National Practitioner Data Bank

2001 Annual Report

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Bureau of Health Professions
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Requests for copies of this report and information on the National Practitioner Data Bank should be directed to the Data Bank Customer Service Center, 1-800-767-6732. This report and other information is also available on the Internet World Wide Web at http://www.npdb-hipdb.com.

NATIONAL PRACTITIONER DATA BANK

2001 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 September 1, 1990. Since 1997 the NPDB also has included reports of exclusions from participation in the Medicare and Medicaid programs. This document shows NPDB activities and accomplishments during 2001 by describing operational improvements, prospects for the future, and presenting program statistics. Also, NPDB guidelines are reviewed, and issues impacting reporting trends are discussed.

Operational Improvements and Prospects for the Future

The NPDB continued improving its policies and operations in 2001 and for the future, including:

- Users and Non-Users Survey Completed
- NPDB Interactive Education and Training Program Released
- Integrated Querying and Reporting Service (IQRS) Improved
- NPDB Information Web Site Improved
- NPDB Guidebook Updated
- Subject Notification Documents and Fact Sheets Improved
- Coding Changes and Operational Improvements In Process
- Reporting Errors Corrected
- Pilot Studies on Clinical Privileges and Malpractice Payment Reporting Compliance Initiated
- NPDB Reporting Compliance Project Continued
- Public Citizen's 20,125 Questionable Doctors Disciplined by State and Federal Governments Books Compared to NPDB and HIPDB

- NPDB Information Helped Compliance Efforts
- Physician Placement Service Fined for Unauthorized Queries
- PREP Program Continued Helping Boards and Hospitals
- Health Plan Assisted with September 11th Recovery

Reports

By December 31, 2001, after 11 years and four months of operations, the NPDB contained reports on 291,520 reportable actions, malpractice payments, and Medicare/Medicaid exclusions involving 178,745 individual practitioners. Of the 178,745 practitioners reported to the NPDB, 69.4 percent were physicians (including M.D. and D.O. residents and interns), 13.9 percent were dentists (including dental residents), 6.8 percent were nurses and nursing-related practitioners, and 9.9 percent were other health care practitioners. About two-thirds of physicians with reports (64.4 percent) had only one report in the NPDB, 84.3 percent had two or fewer reports, 97.2 percent had five or fewer, and 99.6 percent had 10 or fewer. Notably, few physicians had both Medical Malpractice Payment Reports and Reportable Action Reports. Only 6.6 percent had at least one report of both types.

Approximately 73.9 percent of all reports received during 2001 concerned malpractice payments. Cumulatively malpractice payments comprised 72.9 percent of all reports. During 2001, physicians were responsible for 81.1 percent of all Malpractice Payment Reports. Dentists were responsible for 11.3 percent, and all other health care practitioners were responsible for the remaining 7.7 percent. These figures are similar to the percentages from previous years.

Cumulatively, the median malpractice payment for physicians was $100,000 ($109,569 adjusting for inflation to standardize payments made in prior years to 2001 dollars) and the mean malpractice payment for physicians was $209,295 (approximately $236,523 adjusting for inflation)[1]. Both the mean and the median payments for 2001 ($270,854 and $135,000, respectively) were higher than the cumulative figures. During 2001, as in previous years, obstetrics-related cases, which represented approximately 8.7 percent of all physician Malpractice Payment Reports, had the highest median payment amounts ($250,000). The median obstetrics-related payment for physicians was $25,000 more than in 2000, and the mean payment was $71,258 more than in 2000. Incidents relating to miscellaneous incidents (0.96 percent of all reports) had the lowest mean and median payments during 2001 ($115,104 and $32,000 respectively).

For all medical malpractice payments made during 2001, the mean delay between an incident that led to a payment and the payment itself was 4.46 years. This is about seven days less than in 2000. The 2001 mean physician payment delay varied markedly between the States, as in previous years, and ranged from 3.02 years in California to 6.44 years in Rhode Island.

Reportable actions (licensure, clinical privileges, professional society membership, and DEA actions) represent 17.8 percent of all reports received cumulatively and 15.4 percent (4,298 of 27,893) of all reports received by the NPDB during 2001. The 4,298 reportable action reports received during 2001 are 23.3 percent less than the number of reportable action reports submitted to the NPDB during 2000. This is the lowest number of reportable actions reported since 1993 (4,231 reported in 1993). The number of licensure action reports received decreased 29.2 percent from 2000 to 2001. During 2001, licensure actions reports comprised 74.5 percent of all reportable action reports and clinical privilege reports comprised 24.6 percent.

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[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.

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. This concern reflects general agreement at a 1996 HRSA-sponsored conference on the issue of hospital clinical privilege reporting that the level of reporting is unreasonably low. Nationally over the history of the NPDB, there are 3.8 times more licensure reports than clinical privilege reports. Moreover, 55.3 percent of the hospitals currently in "active" registered status with the NPDB have never submitted a clinical privilege report. Clinical privilege reporting seems to be concentrated in a few facilities even in States which have comparatively high overall clinical privileging reporting levels.

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

Queries

From September 1, 1990 through December 31, 2001, the NPDB responded to over 25.9 million inquiries ("queries") from authorized organizations such as hospitals, managed care organizations (HMOs, PPOs, group practices, etc.), State licensing boards, professional societies, and individual practitioners seeking to review their own records. During 2001, entity query volume decreased 1.8 percent, from 3,290,082 queries in 2000 to 3,230,631 queries in 2001. This is the first decrease in queries since the opening of the Data Bank.

Although the number of mandatory hospital queries increased by 6.6 percent from 1997 to 2001, over the NPDB's existence the increase in the number of voluntary queries (queries by all registered entities other than hospitals) usually has been larger than the increase in the number of mandatory hospital queries. However, from 1997 to 2001 there was only a 1.3 percent increase in voluntary queries, from 2,084,376 to 2,112,264. During 2001, 65.4 percent of queries were submitted by voluntary queriers; cumulatively from September 1, 1990 through December 31, 2001 well over half (58.2 percent) of the queries were submitted by voluntary queriers. Of the voluntary queriers, managed care organizations are the most active. Although they represent only 14.0 percent of all entities that have queried the NPDB through December 31, 2001, they had made 47.9 percent of all queries cumulatively. These organizations made 52.0 percent of all queries during 2001.

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 2001 a total of 429,558 matches were made on entity queries; thus, 13.3 percent of all entity queries resulted in a match. Cumulatively 2,715,891 matches have been made on entity queries; the match rate from the opening of the NPDB through the end of 2001 is 10.6 percent.

Disputes and Secretarial Reviews

A practitioner about whom a report has been filed may dispute either the accuracy of the report or the fact that the report should have been filed. 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 2001, 4.5 percent (1,809) of all licensure reports, 15.1 percent (1,592) of all clinical privilege reports, and 3.9 percent (8,204) of all Malpractice Payment Reports in the NPDB were in dispute. Only a few practitioners who dispute reports also request Secretarial Review. There were 87 requests for Secretarial Review during 2001. Reportable actions comprise 65.5 percent of all 2001 requests for Secretarial Review and 61.2 percent of all requests cumulatively for Secretarial Review. This is in sharp contrast to the 15.4 percent of all reports represented by reportable actions in 2001 and the 17.8 percent cumulatively. Of the 87 requests for Secretarial Review received during the year, 55 cases were resolved by the Secretary before the end of the year. Of these, 3.5 percent resulted in positive outcomes for the practitioner (report voided or changed, or Secretarial Review request closed by intervening action, such as an entity changing the report to the

practitioner's satisfaction). Cumulatively, 16.0 percent of 1,463 cumulative requests for Secretarial Review (234 requests) have resulted in positive outcomes for practitioners.

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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 November 14, 1986, the Act authorized the Secretary of Health and Human Services to establish a national data bank intended to protect the public by restricting the ability of unethical or incompetent practitioners to move from State to State without disclosure or discovery of previously damaging or incompetent performance.

The HCQIA also includes provisions encouraging 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 Practitioner Data Banks (DPDB) of the Bureau of Health Professions (BHPr), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (DHHS), is responsible for administering and managing the NPDB program. The NPDB itself is operated by a contractor, SRA International, Inc. (SRA), which began doing so in June 1995[2]. SRA created the Integrated Querying and Reporting Service (IQRS), an Internet reporting and querying system for the NPDB and the Healthcare Integrity and Protection Data Bank (HIPDB).[3]

An Executive Committee advises SRA on operation and policy matters. The committee includes approximately 30 representatives from various health professions, national health organizations, State professional licensing bodies, malpractice insurers, and the public. It usually meets three times a year with both SRA and DPDB personnel.

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

[3] A separate annual report for just the HIPDB is also prepared by DPDB and is available on the Data Banks' web site at www.npdb-hipdb.com.

The Role of the NPDB

The NPDB is a central repository of information about: (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 Administration (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 U.S. jurisdiction.[5]

NPDB information is made available upon request to registered entities eligible to query (State licensing boards, professional societies, and other health care entities that conduct peer review, including HMOs, PPOs, group practices, etc.) or required to query (hospitals). These entities query about practitioners who currently have or are requesting licensure, clinical privileges, or professional society membership. The NPDB's information alerts querying entities of possible problems in a practitioner's past so they may further review a practitioner's background as needed. The NPDB augments and verifies, not replaces, other sources of information. It is a flagging system only, not a system designed to collect and disclose full records of reported incidents or actions. It also is important to note the NPDB does not have information on reportable actions taken or malpractice payments made before September 1, 1990, the date it opened. As reports accumulate over time, the NPDB's information becomes more extensive, and therefore more valuable.

How the NPDB Protects the Public

Although the Act does not allow release of practitioner-specific NPDB information to the public, the public does benefit from it. Licensing authorities and peer reviewers get information needed to identify possibly incompetent or unprofessional physicians, dentists, and other health care practitioners. They can use this information to make better licensing and credentialing decisions that 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 NPDB report also is available.[6] This file can be used to analyze 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 and dollar amounts of payments, and types of incidents leading to payments. Similarly, health care entities could use the file to identify problem areas in the delivery of services so they could target quality improvement actions toward them.

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[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.

[6] Information identifying 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 on the Internet www.ntis.gov/fcpc/cpn8158.htm. For a detailed listing of the variables and values for each variable in the Public Use File, visit www.npdb-hipdb.com/pubs/stats/specs.txt.

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 sent to the NPDB. Revisions to previously reported actions also must be reported.

- A clinical privilege report must be filed with the NPDB when (1) a hospital, HMO, or other health care entity takes certain professional review actions that adversely affect for more than 30 days the clinical privileges of a physician or dentist, or when (2) a physician or dentist voluntarily surrenders or restricts his or her clinical privileges while being investigated for possible professional incompetence or improper professional conduct or in return for an entity not conducting an investigation or reportable professional review action. 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 it is not required.

- When a professional society takes a professional review action based on reasons related to professional competence or professional conduct that adversely affects a physician's or a dentist's membership, that action must be reported. Revisions to previously reported actions also must be reported. Such actions also may be reported for health care practitioners other than physicians or dentists.

- When the DEA revokes the DEA registration ("number") of a practitioner, a report is filed.

Medical Malpractice Payment Reports must be submitted to the NPDB when an entity (but not a self-insured practitioner[7]) makes a payment for the benefit of a physician, dentist, or other health care practitioner in settlement of, or in satisfaction in whole or in part of, a claim or judgment against that practitioner.

The HHS's exclusion of a practitioner from Medicare or Medicaid reimbursement 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.

Requesting Information from the NPDB

Hospitals, certain health care entities, State licensure boards, and professional societies may request information from ("query") the NPDB. Hospitals are required to routinely query the NPDB. Malpractice insurers cannot query the NPDB.[8]

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[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 but not for "insurance" purposes.

A hospital must query the NPDB (A hospital may also query at any time during professional review activity):

- When a physician, dentist, or other health care practitioner applies for medical staff appointments (courtesy or otherwise) or for clinical privileges at the hospital; and

- Every 2 years (biennially) on all physicians, dentists, and other health care practitioners who are on its medical staff (courtesy or otherwise) or who hold clinical privileges at the hospital.

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.

- Other health care entities, including professional societies, may query when entering an employment or affiliation relationship with a practitioner or in conjunction with professional review activities.

The NPDB also may be queried in two other circumstances.

- Physicians, dentists, or other health care practitioners may "self-query" the NPDB about themselves at any time. Practitioners may not query to obtain records of other practitioners.

- An attorney for a plaintiff in a malpractice action against a hospital may query and receive information from the NPDB about a specific practitioner in limited circumstances. In cases where plaintiffs represent themselves, they may obtain information for themselves. This is possible only when independently obtained evidence submitted to DHHS discloses that the hospital did not make a required query to the NPDB on the practitioner. If it is demonstrated the hospital failed to query as required, the attorney or plaintiff will be provided with information the hospital would have received had it queried.

Querying Fees

As mandated by law, user fees, not taxpayer funds, are used to operate the NPDB. The NPDB fee structure is designed to ensure the NPDB is self-supporting. All queriers must pay a fee for each practitioner about whom information is requested. The base entity query fee is $5 per name for queries submitted via IQRS and is paid for electronically. Self-queries, which are more expensive to process because they require some manual intervention, cost a total of $20 for both the NPDB and the Healthcare Integrity and Protection Data Bank (HIPDB)[9]. Self-queries must be submitted to both Data Banks to ensure that queriers receive complete information on all NPDB-HIPDB reports. All query fees must be paid by credit card at the time of query submission or through prior arrangement using automatic electronic funds transfer.

Confidentiality of NPDB Information

Under the terms of the HCQIA, NPDB information that permits identification of particular practitioners, entities, or patients is confidential. The DHHS has designated the NPDB as a confidential "System of Records"

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[9] The Healthcare Integrity and Protection Data Bank (HIPDB) is a flagging system run by the Federal government. Its information is used to flag or identify health care practitioners, providers, and suppliers involved in acts of health care fraud and abuse. The HIPDB includes information on final adverse actions taken against health care practitioners, providers, or suppliers. Information is restricted to Federal and State government agencies and health plans. The NPDB and HIPDB are both run by the DPDB, and entities report to and query both Data Banks through the same web site at www.npdb-hipdb.com.

under the Privacy Act of 1974. Authorized queriers who receive NPDB information must use it solely for the purposes for which it was provided. Any person violating the confidentiality of NPDB information is subject to a civil money penalty of up to $11,000 for each violation.

The Act does not let the NPDB disclose information on specific practitioners 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. 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 accuracy, each practitioner reported to the NPDB is notified a report has been made and is provided a copy of it. Since March 1994, the NPDB has allowed practitioners to submit a statement expressing their views of the circumstances surrounding any Malpractice Payment Report or Adverse Action Report concerning them. The practitioner's statement is disclosed along with the report. If a practitioner decides to dispute the report's accuracy 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 released in response to queries. The practitioner also must attempt to work with the reporting entity to reach agreement on revision or voidance of a disputed report. If a practitioner's concerns are not resolved by the reporting entity, the practitioner may ask the Secretary of Health and Human Services to review the disputed information. The Secretary then makes the final determination 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 (DEA), 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 (DOD) September 21, 1987, with the DEA November 4, 1988, and with the Department of Veterans Affairs (DVA) 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 June 6, 1994 and August 21, 1994, respectively. Policies under which the Public Health Service participates in the NPDB were implemented November 9, 1989 and October 15, 1990.

Under an agreement between HRSA, the Center for Medicaid and Medicare Services (CMS), and the Office of Inspector General (OIG), Medicaid and Medicare exclusions were placed in the NPDB in March 1997 and have been updated periodically. Reinstatement reports were added in October 1997. The initial reports included all exclusions in effect as of the March 1997 submission date to the NPDB regardless of when the penalty was imposed.

2001 NPDB IMPROVEMENTS AND PROSPECTS FOR THE FUTURE

The eleventh full year of operation of the NPDB was marked by the following activities if the Department of Health and Human Services (DHHS):

- Users and Non-Users Survey Completed
- NPDB Interactive Education and Training Program Released
- Integrated Querying and Reporting Service (IQRS) Improved
- NPDB Information Web Site Improved
- NPDB Guidebook Updated
- Subject Notification Documents and Fact Sheets Improved
- Coding Changes and Operational Improvements In Process
- Reporting Errors Corrected
- Pilot Studies on Clinical Privileges and Malpractice Payment Reporting Compliance Initiated
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- NPDB Information Helped Compliance Efforts
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- PREP Program Continued Helping Boards and Hospitals
- Health Plan Assisted with September 11th Recovery

Users and Non-Users Survey Completed

The DPDB sponsored survey of NPDB users and non-users by the University of Illinois at Chicago, Northwestern University, and the University of Tennessee Health Science Center was completed, and its final report was published on April 2001. The survey assessed satisfaction of current NPDB users with the reporting and querying processes, identified methods for improving these processes, and assessed user perception of the usefulness of NPDB information in licensing and credentialing decisions. The report overall shows that queriers and reporters are satisfied with the NPDB and find its information useful.

In the survey of NPDB queriers, satisfaction with querying was relatively high (5.74 out of 7, on a scale of 1 to 7 with 7 being the highest score). Satisfaction with the timeliness of the query responses seemed to have increased between 1994 and 2000. In 1994, depending on the category of queriers, from 28.4 percent and 46.7 percent of respondents indicated that responses were timely, while in 2000, approximately two-thirds of respondents were very satisfied with the timeliness of query results. Queriers tend to rate NPDB querying as very useful, assigning it an average usefulness score of 6.62 out of 7.

In the survey of NPDB reporters, satisfaction rates with the reporting process were reasonable, although lower than that found for querying. Average satisfaction scores were generally around 5 (out of 7), with between 30 and 45 percent of the respondents reporting "very satisfied" (6 or 7).

In a third survey of queriers who received matched responses to their queries the NPDB provided useful information in 87.5 percent of the responses reviewed. When missing survey responses are deleted, this number rises to 91.8 percent of cases. Overall, approximately 15 percent of match responses contained information that was new to the respondents. The information from the NPDB appears to have been relatively influential in decision-making regarding practitioners: in 56.9 percent of cases, respondents indicated that the information was very influential (rating it a 6 or 7 on a 7-point scale).

A separate survey of NPDB non-users was also conducted to determine why these institutions did not use the NPDB, and how they believed that the processes of the NPDB could be improved. Response rates were 69.8 percent for the user survey and 83.3 percent for the non-user survey. More results of the survey are described in its final report.

NPDB Interactive Education and Training Program Released

The NPDB Interactive Education and Training Program was uploaded to the Data Banks' web site at www.npdb-hipdb.com on July 26, 2001. The program helps State licensing boards, hospitals, and other eligible health care entities better understand the reporting requirements for medical malpractice payments made for the benefit of and adverse actions taken against physicians, dentists, and other health care practitioners. Some of the training program's capabilities include answering frequently asked questions, explaining the reporting process, and testing a user's ability to apply NPDB reporting requirements and policies to his or her respective agency. For example, animation and interactive flow charts are used to show the step-by-step processes for submitting, changing, and disputing reports. An interactive quiz describes more than 50 scenarios that resulted in medical malpractice payments, adverse clinical privileges actions, adverse licensure actions, adverse membership actions, and exclusions. Test takers determine which actions are reportable to the NPDB. More than a thousand flyers promoting the NPDB and HIPDB Education and Training Programs were provided to the American Association of Health Plans for distribution.

