

National Practitioner Data Bank 1999 Annual Report



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National Practitioner Data Bank 1999 Annual Report

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Executive Summary

The National Practitioner Data Bank (NPDB) has maintained records of licensure, clinical privileges, professional society membership, and Drug Enforcement Agency (DEA) actions taken against health care practitioners and malpractice payments made for their benefit since its opening on September 1, 1990. Since 1997 the NPDB also has contained reports of exclusions from participation in the Medicare and Medicaid programs. This report highlights the NPDB's activities and accomplishments during 1999 by reviewing the operational improvements realized and presenting program statistics. In addition, an overview of NPDB guidelines is presented, and the issues impacting reporting trends are discussed.

Operational Improvements

During 1999, the NPDB continued improving its policies and operations. Improvements during 1999 included:

- Continued development of the Healthcare Integrity and Protection Data Bank (HIPDB)
- Development and implementation of the Consolidated Adverse Action Report
- Development and implementation of the new Internet-based Integrated Query and Report System (IQRS)
- Initiation of re-registration of all NPDB registered entities in conjunction with opening of the HIPDB
- Improved NPDB-HIPDB Internet site with guidance materials and forms on the Internet
- Consideration of proposed Corporate Shield regulations
- NPDB *Guidebook* revision

- Imposition of sanctions under the NPDB's confidentiality provisions
- Initiation of a malpractice payment reporting review
- Clarification of requirements concerning reporting adverse clinical privileging actions and contract terminations to the data banks

Reports

By December 31, 1999, the end of its 112th month of operations, the NPDB contained reports on 227,541 reportable actions, malpractice payments, and Medicare/Medicaid exclusions involving 145,537 individual practitioners. Of the 145,537 practitioners reported to the NPDB, 71.9 percent were physicians (including M.D. and D.O. residents and interns), 14.7 percent were dentists (including dental residents), and 13.4 percent were other health care practitioners. About two-thirds of physicians with reports (67.2 percent) had only one report in the NPDB; 86.3 percent had two or fewer reports, 97.8 percent of physicians with reports had five or fewer and 99.7 percent had 10 or fewer. Notably, few physicians had both malpractice payment and reportable action reports. Only 5.1 percent had at least one report of both types.

During 1999, approximately 71.0 percent of all reports concerned malpractice payments, although cumulatively malpractice payments comprised 75.8 percent of all reports. The fact that a smaller percentage of reports concern malpractice payments in 1999 than cumulatively reflects the addition of almost 13,000 Medicare/Medicaid exclusions which were not included in the NPDB before 1997. During 1999, physicians were responsible for 79.5 percent of all malpractice payment reports. Dentists were responsible for 12.4 percent, and all other health care practitioners were responsible for the remaining 8.1 percent. These figures are similar to the percentages from previous years.

Cumulatively, the median payment for physicians was \$93,150 (\$100,000 adjusting for inflation to standardize payments made in prior years to 1999 dollars) and the mean malpractice payment for physicians was \$196,863 (\$213,335 adjusting for inflation).¹ Both the mean and the median payments for 1999 were higher than the cumulative figures. During 1999, as in previous years, obstetrics-related cases, which represented approximately 8.1 percent of all physician malpractice payment reports, had the highest median and mean payment amounts (\$200,000 and \$361,852 respectively). However, the median obstetrics-related payment for physicians was unchanged in 1999 from 1997 and 1998, but the mean was over \$26,000 lower than in 1998. Incidents relating equipment/product reports had the lowest mean and median payments during 1999 (\$25,000 and \$62,76 respectively). For all malpractice payments made during 1999, the mean delay between an incident which led to a payment and the payment itself was 4.47 years. This is a 1.8 percent decrease in the average duration of cases from 1998 (4.55 years). The 1999 mean payment delay varied markedly between the States, as in previous years, and ranged from 2.91 years in Minnesota to 6.48 years in West Virginia.

¹ Generally for malpractice payment data the median is a better indicator of the "average" or typical payment than is the mean since the means are skewed by a few very large payments.

Reportable actions (licensure, clinical privileges, professional society membership, and DEA actions) represent 18.6 percent of all reports received from September 1, 1990 through December 31, 1999 and 21.1 percent (5,272 of 26,797) of all reports received by the NPDB during 1999. The 5,272 reportable action reports received during 1999 are 1.6 percent fewer than the record number of reportable actions submitted to the NPDB during 1998. During 1999, licensure actions comprised 78.5 percent of all reportable actions and clinical privileges reports comprised 19.6 percent.

The Health Resources and Services Administration (HRSA) continues to be concerned about the low level of clinical privileges actions reported by hospitals and other clinical privileges reporters such as health maintenance organizations. Nationally over the history of the NPDB, there are 3.8 times more licensure reports than clinical privileges reports. Moreover, 59.5 percent of the hospitals currently in “active” registered status with the NPDB have *never* submitted a clinical privileges report. Clinical privileges reporting seem to be concentrated in a few facilities even in States which have comparatively high overall clinical privileging reporting levels. There was general agreement at a 1996 HRSA-sponsored conference on the issue of hospital clinical privileges reporting that the level of reporting is unreasonably low. During 1999 HRSA continued supervision of two contracts for research into this issue, which resulted in development of a model state adverse action reporting statute and model regulations as well as a report and an article on the issue in *JAMA*.²

A number of other issues are discussed in this Annual Report. These issues include reporting of malpractice payments made for the benefit of resident physicians and nurses and the use of the “corporate shield” to avoid reporting malpractice payments.

Queries

From September 1, 1990 through December 31, 1999, the NPDB had responded to over 19.3 million inquiries (queries) from authorized organizations such as hospitals, managed care organizations (HMOs, PPOs, and group practices), State licensing boards, professional societies, and individual practitioners seeking to review their own records. During 1999, entity query volume increased 2.1 percent, from 3,155,558 queries in 1998 to 3,222,348 queries in 1999. Although the number of mandatory hospital queries increased by 21.0 percent from 1995 to 1999, the increase in the number of voluntary queries (queries by all registered entities other than hospitals) has been much greater. From 1995 to 1999 there was a 59.7 percent increase in voluntary queries, from 1,332,600 to 2,128,492. During 1999, 66.1 percent of queries were submitted by voluntary queriers; cumulatively from September 1, 1990 through December 31, 1999 well over half (55.8 percent) of the queries were submitted by voluntary queriers. Of the voluntary queriers, managed care organizations are the most active. Although they represent 19.1 percent of all entities which have queried the NPDB through December 31, 1999, they had made 44.2 percent of all queries cumulatively. These organizations made 51.7 percent of all queries during 1999.

² Baldwin, LM, Hart G, Oshel RE, Fordyce MA, Cohen R, Rosenblatt, R. Hospital Peer Review and the National Practitioner Data Bank. *JAMA*. 1999; 282: 349-54.

Matches

When a query is submitted concerning a practitioner who has one or more reports in the NPDB, a “match” is made, and the querier is sent copies of the reports. As reports naming additional practitioners are submitted to the NPDB and as more queries are made, both the number and rate of matches increases. During 1999 a total of 401,277 matches were made on entity queries; thus, almost 12.5 percent of all entity queries resulted in a match. Cumulatively 1,869,712 matches have been made on entity queries; the match rate from the opening of the NPDB through the end of 1999 is 9.8 percent. Self-query matches also have increased steadily. Cumulatively 24,132 of 306,119 self-queries have been matched for a cumulative 7.9 percent self-query match rate. During 1999 there were 3,406 self-query matches out of 38,777 self-queries, for a match rate of 8.8 percent.

Disputes and Secretarial Reviews

A practitioner who is reported to the NPDB may dispute the report. The practitioner may dispute either the contents of the report or the fact that a report was filed at all. If the disagreement is not resolved between the practitioner and the reporter, the practitioner may ultimately request a review of the report by the Secretary of Health and Human Services. At the end of 1999, 4.1 percent (1,631) of all licensure reports, 16.0 percent (1,378) of all clinical privileges reports, and 4.3 percent (7,407) of all malpractice payment reports in the NPDB were in dispute. Only a few practitioners who dispute reports also request Secretarial Review. There were only 91 requests for Secretarial Review during 1999. Although reportable actions represent only 19.7 percent of all 1999 reports, they were responsible for 71.4 percent of all requests for Secretarial Review. Of the 91 requests for Secretarial Review received during the year, 60 cases were resolved by the Secretary before the end of the year. Of these, 21.7 percent were resolved in favor of the practitioner or the entity voluntarily changed the report in a way that was acceptable to the practitioner. Cumulatively, 18.3 percent of 1,204 resolved requests for Secretarial Review have been decided in favor of the practitioner or changed by the reporting entity in a way which satisfies the practitioner.

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National Practitioner Data Bank 1999 Annual Report



Introduction: The NPDB Program

The National Practitioner Data Bank (NPDB) was established to implement the Health Care Quality Improvement Act of 1986, Title IV of P.L. 99-660, as amended (the HCQIA). Enacted on November 14, 1986, the Act authorized the Secretary of Health and Human Services to establish a national data bank to ensure that unethical or incompetent physicians, dentists, and other types of health care practitioners do not compromise health care quality. It was intended that such a data bank would restrict the ability of unethical or incompetent practitioners to move from State to State without disclosure or discovery of previous damaging or incompetent performance.

The HCQIA also includes provisions that encourage the use of peer review. Peer review bodies and their members are granted immunity from private damages if their review actions are conducted in good faith and in accordance with established standards. However, entities found not to be in compliance with NPDB reporting requirements may lose immunity for three years.

Administration and Operation of the NPDB Program

The Division of Quality Assurance (DQA) of the Bureau of Health Professions (BHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (DHHS), is responsible for the administration and management of the NPDB program. The NPDB itself is operated by a contractor. SRA International, Inc. (SRA) began operating the NPDB in June 1995.³ SRA has made such significant improvements to the NPDB's computer system that it has been termed the "second generation" NPDB system. Circle Solutions, Inc., is a subcontractor to SRA for operation of the NPDB Help Line.

³ SRA replaced Unisys Corporation, which had operated the NPDB from its opening on September 1, 1990.

An Executive Committee advises the contractor on operation and policy matters. The committee, which usually meets semiannually with both contractor and HRSA personnel, includes representatives of various health professions, national health organizations, State professional licensing bodies, malpractice insurers, and the public.

The Role of the NPDB

The NPDB is a central repository of information for: (1) malpractice payments made for the benefit of physicians, dentists, and other health care practitioners; (2) licensure actions taken by State medical boards and State boards of dentistry against physicians and dentists; (3) professional review actions primarily taken against physicians and dentists by hospitals and other health care entities, including health maintenance organizations, group practices, and professional societies; (4) actions taken by the Drug Enforcement Agency (DEA), and (5) Medicare/Medicaid exclusions.⁴ Information is collected from private and government entities, including the Armed Forces, located in the 50 States and all other areas under the jurisdiction of the United States.⁵

Information reported to the NPDB is made available upon request to registered entities which are eligible to query (State licensing boards, professional societies, and other health care entities which conduct peer review, including HMOs, PPOs, group practices, etc.) or are required to query (hospitals). These entities query concerning practitioners who currently have or who are requesting licensure, clinical privileges, or professional society membership. The NPDB's information is intended to alert querying entities of possible problems in a practitioner's past so they may undertake further review of a practitioner's background as they deem necessary. The information is intended to augment and verify, not replace other sources of information. The NPDB was designed as a flagging system; it was not designed to collect and disclose the full record concerning reported incidents or actions. *It also is important to note that the NPDB does not have information on reportable actions taken or malpractice payments made before September 1, 1990, the date the NPDB opened.* As reports accumulate over time, the value of the NPDB as an information source will continue to increase.

⁴ Hospitals and other health care entities also may voluntarily report professional review (clinical privileges) actions taken against licensed health care practitioners other than physicians and dentists.

⁵ In addition to the 50 States, the District of Columbia, and Armed Forces installations throughout the world, entities eligible to report and query are located in Puerto Rico, the Virgin Islands, American Samoa, the Federated States of Micronesia, Guam, the Northern Mariana Islands, and Palau.

How the NPDB Protects the Public

Although the Act does not provide for the release of practitioner-specific NPDB information to the public, the public benefits from the NPDB's existence. Licensing authorities and peer reviewers now have information needed to identify possibly incompetent or unprofessional physicians, dentists, and other health care practitioners. They can use this information to make licensing and credentialing decisions to protect the public. In addition, to help the public better understand medical malpractice and disciplinary issues, the NPDB responds to individual requests for statistical information, conducts research, publishes articles, and presents educational programs. A Public Use File containing selected information from each report in the NPDB also is made available.⁶ This file can be used to analyze NPDB statistical information. For example, researchers could use the file to compare malpractice payments made for the benefit of physicians to those made for physician assistants in terms of numbers of payments, dollar amounts of payments, and types of incidents that led to payments. Similarly, health care entities could use the file to identify particular problem areas in the delivery of health care services so they could target quality improvement actions toward these problem areas.

How the NPDB Obtains Information

The NPDB receives three types of information: (1) reports on "adverse" actions, (2) reports on malpractice payments, and (3) Medicare/Medicaid exclusion reports.

Adverse action reports must be submitted to the NPDB in several circumstances.

- When a State medical board or State board of dentistry takes certain licensure disciplinary actions, such as revocation, suspension, or restriction of a license, for reasons related to a practitioner's professional competence or conduct, a report must be filed with the NPDB. Revisions to previously reported actions also must be reported.
- A clinical privileges report must be filed with the NPDB when (1) a hospital, HMO or other health care entity takes certain professional review actions which adversely affect for more than 30 days the clinical privileges of a physician or dentist with a staff appointment or clinical privileges, or when (2) a physician or dentist voluntarily surrenders or restricts his or her clinical privileges while under investigation for possible professional incompetence or improper conduct in return for an entity discontinuing the investigation. Revisions to previously-reported actions also must be reported. Clinical privileges adverse actions also may be reported for health care practitioners other than physicians and dentists, but such reports are not required.

⁶ Information that would identify individual practitioners, patients, or reporting entities other than State Licensing Boards is not released to the public in either the Public Use File or in statistical reports. The Public Use File may be obtained from the National Technical Information Service. For Information call 703-605-6000 or visit the Internet web site <http://www.ntis.gov/fpcp/cpn8158.htm>. For a detailed listing of the variables and values for each variable in the Public Use File, visit the Internet web site <http://www.npdb-hipdb.org/docs/publicuse.htm>.

- When a professional society takes a professional review action which adversely affects the membership of a physician or dentist, that action must be reported. Revisions to actions also must be reported. Such actions also may be reported for health care practitioners other than physicians or dentists. Revisions to previously-reported actions also must be reported.
- When the Drug Enforcement Agency takes action to revoke the DEA registration (“number”) of a practitioner, a report is filed.

Malpractice payment reports *must* be submitted to the NPDB when an insurance company or self-insured entity (but not a self-insured individual⁷) makes a payment of any amount for the benefit of a physician, dentist, or other licensed health care practitioner in settlement of, or in satisfaction of, a judgment or malpractice action or claim.

When the Department of Health and Human Services excludes a practitioner from Medicare or Medicaid reimbursement, the exclusion is reported to the NPDB, published in the Federal Register, and posted on the Internet. Placing the information in the NPDB makes it conveniently available to queriers, who do not have to search the *Federal Register* or the Internet to find out if a practitioner has been excluded from participation in these programs. Queriers receive exclusion information along with other reports when they query the NPDB on individual practitioners.

Requesting Information from the NPDB

Hospitals, certain health care entities, State licensure boards, and professional societies may request information (“query”) from the NPDB. Hospitals are routinely *required* to query the NPDB for information. Malpractice insurers are not eligible to query the NPDB.⁸

A hospital *must* query the NPDB:

- When it is considering a physician, dentist, or other health care practitioner for a medical staff appointment or for clinical privileges; and
- At least once every 2 years concerning any physician, dentist, or other health care practitioner who is on its medical staff or has clinical privileges at the hospital.

⁷ Self-insured practitioners originally reported their malpractice payments. However, on August 27, 1993, the U.S. Court of Appeals for the D.C. Circuit reversed the December 12, 1991, Federal District Court ruling in *American Dental Association, et al., v. Donna E. Shalala*, No. 92-5038, and held that self-insured individuals were not “entities” under the HCQIA and did not have to report payments made from personal funds. All such reports have been removed from the NPDB.

⁸ Self-insured health care entities may query for peer review purposes but not for “insurance” purposes.

A hospital *may* query the NPDB at any time with respect to its professional review activity.

Other eligible entities *may* request information from the NPDB.

- Boards of medical or dental examiners or other State licensing boards may query at any time.
- Health care entities such as HMOs, preferred provider organizations, and group practices may query under the following circumstances: (1) when entering an employment or affiliation arrangement with a physician, dentist, or other health care practitioner; (2) when considering an applicant for medical staff appointment or clinical privileges; (3) or when conducting peer review activity. To be eligible, such entities must both provide health care services and have a formal peer review process for the purpose of furthering the quality of health care.
- Professional societies may query when screening applicants for membership or in support of peer review activities.

The NPDB also may be queried in two other circumstances.

- A physician, dentist, or other health care practitioner may “self-query” the NPDB concerning himself or herself at any time. Practitioners may not query to obtain the records of other practitioners.
- An attorney for a plaintiff in a malpractice action against a hospital may query and receive information from the NPDB concerning a specific practitioner in very limited circumstances. In cases where plaintiffs represent themselves, they may obtain information for themselves. This is possible when independently obtained evidence is submitted to DHHS disclosing that the hospital failed to make a required query to the NPDB on the practitioner. If it is demonstrated that the hospital failed to query as required, the attorney or plaintiff will be provided with the information the hospital would have received had it queried.

Querying Fees

As mandated by law, all NPDB costs are recovered from user fees; taxpayer funds are not used to operate the NPDB. The NPDB fee structure is designed to ensure that the NPDB is self-supporting. All queriers are required to pay a fee for each practitioner about whom information is requested. The base entity query fee is \$4.00 per name for queries submitted via modem and paid for electronically. This was necessary due to the increases in telecommunications charges and other operational costs. A surcharge of \$3.00 is applied for queries submitted on diskettes to cover extra handling involved. Self-queries were provided at no charge to practitioners until 1999, when a \$10.00 fee was established to cover their cost. Self-queries are expensive to processes since they require some manual processing. All query fees must be paid by credit card at the time of query submission or through prior arrangement for automatic electronic funds transfer. Because of the high costs involved in maintaining a billing system used by relatively few queriers, the NPDB discontinued its billing system during 1999.

Confidentiality of NPDB Information

Under the terms of the HCQIA, information contained in the NPDB which permits identification of any particular practitioner, entity, or patient is confidential. The Department of Health and Human Services has implemented this requirement by designating the NPDB as a confidential "System of Records" under the Privacy Act of 1974. Authorized queriers who receive information from the NPDB must use it solely for the purposes for which it was provided. Any person who violates the confidentiality of NPDB information is subject to a civil money penalty of up to \$11,000 for each violation.

