

A COMPARATIVE ASSESSMENT OF THE PIAA[†] DATA SHARING PROJECT AND THE NATIONAL PRACTITIONER DATA BANK: POLICY, PURPOSE, AND APPLICATION

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I

INTRODUCTION

The purpose of this paper is to investigate the nature and scope of the differences between the Data Sharing Project conducted by the Physician Insurers Association of America (“PIAA”) and the National Practitioner Data Bank (“NPDB”), which is operated by the U.S. Department of Health and Human Services. These data collection and dissemination projects are similar in the sense that they were both designed to capture codified information regarding medical malpractice claims. However, they are very different in their purposes and in the nature of the data captured.

The NPDB was originally developed to help identify “problem practitioners” on a national basis. This purpose differs greatly from the purpose of the PIAA Data Sharing Project, which was designed to provide clinical loss prevention data for use in physician education programs. Indicative of the wide difference between the two systems, of the seventy-six data fields found in these two data bases, only seven are common to both.

The PIAA Data Sharing Project is utilized extensively by the insurance company members of the Association and others to provide evidence of the medical conditions, procedures, and practices that give rise to medical malpractice claims. It relies on a complex code system incorporating the International Classification of Diseases, 9th. Clinical Modification (ICD-9), to identify medical conditions and treatments, and on other systems of specialized codes to account for medico-legal issues. Importantly, it does not identify individual practitioners.

In addition to medical malpractice payment data, the NPDB captures information regarding hospital privilege restrictions and revocations, licensure, and other disciplinary actions taken by regulatory authorities. The NPDB collectively refers to these as “adverse actions.” Adverse actions encompass only

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18.6% of the records reported to the NPDB, and these incidents are not captured by the PIAA.¹ Consequently, this paper will focus only on the comparison of malpractice claims data collection efforts.

The NPDB data was designed to meet the original purpose of the Data Bank—to identify individual practitioners. Only one data field, a generic act or omission code (two per record), permits the capture of information regarding the substance of the malpractice claim. Therefore, the NPDB is ill suited for research regarding the nature of malpractice claims and industry trends.

Despite this unsuitability, the NPDB has embarked upon a research agenda, which includes drawing conclusions regarding the incidence of claims and substantive research into the underlying causes or extent of medical malpractice. In addition to the unsuitability of the data captured by the NPDB for these purposes, the existing data has a number of definitional shortcomings that affect analytical accuracy:

- (1) The NPDB payment data field captures the value of the first payment made on a claim, but subsequent payments are not reported. While this serves as an indication that a payment has been made, it does not provide an accurate measure of the amount of the total indemnity paid on any claim.
- (2) The NPDB does not have the resources to verify the accuracy of the information reported to it, and acknowledges that it suffers from a “lack of clarity, context, and consistency.”
- (3) The NPDB lacks a unique identifier for each individual practitioner, making precise identification difficult and making it impossible to link together payments made by multiple insurance carriers for the same incident.
- (4) The act or omission codes collected by the NPDB are so general in nature and duplicative that any conclusion drawn from them cannot be relied upon.
- (5) In many instances, the NPDB cannot provide reliable information regarding individual culpability in multiple defendant cases, where the actual amount paid is reported on behalf of each individual is unknown. The NPDB requires that the total amount paid on behalf of all defendants be reported for each defendant. This affects the calculation of even the most basic statistics, such as mean and median payment values.
- (6) Financial payments to patients are not necessarily indicative of physician negligence—a fact recognized in the authorizing legislation of the NPDB. The NPDB, however, lacks any peer review of the ac-

1. See NATIONAL PRACTITIONER DATA BANK, NATIONAL PRACTITIONER DATA BANK 1996 ANNUAL REPORT (1997) [hereinafter NPDB ANNUAL REPORT].

tions reported to it, which would help to identify the payments indicative of negligence. Also, the NPDB attempts to do state-by-state comparisons that ignore local differences in the way legal systems handle malpractice actions, as well as distinct insurance requirements and demographic variations.

The NPDB and PIAA data bases were designed for different purposes. While current efforts to use the NPDB data for research into malpractice insurance trends suggest a substantive component to the NPDB data, a closer look reveals these efforts to be fruitless.

II

HISTORICAL BACKGROUND

A. The Rise of Physician-Owned or -Controlled Physician Insurers

Prior to the malpractice insurance availability crisis of the mid-1970s, the standard commercial market provided most medical malpractice insurance coverage for individual practitioners and institutions. As it was then a small line of business, these insurers made little effort to collect the data necessary beyond basic financial statistics to understand the nature of medical malpractice claims. When the 1970s crisis hit, the insurers suddenly recognized that this minor line of insurance was causing a major hemorrhage of their reserves. Rather than attempt to learn more about medical malpractice issues and determine the causes of the losses, most of the commercial carriers exited the market. Health care providers, who had already experienced skyrocketing insurance premiums, were faced with an even more onerous problem—the threatened unavailability of insurance coverage at any price.

The medical professions responded to this crisis by forming a provider-owned segment of the malpractice insurance industry. As the major carriers left the market, state and local medical associations formed their own carriers ready to assume the commercial carriers' former business. Today, more than fifty physician-owned or controlled companies provide the majority of medical professional liability insurance coverage in the United States. In addition to providing insurance, these new companies were committed to collecting the data necessary to permit adequate forecasting of loss trends, as well as identifying the legal and clinical causes for medical accidents and claims.

