact. (OEI-01-94-00030). Office of the Inspector General, Department of Health and Human Services, Washington, DC, April 1995.
2. National Practitioner Data Bank reports to managed care organizations: their usefulness and impact. (OEI-01-94-00032). Office of the Inspector General, Department of Health and Human Services, April 1995.
3. Hospital reporting to the National Practitioner Data Bank. (OEI-01-94-00050). Office of the Inspector General, Department of Health and Human Services, February 1995.