The Act does *not* provide for disclosure by the NPDB of information on a specific practitioner to medical malpractice insurers or the public. Federal statutes provide criminal penalties, including fines and imprisonment, for individuals who knowingly and willfully query the NPDB under false pretenses or who fraudulently gain access to NPDB information. In addition, there are similar criminal penalties for individuals who knowingly and willfully report to the NPDB under false pretenses.

Accuracy of NPDB Information

Reports to the NPDB are entered *exactly* as received from reporters. To ensure the accuracy of reports, each practitioner reported to the NPDB is notified that a report has been made and is provided a copy of the report. Since March 1994, the NPDB has allowed practitioners to submit a statement expressing their view of the circumstances surrounding any malpractice payment or adverse action report concerning them. The practitioner's statement is disclosed whenever the report is disclosed. If a practitioner decides to dispute the accuracy of information in the report in addition to or instead of filing a statement, the practitioner is requested to notify the NPDB that the report is being disputed. The report in question is then noted as under dispute when it is released in response to queries. The practitioner also must attempt to work with the reporting entity to reach agreement on revision or avoidance of a disputed report. If a practitioner's concerns are not resolved by the reporting entity, the practitioner may request that the Secretary of Health and Human Services review the disputed information. The Secretary then makes the final determination concerning whether a report should remain unchanged, be modified, or be voided and removed from the NPDB.

Federal Participation in the NPDB

Federal agencies and health care entities participate in the NPDB program. Section 432(b) of the Act prescribes that the Secretary shall seek to establish a Memorandum of Understanding (MOU) with the Secretary of Defense and with the Secretary of Veterans Affairs to apply provisions of the Act to hospitals, other facilities, and health care providers under their jurisdictions. Section 432(c) prescribes that the Secretary also shall seek to enter into an MOU with the Administrator of the Drug Enforcement Administration (Department of Justice) concerning the reporting of information on physicians and other practitioners whose registration to dispense controlled substances has been suspended or revoked under section 304 of the Controlled Substances Act.

The Secretary signed an MOU with the Department of Defense on September 21, 1987, with the Drug Enforcement Administration on November 4, 1988, and with the Department of Veterans Affairs on November 19, 1990. In addition, MOUs with the U.S. Coast Guard (Department of Transportation) and with the Bureau of Prisons (Department of Justice) were signed on June 6, 1994 and August 21, 1994, respectively. Policies under which the Public Health Service participates in the NPDB were implemented on November 9, 1989 and October 15, 1990.

Under an agreement between HRSA, the Health Care Financing Administration, and the Office of Inspector General, Medicaid and Medicare exclusions were placed in the NPDB in March 1997 and have been updated monthly. Reinstatement reports were added in October, 1997. The reports include all exclusions as of the date they are submitted to the NPDB regardless of when the penalty was imposed.

1999 NPDB Improvements

The ninth full year of operation of the NPDB was marked by the following activities by the NPDB and the Department of Health and Human Services which have already or will in the future improve service to NPDB customers:

- Continued development of the Healthcare Integrity and Protection Data Bank HIPDB
- Development and implementation of the Consolidated Adverse Action Report
- Development and implementation of the new Internet-based Integrated Query and Report System (IQRS)
- Initiation of re-registration of all NPDB registered entities in conjunction with opening of the HIPDB
- Improved NPDB-HIPDB Internet site with guidance materials and forms on the Internet
- Consideration of proposed Corporate Shield regulations
- Revision of the NPDB *Guidebook*
- Imposition of sanctions under the NPDB's confidentiality provisions
- Initiation of a malpractice payment reporting review
- Clarification of requirements concerning reporting adverse clinical privileging actions and contract terminations to the data banks

Continued Development of the Healthcare Integrity and Protection Data Bank

The Secretary of the U.S. Department of Health and Human Services, acting through the Office of Inspector General was legislatively directed by the Healthcare Insurance Portability and Accountability Act of 1996 to create a fraud and abuse data collection program to combat the escalating cost of fraud and abuse in health insurance care and delivery. Under an Interagency Memorandum of Understanding, the Division of Quality Assurance assumed responsibility to develop and maintain the Healthcare Integrity and Protection Data Bank (HIPDB). The HIPDB is a national program for the reporting and disclosure of certain final adverse actions and civil judgments (excluding malpractice payments and settlements in which no findings of liability have been made) taken against health care providers, suppliers, and practitioners.

The HIPDB is designed to serve as a flagging system for health plans, regulatory agencies, and law enforcement officials. It will contain data on Federal and State agency adverse actions, including licensing and certification information; Medicare, Medicaid, and other exclusions from participation in Federal programs; Federal and State health care criminal convictions; and health care civil judgments other than malpractice payments made against health care providers, suppliers, and practitioners. The data contained in the system is intended to be used in combination with information from other sources to determine employment, licensure/certification, and contracting.

Using appropriated funds rather than NPDB revenues to pay for the work, SRA International, Inc., the current NPDB contractor, continued developing the new HIPDB computer system during 1999 using the NPDB computer system as its model. The HIPDB opened for reporting on November 22, 1999. It will open for querying by authorized entities in the spring of 2000.

Development and Implementation of the Consolidated Adverse Action Report

Some of the types of reports to be included in the HIPDB (primarily licensure reports concerning physicians and dentists) are also required to be reported to the NPDB. An important principle in the design of the new HIPDB computer system is that entities which must report an action to both data banks should have to file only one report, which the computer will route to both data banks for them. Since the data elements to be reported are slightly different for the two data banks, a new Consolidated Adverse Action Report (CAAR) electronic "form" was developed to accommodate all the reporting requirements of both data banks.

Development and Implementation of the IQRS Internet-based Reporting System

The NPDB has used a private data network provided first by CompuServe and then by National Computer Systems and General Electric Information Services since electronic querying was implemented in 1993. The NPDB provided registered users with "QPRAC" software which they installed on their computers to access the network and query and, in more recent years, report to the NPDB. The private data network and QPRAC were substantial improvements over the original paper-based querying and reporting systems. However, they are expensive and unnecessarily complex for users when compared to Internet-based systems.

During 1999 the NPDB completed development of the first phase of its new Internet-based Integrated Query and Report System (IQRS). The IQRS began operation for reporting with limited test operation for querying on November 22, 1999. Registered entities can use any Internet browser with 128 bit encryption (e.g., Netscape and Internet Explorer) to access the NPDB-HIPDB web site and, after entering their entity identification and password, complete malpractice payment or adverse action report forms on-line. They can submit the forms immediately or save drafts for later correction and submission.

After filing, they receive electronic confirmation of the report and can print a copy for mailing to the appropriate State licensing board, as required by law and regulations.

Initiation of Re-registration of All NPDB Registered Entities in Conjunction with Opening the HIPDB

The NPDB has periodically required all registered entities to re-register. This keeps registration information reasonably current. The opening of the HIPDB and the desire to minimize duplication of the querying and reporting burden on entities which are required to report to both data banks or are eligible to query both led to initiation of a re-registration during the summer of 1999. A new consolidated registration package, including a form which collects all information needed to establish registration eligibility for both data banks was created and mailed to all NPDB registered entities as well as to entities which were believed to be eligible to register with the HIPDB. As of December 31, 1999, a total of 9,165 entities had registered or re-registered. Of the entities which had re-registered, 9,020 were eligible to report to or query the NPDB. Re-registration efforts continued into 2000.

Improved NPDB-HIPDB Internet Site with Guidance Materials and Forms

The NPDB and the Division of Quality Assurance undertook a major initiative to make information about the NPDB conveniently available on the Internet. The legislation which led to the establishment of the NPDB, regulations, and notices of proposed regulations, the NPDB *Guidebook*, NPDB Annual Reports, fact sheets, and other guidance were made available at <http://npdb-hipdb.org>. Forms used by the NPDB, including the self-query form, may also be obtained on the Internet. Reports, including Malpractice Payment Reports and Consolidate Adverse Action Reports, may be filed directly over the Internet by registered entities using the IQRS.

Consideration of Proposed Corporate Shield Regulations

Malpractice payment reporting may be affected by use of the “corporate shield.” Attorneys for some practitioners who would otherwise be reported to the NPDB have worked out settlements in which only co-defendant health care organizations (e.g. hospitals or group practices) are named. This is most common when the defendant organization is responsible for the malpractice coverage of the co-defendant employee practitioner (i.e., the defendant organization is self-insured). Under current NPDB regulations, if a practitioner is named in the claim but not in the settlement, no report is required to be filed with the NPDB unless the practitioner is excluded from the settlement as a condition of the settlement. The Department published a Notice of Proposed Rulemaking (NPRM) for public comment on December 24, 1998 to require more complete reporting. The proposed regulations would require reports naming the practitioners whose acts or omissions were the basis of the claim or action, regardless of whether or not they were named as defendants. The Department received numerous public comments opposed to the specific provisions of the NPRM. At the end of 1999, a *Federal Register* notice to withdraw the NPRM awaited clearance by the Office of Management and Budget. The Division of Quality Assurance proceeded with plans to develop a better solution. One meeting was held with the NPDB Executive Committee. Further activities in support of closing the corporate shield loophole are planned for 2000.

Revision of the NPDB *Guidebook*

The Introduction and Eligible Entities chapters of the NPDB *Guidebook* were updated and placed on the NPDB website. The updated Introduction chapter provided clarifications on the NPDB’s confidentiality provisions. The Eligible Entities chapter provided clarification on the NPDB’s eligibility criteria, particularly as it relates to managed care organizations. Additional updates to the NPDB *Guidebook* are planned for 2000.

Imposition of Sanctions under the NPDB’s Confidentiality Provisions

The HHS Inspector General imposed a civil money penalty of \$42,500 in a case involving allegations of unauthorized queries to the NPDB by a Credentials Verification Organization (CVO). The NPDB’s authorizing statute, the *Health Care Quality Improvement Act of 1986*, as amended, provides for a significant civil money penalty for *each* violation of the NPDB’s confidentiality provisions. The Inspector General has the authority to impose a civil money penalty for such violations, which include improper disclosure, or use of, or access to NPDB information. The allegations in this case involved the CVO making queries to the NPDB on behalf of an eligible entity when those queries were not duly authorized by the eligible entity.

Queries into the NPDB are restricted by statute to hospitals, other health care entities, state licensing boards, and professional societies. CVOs, physician recruitment firms, and physician placement services are not eligible to access information in the NPDB under their own authority. These organizations and other organizations that do not meet the statute's specific query eligibility criteria may only interact with the NPDB as Authorized Agents. Authorized Agents may only query the NPDB with the authorization of an eligible entity (i.e., the eligible entity must designate the Authorized Agent to act on its behalf by completing the *Authorized Agent Designation* form) for specifically designated and limited purposes.

Potential violations of the NPDB's confidentiality provisions are referred to the Inspector General for further investigation.

Initiation of a Malpractice Payment Reporting Review

The Division of Quality Assurance obtained information reported by malpractice insurance companies to the National Association of Insurance Commissioners (NAIC) concerning payments made for physicians during 1998 and began a pilot project to reconcile the summary information reported to the NAIC with information contained in their NPDB reports of individual payments. DQA began making inquiries to malpractice insurance companies which reported payments to the NAIC but did not report to the NPDB or for which there were discrepancies between what was reported to the NPDB and the NAIC. This effort will continue in 2000 and be expanded to cover additional reporting years.

Clarification of Requirements Concerning Reporting Adverse Clinical Privileging Actions and Contract Terminations to the Data Banks

Due to the preamble language in the HIPDB final regulations (45 CFR Part 61) which specifically excludes adverse clinical privileging actions taken by Federal or State agencies and "paneling actions" taken by health plans from reporting to the HIPDB, policy guidance was written to provide guidance on reporting adverse clinical privileging actions to the NPDB and contract terminations to the HIPDB. The termination of a practitioner's contract to provide health care services by a health plan or Federal or State agency is reportable to the HIPDB if it meets the definition of an "other adjudicated action." The termination of the contract, in itself, is not reportable to the NPDB. The termination of a practitioner's clinical privileges because of the termination of the contract for reasons relating to professional competence or professional conduct is reported to the NPDB if it is considered a professional review action by the NPDB reporter. In some situations, one incident may result in a separate report to each Data Bank; the contract termination is reported to the HIPDB and the clinical privileging action to the NPDB.

NPDB Operations: Reports, Queries, Matches, Entities, and Disputes

This section primarily discusses descriptive statistics concerning 1999 reports, queries, matches, disputes, and Secretarial reviews. For comparative purposes, information is provided for each of the most recent five years (1995 through 1999) as well as cumulatively from the opening of the NPDB on September 1, 1990 through December 31, 1999.

Reports

Tables 1 through 6 present data on practitioners reported and reports received by the NPDB through December 31, 1999 by report type.⁹ Table 1 shows the number of practitioners, by type, with reports in the NPDB, the number of reports in the NPDB for each type of practitioner, and the ratio of reports per practitioner. There are more physicians with reports than any other type of practitioner. Physicians also have more reports per practitioner than have any other type of practitioners, an average of 1.65 reports per each reported physician. Dentists are second, with 1.53 reports per each reported dentist. Comparison between physicians and dentists and other types of practitioners, however, is misleading since reporting of licensure, clinical privileges, and professional society membership actions is required only for physicians and dentists.

Tables 2 through 6 provide information by type of report (medical malpractice payments and “adverse actions” involving licensure, clinical privileges, professional society membership, or the DEA actions, as well as Medicare/Medicaid exclusions. It should be noted that some “adverse action” reports are not “adverse” to the practitioner involved and concern reinstatements, reductions of penalties, or reversals of previous actions.¹⁰ Therefore, the term “reportable actions” is used unless non-adverse actions are excluded. Table 2 shows the number and percent distribution of reports received by type of report.

⁹ All report statistics in this document concern disclosable reports — reports which would be disclosed in response to a query — in the NPDB as of December 31, 1999. This does not directly measure the workload of the NPDB in processing reports. It excludes, for example, incomplete reports submitted but rejected and reports which were received but later voided. In the case of modified reports, the report as modified is included in the statistics for the year the original report was submitted, not the year the modification was submitted. This is a change from the way modified reports were counted in previous NPDB Annual Reports. Statistics for 1998 and earlier years may also differ slightly from those reported in previous Annual Reports because reports voided during 1999 are no longer included in counts.

¹⁰ Of the 33,124 reported licensure actions in the NPDB, 3,137 reports or 9.5 percent were for licenses reinstated or restored. Of the 8,587 reported clinical privileges actions, 566 reports or 6.6 percent concerned reductions, reinstatements, or reversals of previous actions. Of the 312 reported professional society membership actions, 11 reports or 3.5 percent were reinstatements or reversals of previous actions. None of the 294 reported Drug Enforcement Agency Reports were considered non-adverse. Of the 12,717 exclusion reports, 1,007 or 7.9 percent are reinstatements.

Malpractice Payments

Data from Table 2, as illustrated in Figure 1, show that, for each year, medical malpractice payment reports (MMPRs) represent, by far, the greatest proportion of reports contained in the NPDB. Cumulative data show that at the end of 1999, 75.8 percent of all the NPDB's reports concerned malpractice payments. During 1999 itself, the NPDB received 19,039 such reports (71.0 percent of all reports received). Medicare/Medicaid Exclusion reports (MMERs) were first placed in the NPDB in 1997. Reports that year included practitioners excluded in previous years and not yet reinstated, thus 1997 reporting statistics are not comparable to those of previous or later years. If MMERs are excluded, then malpractice payments constitute 78.3 percent of 1997 reports, 76.7 percent of 1998 reports, and 78.3 percent of 1999 reports. MMPRs steadily decreased as a percentage of all reports (excluding MMERs) for the five years prior to 1999 and then increased slightly during 1999.

Figure 1: Number and Type of Reports Received by the NPDB

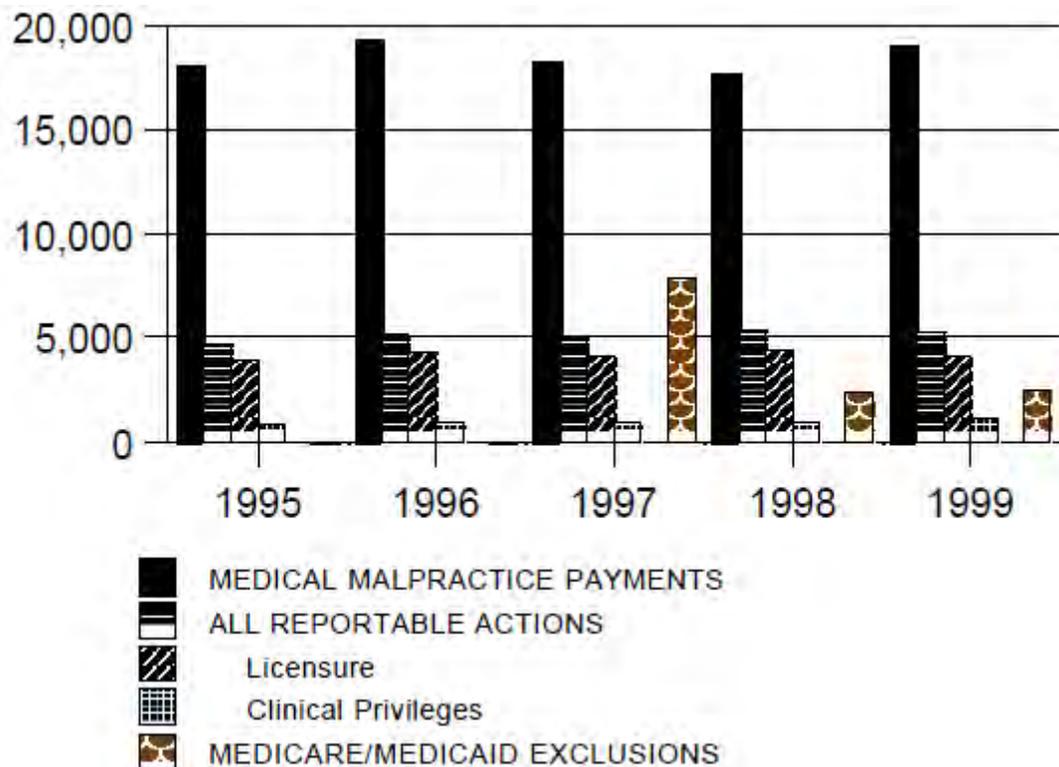


Table 3 shows the percent change by report type from year to year. State licensure action reporting was at a record high level in 1998 but decreased in 1999 back to levels more typical of earlier years. The apparent large decrease in exclusion reports for 1998 and 1999 as compared to 1997 reflects the fact that the count for 1997 reflects both 1997 exclusions and exclusions in earlier years for practitioners who had not been reinstated. Thus the 1998 and 1999 exclusion counts, which include only actions reported during the respective years, are not comparable to the count for 1997.