B. Regulatory Attention

In response to growing concern over the malpractice issue, in 1975 the National Association of Insurance Commissioners ("NAIC") commissioned the first comprehensive medical malpractice data collection effort in.² This three-year study required the mandatory reporting of data on all settled claims, and

2. See NAT'L ASSOCIATION OF INSURANCE COMMISSIONERS, 2 MEDICAL MALPRACTICE CLOSED CLAIMS, 1975-1978 (M. Patricia Sokwa, ed. 1980).

resulted in the production of the first national medical malpractice claims data. However, this study was conducted only once, and ended in 1978. Moreover, such early data collection systems did not produce much relevant loss prevention information. Recognizing the value of compiling nationwide comprehensive malpractice loss statistics on an ongoing basis, in 1985 the PIAA implemented a standardized format for the collection of detailed data.³ This project has grown to contain information on more than 160,000 medical malpractice claims and legal actions. The PIAA program sought to build upon the pioneering efforts of the NAIC study, and was expanded in scope to produce output usable by the PIAA member companies in their risk management efforts.

C. Formation of the National Practitioner Data Bank

Public interest in the medical malpractice problem prompted Congress to enact the Health Care Quality Improvement Act of 1986, which created the NPDB.⁴ This Act sought to improve the quality of health care by encouraging medical professionals to identify and discipline practitioners who engage in unprofessional behavior, and to restrict the ability of health care professionals to move from locale to locale without disclosure of his or her adverse performance record.⁵ The first payment made in settlement of any malpractice action triggers a report to the NPDB.⁶ Subsequent payments on the same claim are not required to be reported to the Data Bank.⁷

The architects of the NPDB legislation directed that data be reported to allow the identification of possible problem practitioners.⁸ Hospitals and other health care entities would then use this data along with other evaluative and credentialing information already in existence.⁹ The information collected was not designed as a definitive measure of the quality of a practitioner's performance, nor for use in measuring or analyzing the nature or trends in medical malpractice claims data.

The role of the NPDB, as described in its 1996 Annual Report, is to be a central repository of the following: (1) medical malpractice payment information; (2) licensure actions taken against physicians and dentists; (3) mandatory professional review actions taken against physicians and dentists, and optional reviews of other licensed practitioners; and (4) actions taken against medical professionals by the Drug Enforcement Agency.¹⁰ The data is intended to alert health care entities, licensing authorities, and professional societies that they

3. PHYSICIAN INSURERS ASS'N OF AM., DATA SHARING PROJECT REFERENCE MANUAL (1995) [hereinafter PIAA REFERENCE MANUAL].

4. See 42 U.S.C. §§ 11101 - 11152 (1997).

5. See NATIONAL PRACTITIONER DATA BANK, NPDB GUIDEBOOK A-2 (1994) [hereinafter NPDB GUIDEBOOK].

6. See *id.*

7. See *id.*

8. See 42 U.S.C. §11131 (1997).

9. See *id.* §11135.

10. See NPDB ANNUAL REPORT, *supra* note 1, at 2.

may need to undertake further review of a practitioner's background.¹¹ The information is intended to augment and verify, not replace, other sources of information, including reports from entities such as state licensing boards, medical malpractice insurers, and prior employers.¹² The NPDB was not designed to provide all details of reported incidents or actions.¹³

The original legislation never contemplated that this information would be made public (in other than aggregate statistical form) or used for unrelated research purposes.¹⁴ The system was not designed with the detail needed to investigate meaningful comparative trends.¹⁵ Necessary information is missing: such as the physician's medical specialty, nature of the illness of the patient, diagnoses, medical procedures performed, and other similar data describing the medical treatment from which the malpractice action arose. In addition, strict confidentiality provisions were included in the regulations implementing the legislation, requiring that information reported to the NPDB not be disclosed outside the Department of Health and Human Services except to qualified querying entities, such as hospitals and other health care organizations conducting clinical peer review.¹⁶ Violators of the confidentiality provisions are subject to civil penalties of up to \$10,000.¹⁷

D. The Development of the PIAA Data Sharing Project

The Physician Insurers Association of America ("PIAA") is a non profit trade association, founded in 1977 to represent the interests of U.S.-based physician-owned or controlled professional liability insurance carriers. While its initial members were all providers of medical malpractice insurance which dealt primarily with physicians, membership has been expanded to include dental insurance carriers and insurers operating outside the United States. The current membership consists of forty-five domestic physician insurers, three domestic dental insurers, six foreign physician insurers, and six reinsurers. The forty-eight primary domestic carriers insure over 250,000 physicians and dentists.

One of the founding purposes of the PIAA was to exchange information regarding malpractice insurance industry trends and operations. Each member insurance company collected loss data for its own use. It was apparent, however, that an individual company's volume of claims was inadequate to accurately evaluate claims trends. For example, a carrier might expect to incur only a few claims for the failure to diagnose or treat a fracture of the femur in any year—too few from which to draw any conclusions regarding the nature of this

11. *See id.*

12. *See id.*

13. *See id.*

14. *See* 42 U.S.C. §11137 (b)(1) (1997).

15. *See* Elements Under Consideration for Expanding the Research Capacity of the National Practitioner Data Bank, 56 Fed. Reg. 8784 (proposed Mar. 1, 1991) [hereinafter EXPANDING NPDB RESEARCH CAPACITY].

16. *See* 45 C.F.R. § 60.13 (1997).

17. 42 U.S.C. §11137(b)(2) (1997).

claim type.

Thus, the concept of sharing and aggregating such information resulted in the formation of the PIAA Data Sharing Project. Twenty-four of the PIAA member carriers participate in the Project, which began operation in 1985.¹⁸ While only PIAA member insurance carriers may report data to the Project, analytical output from the database is provided to any inquiring entity.

