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The National Practitioner Data Bank: History and Data

Kenneth P. Miller, PhD, CFNP

ABSTRACT

The purpose of this manuscript is to provide the reader with an overview of the historical development of the National Practitioner Data Bank and then to compare the malpractice cases that have closed in the past 20 years with the current trend of the past 5 years. These data provide insight into areas that nurse practitioners might wish to focus on in an attempt to keep malpractice claims as low as possible.

Keywords: Health Care Quality Improvement Act, malpractice, national practitioner data bank, NPDB, public use data file

In 1986, Congress passed the Health Care Quality Improvement Act (HCQIA) as part of the Title IV of Public Law 99-660.[1] As part of this act, the National Practitioner Data Bank (NPDB) was established. The goal of this latter piece of legislation was "...to restrict the ability of incompetent physicians [health care providers] to move from state to state without disclosure or discovery of the physician's [health care provider's] previous damaging or incompetent performance."[2] While the law was passed in 1986, it was not fully implemented until September 1, 1990.[3] Since its inception, data have been reported by hospitals and other health care entities on any provider for whom damages, whether by settlement or by trial, have been rendered.

The purpose of this manuscript is 2-fold: first, to provide an historical overview of the NPDB as it relates to nurse practitioners (NPs), and second, to report on the data related to closed cases against NPs that have occurred over the past 20 years and to compare that data with the past 5 years.

HISTORICAL PERSPECTIVE

When compared with other licensed health care providers (Table 1), malpractice cases against NPs have risen at a relatively slow pace. In part, this finding can be attributed not only to the increasing numbers of NPs entering the workforce but also to the increasing autonomy that NPs are achieving through enhanced scope of practice and prescriptive authority.[4] Recent data reports identify more than 140,000 practicing NPs in the United States who see approximately 600 million patients a year and write approximately 556 million prescriptions per year.[5,6]

With these types of numbers and the productivity goals that are set by many practices, errors are bound to occur. When errors occur, a small percentage of patients begin to think "litigation." Generally, patients have a tendency to file a claim for 1 of 2 reasons: specifically, they feel that personal input into their care has been ignored or that the care they have received is below the "standard of care" typically provided in their community. It is this latter category that typically results in a tort claim under the aegis of negligence/malpractice. Even under these circumstances, of the approximately 0.8%-1.0% of patients who become victims of malpractice, only 2.9% will actually file claims.[7]

ELEMENTS OF MALPRACTICE

Malpractice is defined as "an instance of negligence or incompetence on the part of a professional."[8] In order to be successful in a malpractice claim, a plaintiff (injured party) must meet the 4 requisite elements for a negligence claim: duty, breach of duty, proximate causation, and damages must have occurred. In malpractice cases, duty is a "legal obligation that is owed or due to another and that needs to be satisfied."[8] For example, in a clinic setting, if an NP fails to discuss the adverse side effects of a medication and the patient then suffers harm as a result, the NP is liable.

Furthermore, some medications should not be taken with dairy products because they will decrease the amount of drug being absorbed and might lead to deleterious side effects or a worsening condition. The NP has the duty to provide the patient with this information, and failure to do so results in a breach of that duty. This breach of duty is defined as "conduct that exposes others to an unreasonable risk of harm."[9] Once the duty is breached, the plaintiff has the burden of proof in showing that the breach was "...a foreseeable result of the conduct [failure to warn], and that the harm was not brought about by an extraordinary or unforeseeable sequence of events."[10]

A lawyer would have to show that the proximate cause was the direct relationship between the dairy product and the decreased absorption of the drug that caused the harmful effects to the patient. In this case, the damages lie in the fact that the patient had a prolonged illness that led to a chronic condition that would not have occurred if the patient been appropriately informed at the time the medication was ordered.

The above scenario is but 1 example of the myriad cases of negligence for which NPs can be held liable. Having reviewed the historical perspective and the elements that comprise a malpractice case, a review of the past 20 years of NPDB cases against NPs will highlight the areas in which NPs have been most vulnerable to litigation.

NP LITIGATION

While Table 1 clearly shows that the number of overall cases against NPs is relatively small compared with our medicine colleagues, it is still a cause for concern. For more than a decade now, tort reform has been on the radar of most states, and the crisis has been perpetuated by such factors as increased liability insurance premiums, increased jury awards, increased litigation, insurance mismanagement, loss of insurance carriers, and other factors.[11] In an attempt to decrease litigation, 33 states have placed caps on damages.[12] While these caps have limited the actual payout associated with claims, they have not decreased the number of claims that have been filed.

Since 1990, a total of 2,338 claims have been reported closed to the NPDB. As Table 2 shows, little has changed over the past 20 years in terms of malpractice allegation groups for which NPs are being sued. The primary difference between 1990 and 2008 is the fact that

Table 1. Practitioners Field of License and Malpractice Cases Reported to the NPDB Since 1990 (N = 882,094)

Physician	397,789 (45.1%)
Physician Assistant	4,982 (0.6%)
Nurse Practitioner	2,338 (0.3%)

Adapted from NPDB Public Use Data File, SPSS Version, Updated March 2012. Available at www.npdb-hipdb.hrsa.gov/resources/publicdata.jsp.

there have been fewer cases related to diagnoses and more related to treatment in the past 5 years. A possible explanation for this reversal is that educational programs are focusing more on diagnoses than treatment. So while NPs have become better diagnosticians, they have declined slightly in their treatment mode skills. Both of these scenarios require a greater in-depth analysis to discover the root cause.

