

National Practitioner Data Bank

2005 Annual Report



U.S. Department of Health and Human Services
Health Resources and Services Administration
Bureau of Health Professions
Practitioner Data Banks Branch

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NATIONAL PRACTITIONER DATA BANK

2005 ANNUAL REPORT

Contents

<i>A Snapshot of the NPDB for 2005</i>	5
<i>The NPDB's Policies, Operations, and Improvements</i>	10
The NPDB Program: Protecting the Public.....	10
The NPDB Improves Its Operations and Policies in 2005	17
<i>Types of Reports: Medical Malpractice Payments</i>	22
Malpractice Payment Reports Continue to Remain the Majority in the NPDB	22
Malpractice Payments: Physicians	24
Malpractice Payments: Nurses and Physician Assistants	25
States Vary in Malpractice Payment Amounts and Times from Incident to Payments	27
Three Issues – Corporate Shield, Federal Entity Policies, and Physician Residents – Affect Malpractice Payment Reporting.....	30
<i>Types of Reports: Adverse Actions</i>	32
NPDB Receives Many Reports on Adverse Actions.....	32
Under-reporting May Affect Numbers of Adverse Action Reports; States Vary in Reporting Activity	35
<i>Multiple Reports</i>	37
Physicians With Multiple Reports Also Tend to Have Other Types of Reports	37
<i>Types of Practitioners Reported</i>	39
Physicians, Dentists Are Reported Most Often to the NPDB.....	39
<i>Querying</i>	40
Querying Increased in 2005; Match Rate Increased	40

<i>NPDB Reporters and Queriers</i>	44
<i>Ensuring Accurate Reports: Secretarial Review</i>	45
<i>NPDB: The Future</i>	49
The NPDB Will Continue to Improve Its Operations in 2006	49
Conclusion: NPDB Continues to Grow, Become More Useful.....	51
<i>Glossary of Acronyms</i>	52
<i>Statistical Index: List of Tables</i>	55
<i>Statistical Section: Tables 1-29</i>	58

LIST OF FIGURES

<i>Figure 1: Number and Types of Reports Received by the NPDB (2001-2005)</i>	23
<i>Figure 2: Percentage of Physicians with Number of Reports in the NPDB (1990-2005)</i>	38
<i>Figure 3: Queries by Querier Type (September 1, 1990-December 31, 2005)</i>	40
<i>Figure 4: Number of State Licensing Board Queries by Year (2001-2005)</i>	43

A Snapshot of the NPDB for 2005

The National Practitioner Data Bank (NPDB) receives reports of malpractice payments and adverse actions concerning health care practitioners. In 2005, the majority of reports for the NPDB were medical malpractice payments for physicians, dentists, and other licensed practitioners. Most reports for adverse actions were for State licensure actions. Adverse actions include: licensure actions, clinical privileges actions affecting a practitioner's privileges for more than 30 days, Medicare/Medicaid Exclusion actions, professional society membership disciplinary actions, actions taken by the DEA concerning authorization to prescribe controlled substances, and revisions to such actions. All of these must be reported to the NPDB if they are taken against physicians and dentists. Since 1997, the NPDB has also received reports of Medicare/Medicaid Exclusions taken against all types of health care practitioners.

Almost 9 out of 10 reports (85.4 percent) are original, initial reports submitted by reporters. Correction reports, which have been changed by entities to correct errors in previous reports, account for 10.9 percent of reports. Revision to Actions, which are reports concerning additional actions taken in relation to initially reported actions, account for 3.8 percent of reports. Revision to Actions may concern "non-adverse actions" such as reinstatements and reversals of previous actions.

Health care entities and agencies authorized by law can "query" to obtain copies of reports on specific practitioners. Queries increased after a small decrease last year. About 14.0 percent of queries in 2005 showed the practitioner in 2005 had one or more reported medical malpractice payments or adverse actions.

These facts and others are explained in the following snapshot of the NPDB for 2005. This snapshot gives the most important details about the contents of the NPDB, which has maintained records of State 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, and Medicare/Medicaid Exclusions since 1997. The NPDB at the end of 2005 contained reports on 386,210 adverse actions and malpractice payments involving 226,667 individual practitioners. Below in more detail are further significant facts about the NPDB in 2005 and cumulatively.

Most 2005 reports were Medical Malpractice Payment Reports, the majority of them for physicians: During 2005, 73.3 percent of all new reports received concerned malpractice payments; cumulatively, they also comprised 73.5 percent of all reports. During 2005, physicians were responsible for 81.1 percent of Medical Malpractice Payment Reports, dentists 10.0 percent, and all other health care practitioners 8.8 percent. These figures are similar to percentages from previous years.

Medical Malpractice Reports decreased in 2005: The 17,298 Medical Malpractice Payment Reports received during 2005 are 2.1 percent less than the number of Malpractice

Payment Reports received by the NPDB during 2004. This decrease comes after a decrease of 6.7 percent in 2004 in comparison to 2003.

Adverse Action Reports¹, most for State licensure actions, decreased in 2005: The 6,302 Adverse Action Reports (State licensure, clinical privileges, professional society membership, exclusions, and DEA actions) received during 2005 are 16.4 percent less than the number of Adverse Action Reports received by the NPDB during 2004. This decrease comes after an increase of 2.4 percent in 2004. The number of State Licensure Action Reports received increased 0.7 percent from 2004 to 2005. During 2005, State Licensure Action Reports comprised 64.2 percent of all Adverse Action Reports and Clinical Privileges Action Reports comprised 14.4 percent. Most of the decrease in adverse actions from 2004 to 2005 resulted from a 45.9 percent decrease in exclusion action reports: 2,333 in 2004 to 1,261 in 2005. Adverse actions represent 26.5 percent of all reports received cumulatively and 26.7 percent (6,302 of 23,600) of all reports received by the NPDB during 2005.

Entity requests for information from the NPDB (“queries”) grew 1.6 percent in 2005, and total cumulative queries were over 38 million: Over its existence the NPDB has responded to 38,962,333 inquiries (queries) from authorized organizations such as hospitals and managed care organizations (HMOs, PPOs, etc.); State licensing boards; professional societies; and individual practitioners (who can only obtain a copy of their own records). From 2004 to 2005 entity query volume increased 1.6 percent, from 3,448,514 queries in 2004 to 3,503,922 queries in 2005. This increase followed a 7.3 increase in queries from 2003 to 2004.

Most queries were voluntary and not required by law, and almost half of all queries came from Managed Care Organizations (MCOs): Hospitals are required by law to query. All other queries are voluntary. During 2005, 65.3 percent of queries were submitted by voluntary queriers; cumulatively well over half (60.7 percent) of the queries were voluntary. Of the voluntary queriers, MCOs were the most active, making 47.7 percent of all queries during 2005. Although they represented only 10.6 percent of all entities that had ever queried the NPDB, they had made 46.4 percent of all queries cumulatively. Over the NPDB’s existence the increase in voluntary queries has been much larger than the increase in mandatory hospital queries.

¹ “Adverse Action Reports” is a generic term for all licensure action, clinical privileges action, exclusion action, DEA action, and professional society action reports. This includes reports of truly adverse actions (revocations, probations, suspensions, reprimands, etc.) reported in accordance with Sections 60.8 and 60.9 of the NPDB regulations (45 CFR Part 50) as well as reports for non-adverse “Revisions” (reinstatements, reductions of penalties, reversals of previous actions, restorations, etc.) reported under Section 60.6.

In 2005 about one out of seven queries showed the practitioner had at least one reported medical malpractice payment or adverse action: When a query is submitted concerning a practitioner who has one or more reports, a “match” is made, and the querier is sent copies of the reports. During 2005, 14.0 percent of all entity queries resulted in a match (491,945). Cumulatively, the match rate is 11.7 percent (4,571,240 matches). No match on a query means a practitioner has no reports in the NPDB. Since the NPDB has been collecting reports since 1990, a non-match response indicating that a practitioner has no reported payments or actions is valuable to queriers as evidence the practitioner has had no medical malpractice payments or adverse actions for over 15 years.

Physicians, most of whom only have one report, were predominant in the NPDB: Of the 226,667 practitioners reported to the NPDB, 69.7 percent were physicians (including M.D.s and D.O.s and residents and interns), 13.4 percent were dentists and dental residents, 8.8 percent were nurses and nursing-related practitioners, and 2.8 percent were chiropractors. About two-thirds of physicians with reports (66.8 percent) had only one report in the NPDB, 85.4 percent had 2 or fewer reports, 97.2 percent had 5 or fewer, and 99.6 percent had 10 or fewer. Few physicians had both Medical Malpractice Payment Reports and Adverse Action Reports (not including Exclusion Reports). Only 6.0 percent had at least one report of both types.

Physicians had more reports per practitioner than any other practitioner group: Physicians had the highest average number (1.84) of reports per reported physician, and dentists, the second largest group of practitioners reported, had an average of 1.65 reports per reported dentist. Podiatrists and podiatric-related practitioners, who had 1.69 reports per reported practitioner, also had a high average of reports per practitioner as well as 6,955 total reports. Comparison between physicians and dentists and other types of practitioners, however, would be misleading since NPDB reporting of State licensure, clinical privileges, and professional society membership actions is required only for physicians and dentists.

Physicians had more than three-quarters of the malpractice payments in the NPDB: Physicians had 78.8 percent of the Malpractice Payment Reports cumulatively in the NPDB (283,847 reports), and they had 81.1 percent of payment reports in 2005 (14,034 reports). Physician Malpractice Payment Reports decreased by 2.5 percent from 2004 to 2005. This decrease followed a 5.6 percent decrease in the number of payments for physicians in 2004. Dentists had 13.1 percent of Malpractice Payment Reports cumulatively in the NPDB (37,139 reports), and they had 10.0 percent of payment reports in 2005 (1,736 reports). Other practitioners had 8.1 percent of payment reports cumulatively (23,066 reports) and 8.8 percent of payment reports for 2005 (1,528 reports). Payments for dentists decreased by 5.3 percent in 2005.

Average medical malpractice payment amounts for physicians in 2005 were higher than in previous years: The median and mean medical malpractice payment amounts for physicians in 2005 were \$174,569 and \$294,153, respectively. Cumulatively since 1990 for physicians the median amount was \$100,000 (\$128,764 adjusting for inflation to standardize

payments made in prior years to 2005 dollars) and the mean amount was \$229,972 (approximately \$269,256 adjusting for inflation).²

Obstetrics-related medical malpractice payments for physicians continued to be higher than others, while equipment and product related payments were lower: During 2005, as in previous years, obstetrics-related cases, generating 9.0 percent of all 2005 physician Malpractice Payment Reports, had the highest median payment amounts (\$300,000). Equipment and product related incidents (0.5 percent of all reports) had the lowest median payments during 2005 (\$66,875).

Mean delay between an incident and its physician malpractice payment increased by more than 2 weeks: For 2005 physician medical malpractice payments, the mean delay between an incident that led to a payment and the payment itself was 4.66 years. This signifies an increase of 18 days from 2004. The 2005 mean physician payment delay varied markedly between the States, as in previous years, and ranged from 3.20 years in Oregon to 6.16 years in Massachusetts.

Over half of the hospitals registered with the NPDB had not reported a clinical privileges action: Of those hospitals currently in “active” registered status with the NPDB, 52.0 percent of the hospitals had never submitted a Clinical Privileges Action Report. This percentage has slowly decreased over the years. Additionally, over the history of the NPDB, there were nearly four times more State Licensure Action Reports than Clinical Privileges Action Reports. Clinical privilege reporting seemed to be concentrated in a few facilities even in States with comparatively high overall hospital clinical privileging reporting levels. The Health Resources and Services Administration (HRSA) continues its efforts to examine the low level of clinical privilege reporting.

Most reports were not disputed by practitioners: 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. At the end of 2005, 3.8 percent (2,108) of all State Licensure Action Reports, 13.5 percent (1,933) of all Clinical Privileges Action Reports, and 3.3 percent (9,446) of all Malpractice Payment Reports in the NPDB were in dispute.

Few practitioners requested Secretarial Reviews, most of which were for adverse actions: If the disagreement (dispute) 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. Only a few practitioners who disputed reports also requested Secretarial Review; there were 58 requests out of 13,824 disputed reports for Secretarial Review during 2005. Adverse actions comprised 79.3 percent of all 2005 requests for Secretarial Review and 64.1 percent of all requests cumulatively for Secretarial Review. This was in sharp contrast to

²Generally for malpractice payment data the median is a better indicator of the “average” or typical payment than is the mean since the mean is skewed by a few very large payments. Inflation adjustment is based on the seasonally adjusted CPI-U U.S. City Average, All Items, as published by the U.S. Department of Labor, Bureau of Labor Statistics.

the 26.7 percent of all reports represented by adverse actions in 2005 and the 26.5 percent of all Adverse Action Reports cumulatively.

Most Secretarial Review requests resulted in the report staying in the NPDB: Cumulatively, 17.1 percent, or 302 out of 1,765 cumulative requests for Secretarial Review, had resulted in positive outcomes for practitioners (which included the request being closed by an intervening action such as submission of a corrected report by the reporting entity, the Secretary changing the report, and the Secretary voiding the report). If the Secretary believes that a report should be corrected the reporting entity is asked to submit a correction. The Secretary changes reports only if the reporting entity fails to do so. Of the total cumulative 1,765 requests for Secretarial Review received by the NPDB, 1,721 (97.0 percent) have been resolved. Only 53 requests (3.0 percent) are unresolved. Of these resolved requests, 1,367 (77.5 percent) were unchanged and maintained as submitted, and 139 (7.9 percent) were closed by intervening action (such as submission of a corrected report by the reporting entity). There were 144 requests (8.2 percent) that resulted in voids, 19 (1.1 percent) that resulted in changes to reports, and 43 (2.4 percent) were closed because the practitioner did not pursue review.

The NPDB's Policies, Operations, and Improvements

The NPDB Program: Protecting the Public

The National Practitioner Data Bank (NPDB) has an important mission established by law – protecting 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 following explains how this mission is accomplished and the rules and regulations under which the NPDB operates.

The NPDB and its mission were established by a law that also encourages the use of peer review: 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, the NPDB.

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 certain NPDB reporting requirements may lose immunity for three years.

A division of the Federal government administers the NPDB and a contractor operates it, with input from an outside committee: During 2005 the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Bureau of Health Professions (BHP), Office of Workforce Evaluation and Quality Assurance (OWEQA), Practitioner Data Banks Branch (PDBB) was responsible for administering and managing the NPDB program. The PDBB was formerly the Division of Practitioner Data Banks. The NPDB itself is operated by a contractor, SRA International, Inc. (SRA), which began doing so in June 1995.³ 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)⁴.

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

⁴The Healthcare Integrity and Protection Data Bank (HIPDB) is a flagging system run by the Federal government 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 operated under the direction of the PDBB, and entities report to and query both Data Banks through the same Web site at www.npdb-hipdb.hrsa.gov.

An Executive Committee provides health care expertise for SRA on operations 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 two times a year with both SRA and PDBB personnel.

The NPDB receives information about five different types of actions taken against practitioners: 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.⁵ 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.⁶

The NPDB's information is accessible to certain health care entities and licensing boards for specific reasons: 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, affiliation, or professional society membership.

The NPDB's information alerts health care organizations receiving it that they may want to look closer at a practitioner's record: 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 adverse 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.

NPDB information helps health care organizations make good licensing and credentialing decisions: Although the *HCQIA* 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,

⁵Hospitals 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.

⁶In 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, Guam, and the Northern Mariana Islands.

dentists, and other health care practitioners. They can use this information to make better licensing and credentialing decisions that protect the public.

The NPDB research program and public use file helps improve health care through analysis of data: 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.⁷ 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.

The NPDB receives required reports on “adverse” actions: Adverse Action Reports⁸ 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, voluntary surrender while under investigation, 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.
- When a hospital, Health Maintenance Organization (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 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 actions also may be reported for health care practitioners other than physicians and dentists, but it is not required; revisions to these actions must be reported.
- When a professional society takes a professional review action based on reasons related to professional competence or professional conduct that adversely affects a

⁷Information 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 NPDB Web site at www.npdb-hipdb.hrsa.gov/publicdata.html. A detailed listing of the variables and values for each variable is also available at www.npdb-hipdb.hrsa.gov/publicdata.html.