The detailed data reported to the PIAA includes information regarding claims filed only against physicians, dentists, and other health care providers.¹⁹ Ninety-eight percent of the claims reported are filed against physicians. No information regarding the population of physicians from which the claims resulted is reported, which makes it impossible to determine the incidence of claims against any population of physicians. Some view this as a shortcoming. However, collecting underwriting information would allow the PIAA data manager to approximate insurance rates and otherwise evaluate the performance of the carriers reporting the data. This would not only create significant antitrust issues for the Association, but would discourage PIAA members from reporting because of competitive concerns.²⁰ Confidentiality concerns are the major reason only about half of the eligible PIAA members participate. The other reasons include cost and incompatibility with existing data systems.

III

A COMPARATIVE VIEW OF THE PIAA AND NPDB DATABASES

A. Overview of Differing Purposes

The PIAA Data Sharing System continues to track adverse medical outcomes and financial trends for medical malpractice claims, including pending claims and those settled with or without an indemnity payment. This information has helped member companies establish loss prevention initiatives aimed at those claims having a high frequency or severity. For example, many of the PIAA member companies have utilized special reports and slide presentations prepared by the PIAA regarding the failure to diagnose breast, colon and lung cancer.

The NPDB captures information only on malpractice claims that result in a settlement payment, which account for about thirty-two percent of all medical malpractice claims resolved.²¹ The NPDB data set is composed of general information on the nature of the malpractice claims. It does not, however, cap-

18. *See generally* PIAA REFERENCE MANUAL, *supra* note 3.

19. *See generally id.*

20. Because of these antitrust issues, premium and rating information should be collected by a disinterested party, such as the Insurance Services Office. While the PIAA could be viewed as a disinterested party, this does not prevent one of our members or a nonmember from alleging that we collected the data for price-fixing or other anti-competitive purposes. If the PIAA had premium data, it would be able to calculate indicated future insurance premiums, and thus have highly desirable competitive information. This is a vulnerable place for a trade association to be.

21. *See* PHYSICIAN INSURERS ASS'N OF AM., PIAA DATA SHARING REPORTS 11 (1996).

ture basic research demographics, such as the specialty of the physician. The ability of the NPDB to track the adverse medical outcome of a claim is limited to one field in the Data Bank that contains a code indicating a generic act or omission on the part of the doctor that gave rise to the claim.

By definition, the NPDB and PIAA data bases are different in purpose, and were designed to satisfy different requirements.²² The PIAA data base remains in use for its original purpose of providing a comprehensive loss prevention resource of detailed medical malpractice claims data. However, the mission of the NPDB has been expanded beyond its original purpose of identifying possible problem practitioners to include a research agenda aimed at evaluating trends in medical malpractice claims experience.²³

A side-by-side analysis is necessary to understand the differences in the data captured in the PIAA and NPDB databases. While only seven of the data elements are identical, some are similar. Forty-five fields are unique to the PIAA repository, mostly capturing cause-of-loss, medico-legal, and demographic information.²⁴ Twenty-four fields are unique to the NPDB, mainly involving the identification of the practitioner, identification of the reporting entity and payment information.

A comprehensive field-by-field analysis of the two repositories is undertaken in the Appendix A. The overlap of information between the two databases is minimal, with many of the common data elements being descriptive and administrative in nature, such as the reporting entity's identification number. The majority of the data in the PIAA Data Sharing Project is designed to capture the nature of the medical malpractice incident, while the majority of the data in the NPDB is designed to identify the practitioner involved in the malpractice incident.

It is important to recognize that both of these data bases are now viewed by their owners as credible sources of medical malpractice data for loss prevention and research purposes. However, in the case of the NPDB, the design of the data base and included data elements severely limit its application in this regard. This was recognized by the Division of Quality Assurance at the U.S. Department of Health and Human Services soon after the NPDB opened its doors in 1990, when the Division published a notice of proposed rulemaking to expand the NPDB to include additional data elements. The notice specifically stated that "in order to increase the usefulness of the data Bank as a research resource, the data currently collected from medical malpractice payors would require expansion."²⁵ The pursuit of additional data elements was subsequently

22. See PIAA REFERENCE MANUAL, *supra* note 3.

23. See NATIONAL PRACTITIONER DATA BANK, NATIONAL PRACTITIONER DATA BANK EXECUTIVE COMMITTEE MEETING REPORT FOR THE DECEMBER 4, 1996 EXECUTIVE COMMITTEE MEETING, JANUARY 6, 1997, PANEL DISCUSSION: USES OF DATA AND NEED FOR DATA 18-21 (1997).

24. Medico-legal information is information regarding legal issues which can be the primary cause or a contributing factor in a malpractice claim. Examples include informed consent, assault, and abandonment.

25. EXPANDING NPDB RESEARCH CAPACITY, 56 Fed. Reg., *supra* note 15.

dropped by the Department.

B. Performance and Analytical Considerations

1. *The PIAA Data Sharing Project.* The PIAA Data Sharing Project has been in operation since 1985. More than 156,000 claims and suits have been reported, which in most cases provides statistically significant data for analytical purposes.²⁶ The data have been used over the years by PIAA member companies and others to support loss prevention programs, to measure the cost of losses for certain medical procedures, and to assess financial trends in medical malpractice indemnity and expense payments.

