



Physician data profiling proliferates

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For many years, various groups have attempted to expand the availability of physician data to the public. These groups have argued that consumers should have the right to make informed decisions when selecting a physician and, therefore, should have access to such facts as a physician's disciplinary actions, license status, malpractice data, and so on. In addition, the advent of the Internet and the ease with which such information can be made available has driven the trend to transparency with regard to all types of information.

Organized medicine successfully kept a lid on the release of most information until recently, although many states provided basic information (such as disciplinary actions taken against physician licensees) on written or telephone requests from consumers. Then, in 1990, the lid was blown off with the implementation of the National Practitioner Data Bank (NPDB), a federal repository administered by the Department of Health and Human Services that collects information on adverse licensure actions, professional liability payments, clinical privileges actions, and professional society membership actions taken against physicians and dentists. Only selected entities were granted access to the information contained in the NPDB.

In 1996, the Commonwealth of Massachusetts became one of the first states to implement a comprehensive physician profiling program available to consumers through the Internet. Many other states have adopted similar systems. According to an editorial in the January 15, 2001, *USA Today* (p. 12A), physician profiles are available in 30 states, with legislation pending in eight others. In addition, during its final days, the 106th Congress considered a number of bills that would have granted nationwide public access to the information contained in the NPDB; none of the bills passed.

Another factor fueling the debate over the release of physician profiles to the public is patient safety. Since the 1999 release of the Institute of Medicine's report *To Err Is Human: Building a Safer Health System*, many legislators, regulators, and consumer groups have come to see public availability of physician profiles as one aspect of improving patient safety.

This article reviews the status of physician data

profiling requirements in the states and highlights legislative activity taking place in 2001.

Profiling already in place

Most states that offer physician data profiles to the public make this information available through their Web sites, usually the Board of Medicine or Board of Medical Examiners home page. Searching the database generally requires entry of the last and first name of the physician, although a few states also provide a search field for the physician's medical license number. In those cases where multiple physicians have the same name, such as Joseph Jones or William Smith, a drop-down menu shows all of the names, and the correct one can then be selected.

A Web site that serves as a central source for 17 states is the Administrators in Medicine (AIM) DocFinder Web site,¹ found at www.docfinder.org/. This site is maintained by the Association of State Medical Board Executive Directors and provides links to the states' medical board Web sites. DocFinder also helps provide some standards in terms of information formats and types of physician information provided to consumers, most commonly including name and address/location of the physician; license number; status, date issued, and expiration date; medical school and specialty; and disciplinary actions taken against the physician. Beyond these common data fields, information may include CME, whether or not the physician accepts Medicare or Medicaid, telephone/fax numbers, hospitals where the physician may have privileges, and malpractice information.

The 17 states that participate in the DocFinder Web site are **Alabama, Arizona, California, Colorado, Iowa, Kansas, Maine, Maryland, Massachusetts, Minnesota, North Carolina, North Dakota, Ohio, Oregon, Rhode Island, Texas, and Vermont**. In addition, Oklahoma provides a link from the DocFinder Web site to its osteopathic board Web page, and the Washington link connects to the Medical Quality Assurance Commission Web page, which provides a telephone number and address for consumers to call or write to request information on physicians.

States that provide extensive physician profiles but are not part of the DocFinder Web site

include **Florida, Idaho, and Tennessee**. The Florida Department of Health is responsible for that state's physician profile system and has divided the information into the following categories: practitioner information; education and training; professional and postgraduate training; specialty; optional information (professional or community service awards, publications, languages, other affiliations, e-mail address, and other state licensure); financial responsibility (describing level of malpractice coverage); criminal offenses; final disciplinary action within the last 10 years; and liability claims exceeding \$5,000 within the last 10 years (with a general disclaimer statement).²

Idaho provides profiles on a number of health care professionals besides physicians. Information pertaining to physicians is categorized as follows: education; specialty certification(s); special positions (professional membership, medical school faculty, and so on); location and practice history; primary admitting hospital; Medicaid/Medicare; translating services; criminal history; board or other disciplinary history; professional liability insurance; malpractice and settlement history (with footnotes); and professional ownership in facilities, laboratories, and so on.³

In Tennessee, licensed health care providers are required to complete a profile questionnaire. Information in the practitioner profile includes: name, address, and languages; graduate/postgraduate education and training; specialty board certification; faculty appointments; staff privileges; final disciplinary actions; criminal offenses; liability claims (with disclaimer statement); and optional information (publications, awards, and so on).⁴

Meanwhile, two states are in the process of implementing physician data profile systems. **Virginia** passed a law in 1998, and **New York** passed one in 2000. Under the Virginia statute, physician profiles will include information similar to that required by Florida, Idaho, and Tennessee (including malpractice and settlement data). However, Virginia also asks for the names of insurance plans accepted and managed care plans in which the physician participates and requires that any changes in the information contained in the profile be reported to the Board of Medicine within 30 days.⁵

In late 2000, New York's governor signed Senate Bill 8127, the "Patient Health Information and Quality Improvement Act of 2000." This legislation included the provision of physician profiles as part of a larger patient safety initiative (which included hospital and health plan report cards, a study of physician credentialing, creation of a patient safety center, and patient privacy requirement). When implemented, the physician profiles will include, in addition to information common to those in Florida, Idaho, and Tennessee, detailed information on disciplinary actions, malpractice awards and settlements listed in graduated categories as compared with those of other physicians in the same specialty, and criminal convictions.

State legislative activity in 2001

Confirming the continued strong interest in the issue of physician data profiling, a number of state legislatures considered legislation to collect these data and provide them to the public. In some cases, these bills were tied to patient safety or patient safety legislation was introduced as a "vehicle" bill to be amended later in the legislative session, creating a physician data profiling system. Those states with pending legislation include **Arkansas, Georgia, Hawaii, Illinois, Indiana, New Jersey, New Mexico, Ohio, Oregon, Pennsylvania, West Virginia, and Wisconsin**.