⁸ “Adverse Action Reports” is a generic term for all licensure action, clinical privileges action, Exclusion action, DEA action, and professional society action reports. This includes reports of truly adverse actions (revocations, probations, suspensions, reprimands, etc.) reported in accordance with Sections 60.8 and 60.9 of the NPDB regulations as well as reports for non-adverse “Revisions” (reinstatements, reductions of penalties, reversals of previous actions, restorations, etc.) reported under Section 60.6.

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 or receives voluntary surrenders by practitioners of DEA registration "numbers," which is reported under the Memorandum of Understanding (MOU) between the U.S. Department of Health and Human Services and the DEA.
- When HHS excludes a practitioner from Medicare or Medicaid reimbursement. The Exclusion Action is also 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.

The NPDB receives required reports on malpractice payments: Medical Malpractice Payment Reports must be submitted to the NPDB when an entity (but not a practitioner out of his or her personal funds⁹) 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.

Certain health care entities can request 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. A hospital also may query at any time during professional review activity. Malpractice insurers cannot query the NPDB.¹⁰ In all cases, an entity may query only on practitioners who are applicants, current licensees, staff members, or professional society members.

A hospital *must* query the NPDB:

- 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:

⁹Self-insured practitioners originally were required to report 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.

¹⁰Self-insured health care entities may query for peer review but not for insurance purposes.

- 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.
- A plaintiff or 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. This is possible only when independently obtained evidence submitted to HHS discloses that the hospital did not make a required query to the NPDB on the practitioner. If the attorney or plaintiff specifically 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.

Fees for requests for information (queries) are used to operate the NPDB, which is self-supporting: 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 quierers must pay a fee for each practitioner about whom information is requested. Effective May 9, 2006, the fee for queries was increased from \$4.25 per query to \$4.75 per query. Self-queries, which are more expensive to process because they require some manual intervention, cost a total of \$16 for both the NPDB and the Healthcare Integrity and Protection Data Bank (HIPDB). Self-queries must be submitted to both Data Banks to ensure that quierers 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 (EFT).

NPDB information about practitioners is confidential and available to users for only specific reasons: Under the terms of the *HCQIA*, NPDB information that permits identification of particular practitioners or entities is confidential. The HHS has designated the NPDB as a confidential “System of Records” under the Privacy Act of 1974. Authorized quierers 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.

Criminal penalties also may punish those who disclose or report information under false pretenses: The *HCQIA* does not allow the NPDB to disclose information on specific practitioners to medical malpractice insurers or the public. Federal statutes provide criminal and civil 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.

Practitioners receive copies of reports and may add personal statements to their reports: 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 report concerning them. The practitioner's statement is disclosed along with the report.

Practitioners may dispute or ask for Secretarial Review of their reports: 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 correction 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 agencies and health care entities participate in the NPDB program under Memoranda of Understanding (MOUs): Section 432(b) of the Act prescribes that the Secretary shall seek to establish an 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 U.S. Department of Justice, Drug Enforcement Administration (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 U.S. Department of Defense (DOD) September 21, 1987, with the DEA on November 4, 1988 (revised on June 19, 2003), and with the U.S. Department of Veterans Affairs (VA) November 19, 1990. In addition, MOUs with the U.S. Department of Transportation, U.S. Coast Guard and with the U.S. Department of Justice, Bureau of Prisons 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.

According to an October 15, 1990, U.S. Department of Health and Human Services (HHS) policy directive, all settled or adjudicated HHS medical malpractice cases must be reported to the NPDB. This policy applies to all cases regardless of whether the standard of care has been met. The only exception is for those cases in which the adverse event was caused by system error. Since the NPDB became operational in 1990, HHS agencies have reported 257 medical malpractice cases to the NPDB.

As a result of a review, the Office of Inspector General (OIG) has determined that as many as 474 additional cases should have been reported to the NPDB but were not. These unreported cases cover the period June 1997 through September 2004. According to HHS records, 290 Indian Health Service (IHS) cases, 179 Health Resources and Services Administration (HRSA) cases, and 5 National Institutes of Health (NIH) cases have not been reported. Several factors have influenced HHS reporting to the NPDB, including lost files, incomplete records, medical claims review panel decisions, failures to replace key personnel, and late reporting. HHS is working to develop a final action plan to rectify the problem and HHS agencies have begun reporting their backlog of cases to the NPDB.

Medicare/Medicaid Exclusions have been reported under an agreement since 1997: 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.

The NPDB Improves Its Operations and Policies in 2005

The National Practitioner Data Bank (NPDB) had a busy and productive year in 2005. It contributed to Federal government relief efforts during Hurricanes Katrina and Rita; made major improvements to the security and operations of its system and Web site; continued its reporting compliance and outreach efforts educating users about the NPDB; and cleaned up and improved the accuracy of data in NPDB reports. Those efforts are discussed in depth in the following narrative.

HURRICANES KATRINA AND RITA

In 2005 the Practitioner Data Banks Branch (PDBB), the government organization which administers the National Practitioner Data Bank (NPDB), assisted in the Federal government's response to Hurricanes Katrina and Rita. The U.S. Department of Health and Human Services authorized a Credentials Verification Organization (CVO) to act as its agent in querying on health care volunteers/practitioners deployed to deliver care to victims of the hurricanes.

More than 4,600 practitioners and providers were "vetted" using NPDB and Healthcare Integrity and Protection Data Bank (HIPDB) queries at no charge. In the process, these practitioners were made unpaid temporary HHS employees and were brought under the umbrella of the *Federal Tort Claims Act* during their deployment.

In addition to providing free queries on Federal volunteers, the Data Banks assisted State licensing boards that were accepting practitioners who had relocated to their State due to the disaster. This was done upon request and for a limited number of queries. During these public health emergencies, the NPDB proved it could make a valuable contribution to the health care of the nation and its communities.

SYSTEM ACCOMPLISHMENTS

The following improvements were made to the NPDB system and Web site in 2005:

- Security Improvements – The NPDB has assigned a dedicated Information System Security Officer (ISSO), who guides the direction of system security and implements security controls to ensure security breaches are not occurring. The ISSO constantly adapts procedures to mitigate new risks on a daily, weekly, and monthly basis. Security boundary protection was also improved, including the addition of a new firewall to the system, implementation of system vulnerability scanning on all NPDB resources, and tightening of physical security at the SRA location of computer databases and equipment. Lastly, authorization and access controls were improved by: shortening password lives for all users, eliminating grace log-ins, encrypting key data elements, increasing password strength by eliminating easily guessed words and similar password reuse, and revising password reset rules to be more stringent.

- QRXS – The Querying and Reporting XML Service (QRXS), which is used for batched submission of reports, now accepts all report types and serves as an alternative to the IQRS and the Interface Control Document (ICD) Transfer Program (ITP). The QRXS and ITP are for reporters who use their own transaction processing systems to store reportable events. The QRXS offers advantages over ITP and the IQRS, including the ability to integrate it into existing computer systems so data can be submitted directly to the Data Banks and the real-time rejection notifications, eliminating the need for users to wait 2 to 4 hours for validation responses. In the future the QRXS will expand to support queries and provide additional features.
- Reports' Section A – Section A of NPDB reports now has added information about changes to the ownership of the entities filing reports, such as a new address, phone number or contact person. This allows the queriers to contact the entity most likely to have additional information concerning the reported individuals.
- Interactive Training Programs – The Data Bank Interactive Training Programs were given a new look and their content was updated in September. The NPDB training program is a free, online training tool for helping queriers and reporters understand NPDB policy. The program answers the most frequently asked questions and explains the report process for the NPDB. An interactive quiz for each the NPDB describes several scenarios about reportable actions and payments.

POLICY ACCOMPLISHMENTS

Beyond operations improvements, the NPDB had several successful policy-related accomplishments in 2005. For example, the NPDB worked to ensure compliance with reporting requirements. The NPDB staff also attended and presented at several credentialing and health care organization meetings, and developed publications publicizing the Data Bank's mission, requirements, and achievements.

- Proactive Disclosure Service (PDS) – The NPDB will implement a service where queriers will be notified of new reports naming any of their registered practitioners as subjects when reports are received by the Data Banks. In 2005 NPDB staff visited approximately 25 entities around the United States to discuss the PDS and its pricing, design, and rollout options. Attendees indicated a positive interest in the proposed PDS program. The PDS will be an alternative to the current querying service, not a replacement, and it will have support from major health care accrediting organizations.
- Health Plan Letter – A letter was sent to health plans advising them about their responsibilities regarding reporting and querying the Data Banks. The NPDB received a good response to this letter, and provided advice to health plans that needed more information.

- Articles – The PDBB published an article about the NPDB and HIPDB in “The Physician Insurer,” a journal which is published four times a year by the Physician Insurers Association of American (PIAA). The article explains what the Data Banks are; who reports to each of the Data Banks; what information is available from the Data Banks; and who can query the Data Banks. It also explains to physicians how they are notified of a report; how they can self-query; how they can add statements to reports; and how they can dispute reports and ask Secretarial Review of reports. PDBB also published: an article about truths and misperceptions about the Data Banks in the National Register of Health Service Providers in Psychology’s Spring 2005 newsletter, and an article about what health plans and their credentialers should know about the NPDB in the September/October 2005 issue of “SYNERGY,” the official magazine for The National Association Medical Staff Services.
- Hospitals – Hospitals listed in the “American Hospital Association Guidebook” continued to be reviewed for registration in the NPDB. Unregistered hospitals were contacted and made aware of their requirements to query and report to the NPDB. As a result, hospitals in several States registered with the NPDB or provided their Data Bank Identification Number (DBID) to the PDBB, demonstrating that they were registered under another name.
- Outreach – NPDB staff presented at or exhibited materials at the conferences of several organizations, as well as discussed NPDB issues with representatives of several organizations. Groups that NPDB staff presented to include:
 - American College of Nurse Practitioners (ACNP),
 - Joint Commission on Accreditation of Healthcare Organizations (JCAHO),
 - Administrators in Medicine (AIM),
 - National Credentialing Forum,
 - Colorado Physician Insurance Company’s (COPIC),
 - Administrators in Dentistry,
 - National Committee for Quality Assurance (NCQA) Advanced Credentialing Workshop,
 - American Association of Dental Examiners (AADE),
 - Association of Dental Administrators (ADA),
 - Nevada Association of Medical Staff Services,
 - Massachusetts Association of Medical Staff Services,
 - Kansas/Nebraska Association of Medical Staff Services,
 - New Jersey Association of Medical Staff Services (NJAMSS), and
 - Tennessee Association of Medical Staff Services.

The NPDB exhibited materials at meetings of the Physician Insurers Association of American (PIAA) and National Association Medical Staff Services (NAMSS). These contacts greatly promoted the NPDB’s mission and helped increase compliance with reporting and querying requirements.

- Malpractice Payment Reporting – A comparison was made of NPDB report information to 2002 and 2003 data from National Association Insurance Commissioners (NAIC). NAIC data provides information for total amount paid and the total number of payments made for medical malpractice by insurance companies. As a result of the comparison, letters were sent to specific insurance companies asking for information on their reporting and the NPDB received additional Medical Malpractice Payment Reports.
- Compliance – *The Health Care Fraud Report*, *Health Law Reporter*, and *Medical Malpractice Newsletters* were reviewed to find any and all situations that involved adverse actions that should be reported to the NPDB and HIPDB. Adverse actions not reported were investigated by PDBB staff for compliance to NPDB reporting requirements.
- State Boards – NPDB staff called State dental and medical boards to confirm that State boards were continuing to report to the Data Banks. Those State boards that were late or found not to be in compliance with *HCQIA* regulations were sent letters notifying them of their reporting obligations and consequences for not reporting. NPDB staff also mailed letters to State medical and dental boards regarding apparent adverse actions taken against practitioners listed on their Web sites but not found in the NPDB. The NPDB requested that the boards review their records to see if these actions were reportable. If they were reportable, the boards were requested to file reports to the NPDB as quickly as possible.
- Policy Forums – The NPDB held two policy forums in 2005. One took place September 18, 2005 in conjunction with the NAMSS annual conference in Phoenix, Arizona. Attendees participated in small group discussions and answered questions that tested their knowledge of NPDB and HIPDB reporting requirements. On June 16, 2005, PDBB sponsored a policy forum focused on medical malpractice payment reporting.
- Reporting Multiple Actions – NPDB staff sent a letter to State boards explaining the proper way to submit reports from one board order that have multiple action and/or basis for action codes. Boards must submit one report for each board order, using up to five adverse action codes and up to five basis for action codes. They should include a Description of Act(s) or Omission(s) or Other Reasons for Action to explain the circumstances.

RESEARCH ACCOMPLISHMENTS

The following are research activities and achievements that the NPDB accomplished in 2005. They include activities directed at enhancing the accuracy of data in the NPDB.

- Report Clean-Up – NPDB staff recoded Basis for Action and Adverse Action write-ins designated as “Other” in the narratives of reports submitted to the NPDB. NPDB staff also worked on cleaning up reports in which the States submitting the reports were different from any of the States listed as States for the practitioner’s licensure.

- Legally Sufficient Narratives – PDBB staff reviewed NPDB reports in order to assess whether or not the narratives were legally sufficient. They created educational materials on legally sufficient and insufficient narratives to send to reporters who have been identified as submitting unsatisfactory narratives in their reports to the NPDB.
- Duplicate Reports – NPDB staff identified and cleaned up reports for medical malpractice payments, clinical privileges actions, and exclusion or debarment actions that appeared to be duplicates, i.e. reports submitted by the same entity, for the same practitioner, for the same adverse action date. Reports or samples of reports from SRA were critically analyzed to identify which duplicate reports should be corrected, revised, deleted, or maintained in the Data Banks as Initial Reports. NDPB staff also developed a new functionality in the NPDB that will help reduce the number of duplicate reports from the NPDB. The functionality involves matching the action in reports along with matching the subject.

Types of Reports: Medical Malpractice Payments

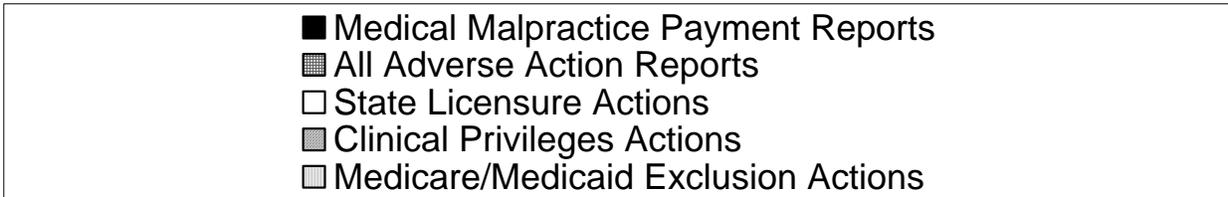
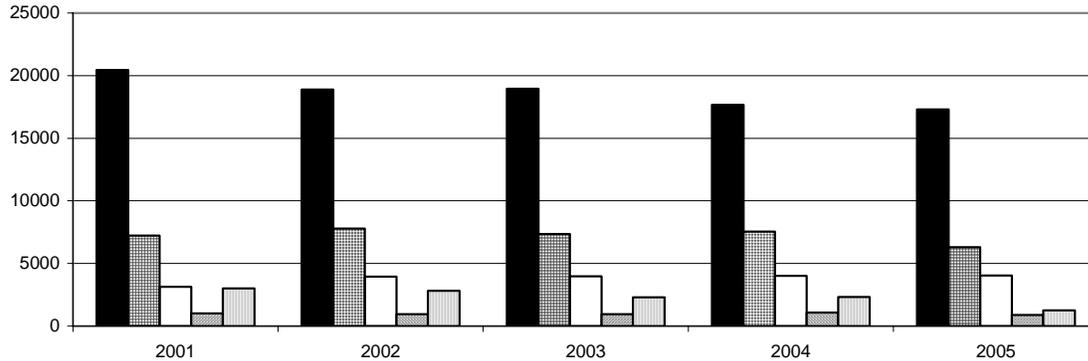
Malpractice Payment Reports Continue to Remain the Majority in the NPDB

Each year, Medical Malpractice Payment Reports have the greatest number of reports filed with the NPDB, as shown in Figure 1. All licensed health care practitioners must be reported to the NPDB if a malpractice payment is made for their benefit.¹¹ The following narratives give details about the nature of these reports, including the number and distribution of reports among dentists, physicians, and other practitioners, and variations in payment amounts and delays. For more information on malpractice reporting, see Tables 1 through 3 in the statistical section of this Annual Report.