As previously noted, a perceived shortcoming that was designed into the system from its inception is the lack of an exposure base (number of doctors) to measure the incidence of claims for various demographic elements such as medical specialty or for the performance of certain procedures. The individual reporting insurance companies do have this information, and the PIAA provides special editions of the standard semi-annual reports to these companies which contain only their reported data. Such disaggregation of an individual insurer's data allows the companies to compare their own experiences with the national experience, and to compare their loss data to the population from which the claims arose. Individual company experience is provided only to the reporting company. Increasingly, PIAA members are expanding their markets into multiple states, although many still principally underwrite in only one state. For this reason, state-by-state comparisons are performed only with the permission of the reporting companies.

Maintaining the accuracy of the reported data is an ongoing process. Many of the critical data elements require codification utilizing ICD-9, which is a hierarchical codification system designed for 1) the classification of morbidity and mortality information for statistical purposes; 2) the indexing of hospital records by disease; and 3) operations for data storage and retrieval. Due to the complexities of the ICD-9 codification system, persons knowledgeable and trained in its use are required to perform the file coding. These individuals must also have a working knowledge of the process of handling claims, and be proficient in medical and legal terminology. The PIAA assists its member companies in identifying the requirements for coding personnel, and conducts structured coding classes for both new and experienced personnel. The PIAA staff also makes site visits to the member companies to provide refresher training and to deal with special problems or situations. Although with the data system complications have been minimal throughout the life of the project, the PIAA also provides consultation in this area.

2. *The National Practitioner Data Bank.* The NPDB has been in operation

26. See PHYSICIAN INSURERS ASS'N OF AM., *supra* note 21.

since September 1990.²⁷ Although it had many data system problems in the early years, it now appears to be performing its designed function at an acceptable level.²⁸ While the operational areas of the NPDB function properly, the level of reporting accuracy relies on the diligence of those required to make reports. The NPDB recognizes the necessity of achieving consistency among those reports. While the large number of reporting entities makes individual training virtually impossible, the NPDB publishes a guidebook and maintains a toll-free number for training purposes.

However, difficulties still exist in the interpretation of the enabling legislation and in the nature of the information required to be reported. For example, since the genesis of the NPDB, there has been confusion about the “corporate shield” issue. The corporate shield refers to the situation where the medical corporation for which the doctor works is named in the suit, and the doctor is either not originally named or is released specifically for the purpose of avoiding a report to the NPDB. There is evidence that some insurers will “cut a deal” with the plaintiff’s attorney to dismiss the doctor from the suit and let the payment be made entirely on behalf of the corporation, hospital, or other entity. These payments are often not reported to the NPDB, and a possibly negligent doctor is never reported. Although some entities report these claims in compliance with their interpretation of the NPDB requirements, NPDB officials acknowledge that “the number of malpractice-payment reports may have been affected by the ‘corporate shield’ effect,” but the extent to which this occurs “cannot be conclusively measured by available data.”²⁹ Based upon his participation in a large number of malpractice cases, plaintiffs’ lawyer Jack H. Olender estimates that this number may be as high as fifty percent.³⁰

NPDB officials have acknowledged that “the value of the Data Bank is diminished by the lack of clarity, context, and consistency in reporting. In effect, lack of uniformity in reporting limits the usefulness of the data.”³¹ Specifically, different interpretations of the reporting requirements may result in incomplete or inaccurate reporting of a situation. This, in turn, may lead to misinterpretation of the results either when queried or conducting research.

Identifying the practitioners for whom information has been reported is the core goal of the NPDB. However, the data system was designed without providing for a unique identifier for each individual practitioner, such as the practitioner’s Social Security number or the medical education number assigned to

27. See Robert E. Oshel et al., *The National Practitioner Data Bank: The First 4 Years*, 110 PUB. HEALTH REP. 383, 385 (1995).

28. See DEP’T OF HEALTH AND HUMAN SERVICES, DIV. OF QUALITY ASSURANCE, NATIONAL PRACTITIONER DATA BANK: USER SATISFACTION WITH REPORTING AND QUERYING AND USEFULNESS OF DISCLOSURE INFORMATION FOR DECISION MAKING, 1992-1994, at xi (1995) [HEREINAFTER NPDB USER SATISFACTION].

29. Wayne J. Guglielmo, *Are Doctors Evading The Malpractice Data Bank?*, MED. ECON., May 28, 1996, at 53.

30. See *id.*

31. Stephen B. Permison et al., *The NPDB Reflects on Issues of Reportability* (visited Jan. 29, 1998) <<http://www.usmedicine.com/npdb.html>>.

all physicians by the American Medical Association. To identify individuals and link their collective experience, the NPDB relies on a combination of reported data elements that include the last name, first name, birth date, and medical school of the practitioner. The social security number and the federal Drug Enforcement Agency identification number are included in the data file, but are optional fields. Thus, they are not reliable as identifiers.

Another essential element missing from the NPDB is the ability to account for and aggregate multiple malpractice payments resulting from a single incident. There is no mechanism to assure that payments by multiple insurers or multiple payments made by one insurer are not represented as multiple incidents. For example, in states where a patient compensation fund exists, a medical malpractice carrier will typically pay the physician's basic policy limit of the verdict or settlement, with the remainder being paid by the compensation fund. There is no case identifier stored in the NPDB that permits the electronic matching of these multiple payments. The same is true for payments made under commercial excess insurance policies, and in situations where multiple primary carriers make payments on behalf of the same practitioners.³² Thus, multiple payments made by multiple payors on behalf of the same practitioner for the same incident appear as separate incidents in the NPDB file. It is critical that credentialing committees are able to recognize this situation when hospitals are using this information to make decisions regarding the grant of clinical privileges. Additionally, as a result of multiple reporting, NPDB statistics are likely to be erroneous when used to measure the number of claims reported and average payment size.