The severity of the alleged malpractice injury has also shifted slightly in the past 5 years, as displayed in Table 3. While death remains the top outcome in terms of the severity of malpractice injuries, both from an historical perspective and currently, the other 2 categories have been markedly reduced in their severity. The past 5 years have shown that the overall severity has gone from *major permanent injury* to *minor temporary injury* in the past 5 years. And the *significant permanent injury* of the past 20 years has decreased to *major temporary injury*. The implications of this change will have to stand the test of time as this could just be attributed to a sample size phenomenon.

The 1 issue that has not changed significantly over the past 20 years has been the practitioner's work state. As Table 4 shows, since the NPDB has been collecting data, Florida has remained at the top of the list of states with the most malpractice cases against NPs. Florida has a long history of malpractice claims against NPs. At 1 point, most malpractice insurance providers had left Florida because of the increasing costs to adjudicate or settle the claims filed in that venue. Since then, many firms have returned to offer insurance services but at a premium price that is much higher than in most states.

Rankings 2 and 3 of the most litigious states have varied over time. California, New York, and Texas have all found themselves in the top 3 at some point. In part, this trend is a result of the large numbers of practitioners who work in those states. Where there are greater numbers, one would expect higher volume of claims.

Table 2. Comparison of Malpractice Allegations Against NPs

Since 1990 (N = 2,187)	Since 2008 (N = 115)
Diagnosis related (n = 530)	Treatment related (n = 50)
Treatment related (n = 352)	Diagnosis related (n = 30)
Medication related (n = 141)	Medication related (n = 13)

Adapted from NPDB Public Use Data File, SPSS Version, Updated March 2012. Available at www.npdb-hipdb.hrsa.gov/resources/publicdata.jsp.

Table 3. Severity of Malpractice Injury Both Historically and Currently

Since 1990 (N = 2,187)	Since 2008 (N = 115)
Death (n = 350)	Death (n = 40)
Major permanent injury (n = 131)	Minor temporary injury (n = 23)
Significant permanent injury (n = 108)	Major temporary injury (n = 15)

Adapted from NPDB Public Use Data File, SPSS Version, Updated March 2012. Available at www.npdb-hipdb.hrsa.gov/resources/publicdata.jsp.

Table 4. Top 3 States With the Most Malpractice Cases Historically and Currently

Since 1990 (N = 2,187)	Since 2008 (N = 115)
Florida (n = 173)	Florida (n = 9)
Alabama (n = 151)	California (n = 8)/Colorado (n = 8)
New York (n = 87)	Texas (n = 6)

Adapted from NPDB Public Use Data File, SPSS Version, Updated March 2012. Available at www.npdb-hipdb.hrsa.gov/resources/publicdata.jsp.

Table 5. Comparison of Claims Payout Over the Past 20 Years and Current 5 Years

	Since 1990 (N = 2,187)	Since 2008 (N = 115)
Mean	$233,292.56	$133,672.61
Median	$97,500.00	$47,500.00
Mode	$47,500.00	$97,500.00

Adapted from NPDB Public Use Data File, SPSS Version, Updated March 2012. Available at www.npdb-hipdb.hrsa.gov/resources/publicdata.jsp.

While the malpractice situation may appear bleak, there is some hope for better times. First, data from the NPDB clearly show that patients are more likely to settle a malpractice claim than go to trial. Approximately 98% of all claims are settled before trial.[13] In the past 5 years, the mean payout has also decreased. Table 5 shows the comparison between the past 20 years and the current 5 years. The decrease in the mean payment is due to the fact that there have been no multimillion-dollar settlements or judgments during this time—those high outlier payments boost the mean. That is why it is important when reviewing data to look at the mode to get a better overview of the actual paid amounts. Because the mode identifies the most common score in the data, it provides a better estimate. A single multimillion-dollar award will increase the mean.

Another positive outcome is that 86.1% of paying entities are either the primary insurer or a self-insured organization. This also provides indirect evidence that NPs are either buying their own malpractice insurance or are being insured by their employers. With our litigious society, it is extremely important that all NPs be insured through some mechanism, whether by their employer or self-insurance.

REFLECTIONS

The NPDB was established to protect patients from incompetent providers.[2] Errors happen regardless of our diligence. However, keeping in mind the previously mentioned causes for litigation, remember that the key to prevention is to listen to your patients and make them an integral part of any care plan. When they feel ignored, they begin to think *lawsuit*.

If you do make an error, document it as soon as it is discovered and seek counsel from your employer or risk management team as to how to handle the specific situation. Do not speak to any lawyer without having your own counsel present. Make sure that your insurer knows your wishes and find out from the insurer's attorney how he or she proposes to handle the case.

If you are reported to the NPDB, remember that you have a right to know the conditions under which the report occurred and ask to see the file so that you can correct any errors that might be present. The NPDB is not a punitive entity; it is simply another mechanism that the government has put in place to protect patients. Above all, do what you do best—care for your patients. JNP

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