Integrated Querying and Reporting Service (IQRS) Improved

The IQRS was improved during 2001, providing several new services to queriers and reporters, including a new on-line self-query process, the new ability of entities to modify some of their registration information on-line, enhancement of password security, and new screens that show queriers' billing histories.

As of June 2001 self-queriers can complete and transmit the informational portion of the self-queries directly to the Data Bank (www.npdb-hipdb.com). After transmitting the self-query, users complete the process by printing the self-query application, signing the application in the presence of a Notary Public, and then mailing the notarized application to the Data Banks. To pay for the queries, practitioners must either enter their credit card information on-line or write the information on the printed, completed application they send back to the Data Banks.

Also, as of March 2001, entities and agents can update selected registration information via the IQRS. This convenience improves the ease and timeliness of updating entity registration information. A new web screen, Update Entity Profile, allows entities and agents to change their department name, mailing address, e-mail address, and Taxpayer Identification Number (TIN). Two additional screens allow users to view entity and agent registration information.

In addition, during this same month the NPDB-HIPDB introduced an enhanced security feature for the IQRS. Prior to March 2001, an entity was required to change its password routinely because of the number of possible users that may have access to that entity's Data Bank Identification Number (DBID) and password. As part of this improvement, an entity can maintain one DBID but set up several user accounts. Under this

improved plan, one user is established as the Account Administrator, and that person has the ability to set up several user ID's and passwords under the one entity DBID.

Lastly, the IQRS introduced a Billing History screen for entities to better reconcile query charges as they appear on Electronic Funds Transfer (EFT) and credit card statements. The screen also simplifies the way agents reconcile the query charges incurred on behalf of their entities. All these improvements make the IQRS more user friendly and more secure. In the future, more manual processes will be automated; for example, entities will be able to set up Electronic Funds Transfer (EFT) accounts and designate agents on-line.

NPDB Information Web Site Improved

Users can now find information more easily on the Data Banks' web site (www.npdb-hipdb.com) because of a re-design that was finalized on-line on December 14, 2001. The re-designed site organizes information more logically and efficiently. Users are now able to click quickly to the IQRS, the on-line Self-Query Service, frequently used NPDB-HIPDB forms, or the NPDB and HIPDB Interactive training programs. One important new addition, the Quick List Icons feature, allows users to navigate the web site more quickly and minimizes time spent searching for information. In compliance with the American with Disabilities Act, the re-designed site also allows persons using special accessibility devices to better interact with the site.

NPDB Guidebook Updated

The first complete revision of the NPDB Guidebook since 1996 became available on the NPDB-HIPDB web site at www.npdb-hipdb.com in September 2001. It can be viewed and/or downloaded from the web site in its entirety or by individual chapter. Highlights of the revised Guidebook include: information on Medicare/Medicaid exclusions in the NPDB; new guidance for the completion of Medical Malpractice Payment Report narratives; new information on the reportability of medical malpractice payments made as a result of "high-low agreements"; new examples of reportable and non-reportable adverse actions; updated contact information for State medical and dental boards, including web site addresses; better integration with other information on the web site (i.e., fact sheets, links); changes to the NPDB as a result of the transition from QPRAC, the previous software-based querying and reporting system, to the on-line IQRS; and revisions to the self-querying section to reflect the current on-line process. This Guidebook edition supersedes all previous versions.

Subject Notification Documents and Fact Sheets Improved

DPDB staff revised the Subject Notification Document and the Subject's Statement and/or Dispute form. The revised forms incorporated changes recommended by the DHHS OIG and provide additional information based on subjects' comments and questions concerning the current documents. The NPDB fact sheets, which give information on various topics concerning the Data Banks, such as reporting and querying requirements, were consolidated, revised and updated. The fact sheets reflect revisions in the NPDB Guidebook and changes resulting from the transition from QPRAC to IQRS. The new fact sheets became part of the revised NPDB-HIPDB web site.

Coding Changes and Operational Improvements In Process

The final report of a study by the Center for Health Policy Studies (CHPS) of Columbia, Maryland on optimal coding schemes for NPDB Adverse Action and Malpractice Payment reports was completed in September 2000. The study examined how reporting to the NPDB could be improved, especially as it relates to coding of the reasons for the malpractice payment or the type of, and reason for, the adverse action taken. A significant fraction of reports of malpractice payments and adverse actions are reported with Other, Not Classified reason codes. The study examined how the use of Other, Not Classified could be reduced. Committees on Adverse Action Reporting and Malpractice Payment Reporting, composed of NPDB Executive Committee members, NPDB users, and other experts, made several suggestions for improving reporting codes.

In 2001, the following MMPR panel recommendations that were initiated for implementation: use of certain Insurers Association of America (PIAA) reporting codes for medical malpractice payment and using codes to gather most of the information currently collected in narratives. In the future DPDB staff will identify entities that frequently report practitioner acts or omissions using Other, Not Classified and encourage them to make better use of specific codes. Due to the complexity of making these changes, they will not be fully implemented for some time.

Several AAR panel recommendations are also initiated for implementation, such as expanding from one to five the number of Adverse Action Classification codes that may be reported on a single report. The Adverse Action Classification code indicates the specific action taken by an entity (e.g., suspension of a professional license). Many reporting entities, particularly State licensing boards, have indicated that they often take several actions based on a single incident. A second reporting enhancement is the development of new Basis for Action code lists for each type of adverse action taken against individual subjects. The NPDB developed these new codes in an effort to provide a more comprehensive list of reasons for taking an adverse action, and to reduce the need for entities to select the Other, Not Classified code. As part of the development process, NPDB program staff reviewed two years of reporting data (including approximately 9,000 records of Basis for Action selections), and contacted more than 20 organizations representing various types of entities that report adverse actions. Third, entities will be able to report up to five separate Basis for Action codes, rather than the four codes they are now able to report. A fourth enhancement is the development of new Occupational/Field of Licensure code lists for individual subjects. The additional Occupational/Field of Licensure codes apply to nurses, psychologists, counselors, and pharmacists. The changes are expected to be fully implemented in 2002.

Reporting Errors Corrected

SRA engaged in a project to correct the following types of reports with the following types of errors: reports with an invalid date of birth; Medical Malpractice Payment Reports (MMPRs) with invalid acts or omissions dates; Adverse Action Reports and Consolidated Adverse Action Reports (AAR & CAAR) with date discrepancies; potentially linked and/or duplicate reports; NPDB reports with invalid Field of Licensure (FOL) codes; and Health Plan Action Conversion. SRA sent letters to reporting entities asking them to correct invalid birth dates on reports they submitted. More than 200 reports were corrected. SRA researched 1,533 reports in the NPDB with FOLs coded as non-licensed health care professionals, who are not reportable to the NPDB but are reported to the HIPDB. These reports were either submitted to the NPDB with incorrect FOLs or were submitted to both Data Banks. Reports that were improperly submitted to both Data Banks were removed from the NPDB only. A future clean up effort for reports in NPDB with improper Fields of Licensure (FOL) is planned. Initially, health plan actions were reported to the HIPDB as Government Administrative Actions because there was no Health Plan Action classification. With this category of reports now added, health plan actions previously reported as Government Administrative Action reports are being converted into Health Plan Action reports.

Reports with faulty dates were also part of the data correction effort. These include AARs with discrepancies in their adverse action and processing dates. Reports for which the date of action is after the processing date of the report, or “early” reports, were also added to the data correction project. DPDB also examined the extent to which reports are being received late – in some cases years late. By law they should be submitted to the NPDB within 30 days of the date an action was taken. Initial efforts concentrated on identifying reports for actions taken before December 1, 1999 that were reported to the NPDB in 2000 or later and on identifying reports for actions taken before December 1, 1998 that were reported to the NPDB/HIPDB in 1999 or later. Based on the findings of this work, DPDB is refining the method used to identify all late reports and reporting entities that are the worst offenders, which could provide information to be used for educational or enforcement efforts. Lastly, DPDB consolidated its continuing efforts to ensure information is reported properly and accurately to the Data Banks. The Data Integrity and Evaluation Team (DIET), made up of several DPDB staff members and with experienced leadership, is now charged with guiding these efforts.

Pilot Studies on Clinical Privileges and Malpractice Payment Reporting Compliance Initiated

The Healthcare Consulting Practice Division of PricewaterhouseCoopers was contracted in Fall 2001 to develop a methodology for auditing records on clinical privileges actions to ensure compliance with NPDB reporting requirements. The project is designed to determine whether hospitals and managed care organizations are willing to test an audit tool designed to ascertain clinical privileges reporting compliance. The methodology will be tested with randomly selected hospital and managed care organization reporters. A similar contract with PricewaterhouseCoopers aimed at malpractice payers was awarded in December 2001. Findings for both studies should be available in late 2002.

NPDB Reporting Compliance Project Continued

Work continues on the compliance project comparing data from the National Association of Insurance Commissioners (NAIC) and the National Practitioner Data Bank (NPDB). The goals of the comparison are to examine the level of compliance with NPDB Medical Malpractice Payment Reporting requirements and to identify specific under-reporting insurers and obtain required reports. If, as a result of the comparison, insurance companies discover unreported malpractice payments for a given year, then they must submit reports on these payments to the NPDB. Individual payments are reported to the NPDB by law, but many insurers also report the number of payments made and total amount paid to the NAIC in "Annual Statements." The NAIC has no information about individual payments. In 2001, the focus was on 1997 and 1998 reporting activity. Most reporting comparison cases for these payment years were resolved, with only 10 of 83 companies needing to send reports/more information for 1998 and 10 out of 30 companies needing to send reports/more information for 1997. At the end of 2001, 30 letters were mailed to medical malpractice insurance companies for the year 2000 to reconcile NAIC malpractice payment data to NPDB malpractice payment data; four had not responded as of March 1, 2002.

Public Citizen's *20,125 Questionable Doctors* Disciplined by State and Federal Governments Books Compared to NPDB and HIPDB

During 2000, DPDB compared a sample of actions listed in Public Citizen's *20,125 Questionable Doctors* books to licensure reports in the NPDB and HIPDB. In 2001, DPDB and SRA completed a report comparing all Public Citizen_listed Licensure Actions to NPDB_HIPDB licensure reports. This report stated that the percentage of reports in the Public Citizen listings but not in the NPDB_HIDB ranged from 7.0 percent for California to 79.8 percent for Washington, D.C. The average for all States was 24.2 percent.

However, the NPDB-HIPDB contained some reports that were not listed in the Public Citizen books. The percentage of NPDB-HIPDB reported actions not also listed by Public Citizen ranged from 5.3 percent in New Hampshire to 53.2 percent in Arkansas. The average for all States was 29.9 percent. DPDB is seeking to work with the Federation of State Medical Boards to compare NPDB-HIPDB information with that reported by State boards to the FSMB Board Action Data Bank so that action can be taken to ensure that all required reports are filed.

SRA also compared Public Citizen listings of DEA actions to those reported to the NPDB. Public Citizen had obtained DEA's "voluntary surrender" data through a lawsuit. Of the DEA reports listed by Public Citizen, 90.8 percent are not in the NPDB. (These figures may overstate non-reporting slightly because the comparison includes events in Public Citizen's listings for the period prior to enactment of the HIPDB that were not reportable to the NPDB; DPDB assumes all reportable actions taken since August 21, 1996 should be reported. DPDB is working to improve DEA reporting.) On the other hand, Public Citizen did not have 22.1 percent of DEA actions listed in the NPDB.

NPDB Information Helped Compliance Efforts

Several informational efforts were undertaken by DPDB in order to ensure compliance with NPDB requirements and regulations. In February, more than 6,000 hospitals received letters reminding them of their

mandated responsibility to report adverse actions. The letter also covered hospitals' mandatory querying of both initial privileging as well as re-querying on these practitioners every two years. Positive responses were received; several hospitals called to say they would comply with these requirements and others requested information on how to report adverse actions to the NPDB. A copy of the letter was shared with the American Hospital Association (AHA) for posting on its web site for member hospitals. In July and August, another letter was sent to all registered entities and Managed Care Organizations (MCOs) describing the correct reporting procedure for the NPDB. It stated hospitals and MCOs should submit a report directly to the NPDB using the IQRS and then immediately submit a printed copy of the report to their State licensing board. An electronic copy of the letter was sent to the American Association of Health Plans (AAHP) at their request.

Physician Placement Service Fined for Unauthorized Queries

On February 6, 2001, the HHS OIG imposed a fine against a physician placement service that was submitting unauthorized queries to the NPDB. The physician placement service certified itself as an eligible entity and performed NPDB queries between February 1, 1998 and January 31, 2000. The physician placement service was neither an eligible entity nor an authorized agent of an eligible entity. The fine is the result of more than a year of work by both the OIG and DPDB. This is the third time the HHS OIG has used the HCQIA's civil monetary penalty authority to fine an entity violating the NPDB's confidentiality provisions.

PREP Program Continued Helping Boards and Hospitals

DPDB continues sponsoring the Practitioner Remediation and Enhancement Partnership (PREP) program, which seeks to foster mutual trust and positive working relationships between hospitals and State Medical and Nursing Boards. The Citizen Advocacy Center, which DPDB contracted with to develop PREP, in conjunction with the Administrators in Medicine (AIM) organized and implemented the program. In October DPDB staff members attended a session on PREP held at an AIM meeting in Washington, D.C. The PREP participants shared their progress and strategies to motivate other States to participate. As of January 2002, six boards of medicine and seven boards of nursing, have voted to participate in the program, three State boards have operational programs, and several other boards are considering participating.

PREP seeks to encourage a more positive approach by health care organizations toward reporting adverse actions to State professional licensing authorities, and by extension, to the NPDB. The PREP's objectives are:

1. To foster mutual trust and positive working relationships between health care organizations and the institutions to which mandatory report requirements require them to report;

2. To assist regulatory agencies in establishing mechanisms and procedures for processing, accessing, and prioritizing mandatory reports as to maximize their utility as a public protection tool without unnecessarily burdening the board or inflicting regulatory overkill on health care institutions or practitioners;

3. To improve health care quality by establishing constructive linkages between total quality improvement initiatives at health care institutions and the regulatory programs of State licensing boards; and

4. To encourage a more positive approach by health care organizations toward reporting adverse actions to State professional licensing authorities, and by extension, to the NPDB, so that reporting is embraced as ethical, socially responsible conduct, rather than "reporting colleagues to the cops."

For more information, see the program's web site at www.4patientsafety.net.

Health Plan Assisted with September 11th Recovery

DPDB was asked to assist Empire Blue Cross/Blue Shield of New York, whose offices were located in the World Trade Center. Their offices and credentialing files were completely destroyed in the September 11 tragedy. DPDB staff gave representatives from Empire and its authorized agent technical assistance and discussed methods to assist Empire in re-creating its NPDB information. Fortunately, Empire discovered back-up credentialing files and neither funds nor further assistance were necessary.

NPDB OPERATIONS: REPORTING SUMMARY

This section primarily summarizes descriptive statistics concerning all reports during calendar year 2001. For comparative purposes, information is provided for each of the most recent five years (1997 through 2001) as well as cumulatively from the opening of the NPDB on September 1, 1990 through December 31, 2001.

Tables 1 through 3 present data on practitioners reported and reports received by the NPDB through December 31, 2001 by report type.[10] 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 with reports. There are more physicians with reports than any other type of practitioner. Physicians have an average of 1.74 reports per each reported physician, and dentists, the second largest group of practitioners reported, have an average of 1.60 reports for each reported dentist. Comparison between physicians and dentists and other types of practitioners, however, would be misleading since reporting of licensure, clinical privileges, and professional society membership actions is required only for physicians and dentists.

Tables 2 through 5 provide information by type of report (medical malpractice payments and "adverse actions" involving licensures, clinical privileges, professional society memberships, or 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.[11] 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 report type. Table 3 shows the number of reports received and percent change by report type for the last five years. Table 4 shows the number, percent distribution, and percent change of Medical Malpractice Payment Reports by practitioner type, and Table 5 shows the number, percent distribution, and percent change of reportable action and Medicare/Medicaid exclusion reports by practitioner type.

MEDICAL MALPRACTICE PAYMENT REPORTS ANALYSIS

This section primarily discusses descriptive statistics concerning 2001 Medical Malpractice Payment Reports. For comparative purposes, information is provided for each of the most recent five years (1997 through 2001) as well as cumulatively from the opening of the NPDB on September 1, 1990 through December 31, 2001.

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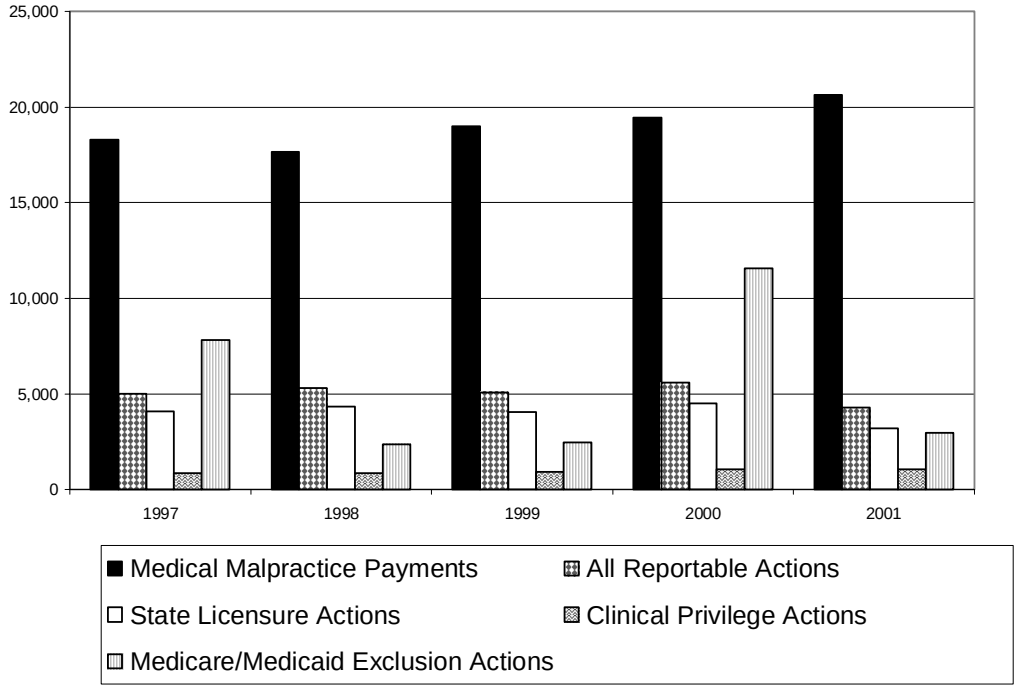
[10] All report statistics in this document concern disclosable reports – reports which would be disclosed in response to a query – in the NPDB as of December 31, 2001. This does not directly measure the workload of the NPDB in processing reports. It excludes, for example, reports that were received 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 NPDB Annual Reports for 1998 and previously. Statistics for 1999 and earlier years may also differ slightly from those reported in previous Annual Reports because reports voided during 1999, 2000, and 2001 are no longer included in counts.

[11] Of the 40,619 reported licensure actions in the NPDB, 3,784 reports or 9.3 percent were for licenses reinstated or restored. Of the 10,553 reported clinical privileges actions, 765 reports or 7.2 percent concerned reductions, reinstatements, or reversals of previous actions. Of the 384 reported professional society membership actions, 16 reports or 4.2 percent were reinstatements or reversals of previous actions. None of the 303 reported DEA Reports were considered non-adverse. Of the 27,186 Exclusion Reports, 2,974 or 10.9 percent are reinstatements.