Querying entities are also not able to glean reliable information from the NPDB regarding individual culpability in multiple defendant cases. Because many malpractice actions involve multiple defendants, it is not uncommon for a single payment to be made on behalf of several practitioners who treated a patient. It is not always possible to discern the extent of liability for each individual, especially in the situation where the claim is expeditiously settled before extensive discovery or expert review. The NPDB provides a field on the reporting form for the amount of the first payment on any claim and the number of practitioners for which that payment is made. In many multiple defendant cases, it is impossible to judge the amount of liability, if any, that should be assessed to each practitioner for whom an individual report will be filed. There are also no means for NPDB reports to link together the individual practitioners involved in the incident.

3. *Other Problems That Hinder Fair and Complete Reporting to the NPDB.* Monetary settlements to patients are often not indicative of negligent treatment by a physician. Settlements are often made when it is more cost-

32. Typically, a medical malpractice insurance policy covers a physician for any payment not to exceed the "primary limit," which is usually \$1,000,000 for any incident. A "commercial excess insurance policy" increases a physician's coverage beyond this primary limit. This coverage is normally sold in multiples of \$1 million, up to \$10 million.

effective for the insurer to pay a small amount of indemnity rather than to incur the costs of litigation to defend the claim. NPDB officials have stated that “since the Data Bank serves only as a flagging system, the mere existence of a report in the Data Bank should not be taken by professional reviewers to mean that a practitioner has performed incompetently.”³³ For example, it is not uncommon for anesthesiologists or certified registered nurse anesthetists to dislodge a tooth or filling during intubation or extubation. This is often caused by the poor condition of the patient’s dentition, and can result in a small settlement to compensate the patient for damage or replacement, which must be reported to the NPDB.

A related problem with monetary settlements is that there are a number of malpractice insurance policies that do not require the practitioner’s consent to settle a malpractice claim. It is not uncommon for an insurer to settle with the patient in order to avoid increased costs as a result of a lengthy discovery and negotiation period. Therefore, it is possible for an insurer to make a payment on behalf of a physician without allowing him or her to provide input to the insurer regarding the circumstances surrounding the alleged incident. Such practices do not take into account the quality of medical care, as the decision to settle was purely economic. Nonetheless, the payments must be reported to the NPDB and are available to querying entities.

The authors of the NPDB legislation acknowledge this economic impetus to settlements. The Health Care Quality Improvement Act of 1986 states that “a payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred.”³⁴ A focus group on reportability conducted by the Health and Human Services Division of Quality Assurance found that, given the absence of peer review of the actions reported to the NPDB, it is impossible to determine which malpractice payments reflect a practitioner’s level of incompetence.³⁵ The focus group found that claims paid due to expediency should be differentiated from those paid because of actual fault.³⁶ NPDB reports are not clear whether a malpractice payment does or does not correspond to medical competence.³⁷ Rather, the querying entity is left to make that judgment, potentially at the expense of the practitioner. This is supported by the NPDB Guidebook, which states that “a payment made in settlement of a medical malpractice action or claim shall not be construed as a presumption that medical malpractice has occurred.”³⁸

The conclusion that data resulting from claims based on negligence should be distinguished from other claims is further supported by a study published in the *New England Journal of Medicine*, which indicates that only 23.8% of

33. Oshel, *supra* note 27.

34. 42 U.S.C. §11137(d).

35. *See generally* Permison et al, *supra* note 31.

36. *Id.*

37. *Id.*

38. NPDB GUIDEBOOK, *supra* note 5.

claims closed with an indemnity payment were a result of negligent treatment.³⁹ Ironically, the paid claims resulting from negligence had indemnity payment values thirty-two percent less than the paid claims that did not result from negligence.⁴⁰ The major conclusion of this study was that “the severity of the patient’s disability, not the occurrence of an adverse event or an adverse event due to negligence, was predictive of payment to the plaintiff.”⁴¹

From an evaluative standpoint, perhaps the biggest shortcoming of the NPDB data set is its inability to identify a physician’s specialty. Therefore, no distinction is given to specialty groups with a higher expected frequency or severity of paid malpractice claims. In order to identify the real outliers, a querying entity should have the benefit of comparative specialty data when reviewing the payment reports.

4. *NPDB Limitations That Affect Research.* NPDB officials assert that their data can be used to describe almost all malpractice payments made on behalf of practitioners in the nation.⁴² They claim that state legislators can use this data to compare the pattern of malpractice payments in their state with neighboring states.⁴³ However, NPDB officials fail to account for the state-to-state differences in the legal systems handling malpractice actions, as well as distinct insurance requirements and demographic variations.

The NPDB is plagued by data definition problems and missing data elements which seem to be essential. Despite this, the NPDB staff contends that the malpractice payment data has advantages for analytical research into industry values and trends.⁴⁴ NPDB officials assert that their repository is the only comprehensive national malpractice payment data set.⁴⁵ With about 125,000 malpractice payments to date, it will grow over time to be the largest data base. However, its inherent limitations, such as the lack of physician, patient, and treatment demographics and incomplete payment data do not allow for fair comparative analyses. Unfortunately, these issues are not easy to resolve, and the collection of more appropriate research data would require redesigning the data base and making a completely new collection effort.