Seven out of ten reports were malpractice payments: Cumulative data show that at the end of 2005, 73.5 percent of all the NPDB's reports concerned malpractice payments. During 2005, the NPDB received 17,298 such reports (73.3 percent of all reports received). Cumulatively, physicians were responsible for 223,642 malpractice payment reports (78.8 percent), dentists were responsible for 37,139 reports (13.1 percent), and all other types of practitioners were responsible for 23,066 reports (8.1 percent).

¹¹Allopathic 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 or have been reported to the NPDB: pharmacists; pharmacy interns; pharmacists, nuclear; pharmacy assistants; pharmacy technicians; registered (professional) nurses; nurse anesthetists; nurse midwives; nurse practitioners; clinical nurse specialists; licensed practical or vocational nurses; nurses aides; certified nurse aides/certified nursing assistants; home health aides (homemakers); health care aides/direct care workers; certified or qualified medication aides; EMTs, basic; EMTs, cardiac/critical care; EMTs, intermediate; EMTs, paramedic; social workers; podiatrists; podiatric assistants; psychologists; school psychologists; psychological assistants, associates, examiners; counselors, mental health; professional counselors; professional counselors, alcohol; professional counselors, family/marriage; professional counselors, substance abuse; marriage and family therapists; dental assistants; dental hygienists; denturists; dieticians; nutritionists; ocularists; opticians; optometrists; physician assistants, allopathic; physician assistants, osteopathic; art/recreation therapists; massage therapists; occupational therapists; occupational therapy assistants; physical therapists; physical therapy assistants; rehabilitation therapists; respiratory therapy technicians; medical technologists; cytotechnologists; nuclear medicine technologists; radiation therapy technologists; radiologic technologists; acupuncturists; athletic trainers; homeopaths; medical assistants; midwives, lay (non nurse); naturopaths; orthotics/prosthetics fitters; perfusionists; psychiatric technicians; and any other type of health care practitioner which is licensed in one or more States.

Figure 1: Numbers and Types of Reports Received by the NPDB (2001-2005)



Medical Malpractice Payment Reports, including those for physicians, decreased in number in 2005: The number of malpractice payments reported in 2005 (17,298) decreased by 2.1 percent from the number reported during 2004 (17,670). The 2005 total represents a 15.4 decrease from 2001. In 2005 the number of physician malpractice payment reports decreased by 2.5 percent from 2004 to 2005. The number of dentist malpractice payment reports decreased by 5.3 percent and the number of “other practitioners” malpractice payment reports increased by 5.6 percent.

Malpractice Payments: Physicians

Physicians have about four-fifths of the Medical Malpractice Payment Reports in the NPDB. They make up the majority of practitioners reported to the NPDB and that are queried on the most by entities. The following describes the information the NPDB contains on them. For more information about this reporting, see Tables 3 through 5 in the statistical section of this Annual Report.

Physicians were responsible for about 8 out of 10 Malpractice Payment Reports: Cumulatively, physicians were responsible for 223,642 (78.8 percent) of the NPDB's Malpractice Payment Reports. The number of physician malpractice payments reported decreased by 2.5 percent from 2004 to 2005. During 2005, physicians were responsible for 14,034 Malpractice Payment Reports (81.1 percent of all Malpractice Payment Reports received during the year).

Equipment or product-related, and miscellaneous incidents for physicians had both few reports and low payments: During 2005, incidents relating to "miscellaneous" and "equipment or product-related" incidents had the lowest median payments (\$70,000 and \$66,875 respectively). Equipment or product-related incidents had the lowest mean payments (\$160,000) with miscellaneous incidents having the next lowest mean payment (\$171,746). There were only 229 miscellaneous reports and 76 equipment and product-related reports. Together they represented only 2.2 percent of all physician malpractice payments in 2005.

Obstetrics-related incidents had the biggest mean payments and largest median payments. Diagnosis-related payments were the most reported for physicians in 2005: As in previous years, physicians' obstetrics-related cases (1,258 reports, 9.0 percent of all 2005 physician Malpractice Payment Reports) in 2005 had the highest mean payments (\$523,534) and the highest median payments (\$300,000) this year. In 2005, diagnosis-related payments for physicians totaling 4,542 (32.4 percent of all physician 2005 payments) were the most frequently reported.

Obstetrics-related incidents took the longest to resolve for physicians and equipment or product-related cases settled the most quickly for physicians: The 1,256 obstetrics-related physician payments in 2005 (9.0 percent of 2005 payments) had the longest mean delay between incident and payment (5.99 years) and the longest median delay (4.94 years). The shortest mean delay for 2005 physician malpractice payments was for equipment or product-related cases (3.74 years). There were 76 such cases for physicians, representing 0.5 percent of all 2005 physician malpractice payments. The shortest median delay for 2005 physician payments was also for equipment or product-related incidents (3.49 years).

The cumulative median and mean malpractice payment delays for physicians were 4.04 years and 4.75 years, respectively: Cumulatively, the mean payment delay for all payments for physicians was 4.75 years and the median was 4.04 years. For 2005, the mean payment delay for all payments for physicians was 4.66 years and the median is 4.13 years.

Malpractice Payments: Professional Nurses and Physician Assistants

Although physicians and dentists have the most Medical Malpractice Payment Reports in the NPDB, there are also many of these reports for professional nurses¹² and physician assistants. There has been particular interest in both of these professions' reports, as shown in requests for information made to the PDBB, and the following describes the information the NPDB contains on them. The NPDB classifies professional nurses into five licensure categories: Nurse Anesthetist, Nurse Midwife, Nurse Practitioner, Clinical Nurse Specialist/Advanced Practice Nurse, and non-specialized Registered Nurse not otherwise classified, referred to in the tables as Registered Nurse¹³. For more information about this reporting, see Tables 6 through 9 in the statistical section of this Annual Report.

Only about 2 out of 100 Malpractice Payment Reports were for professional nurses, most for Non-specialized Registered Nurses: All types of Registered Nurses have been responsible for 5,567 malpractice payments (2.0 percent of all payments) over the history of the NPDB. Non-specialized Registered Nurses were responsible for 61.9 percent of the payments made for nurses. Nurse Anesthetists were responsible for 20.0 percent of nurse payments. Nurse Midwives were responsible for 9.3 percent, Nurse Practitioners were responsible for 8.8 percent, and Advanced Nurse Practitioners were responsible for 0.2 percent of all nurse payments.

Reasons for nurse Malpractice Payment Reports varied depending on type of professional nurse: Monitoring, treatment, and medication problems were responsible for the majority of payments for non-specialized nurses, but obstetrics and surgery-related problems were also responsible for significant numbers of payments for these nurses. As would be expected, anesthesia-related problems were responsible for 82.7 percent of the 1,107 payments for Nurse Anesthetists. Similarly, obstetrics-related problems were responsible for 80.0 percent of the 516 Nurse Midwife payments. Diagnosis-related problems were responsible for 44.6 percent of the 491 payments for Nurse Practitioners. Treatment-related problems were responsible for another 24.2 percent of payments for these nurses. Of the nine reports for Clinical Nurse Specialists/Advanced Nurse Practitioners, five were for treatment-related problems, one was for an anesthesia-related problem, one was for a diagnosis-related problem, one was for a medication-related problem, and one was for a surgery-related problem.

¹²A professional nurse is an individual who has received approved nursing education and training and who holds a BSN degree (or equivalent), an AD degree (or equivalent), or a hospital program diploma, and who holds a State license as a Registered Nurse. This definition includes Registered Nurses who have advanced training as Nurse Midwives, Nurse Anesthetists, and Advanced Practice Nurse Clinical Nurse Specialists, etc.

¹³The category of Advanced Practice Nurse was added in March 2001, but no reports for these practitioners were received until 2002. There were only eight reports for these practitioners, which does not impact the numbers of nurse payments as a whole significantly. The category was replaced with Clinical Nurse Specialists on September 9, 2002.

Median nurse payment amounts were smaller than physicians', but mean nurse payment amounts were larger: The median and mean payment for all types of nurses in 2005 was \$100,000 and \$319,905 respectively. The median nurse payment was \$74,569 less than the median physician payment (\$174,569) but the mean nurse payment was \$25,752 larger than the mean physician payment in 2005 (\$294,153). Similarly, the inflation-adjusted cumulative median nurse payment of \$102,482 was \$26,282 less than the \$128,764 inflation-adjusted cumulative median payment for physicians. The inflation-adjusted cumulative mean nurse payment of \$324,929 was \$55,673 larger than the inflation-adjusted cumulative mean physician payment of \$269,256. The mean payment amount for nurses was likely larger because there were relatively fewer nurse payments, which means one significantly large payment can impact the mean more than if there were more nurse payments. The median payment amount was more representative of typical payments.

There was a wide variation in States' nurse Malpractice Payment Reports compared to physicians' reports: Vermont had only 7 nurse Malpractice Payment Reports in the NPDB while New Jersey had the most (667). The ratio of nurse payment reports to physician payment reports (using adjusted figures¹⁴) for Vermont (with only 7 nurse payments) was one of the lowest in the nation at 0.02 but 7 States had only one nurse payment report for 100 or more physician payment reports. In contrast, the ratio for Alabama, which was the highest in the Nation, was 9 nurse payment reports for every 100 physician payment reports. Massachusetts had 8 nurse payment reports for every 100 physician payment reports and three other States had ratios of 7 nurse payment reports for every 100 physician payment reports. There may be several explanations for differences in the ratio of payment reports for nurses and physicians, including possible differences in the ratio of nurses to physicians in practice in the State.

Physician Assistants had less than one percent of all Medical Malpractice Payment Reports, most of them for diagnosis-related problems: Physician Assistants have been responsible for only 1,021 malpractice payments since the opening of the NPDB (0.36 percent of all payments). Both cumulatively and during 2005, diagnosis-related problems were involved in about half of all Physician Assistant malpractice payments (55.8 percent cumulatively and 57.1 percent in 2005). Treatment-related payments were the second largest category both cumulatively and in 2005 (24.2 percent and 19.6 percent, respectively).

Payments in the diagnosis-related category for Physician Assistants were larger than treatment-related payments: Payments in the diagnosis category had a median payment amount of \$137,500 in 2005 and a cumulative inflation-adjusted median payment amount of \$105,777, while treatment-related payments had a median payment of \$44,375 for 2005 and a cumulative inflation-adjusted median payment of about \$37,022.

¹⁴The "adjusted" number of reports does not include reports concerning payments made by State malpractice funds which usually are a second payment report for an incident. The "adjusted" number of reports is an approximation of the number of incidents leading to payment. These reports accounted for only 1.6 percent of professional nurse payment reports.

States Vary in Malpractice Payment Amounts and Times from Incident to Payments

States vary widely in the number of Medical Malpractice Reports for their practitioners, their mean and median medical malpractice amounts, and their “payment delay,” which is how long it takes to receive a malpractice payment after an incident occurs. The following narrative examines these differences in detail. For more information on malpractice reporting among the States, see Tables 10 through 13 in the statistical section of this Annual Report.

“Adjusted” numbers of Medical Malpractice Payment Reports helped to give a more realistic picture of States payment reports: To make the statistics more informative and realistic, this narrative relies on an “adjusted” number of Malpractice Payment Reports, which excludes reports for malpractice payments made by State malpractice funds. Nine States¹⁵ have (or in the case of Florida, had) such funds, and most, but not all, fund payments pertaining 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 practitioner’s 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” counts so malpractice incidents are not counted twice for the same practitioner.

Although the “adjusted” number 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 also the primary insurer and only payer for some claims. Since these primary payments cannot be readily identified, they are excluded from the “adjusted” scores even though they are the only report in the NPDB for the incident.¹⁶

The ratio of physician payment reports to dental payment reports varied widely among the States: Nationally, using the adjustment described above, there was about one Medical Malpractice Payment Report for dentists for every six payments reports for physicians. In California, Utah, Washington, and Wisconsin, however, there was about one dentist payment report for about every three physician payment reports. In Mississippi, Montana, North Carolina, North Dakota, and West Virginia there was less than 1 dental payment report for every 10 physician payment reports.

¹⁵Florida, Indiana, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania, South Carolina, and Wisconsin. In addition, Wyoming passed legislation to establish a fund but it was never created in practice. New York has a patient compensation program but it has subsidized the purchase of private excess coverage, usually from the practitioner’s primary carrier.

¹⁶Kansas 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.

State reporting numbers can be affected by many settlements for a single practitioner and delinquent reports: 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. For example, the high ratio of dental payment reports to physician payment reports in Utah was largely the result of a very large number of payment reports for one dentist during 1994. 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 the NPDB's receipt of delinquent reports during 1996 and 1997.

States' malpractice statutes affect medical malpractice payment reporting numbers: 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 relatively 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. Some States also limit payments for non-economic damages (e.g., pain and suffering). Caps on recovery of non-economic damages or other limitations on recoveries 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. Plaintiffs with meritorious but complex cases may find it difficult to obtain representation because of legal limitations on attorney contingency fees. 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 Virginia decreased from 2001 to 2005 while the number of dentist payment reports increased over the same period.

Median payment amounts for physician Medical Malpractice Payment Reports varied by thousands of dollars among the States: The cumulative, inflation-adjusted median physician malpractice payment for the NPDB was \$128,764 and the 2005 median payment was \$174,569. Connecticut had the highest 2005 median payment of \$375,000. The lowest 2005 median was found in Nebraska at \$59,618. Next lowest, Utah had a median payment of \$62,500 and California had a median payment of \$70,000.¹⁷ These numbers were not adjusted for the impact of State malpractice funds, which have the effect of lowering the observed mean and median payment. Because mean payments can be substantially impacted by a single large

¹⁷The California median payment for physicians is artificially impacted by a State law which requires reporting to the State only malpractice settlements of \$30,000 or more and all arbitration awards or court judgments in any amount. If a practitioner has three settlements in excess of \$30,000 in a 10-year period beginning on January 1, 2003, the fact that these settlements exist will be made public. During 2005, 144 (12.0 percent) of California physician's 1,196 malpractice payments were for \$29,999. Payments for \$29,999 are extremely rare in other States. Another 77 California payments were for exactly \$30,000, which is immediately below the actual reporting threshold, which required reporting of malpractice payments over \$30,000. When these categories are combined, fully 18.4 percent of California physician malpractice payments are within \$2.00 of the State reporting threshold. In addition to reporting of settlements of more than \$30,000, California law requires reporting of malpractice arbitration awards, judgments and settlements-after-judgment regardless of payment amount.

payment or a few such payments, a State's median payment is normally a better indicator of typical malpractice payment amounts.¹⁸

Mean “payment delays” for physician Medical Malpractice Payment Reports lower in 2005 than average “delays” over time: “Payment delay” is how long it takes to receive a malpractice payment after an incident occurs. For all physician Malpractice Payment Reports in the NPDB, the mean delay between incident and payment was 4.75 years. For 2005 payments, the mean delay was 4.66 years. Thus during 2005, payments were made on average about a month quicker than the average for all payments in the NPDB. The average physician payment came about 18 days later than in 2004, which is a reversal of the previous trend toward quicker resolution of malpractice cases.

States varied widely in their “payment delays”: On average, during 2005 payments were made most quickly in Oregon (a mean payment delay of 3.20 years) and California (3.28 years). Payments were slowest in Massachusetts (6.16 years) and Indiana (6.15 years).

¹⁸Half the payments are larger and half the payments are smaller than the median payments. For example, consider the following eleven malpractice payments, \$11,000; \$12,000; \$13,000; \$14,000; \$15,000; \$16,000; \$17,000; \$18,000; \$19,000; \$20,000 and \$1,000,000, the median payment is \$16,000. The mean of these payments (the total divided by the number of payments) is \$105,000. Clearly the median is a better representation of the typical or “average” payment for this data than is the mean. However the median cannot be used to estimate the total paid out. The mean, when multiplied by the number of payments made, can be used to determine the total paid out.

Three Issues – Corporate Shield, Federal Entity Policies, and Physician Residents – Affect Malpractice Payment Reporting

Three aspects of malpractice payment reporting may be 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 understanding. The third issue, 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” may mask the extent of substandard care and diminish NPDB’s usefulness as a flagging system: Malpractice payment reporting may be affected by use of the “corporate shield.” Attorneys have worked out arrangements 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 about the practitioner is filed with the NPDB unless the practitioner is excluded from the settlement as a condition of the settlement.