Medical Malpractice Payments

Data from Table 2, as illustrated in Figure 1, show that, for each year, Malpractice Payment Reports represent the greatest proportion of reports contained in the NPDB. Cumulative data show that at the end of 2001, 72.9 percent of all the NPDB's reports concerned malpractice payments.

Figure 1: Number and Type of Reports Received by the NPDB (1997-2001)



During 2001 itself, the NPDB received 20,623 such reports (73.9 percent of all reports received). Exclusion Reports 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. Exclusion reporting was also atypical in 2000, as explained below. If Exclusion Reports are not included, then malpractice payments constitute 76.9 percent of 1998 reports, 78.9 percent of 1999 reports, and 77.6 percent of 2000 reports, and 82.8 percent of 2001 reports.

Table 3 shows the number of reports received and their percent change by report type from year to year. State licensure action reporting in 2001 decreased from 2000 and was at its lowest level since 1993. The 2001 Exclusion Reports decreased greatly from 2000. The large increase in the number of Exclusion Reports for 2000 reflects reports for non-healthcare practitioners and nurse practitioner reports being submitted to the NPDB for 2000 and previous years. Exclusion Reports for non-healthcare practitioners are being removed from the NPDB. The apparent large decrease in Exclusion Reports for 1998 as compared to 1997 reflects the fact that the count for 1997 includes both 1997 exclusions and exclusions in earlier years for practitioners who had not been reinstated. Thus the 1998 exclusion counts, which include only actions reported during 1998, are not comparable to the count for 1997.

Table 4 shows the number, percent distribution, and percent change of Medical Malpractice Payment Reports for all types of practitioners[12] 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 165,845 (78.1 percent) of the NPDB's Malpractice Payment Reports. Dentists were responsible for 29,399 reports (13.8 percent), and all other types of practitioners were responsible for 17,114 reports (8.1 percent). The number of malpractice payments reported in 2001 (20,598) increased by 6.2 percent over the number reported during 2000 (19,392). During 2001, physicians were responsible for 16,703 Malpractice Payment Reports (81.1 percent of all Malpractice Payment Reports received during the year). The number of physician malpractice payments reported increased 7.2 percent from 2000 to 2001. In 2001 dentists were responsible for 2,318 Malpractice Payment Reports (11.3 percent). "Other practitioners" were responsible for 1,577 Malpractice Payment Reports (7.7 percent).

Malpractice Payment Reporting Issues

Three 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 issue involves differences in reporting requirements for federal agencies based on memoranda of agreements. The third, reporting physicians in residency programs, concerns the appropriateness of reporting malpractice payments made for the benefit of physicians in training who are supposed to be acting only under the direction and supervision of attending physicians.

"Corporate Shield"

Malpractice Payment Reporting may be affected by use of the "corporate shield." Attorneys have worked out settlements in which the name of a health care organization (e.g., a hospital or group practice) is substituted for the name of the practitioner, who would otherwise be reported to the NPDB. 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 must be filed with the NPDB unless the practitioner is excluded from the settlement as a condition of the settlement.

The extent of use of the "corporate shield" cannot be measured with available data. The "corporate shield" masks the extent of substandard care as measured by individual malpractice payments reported to the NPDB. It also reduces the NPDB's usefulness as a flagging system. The Notice of Proposed Rule Making (NPRM) to

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[12] 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.

change regulations to resolve the "corporate shield" problem is currently being drafted. The proposed rule would require that in all medical malpractice payments in which an individual practitioner cannot be identified, the payer will provide the name of an entity for whose benefit the payment was made.

Malpractice Payment Reporting by Federal Agencies

The HCQIA, as amended, directed the Secretary of HHS to enter into memoranda of understanding with the Secretaries of Defense and Veterans Affairs to apply the requirements of the law to hospitals, other facilities and health care providers under the jurisdiction of the Secretaries. Under the Memorandum of Agreement, 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 the Surgeon Generals of the three military departments apply these criteria differently. DVA uses a similar process when deciding whether to report malpractice payments.

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 2001 as it was in earlier years.[13] Some argue that since residents act under the direction of supervising 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 HCQIA, 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 2001 a total of 1,246 physicians had Malpractice Payment Reports listing them as allopathic or osteopathic interns or residents at the time of the incident which led to the payment. Of these 1,246 physicians, 1,107 were allopathic residents and 139 were osteopathic residents. The NPDB contained a total of 1,759 intern or resident-related Malpractice Payment Reports for these practitioners (1,542 for allopathic interns or residents and 217 for osteopathic interns or residents). A total of 949 of the reported interns and residents had only one Malpractice Payment Report as an intern or resident; 203 had two such reports; two had ten reports; one had 8 reports; and one had 45 Malpractice Payment Reports for incidents while an intern or resident. Later in their career or even while they were in a residency program, these practitioners also may have had other Malpractice Payment Reports that did not identify them as interns or residents. Currently, a committee of the Executive Committee is looking into the issues surrounding the reporting of residents to the NPDB.

They are considering both residents with primary responsibility (practicing independently) and residents with ancillary responsibility (training in a residency program under supervision).

State Reporting Rates: Malpractice Payments

Table 6 shows the number of Malpractice Payment Reports for physicians and dentists from September 1, 1990 through December 31, 2001 by State (generally the State in which the practitioner maintained his or her practice at the time the incident took place).

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[13] 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.

Table 6 also includes the "adjusted" number of Malpractice Payment Reports, which excludes reports for malpractice payments made by State patient compensation funds and similar State funds. Nine States[14] 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 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-limit payments.[15]

In addition to presenting by State the cumulative number of payments and the adjusted number of payments for both physicians and dentists, Table 6 shows the ratio of adjusted dentist Malpractice Payment Reports to adjusted physician Malpractice Payment Reports. Nationally, using the adjusted numbers, there is about one dental payment report for every five physician payment reports. In California and Utah, however, there has been one dentist payment report for every 2.9 and 2.8 physician payment reports, respectively. In Mississippi, North Dakota, West Virginia, and Wyoming there is less than one dental payment report for every 10 physician payment reports. It should be noted that in States with relatively few physicians or dentists, the number of payment reports 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 payment reports to physician payment reports in Utah is largely the result of a very large number of payment reports for one dentist during 1994.

Tables 7 and 8 present the number and adjusted number (as described above) of Malpractice Payment Reports for physicians and dentists, respectively, by State for each of the last five years. As noted above, the number of reports 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 report 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 especially should be noted that the number of payment reports 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 sue for malpractice and obtain a payment. For example, 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, particularly for children or retirees who are unlikely to lose earned income because of malpractice incidents. Sometimes changes in malpractice statutes may be responsible for changes in the number of payment reports within a State observed from year to year. Changes in State statutes, however, are unlikely to explain differences in reporting trends observed for physicians and dentists within the same State. For example, the number of physician payment reports in New

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[14] Florida, Indiana, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania, South Carolina, and Wisconsin.

[15] 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.

York steadily increased from 1997 to 2000 while the number of dentist payment reports varied up and down over the period but was only slightly larger in 2000 than it was in 1997. There was a bigger increase of dentist reports in 2001.

State Differences in Payment Amounts for Physicians

State variations in mean and median malpractice payment amounts also are of interest. We examined all physician Malpractice Payment Reports received by the NPDB between its opening and December 31, 2001. The results are shown in Table 9. 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.[16] The cumulative median for the NPDB was $100,000. The median physician payment in 2001 was $135,000. The highest 2001 medians were found in Connecticut, Illinois, Massachusetts, Rhode Island, Nevada, and Washington, D.C., all of which had a median payment of $225,000 or more. The lowest 2001 median was found in Wyoming at $55,000. Next lowest, California had a median payment of $65,000 and South Dakota had a median payment of $66,250. [17]

The cumulative mean physician malpractice payment for the NPDB was $209,295. Adjusted for inflation, assuming 2001 dollars for all payments, the cumulative mean physician payment was $236,523. The mean payment during 2001 was $270,854. During 2001 mean payments ranged from lows of $119,783 in Michigan and $154,619 in Wyoming to highs of $499,244 in Connecticut and $630,473 in the District of Columbia. Note that the ranking of States by median and mean 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 for Physicians

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 physician Malpractice Payment Reports received from the opening of the NPDB through December 31, 2001, the mean delay between incident and payment was 4.81 years. For 2001 payments, the mean delay was 4.63 years. Thus during 2001, payments were made on average about two months quicker than the average for all payments. On average, during 2001, payments were made most quickly in Minnesota (3.17 years) and Arkansas (3.16 years). Payments were slowest in Rhode Island (6.44 years). Average payment delays continued to decrease in 2001. The average physician payment came about 11 days sooner than in 2000.

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

Malpractice cases with different types of reasons for their occurrence are likely to have different payment amounts and varying payment delays. As shown in Table 10, which includes only payment amounts for

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[16] The median payment is the amount where half the payments are above and half are below. If the payments were $25,000, $50,000 and $225,000, the median payment would be $50,000.

[17] The California median payment for physicians is artificially impacted by a State law which is commonly believed to require reporting to the State only malpractice payments of $30,000 or more. During 2001, 86 (5.9 percent) of California physician's 1,461 malpractice payments were for $29,999. Payments for $29,999 are extremely rare in other States. Another 99 California payments were for exactly $30,000, which is immediately below the actual reporting threshold. When these payments are combined with the $29,999 payments, fully 12.7 percent of California physician malpractice payments are within $2.00 of the State reporting threshold.

physicians, the NPDB categorizes malpractice reasons into ten broad categories. During 2001, incidents relating to miscellaneous incidents had the lowest median and mean payments ($32,000 and $115,104, respectively). However, there were only 160 miscellaneous reports. This category represents only .96 percent of all physician malpractice payments in 2001. As in previous years, obstetrics-related cases (1,449 reports, 8.7 percent of all physician Malpractice Payment Reports) had by far the highest median payments.

The mean payment delay is shown in Table 11, which includes payments for all types of practitioners for each type of case. The 1,536 obstetrics-related payments in 2001 (7.5 percent of all 2001 payments) had the second longest mean delay between incident and payment (5.69 years), with the 64 IV and blood products-related payments (0.3 percent) having the longest mean delay (8.00 years). The shortest average delay for 2001 payments was for equipment and product related cases (3.39 years). There were 58 such cases for all types of practitioners, representing 0.3 percent of all 2001 malpractice payments.

The shortest average mean payment delay for physicians was for 159 miscellaneous cases in 2001 (3.75 years) and 472 anesthesia-related cases cumulative (5.71 years). The longest average mean payment delay for physicians was for 46 IV and blood products-related cases (9.94 years) in 2001 and 28 equipment/product-related cases cumulatively (6.73 years).

Malpractice Payments for Nurses

As reflected in requests for information made to DPDB, there has been increasing interest in nurse malpractice payments. The NPDB classifies registered nurses into four categories: Nurse Anesthetist, Nurse Midwife, Nurse Practitioner, and Registered Nurse not otherwise classified, referred to in the tables as Registered Nurse. Malpractice payments for nurses are relatively rare. As shown in Table 12, all types of Registered Nurses have been responsible for 3,615 malpractice payments (1.7 percent of all payments) over the history of the NPDB. Slightly less than two-thirds of the payments for nurses were made for non-specialized Registered Nurses. Nurse Anesthetists were responsible for 22.7 percent of nurse payments. Nurse Midwives were responsible for 8.2 percent, and Nurse Practitioners were responsible for 5.2 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 84.3 percent of the 820 payments for Nurse Anesthetists. Similarly, obstetrics-related problems are responsible for 79.7 percent of the 296 Nurse Midwife payments. Diagnosis-related problems are responsible for 46.3 percent of the 188 payments for Nurse Practitioners. Treatment-related problems are responsible for another 23.4 percent of payments for these nurses.

As shown in Table 13, the median and mean payment for all types of nurses in 2001 was $125,000 and $462,251 respectively. The median nurse payment is $10,000 less than the median physician payment ($135,000) but the mean nurse payment is $186,911 larger than the mean physician payment in 2001 ($275,340). Similarly, the inflation-adjusted cumulative median nurse payment $85,890 is $23,679 less than the $109,569 inflation-adjusted cumulative median payment for physicians. The inflation-adjusted cumulative mean nurse payment of $288,618 is $52,095 larger than the cumulative mean physician payment of $236,523.

Table 14 shows the cumulative number of nurse Malpractice Payment Reports by State. An adjusted number is provided to account for reports concerning payments made by State compensation and similar funds, but the adjusted reports account for only 1.6 percent of nurse payment reports. Vermont had only three nurse Malpractice Payment Reports in the NPDB while New Jersey had the most, 438. The ratio of nurse payment reports to physicians payment reports may be calculated by referring to Table 6 column 2 for the adjusted number of physician reports and Table 14 column 2 for the adjusted number of nurse reports. The ratio of nurse payment reports to physician payment reports (using adjusted figures) for Vermont (with only three nurse payments) is obviously the lowest in the nation, but six States have fewer than one nurse payment report for every 100 physician payment reports. In contrast, the ratio for Idaho, which is the highest in the nation, is 7.4 nurse payment reports for every 100 physician payment reports. Four other States also have ratios of more than 6 nurse payment reports for every 100 physician payment reports. Since the same malpractice statutes apply

within a State for both physicians and nurses, this suggests that there may be substantial differences in nurses and physicians' safety of practice in different States. [18]

Malpractice Payments for Physician Assistants

DPDB has also had many requests for information on malpractice payment amounts for Physician Assistants. As shown in Table 15, there are relatively few such payments. Physician Assistants have been responsible for only 534 malpractice payments since the opening of the NPDB (0.25 percent of all payments). Both cumulatively and during 2001, diagnosis-related problems were responsible for well over half of all Physician Assistant malpractice payments (53.4 percent cumulatively and 57.3 percent in 2001). Treatment-related payments were the second largest category both cumulatively and in 2001 (27.3 percent and 26.8 percent, respectively). Excepting one obstetrics-related payment, payments in the diagnosis category were responsible for the largest median payment ($75,000).

REPORTABLE ACTION AND MEDICARE/MEDICAID EXCLUSION REPORTS ANALYSIS

This section primarily presents descriptive statistics concerning 2001 reportable actions and Medicare/Medicaid exclusions. For comparative purposes, information is provided for each of the most recent five years (1997 through 2001) as well as cumulatively from the opening of the NPDB on September 1, 1990 through December 31, 2001.

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 15.4 percent of all reports received by the NPDB during 2001 and, cumulatively, 17.8 percent of all reports in the NPDB. The number of reportable action reports received decreased by 1,306 reports to a total of 4,298 (a 23.3 percent decrease) from 2000 to 2001 (Table 3). This followed a 10.1 percent increase in reportable actions from 1999 to 2000. The 4,298 reportable action reports received during 2001 constituted the smallest number of such reports received since 1993, when 4,231 were received.

During 2001, licensure actions made up 74.5 percent of all reportable actions and 11.5 percent of all NPDB reports (including malpractice payments and Medicare/Medicaid exclusions). As shown in Table 2, licensure actions continue to represent the majority of reportable actions (cumulatively 78.3 percent of all reportable actions). Licensure reports decreased by 29.2 percent in 2001 compared to 2000. Licensure reports for physicians decreased by 24.9 percent in 2001. Licensure reports for dentists, in contrast, decreased by 43.6 percent. Licensure reports for physicians constituted 81.9 percent of all licensure reports in 2001.

The number of clinical privileges actions also decreased slightly from 2000 to 2001. There were 1,058 such reports in 2000 and 1,056 in 2001, a decrease of 0.2 percent. Physician clinical privilege reports increased by 13.5 percent and voluntarily submitted clinical privilege reports for non-physician/non-dentists decreased by 38.6 percent to a total of 35. Clinical privileges actions represented 24.6 percent of all 2001 reportable action reports and 3.6 percent of all 2001 NPDB reports.

Professional society membership actions (only 33 reported) made up 0.1 percent of all reportable actions during 2001. Only nine DEA reports were received during 2001. The number of reported professional society and DEA actions has remained almost negligible throughout the NPDB's history. Cumulatively, DEA reports represented only 0.1 percent of all reports and 0.6 percent of reportable action reports. Professional society

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[18] 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 as may perceived "deep pockets." We have not explored these possible differences.

action reports cumulatively represented only 0.1 percent of all reports and 0.7 percent of reportable action reports.

Table 5 presents information on all types of reportable actions and on Exclusion Reports by type of practitioner, type of report, and year. Physicians are responsible for the largest number of all reportable actions during 2001 and earlier years. During 2001, physicians were responsible for 81.9 percent of licensure actions, 92.9 percent of clinical privileges actions, and 69.7 percent of professional society membership actions. In contrast, physicians were responsible for only 19.5 percent of the Medicaid/Medicare exclusion actions added to the NPDB during 2001. All nine DEA reports in 2001 were for physicians.

In 2001 physicians, who represent about 81.5 percent of the nation's total physician-dentist workforce, were responsible for 81.9 percent of licensure reports for this workforce. They were, however, responsible for 96.1 percent of all clinical privilege 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 workforce, during 2001 were responsible for 18.1 percent of physician and dentist licensure actions, 3.9 percent of clinical privileges actions[19], 28.1 percent of professional society membership actions, no DEA actions, and 22.7 percent of Exclusion Reports for physicians and dentists. The number of dental licensure reports has generally grown slightly each year, but 2001 represents the smallest number of dental licensure actions submitted to the NPDB in a single year (579 reports) since 1991 (562 reports).

Only 36 reportable action reports were voluntarily submitted for "other practitioners." Only one professional society membership action is contained in the NPDB for practitioners other than physicians or dentists. However, "other practitioners" accounted for the majority of Exclusion Reports (74.8 percent of 2,972 reports) added to the NPDB during 2001.

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 HRSA, held a conference on clinical privileges reporting by hospitals. Participants included executives from the American Medical Association; American Osteopathic Association; American Hospital Association; Joint Commission on Accreditation of Health Care Organizations; CMS; HHS OIG; DPDB, BHPr, HRSA, HHS (which manages the operations of the NPDB program); Federation of State Medical Boards; Public Citizen Health Research Group; Citizen Advocacy Center; 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."[20] 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 DPDB have been conducting research on the issue and working with relevant organizations to try to ensure that reportable actions should be reported actually are reported. The 21.8 percent increase in clinical privileges reporting from 1997 to 2001 may reflect the results of this effort. However, even with the observed increased reporting, the number of clinical privileges actions

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[19] This small percentage reflects the fact that relatively few dentists have hospital privileges.

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

reported remains unreasonably low. That is why PricewaterhouseCoopers, an accounting firm, was contracted by DPDB to develop and test a methodology for gaining access to needed records on clinical privileges to ensure compliance with NPDB reporting requirements. The project is designed to determine whether hospitals and managed care organizations will voluntarily participate in clinical privileges reporting compliance audits.

Tables 16 and 17 shed additional light on the low level of reporting of clinical privileges actions by hospitals. Table 16 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 26.7 percent in Rhode Island to 75.0 percent in Wyoming. As of December 31, 2001, nationally 55.3 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 a previous year has shown that clinical privileges reporting seems 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 17 compares adverse licensure reporting and adverse clinical privilege reporting for physicians by State. The ratio of adverse clinical privilege reports (excluding reinstatements, etc.) to adverse licensure reports (again excluding reinstatements, etc.) ranges from a low of one adverse clinical privilege report for every 6.7 adverse licensure reports in Connecticut to a high of one adverse clinical privilege report in Nebraska for every 1.07 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 physicians practicing in the various States.