In addition, NPDB officials report “because of their uniquely comprehensive nature, the Data Bank malpractice payment data are also attractive for use, albeit with caution, in studies assessing the underlying extent of medical malpractice incompetence.”⁴⁶ This is in sharp contrast to the original Act’s acknowledgment that the existence of a malpractice payment does not necessarily

39. Troyen A. Brennan et al., *Relation Between Negligent Adverse Events and the Outcomes of Medical Malpractice Litigation*, 335 NEW ENG. J. MED. 1963 (1996).

40. *See id.*

41. *See id.*

42. *See Oshel, supra note 27.*

43. *See id.*

44. *See id.*

45. *See id.*

46. *Id.*

mean that malpractice has occurred.⁴⁷ However, NPDB officials believe that the validity of assumptions necessary to make the connection between payments and incompetency would be fruitful subjects for further research.⁴⁸ This view represents a significant departure from the NPDB's original purpose. Given the questionable quality of the limited data available, the extent to which payment data may be indicative of physician performance should be an issue of grave concern for the medical profession.

5. *Problems the NPDB Has Caused for Practitioners.* There is evidence that the introduction of the NPDB reporting requirements have made physicians much less willing to consent to settle claims.⁴⁹ Seventy-six percent of malpractice insurers queried by the Data Bank in 1994 reported that claims resolution had been affected by NPDB reporting, with 83 percent of larger insurers reporting that practitioners had become less willing to settle cases.⁵⁰ The size of the malpractice payment was not a factor.⁵¹ For those practitioners insured under policies which require their prior consent to settle a claim, certainly a record in the NPDB is a consideration. Reporting requirements have been especially influential deterrents to settlement in those instances in which there was no departure from the standard of care but the risk of a large trial verdict remains.

Health care practitioners feel they are being stigmatized when they are reported to the NPDB for any reason.⁵² Practitioners have expressed concern that there is little distinction between various magnitudes of gravity for which a practitioner may be reported.⁵³ In other words, there is no measure but the size of the malpractice payment, which has been demonstrated to be arbitrary, to indicate the degree of incompetence. However, the frequency of malpractice payments was determined by the NPDB to be a more important factor to querying entities than the size of the payment.⁵⁴

In the past three federal legislative sessions, bills were introduced that would allow public access to the information reported to the NPDB.⁵⁵ Viewed in the context of the original assurances of confidentiality made when the NPDB was created, public access has the potential to hamper seriously the physician's willingness to settle a claim and to cause physicians' competency to be questioned based on incomplete information. The fact that it takes almost five years to make a malpractice insurance payment after the incident occurs guarantees that the NPDB will not provide timely information for its original pur-

47. See 42 U.S.C. §11137(d).

48. See Oshel, *supra* note 27.

49. See NPDB USER SATISFACTION, *supra* note 28, at 28-29.

50. See *id.*

51. See *id.*

52. See Permison, *supra* note 31.

53. See *id.*

54. See NPDB USER SATISFACTION, *supra* note 28, at 28-29.

55. See S. 2004, 104th Cong. (1996); H.R. 4272, 103d Cong. (1994).

pose—identifying practitioners who may have a competency problem.⁵⁶

6. *PIAA Data Sharing Information.* The PIAA Data Sharing Project collects data on a semi-annual basis from twenty-four participating companies. A major difference between the PIAA Data Sharing System and the NPDB is that the Data Sharing System includes claims closed with no indemnity payment. This increases the number of closed claims reported by more than 200 percent, as seventy percent (in 1996) of all claims and suits are closed with no indemnity payment.⁵⁷ PIAA data show that the average claim with an indemnity payment takes about fifty-nine months to resolve from the incident date. Claims with no payment are resolved in an average of fifth-three months. Lawsuits that have been open for one year are also reportable to the Data Sharing System, and the average age of this information when reported is only twenty-one months from the date of the incident.⁵⁸ This allows for more comprehensive analyses of claim trends and provides more current information with regard to claims involving new or controversial procedures.

As previously noted, the PIAA database was created primarily as a loss prevention tool. The data allow users to look at the conditions or procedures for any major specialty group that most frequently result in an adverse outcome. In addition, information such as the degree of severity of the patient's injury is captured, which is helpful in looking at the events that result in the most serious outcomes. Examples of output from the PIAA data base are provided in Appendix B.

IV

CONCLUSION

It is difficult and inappropriate to compare the NPDB and the PIAA Data Sharing Project as similar data capture systems. Each system was designed for a different purpose. The NPDB was specifically intended to identify individual practitioners, while the PIAA Data Sharing Project was designed to capture industry trends, and does not contain any information that permits the identification of individual practitioners. While current efforts to use the NPDB data for research into malpractice insurance trends suggest a substantive component to the NPDB data, a closer look reveals these efforts to be fruitless.

56. See PHYSICIAN INSURERS ASS'N OF AM., PIAA DATA SHARING REPORT nos. 13 & 14 (1996).

57. See PHYSICIAN INSURERS ASS'N OF AM., PIAA DATA SHARING REPORT 11, *supra* note 21.

58. See PHYSICIAN INSURERS ASS'N OF AM., PIAA DATA SHARING REPORTS nos. 13 & 14, *supra* note 56.

APPENDIX A
PIAA DATA SHARING PROJECT—NATIONAL PRACTITIONER DATA BANK
COMMONALITY OF DATA ELEMENTS
(Y = PRESENT IN DATA BASE; N = NOT PRESENT IN DATA BASE)