Table 4 shows malpractice payment reports for all types of practitioners¹¹ during the most recent five years and cumulatively. Although only physicians and dentists must be reported to the NPDB if a reportable action is taken against them, all health care practitioners must be reported to the NPDB if a malpractice payment is made for their benefit. Cumulatively, physicians were responsible for 133,630 (77.5 percent) of the NPDB's malpractice payment reports while dentists were responsible for 24,731 reports (14.3 percent), and all other types of practitioners were responsible for 14,083 reports (8.2 percent). Practitioner type was not specified in 0.03 percent of malpractice payment reports. The number of malpractice payments reported in 1999 (19,039) increased by 7.6 percent over the number reported during 1998 (17,692). During 1999, physicians were responsible for 15,142 malpractice payment reports (79.5 percent of all malpractice payment reports received during the year). The number of physician malpractice payments reported increased 7.45 percent from 1998 to 1999. Dentists were responsible for 2,352 malpractice payment reports (12.4 percent). "Other practitioners" were responsible for 1,532 malpractice payment reports (8.0 percent).

Malpractice Payment Reporting Issues

Two aspects of malpractice payment reporting are of particular interest to reporters, queriers, practitioners, and policy makers. First, the "corporate shield" issue reflects possible under-reporting of malpractice payments. The second, the reporting of physicians in residency programs, concerns the appropriateness of reporting malpractice payments made for the benefit of physicians in training who are supposed to be only acting under the direction and supervision of attending physicians.

¹¹ Allopathic physicians; allopathic interns and residents; osteopathic physicians; and osteopathic physician interns and residents are all considered physicians for statistical purposes. Dentists and dentist residents are considered dentists for statistical purposes. For statistical purposes, the "other" category includes all remaining practitioner types which may be reported to the NPDB: pharmacists; pharmacists (nuclear); pharmacy assistants; registered (professional) nurses; nurse anesthetists; nurse midwives; nurse practitioners; licensed practical or vocational nurses; nurses' aides; home health aides (homemakers); psychiatric technicians; dieticians; nutritionists; EMT, basic; EMT, cardiac/critical care; EMT, intermediate; EMT, paramedic; social workers, clinical; podiatrists; clinical psychologists; audiologists; art/recreation therapists; massage therapists; occupational therapists; occupational therapy assistants; physical therapists; physical therapy assistants; rehabilitation therapists; speech/language pathologists; medical technologists; nuclear medicine technologists; cytotechnologists; radiation therapy technologists; radiologic technologists; acupuncturists; athletic trainers; chiropractors; dental assistants; dental hygienists; denturists; homeopaths; medical assistants; mental health counselors; midwives, lay (non-nurse); naturopaths; ocularists; opticians; optometrists; orthotics/prosthetics fitters; physician assistants; physician assistants, osteopathic; perfusionists; podiatric assistants; professional counselors; professional counselors (alcohol); professional counselors (family/marriage); professional counselors (substance abuse); respiratory therapists; respiratory therapy technicians; and any other type of health care practitioner which is licensed in one or more States.

“Corporate Shield”

Malpractice payment reporting may be affected by use of the “corporate shield.” Attorneys for some practitioners who would otherwise be reported to the NPDB have worked out settlements in which the name of health care organizations (e.g. hospitals or group practices) is substituted for the name of the practitioner. This is most common when the health care organization is responsible for the malpractice coverage of the practitioner. Under current NPDB regulations, if a practitioner is named in the claim but not in the settlement, no report is required to be filed with the NPDB unless the practitioner is excluded from the settlement as a condition of the settlement.

The Department of Defense (DOD) and the Department of Veterans Affairs (DVA) currently use a variant of the “corporate shield” when reporting malpractice payments made by the Federal government for care provided by their practitioners. These practitioners are protected from malpractice claims made against them personally for work performed as part of their government duties. The DOD reports malpractice payments to the NPDB only if the Surgeon General of the affected military department (Air Force, Army, or Navy) concludes on the basis of three criteria that the payment should be reported. Analysis of DOD reports indicates that the Surgeons General of the three military departments apply these criteria differently. DVA uses a similar process in determining whether to report a malpractice payment.

The extent to which the “corporate shield” is used cannot be measured with available data. Use of the “corporate shield” masks the extent of substandard care as measured by individual malpractice payments reported to the NPDB. It also reduces the usefulness of the NPDB as a flagging system.

Malpractice Payments for Physicians in Residency Programs

The reporting of malpractice payments made for the benefit of residents is an issue that continued to be of interest during 1999 as it was in earlier years.¹² Some argue that since residents act under the direction of attending physicians, as long as they are acting within the bounds of their residency program, residents by definition are not responsible for the care provided. Therefore, regardless of whether or not they are named in a claim for which a malpractice payment is ultimately made, they should not be reported to the NPDB. The Health Care Quality Improvement Act, however, makes no exceptions for malpractice payments made for the benefit of residents. Payments for residents must be reported to the NPDB. At the end of 1999 the NPDB contained 1,270 malpractice payments made for the benefit of residents and interns (both M.D. and D.O.) out of 133,630 total payments for the benefit of physicians including interns and residents. Thus payment reports for residents represent less than 1.0 percent of malpractice payments for physicians. A total of 1,164 interns and residents were responsible for the 1,270 payments. Most physicians with at least one payment for an incident while they were an intern or resident (1,103)

¹² Fischer, J.E. and Oshel, R.E. The National Practitioner Data Bank: What You Need to Know. Bulletin of the American College of Surgeons. June 1998, 83:2; 24-26. Fischer, J.E. The NPDB and Surgical Residents. Bulletin of the American College of Surgeons. April 1996. 81:4; 22-25. Ebert, P.A. As I See It. Bulletin of the American College of Surgeons. July 1996. 81:7; 4-5. See also reply by Chen, V. and Oshel, R. Letters, Bulletin of the American College of Surgeons, January 1997. 82:1; 67-68.

have had only one such; 53 have two payments reported for incidents while they were an intern or resident, 3 have had three such payments reported, 1 had four, and 1 had forty-five.¹³

Reportable Actions

Licensure, clinical privileges, professional society membership disciplinary actions, actions taken by the DEA concerning authorization to prescribe controlled substances, and revisions to such actions must be reported to the NPDB if they are taken against physicians and dentists. As shown in Table 2, reportable actions represent 19.7 percent of all reports received by the NPDB during 1999 and, cumulatively, 18.6 percent of all reports in the NPDB. The number of reportable action reports received decreased by 88 reports to a total of 5,272 (a 1.6 percent decrease) from 1998 to 1999 (Table 3). This followed a 5.5 percent increase in reportable actions from 1997 to 1998. The 5,360 reportable action reports received during 1998 was the largest number of such reports received in any single year to date.

During 1999, licensure actions made up 78.5 percent of all reportable actions and 15.4 percent of all NPDB reports (including malpractice payments and Medicare/Medicaid exclusions). As shown in Table 5, licensure actions continue to represent the majority of reportable actions (cumulatively 78.3 percent of all reportable actions). Licensure reports decreased by 6.0 percent in 1999 compared to 1998. Licensure reports for physicians decreased by 8.2 percent in 1999. Licensure reports for dentists, in contrast, increased by 1.8 percent. Licensure reports for physicians constituted 77.8 percent of all licensure reports in 1999.

The number of clinical privileges actions increased substantially from 1998 to 1999. There were 871 such reports in 1998 and 1,052 in 1999, an increase of 20.8 percent. Physician clinical privileges reports increased by 17.0 percent and voluntarily submitted clinical privileges reports for non-physician/non-dentists increased by 138.2 percent to a total of 81. Clinical privileges actions represented 20.0 percent of all 1999 reportable action reports and 3.9 percent of all 1999 NPDB reports.

In 1999, professional society membership actions and Drug Enforcement Agency (DEA) reports combined represented only 1.5 percent of reportable action reports and 0.3 percent of all NPDB reports. Professional society membership actions (only 18 reported) made up 0.3 percent of all reportable actions during 1999. Sixty-two DEA reports were received during 1999. The number of reported professional society and DEA actions has remained almost negligible throughout the NPDB's history. The greatest number of professional society membership actions and DEA actions submitted in one year was 100 in 1994.

Table 5 presents information on all types of reportable actions and on Medicare/Medicaid exclusion reports (MMER) by type of practitioner, type of report, and year. Physicians are responsible for the largest number of all reportable actions during 1999 and earlier years. During 1999, physicians were responsible for 77.8 percent of licensure actions, 90.4 percent of clinical privileges actions, 100 percent of professional society membership actions, and 88.7 percent of the

¹³ One individual had 45 payments. All of the 45 payments for this particular resident were for "Intravenous and Blood Products Related — Wrong Solution." Most were for amounts less than \$1,000 but one was for more than \$600,000.

DEA actions. In contrast, physicians were responsible for only 20.2 percent of the Medicaid/Medicare exclusion actions added to the NPDB during 1999.

Over the past few years physicians were more likely to have reports than were dentists. However, in 1999 physicians, who represent about 81.5 percent of the nation's total physician-dentist work force, were responsible for only 78.9 percent of licensure reports for physicians. They were responsible for 97.9 percent of all clinical privileges reports for physicians and dentists. This result is expected, however, since dentists frequently do not hold clinical privileges at a health care entity and thus could not be reported for a clinical privileges action.

Dentists, who comprise approximately 18.5 percent of the nation's total physician-dentist work force, during 1999 were responsible for 21.1 percent of physician and dentist licensure actions, 2.1 percent of clinical privileges actions,¹⁴ no professional society membership actions, 9.7 percent of DEA actions (6 such actions), and 25.8 percent of exclusion reports for physicians and dentists. The number of dental licensure reports has generally grown slightly each year, and 1999 represents the greatest number of dental licensure actions submitted to the NPDB in a single year (863 reports).

Voluntary reporting of reportable actions against "other practitioners" was not a significant source of reportable action reports to the NPDB during 1999. Only 138 reportable action reports were voluntarily submitted for "other practitioners." No professional society membership actions are contained in the NPDB for practitioners other than physicians or dentists. However, "other practitioners" accounted for the majority of Medicare/Medicaid exclusion reports (72.8 percent of 2,486 reports) added to the NPDB during 1999. Nurses and nurse's aides were responsible for 1,279 reports (70.7 percent of "other practitioner" exclusions and 51.4 percent of all exclusions reported during 1999). Chiropractors were the next largest group. They were responsible for 229 exclusions during 1999 (12.7 percent of "other practitioner" exclusions and 9.2 percent of all exclusions).

Actions Reporting Issue: Under-reporting of Clinical Privileges Actions

There is general agreement that the level of clinical privileges reporting shown in Tables 2 and 3 is unreasonably low. This could reflect either an actual low number of actions taken (perhaps because hospitals substituted non-reportable actions for reportable actions) or failure to file reports concerning reportable actions taken, or both. In October 1996, the Northwestern University Institute for Health Services Research and Policy Studies, under contract with the Health Resources and Services Administration (HRSA), held a conference on clinical privileges reporting by hospitals. Participants included executives from the American Medical Association; the American Osteopathic Association; the American Hospital Association; the Joint Commission on Accreditation of Health Care Organizations; the Health Care Financing Administration; the DHHS Office of Inspector General; the Division of Quality Assurance, Bureau of Health Professions (BHP), HRSA, DHHS (which manages the operations of the NPDB program); the Federation of State Medical Boards; Public Citizen Health Research Group; Citizen Advocacy Center;

¹⁴ This small percentage reflects the fact that relatively few dentists work in hospitals.

individual State hospital associations; individual hospitals; and hospital attorneys. The participants reached consensus that “the number of reports in the NPDB on adverse actions against clinical privileges is unreasonably low, compared with what would be expected if hospitals pursued disciplinary actions aggressively and reported all such actions.”¹⁵ There was also agreement that research was needed to better understand the perceived under-reporting so appropriate steps could be taken to improve reporting. The NPDB and the Division of Quality Assurance have been conducting research on the issue and working with relevant organizations to try to ensure that actions which should be reported actually are reported. The 20.8 percent increase in clinical privileges reporting during 1999 may reflect the results of this effort. However, even with the observed increased reporting, the number of clinical privileges actions reported remains unreasonably low.

Tables 6 and 7 shed additional light on the low level of reporting of clinical privileges actions by hospitals. Table 6 lists for each State the number of non-Federal hospitals with “active” NPDB registrations and the number and percent of these hospitals that have *never* reported to the NPDB. These percentages range from 31.8 percent in New Jersey to 83.9 percent in Tennessee. Nationally, as of December 31, 1999, 59.5 percent of non-Federal hospitals registered with the NPDB and in “active” status had *never* reported a clinical privileges action to the NPDB. Analysis in previous years has shown that clinical privileges reporting seem to be concentrated in a few facilities even in States which have comparatively high over-all clinical privileges reporting levels. This pattern may reflect a willingness (or unwillingness) to take reportable clinical privileges actions more than it reflects a concentration of problem physicians in only a few hospitals.

Table 7 compares licensure reporting and clinical privileges reporting by State. The ratio of adverse clinical privileges reports (excluding reinstatements, etc.) to adverse licensure reports (again excluding reinstatements, etc.) ranges from a low of 1 adverse clinical privileges report for every 7.07 adverse licensure reports in Mississippi to a high of 1 adverse clinical privileges report in Nebraska for every 0.96 adverse licensure reports (i.e., more adverse clinical privileges reports than adverse licensure reports). While these ratios reflect variations in the reporting of both licensure actions and clinical privileges actions, the extreme variation from State to State is instructive. It seems extremely likely that the extent of the observed differences reflect variations in willingness to take actions rather than such a substantial difference in the conduct or competence of the practitioners practicing in the various States.

¹⁵ Institute for Health Services Research and Policy Studies, Northwestern University. HRSA Roundtable Conference Report.

Reports Analysis

Data on malpractice payments and reportable actions can be examined in many ways to discover patterns and relationships. In this report we have chosen to highlight several issues. First, we discuss the variations among the States in the frequency of reportable actions, frequency of malpractice payments, malpractice payment amounts, and incident-to-payment delays. The relationship between malpractice payments and reportable action reports is then examined. Third, information regarding physicians with multiple reports in the NPDB is discussed. In addition we present some discussion of malpractice payments for nurses in relation to both reason for payments and State of practice and the reasons for payments for physician assistants. We do not discuss physician assistants payments by state because of the relatively few such payments which are made.

State Reporting Rates: Malpractice Payments

Table 8 shows the number of medical malpractice payment reports for physicians and dentists from September 1, 1990 through December 31, 1999 by State (generally the State in which the practitioner maintained his or her practice at the time the incident took place)

Table 8 also includes the “adjusted” number of payments, which excludes malpractice payments made by State patient compensation funds and similar State funds. Nine States¹⁶ have or had such funds, and most fund payments pertain to practitioners practicing in these States. Usually when payments are made by these funds, two reports are filed with the NPDB (one from the primary insurer and one from the fund) whenever a total malpractice settlement or award exceeds a maximum set by the State for the practitioners’ primary malpractice carrier. These funds sometimes make payments for practitioners reported to the NPDB as working in other States. Payments by the funds are excluded from the “adjusted” column so that malpractice incidents are not counted twice. *Although the “adjusted” is the best available indicator of the number of distinct malpractice incidents which result in payments, it is an imperfect measure.* Some state funds are the primary insurer and only payer for some claims. Since these payments cannot be readily identified, they are excluded from the “adjusted” column even though they are the only report in the NPDB for the incident. The “adjusted” column also does not take into account insurers of last resort which in most cases provide primary coverage but in other cases provide secondary coverage for payments over primary policy limits and report these over-limits payments.¹⁷

In addition to presenting by State the cumulative number of payments and the adjusted number of payments for both physicians and dentists, Table 8 shows the ratio of payments for dentists to payments for physicians. Nationally, using the adjusted numbers, there is about 1 dental payment for every 5 physician payments. In Utah, however, there has been 1 dentist payment for every 2.4 physician payments. In California there is one dental payment for about every 3 physician payments. In Mississippi, North Dakota, West Virginia, and Wyoming there is less than

¹⁶ Florida, Indiana, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania, South Carolina, and Wisconsin.

¹⁷ Kansas is an example of a state in which the fund is the primary carrier in some cases; the Kansas fund is the primary carrier for payments for practitioners at the University of Kansas Medical Center. New York is an example of a state with an insurer of last resort which sometimes provides over-limits coverage but usually is a practitioner’s primary insurer.

1 dental payment for every 10 physician payments. It should be noted that in States with relatively few physicians or dentists, the number of payments sometimes are heavily impacted by large numbers of reports for a single practitioner, which can skew comparisons between states. For example, the high ratio of dental payments to physician payments in Utah is largely the result of a very large number of payments made for one dentist during 1994.

Table 9 and 10 present the annual number and adjusted number (as described above) of malpractice payment reports for physicians and dentists, respectively, by State for each of the last five calendar years. As noted above, the number of payments in any given year in a state may be impacted by unusual circumstances such as the settlement of a large number of claims against a single practitioner. State payment counts may also be substantially impacted by other reporting artifacts such as a reporter submitting a substantial number of delinquent reports at the same time. Indiana reporting, for example, was impacted by receipt of delinquent reports during 1996 and 1997.

It should also be noted that the number of payments in any given State is affected by the specific provisions of the malpractice statutes in each State. Statutory provisions may make it easier or more difficult for plaintiffs to bring a malpractice suit and obtain a payment. There are differences from State to State in the statute of limitations provisions governing when plaintiffs may sue. There also are differences in the burden of proof. In addition, some States limit payments for non-economic damages (e.g., pain and suffering). These limits may reduce the number of claims filed by reducing the total potential recovery and the financial incentive for plaintiffs and their attorneys to file suit. Sometimes changes in malpractice statutes may be responsible for changes in the number of payments within a state observed from year to year. Changes in State statutes, however, are unlikely to explain differences in payment trends observed for physicians and dentists within the same State. For example, the number of physician malpractice payments in New York has steadily increased over the past five years while the number of dentist payments has varied up and down over the period but was only slightly larger in 1999 than it was in 1995.

State Differences in Payment Amounts

State variations in mean and median malpractice payment amounts also are of interest. We examined all malpractice payment reports received by the NPDB between its opening and December 31, 1999. The results are shown in Table 11. Note that these numbers are not adjusted for the impact of State patient compensation and similar funds, which have the effect of lowering the observed mean and median payment. Because mean payments can be substantially impacted by a single large payment or a few such payments, a State's median payment is normally a better indicator of typical malpractice payment amounts. Half the payments are above the median and half are below. The cumulative median for the NPDB was \$63,000. The median payment in 1999 was \$85,000. The highest 1999 medians were found in the District of Columbia, Pennsylvania, Illinois, New Hampshire, and New Jersey, all of which had a median payment of \$150,000 or more. The lowest 1999 medians were found in California, Idaho, and Nebraska, all of which had median payments of \$30,000.¹⁸

¹⁸ The California median payment is artificially impacted by a State law which is commonly believed to require reporting to the State only of malpractice payments of \$30,000 or more. During 1999, 147 (6.7 percent) of California's 2,205 malpractice payments were for \$29,999. Only one payment during 1999 elsewhere in the country was for \$29,999. Another 93 California payments were for exactly \$30,000, which is immediately below the actual reporting

The cumulative mean malpractice payment for the NPDB was \$165,732. Adjusted for inflation, assuming 1999 dollars for all payments, the mean payment was \$179,868. The mean payment during 1999 was \$195,093. During 1999 mean payments ranged from lows of \$94,195 in Michigan and \$94,521 in Nebraska to highs of \$407,398 in Connecticut and \$374,785 in Washington, D.C. Note that the ranking of States by median payment amounts does not take into account the fact that two separately reported payments may be made for some malpractice claims in States with patient compensation funds and other similar payers. The median (and mean) payment amounts for these States would be higher if a single report were filed showing the total payment for the claim from all payers.