Adverse Licensure Reports for Physicians and Dentists Practicing In-State

Tables 18 and 19 present information on the cumulative number of reportable licensure actions for physicians and 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, 89.8 percent of all licensure actions reported to the NPDB have been adverse in nature. For dentists, about 94.3 percent have been adverse. In Nevada 100 percent of the reported physician licensure actions have been adverse. This contrasts with South Carolina, in which only 73.2 percent of the physician licensure actions have been adverse.

We also examined the proportion of all physician licensure actions that are adverse and affect in-State physicians. Nationally 86.7 percent of licensure actions are both adverse and pertain to in-State physicians. The low was 60.6 percent in the District of Columbia and the high was 99.5 percent in Colorado.

For dentists, about 94.3 percent of all licensure actions reported to the NPDB have been adverse in nature. In seventeen States 100 percent of the reported dentist licensure actions have been adverse. The low was Illinois for which only 70.6 percent of the dental licensure actions were adverse.

We also examined the proportion of all dentist licensure actions that are adverse and affect in-State dentists. Nationally 97.3 percent of licensure actions are both adverse and pertain to in-State dentists. The lows were 82.3 percent in Pennsylvania and 85.8 percent in Iowa. In eighteen States all dental licensure actions were adverse and pertained to in-State dentists.

RELATIONSHIP BETWEEN REPORT TYPES AND MULTIPLE REPORTS ANALYSIS

Data on both malpractice payments and reportable actions can be examined to discover patterns and relationships. Below, we examine the relationship between Malpractice Payment and Reportable Action Reports. We also look at information regarding physicians with multiple reports in the NPDB.

Relationship Between Malpractice Payments and Reportable Actions

Physicians with high numbers of Malpractice Payment Reports tend to have at least some Adverse Action Reports and Medicare/Medicaid Exclusion Reports, and vice versa. Tables 20 and 21 show this data. For example, as shown in Table 20, although 95.0 percent of the 76,825 physicians with only one Malpractice Payment Report in the NPDB have no reportable action reports, only 59.6 percent of the 285 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 reportable action reports also increases. Similarly, as shown in Table 21, there is a tendency for a smaller proportion of physicians to have no Malpractice Payment Reports and no Medicare Medicaid Exclusion Reports as their number of reportable action reports increases. However, the trend reverses for physicians with eight 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 commit malpractice.

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 2001, a total of 178,745 individual practitioners had disclosable reports in the NPDB. Of these, 123,978 (69.4 percent) were physicians. Most physicians (64.4 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 19.9 percent of the total. About 97.2 percent had five or fewer reports and 99.6 percent of physicians with reports had ten or fewer reports. Only 504 (0.4 percent of physicians with reports) had more than 10 reports. Of the 123,978 physicians with reports, 101,902 (82.2 percent) had only Malpractice Payment Reports; 7,578 (6.1 percent) had only licensure reports; 2,367 (1.9 percent) had only clinical privilege reports; and 1,426 (1.2 percent) had only Medicare/Medicaid Exclusion Reports. The remainder had Drug and Enforcement or Professional Society reports. Notably, only 5,424 (4.4 percent) had at least one Malpractice Payment Report and at least one licensure report, and only 2,838 (2.3 percent) had at least one Malpractice Payment Report and at least one clinical privilege report. Only 1,240 (1.0 percent) had Malpractice Payment, licensure, and clinical privilege reports. Only 240 (0.2 percent) had at least one Malpractice Payment, licensure action, clinical privilege, and Exclusion Report at the end of 2001. Approximately 29.6 percent of the 109,113 physicians with at least one Malpractice Payment Report had two or more reports. These 32,288 physicians had 89,114 Malpractice Payment Reports in the NPDB, representing 53.7 percent of the 165,939 Malpractice Payment Reports in the NPDB for physicians.

QUERIES ANALYSIS

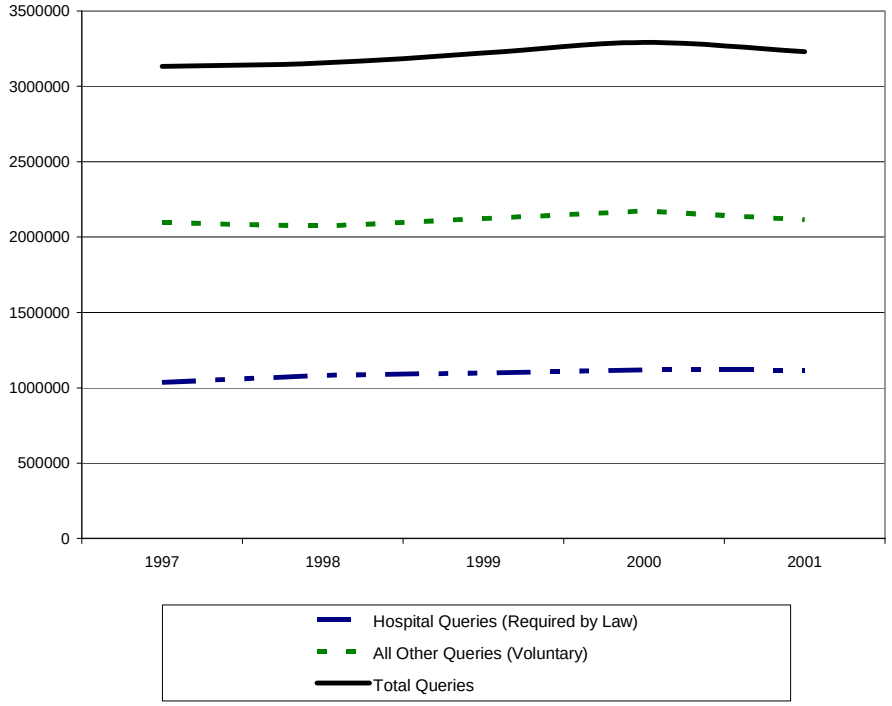
This section primarily discusses queries during 2001. For comparative purposes, information is provided for each of the most recent five years (1997 through 2001) as well as cumulatively from the opening of the NPDB on September 1, 1990 through December 31, 2001.

Query data are presented in Table 22. A total of 3,230,631 entity requests for the disclosure of information (queries) were processed by the NPDB during 2001. 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 2001 decreased 1.8 percent from the 3,290,082 queries processed during 2000. It is almost 4 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 25,540,570 entity queries by the end of 2001.

Practitioner self-queries also are shown in Table 22. 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 2001, the NPDB processed 36,424 self-query requests. This was an increase of 9.4 percent from the number of self-queries processed during 2000 but is a decrease of 30.2 percent from the record 52,603 self-queries processed during 1997. Only 3,299 (9.1 percent) of the self-query requests during 2001 were matched with reports in the NPDB. Cumulatively from the opening of the NPDB, 375,839 self-queries have been processed; 30,195 (8.0 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 5 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 51.1 percent from the 740,262 in 1991 (the NPDB's first full year of operation), to 1,118,279 queries in 2001, the growth in the number of voluntary queries has been much greater. These queries increased from 65,269 in 1991 to 2,112,264 in 2001, an increase of over 3,136 percent. Voluntary queries represented 65.4 percent of all entity queries during 2001 (Table 22).

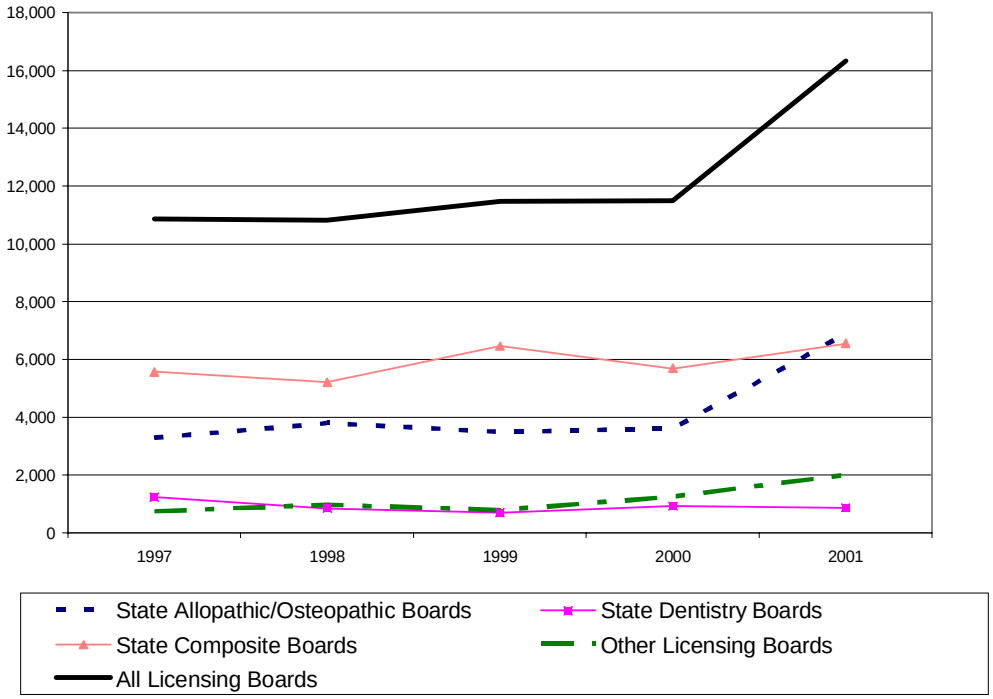
Figure 2: Queries by Querier Type (1997-2001)



The distribution of queries by type of querying entity is shown in Table 23. 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 15.2 percent of all querying entities during 2001 and 14.0 percent of all entities that have ever queried the NPDB, they made 52.2 percent of all queries during 2001 and have been responsible for 47.9 percent of queries ever submitted to the NPDB. Other health care entities (i.e., non-hospitals and non-managed care organizations) made 12.4 percent of the queries in 2001 and 9.6 percent cumulatively. State licensing boards made 0.5 percent of queries during 2001 and 0.4 percent

cumulatively.[21] Figure 3 shows the number of State board queries by year. The large increase in State board queries is largely due to an increase from 2001 to 2002 of more than 3,000 queries by the Maryland Board of Physician Quality Assurance, which queried on its practitioners. Professional societies were responsible for 0.3 percent of queries during 2001 and cumulatively.

Figure 3: Number of State Board Queries by Year (1997-2001)



Queriers request information on many types of practitioners, although most are for physicians and dentists, reflecting the required reporting of many actions for dentists and physicians and the required reporting of hospitals. Table 24 shows the number of queries by practitioner type submitted during a sample period in October and November 2001. Allopathic physicians are the subject of by far the most queries during this period; more than 69.4 percent of queries submitted concerned allopathic physicians, interns and residents. The second largest category, dentists, accounted for only 7.1 percent of all queries. Osteopathic physicians, interns and residents accounted for 3.7 percent, clinical psychologists accounted for 2.4 percent, clinical social workers accounted for 2.2 percent, and optometrists accounted for 1.3 percent.

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 22, the 432,857 entity queries matched during 2001 represents a match rate of 13.2 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.

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[21] 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 require practitioners to submit self-query results with applications for licensure.

About 86.7 percent of entity queries submitted in 2001 received 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. In a 1999 study of NPDB users by the University of Illinois at Chicago, 57.8 of surveyed queriers, including both those who received matches to their queries and those who did not, were very satisfied with querying and 77.8 percent of these queriers rated querying the NPDB as very useful.[22] At the end of 2001 a no-match response to a query confirmed that a practitioner has had no reports in over eleven years. These responses will become even more valuable as the NPDB matures.

REGISTERED ENTITIES ANALYSIS

This section primarily presents descriptive statistics concerning 2001 registered entities. For comparative purposes, information is provided cumulatively from the opening of the NPDB on September 1, 1990 through December 31, 2001.

All reporting and querying to the NPDB (except for practitioner self-querying) is performed by registered entities that certify that they meet the eligibility requirements of the HCQIA. Table 25 provides information on 16,436 registered entities that have reported or queried at least once since the opening of the NPDB and those active as of December 31, 2001. Some entities have (or had in the past) multiple registration numbers either simultaneously or sequentially, so the numbers shown in Table 25 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 2001 hospitals accounted for 6,086 (50.2 percent) of the NPDB's active registered entities. Hospitals made up 46.3 percent of the entities which had ever registered with the NPDB. HMOs, PPOs, and Group Practices accounted for 1,551 active registrations (12.8 percent) at the end of 2001. Other Health Care Entities[23] held 3,910 active registrations (32.3 percent). The 323 malpractice insurers with active registrations accounted for only 2.6 percent of all active registrations. Other categories accounted for even smaller percentages of the NPDB's active registrations at the end of 2001.

DISPUTED REPORTS AND SECRETARIAL REVIEWS ANALYSIS

This section primarily presents descriptive statistics concerning 2001 disputed reports and Secretarial Reviews. For comparative purposes, information is provided for each of the most recent five years (1997 through 2001) as well as cumulatively from the opening of the NPDB on September 1, 1990 through December 31, 2001.

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[22] *National Practitioner Data Bank User and Non-User Surveys*. Final Report. Contract # 230-98-0030. Waters, Teresa, et al. Northwestern University Institute for Health Services Research and Policy Studies and University of Illinois at Chicago Health Policy Center.

[23] Other Health Care Entities must provide health care services and follow a formal peer review process to further quality health care. The phrase "provides health care services" means the delivery of health care services through any of a broad array of coverage arrangements or other relationships with practitioners by either employing them directly, or through contractual or other arrangements. This definition specifically excludes indemnity insurers that have no contractual or other arrangement with physicians, dentists, or other health care practitioners. Examples of other health care entities may include nursing homes, rehabilitation centers, hospices, renal dialysis centers, and free-standing ambulatory care and surgical service centers.

At the end of 2001, there were 1,809 licensure reports, 1,592 clinical privilege reports, 31 professional society membership reports, 13 DEA reports, 228 exclusion actions, and 8,204 Malpractice Payment Reports under dispute by the practitioners named in the reports. Exclusion Reports for actions taken prior to August 21, 1996[24] cannot be disputed with the NPDB. Disputed reports constitute 4.5 percent of all licensure reports, 15.1 percent of all clinical privileges reports, 8.1 percent of professional society membership reports, 4.3 percent of DEA reports, and 3.9 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. When disputed reports are disclosed to queriers, queriers are notified that the practitioner disputes the accuracy of the report.

If practitioners are dissatisfied with the results of their efforts to have reporters modify or void disputed reports they may seek a "Secretarial Review." The only reasons that a review can be considered by the Secretary are that the report was not required or permitted to be filed or that the report did not accurately describe the malpractice payment which was made and the related allegations or the adverse action which was taken and the reasons stated by the reporting entity for taking action. All other reasons (such as a claim that although a malpractice payment was made for the benefit of the named practitioner, the named practitioner did not really commit malpractice or that there were extenuating circumstances) are "outside the scope of review." A practitioner may explain these matters in his or her statement in the report. The Secretary can only remove a report from the NPDB if it was not legally required or permitted to be submitted. The Secretary can change a report only if it did not accurately reflect the malpractice payment and its related allegations or the adverse action taken and the stated reasons the entity took the action. The Secretary may administratively dismiss requests for Secretarial Review if the practitioner does not provide required information or if the matter is resolved with the reporting entity to the satisfaction of the practitioner while the Secretarial Review is in process.

Table 26 presents information on this level of review. Requests for review by the Secretary decreased by 31.5 percent from 2000 to 2001. A total of 87 requests for review by the Secretary was received during 2001 compared to 127 in 2000. 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 2001, the number of new requests for Secretarial Review was about 0.3 percent of the number of new Malpractice Payment Reports and Reportable Action Reports received.

As Table 26 shows, reportable action reports were more likely to be appealed to the Secretary than were Malpractice Payment Reports. During 2001, 65.5 percent (57 requests) of all requests for Secretarial Review concerned reportable actions (i.e., licensure, clinical privileges, or professional society membership reports) even though only 15.4 percent of all 2001 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 privilege reports are the most likely to be involved in Secretarial Review.

Table 27 presents data on the distribution of requests for Secretarial Review by type of outcome. At the end of 2001, 32 (36.8 percent) of the 87 requests for Secretarial Review received during the year remained unresolved. Of the 55 new 2001 cases which were resolved, only one (1.8 percent) was voided. Reports were

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[24] Exclusion actions taken before August 21, 1996 are included in the NPDB by a memorandum of agreement between HRSA, Centers for Medicare and Medicaid Services (formerly HCFA), and Department of Health and Human Services Officer of Inspector General. Exclusion actions taken on August 21, 1996 and later are reported to the HIPDB by law and are disputed under the normal process. HIPDB Secretarial Review decisions on these reports also apply to the NPDB.

not changed (Secretary maintained report as submitted or Secretary decided the Secretarial Review request was outside the scope of review[25]) in 52 cases (94.5 percent of the 2001 cases which were resolved).

Table 28 presents cumulative information on resolved requests for Secretarial Review by report type and outcome type. By the end of 2001 16.0 percent of all closed requests for Secretarial Review had resulted in outcomes that were beneficial to the practitioner (a void of a report, a change in the report, or a closure because of an intervening action, such as the entity changing the report to the practitioner's satisfaction.) At the end of 2001, 5.2 percent of all requests for Secretarial Review remained unresolved. Only 57 (10.1 percent) of the total of 567 Malpractice Payment Reports with completed Secretarial Reviews (the total number of requests minus the number of unresolved requests) have resulted in outcomes that were beneficial to the practitioner. In the case of reviews of privileges actions, 94 (16.4 percent) of the 573 closed requests resulted in a positive outcome. For licensure actions and professional society membership actions, these numbers were 67 (23.3 percent) of 288 closed requests and 5 closed requests, respectively.

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[25] Out-of-scope determinations are made when the issues at dispute can not be reviewed because they do not challenge the information's accuracy or its requirement to be reported to the NPDB, e.g. the practitioner claims not to have committed malpractice. The Secretary can only determine whether a payment was made. If a payment was made, the report must remain in the NPDB. Whether or not the practitioner committed malpractice is not relevant to keeping the payment report in the NPDB.

CONCLUSION

The total number of reports in the NPDB now exceeds 290,000 and the cumulative number of queries is more than 25.5 million. Although Medical Malpractice Payment Reports still represent the majority of reports in the NPDB, more reportable actions (e.g., Medicare/Medicaid exclusion, licensure, clinical privileges, professional society membership, Federal Licensure and DEA reports) have been entered into the NPDB. From 2000 to 2001 queries and submission of reportable actions decreased, while Malpractice Payment Report numbers still went up. Several compliance projects are studying ways to make sure that the NPDB is receiving all the reports it should be.

As NPDB information accumulates, the NPDB's value as a source of aggregate information and public use data for research increases, and its usefulness as an information clearinghouse for eligible queriers about specific practitioners grows. 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 that facilitates comprehensive peer review, and thereby, improves U.S. health care quality.

The "Third Generation" contract for the Data Banks continues to update and improve the IQRS. System improvements – most notably self-queries being transmitted online and entities being able to update registration information through the IQRS – continue to be made to better serve the NPDB's customers. The continuing work to educate users about the NPDB, while using NAIC and Public Citizen data in reporting compliance efforts, ensures the NPDB will remain a prime source of medical malpractice and disciplinary information. This supports the legislative intent to protect the public by restricting the ability of incompetent or unprofessional practitioners to move from State to State without disclosure or discovery of their past history.