Description Of Data Element	PIAA	NPDB
Reporting Entity Identification	Y	Y
Reporting Entity ID Number	N	Y
Relationship Of Entity to Practitioner	N	Y
Type Of Report	N	Y
Entity Name And Address		
<u>Insurance And Legal Information</u>		
Incident Number (Case File Number)	Y	N
Insured Number (Claim File Number)	Y	N
Accident Date	Y	Y
Report Date	Y	N
Claim/Suit Date	Y	N
Close Date	Y	N
Payment Date	N	Y
Judgment Or Settlement Date	N	Y
Adjudicative Body Case Number	N	Y
Adjudicative Body Name	N	Y
Status (Open Or Closed File)	Y	N
Coverage Type (Claims Made Or Occurrence)	Y	N
<u>Plaintiff/Patient Information</u>		
Age	Y	N
Gender	Y	N
Income	Y	N
Marital Status	Y	N
Collateral Source Payor	Y	N
<u>Practitioner Information</u>		
Name	N	Y
Organization Name	N	Y
Work Address	N	Y
Home Address	N	Y
Country	N	Y
License Number	N	Y

Description Of Data Element	PIAA	NPDB
State Of Licensure	N	Y
Field Of Licensure	N	Y
Social Security Number	N	Y
Federal DEA Number	N	Y
Professional School Attended	N	Y
Year Of Graduation	N	Y
Hospital Affiliation, City, State	N	Y
Specialty	Y	N
Board Certification	Y	N
Board Eligibility	Y	N
Insurance Policy Limits	Y	N
Type of Practice (Solo, Corporate, etc.)	Y	N
Medical School Attended	Y	Y
Full/Part Time Practice	Y	N
Age/Birth Date Of Practitioner	Y	Y
Gender	Y	N
<u>Location Within Institution</u>		
Type Of Institution	Y	N
Incident Location	Y	N
Type Of Hospital	Y	N
State Where Action Brought	Y	N
<u>Payment Data</u>		
Total Indemnity Paid For Practitioner	Y	N
Narrative Description Of Payment(s)	N	Y
Amount Of Initial Individual Indemnity Payment	N	Y
Indication Of Single Or Multiple Payments	N	Y
Number Of Practitioners For Which Payment Was Made	N	Y
Loss Adjustment Expenses—Defense Counsel	Y	N
Loss Adjustment Expenses—Expert Witness	Y	N
Total Loss Adjustment Expenses	Y	N
Lump Sum/Structured Settlement	Y	N
<u>Cause Of Loss Information</u>		
Narrative Description Of Act Or Omission	N	Y
Severity Of Injury Indicator	Y	N
Medical Condition	Y	N

Description Of Data Element	PIAA	NPDB
Misdiagnosis	Y	N
Care Rendered (Procedure Performed)	Y	N
Anesthesia Procedure	Y	N
Medical Misadventure	Y	Y
Treatment Delay/Not Performed	Y	N
Iatrogenic Injuries	Y	N
Medical Outcome	Y	N
Associated Legal Issues	Y	N
Associated Personnel	Y	N
Emergency Situation	Y	N
Treatment Length	Y	N
Disposition Code (Settlement, Judgment, etc.)	Y	Y
Disposition Time	Y	N
Review Panel Decision	Y	N
Arbitration Panel Decision	Y	N
Company Liability Decision	Y	N
Previous Claim Experience	Y	N

SUMMARY

Number Of Fields Both Databases Include	7
Number Of Fields Only PIAA Includes	45
Number Of Fields Only NPDB Includes	24

APPENDIX B
EXAMPLES OF DATA TABULATED FROM PIAA DATA SHARING PROJECT

TABLE B1
CLOSED FILES
JAN. 1995 - JUNE 1997

	# Files	% Closed Files	Total Indemnity Paid	Average Per File
Total Closed Files	135,423	100.0	\$ 6.5 Billion	\$ 48,211
Files Closed				
With Indemnity	43,020	31.8	\$6.28 Billion	\$151,764
Files Closed				
Without Indemnity	92,403	68.2	0	\$0
Method of Payment:	Lump Sum		39,760 (92.4%)	
	Structured Settlement		3,249 (7.6%)	

TABLE B2
EXPENSE INFORMATION: ALL CLOSED CLAIMS
JAN. 1995 - JUNE 1997

	# Files With Data Reported	Total Expenses Dollars Paid	Average Paid Per File
ALAE - Defense Attorney	92,473	\$1.35 Billion	\$14,633
ALAE - Expert Witnesses	61,077	\$182 Million	\$ 2,978
ALAE - Other	100,829	\$426 Million	\$ 4,234
TOTAL ALAE	118,541	\$1.96 Billion	\$16,551

RATIO OF EXPENSE TO INDEMNITY: All Closed Claims: 30.1 cents expense per indemnity dollar.

TABLE B3
EXPENSE INFORMATION: CLOSED CLAIMS WITH INDEMNITY PAYMENT
JAN. 1995 - JUNE 1997

	# Files With Data Reported	Total Expenses Dollars Paid	Average Paid Per File
TOTAL ALAE	39,595	\$936 Million	\$23,644

RATIO OF EXPENSE TO INDEMNITY: Closed Claims with Indemnity Payment: 14.3 cents expense per indemnity dollar.

