Equitable Peer Review and the National Practitioner Data Bank

The General Accounting Office (GAO) recently reported that Department of Veterans Affairs (VA) did not report most physicians whose clinical care was found to be, or suspected of being, substandard to the National Practitioner Data Bank (NPDB) or to state licensing boards (1). The GAO examined 5 VAMCs and found required reviews of 148 providers' clinical care after concerns were raised from October 2013 through March 2017. Of the 148, 5 were subjected to adverse privileging actions and 4 resigned or retired while under review but before adverse actions were taken. Only 1 of these 9 was reported to the NPDB and none was reported to his or her state medical board.

In response to GAO's report and in testimony to the Subcommittee on Oversight and Investigations, VA officials said the agency was taking three steps to improve reporting of providers who don't meet required standards:

1. Reporting more clinical occupations to the NPDB;
2. Improving the timeliness of reporting;
3. Enhancing oversight to ensure that no settlement agreements waive the VA's ability to report to NPDB and state licensing boards (2).

What is lacking in the report is determination if substandard actually occurred and how it was determined. The VA has 3 ways of identifying substandard care (1).

1. Tort claims (the VA equivalent of a medical malpractice lawsuit);
2. Complaints or incident reports;
3. Peer review.

Each has major problems of accuracy and fairness at the VA.

The majority of US physicians have been sued (3). The minority of suits are associated with malpractice and malpractice has no apparent association with the outcome of the litigation (4). Over 90% of medical malpractice cases are settled out of court (5). A common misconception is that settling a case before trial means a large financial settlement. However, 90% of the 90% or 82% of all claims, close with no payment (5). However, the VA uses US District Attorney to defend malpractice claims (6). In many instances, the US District Attorney's office settles the case without determining if there is malpractice. The VA then submits the offending physician(s) name to the NPDB or state boards whether malpractice has been shown or not.

Complaints or incident reports are common in many hospitals, and many, if not most, have little merit (7). However, the weight given to a complaint should be viewed differently depending on the source. When colleagues raise concern about a physician's care this is more credible than a patient complaining about not receiving their narcotics to a patient advocate. In the GAO report it is unclear if this was a source the of possible substandard care.

Lastly, there is peer review. There are several problems with this process in the VA. The VA selects the “peers”. In many instances the reviewers are un- or under-qualified to review the case (6). Furthermore, the selected reviewers may be conflicted clouding a balanced and fair determination if the physician’s care met the standard of care. There are multiple instances of this at the VA, of which a couple have been cited in the SWJPCC (6).

No surprisingly, a bureaucracy in the federal government has suggested a bureaucratic solution to a nonexistent problem. The goal should not be for more bureaucratic reporting, but a system for determining if a physician’s care has met the standard of care. The VA has shown it is incapable of making this determination fairly and accurately. What is needed is an outside review separated from VA influence and politics. If malpractice is still questioned after an initial VA review, the medical schools or private practioners could provide a source of physician peer review. The case could be presented to a panel of non-VA physician peers chosen in an equitable ratio by the VA and the accused practitioner. In the absence of a more equitable review process, the VA will only succeed in driving away the quality practitioners the veterans need.

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