GLOSSARY OF ACRONYMS

BHPr - Bureau of Health Professions

CMS - Centers for Medicare and Medicaid Services

DEA - Drug Enforcement Administration

HHS - Department of Health and Human Services

D.O. - Doctor of Osteopathy

DOD - Department of Defense

DPDB - Division of Practitioner Data Banks

DVA - Department of Veterans Affairs

HCQIA - Health Care Quality Improvement Act of 1986

HIPDB - Healthcare Integrity and Protection Data Bank

HMO - Health Maintenance Organization

HRSA - Health Resources and Services Administration

ICD - Interface Control Document

IQRS - Integrated Querying and Reporting Service

MCO - Managed Care Organization

M.D. - Doctor of Medicine (Allopathic Physician)

MMER - Medicare/Medicaid Exclusion Report

MMPR - Medical Malpractice Payment Report

MOU - Memorandum of Understanding

NAIC - National Association of Insurance Commissioners

NPDB - National Practitioner Data Bank

NPRM - Notification of Proposed Rule Making

OIG - Office of Inspector General

PPO - Preferred Provider Organization

PREP - Practitioner Remediation and Enhancement Partnership

SRA - SRA International, Inc.

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Table 1: Practitioners with Reports
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Practitioner Type	Number of Practitioners with	Number of Reports*	Reports per Practitioner
Acupuncturists	40	42	1.05
Audiologists	20	22	1.10
Chiropractors	5,341	6,853	1.28
Counselors	429	520	1.21
Dental Assistants, Technicians, Hygienists	17	17	1.00
Dentists	24,873	39,735	1.60
Denturists	14	23	1.64
Dieticians	5	5	1.00
Emergency Medical Practitioners	103	129	1.25
Homeopaths and Naturopaths	11	16	1.45
Nurses and Nursing-Related Practitioners	12,203	13,756	1.13
Occupational Therapists and Related Practitioners	42	42	1.00
Optical-related Practitioners	478	587	1.23
Pharmacists and Pharmacy Assistants	1,907	2,160	1.13
Physicial Therapists and Related Practitioners	563	600	1.07
Physician Assistants and Medical Assistants	656	755	1.15
Physicians**	123,978	215,260	1.74
Podiatrists and Podiatric-Related Practitioners	3,418	5,782	1.69
Prosthetists	4	4	1.00
Psychiatric Technicians and Aides	11	18	1.64
Pyschology-Related Practitioners	1,093	1,447	1.32
Respiratory Therapists and Related Practitioners	26	27	1.04
Social Workers	187	222	1.19
Speech and Language-Related Practitioners	3	3	1.00
Technologists	127	142	1.12
Non-Healthcare Practitioners	2,885	2,994	1.04
Unspecified or Unknown***	311	359	1.15
Total	**178,745**	**291,520**	**1.63**

* "Number of Reports" include medical malpractice payment reports, adverse licensure action reports, clinical privilege reports, professional society membership reports, Drug Enforcement Administration reports, and Medicare/Medicaid exclusion reports. Only physicians and dentists are reported for adverse licensure, clinical privilege, and professional society actions.

** Of physicians with reports at least 116,235 (93.7%) of them are allopathic physicians, interns, and residents; and at least 7,510 (6.05%) are osteopathic physicians, interns, and residents. Similarly, at least 201,102 (93.4%) of the physicians reports are for allopathic physicians, interns, and residents; and at least 13,916 (6.5%) of the physician reports are for osteopathic physicians, interns, and residents. The physician type could not be determined for 233 physicians responsible for 242 reports. The ratio of reports per practitioner for allopathic physicians was 1.73 and for osteopathic physicians was 1.85.

*** Reports with license summary information defined as "unspecified or unknown" or "non-healthcare practitioner" are Medicare/Medicaid exclusion reports. Reports for "non-health care practitioners" are being removed from the NPDB.

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, 2001)

Report Type	1997		1998		1999		2000		2001		Cumulative	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Malpractice Payment	**18,297**	**58.8%**	**17,671**	**69.8%**	**19,008**	**71.5%**	**19,439**	**53.1%**	**20,623**	**73.9%**	**212,475**	**72.9%**
Reportable Action Reports*	**5,033**	**16.2%**	**5,294**	**20.9%**	**5,088**	**19.2%**	**5,604**	**15.3%**	**4,298**	**15.4%**	**51,859**	**17.8%**
State Licensure	4,108	13.2%	4,348	17.2%	4,063	15.3%	4,518	12.3%	3,200	11.5%	40,619	13.9%
Clinical Privilege	867	2.8%	859	3.4%	945	3.6%	1,058	2.9%	1,056	3.8%	10,553	3.6%
Professional Society Membership	32	0.1%	31	0.1%	18	0.1%	28	0.1%	33	0.1%	384	0.1%
DEA	26	0.1%	56	0.2%	62	0.2%	0	0.0%	9	0.0%	303	0.1%
Medicare/Medicaid Exclusion**	7,812	25.1%	2,369	9.4%	2,471	9.3%	11,562	31.6%	2,972	10.7%	27,186	9.3%
Total	**31,142**	**100.0%**	**25,334**	**100.0%**	**26,567**	**100.0%**	**36,605**	**100.0%**	**27,893**	**100.0%**	**291,520**	**100.0%**

This table includes only disclosable reports in the NPDB as of December 31, 2001. The numbers of reports for 1997 through 2000 may differ from those shown in previous Annual Reports because of voided reports and the fact that modified reports (Correction and Revision to Action Reports) are now counted in the year they were originally submitted, not the year they were modified.

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

** Medicare/Medicaid Exclusions were first reported during 1997. Reports for that year include exclusion actions taken in previous years if the practitioner had not been reinstated. The large increase in the number of exclusion reports for 2000 reflects reports for non-healthcare practitioners and nurse practitioner reports being submitted to the NPDB for 2000 and previous years. Exclusion reports for non-healthcare practitioners are being removed from the NPDB.

Table 3: Number of Reports Received and Percent Change by Report Type, Last Five Years
National Practitioner Data Bank (January 1, 1997 - December 31, 2001)

Report Type	1997		1998		1999		2000		2001	
	Number	% Change 1996-1997	Number	% Change 1997-1998	Number	% Change 1998-1999	Number	% Change 1999-2000	Number	% Change 2000-2001
Malpractice Payment	**18,297**	**-5.0%**	**17,671**	**-3.4%**	**19,008**	**7.6%**	**19,439**	**2.3%**	**20,623**	**6.1%**
Reportable Action Reports*	**5,033**	**-2.9%**	**5,294**	**5.2%**	**5,088**	**-3.9%**	**5,604**	**10.1%**	**4,298**	**-23.3%**
State Licensure	4,108	-2.8%	4,348	5.8%	4,063	-6.6%	4,518	11.2%	3,200	-29.2%
Clinical Privilege	867	-6.4%	859	-0.9%	945	10.0%	1,058	12.0%	1,056	-0.2%
Professional Society Membership	32	14.3%	31	-3.1%	18	-41.9%	28	55.6%	33	17.9%
DEA	26	…	56	115.4%	62	10.7%	0	…	9	…
Medicare/Medicaid Exclusion**	7,812	…	2,369	-69.7%	2,471	4.3%	11,562	367.9%	2,972	-74.3%
Total	**31,142**	**27.4%**	**25,334**	**-18.7%**	**26,567**	**4.9%**	**36,605**	**37.8%**	**27,893**	**-23.8%**

This table includes only disclosable reports in the NPDB as of December 31, 2001. The numbers of reports for 1997 through 2000 may differ from thos shown in previous Annual Reports because of voided reports and the fact that modified reports (Correction and Revision to Action Reports) are now counted in the year they were originally submitted, not the year they were modified.

Percent changes that cannot be calculated because no reports were submitted for specified periods are indicated by "…"

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

** Medicare/Medicaid Exclusions were first reported during 1997. Reports for that year include exclusion actions taken in previous years if the practitioner had not been reinstated. The large increase in the number of exclusion reports for 2000 reflects reports for non-healthcare practitioners and nurse practitioners being submitted to the NPDB for 2000 and previous years. Exclusion reports for non-healthcare practitioners are being removed from the NPDB.

Table 4: Number, Percent Distribution, and Percent Change of Medical Malpractice Payment Reports by Practitioner Type, Last Five Years and Cumulative
National Practitioner Data Bank (September 1, 1990 - December 31, 2001)

Practitioner Type	1997			1998			1999		
	Number	Percent	% Change 1996-1997	Number	Percent	% Change 1997-1998	Number	Percent	% Change 1998-1999
Physicians	14,608	79.9%	-4.4%	14,085	79.7%	-3.6%	15,113	79.6%	7.3%
Dentists	2,429	13.3%	-1.9%	2,348	13.3%	-3.3%	2,351	12.4%	0.1%
Other Practitioners*	1,255	6.9%	-16.9%	1,236	7.0%	-1.5%	1,531	8.1%	23.9%
Total	**18,292**	**100.0%**	**-5.0%**	**17,669**	**100.0%**	**-3.4%**	**18,995**	**100.0%**	**7.5%**

Practitioner Type	2000			2001			Cumulative	
	Number	Percent	% Change 1999-2000	Number	Percent	% Change 2000-2001	Number	Percent
Physicians	15,581	80.3%	3.1%	16,703	81.1%	7.2%	165,845	78.1%
Dentists	2,358	12.2%	0.3%	2,318	11.3%	-1.7%	29,399	13.8%
Other Practitioners*	1,453	7.5%	-5.1%	1,577	7.7%	8.5%	17,114	8.1%
Total	**19,392**	**100.0%**	**2.1%**	**20,598**	**100.0%**	**6.2%**	**212,358**	**100.0%**

This table includes only disclosable reports in the NPDB as of December 31, 2001. The numbers of reports for 1997 through 2000 may differ from those shown in previous Annual Reports because of modifications and voided reports. Modified reports are counted in the year they were originally submitted, not the year they were modified. The physician category includes allopathic and osteopathic physicians, interns and residents. The dentist category includes dental residents.

* "Other Practitioners" includes other healthcare practitioners, non-healthcare professionals and non-specified professionals. The total excludes practitioners for whom practitioner type was unidentified.

Table 5: Number, Percent Distribution, and Percent Change of Reportable Action and Medicare/Medicaid Exclusion Reports by Practitioner Type, Last Five Years and Cumulative
National Practitioner Data Bank (September 1, 1990 - December 31, 2001)

Report Type	1997			1998			1999			2000			2001			Cumulative	
	Number	Percent	% Change 1996-1997	Number	Percent	% Change 1997-1998	Number	Percent	% Change 1998-1999	Number	Percent	% Change 1999-2000	Number	Percent	% Change 2000-2001	Number	Percent
State Licensure Total	**4,108**	**32.0%**	**-2.8%**	**4,348**	**56.7%**	**5.8%**	**4,063**	**53.8%**	**-6.6%**	**4,518**	**26.3%**	**11.2%**	**3,200**	**44.0%**	**-29.2%**	**40,619**	**51.4%**
Physicians	3,286	25.6%	-7.7%	3,500	45.7%	6.5%	3,173	42.0%	-9.3%	3,491	20.3%	10.0%	2,621	36.1%	-24.9%	32,453	41.1%
Dentists	822	6.4%	22.9%	848	11.1%	3.2%	861	11.4%	1.5%	1,027	6.0%	19.3%	579	8.0%	-43.6%	8,137	10.3%
Other Pracitioners*	0	0.0%	0.0%	0	0.0%	…	29	0.4%	…	0	0.0%	-100.0%	0	0.0%	…	29	0.0%
Clinical Privilege Total	**867**	**6.7%**	**-6.4%**	**859**	**11.2%**	**-0.9%**	**945**	**12.5%**	**10.0%**	**1,058**	**6.2%**	**12.0%**	**1,056**	**14.5%**	**-0.2%**	**10,553**	**13.4%**
Physicians	836	6.5%	-6.2%	801	10.5%	-4.2%	886	11.7%	10.6%	977	5.7%	10.3%	981	13.5%	0.4%	10,032	12.7%
Dentists	11	0.1%	-26.7%	24	0.3%	118.2%	20	0.3%	-16.7%	24	0.1%	20.0%	40	0.6%	66.7%	198	0.3%
Other Practitioners*	20	0.2%	0.0%	34	0.4%	70.0%	39	0.5%	14.7%	57	0.3%	46.2%	35	0.5%	-38.6%	323	0.4%
Professional Society Membership Total	**32**	**0.2%**	**14.3%**	**31**	**0.4%**	**-3.1%**	**18**	**0.2%**	**-41.9%**	**28**	**0.2%**	**55.6%**	**33**	**0.5%**	**17.9%**	**384**	**0.5%**
Physicians	30	0.2%	15.4%	30	0.4%	0.0%	18	0.2%	-40.0%	26	0.2%	44.4%	23	0.3%	-11.5%	347	0.4%
Dentists	2	0.0%	0.0%	1	0.0%	-50.0%	0	0.0%	-100.0%	0	0.0%	0.0%	9	0.1%	…	34	0.0%
Other Practitioners*	0	0.0%	…	0	0.0%	…	0	0.0%	…	2	0.0%	0.0%	1	0.0%	-50.0%	3	0.0%
DEA Total	**26**	**0.2%**	**…**	**56**	**0.7%**	**115.4%**	**62**	**0.8%**	**10.7%**	**0**	**0.0%**	**-100.0%**	**9**	**0.1%**	**…**	**303**	**0.4%**
Physicians	26	0.2%	…	52	0.7%	100.0%	55	0.7%	5.8%	0	0.0%	-100.0%	9	0.1%	…	292	0.4%
Dentists	0	0.0%	…	4	0.1%	…	6	0.1%	50.0%	0	0.0%	-100.0%	0	0.0%	…	10	0.0%
Other Practitioners	0	0.0%	…	0	0.0%	…	1	0.0%	…	0	0.0%	-100.0%	0	0.0%	…	1	0.0%
Medicare/Medicaid Exclusion Total**	**7,812**	**60.8%**	**…**	**2,369**	**30.9%**	**-69.7%**	**2,471**	**32.7%**	**4.3%**	**11,562**	**67.4%**	**367.9%**	**2,972**	**40.9%**	**-74.3%**	**27,186**	**34.4%**
Physicians	1,173	9.1%	…	572	7.5%	-51.2%	465	6.2%	-18.7%	2,273	13.2%	388.8%	580	8.0%	-74.5%	5,063	6.4%
Dentists	497	3.9%	…	206	2.7%	-58.6%	168	2.2%	-18.4%	664	3.9%	295.2%	170	2.3%	-74.4%	1,705	2.2%
Other Practitioners*	6,142	47.8%	…	1,591	20.8%	-74.1%	1,838	24.3%	15.5%	8,625	50.2%	369.3%	2,222	30.6%	-74.2%	20,418	25.8%
Total	**12,845**	**100.0%**	**147.9%**	**7,663**	**100.0%**	**-40.3%**	**7,559**	**100.0%**	**-1.4%**	**17,166**	**100.0%**	**127.1%**	**7,270**	**100.0%**	**-57.6%**	**79,045**	**100.0%**

This table includes only disclosable reports in the NPDB as of December 31, 2001. The numbers of reports for 1997 through 2000 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 which cannot be calculated when no reports were submitted for specified periods are indicated by "…"

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).

* "Other Practitioners" includes all other healthcare practitioners, non-healthcare professionals, and non-specified professionals.

** 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. The number of exclusion reports in 2001 includes those reported to the HIPDB and the NPDB. Exclusion reports for non-healthcare practitioners are being removed from the NPDB.

Table 6: Actual and Adjusted Medical Malpractice Payment Reports and Ratio of Adjusted Medical Malpractice Reports by State - Physicians and Dentists
National Practitioner Data Bank (September 1, 1990 - December 31, 2001

State	Physicians		Dentists		Ratio of Adjusted Physician Reports to Adjusted Dentist Reports	Ratio of Adjusted Dentist Reports to Adjusted Physician Reports
	Number of Reports	Adjusted Number of Reports*	Number of Reports	Adjusted Number of Reports*		
Alabama	674	667	140	140	4.76	0.21
Alaska	206	206	58	57	3.61	0.28
Arizona	2,512	2,499	431	431	5.80	0.17
Arkansas	765	759	122	122	6.22	0.16
California	17,854	17,834	6,050	6,050	2.95	0.34
Colorado	1,751	1,735	353	353	4.92	0.20
Connecticut	1,636	1,632	440	440	3.71	0.27
Delaware	389	382	53	53	7.21	0.14
Florida*	10,937	10,894	1,470	1,470	7.41	0.13
Georgia	2,769	2,758	532	532	5.18	0.19
Hawaii	380	380	105	105	3.62	0.28
Idaho	337	337	46	46	7.33	0.14
Illinois	7,174	7,163	1,185	1,185	6.04	0.17
Indiana*	3,305	2,224	344	318	6.99	0.14
Iowa	1,309	1,306	161	161	8.11	0.12
Kansas*	1,867	1,254	202	200	6.27	0.16
Kentucky	1,664	1,652	296	296	5.58	0.18
Louisiana*	2,930	2,103	322	307	6.85	0.15
Maine	452	452	86	86	5.26	0.19
Maryland	2,559	2,554	686	686	3.72	0.27
Massachusetts	3,053	3,047	787	787	3.87	0.26
Michigan	9,079	9,073	1,376	1,376	6.59	0.15
Minnesota	1,293	1,287	271	271	4.75	0.21
Mississippi	1,241	1,236	114	113	10.94	0.09
Missouri	3,072	2,980	477	477	6.25	0.16
Montana	710	708	69	69	10.26	0.10
Nebraska*	717	609	111	111	5.49	0.18
Nevada	870	868	112	112	7.75	0.13
New Hampshire	632	632	133	133	4.75	0.21
New Jersey	6,539	6,496	1,010	1,010	6.43	0.16
New Mexico*	1,143	871	144	144	6.05	0.17
New York	21,456	21,437	3,262	3,262	6.57	0.15
North Carolina	2,468	2,445	236	236	10.36	0.10
North Dakota	268	265	25	25	10.60	0.09
Ohio	7,538	7,526	1,017	1,017	7.40	0.14
Oklahoma	1,116	1,100	284	284	3.87	0.26
Oregon	1,025	1,024	228	228	4.49	0.22
Pennsylvania*	14,335	9,993	1,961	1,961	5.10	0.20
Rhode Island	721	720	109	109	6.61	0.15
South Carolina*	1,185	971	106	105	9.25	0.11
South Dakota	252	251	51	51	4.92	0.20
Tennessee	1,922	1,909	267	267	7.15	0.14
Texas	11,568	11,542	1,695	1,695	6.81	0.15
Utah	1,158	1,156	417	417	2.77	0.36
Vermont	340	340	64	64	5.31	0.19
Virginia	2,371	2,366	443	443	5.34	0.19
Washington	2,726	2,720	793	793	3.43	0.29
Washington, DC	653	652	114	114	5.72	0.17
West Virginia	1,643	1,640	130	130	12.62	0.08
Wisconsin*	1,317	1,107	400	400	2.77	0.36
Wyoming	293	292	23	23	12.70	0.08
Total**	**165,842**	**157,720**	**29,398**	**29,352**	**5.37**	**0.19**

This table includes only disclosable reports in the NPDB as of December 31, 2001.