State Differences in Payment Delays

There also are substantial differences between the States in how long it takes to receive a malpractice payment after an incident occurs (payment delay). For all reports received from the opening of the NPDB through December 31, 1999, the mean delay between incident and payment was 4.64 years. For 1999 payments, the mean delay was 4.47 years. Thus during 1999, payments were made on average about two months quicker than the average for all payments. On average, during 1999, payments were made most quickly in Idaho (3.01 years). Payments were slowest in West Virginia (6.48 years). Average payment delays increased by 1.8 months in 1999 compared to 1998. This is in contrast to a trend of decreasing payment delays in recent years.

Variations in Payment Amounts and Payment Delays for Different Types of Cases

Different types of malpractice cases are likely to have different payment amounts and varying payment delays. As shown in Table 12, which includes only payments for physicians, the NPDB categorizes malpractice events into ten broad categories. During 1999, incidents relating to equipment and product problems had the lowest median and mean payments (\$25,000 and \$74,395, respectively). The second lowest median and the lowest mean payment amounts for physicians were for miscellaneous incidents (\$27,500 and \$113,090 respectively). However, there were only 58 equipment and product reports and only 187 miscellaneous reports. Together these categories represent only 1.6 percent of all malpractice payments in 1999. As in previous years, obstetrics-related cases (1,231 reports; 8.1 percent of all malpractice payment reports) had by far the highest median and mean payments (\$200,000 and \$361,852 respectively).

The mean payment delay is shown in Table 13, which includes payments for all types of practitioners for each type of case. The 43 IV and blood products-related payments in 1999 (0.2 percent of all 1999 payments) had the longest mean delay between incident and payment (5.89 years), followed closely by 1,271 payments (6.7 percent) for obstetrics-related cases (5.86 years). The shortest average delay for 1999 payments was for miscellaneous cases (3.61 years). There were 316 such cases for all types of practitioners, representing 1.7 percent of all 1999 malpractice payments.

threshold. When these payments are combined with the \$29,999 payments, fully 10.9 percent of California malpractice payments are within \$2.00 of the State reporting threshold.

Adverse Licensure Reports for Physicians and Dentists Practicing In-State

Table 14 presents information on the cumulative number of licensure reports for physicians and for dentists by State. For both types of practitioners, data are presented for the total number of licensure reports, the number of licensure reports which are adverse (i.e., are not reinstatements, etc.), and the number of adverse licensure reports for in-State practitioners. Physicians and dentists are often licensed in more than one State. If one State takes a licensure action, other States often take a parallel action because of the first State's action. Typically the practitioner is actively practicing in the first State which takes action; actions taken by the other States in which the practitioner is licensed prevent the practitioner from moving back to those states and resuming practice, but these actions do not reflect the extent of actions taken by the boards in relation to problems occurring in their States.

For physicians, 89.6 percent of all licensure actions reported to the NPDB have been adverse in nature. For dentists, the 94.1 percent have been adverse. In Nevada and New Mexico 100 percent of the reported physician licensure actions have been adverse. This contrasts with South Carolina, in which only 72.3 percent of the physician licensure actions have been adverse.

We also examined the proportion of all physician licensure actions which are adverse and affect in-State physicians. Nationally 79.8 percent of licensure actions are both adverse and pertain to in-State physicians. The low was 53.3 percent in the District of Columbia and the high was 94.0 percent in Oregon.

For dentists, a 94.1 percent of all licensure actions reported to the NPDB have been adverse in nature. In eighteen States 100 percent of the reported physician licensure actions have been adverse. The low was Illinois for which only 71.6 percent of the dental licensure actions were adverse.

We also examined the proportion of all dentist licensure actions which are adverse and affect in-State dentists. Nationally 91.8 percent of licensure actions are both adverse and pertain to in-State dentists. The lows were 66.7 percent in Illinois and 66.0 percent in Utah. In ten states all dental licensure actions were adverse and pertained to in-State dentists.

Relationship between Malpractice Payments and Reportable Actions

Physicians with high numbers of malpractice payment reports tend to have at least some adverse actions reports and vice versa. Tables 15 and 16 show this data. For example, as shown in Table 15, although 95.4 percent of the 66,835 physicians with only one malpractice payment report in the NPDB have no reportable action reports, only 58.4 percent of the 178 physicians with ten or more malpractice payment reports have no reportable action reports. Generally, as a physician's number of malpractice payment reports increases, the likelihood that the physician has action reports also increases. Similarly, as shown in Table 16, there is a tendency for a smaller proportion of physicians to have no malpractice payment reports as their number of reportable action reports increases. However, the trend reverses for physicians with nine or more reportable action reports. One explanation may be that physicians with large numbers of reportable action reports leave the profession and no longer have the opportunity to be the targets of malpractice claims.

Physicians with Multiple Reports in the NPDB

A related area of interest is the number and percentage of practitioners with multiple malpractice payment or reportable action reports in the NPDB. As seen in Table 1, at the end of 1999, a total of 145,534 individual practitioners had disclosable reports in the NPDB. Of these, 104,678 (71.9 percent) were physicians. Most physicians (67.2 percent) with reports in the NPDB had only one report, but the mean number of reports per physician was 1.7. Physicians with exactly two reports made up 19.0 percent of the total. Over 99.6 percent of physicians with reports had nine or fewer reports. Only 405 physicians had ten or more reports. Of the physicians with disclosable reports, 82.3 percent had only malpractice payment reports; 6.7 percent had only licensure reports, 2.1 percent had only clinical privileges reports and 0.9 percent had only exclusion reports. Notably, only 3.9 percent had at least one malpractice payment report and at least one licensure report, and only 2.1 percent had at least one malpractice payment report and at least one clinical privileges report. Only 0.8 percent had malpractice payment, licensure, and clinical privileges reports. Only 0.1 percent had at least one malpractice payment, licensure action, clinical privileges action and exclusion report at the end of 1999.

Approximately 30.5 percent of the 91,613 physicians in the NPDB with at least one malpractice payment report had two or more malpractice reports. Over 52.3 percent of *all* physician malpractice payment reports in the NPDB concern physicians with at least two reports.

Malpractice Payments for Nurses

As reflected in requests for information made to the Division of Quality Assurance, there has been increasing interest in nurse malpractice payments. The NPDB classifies registered nurses into four categories: Nurse Anesthetists, Nurse Midwives, Nurse Practitioners, and Registered Nurses not otherwise classified, referred to in the tables as Registered Nurses. Malpractice Payments for nurses are relatively rare. As shown in Table 17, all types of Registered Nurses have been responsible for 2,842 malpractice payments (1.6 percent of all payments) over the history of the NPDB. Slightly fewer than two-thirds of the payments for nurses were made for non-specialized Registered Nurses. Nurse Anesthetists were responsible for 23.9 percent of nurse payments. Nurse Midwives were responsible for 7.2 percent, and Nurse Practitioners were responsible for 4.2 percent of all nurse payments. Monitoring, treatment, and medication problems are responsible for the majority of payments for non-specialized nurses, but obstetrics and surgery-related problems are also responsible for significant numbers of payments for these nurses. As would be expected, anesthesia-related problems are responsible for 85 percent of the 680 payments for Nurse Anesthetists. Similarly, obstetrics-related problems are responsible for 79.6 percent of the 206 Nurse Midwife payments. Diagnosis-related problems are responsible for 38.8 percent of the 129 payments for Nurse Practitioners. Treatment-related problems are responsible for another 26.4 percent of payments for these nurses.

As shown in Table 18, the median and mean payment for all types of nurses in 1999 was \$100,000 and \$290,697, respectively. The median is \$8,675 less than the median physician payment but the mean is \$63,958 larger than the mean physician payment in 1999. Similarly, the inflation-adjusted cumulative median nurse payment (\$74,309 is \$24,489 less than the \$100,000 inflation-adjusted cumulative median payment for physicians and the inflation-adjusted cumulative mean nurse payment of \$246,230 is \$47,457 larger than the cumulative mean physician payment.

Table 19 shows the cumulative nurse malpractice payment rate by State. An adjusted number is also provided to account for payments by State patient compensation and similar funds, but the adjustment accounts for only 1.6 percent of nurse payments. Vermont has no nurse malpractice payment reports. New Jersey has by far the most. The ratio of nurse payments to physician payments (using adjusted figures) for Vermont (zero) is obviously the lowest in the nation, but five states have fewer than one nurse payment for every 100 physician payments. In contrast, the ratio for New Jersey, which is the highest in the nation, is 7.3 per nurse payments for every 100 physician payments. Four other states also have ratios of more than 5 nurse payments for every 100 physician payments. Since the same malpractice statutes apply within a state for both physicians and nurses, this suggests that there may be substantial differences the safety of practice by nurses and physicians different states.¹⁹

Malpractice Payments for Physician Assistants

The Division of Quality Assurance has also had many requests for information on malpractice payments for physician assistants. As shown in Table 20, there are relatively few such payments. Physician Assistants have been responsible for only 379 malpractice payments since the opening of the NPDB (0.2 percent of all payments). Both cumulatively and during 1999, diagnosis-related problems were responsible for well over half of all physician assistant malpractice payments (52.5 percent cumulatively and 54.7 percent in 1999). Treatment-related payments were the second largest category both cumulatively and in 1999 (27.7 percent and 21.3 percent, respectively). Excepting one obstetrics-related payment and six monitoring-related payments, payments in the diagnosis category were responsible for the largest median payment (\$70,000).

Queries

Query data are presented in Table 21. A total of 3,222,348 entity requests for the disclosure of information (queries) were successfully processed by the NPDB during 1999. This is an average of over six queries every minute, 24 hours a day, 365 days a year, or one query about every 10 seconds. The number of queries in 1999 increased 0.7 percent from the 3,155,558 queries processed during 1998. It is also almost 3.9 times as many queries as the 809,844 queries processed during the NPDB's first full year of operation, 1991. Cumulatively, the NPDB had processed 19,019,945 entity queries by the end of 1999.

¹⁹ Other explanations may also be applicable; possible differences in the ratio of nurses to physicians in practice in the States may play a particularly important role. We have not explored these possible differences.

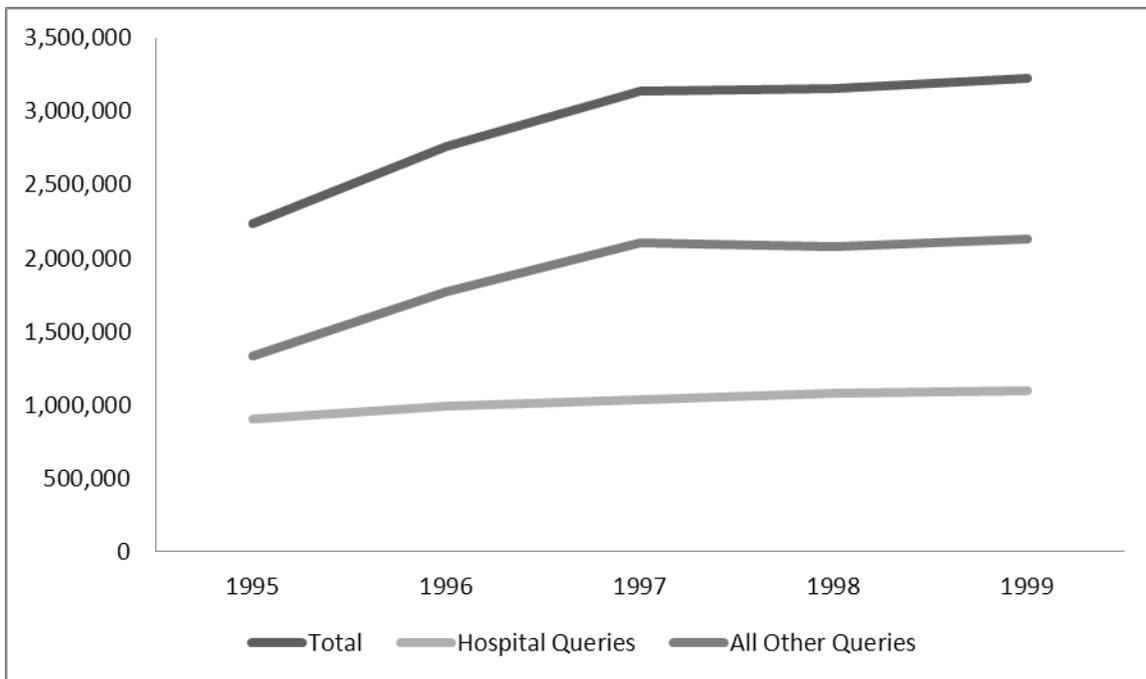
Practitioner self-queries also are shown in Table 21. Practitioners who want to verify their record (or lack of a record) in the NPDB can query on their own record at any time. Some State boards, which could query the NPDB, instead require practitioners to submit self-query results with license applications. During 1999, the NPDB processed 38,777 self-query requests. This was a decrease of 19.7 percent from the number of self-queries processed during 1998 and is a decrease of 26.3 percent from the record 52,603 self-queries processed during 1997. Only 3,406 (8.8 percent) of the self-query requests during 1999 were matched with reports in the NPDB. Cumulatively from the opening of the NPDB, 267,342 self-queries have been processed; 24,132 (7.9 percent) of these queries were matched with reports in the NPDB.

The NPDB classifies entity queries as “required” and “voluntary.” Hospitals are required to query for all new applicants for privileges or staff appointment and once every two years concerning their privileged staff. Hospitals voluntarily may query for other peer review activities, but for analysis purposes we assume that all hospital queries are required. Figure 2 shows querying volumes for the last five years. Hospitals made most of the queries to the NPDB in its first few years of operation. Although the number of hospital queries increased by 148 percent from the 739,265 in 1991 (the NPDB’s first full year of operation), to 1,093,856 queries in 1999, the increase in the number of voluntary queries has been much greater. These queries increased from 72,801 in 1991 to 2,128,492 in 1999, an increase of over 2,800 percent. Voluntary queries represented 66.1 percent of all entity queries during 1999 (Table 22).

The distribution of queries by querier type is shown in Table 22. Of the voluntary queriers, managed care organizations (defined for this purpose as entities registered as HMOs PPOs and Group Practices) are the most active. Although they represent 17.2 percent of all querying entities during 1999 and 19.1 percent of all entities which have ever queried the NPDB, they made 51.7 percent of all queries during 1999 and have been responsible for 44.2 percent of queries ever submitted to the NPDB. Other health care entities (i.e., non-hospitals and non-managed care organizations) made 13.6 percent of the queries in 1999 and 10.7 percent cumulatively. State licensing boards made 0.4 percent of queries during 1999 and 0.5 percent cumulatively.²⁰ Professional societies were responsible for 0.4 percent of all queries during 1999 and 0.3 percent of all queries cumulatively.

²⁰ The low volume of State board queries may be explained by the fact that entities are required to provide State Boards copies of reports when they are sent to the NPDB so the boards do not need to query to obtain reports for in-State practitioners and by the fact that some boards requires practitioners to submit self-query results with applications for licensure.

**Figure 2: Growth in Queries, by Querier Type
 1995-1999**



Queriers request information on many types of practitioners. Physicians are the subject of by far the most queries. Almost 80 percent of queries submitted during a sample period in late 1999 concerned physicians [allopathic physicians (MDs), osteopathic physicians (DOs), and interns and residents]. The second largest category, dentists, accounted for only 5.6 percent of all queries. Clinical psychologists accounted for 2.3 percent, clinical social workers accounted for 2.1 percent, chiropractors accounted for slightly more than 1.4 percent, and non-specialized registered nurses accounted for slightly less than 1.4 percent. No other categories of practitioners were responsible for as much as 1 percent of all queries.

Matches

When an entity submits a query on a practitioner, a “match” occurs when that individual is found to have a report in the NPDB. As shown in Table 21, the 401,277 entity queries matched during 1999 represents a match rate of 12.5 percent. Although the match rate has steadily risen since the opening of the NPDB, we hypothesize that it will plateau once the NPDB has been in operation the same length of time as the average practitioner practices, all other factors (such as malpractice payment rates for older and younger physicians) being equal.

About 87.5 percent of entity queries submitted receive a “no-match” response from the NPDB, meaning that the practitioner in question does not have a report in the NPDB. This does not mean, however, that there was no value in receiving these responses. During 1995 the Office of Inspector General completed an evaluation of the utility of the NPDB and found that 77 percent of the hospitals and 96 percent of the managed care organizations found “no match” responses useful,²¹ presumably because they confirm that practitioners have had no reports in over six years. At the end of 1999 a no-match response to a query confirmed that a practitioner has had no reports in over nine years. These responses will become even more valuable as the NPDB matures.

Registered Entities

All reporting and querying to the NPDB (except for practitioner self-querying) is performed by registered entities which certify that they meet the eligibility requirements of the Health Care Quality Improvement Act of 1986. Table 24 provides information on the more than 14,000 registered entities that have reported or queried at least once since the opening of the NPDB and those active as of December 31, 1999. Some entities have (or had in the past) multiple registration numbers either simultaneously or sequentially, so the numbers shown in Table 24 do not necessarily reflect the actual number of individual entities which have reported to or queried the NPDB. Hospitals make up the largest category of registered entities. At the end of 1999 hospitals accounted for 6,546 (50.8 percent) of the NPDB’s active registered entities. Hospitals made up 50.5 percent of the entities which had ever registered with the NPDB. HMOs, PPOs, and Group Practices accounted for 2,384 active registrations (18.5 percent) at the end of 1999. Other Health Care Entities held 3,464 active registrations (26.9 percent). The 196 malpractice insurers with active registrations accounted for only 1.5 percent of all active registrations. Other categories accounted for even smaller percentages of the NPDB’s active registrations at the end of 1999.

Disputed Reports and Secretarial Review

At the end of 1999, there were 1,631 licensure reports, 1,378 clinical privileges reports, 28 professional society membership reports, 13 DEA reports, and 7,407 malpractice payment reports under dispute by the practitioners named in the reports. Medicare/Medicaid exclusion reports cannot be disputed with the NPDB. Disputed reports constitute 4.1 percent of all licensure reports, 16.0 percent of all clinical privileges reports, 8.7 percent of professional society membership reports, 4.4 percent of DEA reports, and 4.3 percent of malpractice payment reports. Practitioners who have disputed reports first attempt to negotiate with entities that filed the reports to revise or void the reports before requesting Secretarial review. The fact that a report is disputed simply means that the practitioner disagrees with the accuracy of the report but has not filed a formal request for Secretarial Review. When disputed reports are disclosed to queriers, queriers are notified that the practitioner disputes the accuracy of the report.

²¹ Office of Inspector General, DHHS. National Practitioner NPDB Reports to Hospitals: Their Usefulness and Impact. OEI-01-94-00030. April 1995. Office of Inspector General, DHHS. National Practitioner Data Bank Reports to Managed Care Organizations: Their Usefulness and Impact. OEI-01-94-00032. April 1995. The Division of Quality Assurance will conduct a new survey to examine this issue and others during 2000.