As required by *HCQIA*, Federal agencies have negotiated policies with HHS for malpractice payment reporting to the NPDB: Under the provisions of the Federal Tort Claims Act, the government, not individual practitioners, is sued when malpractice is alleged concerning a Federal practitioner. The U.S. Department of Defense’s (DOD) policy requires malpractice payments to be reported to the NPDB only if the practitioner was responsible for an act or omission that was the cause (or a major contributing cause) of the harm that gave rise to the payment. Also, it is reported only if at least one of the following circumstances exists about the act or omission: (1) The Surgeon General of the affected military department (Air Force, Army, or Navy) determines that the practitioner deviated from the standard of care; (2) The payment was the result of a judicial determination of negligence and the Surgeon General finds that the court’s determination was clearly based on the act or omission; and (3) The payment was the result of an administrative or litigation settlement and the Surgeon General finds that based on the case’s record as whole, the purpose of the NPDB requires that a report be made. The U.S. Department of Veterans Affairs (VA) uses a similar process when deciding whether to report malpractice payments. According to an October 15, 1990, U.S. Department of Health and Human Services (HHS) policy directive, all settled or adjudicated HHS medical malpractice cases must be reported to the NPDB.

In 2003 and 2005 the NPDB Executive Committee examined the issue of required reporting of residents’ malpractice payments: The *HCQIA* makes no exceptions for malpractice payments made for the benefit of residents. Payments for residents must be reported

to the NPDB. A committee of the Executive Committee examined the issues surrounding the reporting of residents to the NPDB. They considered both residents with primary responsibility (practicing independently) and residents with ancillary responsibility (training in a residency program under supervision). The issue of reporting residents has also been discussed in articles in the *Bulletin of the American College of Surgeons*.¹⁹ A common misperception is 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, it is incorrectly believed that 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. However the *HCQIA* requires reporting of all licensed practitioners for whom a payment is made, regardless of residency status.

Physician interns and residents had 1,882 Medical Malpractice Payment Reports in the NPDB: At the end of 2005 a total of 1,756 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 1,756 physicians, 1,521 were allopathic residents and 235 were osteopathic residents. The NPDB contained a total of 1,872 intern or resident-related Malpractice Payment Reports for these practitioners (1,619 for allopathic interns or residents and 253 for osteopathic interns or residents). These payments constituted only 0.8 percent of all physician Malpractice Payment Reports cumulatively.

Most allopathic physician interns and residents had only one Medical Malpractice Payment Report: A total of 1,460 of the reported allopathic interns and residents had only 1 Malpractice Payment Report as an intern or resident; 57 had 2 such reports; 2 had 3 reports; 1 had 4 reports; and one had 45 Malpractice Payment Reports for incidents while an intern or resident.

Most osteopathic physician interns and residents had only one Medical Malpractice Payment Report: A total of 218 of the reported osteopathic interns and residents had only 1 Malpractice Payment Report as an intern or resident; 16 had 2 such reports; and 1 had 3 reports.

¹⁹Fischer, 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.

Types of Reports: Adverse Actions

NPDB Receives Many Reports on Adverse Actions

Beyond Medical Malpractice Payment reports, which make up more than 70 percent of NPDB reports, the NPDB also receives many reports on “adverse actions,”²⁰ which must be reported to the NPDB if they are taken against physicians and dentists. Reporting of Medicare/Medicaid Exclusions taken against any type of health care practitioner, which are considered to be adverse actions, began in 1997. Reporting of all other types of adverse actions began in 1990 when the NPDB opened. The following gives significant details about these types of reports. For more information, see Tables 1, 2 and 14 in the statistical section of this Annual Report.

Adverse Action Reports,²¹ more than a quarter of all reports, decreased in 2005: Adverse actions represented 26.7 percent of all reports received during 2005 and, cumulatively, 26.5 percent of all NPDB reports. The number of Adverse Action Reports received decreased by 1,238 to a total of 6,302 (a 16.4 percent decrease) from 2004 to 2005.

State Licensure Action Reports, most of them for physicians, increased in 2005: During 2005, State licensure actions made up 64.2 percent of all adverse actions and 17.1 percent of all NPDB reports (including malpractice payments and Medicare/Medicaid Exclusions). They continued to represent the majority of adverse actions (cumulatively 54.8 percent of all adverse actions). State Licensure Action Reports increased by 0.7 percent from 2004 to 2005. Those for physicians decreased by 0.1 percent in 2005. State Licensure Action Reports for dentists increased by 4.8 percent. State Licensure Action Reports for physicians constituted 82.3 percent of all State Licensure Action Reports in 2005.

²⁰ “Adverse Action Reports” is a generic term for all licensure action, clinical privileges action, Exclusion action, DEA action, and professional society action reports. This includes reports of truly adverse actions (revocations, probations, suspensions, reprimands, etc.) reported in accordance with Sections 60.8 and 60.9 of the NPDB regulations as well as reports for non-adverse “Revisions” (reinstatements, reductions of penalties, reversals of previous actions, restorations, etc.) reported under Section 60.6.

²¹ Some Adverse Action Reports are non-adverse “Revisions.” Of the 56,128 reported licensure actions in the NPDB, 6,576 reports or 11.7 percent were for licenses reinstated or restored. Of the 14,311 reported clinical privileges actions, 1,142 reports or 8.0 percent concerned reductions, reinstatements, or reversals of previous actions. Of the 589 reported professional society membership actions, 43 reports or 7.3 percent were reinstatements or reversals of previous actions. None of the 436 reported DEA Reports were considered non-adverse. Of the 30,899 Exclusion Reports, 3,830 or 12.4 percent are reinstatements.

Clinical Privileges Action Reports, making up only about four percent of all 2005 NPDB reports, decreased: There were 1,084 Clinical Privileges Action Reports in 2004 and 908 in 2005, a decrease of 16.2 percent. Physician Clinical Privileges Action Reports decreased by 11.3 percent.

Only one out of a hundred NPDB reports were for professional society membership actions and DEA actions: Professional society membership actions (only 68 reported) made up 1.1 percent of all adverse actions during 2005. Twenty DEA reports were received during 2005, 0.3 percent of all adverse actions during 2005. The number of reported professional society and DEA actions has remained almost negligible throughout the NPDB's history. Cumulatively, DEA reports and professional society action reports together represented only 1.0 percent of all Adverse Action Reports.

Physicians were responsible for most 2005 State licensure, clinical privileges, and professional society membership actions but less than 1 of 10 Medicare/Medicaid Exclusion actions: During 2005, physicians were responsible for 82.3 percent of State licensure actions, 92.2 percent of clinical privileges actions, and 61.8 percent of professional society membership actions. In contrast, physicians were responsible for only 8.1 percent of all Exclusion actions, but were responsible for 69.9 percent of the Exclusion actions reported for physicians and dentists.

Physicians were responsible for almost all physician and dentist Clinical Privileges Action Reports: In 2005 physicians, representing slightly over four-fifths of the Nation's total physician-dentist workforce, were responsible for 82.3 percent of State Licensure Action Reports for this workforce. They were also responsible for 97.8 percent of all Clinical Privileges Action 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 had a much smaller percentage of reports than physicians: Dentists, who comprise approximately a fifth of the nation's total physician-dentist workforce, were responsible for 17.7 percent of physician and dentist State licensure actions, 2.2 percent of clinical privileges actions, 37.3 percent of professional society membership actions, 5.0 percent of DEA actions, and 30.1 percent of Exclusion actions for physicians and dentists in 2005. Thus, dentists had a greater number of Exclusions than might be expected, but were relatively under-represented for other types of adverse actions except for professional society membership actions.

Reporting of Medicare/Medicaid Exclusion Reports decreased slightly from 2004: There were 2,333 Exclusion Reports in 2004 and 1,261 in 2005, a decrease of 45.9 percent. Physician Exclusion Reports decreased by 42.4 percent and Exclusion Reports for non-physicians/non-dentists decreased by 46.2 percent to a total of 1,115. Exclusion Reports represented 5.3 percent of all 2005 reports and 8.0 percent of all NPDB reports cumulatively. Exclusion Reports for non-health care practitioners are being removed from the NPDB.

Reports for “other practitioners” in 2005 were mostly for Medical Malpractice Payments: “Other practitioners” had 1,115 Exclusion Reports in 2005, which made up 41.4 percent of their reports in 2005. “Other Practitioners” also had 1,528 Medical Malpractice Payment Reports (56.7 percent), 52 Clinical Privileges Action Reports, and 1 Professional Society Membership Action Report. “Other practitioners” accounted for about 9 out of 10 Exclusion Reports (88.4 percent of 1,261 reports) added to the NPDB during 2005. Entities are not required to report clinical privileges actions and professional membership actions on “other practitioners” to the NPDB. Exclusion actions for “other practitioners” are reported to the NPDB.

Cumulatively, almost half of “other practitioners” reports were for Medicare/Medicaid Exclusions: “Other practitioners” had 22,076 Exclusion Reports in the NPDB, which was 48.3 percent of all their reports and 97.6 percent of all their Adverse Action Reports (they had only 1 Professional Membership Action Report). Cumulatively, “other practitioners” accounted for almost three-quarters of Exclusion Reports (71.4 percent of 30,899 reports) in the NPDB. “Other practitioners” are required to be reported for Medicare/Medicaid Exclusions to the NPDB.

Under-reporting May Affect Numbers of Adverse Action Reports; States Vary in Reporting Activity

Two issues can affect the interpretation of the reporting of adverse actions – the under-reporting of clinical privileges actions and the reporting of adverse State licensure actions taken by Boards against their physician or dentists licensees who are actually practicing in another State. Both of them have an impact on how the information on Adverse Action Reports²² should be viewed. The following narrative explores these issues in depth. For more in-depth data on these issues, see Tables 15 through 18 in the statistical companion to the Annual Report.

Efforts to increase clinical privileges reporting and research into the issue of clinical privileges reporting are making a difference and are continuing: The NPDB has been conducting research on the reporting issue and working with relevant organizations to try to ensure that actions that should be reported actually are reported. However, even with some progress in these efforts, the number of clinical privileges actions reported remains low. For this reason, in 2003 PricewaterhouseCoopers was contracted by PDBB to develop and test a methodology for gaining access to needed records on clinical privileges actions to ensure compliance with NPDB reporting requirements. The project was designed to determine whether hospitals and managed care organizations will voluntarily participate in clinical privileges reporting compliance audits and to develop a methodology for such audits. Hospitals and Managed Care Organizations (MCOs) proved to be reluctant to participate in voluntary audits, although the methodology worked well in the few entities that agreed to participate in testing it.

Less than half of non-Federal hospitals with “active” NPDB registrations had reported an action to the NPDB: As of December 31, 2005, 52.0 percent of non-Federal hospitals registered with the NPDB and in “active”²³ status had never reported a clinical privileges action to the NPDB. Percentages of “active” registered non-Federal hospitals that had never reported an action to the NPDB range from 26.7 percent in Rhode Island to 75.9 percent in South Dakota. This percentage of non-reporters has steadily decreased over the years. Analysis in a previous year showed 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 adverse clinical privileges actions more than it reflects a concentration of problem physicians in only a few hospitals.

²² “Adverse Action Reports” is a generic term for all licensure action, clinical privileges action, Exclusion action, DEA action, and professional society action reports. This includes reports of truly adverse actions (revocations, probations, suspensions, reprimands, etc.) reported in accordance with Sections 60.8 and 60.9 of the NPDB regulations as well as reports for non-adverse “Revisions” (reinstatements, reductions of penalties, reversals of previous actions, restorations, etc.) reported under Section 60.6.

²³ “Active” registration excludes formerly registered hospitals which have closed, merged into other hospitals, etc.

States showed extreme variations in clinical privileges reporting and adverse State licensure action reporting: The ratio of adverse Clinical Privileges Action Reports (excluding reinstatements, etc.) to adverse State Licensure Action Reports (again excluding reinstatements, etc.) ranged from a low of one adverse Clinical Privileges Action Report for every 5 adverse State Licensure Action Reports in Alaska and Connecticut to a high of 1.48 adverse Clinical Privileges Action Reports in Nevada for every adverse State Licensure Action Report (i.e., more adverse Clinical Privilege Action Reports than adverse State Licensure Action Reports). While these ratios reflect variations in the reporting of both State licensure actions and clinical privileges actions, the extreme variation from State to State is instructive. It seems likely that the extent of the observed differences may at least in part reflect variations in willingness to take actions rather than a substantial difference in the conduct or competence of the physicians practicing in the various States.

Most State licensure actions for physicians and dentists were adverse (i.e., are not reinstatements, etc.): For physicians, 87.0 percent of all State licensure actions reported to the NPDB had been adverse in nature. For dentists, about 93.6 percent had been adverse. In Nevada and New York 99.4 percent of physician State licensure actions had been adverse. This contrasts with North Dakota, in which only 73.4 percent of the physician State licensure actions had been adverse.

Overall, almost three-fourths of physicians' adverse State licensure actions were for in-State physicians: Nationally, 73.0 percent of State licensure actions were both adverse and concerned physicians who were actively practicing in the State whose Board took the licensure action ("in-State physicians"). There was a wide range of percentages, from a low of 37.9 percent of all adverse licensure actions for in-State physicians in Hawaii to a high of 90.2 percent in Oregon. Thirteen States had more than 80 percent of their adverse State licensure actions concerning in-State physicians.

Almost all dentist State licensure actions were adverse and affect in-State dentists: Nationally, 92.8 percent of State licensure actions were both adverse and pertain to in-State dentists. Percentages ranged from a low of 73.0 percent in Iowa to a high of 100.0 percent in Arkansas, Delaware, District of Columbia, North Dakota, South Dakota, and Wyoming in which all dental State licensure actions were adverse and pertained to in-State dentists.

Multiple Reports

Physicians With Multiple Reports Also Tend to Have Other Types of Reports

Most reported physicians had only one report, usually a Medical Malpractice Report, but there were also some who had multiple reports of different types. Physicians with multiple reports of different types have certain characteristics that the following narrative explains in detail. For more information about these characteristics, see Tables 19, 20 and 21 in the statistical companion to the Annual Report.

Over two-thirds of physicians had only one report, one in five had only two reports, and very few had more than five: At the end of 2005, a total of 226,667 individual practitioners had disclosable reports in the NPDB. Of these, 157,914 (69.7 percent) were physicians. As shown in Figure 2 on the next page, most physicians (66.8 percent) with reports in the NPDB had only one report, but the mean number of reports per physician was 1.84. Physicians with only two reports made up 18.5 percent of the total. About 97.2 percent had 5 or fewer reports and 99.6 percent of physicians with reports had 10 or fewer reports. Only 889 (0.4 percent of physicians with reports) had more than 10 reports.

Most physicians with reports had only Medical Malpractice Payment Reports: Of the 157,914 physicians with reports, 129,254 (81.9 percent) had only Malpractice Payment Reports; 9,414 (6.0 percent) had only State Licensure Action Reports; 2,769 (1.8 percent) had only Clinical Privileges Action Reports; and 1,403 (0.9 percent) had only Medicare/Medicaid Exclusion Reports.

About one in twenty had a Malpractice Payment Report and another type of report: Notably, only 8,330 (5.3 percent) had at least one Malpractice Payment Report and at least one State Licensure Action Report, and only 3,816 (2.5 percent) had at least one Malpractice Payment Report and at least one Clinical Privileges Action Report. Only 1,896 (1.2 percent) had Malpractice Payment, State Licensure Action, and Clinical Privileges Action Reports. Only 357 (0.2 percent) had at least one Medical Malpractice Payment, State Licensure Action, Clinical Privileges Action, and Exclusion Report at the end of 2005.