*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. 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 prin malpractice insurer. The States marked with asterisks have or had these funds. Thus, the adjusted columns provide the approximate 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 Annual Report narrative for additional details.

**"Total" includes counts for reports in jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.). Totals for reports that did not specify States were excluded.

Table 7: Number of Medical Malpractice Payment Reports by State, Last Five Years - Physicians
National Practitioner Data Bank (January 1, 1997 - December 31, 2001

State	1997		1998		1999		2000		2001	
	Number of Reports	Adjusted Number of Reports*	Number of Reports	Adjusted Number of Reports*	Number of Reports	Adjusted Number of Reports*	Number of Reports	Adjusted Number of Reports*	Number of Reports	Adjusted Number of Reports*
Alabama	65	65	69	68	45	41	83	82	75	75
Alaska	16	16	15	15	20	20	17	17	20	20
Arizona	248	247	222	219	221	221	265	263	299	297
Arkansas	56	55	78	78	69	68	69	69	83	82
California	1,817	1,817	1,486	1,484	1,492	1,489	1,401	1,401	1,461	1,459
Colorado	158	157	152	148	147	147	145	144	136	134
Connecticut	138	138	145	145	155	155	167	167	172	170
Delaware	27	27	30	29	24	23	31	30	52	52
Florida*	1,110	1,110	1,047	1,043	1,054	1,050	1,228	1,225	1,303	1,294
Georgia	269	267	284	283	270	267	276	275	274	274
Hawaii	20	20	45	45	41	41	40	40	41	41
Idaho	31	31	26	26	34	34	33	33	30	30
Illinois	609	607	561	560	550	549	590	589	529	528
Indiana*	283	188	260	155	289	179	286	168	323	217
Iowa	130	130	109	109	73	72	121	121	145	144
Kansas*	217	157	151	92	184	123	188	123	162	112
Kentucky	154	154	127	125	153	153	187	186	186	185
Louisiana*	262	166	283	202	312	189	295	189	306	208
Maine	41	41	34	34	47	47	65	65	39	39
Maryland	229	228	255	255	238	237	249	249	283	283
Massachusetts	222	222	224	224	253	252	325	324	341	339
Michigan	651	651	735	734	750	750	667	665	803	802
Minnesota	95	94	75	75	84	84	87	86	109	109
Mississippi	129	128	116	116	112	112	116	116	145	144
Missouri	241	236	212	201	284	280	200	196	299	289
Montana	59	58	55	55	93	93	67	67	69	69
Nebraska*	68	58	58	51	53	49	78	59	94	75
Nevada	74	74	82	82	83	83	117	117	90	89
New Hampshire	50	50	57	57	42	42	64	64	59	59
New Jersey	459	454	570	567	480	479	617	609	950	940
New Mexico*	108	90	130	90	105	73	108	89	112	91
New York	1,828	1,827	1,951	1,950	2,030	2,030	2,109	2,107	2,088	2,085
North Carolina	233	231	225	223	197	189	217	216	224	224
North Dakota	18	18	23	21	22	22	16	16	24	24
Ohio	617	615	416	415	876	874	846	846	677	677
Oklahoma	69	63	81	81	76	73	104	103	137	136
Oregon	84	84	74	74	85	85	81	81	87	87
Pennsylvania*	1,366	923	1,148	744	1,437	976	1,403	875	1,569	1,049
Rhode Island	84	84	69	69	67	67	67	67	59	59
South Carolina*	120	101	139	116	142	110	160	124	187	131
South Dakota	27	27	27	27	15	15	26	26	24	24
Tennessee	190	188	150	147	189	188	180	179	203	203
Texas	895	891	974	973	1,022	1,019	1,119	1,117	1,174	1,172
Utah	100	100	86	86	113	113	105	105	109	108
Vermont	35	35	49	49	33	33	23	23	24	24
Virginia	186	185	247	246	230	230	200	199	216	215
Washington	257	257	268	267	325	325	211	211	254	254
Washington, DC	63	63	82	82	55	55	62	62	76	76
West Virginia	124	124	144	144	131	131	169	169	207	207
Wisconsin*	85	68	79	63	72	57	76	71	106	99
Wyoming	20	20	30	30	30	30	26	26	27	27
Total**	**14,608**	**13,811**	**14,085**	**13,304**	**15,113**	**14,233**	**15,581**	**14,649**	**16,703**	**15,771**

This table includes only disclosable reports in the NPDB as of December 31, 2001.

*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 paym 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 Stat the practitioner's primary malpractice carrier. The States marked with asterisks have or had 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 Annual Report narrative f detailed explanation.

**"Total" includes counts for reports in jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.). Totals for reports which did not specify States were excluded.

Table 8: Number of Medical Malpractice Payment Reports by State, Last Five Years - Dentists
National Practitioner Data Bank (January 1, 1997 - December 31, 2001

State	1997		1998		1999		2000		2001	
	Number of Reports	Adjusted Number of Reports*	Number of Reports	Adjusted Number of Reports*	Number of Reports	Adjusted Number of Reports*	Number of Reports	Adjusted Number of Reports*	Number of Reports	Adjusted Number of Reports*
Alabama	8	8	10	10	18	18	12	12	14	14
Alaska	0	0	5	5	3	2	7	7	7	7
Arizona	44	44	27	27	36	36	27	27	32	32
Arkansas	11	11	14	14	8	8	11	11	13	13
California	545	545	525	525	438	438	432	432	387	387
Colorado	32	32	18	18	34	34	21	21	24	24
Connecticut	27	27	33	33	26	26	36	36	20	20
Delaware	2	2	5	5	2	2	2	2	5	5
Florida*	153	153	118	118	116	116	118	118	128	128
Georgia	37	37	34	34	151	151	93	93	34	34
Hawaii	10	10	10	10	13	13	15	15	7	7
Idaho	6	6	7	7	4	4	2	2	2	2
Illinois	88	88	77	77	101	101	68	68	79	79
Indiana*	30	26	28	27	22	19	12	11	15	15
Iowa	8	8	12	12	12	12	7	7	13	13
Kansas*	18	18	13	13	17	17	8	8	14	14
Kentucky	25	25	27	27	16	16	13	13	24	24
Louisiana*	22	20	35	34	25	23	21	18	24	19
Maine	10	10	9	9	7	7	8	8	5	5
Maryland	51	51	40	40	40	40	66	66	56	56
Massachusetts	55	55	58	58	89	89	92	92	42	42
Michigan	85	85	81	81	114	114	71	71	79	79
Minnesota	24	24	12	12	11	11	19	19	14	14
Mississippi	11	11	23	23	4	4	11	10	10	10
Missouri	38	38	51	51	44	44	23	23	30	30
Montana	4	4	3	3	5	5	3	3	4	4
Nebraska*	7	7	1	1	4	4	6	6	8	8
Nevada	13	13	5	5	10	10	8	8	17	17
New Hampshire	13	13	8	8	3	3	5	5	8	8
New Jersey	97	97	69	69	63	63	46	46	126	126
New Mexico*	16	16	12	12	9	9	13	13	19	19
New York	254	254	237	237	226	226	388	388	474	474
North Carolina	30	30	16	16	20	20	11	11	18	18
North Dakota	0	0	2	2	3	3	5	5	1	1
Ohio	81	81	75	75	77	77	85	85	53	53
Oklahoma	21	21	17	17	18	18	70	70	34	34
Oregon	15	15	15	15	11	11	44	44	25	25
Pennsylvania*	158	158	145	145	124	124	163	163	149	149
Rhode Island	9	9	4	4	12	12	7	7	8	8
South Carolina*	6	6	4	4	18	18	12	11	10	10
South Dakota	3	3	1	1	5	5	5	5	1	1
Tennessee	22	22	24	24	24	24	26	26	23	23
Texas	119	119	250	250	91	91	93	93	99	99
Utah	18	18	14	14	16	16	13	13	6	6
Vermont	4	4	3	3	2	2	7	7	4	4
Virginia	34	34	54	54	85	85	37	37	29	29
Washington	86	86	62	62	114	114	56	56	56	56
Washington, DC	14	14	11	11	8	8	8	8	8	8
West Virginia	6	6	11	11	10	10	10	10	16	16
Wisconsin*	44	44	24	24	27	27	25	25	33	33
Wyoming	0	0	2	2	2	2	2	2	3	3
Total**	**2,429**	**2,423**	**2,348**	**2,346**	**2,351**	**2,345**	**2,358**	**2,352**	**2,318**	**2,313**

This table includes only disclosable reports in the NPDB as of December 31, 2001.

*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 malpract 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 or had 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 Annual Report narrative for a detailed explanation.

**"Total" includes counts for reports in jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.). Totals for reports which did not specify States were excluded.

Table 9: Mean and Median Medical Malpractice Payment and Mean Delay Between Incident and Payment by State, 2001 and Cumulative - Physicians
National Practitioner Data Bank (September 1, 1990 - December 31, 2001)

State	2001 Only		Cumulative			2001 Only		Cumulative	
	Mean Payment	Median Payment	Mean Payment	Median Payment	Rank of Cumulative Median Payment**	Mean Delay Between Incident	Median Delay Between Incident	Mean Delay Between Incident	Median Delay Between Incident
Alabama	$ 331,101	$ 150,000	$ 340,658	$ 150,000	5	4.32	4.21	4.30	3.99
Alaska	$ 314,455	$ 222,500	$ 225,460	$ 85,000	30	3.46	3.54	3.87	3.60
Arizona	$ 290,981	$ 161,500	$ 214,391	$ 100,000	18	4.34	3.50	3.87	3.31
Arkansas	$ 198,939	$ 100,000	$ 161,406	$ 90,000	28	3.16	2.95	3.40	3.01
California	$ 178,499	$ 65,000	$ 127,406	$ 45,000	51	3.02	2.59	3.39	2.82
Colorado	$ 257,285	$ 123,500	$ 171,285	$ 60,000	47	3.35	2.88	3.33	2.94
Connecticut	$ 499,244	$ 262,500	$ 340,560	$ 149,529	6	5.62	5.62	5.47	5.35
Delaware	$ 337,416	$ 166,875	$ 222,785	$ 100,000	18	4.00	3.82	4.48	4.03
Florida*	$ 250,051	$ 150,000	$ 219,768	$ 128,165	8	3.77	3.53	4.03	3.43
Georgia	$ 371,831	$ 193,750	$ 282,621	$ 125,000	9	3.68	3.48	3.61	3.20
Hawaii	$ 243,466	$ 175,000	$ 237,148	$ 85,000	30	4.20	3.88	4.12	3.76
Idaho	$ 159,883	$ 99,500	$ 202,739	$ 50,000	49	4.01	3.62	3.40	2.95
Illinois	$ 433,838	$ 250,000	$ 323,562	$ 187,500	1	5.41	4.97	5.78	5.21
Indiana*	$ 174,286	$ 75,001	$ 156,808	$ 75,001	36	5.94	5.93	5.45	5.06
Iowa	$ 269,811	$ 137,500	$ 171,157	$ 72,222	43	3.39	3.25	3.21	3.02
Kansas*	$ 136,727	$ 100,000	$ 161,898	$ 103,125	16	3.87	3.31	4.02	3.30
Kentucky	$ 175,794	$ 89,000	$ 181,281	$ 75,000	37	4.26	3.94	4.09	3.50
Louisiana*	$ 171,095	$ 100,000	$ 140,451	$ 85,000	30	5.37	4.88	4.96	4.43
Maine	$ 293,501	$ 180,000	$ 244,041	$ 125,000	9	4.23	3.65	4.09	3.71
Maryland	$ 272,349	$ 150,000	$ 244,847	$ 125,000	9	4.48	4.08	4.71	4.27
Massachusetts	$ 401,763	$ 250,000	$ 296,973	$ 155,000	4	5.59	5.38	5.92	5.55
Michigan	$ 119,783	$ 75,000	$ 102,074	$ 70,000	44	4.12	3.84	4.33	3.56
Minnesota	$ 300,004	$ 110,000	$ 186,539	$ 75,000	37	3.17	2.94	3.16	2.78
Mississippi	$ 282,494	$ 130,000	$ 198,474	$ 100,000	18	4.60	3.75	4.12	3.44
Missouri	$ 250,369	$ 133,333	$ 213,981	$ 100,000	18	4.29	3.76	4.51	3.87
Montana	$ 180,235	$ 90,000	$ 152,355	$ 60,000	47	4.59	3.96	4.33	3.84
Nebraska*	$ 178,577	$ 125,000	$ 126,532	$ 75,000	37	3.73	3.42	3.87	3.40
Nevada	$ 372,728	$ 225,000	$ 254,844	$ 100,000	18	5.04	4.74	4.35	4.02
New Hampshire	$ 305,416	$ 175,000	$ 248,030	$ 130,000	7	4.34	3.61	4.80	4.21
New Jersey	$ 349,111	$ 180,991	$ 253,934	$ 125,000	9	5.76	5.24	6.17	5.09
New Mexico*	$ 202,091	$ 150,000	$ 139,281	$ 100,000	18	4.10	3.72	3.86	3.38
New York	$ 330,255	$ 200,000	$ 263,461	$ 125,000	9	6.22	5.67	6.98	6.08
North Carolina	$ 338,168	$ 165,000	$ 247,261	$ 100,000	18	3.92	3.83	3.69	3.32
North Dakota	$ 279,666	$ 187,500	$ 177,880	$ 80,000	34	3.18	3.23	3.47	3.24
Ohio	$ 305,065	$ 150,000	$ 223,105	$ 97,593	27	4.39	3.73	4.49	3.56
Oklahoma	$ 233,303	$ 60,000	$ 240,234	$ 75,000	37	3.54	2.95	3.82	3.17
Oregon	$ 297,013	$ 135,000	$ 188,074	$ 77,500	35	3.74	3.32	3.42	2.99
Pennsylvania*	$ 270,831	$ 200,000	$ 218,060	$ 164,112	3	5.70	5.22	5.96	5.57
Rhode Island	$ 406,411	$ 244,116	$ 265,594	$ 120,000	15	6.44	5.71	6.14	5.85
South Carolina*	$ 267,722	$ 100,000	$ 174,261	$ 100,000	18	4.70	4.51	4.67	4.12
South Dakota	$ 308,476	$ 66,250	$ 209,569	$ 65,500	46	3.45	3.42	3.48	3.22
Tennessee	$ 254,668	$ 125,000	$ 219,144	$ 90,000	28	4.07	3.35	3.66	3.19
Texas	$ 275,595	$ 150,000	$ 185,563	$ 100,000	18	3.76	3.44	3.88	3.43
Utah	$ 235,728	$ 85,000	$ 156,569	$ 50,000	49	3.74	3.54	3.52	3.26
Vermont	$ 181,976	$ 112,500	$ 146,891	$ 70,000	44	4.86	3.23	4.41	4.18
Virginia	$ 223,749	$ 150,000	$ 192,441	$ 102,500	17	3.64	3.28	3.78	3.22
Washington	$ 247,168	$ 100,000	$ 198,602	$ 75,000	37	4.15	3.54	4.36	3.68
Washington, DC	$ 630,473	$ 225,000	$ 425,131	$ 185,000	2	4.82	3.64	4.83	4.03
West Virginia	$ 230,554	$ 100,000	$ 205,635	$ 81,250	33	4.60	4.15	5.54	4.24
Wisconsin*	$ 325,995	$ 115,313	$ 322,157	$ 125,000	9	4.22	4.33	4.84	4.17
Wyoming	$ 154,619	$ 55,000	$ 161,664	$ 75,000	37	3.34	3.13	3.20	2.98
Total* **	**$ 270,854**	**$ 135,000**	**$ 209,272**	**$ 100,000**		**4.63**	**4.08**	**4.81**	**4.02**

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 amounts received by claimants. Payments made by these funds may also affect mean and median delay times between incidents and payments. States with these funds are marked with an asterisk.

** Rank of cumulative median payment amounts as of December 31, 2001 is based on the cumulative median payment amount for each State. One is the highest amount; 51 is lowest amount.

*** "Total" includes counts for reports in jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.). Totals for reports which did not specify States were excluded.

Table 10: Mean and Median Medical Malpractice Payment Amounts by Malpractice Reason, 2001 and Cumulative - Physicians
National Practitioner Data Bank (September 1, 1990 - December 31, 2001)

Malpractice Reason	2001 Only			Cumulative				
				Actual			Inflation-Adjusted	
	Number of Payments	Mean Payment	Median Payment	Number of Payments	Mean Payment	Median Payment	Mean Payment	Median Payment
Anesthesia Related	473	$ 322,677	$ 150,000	5,227	$ 237,800	$ 85,000	$ 271,243	$ 97,886
Diagnosis Related	6,179	$ 292,120	$ 160,132	56,048	$ 230,825	$ 125,000	$ 259,081	$ 136,911
Equipment / Product Related	30	$ 197,712	$ 112,500	653	$ 69,489	$ 16,000	$ 79,431	$ 18,973
IV & Blood Products Related	46	$ 165,654	$ 51,000	668	$ 166,326	$ 62,108	$ 191,337	$ 73,747
Medication Related	840	$ 226,951	$ 100,000	9,653	$ 155,803	$ 50,000	$ 177,261	$ 59,852
Monitoring Related	178	$ 261,969	$ 100,000	1,935	$ 210,103	$ 89,500	$ 276,744	$ 100,000
Obstetrics Related	1,449	$ 488,439	$ 250,000	14,393	$ 366,631	$ 200,000	$ 415,778	$ 217,273
Surgery Related	4,572	$ 207,248	$ 100,000	45,308	$ 167,565	$ 79,000	$ 188,828	$ 92,025
Treatment Related	2,776	$ 231,238	$ 100,000	29,287	$ 181,884	$ 78,500	$ 205,265	$ 92,025
Miscellaneous	160	$ 115,104	$ 32,000	2,550	$ 94,798	$ 25,000	$ 110,065	$ 28,290
Total	**16,703**	**$ 270,854**	**$ 135,000**	**165,722**	**$ 209,295**	**$ 100,000**	**$ 236,523**	**$ 109,569**

This table includes only disclosable reports in the NPDB as of December 31, 2001. Malpractice payment reports that are missing data necessary to calculate payment or malpractice reason are excluded.

Table 11: Mean and Median Delay Between Incident and Payment by Malpractice Reason, 2001 and Cumulative - All Practitioners
National Practitioner Data Bank (September 1, 1990 - December 31, 2001)

Malpractice Reason	2001 Only			Cumulative		
	Number of Payments	Mean Delay Between Incident and Payment (Years)	Median Delay Between Incident and Payment (Years)	Number of Payments	Mean Delay Between Incident and Payment (Years)	Median Delay Between Incident and Payment (Years)
Anesthesia Related	583	3.81	3.58	6,340	3.61	3.10
Diagnosis Related	6,617	4.77	4.24	60,291	4.85	4.21
Equipment / Product Related	58	3.39	2.99	987	5.42	3.26
IV & Blood Products Related	64	8.00	4.24	848	5.05	3.95
Medication Related	981	4.09	3.51	11,923	4.80	3.40
Monitoring Related	255	4.32	3.80	2,762	4.87	3.97
Obstetrics Related	1,536	5.69	4.82	14,844	6.23	4.92
Surgery Related	5,048	4.23	3.82	51,090	4.27	3.70
Treatment Related	5,114	4.10	3.59	57,814	4.29	3.57
Miscellaneous	284	3.65	3.17	4,033	4.63	3.60
Total	**20,540**	**4.46**	**3.93**	**210,932**	**4.61**	**3.86**

This table includes only disclosable reports in the NPDB as of December 31, 2001. Malpractice payment reports which are missing data necessary to calculate payment delay or malpractice reason are excluded.

