JCAHO Report Fails to Identify Ways to Improve NPDB

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On February 10, 2005, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) released a report recommending reforms to increase patient safety.1 Among other recommendations, the report calls for the redesign or replacement of the National Practitioner Data Bank (NPDB) citing its “relative ineffectiveness.”2 Although it attempts to follow-up on a 2000 General Accounting Office report addressing the same issue, the JCAHO report fails to identify any new or meaningful ways in which the NPDB should be redesigned or its responsibilities reassigned.

Congress enacted the Health Care Quality Improvement Act of 1986 (HCQIA) in part because of the increasing occurrence of medical malpractice and the need to improve the quality of medical care had become nationwide problems that warranted greater efforts than those that could be undertaken by any individual state.3 Congress also had identified a need to restrict incompetent physicians from moving from state to state without disclosure or discovery of the physicians’ previous damaging or incompetent performance.4

To satisfy these needs, HCQIA attempts to encourage health care practitioner peer review by providing immunity for certain professional review bodies that take

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2 Id. at 15, 37-38.
3 42 U.S.C. § 11101(1).
4 Id. § 11101(2).
professional review actions meeting certain standards. HCQIA also requires the reporting of certain medical malpractice payments and settlements by insurance companies; certain licensure revocations, suspensions, censures, probations, and reprimands by state boards of medical examiners; and certain adverse clinical privilege actions taken by certain health care entities. When physicians, dentists, and other health care practitioners apply for initial or biannual appointment to a hospital’s medical staff, the hospital must query the NPDB in an attempt to identify such malpractice, licensure, and clinical privileges actions. The theory is that the appointing hospital will not grant medical staff membership or clinical privileges to physicians with bad track records.

In HCQIA, Congress also directed the Secretary of the federal Department of Health and Human Services (HHS) to identify or establish an agency to which the malpractice and adverse licensure and clinical privilege reports should be made as well as the process pursuant to which such reports should be made. In 1988, the Health Resources and Services Administration (HRSA) and the Bureau of Health Professions responded by establishing the NPDB as the organization that would receive and process reports and provide information to entities required to query the NPDB. On October 17, 1989, HHS published final regulations governing the NPDB’s reporting and disclosure requirements and, on September 1, 1990, the NPDB opened in Camarillo, California, under the administration of the HRSA.

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5 Id. §§ 11111, 11112.
6 Id. § 11131.
7 Id. § 11132.
8 Id. § 11133.
9 45 C.F.R. § 60.10.
10 42 U.S.C. § 11134(a), (b).
Today, the NPDB continues to be the only database authorized by the federal government to collect information relating to physicians, dentists, and other health care practitioners who have been disciplined by a state licensing board, professional society, or health care entity or who have been named in a medical malpractice settlement or judgment. Since its inception, however, questions have been raised about the validity and reliability of the information collected by the NPDB. In 2000, for example, the United States General Accounting Office issued a report finding that hospitals underreported adverse clinical privileges actions and that much of the information collected by the NPDB was incomplete, inaccurate, misleading, or was not submitted on a timely basis. The GAO concluded that major improvements were needed to enhance the reliability of the NPDB.  

JCAHO’s February 2005 report finds that “no substantial progress” has been made since the GAO’s 2000 report. Relying on findings set forth in the GAO’s 2000 report, the JCAHO report also states that the NPDB: (1) is operationally unsound; (2) represents a significant threat to physicians concerned about their reputations and ability to practice medicine; (3) is philosophically dissonant with patient safety theory because it only provides information relating to individual failures and not related systems failures; and (4) is antithetical to the goal of transparency in the patient-physician relationship. JCAHO thus concludes that the NPDB needs to be redesigned or its responsibilities reassigned to other more reliable information repositories.

14 JCAHO REPORT, supra note 1, at 15.
15 Id. at 38.
Unfortunately, JCAHO does not identify ways in which the NPDB should be redesigned or its responsibilities reassigned. Although JCAHO does recognize the need for a centralized information source that can reliably capture information relating to physicians and other health care practitioners, JCAHO simply states that, “options other than the NPDB exist.”\textsuperscript{16} And, although JCAHO refers to the Federation of State Medical Boards (FSMB), which makes publicly available information on disciplinary actions taken against physicians,\textsuperscript{17} JCAHO does not otherwise identify how the FSMB’s information collection procedures are superior to those of the NPDB or whether reassigning the NPDB’s responsibilities to the FSMB or another organization would improve the accuracy of malpractice and adverse clinical privileges and licensure reports. In summary, notwithstanding its subtitle (“Strategies for Improving the Medical Liability System”), the JCAHO report offers few tactics for improving our current medical malpractice and adverse licensure and clinical privileges reporting system.

\textsuperscript{16} \textit{Id.}

\textsuperscript{17} \textit{Id.}