If practitioners are dissatisfied with the results of their efforts to have reporters modify or void disputed reports, they may seek a “Secretarial Review.” Table 25 presents information on this level of review. Requests for review by the Secretary decreased by 20.2 percent from 1998 to 1999. A total of 91 requests for review by the Secretary were received during 1999 compared to 114 in 1998. Bearing in mind that requests for Secretarial Review during a given year cannot be tied directly to either reports or disputes received during the same year, we can still approximate the relationship between requests for Secretarial Review, disputes, and reports. During 1999, the number of new requests for Secretarial Review was about 0.4 percent of the number of new malpractice payment and adverse action reports received.

As Table 25 shows, reportable action reports were more likely to be appealed to the Secretary than were malpractice payment reports. During 1999, 71.4 percent (65 requests) of all requests for Secretarial Review concerned reportable actions (i.e., licensure, clinical privileges, or professional society membership reports) even though only 21.7 percent of all 1999 reports fell in this category. Since the opening of the NPDB reportable actions have represented a much larger proportion of Secretarial Reviews than would be expected from the number of reportable action reports received by the NPDB. Within the reportable action category, clinical privileges reports are the most likely to be involved in Secretarial Review.

Table 26 presents data on the outcome of requests for Secretarial Review. At the end of 1999, 31 (31.4 percent) of the 91 requests for Secretarial Review received during the year remained unresolved. Of the 60 new 1999 cases which were resolved, only 9 (21.7 percent) were resolved in a way favorable to the practitioner (Secretarial decision in favor of the practitioner or the reporter voluntarily changed the report). Reports were not changed (Secretary decided in favor of entity or alleged facts were “Out-of-Scope”) in 47 cases (78.3 percent of the 1999 cases which were resolved).

Table 27 presents cumulative information on Secretarial Reviews by report type and outcome. By the end of 1999 only 18.2 percent of all closed requests for Secretarial Review had resulted in a change to a report in the NPDB either through Secretarial action or voluntary action by a reporter while Secretarial action was pending. At the end of 1999, 3.1 percent of all requests for Secretarial Review remained unresolved. Only 57 (12.8 percent) of the total of 477 malpractice payment reports with completed Secretarial Reviews have been changed because the Secretary decided in favor of the practitioner or the reporter voluntarily voided or changed the report. In the case of reviews of privileges actions, 91 (19.2 percent) of the 475 closed requests resulted in a change in favor of the practitioner. For licensure actions and professional society membership actions, these numbers were 69 (28.8 percent) of 240 closed requests and 3 (25.0 percent) of 12 closed requests, respectively.

Conclusion

The NPDB continued to improve its operations during 1999. The SRA International, Inc. (SRA) “second generation” system based on the use of modern data base technology operated reliably and processed a record number of queries. System improvements — most notably the introduction of secure Internet-based reporting with introduction of a new Consolidated Adverse Action Report electronic form for use with both NPDB and HIPDB reports accompanied by pilot use of Internet querying — continued to be made to better serve the NPDB’s customers. The continuing of work by SRA to set up the new HIPDB, which will be operated in conjunction with the NPDB, was another major accomplishment.

As data continue to accumulate, the NPDB’s value increases as a source of aggregate information for research. Over time, the data generated will provide useful information on trends in malpractice payments, adverse actions, and professional disciplinary behavior. Most importantly, however, the NPDB will continue to benefit the public by serving as an information clearinghouse which facilitates comprehensive peer review and, thereby, improves the quality of health care in the United States.

Statistical Appendix

TABLE 1: Practitioners with Reports in the NPDB. **TABLE 2:** Number and Percent Distribution of Reports by Report Type, Last Five Years and Cumulative

TABLE 3: Number of Reports Received and Percent Change, by Report Type, Last Five Years

TABLE 4: Number, Percent Distribution, and Percent Change of Malpractice Payment Reports by Practitioner Type, Last Five Years and Cumulative

TABLE 5: Number, Percent Distribution, and Percent Change of Reportable Actions and Medicare/Medicaid Reports by Practitioner Type, Last Five Years and Cumulative

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TABLE 16: Relationship between Frequency of Reportable Action Reports and Having No Malpractice Payments Reports and No Medicare/Medicaid Exclusion Reports, Physicians

TABLE 17: Nurse Malpractice Payments, by Reason for Report and Type of Nurse

TABLE 18: Mean and Median Malpractice Payment Amounts (Actual and Inflation Adjusted) Made for the Benefit of Nurses, by Malpractice Reason, 1999 and Cumulative

TABLE 19: Nurse (Registered Nurses, Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners) Malpractice Payments, by State

TABLE 20: Mean and Median Malpractice Payment Amounts (Actual and Inflation Adjusted) Made for the Benefit of Physician Assistants, by Malpractice Reason, 1999 and Cumulative

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TABLE 22: Number and Percent of Queries by Type of Querying Entity, Last Five Years and Cumulative

TABLE 23: Number of Queries by Practitioner Type

TABLE 24: Entities That Have Queried or Reported to the National Practitioner Data Bank at Least Once, by Entity Type

TABLE 25: Requests for Secretarial Review, by Report Type, Last Five Years and Cumulative

TABLE 26: Requests for Secretarial Review, by Outcome Type, Last Five Years and Cumulative

TABLE 27: Cumulative Requests for Secretarial Review, by Report Type and Outcome Type

TABLE 1: Practitioners with Reports
National Practitioner Data Bank, September 1, 1990 - December 31, 1999

Practitioner Type	Number of Practitioners with Reports	Number of Reports*	Reports per Practitioner
Physicians	104,678	172,209	1.65
Dentists	21,336	32,586	1.53
Nurses and Nursing-related Practitioners	8,145	8,453	1.04
Chiropractors	4,226	4,870	1.15
Podiatrists and Podiatry-related Practitioners	2,879	4,581	1.59
Pharmacists and Pharmacy Assistants	957	1,018	1.06
Psychology-related Practitioners	910	1,125	1.24
Physician Assistants and Medical Assistants	494	561	1.14
Physical Therapists and Related Practitioners	416	437	1.05
Optical-related Practitioners	313	375	1.20
Counselors	276	345	1.25
Emergency Medical Practitioners	255	279	1.09
Social Workers	240	264	1.10
Technologists	155	159	1.03
Dental Assistants and Technicians	48	51	1.06
Occupational Therapists and Related Practitioners	33	33	1.00
Respiratory Therapists and Related Practitioners	22	23	1.05
Acupuncturists	21	23	1.10
Denturists	12	16	1.33
Audiologists	12	13	1.08
Psychiatric Technicians and Aides	9	12	1.33
Homeopaths and Naturopaths	6	8	1.33
Dieticians	4	4	1.00
Prosthetists	4	5	1.25
Speech and Language-related Practitioners	1	1	1.00
Facility Administrators	1	1	1.00
Unspecified or Unknown	81	89	1.10
TOTAL	145,534	227,541	1.56

Note: Reports include medical malpractice payment reports, adverse action reports, clinical privilege reports, professional society membership reports, Drug Enforcement Administration actions, and Medicare/Medicaid exclusion reports.

TABLE 2: Number and Percent Distribution of Reports by Report Type, Last Five Years and Cumulative National Practitioner Data Bank, September 1, 1990 - December 31, 1999

Report Type	1995		1996		1997		1998		1999		Cumulative through 1999 Number	Cumulative through 1999 Percent
	Number	Percent										
Reportable Action Reports	4,740	20.8%	5,208	21.3%	5,080	16.3%	5,360	21.1%	5,272	19.7%	42,328	18.6%
Licensure	3,864	17.0%	4,249	17.4%	4,143	13.3%	4,402	17.3%	4,140	15.4%	33,124	14.6%
Clinical Privileges	841	3.7%	931	3.8%	879	2.8%	871	3.4%	1,052	3.9%	8,587	3.8%
Professional Society Membership	35	0.2%	28	0.1%	32	0.1%	31	0.1%	18	0.1%	323	0.1%
Drug Enforcement Agency	0	0.0%	0	0.0%	26	0.1%	56	0.2%	62	0.2%	294	0.1%
Medicare/Medicaid Exclusions	0	0.0%	0	0.0%	7,831	25.1%	2,400	9.4%	2,486	9.3%	12,717	5.6%
Medical Malpractice Payment Reports	18,005	79.2%	19,272	78.7%	18,305	58.6%	17,692	69.5%	19,039	71.0%	172,496	75.8%
Total	22,745	100.0%	24,480	100.0%	31,216	100.0%	25,452	100.0%	26,797	100.0%	227,541	100.0%

*"Reportable Actions" include truly adverse actions (revocations, probations, suspensions, reprimands, etc.) as well as non-adverse actions reported as adverse actions (restorations and reinstatements).

This table includes only disclosable reports in the NPDB as of December 31, 1999. The numbers of reports for 1995 through 1998 may differ from those shown in previous Annual Reports because of voided reports and the fact that modified reports are now counted in the year they were originally submitted, not the year they were modified.

Medicare/Medicaid Exclusions were first reported during 1997. Reports that year include exclusion actions taken in previous years if the practitioner had not been reinstated.

**TABLE 3: Number of Reports Received and Percent Change, by Report Type, Last Five Years
National Practitioner Data Bank, September 1, 1990 - December 31, 1999**

Report Type	1995 Number	% Change 1994-1995	1996 Number	% Change 1995-1996	1997 Number	% Change 1996-1997	1998 Number	% Change 1997-1998	1999 Number	% Change 1998-1999
Reportable Action Reports	4,740	12.4%	5,208	9.9%	5,080	-2.5%	5,360	5.5%	5,272	-1.6%
Licensure	3,864	4.2%	4,249	10.0%	4,143	-2.5%	4,402	6.3%	4,140	-6.0%
Clinical Privilege	841	-11.6%	931	10.7%	879	-5.6%	871	-0.9%	1,052	20.8%
Professional Society Membership	35	-16.7%	28	-20.0%	32	14.3%	31	-3.1%	18	-41.9%
Drug Enforcement Agency Medicare/Medicaid Exclusions	0	-100.0%	0	---	26	---	56	115.4%	62	10.7%
Medical Malpractice Payment Reports	0	0.0%	0	0.0%	7,831	0.0%	2,400	-69.4%	2,486	3.6%
Total	18,005	-8.6%	19,272	7.0%	18,305	-5.0%	17,692	-3.3%	19,039	7.6%
Total	22,745	-7.0%	24,480	7.6%	31,216	27.5%	25,452	-18.5%	26,797	5.3%

*"Reportable Actions" include truly adverse actions (revocations, probations, suspensions, reprimands, etc.) as well as non-adverse actions reported as "Adverse Actions" (restorations and reinstatements).

This table includes only disclosable reports in the NPDB as of December 31, 1999. The numbers of reports for 1995 through 1998 may differ from those shown in previous Annual Reports because of voided reports and the fact that modified reports are now counted in the year they were originally submitted, not the year they were modified.

Percent changes from a zero base are indicated by "---."

TABLE 4: Number, Percent Distribution, and Percent Change of Malpractice Payment Reports by Practitioner Type, Last Five Years and Cumulative National Practitioner Data Bank, September 1, 1990 - December 31, 1999

Year	Practitioner Type				Total
	Physicians	Dentist	All Others	Not Specified	
1995					
Malpractice Payments Reports	14,051	2,525	1,425	4	18,005
Percent of 1995 Malpractice Reports	78.0%	14.0%	7.9%	0.0%	100.0%
Percent Change (1994 to 1995)	-7.4%	-14.9%	-8.4%	0.0%	-8.6%
1996					
Malpractice Payment Reports	15,281	2,479	1,510	2	19,272
Percent of 1996 Malpractice Reports	79.3%	12.9%	7.8%	0.0%	100.0%
Percent Change (1995 to 1996)	8.8%	-1.8%	6.0%	-50.0%	7.0%
1997					
Malpractice Payment Reports	14,613	2,341	1,256	5	18,215
Percent of 1997 Malpractice Reports	80.2%	12.9%	6.9%	0.0%	100.0%
Percent Change (1996 to 1997)	-4.4%	-5.6%	-16.8%	150.0%	-5.5%
1998					
Malpractice Payment Reports	14,104	2,350	1,236	2	17,692
Percent of 1998 Malpractice reports	79.7%	13.3%	7.0%	0.0%	100.0%
Percent Change(1997 to 1998)	-3.5%	0.4%	-1.6%	-60.0%	-2.9%
1999					
Malpractice Payment Reports	15,142	2,352	1,532	13	19,039
Percent of 1999 Malpractice Reports	79.5%	12.4%	8.0%	0.1%	100.0%
Percent Change (1998 to 1999)	7.4%	0.1%	23.9%	550.0%	7.6%
Cumulative (9/1/90 – 12/31/99)					
Malpractice Reports	133,630	24,731	14,083	52	172,496
Percent reports	77.5%	14.3%	8.2%	0.0%	100.0%

This table includes only disclosable reports in the NPDB as of December 31, 1999. The numbers of reports for 1995 through 1998 may differ from those shown in previous Annual Reports because of modifications and voided reports. Modified reports are now counted in the year they were originally submitted, not the year they were modified. Physicians include Allopathic and Osteopathic physicians and interns and residents. Dentists include dental residents.

TABLE 5: Number, Percent Distribution, and Percent Change of Reportable Actions and Medicare/Medicaid Exclusion Reports by Practitioner Type, Last Five Years and Cumulative National Practitioner Data Bank, September 1, 1990 - December 31, 1999

Report Type	1998			1999			2000			2001			2002			Cumulative through 2002 Number	Cumulative through 2002 Percent
	Number	Percent	% Change 1997-1998	Number	Percent	% Change 1998-1999	Number	Percent	% Change 1999-2000	Number	Percent	% Change 2000-2001	Number	Percent	% Change 2001-2002		
Licensure	3,864	81.5%	4.2%	4,249	81.6%	10.0%	4,143	32.1%	-2.5%	4,402	56.7%	6.3%	4,140	40.4%	-6.0%	33,124	60.2%
Physicians	3,167	66.8%	4.4%	3,561	68.4%	12.4%	3,289	25.5%	-7.6%	3,509	45.2%	6.7%	3,221	31.4%	-8.2%	26,412	48.0%
Dentists	677	14.3%	0.0%	670	12.9%	-1.0%	822	6.4%	22.7%	848	10.9%	3.2%	863	8.4%	1.8%	6,540	11.9%
Other Health Care Practitioners or Not Specified	20	0.4%	---	18	0.3%	---	32	0.2%	77.8%	45	0.6%	40.6%	56	0.5%	24.4%	172	0.3%
Clinical Privileges	841	17.7%	-11.6%	931	17.9%	10.7%	879	6.8%	-5.6%	871	11.2%	-0.9%	1,052	10.3%	20.8%	8,587	15.6%
Physicians	815	17.2%	-10.5%	896	17.2%	9.9%	847	6.6%	-5.5%	813	10.5%	-4.0%	951	9.3%	17.0%	8,179	14.9%
Dentists	10	0.2%	-37.5%	15	0.3%	50.0%	12	0.1%	-20.0%	24	0.3%	100.0%	20	0.2%	-16.7%	135	0.2%
Other Health Care Practitioners or Not Specified	16	0.3%	-33.3%	20	0.4%	25.0%	20	0.2%	0.0%	34	0.4%	70.0%	81	0.8%	138.2%	273	0.5%
Professional Society Membership	35	0.7%	-16.7%	28	0.5%	-20.0%	32	0.2%	14.3%	31	0.4%	-3.1%	18	0.2%	-41.9%	323	0.6%
Physicians	31	0.7%	-16.2%	26	0.5%	-16.1%	30	0.2%	15.4%	30	0.4%	0.0%	18	0.2%	-40.0%	298	0.5%
Dentists	4	0.1%	-20.0%	2	0.0%	-50.0%	2	0.0%	0.0%	1	0.0%	-50.0%	0	0.0%	-100.0%	25	0.0%
Other Health Care Practitioners or Not Specified	0	0.0%	---	0	0.0%	---	0	0.0%	---	0	0.0%	---	0	0.0%	---	0	0.0%
DEA Actions	0	0.0%	-100.0%	0	0.0%	---	26	0.2%	---	56	0.7%	---	62	0.6%	10.7%	294	0.5%
Physicians	0.0%	-100.0%	0	0.0%	---	26	0.2%	---	52	0.7%	---	55	0.5%	5.8%	283	0.5%	
Dentists	0	0.0%	---	0	0.0%	---	0	0.0%	---	4	0.1%	---	6	0.1%	---	10	0.0%
Other Health Care Practitioners or Not Specified	0	0.0%	---	0	0.0%	---	0	0.0%	---	0	0.0%	---	1	---	1	0.0%	
Medicare/Medicaid Exclusion	0	0.0%	---	0	0.0%	---	7,831	60.7%	---	2,400	30.9%	---	2,486	24.3%	3.6%	12,717	23.1%
Physicians	0	0.0%	---	0	0.0%	---	2,295	17.8%	---	611	7.9%	---	501	4.9%	-18.0%	3,407	6.2%
Dentists	0	0.0%	---	0	0.0%	---	760	5.9%	---	210	2.7%	---	175	1.7%	-16.7%	1,145	2.1%
Other Health Care Practitioners or Not Specified	0	0.0%	---	0	0.0%	---	4,776	37.0%	---	1,579	20.3%	---	1,810	17.7%	14.6%	8,165	14.8%
Total	4,740	100.0%	-0.4%	5,208	100.0%	9.9%	12,911	100.0%	147.9%	7,760	100.0%	-39.9%	10,244	100.0%	32.0%	55,045	100.0%

"Reportable Actions" include true adverse actions (e.g., revocations, probations, suspensions, reprimands, etc.) as well as non-adverse actions reported as Adverse Actions (e.g., restorations and reinstatements).

Medicare/Medicaid Exclusions were first reported during 1997. Reports that year include exclusion actions taken in previous years if the practitioner had not been reinstated.

This table includes only disclosable reports in the NPDB as of December 31, 1999. The numbers of reports for 1995 through 1998 may differ from those shown in previous Annual Reports because of voided reports and the fact that modified reports are now counted in the year they were originally submitted, not the year they were modified.

Percent changes from a zero base are indicated by "---."