Other profiling activity

The Federation of State Medical Boards (FSMB) has collected information on disciplinary actions taken against physicians since 1912 and has developed the All Licensed Physicians Project. This project creates a national database (the Federation Physician Data Center) containing biographical, educational, licensure, and disciplinary information on physicians licensed to practice medicine in the U.S.⁶ This information was made available to the public in January 2001 through the FSMB Web site at a cost of \$9.95 per report.⁷

Profiling experience

During debate over the development of physician profiling systems, numerous pros and cons were discussed by many interested parties. Consumer groups felt that access to physician information, including disciplinary actions and mal-

practice data, was important to help consumers select competent physicians and to protect consumers from “bad” physicians. State government entities, charged with protecting the public health and welfare through licensure and discipline of licensed professionals, felt great pressure to protect the public by providing it with physician information.

Organized medicine, however, felt that providing all types of information, including malpractice settlements and awards, would not be accurate, reliable, or relevant. There was concern that consumers would not understand the complexities of the civil justice system, especially malpractice information, and would think that because a physician had a number of malpractice settlements during a certain time period that he or she was a “bad” or incompetent physician. Concern was also expressed with regard to the reporting of loss or modification of hospital privileges without adequate explanation, as this can be done for administrative or economic credentialing reasons and not necessarily for reasons of physician competence. In addition, it was felt that some information, such as participation in Medicaid, which health plans the physician contracts with, and so on, might not be appropriate because they can change rapidly, making the information in the profile inaccurate. Personal information, such as home address and telephone, should not be included, as this could lead to a dangerous situation for a physician and his or her family.

Open to the public for five years, the Massachusetts Physician Profile System, which includes malpractice information, has the longest track record for this activity. In its first full year of operation (1998), the Massachusetts Board of Registration in Medicine took almost 30,000 telephone calls, received 1.6 million hits on the Web site, and faxed out 58,000 profiles. In 2000, the Web site received about 3 million hits. The executive director of the board also notes that in her opinion, the profiles are “an essential part of the health care environment.”⁸ Although the Massachusetts Medical Society originally had many concerns with the profile system, physicians are now living with it and believe it is working.⁹

An important element of the Massachusetts sys-

tem is the statement included in the section of the physician profile pertaining to malpractice information. This statement, which could be part of any state legislation requiring inclusion of malpractice information in physician profiles, states:

Some studies have shown that there is no significant correlation between malpractice history and a doctor’s competence. At the same time, the board believes that consumers should have access to malpractice information. In these profiles, the board has given you information about both the malpractice history of the physician’s specialty and the physician’s history of payments. The board has placed payment amounts into three categories: below average, average, and above average. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high quality care by selecting a doctor based solely on malpractice history.

- When considering malpractice data, please keep in mind: Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares doctors only to the members of their specialty, not to all doctors, in order to make individual doctor’s [sic] history more meaningful.

- This report reflects data for the last 10 years of a doctor’s practice. For doctors practicing less than 10 years, the data covers their total years of practice. You should take into account how long the doctor has been in practice when considering malpractice averages.

- The incident causing the malpractice claim may have happened years before a payment is finally made. Sometimes, it takes a long time for a malpractice lawsuit to move through the legal system.

- Some doctors work primarily with high-risk patients. These doctors may have malpractice histories that are higher than average because they specialize in cases or patients who are at very high risk for problems.

- Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that

medical malpractice has occurred.

You may wish to discuss information provided in this report, and malpractice generally, with your doctor. The board can refer you to other articles on this subject.¹⁰

Principles for profiling systems

Discussion of physician profiling systems and the NPDB took place during the AMA's Interim House of Delegates meeting held in December 2000. Delegates accepted the recommendations contained in AMA Board of Trustees Report 31-I-00, which included the policy that the AMA strongly support and actively encourage the provision of accurate and relevant physician-specific information through a system developed and operated by state licensing boards or other appropriate state agencies. Under the adopted recommendations in this report, the AMA believes this information should include felony convictions of physicians reported to state medical boards. In addition, the AMA believes that since serious problems exist in correlating lawsuits with physician competence or negligence and some studies indicate lawsuits seldom correlate with findings of incompetence, only a state licensing board should determine when lawsuit settlements and judgments should result in a disciplinary action, and public disclosure of lawsuit settlements and judgments should only occur in connection with a negative state medical board licensing action.¹¹

ACS views

The College has not adopted a formal position on state profiling systems. At the federal level, however, the College has successfully opposed opening the NPDB to the public, despite the attempts of several lawmakers. The College has argued that Congress created the NPDB for the limited purpose of serving as a flagging mechanism for state licensing boards, health plans, and hospitals. In addition, the College believes that the data contained in the NPDB is incomplete and often inaccurate. A November 2000 report from the General Accounting Office confirmed the College's view of the data. As such, the College firmly believes that this flawed information should not be used to measure physician competence. Finally, the College does not support the inclusion

of residents in the data bank, as they do not have ultimate authority over patient care and are generally named in lawsuits because of trial lawyers' efforts to name all possible defendants.

Because the NPDB will remain an important issue for the foreseeable future, the College will continue to advocate on behalf of its Fellows and continue to oppose the opening of the NPDB to the public. □

Author's note

The ACS *Health Policy Brief*, "Physician Data Profiling," provides a more detailed review of physician profiling systems instituted by various state medical licensing boards. This publication is available on the ACS Web site at http://www.facs.org/about_college/acdsept/hpa_dept/hpa_pubs/pubs.html.

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