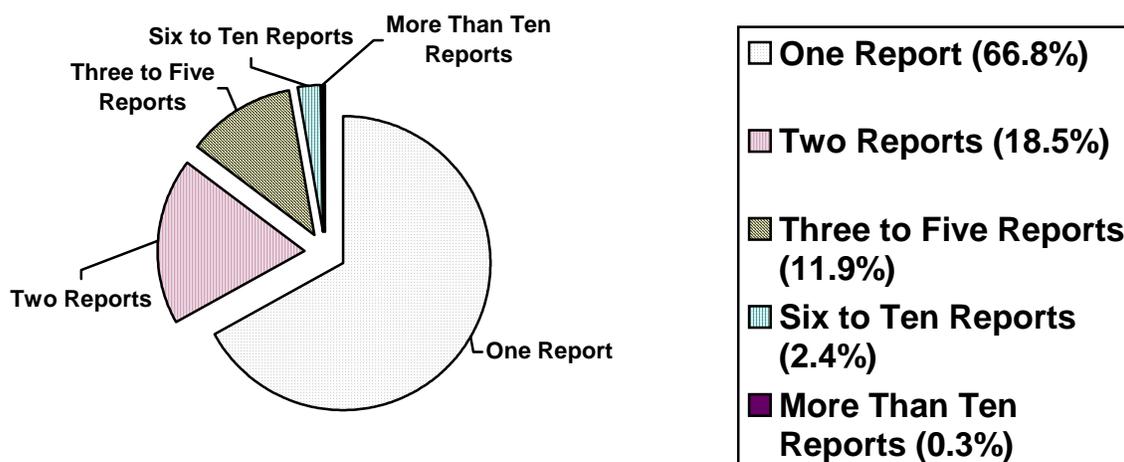
Physicians with high numbers of Malpractice Payment Reports tended to have at least some Adverse Action Reports²⁴ and Medicare/Medicaid Exclusion Reports, and vice versa: Although 95.4 percent of the 94,332 physicians with only one Malpractice Payment Report in the NPDB had no Adverse Action Reports, only 66.5 percent of the 481 physicians with 10 or more Malpractice Payment Reports had no Adverse Action Reports. Generally, the

²⁴ Adverse Action Reports discussed in this paragraph do not include Medicare/Medicaid Exclusion Reports.

data show that as a physician's number of Malpractice Payment Reports increases, the likelihood that the physician has Adverse Action Reports²⁵ also increases.

Physicians with at least two Malpractice Payment Reports were responsible for the majority of Malpractice Payment Reports for physicians: Approximately 32.6 percent of the 140,059 physicians with Malpractice Payment Reports had 2 or more such reports. These 45,727 physicians had a total of 120,561 Malpractice Payment Reports. This was 57.2 percent of the 210,647 Malpractice Payment Reports in the NPDB for physicians.

Figure 2: Percentage of Physicians with Number of Reports in the NPDB (1990-2005)



A few physicians were responsible for a large proportion of malpractice payment dollars paid: The 1 percent of physicians with the largest total payments in the NPDB were responsible for about 11.7 percent of all the money paid for physicians in malpractice judgments or settlements reported to the NPDB. The five percent of physicians with the largest total payments in the NPDB were responsible for just under a third (31.5 percent) of the total dollars paid for physicians. About eleven percent (11.5 percent) of physicians with at least one malpractice payment were responsible for half of all malpractice dollars paid from September 1, 1990 through December 31, 2005.

²⁷ "Adverse Action Reports" is a generic term for all licensure action, clinical privileges action, Exclusion action, DEA action, and professional society action reports. This includes reports of truly adverse actions (revocations, probations, suspensions, reprimands, etc.) reported in accordance with Sections 60.8 and 60.9 of the NPDB regulations as well as reports for non-adverse "Revisions" (reinstatements, reductions of penalties, reversals of previous actions, restorations, etc.) reported under Section 60.6.

Types of Practitioners Reported

Physicians, Dentists Are Reported Most Often to the NPDB

Physicians make up the majority of practitioners reported to the NPDB, having about seven out of three reports in the NPDB. The following describes the number of practitioners reported to the NPDB and the number of reports for each practitioner type. For more information about types of practitioners reported, see Table 21 in the statistical section of this Annual Report.

Physicians, most of whom only have one report, were predominant in the NPDB: Of the 226,667 practitioners reported to the NPDB, 69.7 percent were physicians (including M.D.s and D.O.s residents and interns), 13.4 percent were dentists, 8.8 percent were nurses and nursing-related practitioners, and 2.8 percent were chiropractors. About two-thirds of physicians with reports (66.8 percent) had only 1 report in the NPDB, 85.4 percent had 2 or fewer reports, 97.2 percent had 5 or fewer, and 99.6 percent had 10 or fewer. Few physicians had both Medical Malpractice Payment Reports and Adverse Action Reports. Only 6.0 percent had at least one report of both types.

Physicians had more reports per practitioner than any other practitioner group: Physicians had the highest average number (1.84) of reports per reported practitioner, and dentists, the second largest group of practitioners reported, had an average of 1.65 reports per reported dentist. Podiatrists and podiatric-related practitioners, who had 1.69 reports per reported practitioner, also had a high average of reports per practitioner as well as 6,955 reports. Comparison between physicians and dentists and other types of practitioners, however, would be misleading since reporting of State licensure, clinical privileges, and professional society membership actions is required only for physicians and dentists.

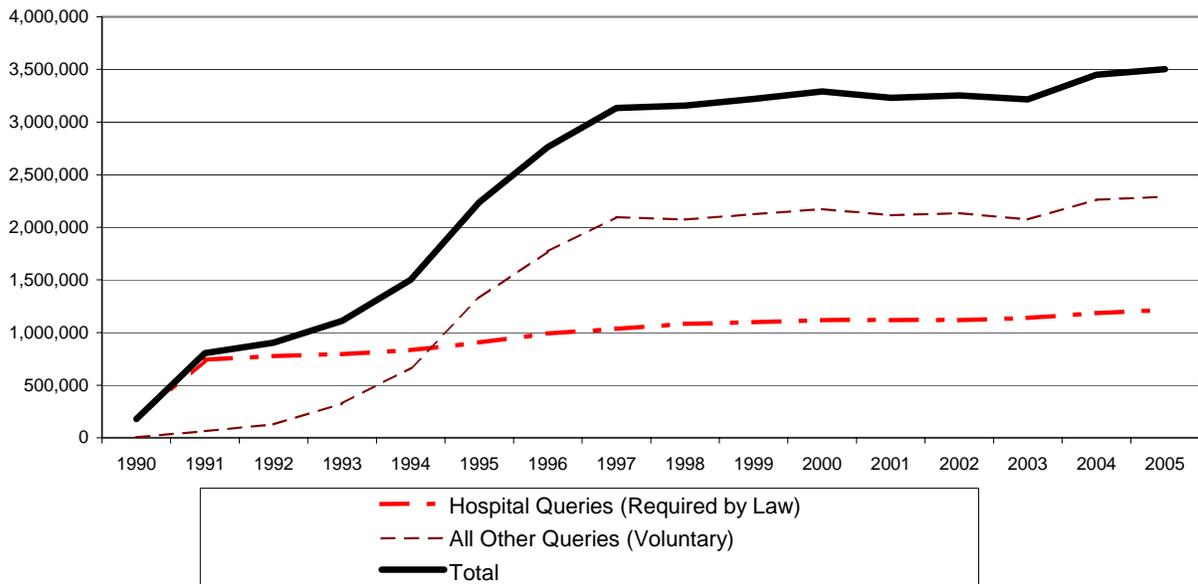
Querying

Querying Increased in 2005; Match Rate Increased

The NPDB experienced an increase (1.6 percent) in querying during 2005. The number of entity queries increased from 3,448,514 in 2004 to 3,503,922 in 2005. There's been an 8.4 percent increase in queries since 2001.

The 2005 count represents an average of 1 query every 10 seconds. It is more than 4 times as many queries as the 809,844 queries processed during the NPDB's first full year of operation, 1991. Over the 15 years the NPDB has been open, there have been cumulatively 38,962,333 entity queries. The following graph, Figure 3, gives more information about the types of queries to the NPDB. For additional information about querying, see Tables 22 through 25 in the statistical section of this Annual Report.

Figure 3: Queries by Querier Type (September 1, 1990 - December 31, 2005)



Entity queriers showed they valued information with a large number of queries over NPDB's existence: Over time NPDB information has become much more valuable to users.

The number of voluntary queries (those not required by law) from entities grew from 65,269 in 1991 to 2,289,286 in 2005, an increase of over 3,507 percent. Voluntary queries represented 65.3 percent of all entity queries during 2005.

Hospitals, which are required to query the NPDB, also increased querying over time: The growth in required queries by hospitals has not been as large as that of voluntary queriers. Their queries increased by 64.1 percent from 740,262 in 1991 (the NPDB's first full year of operation), to 1,214,636 queries in 2005. Hospitals are required to query for all new applicants for privileges or staff appointment, existing applicants when changes in privileges occur, and once every 2 years concerning their privileged staff. They made most of the queries to the NPDB during its first few years of operation but now are responsible for only about one-third of all queries. Hospitals may voluntarily query for other peer review activities, but for analysis purposes it is assumed all hospital queries are required.

MCOs submitted almost half of all voluntary entity queries: Managed care organizations (MCOs) are the most active voluntary queriers. MCOs in this case are defined as including HMOs and PPOs. Although they represented 7.3 percent of all querying entities during 2005 and 10.6 percent of all entities that have ever queried the NPDB, they made 47.7 percent of all queries during 2005 and have been responsible for 46.4 percent of queries ever submitted to the NPDB.

State licensing boards made less than one percent of all queries: State licensing boards made 0.5 percent of queries during 2005 and 0.4 percent cumulatively, but queries by State boards increased by 6.8 percent in 2005. (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.) Figure 4 on the next page shows the number of State board queries by year and the increase in queries for 2005.

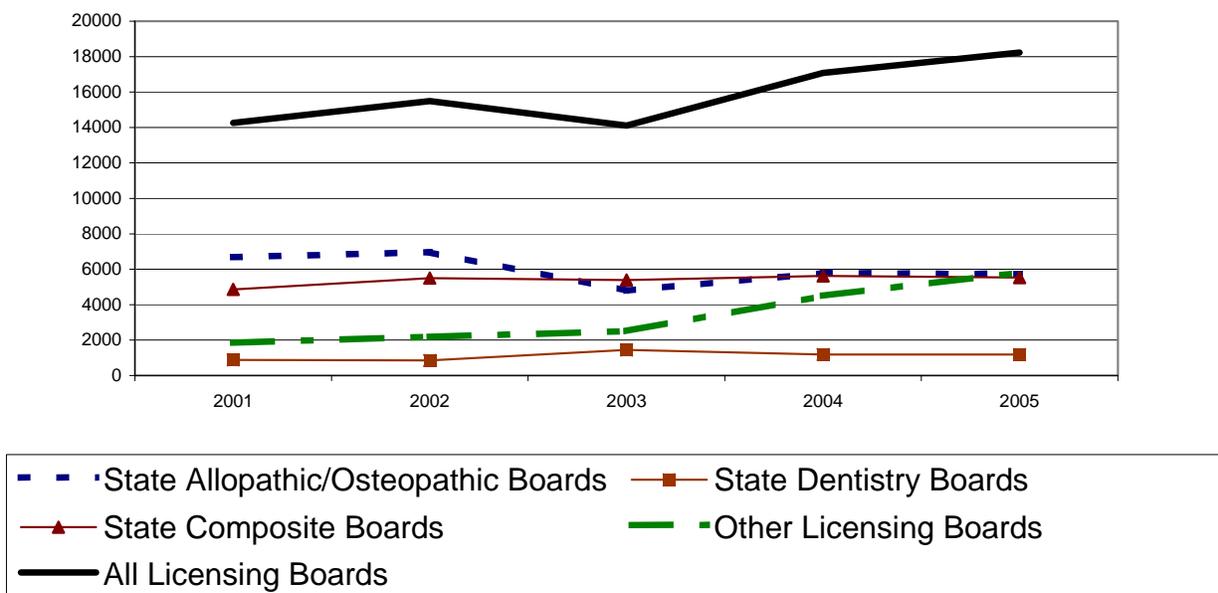
Other entities also requested information from the NPDB: Other health care entities made 16.9 percent of the queries in 2005 and 13.6 percent cumulatively. Examples of other health care entities include health maintenance organizations (HMOs), preferred provider organizations (PPOs), group practices, nursing homes, rehabilitation centers, hospices, renal dialysis centers, and free-standing ambulatory care and surgical service centers. Professional societies were responsible for 0.3 percent of queries during 2005 and 0.3 percent cumulatively.

Entities submitted most of their queries for physicians and dentists: Queriers request information on many types of practitioners, but mostly query on physicians and dentists. During 2005, allopathic physicians were by far the subject of most queries; 65.6 percent of queries submitted concerned allopathic physicians, interns and residents. The second largest category, dentists and dental residents, accounted for 6.0 percent of all queries. Osteopathic physicians accounted for 4.0 percent, clinical social workers for 2.7 percent, psychologists for 2.5 percent, and chiropractors accounted for 2.4 percent.

Query match rate stayed level in 2005: When an entity submits a query on a practitioner, a match occurs when that individual is found to have a report in the NPDB. The 491,945 entity queries matched during 2005 represented a match rate of 14.0 percent, were slightly higher than the match rate in 2004. 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 for the same length of time as the average practitioner practices, all other factors (such as malpractice payment rates for older and younger physicians) remaining constant.

A “no match” response is useful and valuable to queriers: About 86.0 percent of entity queries submitted in 2005 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 Institute for Health Services Research and Policy Studies at Northwestern University and the Health Policy Center Survey Research Laboratory at the University of Illinois at Chicago, three-quarters of surveyed queriers rated NPDB information, including responses that there were no reports in the NPDB on a queried practitioner, a “six” or a “seven,” with seven representing

Figure 4: Number of State Licensing Board Queries by Year (2000-2004)



“very useful” on a one to seven scale. A majority of surveyed queriers rated NPDB information influential in decision-making regarding practitioners (6 and 7 on a 7 point scale). At the end of 2005, a “no match” response to a query confirmed that a practitioner has had no reports in over 15 years. These responses will become even more valuable as the NPDB continues to receive reports.

Self-queries increased during 2005, but most do not show reports for practitioners:

In addition to entity queries, the NPDB also processes self-queries from practitioners seeking copies of their own records, which includes 52,041 self-query requests during 2005. The 2005 number of self-queries represented an increase of 8.5 percent from the number of self-queries processed during 2004. Of the self-query requests during 2005, 5,487 (10.5 percent) were matched with reports in the NPDB. Cumulatively, from the opening of the NPDB, 555,978 self-queries have been processed; 48,414 (8.7 percent) of these queries were matched with reports in the NPDB.

Physicians, dentists, and physician assistants submitted most of the NPDB self-queries: As shown in Table 25, many types of practitioners request information on themselves, but the majority of them are physicians. During a sample period of April through December 2005, allopathic physicians and allopathic physician interns/residents made the most self-queries (73.3 percent of all self-queries). Osteopathic physicians and osteopathic physicians/interns made the third largest number of self-queries (6.0 percent of all self-queries), dentists and dental residents the second largest (6.4 percent), and physician assistants the fourth largest (2.2 percent). Some licensure boards, malpractice insurers, or health care service providers may request that practitioners submit self-query results with their applications for licensure, malpractice insurance, clinical privileges, panel participation, etc. The level of self-querying and types of self-queries may be influenced by these requests.

NPDB Reporters and Queriers

The NPDB receives information from and provides information to registered entities that certify that they meet the eligibility requirements of the *HCQIA*. The following gives some information about these entities. Some entities have (or had in the past) multiple registration numbers either simultaneously or sequentially, so the data may not necessarily reflect the actual number of individual entities which have reported to or queried the NPDB. For more information, see Table 26 in the statistical section of the Annual Report.

Almost half of registered entities that have reported or queried were Other Health Care Entities: A total of 16,619 registered entities had active²⁶ status as of December 31, 2005. At the end of 2005, Other Health Care Entities²⁷ held 7,971 active registrations (48.0 percent). Hospitals accounted for 6,556 (39.4 percent) of the NPDB's active registered entities and Managed Care Organizations accounted for 1,354 active registrations (8.1 percent). The 442 malpractice insurers with active registrations accounted for only 2.7 percent of all active registrations. Other categories accounted for even smaller percentages of the NPDB's active registrations at the end of 2005.

About 4 out of 10 registered entities active at any time over the NPDB's existence were Other Health Care Entities: A total of 20,935 registered entities were ever active over the NPDB's existence. Other Health Care Entities accounted for 9,485 (45.3 percent) of the entities which had ever registered with the NPDB and had queried or reported at least once. (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.) Hospitals accounted for 8,042 (38.4 percent) registrations at any time and MCOs accounted for 2,159 registrations (10.3 percent). The 823 malpractice insurers ever registered accounted for only 3.9 percent of all registrations. Other categories accounted for even smaller percentages of the NPDB's registrations throughout its existence.

²⁶ "Active" registration excludes formerly registered entities which have closed, merged into other entities, etc.