**TABLE 6: Currently Active Registered Non-Federal Hospitals That Have Never Reported to the National Practitioner Data Bank, by State
National Practitioner Data Bank, September 1, 1990 - December 31, 1999**

State	# of Hospitals with "Active Registrations"	# of Hospitals That have Never Reported	% That Have Never Reported
Alabama	127	89	70.1%
Alaska	19	12	63.2%
Arizona	82	38	46.3%
Arkansas	95	64	67.4%
California	510	225	44.1%
Colorado	85	48	56.5%
Connecticut	50	28	56.0%
Delaware	13	5	38.5%
Florida	283	164	58.0%
Georgia	198	115	58.1%
Hawaii	26	17	65.4%
Idaho	47	31	66.0%
Illinois	226	129	57.1%
Indiana	152	82	53.9%
Iowa	120	90	75.0%
Kansas	148	107	72.3%
Kentucky	129	89	69.0%
Louisiana	190	147	77.4%
Maine	46	25	54.3%
Maryland	80	37	46.3%
Massachusetts	137	87	63.5%
Michigan	194	99	51.0%
Minnesota	142	106	74.6%
Mississippi	111	85	76.6%
Missouri	146	88	60.3%
Montana	52	39	75.0%
Nebraska	92	67	72.8%
Nevada	37	24	64.9%
New Hampshire	32	16	50.0%
New Jersey	110	35	31.8%
New Mexico	55	38	69.1%
New York	281	130	46.3%
North Carolina	147	90	61.2%
North Dakota	49	36	73.5%
Ohio	223	110	49.3%
Oklahoma	145	97	66.9%
Oregon	62	25	40.3%
Pennsylvania	276	155	56.2%
Rhode Island	16	6	37.5%
South Carolina	78	39	50.0%
South Dakota	56	47	83.9%
Tennessee	165	115	69.7%
Texas	532	357	67.1%

State	# of Hospitals with "Active Registrations"	# of Hospitals That have Never Reported	% That Have Never Reported
Utah	49	31	63.3%
Vermont	17	9	52.9%
Virginia	123	66	53.7%
Washington	94	45	47.9%
West Virginia	64	39	60.9%
Wisconsin	142	92	64.8%
Wyoming	27	21	77.8%
Washington, DC	15	10	66.7%
Total	6,295	3,746	59.5%

"Currently active" registered hospitals are those listed by the NPDB in "active status" on December 31, 1999.

TABLE 7: Cumulative Reportable Physician Licensure and Privileges Action Reports, by State
National Practitioner Data Bank, September 1, 1990 - December 31, 1999

State	Privileges Reports	Adverse Privileges Reports	Adverse Licensure Reports for In-State Physicians	Ratio of Adverse Clinical Privileges Reports to Adverse In-State Licensure
Alabama	96	90	247	0.36
Alaska	15	15	81	0.19
Arizona	232	210	553	0.38
Arkansas	78	70	159	0.44
California	955	897	2,091	0.43
Colorado	168	161	735	0.22
Connecticut	57	55	348	0.16
Delaware	20	20	27	0.74
Florida	432	402	1,056	0.38
Georgia	241	231	514	0.45
Hawaii	42	38	56	0.68
Idaho	32	30	47	0.64
Illinois	215	204	543	0.38
Indiana	193	178	183	0.97
Iowa	62	60	304	0.20
Kansas	152	144	160	0.90
Kentucky	104	98	381	0.26
Louisiana	99	90	329	0.27
Maine	45	42	118	0.36
Maryland	211	203	725	0.28
Massachusetts	155	149	460	0.32
Michigan	293	271	988	0.27
Minnesota	123	117	292	0.40
Mississippi	56	54	382	0.14
Missouri	150	144	467	0.31
Montana	30	25	82	0.30
Nebraska	74	70	67	1.04
Nevada	102	91	92	0.99
New Hampshire	47	44	65	0.68
New Jersey	270	245	790	0.31
New Mexico	53	48	53	0.91
New York	540	496	1,851	0.27
North Carolina	153	142	291	0.49
North Dakota	30	27	112	0.24

State	Privileges Reports	Adverse Privileges Reports	Adverse Licensure Reports for In-State Physicians	Ratio of Adverse Clinical Privileges Reports to Adverse In-State Licensure
Ohio	378	352	1,496	0.24
Oklahoma	140	129	400	0.32
Oregon	91	87	337	0.26
Pennsylvania	321	300	568	0.53
Rhode Island	34	31	113	0.27
South Carolina	104	97	245	0.40
South Dakota	13	13	34	0.38
Tennessee	130	118	249	0.47
Texas	564	525	1,467	0.36
Utah	48	47	92	0.51
Vermont	19	17	86	0.20
Virginia	165	150	306	0.49
Washington	220	201	385	0.52
West Virginia	62	56	334	0.17
Wisconsin	136	123	227	0.54
Wyoming	18	18	33	0.55
Washington, DC	26	25	40	0.63
All Reports	8,032	7,483	21,073	0.36

This table includes only disclosable reports in the NPDB as of December 31, 1999. Privileges reports are attributed to States on the basis of the physician's work state. Licensure reports are attributed according to the State of the board taking the action.

The All Reports row includes jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.).

**TABLE 8: Cumulative Physician and Dentist Malpractice Payments
National Practitioner Data Bank, September 1, 1990 - December 31, 1999**

State	Physicians Number of Reports	Physicians Adjusted Number of Reports	Dentists Number of Reports	Dentists Adjusted Number of Reports	Ratio of Dentist Reports to Physician Reports
Alabama	516	510	144	114	0.28
Alaska	169	169	44	43	0.26
Arizona	1,950	1,941	372	372	0.19
Arkansas	613	608	98	98	0.16
California	15,008	14,990	5,233	5,233	0.35
Colorado	1,470	1,457	308	308	0.21
Connecticut	1,298	1,296	384	384	0.30
Delaware	306	300	46	46	0.15
Florida*	8,408	8,377	1,221	1,221	0.15
Georgia	2,219	2,209	405	405	0.18
Hawaii	299	299	83	83	0.28
Idaho	274	274	42	42	0.15
Illinois	6,059	6,050	1,039	1,039	0.17
Indiana*	2,695	1,838	317	292	0.12
Iowa	1,042	1,040	141	141	0.14
Kansas*	1,517	1,019	180	178	0.12
Kentucky	1,291	1,281	259	259	0.20
Louisiana*	2,331	1,708	278	271	0.12
Maine	349	349	73	73	0.21
Maryland	2,027	2,022	566	566	0.28
Massachusetts	2,387	2,384	653	653	0.27
Michigan	7,617	7,614	1,226	1,226	0.16
Minnesota	1,097	1,092	238	238	0.22
Mississippi	981	977	93	93	0.09
Missouri	2,572	2,494	424	424	0.16
Montana	574	572	62	62	0.11
Nebraska*	545	475	97	97	0.18
Nevada	663	662	87	87	0.13
New Hampshire	510	510	120	120	0.24
New Jersey	4,971	4,946	838	838	0.17
New Mexico*	923	691	112	112	0.12
New York	17,266	17,252	2,400	2,400	0.14
North Carolina	2,032	2,010	207	207	0.10
North Dakota	228	225	19	19	0.08
Ohio	6,018	6,006	880	880	0.15
Oklahoma	876	862	180	180	0.21
Oregon	857	856	160	160	0.19
Pennsylvania*	11,365	8,070	1,651	1,651	0.15
Rhode Island	596	595	94	94	0.16
South Carolina*	839	717	84	84	0.10
South Dakota	202	201	45	45	0.22
Tennessee	1,542	1,530	218	218	0.14
Texas	9,280	9,258	1,504	1,504	0.16
Utah	945	944	398	398	0.42
Vermont	293	293	53	53	0.18
Virginia	1,956	1,953	377	377	0.19
Washington	2,261	2,255	681	681	0.30
West Virginia	1,268	1,265	104	104	0.08

State	Physicians Number of Reports	Physicians Adjusted Number of Reports	Dentists Number of Reports	Dentists Adjusted Number of Reports	Ratio of Dentist Reports to Physician Reports
Wisconsin*	1,136	938	342	342	0.30
Wyoming	240	239	18	18	0.08
Washington, DC	521	520	99	99	0.19
All Reports	133,611	127,352	24,726	24,691	0.19

This table includes only disclosable reports in the NPDB as of December 31, 1999.

The All Reports row includes jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.).

Adjusted columns exclude reports from State patient compensation and similar State funds which make payments in excess of amounts paid by a practitioner's primary malpractice carrier. When payments are made by these funds, two reports are filed with the NPDB (one from the primary insurer and one from the fund) whenever a total malpractice settlement or award exceeds a maximum set by the State for the practitioner's primary malpractice carrier. The States marked with asterisks have these funds. Thus, the adjusted columns provide an approximation of the number of incidents resulting in payments rather than the number of payments. These funds occasionally make payments for practitioners practicing in other States at the time of a malpractice event. See the text for a detailed explanation.

**TABLE 9: Physician Malpractice Payments, by State and Year
National Practitioner Data Bank, 1995-1999**

State	1995 Number of Reports	1995 Adjusted Number of Reports**	1996 Number of Reports	1996 Adjusted Number of Reports**	1997 Number of Reports	1997 Adjusted Number of Reports**	1998 Number of Reports	1998 Adjusted Number of Reports**	1999 Number of Reports	1999 Adjusted Number of Reports**
Alabama	58	58	65	65	65	65	69	68	45	41
Alaska	19	19	31	31	16	16	15	15	20	20
Arizona	179	179	244	244	249	248	222	219	222	222
Arkansas	59	59	56	55	56	55	78	78	69	68
California	1,533	1,530	1,744	1,740	1,820	1,820	1,491	1,489	1,494	1,491
Colorado	164	163	150	146	158	157	152	148	147	147
Connecticut	154	154	126	125	138	138	145	145	156	156
Delaware	41	40	39	37	27	27	30	29	24	23
Florida*	857	855	1,093	1,087	1,110	1,110	1,048	1,044	1,052	1,048
Georgia	245	245	254	253	269	267	284	283	270	267
Hawaii	38	38	35	35	20	20	45	45	41	41
Idaho	29	29	33	33	31	31	26	26	34	34
Illinois	592	592	597	597	609	607	562	561	552	551
Indiana*	189	188	727	181	283	188	260	155	289	179
Iowa	107	107	133	133	130	130	109	109	72	71
Kansas*	139	83	157	84	217	157	151	92	184	123
Kentucky	152	150	136	133	154	154	127	125	153	153
Louisiana*	173	142	222	168	262	166	283	202	314	191
Maine	32	32	33	33	41	41	34	34	48	48
Maryland	219	218	241	241	229	228	255	255	238	237
Massachusetts	235	235	255	254	222	222	224	224	253	252
Michigan	1,017	1,016	666	666	651	651	739	738	753	753
Minnesota	119	119	123	123	95	94	75	75	84	84
Mississippi	112	111	117	116	129	128	116	116	113	113
Missouri	310	293	302	291	241	236	212	201	284	280
Montana	51	51	65	64	59	58	55	55	93	93
Nebraska*	64	58	60	48	68	58	58	51	53	49
Nevada	84	84	63	63	74	74	82	82	83	83
New Hampshire	52	52	66	66	50	50	57	57	42	42
New Jersey	515	512	525	522	459	454	570	567	481	480
New Mexico*	95	75	136	106	108	90	130	90	105	73
New York	1,681	1,679	1,784	1,782	1,829	1,828	1,951	1,950	2,032	2,032
North Carolina	214	212	227	222	233	231	226	224	201	193
North Dakota	23	23	30	30	18	18	23	21	22	22
Ohio	637	635	671	669	617	615	418	417	876	874
Oklahoma	94	94	101	101	69	63	81	81	77	74
Oregon	87	87	76	75	84	84	74	74	85	85
Pennsylvania*	1,267	957	1,413	948	1,366	923	1,148	744	1,438	977
Rhode Island	59	58	58	58	84	84	69	69	68	68
South Carolina*	73	58	94	79	120	101	139	116	143	111

State	1995 Number of Reports	1995 Adjusted Number of Reports**	1996 Number of Reports	1996 Adjusted Number of Reports**	1997 Number of Reports	1997 Adjusted Number of Reports**	1998 Number of Reports	1998 Adjusted Number of Reports**	1999 Number of Reports	1999 Adjusted Number of Reports**
South Dakota	25	25	23	23	27	27	27	27	15	15
Tennessee	166	165	146	144	190	188	151	148	189	188
Texas	1,030	1,027	1,091	1,086	895	891	974	973	1,024	1,021
Utah	133	133	122	122	100	100	86	86	113	113
Vermont	26	26	28	28	35	35	49	49	33	33
Virginia	195	195	215	214	186	185	247	246	231	231
Washington	241	240	231	230	257	257	268	267	325	325
West Virginia	148	147	117	116	124	124	144	144	132	132
Wisconsin*	117	96	135	115	85	68	80	64	72	57
Wyoming	17	17	32	32	20	20	30	30	30	30
Washington, DC	41	41	68	68	63	63	85	85	59	59
All Reports	14,050	13,545	15,279	14,005	14,612	13815	14,103	13,322	15,142	14,262

This table includes only disclosable reports in the NPDB as of December 31, 1999.
The All Reports row includes jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.).

Adjusted columns exclude reports from State patient compensation and similar State funds which make payments in excess of amounts paid by a practitioner's primary malpractice carrier. When payments are made by these funds, two reports are filed with the NPDB (one from the primary insurer and one from the fund) whenever a total malpractice settlement or award exceeds a maximum set by the State for the practitioner's primary malpractice carrier. The States marked with asterisks have these funds. Thus, the adjusted columns provide an approximation of the number of incidents resulting in payment rather than the number of payments. These funds occasionally make payments for practitioners practicing in other States at the time of a malpractice event. See the text for a detailed explanation.

**TABLE 10: Dentist Malpractice Payments Reported, by State and Year
National Practitioner Data Bank, 1995-1999**

State	1995 Number of Reports	1995 Adjusted Number of Reports	1996 Number of Reports	1996 Adjusted Number of Reports	1997 Number of Reports	1997 Adjusted Number of Reports	1998 Number of Reports	1998 Adjusted Number of Reports	1999 Number of Reports	1999 Adjusted Number of Reports
Alabama	6	6	9	9	8	8	10	10	18	18
Alaska	1	1	4	4	0	0	5	5	3	2
Arizona	18	18	68	68	44	44	27	27	36	36
Arkansas	13	13	8	8	11	11	14	14	8	8
California	518	518	562	562	546	546	526	526	438	438
Colorado	25	25	41	41	32	32	18	18	34	34
Connecticut	36	36	44	44	27	27	33	33	26	26
Delaware	2	2	7	7	2	2	5	5	2	2
Florida*	131	131	126	126	153	153	118	118	113	113
Georgia	20	20	28	28	37	37	34	34	151	151
Hawaii	9	9	10	10	10	10	10	10	13	13
Idaho	2	2	4	4	6	6	7	7	4	4
Illinois	115	115	92	92	88	88	77	77	102	102
Indiana*	42	42	52	35	30	26	28	27	22	19
Iowa	19	19	13	13	8	8	12	12	12	12
Kansas*	20	20	13	12	18	18	13	13	17	17
Kentucky	34	34	15	15	25	25	27	27	16	16
Louisiana*	28	28	28	28	22	20	35	34	25	23
Maine	11	11	13	13	10	10	9	9	7	7
Maryland	49	49	34	34	51	51	41	41	41	41
Massachusetts	87	87	67	67	55	55	58	58	89	89
Michigan	145	145	67	67	85	85	81	81	114	114
Minnesota	28	28	18	18	24	24	12	12	11	11
Mississippi	4	4	12	12	11	11	23	23	4	4
Missouri	40	40	38	38	38	38	51	51	44	44
Montana	6	6	5	5	4	4	3	3	5	5
Nebraska*	19	19	3	3	7	7	1	1	4	4
Nevada	9	9	7	7	13	13	5	5	10	10
New Hampshire	22	22	11	11	13	13	8	8	3	3
New Jersey	98	98	83	83	97	97	69	69	63	63
New Mexico*	12	12	13	13	16	16	12	12	9	9
New York	218	218	209	209	254	254	237	237	226	226
North Carolina	19	19	20	20	30	30	16	16	20	20
North Dakota	1	1	2	2	0	0	2	2	3	3
Ohio	92	92	92	92	82	82	75	75	77	77
Oklahoma	19	19	12	12	21	21	17	17	18	18
Oregon	7	7	25	25	15	15	15	15	11	11
Pennsylvania*	188	188	154	154	158	158	145	145	126	126
Rhode Island	11	11	6	6	9	9	4	4	12	12
South Carolina*	6	6	5	5	6	6	4	4	18	18

State	1995 Number of Reports	1995 Adjusted Number of Reports	1996 Number of Reports	1996 Adjusted Number of Reports	1997 Number of Reports	1997 Adjusted Number of Reports	1998 Number of Reports	1998 Adjusted Number of Reports	1999 Number of Reports	1999 Adjusted Number of Reports
South Dakota	8	8	4	4	3	3	1	1	5	5
Tennessee	31	31	19	19	22	22	24	24	24	24
Texas	168	168	199	199	119	119	250	250	91	91
Utah	18	18	16	16	18	18	14	14	16	16
Vermont	6	6	6	6	4	4	3	3	2	2
Virginia	31	31	43	43	34	34	54	54	85	85
Washington	67	67	114	114	86	86	62	62	114	114
West Virginia	14	14	8	8	6	6	11	11	10	10
Wisconsin*	37	37	28	28	44	44	24	24	27	27
Wyoming	3	3	4	4	0	0	2	2	2	2
Washington, DC	6	6	12	12	14	14	11	11	8	8
All Reports	2,525	2,525	2,479	2,461	2,431	2,425	2,350	2,348	2,352	2,346

This table includes only disclosable reports in the NPDB as of December 31, 1999. The All Reports row includes jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.).

Adjusted columns exclude reports from State patient compensation and similar State funds which make payments in excess of amounts paid by a practitioner's primary malpractice carrier. When payments are made by these funds, two reports are filed with the NPDB (one from the primary insurer and one from the fund) whenever a total malpractice settlement or award exceeds a maximum set by the State for the practitioner's primary malpractice carrier. The States marked with asterisks have these funds. Thus, the adjusted columns provide an approximation of the number of incidents resulting in payment rather than the number of payments. These funds occasionally make payments for practitioners practicing in other States at the time of a malpractice event. See the text for a detailed explanation.

