

information about malpractice and unprofessional conduct public, we will bring consumers another step toward controlling their own medical care. The

ultimate goal for the Data Bank is transparency, where health professionals share with the public what they know of themselves.

Putting the Controversy Aside, How is the Data Bank Doing?

MARK R. YESSIAN, PhD

Dr. Yessian is the Regional Inspector General for Evaluation and Inspections, Office of Inspector General, Department of Health and Human Services, Region I, Boston, MA.

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.

Tearsheet requests and requests for copies of Inspector General reports on the National Practitioner Data Bank to Mark R. Yessian, PhD, HHS/OIG, JFK Building, Room 2425, Boston, MA; tel. 617-565-1050; FAX 617-565-3751.

IN TODAY'S QUALITY assurance environment, where continuous quality improvement is the dominant tenet, the National Practitioner Data Bank runs against the grain. It seeks to ensure that minimum standards of health care are not breached at a time when the emphasis is on improving the mainstream of care and identifying benchmarks of excellence. It pinpoints people whose knowledge or practice skills, or both, may be questionable at a time when the priority is on improving systems of care offered by health care organizations. It raises the specter of punitive actions at a time when the watchword is collaboration. Therein lies the basis for much of the controversy that surrounds the Data Bank.

Oshel, Croft, and Rodak venture into this highly charged territory and provide us with bundles of useful data. Both critics and advocates of the Data Bank are sure to find information here to bolster their cases. For example, while critics might point out that "only" 5.3 percent of all queries to the Data Bank have resulted in matched reports (which identify practitioners included in the Data Bank), supporters might stress that voluntary queries have increased sharply to the point where by the end of the 4-year period covered they were accounting for more than half of all queries. For those in neither camp, the article helps them sort through the issues and reach more informed assessments.

In the Inspector General's Office we, too, have ventured into Data Bank territory, seeking for the most part to gain understanding of the usefulness and impact of Data Bank reports provided to hospitals and managed care organizations (MCOs) (1-3). For

those hoping the Data Bank succeeds, our findings have been reasonably encouraging. We found, for instance, that 83 percent of hospital officials and 96 percent of MCO officials we surveyed regarded the Data Bank reports they received on practitioners to be useful to them. Moreover, we learned that after some early startup problems, the Data Bank had become a timely, highly accurate source of information.

In regard to the impact of the reports, we found that 2 percent of the Data Bank reports in our sample led hospital officials to make different privileging decisions than they would have made without them and that 3 percent had the same effect on MCO officials. Whether these findings on impact are encouraging or not tends to depend on one's point of view. Critics see them as an indication that queries to the Data Bank rarely affect privileging decisions and are not cost-effective. Supporters are apt to point out that 2-3 percent of reports involve hundreds of practitioners and affect many thousands of patients they serve. They are also likely to point out that the very existence of the Data Bank may deter some unfit practitioners from even applying to hospitals or MCOs for practice privileges.

Our most disturbing findings concern the extent of hospital reporting to the Data Bank. Hospitals, as Oshel and colleagues point out, must report to the Data Bank all adverse actions they take that affect a practitioner's clinical privileges for more than 30 days. Yet, we found that from September 1, 1990, to December 31, 1993, about 75 percent of all hospitals in the United States never reported an adverse action to the Data Bank. Further, we learned that the State-by-State variation in the rate of nonreporting hospitals was considerable—ranging from 93.2 percent in South Dakota to 51.7 percent in New Jersey.

It is, of course, possible that these minimal levels of reporting exist because there are few practitioners with performance problems serious enough to warrant adverse actions by hospitals. That is highly unlikely, however, given recent studies on the numbers of adverse events caused by medical error or negligence (4,5) and given that State medical licensure boards in