TABLE B4
SPECIALTY GROUP: INTERNAL MEDICINE, NON-SURGICAL
CUMULATIVE ANALYSIS OF PROCEDURES PERFORMED
JAN. 1985 - DEC. 1994

Procedure Performed	Closed Claims	Paid Claims	% Paid/ Closed	Indemnity: Total (\$)	Indemnity: Average (\$)
Diagnostic Interview, Evaluation Or Consultation	5,754	1,313	22.82	189,470,745	144,304
Prescription Of Medication	2,275	808	35.52	96,657,558	119,626
General Physical Examination	917	217	29.55	45,407,918	167,557
Injections And Vaccinations	625	206	32.96	25,422,495	123,410
No Care Rendered	575	62	10.78	6,919,892	111,611
Diagnostic Procedures Inv. Cardiac And Circulatory Functions	478	151	31.59	33,549,452	222,182
Miscellaneous Manual Exams & Non-Operative Procedures	427	119	27.87	18,981,186	159,506
Diagnostic Radiographic Procedures, Exc. CAT Scans	364	161	44.23	29,174,955	181,211
Diagnostic Procedures Of The Large Intestine	293	103	35.15	10,936,402	106,179
Cardiac Catheterization	140	37	26.43	7,191,406	194,362

TABLE B5
SPECIALTY GROUP: INTERNAL MEDICINE, NON-SURGICAL
CUMULATIVE ANALYSIS OF PATIENT CONDITION
JAN. 1985 - DEC. 1994

Patient Condition	Closed Claims	Paid Claims	% Paid/ Closed	Indemnity: Total (\$)	Indemnity: Average (\$)
Myocardial Infarction, Acute	617	225	36.5	44,670,027	198,533
Malignant Neoplasms Of The Lung And Bronchus	466	166	35.6	29,580,025	178,193
Malignant Neoplasms Of The Female Breast	294	121	41.2	21,387,248	176,754
Pulmonary Embolism	216	73	33.8	12,251,276	167,826
Diabetes	221	61	27.6	5,962,966	97,754
Renal Failure	212	36	17.0	6,705,616	186,267
Hypertension	182	47	25.8	6,515,053	138,618
Malignant Neoplasms Of The Colon And Rectal Region	182	78	42.9	16,795,185	215,323
Pneumonia	178	52	29.2	7,087,913	136,306
Coronary Atherosclerosis	161	46	28.6	5,800,265	126,093

TABLE B6
SPECIALTY GROUP: INTERNAL MEDICINE NON-SURGICAL
DIAGNOSIS ERROR CLAIMS —MOST PREVALENT CLAIMS
JAN. 1985 - DEC. 1994

	Total Files	Closed Files	Paid Files	% Paid/ Closed	Indemnity Paid (\$)	Avg. Per Paid File (\$)
Errors In Diagnosis	4,710	3,842	1,383	36.00	225,612,873	163,133
<u>Most Prevalent Conditions</u>						
Malignant Neoplasms Of The Bronchus and Lung	308	259	116	44.79	20,794,198	179,260
Myocardial Infarction, Acute	244	193	95	49.22	20,338,997	214,095
Malignant Neoplasms Of The Female Breast	182	148	76	51.35	14,874,441	195,716
Malignant Neoplasms Of The Colon Or Rectal Region	108	91	49	53.85	11,081,044	226,144
Malignant Neoplasms Of The Rectum Or Anus	99	76	40	52.63	11,073,549	276,839

TABLE B7
SPECIALTY GROUP STATISTICS
JAN. 1985 - JUNE 1997

Specialty Group	# Files Closed	# Files Paid	% Paid/ Closed	Indemnity Paid (\$)	Avg. Per Paid File (\$)
Anesthesiology	5,364	1,972	36.76	343,800,412	\$174,341
Cardio Diseases-NS*	1,749	326	18.64	60,143,653	\$184,490
Cardio & Thoracic Surgery	3,657	888	24.28	142,528,653	\$160,505
Dentists	403	200	49.63	7,607,768	\$38,039
Dermatology- NS	1,526	489	32.04	37,402,563	\$76,488
Emergency Med.- NS	1,971	557	28.26	78,183,950	\$140,366
Gastroenterology- NS	995	223	22.41	27,339,986	\$122,601
General Surgery	15,023	5,437	36.19	771,031,575	\$141,812
General & Family Practice- NS	15,775	5,860	37.15	700,356,675	\$119,515
Gynecology	1,621	532	32.82	60,623,133	\$113,953
Internal Medicine- NS	17,725	4,847	27.35	721,401,701	\$148,835
Neurology- NS	1,900	383	20.16	80,626,171	\$210,512
Neurosurgery	3,318	950	28.63	221,733,153	\$233,403
OB/GYN Surgery	19,249	7,030	36.52	1,501,245,591	\$213,548
Ophthalmology	3,970	1,203	30.30	159,793,679	\$132,829
Oral Surgery	39	13	33.33	438,583	\$33,737
Orthopedic Surgery	14,101	4,235	30.03	554,906,002	\$131,029
Other Nonsurgical Specialties	1,128	258	22.87	31,399,602	\$121,704
Otorhinolaryngology	2,205	714	32.38	107,494,071	\$150,552
Paraprofessional	35	3	8.57	779,000	\$259,667
Pathology- NS	916	287	31.33	58,482,250	\$203,771
Pediatrics- NS	4,270	1,253	29.34	279,705,207	\$223,228
Plastic Surgery	5,319	1,582	29.74	131,000,643	\$82,807
Psychiatry- NS	1,393	320	22.97	45,034,915	\$140,734
Radiation Therapy- NS	1,034	232	22.44	49,294,292	\$212,475
Radiology- NS	7,214	2,152	29.83	263,561,563	\$122,473
Resident/Intern	109	36	33.03	1,957,182	\$54,366
Urologic Surgery	3,414	1,308	30.40	127,313,842	\$122,653
TOTALS	135,423	43,020	31.80	6,565,185,815	\$152,608

* NS = "nonsurgical."