**TABLE 11: Mean and Median Malpractice Payment and Mean Delay between Incident and Payment, by State
National Practitioner Data Bank, September 1, 1990 - December 31, 1999**

State	Cumulative Mean Payment	Cumulative Median Payment	1999 Only Mean Payment	1999 Only Median Payment	Rank of Median Payment	Cumulative Mean Delay Between Incident and Payment (years)	1999 Mean Delay Between Incidents and Payment (years)
Alabama	\$265,962	\$75,000	\$265,336	\$50,000	39	3.80	3.77
Alaska	\$168,275	\$60,915	\$275,660	\$100,000	13	3.89	4.30
Arizona	\$168,005	\$60,000	\$179,321	\$75,000	29	3.62	3.53
Arkansas	\$140,592	\$60,000	\$190,015	\$122,500	9	3.29	3.61
California	\$92,958	\$29,999	\$111,412	\$30,000	49	3.38	3.03
Colorado	\$130,539	\$36,250	\$145,959	\$45,000	46	3.27	3.18
Connecticut	\$236,811	\$75,000	\$407,378	\$127,500	6	5.27	4.96
Delaware	\$164,291	\$67,750	\$174,884	\$85,000	24	4.48	3.95
Florida*	\$185,032	\$95,000	\$211,596	\$125,000	7	3.95	3.63
Georgia	\$217,808	\$75,000	\$211,671	\$50,000	39	3.34	3.12
Hawaii	\$185,565	\$42,500	\$170,871	\$38,000	48	4.09	4.75
Idaho	\$160,809	\$27,500	\$159,832	\$30,000	49	3.10	3.01
Illinois	\$251,862	\$110,000	\$294,813	\$150,000	3	5.57	5.33
Indiana*	\$129,128	\$52,000	\$169,918	\$75,001	28	5.04	5.72
Iowa	\$128,865	\$45,000	\$162,634	\$100,000	13	3.14	3.23
Kansas	\$142,076	\$81,900	\$175,037	\$100,000	13	3.86	3.71
Kentucky	\$148,440	\$48,629	\$133,121	\$50,000	39	3.72	4.11
Louisiana*	\$115,678	\$62,500	\$161,377	\$91,500	22	4.60	4.96
Maine	\$189,708	\$80,000	\$227,890	\$85,000	24	3.84	4.34
Maryland	\$184,849	\$70,000	\$207,924	\$100,000	13	4.53	4.32
Massachusetts	\$215,326	\$90,000	\$255,767	\$116,250	10	5.64	5.44
Michigan	\$86,776	\$50,000	\$94,195	\$50,000	39	4.28	4.42
Minnesota	\$136,918	\$42,500	\$206,784	\$85,000	24	3.10	2.91
Mississippi	\$168,963	\$75,000	\$234,407	\$115,000	11	3.91	3.97
Missouri	\$178,922	\$73,000	\$183,950	\$80,000	27	4.41	4.09
Montana	\$121,711	\$45,000	\$118,165	\$30,000	49	4.15	4.08
Nebraska*	\$92,587	\$40,000	\$94,521	\$69,379	36	3.69	3.77
Nevada	\$198,091	\$73,500	\$254,272	\$150,000	3	4.00	4.67
New Hampshire	\$191,900	\$75,000	\$214,875	\$150,000	3	4.92	4.93
New Jersey	\$200,885	\$85,000	\$244,447	\$125,000	7	6.13	5.57
New Mexico*	\$115,677	\$67,253	\$135,282	\$75,000	29	3.71	3.96
New York	\$215,147	\$85,000	\$244,537	\$101,127	12	6.95	6.19
North Carolina	\$204,480	\$75,000	\$266,993	\$100,000	13	3.57	3.93

State	Cumulative Mean Payment	Cumulative Median Payment	1999 Only Mean Payment	1999 Only Median Payment	Rank of Median Payment	Cumulative Mean Delay Between Incident and Payment (years)	1999 Mean Delay Between Incidents and Payment (years)
North Dakota	\$141,625	\$62,500	\$172,758	\$75,000	29	3.59	3.48
Ohio	\$177,938	\$55,000	\$196,180	\$91,000	23	4.27	4.30
Oklahoma	\$191,188	\$50,000	\$261,581	\$50,000	39	3.61	3.63
Oregon	\$133,261	\$44,738	\$180,260	\$75,000	29	3.23	3.11
Pennsylvania*	\$181,080	\$110,000	\$227,420	\$152,101	2	5.86	5.66
Rhode Island	\$215,746	\$87,500	\$276,525	\$100,000	13	6.07	6.08
South Carolina*	\$136,709	\$75,000	\$147,613	\$92,500	21	4.58	4.40
South Dakota	\$159,141	\$40,000	\$187,995	\$47,500	45	3.30	3.66
Tennessee	\$184,021	\$60,000	\$221,232	\$75,000	29	3.41	3.72
Texas	\$152,814	\$73,000	\$196,053	\$97,000	19	3.80	3.54
Utah	\$97,673	\$19,084	\$149,981	\$62,500	37	3.39	3.60
Vermont	\$119,456	\$45,000	\$136,588	\$39,250	47	4.56	4.48
Virginia	\$156,436	\$70,000	\$143,547	\$60,000	38	3.67	3.31
Washington	\$145,578	\$40,000	\$159,521	\$50,000	39	4.14	5.00
West Virginia	\$180,774	\$57,500	\$153,145	\$70,000	35	5.51	6.48
Wisconsin*	\$228,175	\$50,000	\$237,657	\$75,000	29	4.50	3.97
Wyoming	\$136,743	\$56,000	\$152,607	\$95,000	20	3.07	3.40
Washington, DC	\$316,958	\$125,000	\$374,785	\$191,250	1	4.65	4.18
All Reports	\$165,732	\$63,000	\$195,093	\$85,000		4.64	4.47

The All Reports row includes jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.).

Rank for 1999 payments is based on the median payment amount for each State. 1 is highest; 51 is lowest.

These data are not adjusted for payments by State compensation funds and other similar funds. Mean and median payments for States with payments made by these funds understate the actual mean and median of amounts received by claimants. Payments made by these funds may also affect mean delay times between incidents and payments. States with these funds are marked with an asterisk.

TABLE 12: Mean and Median Malpractice Payment Amounts (Actual and Inflation Adjusted) Made for the Benefit of Physicians, by Malpractice Reason, 1999 and Cumulative National Practitioner Data Bank, September 1, 1990 - December 31, 1999

Malpractice Reason	1999 Only			Cumulative 9/1/90-12/31/99			Inflation Adjusted Mean Payment	Inflation Adjusted Median Payment
	Number of Payments	Mean Payment	Median Payment	Number of Payments	Mean Payment	Median Payment		
Diagnosis Related	5,297	\$253,868	\$150,000	44,305	\$216,287	\$109,875	\$233,861	\$121,324
Anesthesia Related	433	\$304,211	\$100,000	4,266	\$225,516	\$75,000	\$247,204	\$83,640
Surgery Related	4,225	\$181,912	\$100,000	36,472	\$159,161	\$75,000	\$172,260	\$82,382
Medication Related	731	\$183,949	\$85,000	7,999	\$145,048	\$47,500	\$158,725	\$50,613
IV or Blood Products Related	38	\$185,688	\$77,500	576	\$166,112	\$52,500	\$181,285	\$60,662
Obstetrics Related	1,231	\$361,852	\$200,000	11,666	\$345,211	\$185,000	\$376,694	\$200,000
Treatment Related	2,757	\$196,803	\$97,500	23,818	\$171,760	\$75,000	\$186,113	\$82,382
Monitoring Related	185	\$179,626	\$100,000	1,579	\$201,482	\$85,000	\$218,702	\$90,993
Equipment or Product Related	58	\$74,395	\$25,000	595	\$62,726	\$15,000	\$68,385	\$16,728
Miscellaneous	187	\$113,090	\$27,500	2,229	\$91,114	\$25,000	\$100,851	\$25,891
All Reasons	15,142	\$226,739	\$108,675	133,505	\$196,863	\$93,150	\$213,335	\$100,000

This table includes only disclosable reports in the NPDB as of December 31, 1999. Malpractice payment reports which are missing data necessary to calculate payment or malpractice reason (cumulatively 125 reports, none in 1999) are excluded.

TABLE 13: Mean Delay between Incident and Payment by Malpractice Reason, 1999 and Cumulative National Practitioner Data Bank, September 1, 1990 - December 31, 1999

Malpractice Reason	1999 Only		Cumulative, 9/1/90-12/31/99	
	Number of Payments	Mean Delay Between Incident and Payment (Years)	Number of Payments	Mean Delay Between Incident and Payment (Years)
Diagnosis Related	5,586	4.78	47,701	4.87
Anesthesia Related	525	3.57	5,193	3.58
Surgery Related	4,807	4.31	41,277	4.27
Medication Related	898	4.22	9,906	4.95
IV & Blood Products Related	43	5.89	724	4.82
Obstetrics Related	1,271	5.86	11,969	6.35
Treatment Related	5,136	4.10	47,687	4.33
Monitoring Related	228	4.38	2,246	4.92
Equipment or Product Related	87	6.42	871	5.66
Miscellaneous	316	3.61	3,441	4.76
All Reasons	18,897	4.47	171,015	4.65

This table includes only disclosable reports in the NPDB as of December 31, 1999. Malpractice payment reports which are missing data necessary to calculate payment delay or malpractice reason (142 reports in 1999 and 1,481 reports cumulatively) are excluded.

*The long delay found in 1999 for equipment and product-related payments results from a relatively large number of reports concerning payments in extended class action litigation for defective silicone breast implants.

**TABLE 14: Cumulative Physician and Dentist Licensure Actions, by State
National Practitioner Data Bank, September 1, 1990 - December 31, 1999**

State	Physicians				
	Number of Reportable Licensure Actions	Number of Adverse Licensure Reportable Actions	Percent of Reportable Licensure actions which are Adverse	Number of Adverse Licensure Actions for In-State Physicians	Percent of All Reportable Licensure Actions Which Are Adverse for In-State Physicians
Alabama	288	261	90.63%	247	85.76%
Alaska	88	81	92.05%	81	92.05%
Arizona	612	577	94.28%	553	90.36%
Arkansas	192	165	85.94%	159	82.81%
California	2,811	2,510	89.29%	2,091	74.39%
Colorado	809	739	91.35%	735	90.85%
Connecticut	372	363	97.58%	348	93.55%
Delaware	36	31	86.11%	27	75.00%
Florida	1,381	1,166	84.43%	1,056	76.47%
Georgia	664	578	87.05%	514	77.41%
Hawaii	73	71	97.26%	56	76.71%
Idaho	82	71	86.59%	47	57.32%
Illinois	889	701	78.85%	543	61.08%
Indiana	292	245	83.90%	183	62.67%
Iowa	438	369	84.25%	304	69.41%
Kansas	202	165	81.68%	160	79.21%
Kentucky	495	426	86.06%	381	76.97%
Louisiana	405	377	93.09%	329	81.23%
Maine	127	120	94.49%	118	92.91%
Maryland	802	764	95.26%	725	90.40%
Massachusetts	503	488	97.02%	460	91.45%
Michigan	1,170	1,084	92.65%	988	84.44%
Minnesota	369	313	84.82%	292	79.13%
Mississippi	441	404	91.61%	382	86.62%
Missouri	569	553	97.19%	467	82.07%
Montana	97	86	88.66%	82	84.54%
Nebraska	75	72	96.00%	67	89.33%
Nevada	101	101	100.00%	92	91.09%
New Hampshire	70	69	98.57%	65	92.86%
New Jersey	1,062	919	86.53%	790	74.39%
New Mexico	57	57	100.00%	53	92.98%
New York	2,271	2,256	99.34%	1,851	81.51%

State	Physicians				
	Number of Reportable Licensure Actions	Number of Adverse Licensure Reportable Actions	Percent of Reportable Licensure actions which are Adverse	Number of Adverse Licensure Actions for In-State Physicians	Percent of All Reportable Licensure Actions Which Are Adverse for In-State Physicians
North Carolina	376	316	84.04%	291	77.39%
North Dakota	150	118	78.67%	112	74.67%
Ohio	1,681	1,600	95.18%	1,496	88.99%
Oklahoma	497	420	84.51%	400	80.48%
Oregon	357	338	94.68%	337	94.40%
Pennsylvania	836	769	91.99%	568	67.94%
Rhode Island	135	125	92.59%	113	83.70%
South Carolina	350	253	72.29%	245	70.00%
South Dakota	41	38	92.68%	34	82.93%
Tennessee	321	273	85.05%	249	77.57%
Texas	1,766	1,549	87.71%	1,467	83.07%
Utah	137	111	81.02%	92	67.15%
Vermont	101	99	98.02%	86	85.15%
Virginia	416	323	77.64%	306	73.56%
Washington	529	426	80.53%	385	72.78%
West Virginia	418	355	84.93%	334	79.90%
Wisconsin	303	259	85.48%	227	74.92%
Wyoming	40	35	87.50%	33	82.50%
Washington, DC	75	66	88.00%	40	53.33%
All Reports	26,412	23,668	89.61%	21,073	79.79%

This table includes only disclosable reports in the NPDB as of December 31, 1999.

The All Reports row includes jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.).

State	Dentists				
	Number of Reportable Licensure Actions	Number of Adverse Licensure Reportable Actions	Percent of Reportable Licensure actions which are Adverse	Number of Adverse Licensure Actions for In-State Dentist	Percent of All Reportable Licensure Actions Which Are Adverse for In-State Dentist
Alabama	67	67	100.00%	64	95.52%
Alaska	37	35	94.59%	35	94.59%
Arizona	477	477	100.00%	477	100.00%
Arkansas	24	21	87.50%	21	87.50%
California	335	332	99.10%	327	97.61%
Colorado	394	391	99.24%	383	97.21%
Connecticut	115	113	98.26%	112	97.39%
Delaware	2	2	100.00%	2	100.00%
Florida	280	254	90.71%	252	90.00%
Georgia	126	126	100.00%	125	99.21%
Hawaii	7	7	100.00%	7	100.00%
Idaho	11	11	100.00%	10	90.91%
Illinois	370	265	71.62%	247	66.76%
Indiana	61	49	80.33%	43	70.49%
Iowa	136	133	97.79%	113	83.09%
Kansas	21	21	100.00%	19	90.48%
Kentucky	71	71	100.00%	71	100.00%
Louisiana	91	89	97.80%	89	97.80%
Maine	26	26	100.00%	25	96.15%
Maryland	132	117	88.64%	110	83.33%
Massachusetts	108	103	95.37%	98	90.74%
Michigan	344	324	94.19%	314	91.28%
Minnesota	170	127	74.71%	127	74.71%
Mississippi	53	53	100.00%	52	98.11%
Missouri	79	78	98.73%	73	92.41%
Montana	17	17	100.00%	16	94.12%
Nebraska	30	28	93.33%	27	90.00%
Nevada	30	29	96.67%	28	93.33%
New Hampshire	18	18	100.00%	17	94.44%
New Jersey	225	211	93.78%	209	92.89%
New Mexico	8	7	87.50%	7	87.50%
New York	337	334	99.11%	333	98.81%
North Carolina	222	216	97.30%	216	97.30%
North Dakota	1	1	100.00%	1	100.00%
Ohio	642	617	96.11%	617	96.11%
Oklahoma	82	81	98.78%	80	97.56%

State	Dentists				
	Number of Reportable Licensure Actions	Number of Adverse Licensure Reportable Actions	Percent of Reportable Licensure actions which are Adverse	Number of Adverse Licensure Actions for In-State Dentist	Percent of All Reportable Licensure Actions Which Are Adverse for In-State Dentist
Oregon	214	213	99.53%	209	97.66%
Pennsylvania	157	152	96.82%	126	80.25%
Rhode Island	13	13	100.00%	12	92.31%
South Carolina	46	46	100.00%	46	100.00%
South Dakota	3	3	100.00%	3	100.00%
Tennessee	133	122	91.73%	121	90.98%
Texas	250	247	98.80%	246	98.40%
Utah	50	37	74.00%	33	66.00%
Vermont	2	2	100.00%	2	100.00%
Virginia	208	181	87.02%	181	87.02%
Washington	158	146	92.41%	139	87.97%
West Virginia	9	9	100.00%	9	100.00%
Wisconsin	144	129	89.58%	127	88.19%
Wyoming	0	0	--	0	--
Washington, DC	1	1	100.00%	1	100.00%
All Reports	6,540	6,155	94.11%	6,005	91.82%

This table includes only disclosable reports in the NPDB as of December 31, 1999.

The All Reports row includes jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.).s

**Table 15: Relationship between Frequency of Malpractice Payment Reports and Having No Reportable Action Reports and No Medicare/Medicaid Exclusion Reports, Physicians
National Practitioner Data Bank, September 1, 1990 - December 31, 1999**

Number of Adverse Action Reports for Each Physician	Number of Physicians	Number of Physicians with Specified Number of Adverse Action Reports Having One or More Medical Malpractice Payment Reports		Number of Physicians with Specified Number of Adverse Action Reports Having One or More Medicare/Medicaid Exclusion Reports	
		Number	Percent	Number	Percent
1	66,835	63,759	95.4%	63,700	95.3%
2	16,429	15,276	93.0%	15,258	92.9%
3	4,898	4,397	89.8%	4,392	89.7%
4	1,821	1,565	85.9%	1,563	85.8%
5	723	585	80.9%	584	80.8%
6	379	311	82.1%	310	81.8%
7	176	131	74.4%	131	74.4%
8	92	73	79.3%	73	79.3%
9	82	58	70.7%	58	70.7%
10 or More	178	104	58.4%	103	57.9%
Total	91,613	86,259	94.2%	86,172	94.1%

This table includes only disclosable reports in the NPDB as of December 31, 1999.

**Table 16: Relationship between Frequency of Reportable Action Reports and Having No Malpractice Payment Reports and No Medicare/Medicaid Exclusion Reports, Physicians
National Practitioner Data Bank, September 1, 1990 - December 31, 1999**

Physicians with Specific Number of Reportable Action Reports	Number of Physicians	Physicians with No Malpractice Reports		Physicians with No Malpractice Payments and no Exclusions	
		Number	Percentage	Number	Percentage
1	8,853	6,294	71.1%	5,808	65.6%
2	4,270	2,961	69.3%	2,566	60.1%
3	2,074	1,384	66.7%	1,138	54.9%
4	1,001	658	65.7%	536	53.5%
5	563	362	64.3%	283	50.3%
6	281	162	57.7%	121	43.1%
7	152	89	58.6%	76	50.0%
8	88	50	56.8%	38	43.2%
9	40	28	70.0%	23	57.5%
10 or more	78	58	74.4%	44	56.4%
Total	17,400	12,046	69.2%	10,633	61.1%

This table includes only disclosable reports in the NPDB as of December 31, 1999.

**TABLE 17: Nurse Malpractice Payments, by Reason for Report and Type of Nurse
National Practitioner Data Bank, September 1, 1990 - December 31, 1999**

Malpractice Reason	Number of Payments for Registered Nurses	Number of Payments for Nurse Anesthetist	Number of Payments for Nurse Midwives	Number of Payments for Nurse Practitioners	Total
Diagnosis Related	114	6	18	50	188
Anesthesia Related	75	578	0	3	656
Surgery Related	202	37	5	1	245
Medication Related	281	20	1	19	321
IV or Blood Products Related	103	7	0	2	112
Obstetrics Related	180	6	164	7	357
Treatment Related	361	18	10	34	423
Monitoring Related	382	3	6	6	397
Equipment or Product Related	24	2	0	1	27
Miscellaneous	105	3	2	6	116
All Reasons	1,827	680	206	129	2,842

TABLE 18: Mean and Median Malpractice Payment Amounts (Actual and Inflation Adjusted) Made for the Benefit of Nurses, by Malpractice Reason, 1999 and Cumulative National Practitioner Data Bank, September 1, 1990 - December 31, 1999

Malpractice Reason	1999 Only			Cumulative, 9/1/90-12/31/99				
	Number of Payments	Mean Payment	Median Payment	Number of Payments	Actual Mean Payment	Actual Median Payment	Inflation-Adjusted Mean Payment	Inflation-Adjusted Median Payment
Diagnosis Related	25	\$255,182	\$75,000	188	\$313,694	\$95,783	\$345,842	\$100,341
Anesthesia Related	62	\$190,468	\$47,500	656	\$213,854	\$75,000	\$236,017	\$83,640
Surgery Related	37	\$501,045	\$25,000	245	\$165,068	\$30,000	\$173,996	\$30,879
Medication Related	30	\$325,973	\$128,720	321	\$203,141	\$50,000	\$222,988	\$57,133
IV or Blood Products Related	4	\$257,175	\$11,850	112	\$224,448	\$50,000	\$241,566	\$54,729
Obstetrics Related	50	\$437,980	\$250,000	357	\$394,570	\$200,000	\$422,983	\$205,863
Treatment Related	33	\$114,858	\$45,000	423	\$125,718	\$50,000	\$135,596	\$52,648
Monitoring Related	34	\$242,985	\$92,500	397	\$240,493	\$75,000	\$262,669	\$85,937
Equipment or Product Related	5	\$129,450	\$200,000	27	\$248,832	\$35,000	\$281,251	\$35,429
Miscellaneous	14	\$237,973	\$63,910	116	\$144,397	\$35,000	\$158,956	\$39,032
All Reports	294	\$290,697	\$100,000	2,842	\$226,262	\$65,650	\$246,230	\$74,309

This table includes only disclosable reports in the NPDB as of December 31, 1999. Malpractice payment reports which are missing data necessary to determine the malpractice reason (8 reports) are excluded.