²⁷ 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.

Ensuring Accurate Reports: Secretarial Review

Through the dispute and Secretarial Review process, practitioners get a chance to challenge reports that they feel should be changed or should not be in the NPDB because they are either inaccurate or should not have been filed under applicable regulations. Only a small percentage of reports are disputed, though, and those that have gone through Secretarial Review usually have been upheld by the Secretary as being accurate and reportable. The following narrative explains the process of NPDB disputes and Secretarial Reviews. For more information about Secretarial Review data, see Tables 27 through 29 in the statistical section of the Annual Report.

Practitioners must use an established administrative process when disputing a report, including working through the reporting entity to change the report: When practitioners are notified of a report in the NPDB that they believe is inaccurate or should not have been filed, they may dispute the report and/or insert their own statement. Before requesting Secretarial Review, they must first contact the reporting entity to ask them to correct the matter. When the NPDB receives a dispute from a practitioner, notification of the dispute is sent to all queriers who received the report within the last 3 years and is included with the report when it is released to future queriers.

Queriers are informed about a report's status as "disputed": Practitioners who have disputed reports must 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, they are notified that the practitioner disputes the accuracy of the report.

If the reporting entity does not change the disputed report to the practitioner's satisfaction, then the practitioner may ask the Secretary of HHS to review the disputed report: When asking for Secretarial Review, the practitioner must send documentation to the NPDB that briefly discusses the facts in dispute, documents the inaccuracy of the report, and proves that he or she tried to resolve the disagreement with the reporting entity.

Secretarial Reviews are limited to accuracy and appropriateness of reporting, not the underlying decision to make a malpractice payment or take an adverse action: Secretarial Review does not include a review of the merits of a medical malpractice claim or the basis for an adverse action. Reviews are limited to factual accuracy and whether the report was submitted in accordance with the NPDB reporting requirements. 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." Factual accuracy means that the report accurately described the practitioner and the payment or action and reasons for the payment or action as reflected in decision documents.

Reviewed reports can be determined to be accurate or inaccurate: If the Secretary concludes the information in the report is accurate, the Secretary sends an explanation of the decision to the practitioner. The practitioner may then submit a statement (limited to 2,000 characters) that is added to the report. If the practitioner had already submitted a statement, any new statement will replace the original statement. If a report is determined to be inaccurate, the Secretary will request that the reporting entity file a correction. If no correction is forthcoming the Secretary notes the correction in the report. The Secretary can only remove (“void”) a report from the NPDB if it was not legally required or permitted to be submitted.

Issues raised also can be determined to be “outside the scope of review”: The Secretary also may conclude that the issue in dispute is outside the scope of review, i.e., that the only issues raised concern whether a payment should have been made or an action should have been taken. The Secretary cannot substitute his or her judgment on the merits for that of the entity that made the payment or took the action. In such cases determined to be “outside the scope of review,” the Secretary directs the NPDB to add an entry to that effect to the report and to remove the dispute notation from the report. The practitioner may also submit a statement that is added to the report.

Reviews may be administratively dismissed or reconsidered: 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 progress. Practitioners may ask for a reconsideration of a Secretarial Review decision.

The majority of disputed reports were for medical malpractice payments: At the end of 2005, a total of 13,824 reports, or 3.6 percent of all reports, were disputed. This number was made up of 2,108 State Licensure Action reports, 1,933 Clinical Privileges Action Reports, 34 Professional Society Membership Reports, 16 DEA reports, 287 Exclusion actions, and 9,446 Malpractice Payment Reports. Exclusion Reports for actions taken prior to August 21, 1996²⁸ cannot be disputed with the NPDB.

Clinical Privileges Action Reports had the biggest percentage of reports that were disputed among the types of reports: Disputed reports constituted 3.8 percent of all State Licensure Action Reports, 13.5 percent of all Clinical Privileges Action Reports, 5.8 percent of Professional Society Membership Reports, 3.7 percent of DEA reports, and 3.3 percent of Malpractice Payment Reports.

Secretarial Reviews decreased by one-seventh from 2004 to 2005: Requests for review by the Secretary decreased by 14.7 percent from 2004 to 2005. A total of 58 requests for review by the Secretary were received during 2005 compared to 68 in 2004. Bearing in mind

²⁸Exclusion 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 U.S. Department of Health and Human Services, Office 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.

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 2005, the number of new requests for Secretarial Review was 0.2 percent of the number of new Malpractice Payment Reports and Adverse Action Reports received by the NPDB.

Adverse Action Reports²⁹ were more likely to be appealed to the Secretary than were Malpractice Payment Reports: During 2005, 79.3 percent (46 requests) of all requests for Secretarial Review concerned adverse actions (i.e., State Licensure Action, Clinical Privileges Action, or Professional Society Membership Reports) even though only 26.7 percent of all 2005 reports fell in this category. While about three-fourths of all cumulative reports in the NPDB are for malpractice payments almost 8 out of 10 of 2005 reports in Secretarial Review are for Adverse Action Reports. During 2005 Clinical Privileges Action Reports represented 67.2 percent of all Adverse Action Reports involved in Secretarial Review.

Most resolved Secretarial Reviews in 2005 resulted in unchanged reports: At the end of 2005, 30 (51.7 percent) of the 58 requests for Secretarial Review received during the year remained unresolved. Of the 28 new 2005 cases which were resolved, one was voided. Reports were not changed (the Secretary maintained report as submitted or the Secretary decided the Secretarial Review request was outside the scope of review³⁰) in 16 cases (57.1 percent) of the 2005 cases that were resolved. For 11 cases the result was submission of a corrected report by the reporting entity, closing the case by “intervening action.” Generally the corrections were filed at the request of the Secretary.

About one in six of all Secretarial Reviews resulted in outcomes that were beneficial for the practitioners: By the end of 2005, 17.6 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 2005, 3.0 percent of all requests for Secretarial Review remained unresolved. Only 73 (11.7 percent) of the total of 633 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 clinical privileges actions, 137 (19.4 percent) of the 706 closed requests resulted in a positive outcome for the practitioner. For licensure actions, 82 (24.8

²⁹ “Adverse Action Reports” is a generic term for all licensure action, clinical privileges action, Exclusion action, DEA action, and professional society action reports. This includes reports of truly adverse actions (revocations, probations, suspensions, reprimands, etc.) reported in accordance with Sections 60.8 and 60.9 of the NPDB regulations as well as reports for non-adverse “Revisions” (reinstatements, reductions of penalties, reversals of previous actions, restorations, etc.) reported under Section 60.6.

³⁰ 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 and if the report is otherwise accurate. If a payment was made, a report of the payment must remain in the NPDB. Whether or not the practitioner committed malpractice is not relevant to keeping the payment report in the NPDB.

percent) of the 331 closed requests resulted in a positive outcome, and for professional society membership actions, six closed requests (33.3 percent) resulted in a positive outcome.

NPDB: The Future

The NPDB Will Continue to Improve Its Operations in 2006

The NPDB will make several improvements to its operations and future policy initiatives in 2006. It will also continue updating and organizing its Web site, www.npdb-hipdb.hrsa.gov, to make it easier for customers to find information.

The following system improvements will be made to the NPDB-HIPDB in 2006:

- The Data Banks' Web site's new domain name changes in May 2006 from www.npdb-hipdb.com to www.npdb-hipdb.hrsa.gov. The move will be made to a .gov domain to help prevent fraud by showing Data Bank users that the NPDB-HIPDB Web site is under the Government-run domain.
- IQRS users will gain the ability to assign specific privileges to agents in May 2006 (i.e. reporting only querying or querying only or both querying and reporting). Authorized agents will also be able to log in to the IQRS and select an entity by name from a dropdown menu. They will no longer be required to manually enter the entity's Data Bank Identification Number (DBID).
- Agents' administrators in May will gain the ability to assign querying and reporting privileges to each of their staff numbers. For example, an agent administrator can specify that a staff member may submit queries on behalf of a particular entity rather than all designated entities. A new screen, the *Active Entity Relationships* screen, will become available in May for authorized agent administrators. The screen displays a history of the authorized agent's entity relationships and the staff members authorized by the agent's administrator to act on behalf of each entity.
- The Historical Query and Report Summary for IQRS users will be enhanced in May 2006. This functionality enables entities to obtain a summary of subjects it has previously queried on or reported. Improvements to the functionality include expanding the searchable data range, expanding the search criteria, and adding additional primary and secondary search result sort options. IQRS users will be able to search queries and reports that were submitted from June 2000 to the present. Previously, users could only search for queries and reports submitted up to 4 years prior to the search date.

- The NPDB is developing the Proactive Disclosure Service (PDS), which allows eligible entities to choose to register their practitioners with the NPDB and/or the HIPDB to be notified of new reports that name any of their registered practitioners as subjects within one business day of the Data Bank's receipt of the report. The first stage of the service's roll-out is to offer the PDS as a prototype in Spring 2007 to selected organizations. The prototype is expected to be in use for approximately one or two years before there will be a transition to a PDS open to all registered entities.

Some of the policy initiatives that will take place in 2006 include:

- The Federal Register notice relative to the proposed rule that would revise existing regulations governing the National Practitioner Data Bank, to incorporate statutory requirements under Section 1921 of the Social Security Act will be published on March 21, 2006. Section 1921 would add adverse action reports, which are not restricted to issues related to professional competence and conduct, on all licensed practitioners. Also it would add adverse action reports relative to certain negative actions or findings, mainly those taken by private accrediting organizations (e.g., the Joint Commission on Accreditation of Healthcare Organizations, National Committee for Quality Assurance, URAC, Commission on Accreditation of Rehabilitation Facilities). This regulation allows hospitals access to adverse action reports on all licensed health care practitioners. Comments on this proposed rule were invited and had to be received on or before May 22, 2006.
- The Data Banks will have a Policy Forum in Virginia on March 9th, 2006 for licensing boards. The purpose of the forum is to bring Data Bank reporters together to exchange information and ideas about the Data Banks.
- NPDB staff will make presentations at several meetings of health care organizations in 2006, including the National Association Medical Staff Services (NAMSS) Institute and Seminar Series, the Ohio Association Medical Staff Services (OAMSS) Spring Seminar, the Minnesota Association Medical Staff Services (MAMSS) Spring Conference, the New York State Association Medical Staff Services (NYSAMSS) Seminar, and the National Committee for Quality Assurance (NCQA) Introduction to Credentialing and Advanced Credentialing Workshops.
- Continual reporting enforcement efforts, including comparing the Data Bank registrations of hospitals with the American Hospital Association (AHA) Guide, are ongoing to ensure all hospitals are properly querying and reporting to the Data Banks.

Conclusion: NPDB Continues to Grow, Become More Useful

The total number of reports in the NPDB now exceeds 386,000 and the cumulative number of queries is more than 38 million. Although Medical Malpractice Payment Reports still represent the majority of reports in the NPDB, an increasing number of Adverse Action Reports (e.g., Medicare/Medicaid Exclusion, State Licensure Action, Clinical Privileges Action, Professional Society Membership, and Federal Licensure and DEA reports) have been entered into the NPDB. Several compliance projects are studying ways to make sure that the NPDB is receiving all the reports it should be, data improvement efforts are ensuring the accuracy of NPDB reports, and projects to market the benefits of the NPDB to reporters and queriers are being implemented.

As NPDB information accumulates, the NPDB's value as a source of aggregate information and its 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 Integrated Querying and Reporting Service (IQRS). System improvements – such as giving users the ability to retrieve historical summaries of their queries and reports – continue to be made to better serve the NPDB's customers. The continuing work to educate users about the NPDB and improve the data and reporting compliance 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

AAR - Adverse Action Report

ACSI - American Consumer Satisfaction Index

AHA - American Hospital Association

AHIP - America's Health Insurance Plans

AHRQ - Agency for Healthcare Research and Quality

BHPr - Bureau of Health Professions

CAMSS - California Association Medical Staff Services

CMS - Centers for Medicare and Medicaid Services

DBID - Data Banks Identification Number

DEA - Drug Enforcement Administration

D.O. - Doctor of Osteopathy

DOD – U.S. Department of Defense

DPDB - Division of Practitioner Data Banks

EFT - Electronic Funds Transfer

FMS - Financial Management Service

FSMB - Federation of State Medical Boards

HCQIA - The Health Care Quality Improvement Act of 1986, as amended 42 USC, Sec. 11101, et. reg.

HFAP - Healthcare Facilities Accreditation Program

HHS – U.S. Department of Health and Human Services

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

ITP - Interface Control Document (ICD) Transfer Program

JCAHO - Joint Commission on Accreditation of Healthcare Organizations

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

NCF - National Credentialing Forum

NCQA - National Committee for Quality Assurance

NCSBN - National Council of State Boards of Nursing

NPDB - National Practitioner Data Bank

NPRM - Notification of Proposed Rule Making

OIG - Office of Inspector General

OWEQA - Office of Workforce Evaluation and Quality Assurance

PDBB - Practitioner Data Banks Branch

PDS - Proactive Disclosure Service

PPO - Preferred Provider Organization

QRXS - Querying and Reporting XML Service

RN - Registered Nurse

SRA - SRA International, Inc.

URAC - American Accreditation HealthCare Commission

URP - Users Review Panel

VA – U.S. Department of Veterans Affairs

XML - Extensible Markup Language

Statistical Index: List of Tables

- Table 1: Number and Percent Distribution of Reports by Report Type, Last 5 Years and Cumulative Through 2005
- Table 2: Number of Reports Received and Percent Change by Report Type, Last 5 Years
- Table 3: Number, Percent Distribution, and Percent Change of Medical Malpractice Payment Reports by Practitioner Type, Last Five Years and Cumulative Through 2005
- Table 4: Mean and Median Medical Malpractice Payment Amounts by Malpractice Reason, 2005 and Cumulative Through 2005 - Physicians
- Table 5: Mean and Median Delay Between Incident and Payment by Malpractice Reason, 2005 and Cumulative Through 2005 – Physicians
- Table 6: Number of Medical Malpractice Payment Reports by Malpractice Reason – Nurses (Registered Nurses, Nurse Anesthetists, Nurse Midwives, Nurse Practitioners, and Advanced Practice Nurses/Clinical Nurse Specialists)
- Table 7: Mean and Median Medical Malpractice Payment Amounts by Malpractice Reasons, 2005 and Cumulative Through 2005 - Nurses (Registered Nurses, Nurse Anesthetists, Nurse Midwives, Nurse Practitioners, and Advanced Practice/Clinical Nurse Specialists)
- Table 8: 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, Nurse Practitioners, and Advanced Practice/Clinical Nurse Specialists)
- Table 9: Mean and Median Medical Malpractice Payment Amounts by Malpractice Reason, 2005 and Cumulative Through 2005 - Physician Assistants
- Table 10: Actual and Adjusted Medical Malpractice Payment Reports and Ratio of Adjusted Medical Malpractice Reports by State - Physicians and Dentists, Cumulative Through 2005
- Table 11: Number of Medical Malpractice Payment Reports by State, Last 5 Years - Physicians
- Table 12: Number of Medical Malpractice Payment Reports by State, Last 5 Years - Dentists

- Table 13: Mean and Median Medical Malpractice Payment and Mean and Median Delay Between Incident and Payment by State, 2005 and Cumulative Through 2005 - Physicians
- Table 14: Number, Percent Distribution, and Percent Change of Adverse Action and Medicare/Medicaid Exclusion Reports by Practitioner Type, Last 5 Years and Cumulative Through 2005
- Table 15: Currently Active Registered Non-Federal Hospitals That Have Never Reported to the National Practitioner Data Bank by State
- Table 16: Clinical Privilege Reports and Ratio of Adverse Clinical Privileges Reports to Adverse In-State Licensure Reports by State - Physicians
- Table 17: Licensure Actions by State, Cumulative Through 2005 - Physicians
- Table 18: Licensure Actions by State, Cumulative Through 2005 - Dentists
- Table 19: Relationship Between Frequency of Medical Malpractice Payment Reports, Adverse Action Reports, and Medicare/Medicaid Exclusion Reports – Physicians
- Table 20: Relationship Between Frequency of Adverse Action Reports, Medical Malpractice Payment Reports, and Medicare/Medicaid Exclusion Reports – Physicians
- Table 21: Practitioners with Reports
- Table 22: Number, Percent, and Percent Change in Queries and Queries Matched, Last 5 Years and Cumulative Through 2005
- Table 23: Queries by Type of Querying Entity, Last 5 Years and Cumulative Through 2005
- Table 24: Number of Entity Queries and Matched Entity Queries by Practitioner Subject Type
- Table 25: Self-Queries and Self-Queries Matched with Reports by Practitioner Type
- Table 26: Entities That Have Queried or Reported to the National Practitioner Data Bank
- Table 27: Requests for Secretarial Review by Report Type, Last 5 Years and Cumulative Through 2005
- Table 28: Distribution of Requests for Secretarial Review by Type of Outcome, Last 5 Years and Cumulative Through 2005

Table 29: Resolved Requests for Secretarial Review by Report Type and Outcome Type,
Cumulative Through 2005

Table 1: Number and Percent Distribution of Reports by Report Type, Last Five Years and Cumulative Through 2005
National Practitioner Data Bank (September 1, 1990 - December 31, 2005)

Report Type	2001		2002		2003		2004		2005		Cumulative through 2005	
	Number	Percent	Number	Percent								
Malpractice Payment Reports	20,447	73.9%	18,893	70.8%	18,942	72.0%	17,670	70.1%	17,298	73.3%	283,847	73.5%
Adverse Action Reports*	7,224	26.1%	7,789	29.2%	7,361	28.0%	7,540	29.9%	6,302	26.7%	102,363	26.5%
State Licensure	3,146	11.4%	3,950	14.8%	3,977	15.1%	4,017	15.9%	4,045	17.1%	56,128	14.5%
Clinical Privilege	1,027	3.7%	962	3.6%	972	3.7%	1,084	4.3%	908	3.8%	14,311	3.7%
Professional Society Membership	33	0.1%	44	0.2%	46	0.2%	47	0.2%	68	0.3%	589	0.2%
DEA	9	0.0%	0	0.0%	54	0.2%	59	0.2%	20	0.1%	436	0.1%
Medicare/Medicaid Exclusion**	3,009	10.9%	2,833	10.6%	2,312	8.8%	2,333	9.3%	1,261	5.3%	30,899	8.0%
All Reports	27,671	100.0%	26,682	100.0%	26,303	100.0%	25,210	100.0%	23,600	100.0%	386,210	100.0%

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

* "Adverse Action Reports" are defined in footnote 1 on page 6 of this report.