Table 12: Number of Medical Malpractice Payment Reports by Malpractice Reason - Nurses (Registered Nurses, Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners)
National Practitioner Data Bank (September 1, 1990 - December 31, 2001)

Malpractice Reason	RN (Professional) Nurse	Nurse Anesthetist	Nurse Midwife	Nurse Practitioner	Total
Anesthesia Related	86	691	0	5	782
Diagnosis Related	149	10	26	87	272
Equipment / Product Related	36	3	0	1	40
IV & Blood Products Related	114	12	0	2	128
Medication Related	380	23	1	23	427
Monitoring Related	483	6	8	8	505
Obstetrics Related	228	7	236	9	480
Surgery Related	246	42	7	3	298
Treatment Related	461	21	17	44	543
Miscellaneous	128	5	1	6	140
Total	**2,311**	**820**	**296**	**188**	**3,615**

This table includes only disclosable reports in the NPDB as of December 31, 2001. Malpractice payment reports which are missing data necessary to determine the malpractice reason are excluded.

Table 13: Mean and Median Medical Malpractice Payment Amounts by Malpractice Reason, 2001 and Cumulative - Nurses (Registered Nurses, Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners)
National Practitioner Data Bank (September 1, 1990 - December 31, 2001)

Malpractice Reason	2001 Only			Cumulative				
				Actual			Inflation-Adjusted	
	Number of Payments	Mean Payment	Median Payment	Number of Payments	Mean Payment	Median Payment	Mean Payment	Median Payment
Anesthesia Related	73	$380,149	$150,000	782	$231,132	$ 95,000	$265,380	$100,000
Diagnosis Related	48	$327,905	$181,875	272	$315,468	$125,000	$356,819	$141,999
Equipment / Product Related	6	$174,500	$111,250	40	$202,605	$ 40,000	$238,780	$ 41,358
IV & Blood Products Related	8	$ 61,063	$ 40,000	128	$217,461	$ 50,000	$248,974	$ 58,781
Medication Related	39	$516,576	$ 75,000	427	$239,926	$ 50,000	$268,514	$ 51,462
Monitoring Related	50	$666,780	$100,000	505	$296,178	$ 90,000	$330,104	$ 99,000
Obstetrics Related	75	$927,967	$200,000	480	$483,311	$200,000	$528,639	$217,273
Surgery Related	34	$124,693	$ 99,750	298	$166,337	$ 38,750	$184,342	$ 44,159
Treatment Related	68	$250,205	$ 63,750	543	$137,251	$ 50,000	$152,916	$ 55,060
Miscellaneous	13	$154,577	$115,000	140	$151,277	$ 35,000	$173,420	$ 41,896
Total	**414**	**$462,251**	**$125,000**	**3,615**	**$257,752**	**$ 75,000**	**$288,618**	**$ 85,890**

This table includes only disclosable reports in the NPDB as of December 31, 2001.

Table 14: Actual and Adjusted Medical Malpractice Payment Reports and Ratio of Adjusted Medical Malpractice Payment Reports by State - Physicians and Nurses (Registered Nurses, Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners)
National Practitioner Data Bank (September 1, 1990 - December 31, 2001)

State	Number of Nurse Reports	Adjusted Number of Nurse Reports*	Adjusted Number of Physician Reports*	Ratio of Adjusted Physician Reports to Adjusted Nurse Reports	Ratio of Adjusted Nurse Reports to Adjusted Physician Reports
Alabama	48	48	667	0.07	0.07
Alaska	8	8	206	0.04	0.04
Arizona	51	51	2,499	0.02	0.02
Arkansas	29	29	759	0.04	0.04
California	141	141	17,834	0.01	0.01
Colorado	53	53	1,735	0.03	0.03
Connecticut	24	24	1,632	0.01	0.01
Delaware	4	4	382	0.01	0.01
Florida*	263	263	10,894	0.02	0.02
Georgia	104	104	2,758	0.04	0.04
Hawaii	8	8	380	0.02	0.02
Idaho	25	25	337	0.07	0.07
Illinois	149	149	7,163	0.02	0.02
Indiana*	20	16	2,224	0.01	0.01
Iowa	18	18	1,306	0.01	0.01
Kansas*	67	47	1,254	0.04	0.04
Kentucky	45	45	1,652	0.03	0.03
Louisiana*	126	108	2,103	0.05	0.05
Maine	9	9	452	0.02	0.02
Maryland	66	66	2,554	0.03	0.03
Massachusetts	221	221	3,047	0.07	0.07
Michigan	89	89	9,073	0.01	0.01
Minnesota	24	24	1,287	0.02	0.02
Mississippi	40	40	1,236	0.03	0.03
Missouri	161	161	2,980	0.05	0.05
Montana	7	7	708	0.01	0.01
Nebraska*	28	28	609	0.05	0.05
Nevada	14	14	868	0.02	0.02
New Hampshire	28	28	632	0.04	0.04
New Jersey	438	438	6,496	0.07	0.07
New Mexico*	64	63	871	0.07	0.07
New York	194	194	21,437	0.01	0.01
North Carolina	59	59	2,445	0.02	0.02
North Dakota	4	4	265	0.02	0.02
Ohio	123	123	7,526	0.02	0.02
Oklahoma	51	51	1,100	0.05	0.05
Oregon	25	25	1,024	0.02	0.02
Pennsylvania*	111	100	9,993	0.01	0.01
Rhode Island	10	10	720	0.01	0.01
South Carolina*	19	17	971	0.02	0.02
South Dakota	12	12	251	0.05	0.05
Tennessee	91	91	1,909	0.05	0.05
Texas	338	338	11,542	0.03	0.03
Utah	12	12	1,156	0.01	0.01
Vermont	3	3	340	0.01	0.01
Virginia	55	55	2,366	0.02	0.02
Washington	49	49	2,720	0.02	0.02
Washington, DC	23	23	652	0.04	0.04
West Virginia	25	25	1,640	0.02	0.02
Wisconsin*	28	26	1,107	0.02	0.02
Wyoming	8	8	292	0.03	0.03
Total**	**3,623**	**3,565**	**157,720**	**0.02**	**0.02**

This table includes only disclosable reports in the NPDB as of December 31, 2001.

*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. 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 or had these funds. Thus, the adjusted columns provide approximate 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 Annual Report narrative for additional details.

** "Total" includes counts for reports in jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.). Totals for reports that did not specify States were excluded.

Table 15: Mean and Median Medical Malpractice Payment Amounts by Malpractice Reason, 2001 and Cumulative - Physician Assistants
National Practitioner Data Bank (September 1, 1990 - December 31, 2001)

Malpractice Reason	2001 Only			Cumulative				
				Actual			Inflation-Adjusted	
	Number of Payments	Mean Payment	Median Payment	Number of Payments	Mean Payment	Median Payment	Mean Payment	Median Payment
Anesthesia Related	0	$ -	$ -	2	$ 3,945	$ 3,945	$ 4,247	$ 4,247
Diagnosis Related	47	$190,513	$ 95,000	285	$144,837	$ 75,000	$156,838	$ 85,434
Medication Related	6	$ 49,750	$ 14,000	45	$ 59,229	$ 15,000	$ 66,429	$ 15,337
Monitoring Related	1	$ 20,000	$ 20,000	7	$129,627	$ 55,000	$143,062	$ 65,837
Obstetrics Related	0	$ -	$ -	1	$750,000	$750,000	$814,775	$814,775
Surgery Related	4	$ 20,829	$ 15,409	26	$ 67,691	$ 32,500	$ 77,632	$ 36,384
Treatment Related	22	$155,939	$ 42,500	146	$ 85,006	$ 25,000	$ 93,033	$ 25,365
Miscellaneous	2	$107,500	$107,500	22	$ 51,068	$ 50,000	$ 53,827	$ 51,462
Total	**82**	**$158,556**	**$ 77,500**	**534**	**$114,051**	**$ 50,000**	**$124,154**	**$ 53,396**

This table includes only disclosable reports in the NPDB as of December 31, 2001. There were no reports for physician assistants in the "Equipment/Product Related" and "IV & Blood Products Related" categories.

Table 16: 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, 2001)

State	Number of Hospitals with "Active" NPDB Registrations	Number of "Active" Hospitals that Have Never Reported	Percent of Hospitals that Have Never Reported
Alabama	119	79	66.4%
Alaska	18	12	66.7%
Arizona	75	32	42.7%
Arkansas	91	57	62.6%
California	454	189	41.6%
Colorado	71	40	56.3%
Connecticut	43	18	41.9%
Delaware	10	3	30.0%
Florida	230	121	52.6%
Georgia	184	93	50.5%
Hawaii	25	15	60.0%
Idaho	43	26	60.5%
Illinois	220	104	47.3%
Indiana	143	76	53.1%
Iowa	120	85	70.8%
Kansas	146	107	73.3%
Kentucky	116	70	60.3%
Louisiana	185	138	74.6%
Maine	42	21	50.0%
Maryland	72	30	41.7%
Massachusetts	112	67	59.8%
Michigan	167	77	46.1%
Minnesota	138	100	72.5%
Mississippi	103	69	67.0%
Missouri	139	73	52.5%
Montana	47	34	72.3%
Nebraska	86	59	68.6%
Nevada	40	27	67.5%
New Hampshire	30	11	36.7%
New Jersey	100	28	28.0%
New Mexico	44	26	59.1%
New York	265	103	38.9%
North Carolina	132	70	53.0%
North Dakota	48	35	72.9%
Ohio	205	90	43.9%
Oklahoma	141	95	67.4%
Oregon	64	24	37.5%
Pennsylvania	258	131	50.8%
Rhode Island	15	4	26.7%
South Carolina	73	41	56.2%
South Dakota	56	45	80.4%
Tennessee	144	90	62.5%
Texas	486	321	66.0%
Utah	47	23	48.9%
Vermont	17	9	52.9%
Virginia	111	55	49.5%
Washington	89	37	41.6%
Washington, DC	16	6	37.5%
West Virginia	62	32	51.6%
Wisconsin	137	88	64.2%
Wyoming	24	18	75.0%
Total	**5,842**	**3,232**	**55.3%**

"Currently active" registered hospitals are those listed by the NPDB as being active on December 31, 2001.

Table 17: Clinical Privilege Reports and Ratio of Adverse Clinical Privilege Reports to Adverse In-State Licensure Reports by State - Physicians
National Practitioner Data Bank (September 1, 1990 - December 31, 2001

State	Clinical Privilege Reports*	Adverse Clinical Privilege Reports*	Adverse Licensure Reports for In-State Physicians	Ratio of Adverse Clinical Privilege Reports to Adverse In-State Licensure
Alabama	124	112	307	0.36
Alaska	16	15	116	0.13
Arizona	294	268	621	0.43
Arkansas	89	79	185	0.43
California	1,152	1,085	2,541	0.43
Colorado	188	180	834	0.22
Connecticut	63	61	409	0.15
Delaware	24	24	30	0.80
Florida	521	483	1,281	0.38
Georgia	301	284	595	0.48
Hawaii	49	45	57	0.79
Idaho	40	36	59	0.61
Illinois	266	249	597	0.42
Indiana	235	214	215	1.00
Iowa	90	84	382	0.22
Kansas	161	153	181	0.85
Kentucky	124	116	448	0.26
Louisiana	129	119	369	0.32
Maine	52	49	143	0.34
Maryland	252	235	771	0.30
Massachusetts	312	282	559	0.50
Michigan	339	314	1,202	0.26
Minnesota	127	119	364	0.33
Mississippi	67	64	389	0.16
Missouri	182	172	549	0.31
Montana	41	35	93	0.38
Nebraska	89	83	77	1.08
Nevada	123	110	109	1.01
New Hampshire	52	49	96	0.51
New Jersey	310	278	934	0.30
New Mexico	61	56	60	0.93
New York	717	660	2,286	0.29
North Carolina	185	168	323	0.52
North Dakota	34	31	125	0.25
Ohio	447	417	1,537	0.27
Oklahoma	167	156	481	0.32
Oregon	116	109	408	0.27
Pennsylvania	371	346	671	0.52
Rhode Island	47	43	113	0.38
South Carolina	121	112	298	0.38
South Dakota	16	15	36	0.42
Tennessee	163	147	298	0.49
Texas	655	606	1,646	0.37
Utah	68	67	133	0.50
Vermont	28	24	100	0.24
Virginia	206	189	1,069	0.18
Washington	248	225	444	0.51
Washington, DC	35	33	40	0.83
West Virginia	84	73	369	0.20
Wisconsin	170	153	242	0.63
Wyoming	22	21	43	0.49
Total**	**10,032**	**9,290**	**25,247**	**0.37**

This table includes only disclosable reports in the NPDB as of December 31, 2001. Clinical privilege reports are attributed to States on the basis of where the physician worked. Licensure reports are attributed to the State of the board taking the action. "In-State" refers to the State where the physician or dentist was practicing at the time the reportable licensure action was taken.

* "Clinical Privilege Reports" include truly adverse actions (e.g., revocations, probations, suspensions, reprimands, etc.) as well as non-adverse actions reported as adverse (e.g., restorations and reinstatements). "Adverse Clinical Privileges Reports" include only non-adverse reportable actions.

** "Total" includes counts for reports in jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.). Totals for reports that did not specify States were excluded.

Table 18: Cumulative Licensure Actions by State - Physicians
National Practitioner Data Bank (September 1, 1990 - December 31, 2001

State	Number of Reportable Licensure Actions*	Number of Reportable Adverse Licensure Actions*	Percent of Reportable Adverse Licensure Actions	Number of Adverse Licensure Actions for In-State Physicians**	Percent of All Reportable Adverse Licensure Actions for In-State Physicians
Alabama	392	351	89.5%	307	87.5%
Alaska	124	117	94.4%	116	99.1%
Arizona	925	866	93.6%	621	71.7%
Arkansas	218	191	87.6%	185	96.9%
California	3,611	3,152	87.3%	2,541	80.6%
Colorado	908	838	92.3%	834	99.5%
Connecticut	442	425	96.2%	409	96.2%
Delaware	40	34	85.0%	30	88.2%
Florida	1,638	1,412	86.2%	1,281	90.7%
Georgia	749	661	88.3%	595	90.0%
Hawaii	74	72	97.3%	57	79.2%
Idaho	103	89	86.4%	59	66.3%
Illinois	985	776	78.8%	597	76.9%
Indiana	331	280	84.6%	215	76.8%
Iowa	550	481	87.5%	382	79.4%
Kansas	226	188	83.2%	181	96.3%
Kentucky	611	520	85.1%	448	86.2%
Louisiana	491	426	86.8%	369	86.6%
Maine	153	145	94.8%	143	98.6%
Maryland	886	840	94.8%	771	91.8%
Massachusetts	631	606	96.0%	559	92.2%
Michigan	1,489	1,364	91.6%	1,202	88.1%
Minnesota	468	385	82.3%	364	94.5%
Mississippi	450	411	91.3%	389	94.6%
Missouri	679	648	95.4%	549	84.7%
Montana	109	98	89.9%	93	94.9%
Nebraska	86	83	96.5%	77	92.8%
Nevada	127	127	100.0%	109	85.8%
New Hampshire	102	101	99.0%	96	95.0%
New Jersey	1,297	1,135	87.5%	934	82.3%
New Mexico	67	66	98.5%	60	90.9%
New York	2,959	2,944	99.5%	2,286	77.6%
North Carolina	443	369	83.3%	323	87.5%
North Dakota	177	135	76.3%	125	92.6%
Ohio	1,740	1,653	95.0%	1,537	93.0%
Oklahoma	583	503	86.3%	481	95.6%
Oregon	431	412	95.6%	408	99.0%
Pennsylvania	1,076	1,004	93.3%	671	66.8%
Rhode Island	135	125	92.6%	113	90.4%
South Carolina	421	308	73.2%	298	96.8%
South Dakota	43	40	93.0%	36	90.0%
Tennessee	394	335	85.0%	298	89.0%
Texas	1,998	1,749	87.5%	1,646	94.1%
Utah	193	161	83.4%	133	82.6%
Vermont	119	114	95.8%	100	87.7%
Virginia	1,212	1,091	90.0%	1,069	98.0%
Washington	622	496	79.7%	444	89.5%
Washington, DC	75	66	88.0%	40	60.6%
West Virginia	482	400	83.0%	369	92.3%
Wisconsin	323	279	86.4%	242	86.7%
Wyoming	52	47	90.4%	43	91.5%
Total* **	**32,453**	**29,132**	**89.8%**	**25,247**	**86.7%**

This table includes only disclosable reports in the NPDB as of December 31, 2001.

* "Number of Reportable Licensure 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). "Number of Adverse Reportable Licensure Actions" inclu only non-adverse reportable actions.

** "In-State" refers to the State where the physician practiced at the time the licensure action was taken.

*** "Total" includes counts for reports in jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.). Totals for reports that did not specify State were excluded.

Table 19: Cumulative Licensure Actions by State - Dentists
National Practitioner Data Bank (September 1, 1990 - December 31, 2001)

State	Number of Reportable Licensure Actions*	Number of Reportable Adverse Licensure Actions*	Percent of Reportable Adverse Licensure Actions	Number of Adverse Licensure Actions for In-State Dentists**	Percent of All Reportable Adverse Licensure Actions for In-State Dentists
Alabama	93	92	98.9%	89	96.7%
Alaska	42	40	95.2%	40	100.0%
Arizona	597	596	99.8%	596	100.0%
Arkansas	31	28	90.3%	28	100.0%
California	400	397	99.3%	392	98.7%
Colorado	466	463	99.4%	454	98.1%
Connecticut	134	129	96.3%	127	98.4%
Delaware	2	2	100.0%	2	100.0%
Florida	382	350	91.6%	346	98.9%
Georgia	148	148	100.0%	147	99.3%
Hawaii	7	7	100.0%	7	100.0%
Idaho	17	17	100.0%	16	94.1%
Illinois	398	281	70.6%	260	92.5%
Indiana	67	55	82.1%	49	89.1%
Iowa	162	155	95.7%	133	85.8%
Kansas	32	32	100.0%	30	93.8%
Kentucky	78	78	100.0%	78	100.0%
Louisiana	117	113	96.6%	113	100.0%
Maine	40	40	100.0%	39	97.5%
Maryland	175	146	83.4%	136	93.2%
Massachusetts	156	149	95.5%	140	94.0%
Michigan	454	418	92.1%	389	93.1%
Minnesota	189	146	77.2%	146	100.0%
Mississippi	56	56	100.0%	53	94.6%
Missouri	114	113	99.1%	105	92.9%
Montana	17	17	100.0%	16	94.1%
Nebraska	37	34	91.9%	32	94.1%
Nevada	30	29	96.7%	28	96.6%
New Hampshire	24	24	100.0%	24	100.0%
New Jersey	263	241	91.6%	239	99.2%
New Mexico	9	8	88.9%	8	100.0%
New York	410	407	99.3%	406	99.8%
North Carolina	246	240	97.6%	239	99.6%
North Dakota	1	1	100.0%	1	100.0%
Ohio	657	632	96.2%	632	100.0%
Oklahoma	90	89	98.9%	87	97.8%
Oregon	256	255	99.6%	249	97.6%
Pennsylvania	186	181	97.3%	149	82.3%
Rhode Island	15	15	100.0%	14	93.3%
South Carolina	66	66	100.0%	65	98.5%
South Dakota	3	3	100.0%	3	100.0%
Tennessee	146	134	91.8%	133	99.3%
Texas	300	297	99.0%	296	99.7%
Utah	79	64	81.0%	55	85.9%
Vermont	6	5	83.3%	5	100.0%
Virginia	617	586	95.0%	586	100.0%
Washington	157	145	92.4%	138	95.2%
Washington, DC	1	1	100.0%	1	100.0%
West Virginia	10	10	100.0%	10	100.0%
Wisconsin	147	132	89.8%	130	98.5%
Wyoming	4	4	100.0%	4	100.0%
Total* **	**8,137**	**7,674**	**94.3%**	**7,468**	**97.3%**

This table includes only disclosable reports in the NPDB as of December 31, 2001.