**Table 19: Nurse (Registered Nurses, Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners) Malpractice Payments, by State
National Practitioner Data Bank, September 1, 1990 - December 31, 1999**

State	Number of Reports	Adjusted Number of Reports
Alabama	35	35
Alaska	6	6
Arizona	44	44
Arkansas	21	21
California	110	110
Colorado	46	46
Connecticut	21	21
Delaware	3	3
Florida*	185	185
Georgia	86	86
Hawaii	6	6
Idaho	19	19
Illinois	117	117
Indiana*	16	12
Iowa	17	17
Kansas*	47	30
Kentucky	37	37
Louisiana*	107	94
Maine	7	7
Maryland	58	58
Massachusetts	170	170
Michigan	73	73
Minnesota	14	14
Mississippi	30	30
Missouri	123	123
Montana	6	6
Nebraska*	23	23
Nevada	7	7
New Hampshire	23	23
New Jersey	364	364
New Mexico*	30	29
New York	151	151
North Carolina	43	43

State	Number of Reports	Adjusted Number of Reports
North Dakota	4	4
Ohio	109	109
Oklahoma	40	40
Oregon	18	18
Pennsylvania	89	81
Rhode Island	9	9
South Carolina*	13	12
South Dakota	10	10
Tennessee	75	75
Texas	277	277
Utah	9	9
Vermont	0	0
Virginia	43	43
Washington	38	38
West Virginia	16	16
Wisconsin*	24	22
Wyoming	8	8
Washington, DC	19	19
All Reports	2,850	2,804

This table includes only disclosable reports in the NPDB as of December 31, 1999.

The All Reports row includes jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.).

"Adjusted" columns exclude reports from State patient compensation funds and other similar funds which make payments in excess of amounts paid by a practitioner's primary malpractice carrier. When payments are made by these funds, two reports are filed with the NPDB (one from the primary insurer and one from the fund) whenever a total malpractice settlement or award exceeds a maximum set by the State for the practitioner's primary malpractice carrier. The States marked with asterisks have these funds. Thus, the adjusted columns provide an approximation of the number of incidents resulting in payments rather than the number of payments. See the text for details.

TABLE 20: Mean and Median Malpractice Payment Amounts (Actual and Inflation Adjusted) Made for the Benefit of Physician Assistants, by Malpractice Reason, 1999 and Cumulative National Practitioner Data Bank, September 1, 1990 - December 31, 1999

Malpractice Reason	1999 Only			Cumulative, 9/1/90 – 12/31/99				
	Number of Payments	Mean Payment	Median Payment	Actual Number of Payments	Actual Mean Payment	Actual Median Payment	Inflation-Adjusted Mean Payment	Inflation-Adjusted Median Payment
Diagnosis Related	41	\$191,891	\$90,000	199	\$128,128	\$70,000	\$134,662	\$74,346
Anesthesia Related	0	\$0	\$0	1	\$1,889	\$1,889	\$2,158	\$2,158
Surgery Related	6	\$22,575	\$18,250	20	\$73,832	\$32,500	\$80,619	\$33,934
Medication Related	6	\$94,167	\$100,000	36	\$57,293	\$18,500	\$61,730	\$20,304
IV & Blood Products Related	0	\$0	\$0	0	\$0	\$0	\$0	\$0
Obstetrics Related	0	\$0	\$0	1	\$750,000	\$750,000	\$759,202	\$759,202
Treatment Related	16	\$35,828	\$18,750	105	\$69,786	\$20,000	\$74,828	\$21,250
Monitoring Related	2	\$312,500	\$312,500	6	\$147,898	\$115,000	\$152,919	\$118,168
Equipment or Product Related	0	\$0	\$0	0	\$0	\$0	\$0	\$0
Miscellaneous	4	\$30,750	\$32,500	11	\$32,318	\$22,000	\$33,920	\$25,891
All Reports	75	\$131,856	\$55,000	379	\$101,211	\$40,000	\$106,969	\$42,515

This table includes only disclosable reports in the NPDB as of December 31, 1999.

TABLE 21: Number, Percent, and Percent Change in Queries and Queries Matched, Last Five Years and Cumulative National Practitioner Data Bank, September 1, 1990 - December 31, 1999

Query Type	1995	1996	1997	1998	1997	Cumulative 9/1/90 – 12/31/99
ENTITY QUERIES*						
Total Entity Queries	2,235,812	2,762,643	3,133,471	3,155,558	3,222,348	19,019,945
Queries Percent Increase from Previous Year	99.6%	23.6%	13.4%	0.7%	2.1%	
Matched Queries	206,374	291,078	359,255	374,002	401,277	1,869,712
Percent Matched	9.2%	10.5%	11.5%	11.9%	12.5%	9.8%
Matches Percent Increase from Previous Year	208.2%	41.0%	23.4%	4.1%	7.3%	
SELF-QUERIES						
Total Practitioner Self-Queries	43,617	45,344	52,603	48,287	38,777	306,119
Self-Queries Percent Increase from Previous Year	75.3%	4.0%	16.0%	-8.2%	-19.7%	
Matched Self-Queries	3,154	3,774	4,704	4,293	3,406	24,132
Self-Queries Percent Matched	7.2%	8.3%	8.9%	8.9%	8.8%	7.9%
Matches Percent Increase from Previous Year	126.7%	19.7%	24.6%	-8.7%	-20.7%	
TOTAL QUERIES (ENTITY AND SELF)	2,279,429	2,807,987	3,186,074	3,203,845	3,261,125	19,326,064
TOTAL MATCHED (ENTITY AND SELF)	209,528	294,852	363,959	378,295	404,683	1,893,844
TOTAL PERCENT MATCHED (ENTITY AND SELF)	9.2%	10.5%	11.4%	11.8%	12.4%	9.8%

*Entity queries exclude practitioner self-queries except those submitted electronically by entities using QPRAC during 1999.

TABLE 22: Queries by Type of Querying Entity, Last Five Years and Cumulative National Practitioner Data Bank, September 1, 1990 - December 31, 1999

Type of Querying Entity	1995			1996			1997		
	Number of Querying Entities	Number of Queries	Percent of Queries	Number of Querying Entities	Number of Queries	Percent of Queries	Number of Querying Entities	Number of Queries	Percent of Queries
Required Queriers									
Hospitals	5,910	903,212	40.4%	5,755	988,618	35.8%	5,806	1,031,297	32.9%
Voluntary Queriers									
State Licensing Boards	46	9,846	0.4%	39	10,698	0.4%	50	11,789	0.4%
HMOs, PPOs, Group Practices	1,059	1,102,163	49.3%	1,374	1,418,303	51.3%	1,583	1,632,319	52.1%
Other Health Care Entities	1,026	213,829	9.6%	1,264	336,691	12.2%	1,683	444,063	14.2%
Professional Societies	50	6,762	0.3%	59	8,333	0.3%	73	14,003	0.4%
Total Voluntary Queriers	2,181	1,332,600	59.6%	2,736	1,774,025	64.2%	3,389	2,102,174	67.1%
Total**	8,091	2,235,812	100.0%	8,491	2,762,643	100.0%	9,195	3,133,471	100.0%

Entity Type*	1998			1999			Cumulative 9/1/90-12/31/99		
	Number of Querying Entities	Number of Queries	Percent of Queries	Number of Querying Entities	Number of Queries	Percent of Queries	Number of Querying Entities	Number of Queries	Percent of Queries
Required Queriers									
Hospitals	5,803	1,079,335	34.2%	5,788	1,093,856	33.9%	7,410	8,409,581	44.2%
Voluntary Queriers									
State Licensing Boards	55	10,649	0.3%	56	11,285	0.4%	118	91,249	0.5%
HMOs, PPOs, Group Practices	1,785	1,636,585	51.9%	1,721	1,666,803	51.7%	2,646	8,414,253	44.2%
Other Health Care Entities	2,100	413,962	13.1%	2,345	437,821	13.6%	3,506	2,039,425	10.7%
Professional Societies	93	15,027	0.5%	86	12,583	0.4%	169	65,437	0.3%
Total Voluntary Queriers	4,033	2,076,223	65.8%	4,208	2,128,492	66.1%	6,439	10,610,364	55.8%
Total**	9,836	3,155,558	100%	9,996	3,222,348	100%	13,849	19,019,945	100.0%

*Excludes practitioner self-queries except those submitted electronically by entities using QPRAC during 1999.

**TABLE 23: Number of Queries by Practitioner Type
National Practitioner Data Bank, October - November, 1999**

Practitioner	Queries October & November 1999	Percent of Total Queries
Acupuncturists	494	0.08%
Allopathic Physician Interns/Residents	2,015	0.31%
Allopathic Physicians(M.D.)	494,857	75.62%
Art/Recreation Therapist	10	0.00%
Athletic trainers	11	0.00%
Audiologists	559	0.09%
Chiropractors	9,383	1.43%
Cytotechnologists	11	0.00%
Dental Assistants	118	0.02%
Dental Hygienists	64	0.01%
Dental Residents	53	0.01%
Dentists	36,865	5.63%
Denturists	41	0.01%
Dietitians	209	0.03%
EMT, Basic	31	0.00%
EMT, Cardiac/Critical Care	9	0.00%
EMT, Intermediate	10	0.00%
EMT, Paramedic	28	0.00%
Home Health Aids(Homemakers)	8	0.00%
Homeopaths	11	0.00%
Massage Therapists	17	0.00%
Medical Assistants	307	0.05%
Medical Technologists	212	0.03%
Mental Health Counselors	1,876	0.29%
Midwives, Lay(Non-Nurse)	59	0.01%
Naturopaths	63	0.01%
Nuclear Medicine Technologists	14	0.00%
Nurse Anesthetists	4,394	0.67%
Nurse Midwives	1,276	0.19%
Nurse Practitioners	5,974	0.91%
Nurses (R.N., Not Specialized)	9,044	1.38%
Nurses Aides	77	0.01%
Nurses, Licensed Practical or Vocational	647	0.10%
Nutritionists	73	0.01%
Occupational Therapists	1,115	0.17%
Occupational Therapy Assistants	56	0.01%
Ocularists	43	0.01%

Practitioner	Queries October & November 1999	Percent of Total Queries
Opticians	52	0.01%
Optometrists	12,398	1.89%
Orthotics/Prosthetics Fitters	86	0.01%
Osteopathic Physician Interns/Residents	174	0.03%
Osteopathic Physicians(D.O.)	25,721	3.93%
Other, Not Classified	105	0.02%
Perfusionists	8	0.00%
Pharmacists	232	0.04%
Pharmacists, Nuclear	24	0.00%
Pharmacy Assistants	103	0.02%
Physical Therapists	6,012	0.92%
Physical Therapy Assistants	208	0.03%
Physician Assistants (Allopathic)	5,737	0.88%
Physician Assistants (Osteopathic)	70	0.01%
Podiatric Assistants	65	0.01%
Podiatrists	11,643	1.78%
Professional Counselors	3,739	0.57%
Professional Counselors, Alcohol	123	0.02%
Professional Counselors, Family/Marriage	2,220	0.34%
Professional Counselors, Substance Abuse	320	0.05%
Psychiatric Technicians	50	0.01%
Psychologists, Clinical	14,850	2.27%
Radiation Therapy Technologists	25	0.00%
Radiological Technologists	149	0.02%
Rehabilitation Therapist	197	0.03%
Respiratory Therapists	67	0.01%
Respiratory Therapy Technicians	10	0.00%
Social Workers, Clinical	13,617	2.08%
Speech/Language Pathologists	832	0.13%
Total	654,422	100.00%

Queries for this sample period may not be representative of other times.

Table 24: Entities that Have Queried or Reported to the National Practitioner Data Bank at Least Once, by Entity Type
National Practitioner Data Bank September 1, 1990 - December 31, 1999

Entity Type	Active Status, 12/31/99	Active At Any Time
Malpractice Payers	196	447
Hospitals	6,546	7,424
State Licensing Boards	147	172
HMOs, PPOs, Group Practices	2,384	2,690
Other Health Care Entities	3,464	3,778
Professional Societies	143	180
Total	12,880	14,691

The counts shown in this table are based on entity registrations. A few entities have registered more than once. The registration counts shown in this table may, therefore, slightly over-count the actual number of separate, individual entities in each category. Entities that may report both clinical privileges actions and malpractice payments, such as hospitals and HMOs, are instructed to register as health care entities, not malpractice payers, and are not double counted in this table.

TABLE 25: Requests for Secretarial Review, by Report Type, Last Five Years and Cumulative National Practitioner Data Bank, September 1, 1990 - December 31, 1999

Category	1995			1996			1997		
	Number	Percent	% Change 1994-1995	Number	Percent	% Change 1995-1996	Number	Percent	% Change 1996-1997
Reportable Actions	60	61.9%	-25.9%	75	65.2%	25.0%	79	6.4%	5.3%
Licensure	19	19.6%	0.0%	29	25.2%	52.6%	34	2.7%	17.2%
Clinical Privileges	41	42.3%	-31.7%	43	37.4%	4.9%	45	3.6%	4.7%
Professional Society Membership	0	0.0%	-100.0%	3	2.6%	---	0	0.0%	-100.0%
Medical Malpractice Payments	37	38.1%	-26.0%	40	34.8%	8.1%	51	4.1%	27.5%
Total	97	100.0%	-26.0%	115	100.0%	18.6%	130	100.0%	13.0%

Category	1998			1999			Cumulative 9/1/90 - 12/31/99	
	Number	Percent	% Change 1997-1998	Number	Percent	% Change 1998-1999	Number	Percent
Reportable Actions	65	57.0%	-17.7%	65	71.4%	0.0%	761	61.3%
Licensure	23	20.2%	-32.4%	25	27.5%	8.7%	248	20.0%
Clinical Privileges	42	36.8%	-6.7%	39	42.9%	-7.1%	500	40.3%
Professional Society Membership	0	0.0%	---	1	1.1%	---	13	1.0%
Medical Malpractice Payments	49	43.0%	-3.9%	26	28.6%	-46.9%	481	38.7%
Total	114	100.0%	-12.3%	91	100.0%	-20.2%	1,242	100.0%

Data in this table represent the number of requests for Secretarial review dated during each year. For undated requests, the date the request was received by the Division of Quality Assurance was used.

TABLE 26: Distribution of Requests for Secretarial Review, by Type of Outcome, Last Five Years and Cumulative National Practitioner Data Bank, September 1, 1990 - December 31, 1999

Outcome	1995			1996			1997		
	Number	Percent	Percent of Resolved Requests	Number	Percent	Percent of Resolved Requests	Number	Percent	Percent of Resolved Requests
In Favor of Entity (No Change in Report)	35	36.1%	36.1%	48	41.7%	41.7%	59	45.4%	4.9%
Request "Out of Scope" (No Change in Report)	42	43.3%	43.3%	37	32.2%	32.2%	39	30.0%	3.2%
In Favor of Practitioner (Report Voided or Changed)	11	11.3%	11.3%	19	16.5%	16.5%	18	13.8%	1.5%
Voluntary Voiding or Changing of Report	6	6.2%	6.2%	11	9.6%	9.6%	11	0.9%	0.9%
Administratively Dismissed	3	3.1%	3.1%	0	0.0%	0.0%	2	1.5%	0.2%
Unresolved	0	0.0%	N/A	0	0.0%	N/A	1	0.8%	N/A
Total	97	100.0%	100.0%	115	100.0%	100.0%	130	100.0%	10.7%

Outcome	1998			1999			Cumulative, 9/1/90 – 12/31/99		
	Number	Percent	Percent of Resolved Requests	Number	Percent	Percent of Resolved Requests	Number	Percent	Percent of Resolved Requests
In Favor of Entity (No Change in Report)	64	56.1%	59.3%	27	29.7%	45.0%	501	40.3%	41.6%
Request "Out of Scope" (No Change in Report)	32	28.1%	29.6%	20	22.0%	33.3%	461	37.1%	38.3%
In Favor of Practitioner (Report Voided or Changed)	4	3.5%	3.7%	9	9.9%	15.0%	153	12.3%	12.7%
Voluntary Voiding or Changing of Report	6	5.3%	5.6%	4	4.4%	6.7%	67	5.4%	5.6%
Administratively Dismissed	2	1.8%	1.9%	0	0.0%	0.0%	22	1.8%	1.8%
Unresolved	6	5.3%	N/A	31	34.1%	N/A	38	3.1%	N/A
Total	114	100.0%	100.0%	91	100.0%	100.0%	1,242	100.0%	100.0%

This table represents the outcome of requests for Secretarial review based on the date of the request. For undated requests, the date the request was received by the Division of Quality Assurance was used.

**TABLE 27: Cumulative Requests for Secretarial Review, by Report Type and Outcome Type
National Practitioner Data Bank, September 1, 1990 - December 31, 1999**

Outcome	Malpractice Payments		Licensure Actions		Clinical Privileges Actions	
	Number	Percent of Resolved Requests	Number	Percent of Resolved Requests	Number	Percent of Resolved Requests
Decision In Favor of Entity (No Change in Report)	149	31.2%	117	48.8%	232	48.8%
Request "Out of Scope" (No Change in Report)	262	54.9%	51	21.3%	143	30.1%
Decision In Favor of Practitioner (Report Voided or Changed)	35	7.3%	48	20.0%	68	14.3%
Voluntary Voiding or Changing of Report by Reporting Entity	22	4.6%	21	8.8%	23	4.8%
Administratively Dismissed	9	1.9%	3	1.3%	9	1.9%
Under Review (open cases)	4	N/A	8	N/A	25	N/A
Total	481	100.0%	248	100.0%	500	100.0%

Outcome	Professional Society Membership Actions		Total	
	Number	Percent of Resolved Requests	Number	Percent of Requests
Decision In Favor of Entity (No Change in Report)	3	25.0%	501	41.6%
Request "Out of Scope" (No Change in Report)	5	41.7%	461	38.3%
Decision In Favor of Practitioner (Report Voided or Changed)	2	16.7%	153	12.7%
Voluntary Voiding or Changing of Report by Reporting Entity	1	8.3%	67	5.6%
Administratively Dismissed	1	8.3%	22	1.8%
Under Review (open cases)	1	N/A	38	N/A
Total	13	100.0%	1,242	100.0%