** The large increase in the number of Exclusion Reports for 2000 reflects reports for practitioners other than physicians and dentists submitted to the NPDB for 2000 and previous years with the initiation of reporting to the HIPDB.

Table 2: Number of Reports Received and Percent Change by Report Type, Last Five Years
National Practitioner Data Bank (January 1, 2001 - December 31, 2005)

Report Type	2001		2002		2003		2004		2005	
	Number	% Change 2000-2001	Number	% Change 2001-2002	Number	% Change 2002-2003	Number	% Change 2003-2004	Number	% Change 2004-2005
Malpractice Payment Reports	20,447	6.1%	18,893	-7.6%	18,942	0.3%	17,670	-6.7%	17,298	-2.1%
Adverse Action Reports*	7,224	-40.8%	7,789	7.8%	7,361	-5.5%	7,540	2.4%	6,302	-16.4%
State Licensure	3,146	-26.3%	3,950	25.6%	3,977	0.7%	4,017	1.0%	4,045	0.7%
Clinical Privilege	1,027	-1.3%	962	-6.3%	972	1.0%	1,084	11.5%	908	-16.2%
Professional Society Membership	33	17.9%	44	33.3%	46	4.5%	47	2.2%	68	44.7%
DEA	9	...	0	...	54	...	59	9.3%	20	-66.1%
Medicare/Medicaid Exclusion**	3,009	-56.1%	2,833	-5.8%	2,312	-18.4%	2,333	0.9%	1,261	-45.9%
All Reports	27,671	-12.1%	26,682	-3.6%	26,303	-1.4%	25,210	-4.2%	23,600	-6.4%

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

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

* "Adverse Action Reports" are defined in footnote 1 on page 6 of this report.

Table 3: Number, Percent Distribution, and Percent Change of Medical Malpractice Payment Reports by Practitioner Type, Last Five Years and Cumulative Through 2005
National Practitioner Data Bank (September 1, 1990 - December 31, 2005)

Practitioner Type*	2001			2002			2003		
	Number	Percent	% Change 1999-2000	Number	Percent	% Change 2000-2001	Number	Percent	% Change 2001-2002
Physicians	16,589	81.1%	7.2%	15,221	80.6%	-8.2%	15,245	80.5%	0.2%
Dentists	2,306	11.3%	-1.2%	2,076	11.0%	-10.0%	2,235	11.8%	7.7%
Other Practitioners	1,552	7.6%	5.5%	1,596	8.4%	2.8%	1,462	7.7%	-8.4%
All Practitioners	20,447	100.0%	6.1%	18,893	100.0%	-7.6%	18,942	100.0%	0.3%

Practitioner Type*	2004			2005			Cumulative through 2005	
	Number	Percent	% Change 2002-2003	Number	Percent	% Change 2003-2004	Number	Percent
Physicians	14,389	81.4%	-5.6%	14,034	81.1%	-2.5%	223,642	78.8%
Dentists	1,834	10.4%	-17.9%	1,736	10.0%	-5.3%	37,139	13.1%
Other Practitioners	1,447	8.2%	-1.0%	1,528	8.8%	5.6%	23,066	8.1%
All Practitioners	17,670	100.0%	-6.7%	17,298	100.0%	-2.1%	283,847	100.0%

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

* The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents. The "Dentists" category includes dental residents. The "Other Practitioners" category includes other health care practitioners, non-health care professionals and non-specified professionals.

Table 4: Mean and Median Medical Malpractice Payment Amounts by Malpractice Reason, 2005 and Cumulative Through 2005 - Physicians*
National Practitioner Data Bank (September 1, 1990 - December 31, 2005)

Malpractice Reason	2005 Only			Cumulative through 2005				
	Number of Payments	Mean Payment	Median Payment	Number of Payments	Mean Payment	Median Payment	Actual Mean Payment	Inflation-Adjusted Median Payment
Anesthesia Related	464	\$357,673	\$200,000	7,062	\$271,465	\$100,000	\$318,926	\$119,226
Behavioral Health Related**	47	\$310,647	\$120,000	90	\$246,910	\$100,000	\$249,011	\$101,241
Diagnosis Related	4,542	\$315,543	\$200,000	76,133	\$251,889	\$140,912	\$294,195	\$163,751
Equipment or Product Related	76	\$160,000	\$66,875	853	\$88,411	\$25,000	\$102,732	\$28,975
IV or Blood Products Related	26	\$183,973	\$131,250	811	\$177,058	\$75,000	\$214,427	\$92,900
Medication Related	656	\$245,034	\$135,000	12,457	\$171,424	\$70,000	\$203,042	\$79,601
Monitoring Related	456	\$252,291	\$146,341	3,093	\$241,162	\$100,000	\$275,489	\$125,000
Obstetrics Related	1,258	\$523,534	\$300,000	19,304	\$395,762	\$200,000	\$464,859	\$250,000
Surgery Related	3,670	\$252,737	\$150,000	60,812	\$186,019	\$95,000	\$217,601	\$107,606
Treatment Related	2,610	\$228,423	\$112,101	39,785	\$197,515	\$92,500	\$231,621	\$105,777
Miscellaneous	229	\$171,746	\$70,000	3,097	\$119,855	\$30,000	\$142,358	\$37,160
All Reasons	14,034	\$294,153	\$174,569	223,497	\$229,972	\$100,000	\$269,256	\$128,764

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded. Cumulative totals exclude 120 Medical Malpractice Payment Reports that are missing data necessary to calculate payment or malpractice reason.

* The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents.

** The "Behavioral Health" category was added on January 31, 2004. Reports involving behavioral health issues filed before January 31, 2004 used other reporting categories. Cumulative data in this category includes only reports filed after January 31, 2004.

Table 5: Mean and Median Delay Between Incident and Payment by Malpractice Reason, 2005 and Cumulative Through 2005 - Physicians***National Practitioner Data Bank (September 1, 1990 - December 31, 2005)**

Malpractice Reason	2005 Only			Cumulative through 2005		
	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	463	4.09	4.01	7,032	3.76	3.30
Behavioral Health Related**	47	5.50	4.87	90	4.83	4.17
Diagnosis Related	4,530	4.85	4.38	75,784	4.82	4.24
Equipment or Product Related	76	3.74	3.49	846	6.03	3.65
IV or Blood Products Related	26	4.70	3.93	807	5.39	4.22
Medication Related	656	4.16	3.81	12,361	5.12	3.76
Monitoring Related	456	4.62	4.27	3,082	4.80	4.09
Obstetrics Related	1,256	5.99	4.94	19,218	6.16	4.93
Surgery Related	3,662	4.27	3.84	60,585	4.26	3.72
Treatment Related	2,604	4.50	4.04	39,598	4.70	4.01
Miscellaneous	229	4.27	3.61	3,057	4.41	3.52
All Reasons	14,005	4.66	4.13	222,460	4.75	4.04

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded. Medical Malpractice Payment Reports which are missing data necessary to calculate payment delay or malpractice reason (29 reports for 2003 and 1,037 reports cumulatively) are excluded.

* The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents.

** The "Behavioral Health" category was added on January 31, 2004. Reports involving behavioral health issues filed before January 31, 2004 used other reporting categories. Cumulative data in this category includes only reports filed after January 31, 2004.

**Table 6: Number of Medical Malpractice Payment Reports by Malpractice Reason - Professional Nurses (Registered Nurses, Nurse Anesthetists, Nurse Midwives, Nurse Practitioners, and Advanced Practice Nurses/Clinical Nurse Specialists)
National Practitioner Data Bank (September 1, 1990 - December 31, 2005)**

Malpractice Reason	RN (Professional) Nurse	Nurse Anesthetist	Nurse Midwife	Nurse Practitioner	Advanced Practice Nurse/ Clinical Nurse Specialist*	Total
Anesthesia Related	128	915	1	8	1	1,053
Behavioral Health Related**	3	1	0	1	0	5
Diagnosis Related	229	17	39	219	1	505
Equipment or Product Related	55	6	0	4	0	65
IV or Blood Products Related	161	14	0	2	0	177
Medication Related	555	29	3	62	1	650
Monitoring Related	695	17	15	24	0	751
Obstetrics Related	376	7	413	28	0	824
Surgery Related	361	63	9	12	1	446
Treatment Related	677	33	35	119	5	869
Miscellaneous	204	5	1	12	0	222
All Reasons	3,444	1,107	516	491	9	5,567

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded. Medical Malpractice Payment Reports which are missing data necessary to determine the malpractice reason (8 reports for RNs) are excluded.

* Reporting using the "Advanced Nurse Practitioner" category began on March 5, 2002. The "Advanced Nurse Practitioner" category was changed to "Clinical Nurse Specialist" on September 9, 2002. Prior to March 5, 2002, these nurses were included in the "RN (Professional Nurse)" category.

** The "Behavioral Health" category was added on January 31, 2004. Reports involving behavioral health issues filed before January 31, 2004 used other reporting categories. Cumulative data in this category includes only reports filed after January 31, 2004.

"A Professional Nurse is an individual who has received approved nursing education and training who holds a BSN degree (or equivalent), an ADN degree (or equivalent), or a hospital program diploma, and who holds a State license as a Registered Nurse. This definition includes Registered Nurses who have advanced training as Nurse Midwives, Nurse Anesthetists, Advanced Practice Nurses, etc."

Table 7: Mean and Median Medical Malpractice Payment Amounts by Malpractice Reason, 2005 and Cumulative through 2005 - Professional Nurses (Registered Nurses, Nurse Anesthetists, Nurse Midwives, Nurse Practitioners, and Advanced Practice Nurses/Clinical Nurse Specialists) National Practitioner Data Bank (September 1, 1990 - December 31, 2005)

Malpractice Reason	2005 Only			Cumulative through 2005				
	Number of Payments	Mean Payment	Median Payment	Actual			Inflation-Adjusted	
				Number of Payments	Mean Payment	Median Payment	Mean Payment	Median Payment
Anesthesia Related	68	\$368,594	\$110,938	1,053	\$261,779	\$100,000	\$309,042	\$123,867
Behavioral Health Related**	3	\$236,667	\$60,000	6	\$126,851	\$37,500	\$127,062	\$37,810
Diagnosis Related	80	\$263,207	\$100,000	504	\$290,458	\$125,000	\$335,067	\$140,494
Equipment or Product Related	6	\$64,002	\$61,695	65	\$155,682	\$40,000	\$193,125	\$43,667
IV or Blood Products Related	6	\$102,500	\$67,500	177	\$222,399	\$75,000	\$264,523	\$79,332
Medication Related	62	\$406,830	\$87,500	650	\$267,366	\$62,500	\$306,440	\$70,087
Monitoring Related	97	\$267,559	\$100,000	751	\$297,705	\$95,000	\$345,137	\$107,040
Obstetrics Related	90	\$675,032	\$288,750	824	\$533,086	\$249,832	\$598,187	\$264,483
Surgery Related	52	\$124,505	\$60,000	446	\$148,716	\$50,000	\$173,544	\$55,471
Treatment Related	99	\$192,159	\$75,000	869	\$168,650	\$50,000	\$191,070	\$61,934
Miscellaneous	23	\$95,952	\$47,500	222	\$237,216	\$40,000	\$268,997	\$49,547
All Reasons	586	\$319,905	\$100,000	5,567	\$282,821	\$90,000	\$324,929	\$102,482

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded. Medical Malpractice Payment Reports which are missing data necessary to determine the malpractice reason (8 reports cumulatively) are excluded.

** The "Behavioral Health" category was added on January 31, 2004. Reports involving behavioral health issues filed before January 31, 2004 used other reporting reports filed after January 31, 2004.

"A Professional Nurse is an individual who has received approved nursing education and training who holds a BSN degree (or equivalent), an ADN degree (or equivalent), or a hospital program diploma, and who holds a State license as a Registered Nurse. This definition includes Registered Nurses who have advanced training as Nurse Midwives, Nurse Anesthetists, Advanced Practice Nurses, etc."

Table 8: Actual and Adjusted Medical Malpractice Payment Reports and Ratio of Adjusted Medical Malpractice Payment Reports by State - Physicians* and Professional Nurses (Registered Nurses, Nurse Anesthetists, Nurse Midwives, Nurse Practitioners, and Advanced Practice Nurses/Clinical National Practitioner Data Bank (September 1, 1990 - December 31, 2005)

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	82	82	905	11.04	0.09
Alaska	18	18	283	15.72	0.06
Arizona	100	100	3,577	35.77	0.03
Arkansas	44	44	1,071	24.34	0.04
California	229	229	22,906	100.03	0.01
Colorado	94	94	2,369	25.20	0.04
Connecticut	32	32	2,349	73.41	0.01
Delaware	9	9	559	62.11	0.02
District of Columbia	52	52	856	16.46	0.04
Florida**	455	455	15,784	34.69	0.03
Georgia	172	172	3,938	22.90	0.04
Hawaii	10	10	517	51.70	0.02
Idaho	35	35	474	13.54	0.07
Illinois	175	175	9,086	51.92	0.02
Indiana**	27	23	2,833	123.17	0.01
Iowa	31	31	1,777	57.32	0.02
Kansas**	99	74	1,693	22.88	0.04
Kentucky	67	67	2,449	36.55	0.03
Louisiana**	173	150	2,866	19.11	0.05
Maine	15	15	605	40.40	0.02
Maryland	105	105	3,658	34.84	0.03
Massachusetts	304	304	4,049	13.32	0.08
Michigan	127	127	11,365	89.49	0.01
Minnesota	43	43	1,662	38.65	0.03
Mississippi	60	60	1,695	28.25	0.04
Missouri	230	229	3,914	17.09	0.06
Montana	18	18	919	51.06	0.02
Nebraska**	46	44	927	21.07	0.05
Nevada	32	32	1,306	40.81	0.02
New Hampshire	40	40	826	20.65	0.05
New Jersey	667	667	8,991	13.48	0.07
New Mexico**	89	87	1,179	13.55	0.07
New York	300	300	28,743	95.81	0.01
North Carolina	104	104	3,374	32.44	0.03
North Dakota	8	8	380	47.50	0.02
Ohio	154	154	9,327	60.56	0.02
Oklahoma	84	84	1,707	20.32	0.06
Oregon	47	47	1,451	30.87	0.03
Pennsylvania**	184	158	13,179	83.41	0.01
Rhode Island	17	17	931	54.76	0.02
South Carolina**	41	37	1,463	39.54	0.03
South Dakota	16	16	369	23.06	0.04
Tennessee	139	139	2,659	19.13	0.05
Texas	478	478	15,789	33.03	0.03
Utah	24	24	1,565	65.21	0.02
Vermont	7	7	420	60.00	0.02
Virginia	97	97	3,132	32.29	0.03
Washington	83	83	3,577	43.10	0.02
West Virginia	43	43	2,967	69.47	0.01
Wisconsin**	46	44	1,469	33.84	0.03
Wyoming	10	10	393	39.30	0.03
All Jurisdictions***	5,575	5,486	211,917	38.63	0.03

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

* The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents.