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

** "In-State" refers to the State where the dentist practiced at the time the licensure action was taken.

*** "Total" includes counts for reports in jurisdictions not listed above (Puerto Rico, Virgin Islands, etc.).

Table 20: Relationship Between Frequency of Physician Medical Malpractice Payment Reports, Reportable Action Reports, and Medicare/Medicaid Exclusion Reports

National Practitioner Data Bank (September 1, 1990 - December 31, 2001)

Number of Malpractice Payment Reports for Each Physician	Number of Physicians	Number of Physicians with One or More Reportable Actions		Number of Physicians with One or More Medicare/Medicaid Exclusion Reports	
		Number	Percent	Number	Percent
1	76,825	3,875	5.0%	551	0.7%
2	20,692	1,542	7.5%	204	1.0%
3	6,564	678	10.3%	108	1.6%
4	2,560	384	15.0%	46	1.8%
5	1,071	184	17.2%	28	2.6%
6	570	115	20.2%	19	3.3%
7	277	68	24.5%	12	4.3%
8	166	38	22.9%	8	4.8%
9	103	36	35.0%	5	4.9%
10 or More	285	115	40.4%	25	8.8%
Total	**109,113**	**7,035**	**6.4%**	**1,006**	**0.9%**

This table includes only disclosable reports in the NPDB as of December 31, 2001.

Table 21: Relationship Between Frequency of Physician Reportable Action Reports, Medical Malpractice Payment Reports, and Medicare/Medicaid Exclusion Reports

National Practitioner Data Bank (September 1, 1990 - December 31, 2001)

Number of Reportable Action Reports for Each Physician	Number of Physicians	Number of Physicians with One or More Malpractice Payment Reports		Number of Physicians with One or More Medicare/Medicaid Exclusion Reports	
		Number	Percent	Number	Percent
1	10,096	3,256	32.3%	865	8.6%
2	5,056	1,727	34.2%	740	14.6%
3	2,424	884	36.5%	487	20.1%
4	1,260	484	38.4%	265	21.0%
5	724	290	40.1%	176	24.3%
6	384	156	40.6%	113	29.4%
7	217	106	48.8%	56	25.8%
8	138	58	42.0%	42	30.4%
9	59	26	44.1%	26	44.1%
10 or More	126	48	38.1%	44	34.9%
Total	**20,484**	**7,035**	**34.3%**	**2,814**	**13.7%**

This table includes only disclosable reports in the NPDB as of December 31, 2001.

Table 22: Number, Percent, and Percent Change in Queries and Queries Matched, Last Five Years and Cumulative
National Practitioner Data Bank (September 1, 1990 - December 31, 2001)

Query Type	1997	1998	1999	2000	2001	Cumulative
ENTITY QUERIES*						
Total Entity Queries	3,133,471	3,155,558	3,222,348	3,290,082	3,230,631	25,540,570
Queries Percent Increase/Decrease from Previous Year	13.4%	0.7%	2.1%	2.1%	-1.8%	n/a
Matched Queries	359,255	374,002	401,277	416,621	429,558	2,715,891
Percent Matched	11.5%	11.9%	12.5%	12.7%	13.3%	10.6%
Matches Percent Increase/Decrease from Previous Year	23.4%	4.1%	7.3%	3.8%	3.1%	n/a
SELF-QUERIES						
Total Practitioner Self Queries	52,603	48,287	41,418	33,296	36,424	375,839
Self-Queries Percent Increase/Decrease From Previous Year	16.0%	-8.2%	-14.2%	-19.6%	9.4%	n/a
Matched Self-Queries	4,704	4,293	3,655	2,764	3,299	30,195
Self-Queries Percent Matched	8.9%	8.9%	8.8%	8.3%	9.1%	8.0%
Matches Percent Increase/Decrease from Previous Year	24.6%	-8.7%	-14.9%	-24.4%	19.4%	n/a
TOTAL QUERIES (ENTITY AND SELF)	**3,186,074**	**3,203,845**	**3,263,766**	**3,323,378**	**3,267,055**	**25,916,409**
TOTAL MATCHED (ENTITY AND SELF)	**363,959**	**378,295**	**404,932**	**419,385**	**432,857**	**2,746,086**
TOTAL PERCENT MATCHED (ENTITY AND SELF)	**11.4%**	**11.8%**	**12.4%**	**12.6%**	**13.2%**	**10.6%**

* "ENTITY QUERIES" exclude practitioner self-queries except those submitted electronically by entities using QPRAC in 1999 and 2000.

Table 23: Queries by Type of Querying Entity, Last Five Years and Cumulative
National Practitioner Data Bank (September 1, 1990 - December 31, 2001)

Entity Type*	1997			1998			1999		
	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	5,819	1,049,095	33.5%	5,824	1,087,437	34.5%	5,818	1,103,235	34.2%
Voluntary Queriers									
State Licensing Board	54	10,852	0.3%	61	10,832	0.3%	62	11,464	0.4%
HMOs, PPOs, Group Practices	1,581	1,658,797	52.9%	1,782	1,643,856	52.1%	1,713	1,680,505	52.2%
Professional Societies	71	14,034	0.4%	94	15,243	0.5%	90	13,348	0.4%
Other Health Care Entities	1,670	400,693	12.8%	2,075	398,190	12.6%	2,313	413,796	12.8%
Total Voluntary Queriers	**3,376**	**2,084,376**	**66.5%**	**4,012**	**2,068,121**	**65.5%**	**4,178**	**2,119,113**	**65.8%**
Total**	**9,195**	**3,133,471**	**100.0%**	**9,836**	**3,155,558**	**100.0%**	**9,996**	**3,222,348**	**100.0%**

Entity Type*	2000			2001			Cumulative		
	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	5,842	1,121,934	34.1%	5,819	1,118,279	34.6%	7,594	10,664,181	41.8%
Voluntary Queriers									
State Licensing Board	79	11,494	0.3%	82	16,328	0.5%	146	112,773	0.4%
HMOs, PPOs, Group Practices	1,691	1,753,701	53.3%	1,592	1,685,228	52.2%	2,182	12,239,093	47.9%
Professional Societies	85	10,390	0.3%	82	9,051	0.3%	197	85,006	0.3%
Other Health Care Entities	2,586	392,563	11.9%	2,890	401,657	12.4%	5,434	2,439,517	9.6%
Total Voluntary Queriers	**4,441**	**2,168,148**	**65.9%**	**4,646**	**2,112,264**	**65.4%**	**7,959**	**14,876,389**	**58.2%**
Total**	**10,283**	**3,290,082**	**100.0%**	**10,465**	**3,230,543**	**100.0%**	**15,553**	**25,540,570**	**100.0%**

* "Entity Type" is based on how an entity is currently registered and may be different from previous years. Thus, the number of queriers within each entity type also may vary slight from previous years.

** "Total" excludes practitioner self-queries except those submitted by entities using QPRAC in 1999 and 2000.

Table 24: Number of Queries by Practitioner Type
National Practitioner Data Bank (October 2001- November 30, 2001)

Practitioner Type	(October 1, 2001-November 2001)	Percent of Total Queries
Accountant	2	0.00%
Acupuncturist	186	0.04%
Adult Care Facility Administrator	1	0.00%
Advanced Practice Nurse	618	0.13%
Allopathic Physician	321,031	69.14%
Allopathic Physician Intern/Resident	1,115	0.24%
Art/Recreation Therapist	9	0.00%
Athletic Trainer	12	0.00%
Audiologist	423	0.09%
Bookkeeper	15	0.00%
Business Manager	0	0.00%
Business Owner	0	0.00%
Chiropractor	6,800	1.46%
Corporate Officer	0	0.00%
Counselor, Mental Health	1,242	0.27%
Cytotechnologist	2	0.00%
Dental Assistant	166	0.04%
Dental Hygienist	25	0.01%
Dental Resident	12	0.00%
Dentist	33,176	7.14%
Denturist	3	0.00%
Dietician	125	0.03%
EMT, Basic	19	0.00%
EMT, Cardiac/Critical Care	4	0.00%
EMT, Intermediate	7	0.00%
EMT, Paramedic	23	0.00%
Home Health Aide (Homemaker)	7	0.00%
Homeopath	0	0.00%
Hospital Administrator	0	0.00%
Insurance Agent	0	0.00%
Insurance Broker	0	0.00%
Licensed Practical or Vocational Nurse	606	0.13%
Long-Term Care Administrator	1	0.00%
Medial Assistant	195	0.04%
Medical Technologist	179	0.04%
Massage Therapist	151	0.03%
Midwife, Lay (Non-nurse)	23	0.00%
Naturopath	38	0.01%
Nuclear Medicine Technologist	8	0.00%
Nurse Aide	85	0.02%

Practitioner Type	(October 1, 2001-November 2001)	Percent of Total Queries
Nurse Anesthetist	5,059	1.09%
Nurse Midwife	1,361	0.29%
Nurse Practitioner	5,777	1.24%
Nutritionist	36	0.01%
Occupational Therapist	1,150	0.25%
Occupational Therapy Assistant	38	0.01%
Ocularist	4	0.00%
Optician	151	0.03%
Optometrist	6,108	1.32%
Orthotics/Prosthetic Fitter	93	0.02%
Osteopathic Physician	16,795	3.62%
Osteopathic Physician Intern/Resident	166	0.04%
Other Health Care Practitioner Not Classified, Specify	2,348	0.51%
Other Occupation Not Classified, Specify	213	0.05%
Perfusionist	156	0.03%
Pharmacist	167	0.04%
Pharmacist, Nuclear	15	0.00%
Pharmacy Assistant	97	0.02%
Physical Therapist	5,641	1.21%
Physical Therapy Assistant	68	0.01%
Physician Assistant, Allopathic	6,071	1.31%
Physician Assistant, Osteopathic	126	0.03%
Podiatric Assistant	49	0.01%
Podiatrist	8,101	1.74%
Professional Counselor	3,696	0.80%
Professional Counselor, Alcohol	385	0.08%
Professional Counselor, Family/Marriage	2,294	0.49%
Professional Counselor, Substance Abuse	339	0.07%
Psychiatric Technician	27	0.01%
Psychologist, Clinical	11,029	2.38%
Radiation Therapy Technologist	9	0.00%
Radiologic Technologist	109	0.02%
Registered (Professional) Nurse	9,367	2.02%
Rehabilitation Therapist	144	0.03%
Researcher, Clinical	22	0.00%
Respiratory Therapist	50	0.01%
Respiratory Therapy Technician	10	0.00%
Salesperson	2	0.00%
Social Worker	10,045	2.16%
Speech-Language Pathologist	708	0.15%
Total	**464,335**	**100.00%**

Table 25: 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, 2001)

Entity Type	Active Status 12/31/2001	Active At Any Time
Malpractice Payers	323	724
State Licensing Boards	140	184
Hospitals	6,086	7,608
HMOs, PPOs, Group Practices	1,551	2,227
Professional Societies	110	207
Other Health Care Entities	3,910	5,486
Total	**12,120**	**16,436**

The counts shown in this table are based on entity registrations. A few entities have registered more than once. Thus, the entity counts shown in this table may be slightly exaggerated. Entities that report both clinical privileges actions and malpractice payments (e.g., hospitals and HMOs) are instructed to register as health care entities, not malpractice payers, and are not double counted so long as they registered only once.

Table 26: Requests for Secretarial Review by Report Type, Last Five Years and Cumulative
National Practitioner Data Bank (September 1, 1990 - December 31, 2001)

Category	1997			1998			1999		
	Number	Percent	% Change 1996-1997	Number	Percent	% Change 1997-1998	Number	Percent	% Change 1998-1999
Reportable Actions	**82**	**65.6%**	**3.8%**	**59**	**54.1%**	**-39.0%**	**74**	**65.5%**	**25.4%**
State Licensure Actions	36	43.9%	33.3%	21	35.6%	-71.4%	30	40.5%	42.9%
Clinical Privilege Actions	46	56.1%	-6.1%	38	64.4%	-21.1%	43	58.1%	13.2%
Professional Society Actions	0	0.0%	0.0%	0	0.0%	0.0%	1	1.4%	0.0%
Medicare/Medicaid Exclusions	0	0.0%	0.0%	0	0.0%	0.0%	0	0.0%	0.0%
Medical Malpractice Payments	43	34.4%	4.9%	50	45.9%	14.0%	39	34.5%	-22.0%
Total	**125**	**100.0%**	**4.2%**	**109**	**100.0%**	**-14.7%**	**113**	**100.0%**	**3.7%**

Category	2000			2001			Cumulative	
	Number	Percent	% Change 1999-2000	Number	Percent	% Change 2000-2001	Number	Percent
Reportable Actions	**76**	**59.8%**	**2.7%**	**57**	**65.5%**	**-25.0%**	**896**	**61.24%**
State Licensure Actions	23	30.3%	-23.3%	16	28.1%	-30.4%	288	32.1%
Clinical Privilege Actions	41	53.9%	-4.7%	31	54.4%	-24.4%	573	64.0%
Professional Society Actions	2	2.6%	100.0%	1	1.8%	-50.0%	16	1.8%
Medicare/Medicaid Exclusions	10	13.2%	0.0%	9	15.8%	-10.0%	19	2.1%
Medical Malpractice Payments	51	40.2%	30.8%	30	34.5%	-41.2%	567	38.8%
Total	**127**	**100.0%**	**12.4%**	**87**	**100.0%**	**-31.5%**	**1,463**	**100.0%**

Table 27: Distribution of Requests for Secretarial Review by Type of Outcome, Last Five Years and Cumulative
National Practitioner Data Bank (September 1, 1990 - December 31, 2001)

Outcome	1997			1998			1999		
	Number	Percent	Percent of Resolved Requests	Number	Percent	Percent of Resolved Requests	Number	Percent	Percent of Resolved Requests
Request Closed by Intervening Action	11	8.8%	8.9%	2	1.8%	1.9%	12	10.6%	11.0%
Request Closed: Practitioner Did Not Pursue Review*	6	4.8%	4.8%	6	5.5%	5.6%	2	1.8%	1.8%
Request Outside Scope of Review (No Change in Report)	39	31.2%	31.5%	35	32.1%	32.4%	34	30.1%	31.2%
Secretary Changes Report	1	0.8%	0.8%	0	0.0%	0.0%	0	0.0%	0.0%
Secretary Maintains Report as Submitted	55	44.0%	44.4%	60	55.0%	55.6%	52	46.0%	47.7%
Secretary Voids Report	12	9.6%	9.7%	5	4.6%	4.6%	9	8.0%	8.3%
Unresolved as of December 31, 2001	1	0.8%	0.8%	1	0.9%	0.9%	4	3.5%	3.7%
Total	**125**	**100.0%**	**100.0%**	**109**	**100.0%**	**100.0%**	**113**	**100.0%**	**100.0%**

Outcome	2000			2001			Cumulative		
	Number	Percent	Percent of Resolved Requests	Number	Percent	Percent of Resolved Requests	Number	Percent	Percent of Resolved Requests
Request Closed by Intervening Action	11	8.7%	9.7%	1	1.1%	1.8%	75	5.1%	5.4%
Request Closed: Practitioner Did Not Pursue Review*	0	0.0%	0.0%	0	0.0%	0.0%	41	2.8%	2.9%
Request Outside Scope of Review (No Change in Report)	71	55.9%	62.8%	37	42.5%	67.3%	587	40.1%	42.2%
Secretary Changes Report	1	0.8%	0.9%	1	1.1%	1.8%	17	1.2%	1.2%
Secretary Maintains Report as Submitted	28	22.0%	24.8%	15	17.2%	27.3%	540	36.9%	38.8%
Secretary Voids Report	2	1.6%	1.8%	1	1.1%	1.8%	131	9.0%	9.4%
Unresolved as of December 31, 2001	14	11.0%	12.4%	32	36.8%	58.2%	72	4.9%	5.2%
Total	**127**	**100.0%**	**100.0%**	**87**	**100.0%**	**100.0%**	**1,463**	**100.0%**	**100.0%**

This table represents the outcomes of Secretarial Review requests based on the date of the requests. For undated requests, the date they were received by the Division of Practitioner Data Banks was used.

* "Request Closed: Practitioner Did Not Pursue Review" refers to requests for Secretarial Review that were closed because of practitioner actions (written statements) or inactions (failing to submit supporting documentation) that terminated the Secretarial Review process.

Table 28: Cumulative Resolved Requests for Secretarial Review by Report Type and Outcome Type
National Practitioner Data Bank (September 1, 1990 - December 31, 2001)

Outcome	Malpractice Payments		Licensure Actions		Clinical Privileges Actions	
	Number	Percent of Requests	Number	Percent of Requests	Number	Percent of Requests
Request Closed by Intervening Action	23	4.1%	22	7.6%	28	4.9%
Request Closed: Practitioner Did Not Pursue Review*	16	2.8%	10	3.5%	14	2.4%
Request Outside Scope of Review (No Change in Report)	319	56.3%	63	21.9%	184	32.1%
Secretary Changes Report	6	1.1%	8	2.8%	3	0.5%
Secretary Maintains Report as Submitted	156	27.5%	129	44.8%	250	43.6%
Secretary Voids Report	28	4.9%	37	12.8%	63	11.0%
Unresolved as of December 31, 2001	19	3.4%	19	6.6%	31	5.4%
Total	**567**	**100.0%**	**288**	**100.0%**	**573**	**100.0%**

Outcome	Professional Society Actions		Medicare/Medicaid Exclusions		Total	
	Number	Percent of Requests	Number	Percent of Requests	Number	Percent of Requests
Request Closed by Intervening Action	2	12.5%	0	0.0%	75	5.13%
Request Closed: Practitioner Did Not Pursue Review*	1	6.3%	0	0.0%	41	2.80%
Request Outside Scope of Review (No Change in Report)	5	31.3%	16	84.2%	587	40.12%
Secretary Changes Report	0	0.0%	0	0.0%	17	1.16%
Secretary Maintains Report as Submitted	4	25.0%	1	5.3%	540	36.91%
Secretary Voids Report	3	18.8%	0	0.0%	131	8.95%
Unresolved as of December 31, 2001	1	6.3%	2	10.5%	72	4.92%
Total	**16**	**100.0%**	**19**	**100.0%**	**1,463**	**100.0%**

This table represents the outcomes of Secretarial Review requests based on the date of the requests. For undated requests, the date they were received by the Division of Practitioner Data Banks was used.

* "Request Closed: Practitioner Did Not Pursue Review" refers to requests for Secretarial Review which were closed because of practitioner actions (written statements) or inactions (failing to submit supporting documentation) that terminated the Secretarial Review process.