** A Professional Nurse is an individual who has received approved nursing education and training who holds a BSN degree (or equivalent), an ADN degree (or equivalent), or a hospital program diploma, and who holds a State license as a Registered Nurse. This definition includes Registered Nurses who have advanced training as Nurse Midwives, Nurse Anesthetists, Advanced Practice Nurses, etc."

*** Adjusted columns exclude reports from State patient compensation funds 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 an 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.

*** The total includes reports for American Samoa, Guam, Northern Mariana Islands, Puerto Rico, U.S. Virgin Islands, and Armed Forces locations overseas (11 reports for nurses and 1573 reports for physicians); additional reports that lack information about the State are also included (2 reports for nurses and 20 reports for physicians).

**Table 9: Mean and Median Medical Malpractice Payment Amounts by Malpractice Reason, 2005 and Cumulative Through 2005 - Physician Assistants
National Practitioner Data Bank (September 1, 1990 - December 31, 2005)**

Malpractice Reason	2005 Only			Cumulative through 2005				
	Number of Payments	Mean Payment	Median Payment	Number of Payments	Mean Payment	Median Payment	Mean Payment	Median Payment
Anesthesia Related	1	\$75,000	\$75,000	7	\$106,841	\$50,000	\$113,857	\$52,888
Behavioral Health Related*	0	--	--	0	--	--	--	--
Diagnosis Related	64	\$223,948	\$137,500	570	\$191,621	\$100,000	\$210,359	\$105,777
Equipment or Product Related	1	\$67,500	\$67,500	2	\$47,500	\$47,500	\$47,841	\$47,481
IV or Blood Products Related	0	--	--	3	\$256,250	\$225,000	\$266,000	\$237,997
Medication Related	13	\$136,546	\$36,000	89	\$108,212	\$40,000	\$118,554	\$43,205
Monitoring Related	1	\$50,000	\$50,000	15	\$143,788	\$119,827	\$158,788	\$122,801
Obstetrics Related	0	--	--	5	\$258,000	\$125,000	\$291,989	\$135,017
Surgery Related	5	\$118,000	\$100,000	47	\$87,297	\$40,000	\$98,283	\$44,577
Treatment Related	22	\$303,294	\$44,375	247	\$117,908	\$35,000	\$129,493	\$37,022
Miscellaneous	5	\$67,850	\$56,250	36	\$119,450	\$50,000	\$128,437	\$57,411
All Reasons	112	\$213,411	\$97,625	1021	\$158,119	\$75,000	\$173,571	\$81,010

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

* The "Behavioral Health" category was added on January 31, 2004. Reports involving behavioral health issues filed before January 31, 2004 used other reporting categories. Cumulative data in this category includes only reports filed after January 31, 2004.

Table 10: Actual and Adjusted Medical Malpractice Payment Reports and Ratio of Adjusted Medical Practitioner Reports by State, Physicians and Dentists, Cumulative Through 2005
National Practitioner Data Bank (September 1, 1990 - December 31, 2005)

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	915	905	179	179	5.06	0.20
Alaska	283	283	81	80	3.54	0.28
Arizona	3,598	3,577	549	549	6.52	0.15
Arkansas	1,081	1,071	157	157	6.82	0.15
California	22,939	22,906	7,580	7,580	3.02	0.33
Colorado	2,388	2,369	452	452	5.24	0.19
Connecticut	2,354	2,349	574	574	4.09	0.24
Delaware	572	559	60	60	9.32	0.11
District of Columbia	859	866	136	136	6.72	0.16
Florida**	15,860	15,784	1,855	1,855	8.51	0.12
Georgia	3,958	3,938	682	682	5.77	0.17
Hawaii	517	517	130	130	3.98	0.25
Idaho	476	474	68	68	6.97	0.14
Illinois	9,108	9,086	1,410	1,410	6.44	0.16
Indiana**	4,325	2,833	407	377	7.51	0.13
Iowa	1,780	1,777	212	212	8.38	0.12
Kansas**	2,528	1,693	251	249	6.80	0.15
Kentucky	2,472	2,449	365	365	6.71	0.15
Louisiana**	4,126	2,866	411	385	7.44	0.13
Maine	608	606	111	111	5.46	0.18
Maryland	3,669	3,658	822	822	4.45	0.22
Massachusetts	4,060	4,049	988	988	4.10	0.24
Michigan	11,378	11,365	1,597	1,597	7.12	0.14
Minnesota	1,675	1,662	315	315	5.28	0.19
Mississippi	1,702	1,695	150	149	11.38	0.09
Missouri	4,041	3,914	536	536	7.50	0.14
Montana	922	919	88	88	10.44	0.10
Nebraska**	1,181	927	143	143	6.48	0.15
Nevada	1,310	1,306	214	214	6.10	0.16
New Hampshire	827	826	167	167	4.95	0.20
New Jersey	9,087	8,991	1,270	1,270	7.08	0.14
New Mexico**	1,516	1,179	193	193	6.11	0.16
New York	28,777	26,743	4,535	4,535	6.34	0.16
North Carolina	3,411	3,374	291	291	11.59	0.09
North Dakota	384	380	37	37	10.27	0.10
Ohio	9,348	9,327	1,204	1,204	7.75	0.13
Oklahoma	1,728	1,707	370	370	4.61	0.22
Oregon	1,456	1,451	286	286	5.07	0.20
Pennsylvania**	19,333	13,197	2,343	2,343	5.63	0.18
Rhode Island	933	931	127	127	7.33	0.14
South Carolina**	1,870	1,463	158	152	9.63	0.10
South Dakota	371	369	59	59	6.25	0.16
Tennessee	2,674	2,659	334	334	7.96	0.13
Texas	15,831	15,799	2,068	2,068	7.63	0.13
Utah	1,567	1,565	497	497	3.15	0.32
Vermont	421	420	84	84	5.00	0.20
Virginia	3,144	3,132	543	543	5.77	0.17
Washington	3,586	3,577	1,225	1,225	2.92	0.34
West Virginia	2,091	2,087	166	166	12.57	0.08
Wisconsin**	1,731	1,489	493	493	3.02	0.33
Wyoming	394	393	40	40	9.83	0.10
All Jurisdictions***	223,642	211,917	37,139	37,073	5.72	0.17

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

* The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents. The "Dentists" category includes dental residents.

** Adjusted columns exclude reports from State patient compensation and similar State funds which make payments in excess of amounts paid by a practitioner's primary malpractice carrier. When payments are made by these funds, two reports are filed with the NPDB (one from the primary insurer and one from the fund) whenever a total malpractice settlement or award exceeds a maximum set by the State for the practitioner's primary malpractice carrier. The States marked with double 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 additional details.

*** The total includes reports for American Samoa, Guam, Northern Mariana Islands, Puerto Rico, U.S. Virgin Islands, and Armed Forces locations overseas (2457 reports for physicians and 121 reports for dentists); an additional 25 reports (20 reports for physicians and 5 reports for dentists) that lack information about the State are also included in the total.

Table 11: Number of Medical Malpractice Payment Reports by State, Last Five Years - Physicians*
National Practitioner Data Bank (January 1, 2001 - December 31, 2005)

State	2001		2002		2003		2004		2005	
	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	75	75	78	78	57	57	64	64	49	48
Alaska	20	20	20	20	19	19	17	17	22	22
Arizona	296	294	272	269	316	315	212	210	293	291
Arkansas	82	81	95	94	73	72	78	78	76	74
California	1,461	1,459	1,382	1,378	1,362	1,359	1,243	1,240	1,196	1,193
Colorado	135	133	179	179	178	176	151	151	135	135
Connecticut	172	170	177	177	225	225	168	168	148	147
Delaware	51	51	55	50	67	66	29	29	34	34
District of Columbia	75	75	60	58	45	45	46	46	61	61
Florida**	1,299	1,290	1,259	1,253	1,357	1,347	1,212	1,202	1,149	1,142
Georgia	265	265	281	280	328	326	335	332	283	280
Hawaii	41	41	35	35	49	49	36	36	19	19
Idaho	30	30	29	28	39	38	31	31	41	41
Illinois	529	528	499	487	504	502	478	474	486	483
Indiana**	322	217	155	154	433	190	236	136	201	131
Iowa	145	144	134	134	124	124	101	101	113	113
Kansas**	163	112	158	108	151	96	171	105	188	133
Kentucky	185	184	265	263	220	217	161	158	169	166
Louisiana**	308	212	318	198	294	187	279	194	315	193
Maine	39	39	37	37	39	38	37	37	44	43
Maryland	283	283	296	296	311	311	267	263	252	250
Massachusetts	338	336	227	227	257	255	267	266	269	267
Michigan	793	792	756	754	583	582	546	545	472	469
Minnesota	108	108	104	101	108	105	96	96	78	77
Mississippi	145	144	158	158	112	112	103	102	92	91
Missouri	297	287	252	250	229	220	271	268	236	235
Montana	68	68	64	64	62	62	41	41	51	50
Nebraska**	94	75	102	83	89	64	83	64	195	112
Nevada	90	89	122	122	110	110	103	102	112	111
New Hampshire	59	59	42	42	54	54	46	45	57	57
New Jersey	913	903	683	671	610	596	618	606	728	713
New Mexico**	110	89	89	89	76	74	83	83	152	88
New York	2,072	2,069	1,836	1,831	1,816	1,812	1,948	1,947	1,825	1,820
North Carolina	224	224	269	266	222	217	262	260	202	198
North Dakota	23	23	29	29	34	33	25	25	31	31
Ohio	674	674	533	530	586	583	486	485	441	439
Oklahoma	137	136	124	124	142	138	166	166	183	182
Oregon	87	87	111	110	128	128	112	111	81	80
Pennsylvania**	1,560	1,042	1,334	890	1,281	830	1,328	881	1,126	727
Rhode Island	59	59	55	55	75	74	44	44	41	41
South Carolina*	186	130	162	121	167	128	175	116	192	137
South Dakota	23	23	21	21	40	40	24	23	37	37
Tennessee	203	203	211	211	171	171	209	209	169	167
Texas	1,165	1,163	1,082	1,080	1,097	1,091	1,101	1,098	1,060	1,055
Utah	108	107	117	117	100	100	92	92	106	106
Vermont	24	24	19	19	27	26	21	21	16	16
Virginia	216	214	221	218	203	202	188	186	167	167
Washington	254	254	244	243	222	222	205	203	193	193
West Virginia	207	207	177	177	111	111	85	85	83	82
Wisconsin**	106	99	121	109	118	110	86	81	92	86
Wyoming	27	27	34	34	25	25	17	17	28	28
All Jurisdictions***	16,589	15,659	15,221	14,408	15,245	14,232	14,389	13,536	14,034	13,096

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

* The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents.

** Adjusted columns exclude reports from State patient compensation and similar State funds which make payments in excess of amounts paid by a practitioner's primary malpractice carrier. When payments are made by these funds, two reports are filed with the NPDB (one from the primary insurer and one from the fund) whenever a total malpractice settlement or award exceeds a maximum set by the State for the practitioner's primary malpractice carrier. The States marked with double 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 additional details.

*** The total includes reports for American Samoa, Guam, Northern Mariana Islands, Puerto Rico, U.S. Virgin Islands, and Armed Forces locations overseas (242 reports in 2001, 168 reports in 2002, 197 reports in 2003, 204 reports in 2004, and 245 reports in 2005); one additional report (in 2003) that lacks information about the State is also included in the total.

Table 12: Number of Medical Malpractice Payment Reports by State, Last Five Years - Dentists*
National Practitioner Data Bank (January 1, 2001 - December 31, 2005)

State	2001		2002		2003		2004		2005	
	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	14	14	12	12	10	10	9	9	8	8
Alaska	7	7	2	2	8	8	6	6	8	8
Arizona	32	32	33	33	35	35	23	23	28	28
Arkansas	12	12	12	12	7	7	4	4	13	13
California	385	385	451	451	374	374	383	383	345	345
Colorado	24	24	24	24	28	28	20	20	28	28
Connecticut	20	20	21	21	42	42	46	46	25	25
Delaware	5	5	3	3	1	1	2	2	1	1
District of Columbia	8	8	4	4	7	7	4	4	7	7
Florida**	126	126	111	111	112	112	69	69	102	102
Georgia	34	34	57	57	37	37	23	23	37	37
Hawaii	7	7	3	3	6	6	7	7	9	9
Idaho	2	2	4	4	8	8	7	7	3	3
Illinois	78	78	84	84	48	48	47	47	48	48
Indiana**	15	15	14	14	14	14	18	18	17	13
Iowa	13	13	17	17	13	13	11	11	10	10
Kansas**	14	14	9	9	11	11	15	15	14	14
Kentucky	24	24	21	21	15	15	17	17	17	17
Louisiana**	24	19	18	17	30	25	27	23	17	16
Maine	5	5	7	7	7	7	8	8	3	3
Maryland	56	56	52	52	28	28	34	34	23	23
Massachusetts	42	42	59	59	54	54	44	44	49	49
Michigan	79	79	60	60	61	61	50	50	58	58
Minnesota	14	14	10	10	15	15	13	13	6	6
Mississippi	10	10	12	12	7	7	9	9	8	8
Missouri	30	30	21	21	12	12	15	15	13	13
Montana	4	4	7	7	2	2	3	3	7	7
Nebraska**	8	8	6	6	10	10	7	7	11	11
Nevada	17	17	26	26	16	16	52	52	11	11
New Hampshire	8	8	7	7	8	8	10	10	9	9
New Jersey	125	125	76	76	70	70	61	61	57	57
New Mexico**	19	19	16	16	12	12	9	9	13	13
New York	471	471	255	255	430	430	314	314	297	297
North Carolina	18	18	19	19	13	13	11	11	13	13
North Dakota	1	1	7	7	1	1	2	2	2	2
Ohio	53	53	55	55	51	51	39	39	47	47
Oklahoma	34	34	30	30	28	28	16	16	14	14
Oregon	25	25	14	14	14	14	15	15	16	16
Pennsylvania**	147	147	121	121	100	100	81	81	88	86
Rhode Island	8	8	4	4	4	4	5	5	6	6
South Carolina**	10	10	15	12	13	12	15	15	9	8
South Dakota	1	1	3	3	2	2	3	3	4	4
Tennessee	23	23	26	26	14	14	16	16	16	16
Texas	99	99	114	114	84	84	107	1107	79	79
Utah	6	6	32	32	17	17	17	17	14	14
Vermont	4	4	8	8	6	6	2	2	4	4
Virginia	29	29	22	22	17	17	22	22	40	40
Washington	56	56	51	51	278	278	57	57	49	49
West Virginia	16	16	7	7	14	14	11	11	7	7
Wisconsin**	33	33	16	16	25	25	36	36	17	17
Wyoming	3	3	11	11	2	2	2	2	2	2
All Jurisdictions***	2,306	2,301	2,076	2,072	2,235	2,229	1,834	1,830	1,736	1,730

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

*The "Dentists" category includes dental residents.

** Adjusted columns exclude reports from State patient compensation and similar State funds which make payments in excess of amounts paid by a practitioner's primary malpractice carrier. When payments are made by these funds, two reports are filed with the NPDB (one from the primary insurer and one from the fund) whenever a total malpractice settlement or award exceeds a maximum set by the State for the practitioner's primary malpractice carrier. The States marked with asterisks have 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 additional details.

*** The total includes reports for American Samoa, Guam, Northern Mariana Islands, Puerto Rico, U.S. Virgin Islands, and Armed Forces locations overseas (8 reports in 2001, 7 reports in 2002, 14 reports in 2003, 10 reports in 2004, and 9 reports in 2005).

Table 13: Mean and Median Medical Malpractice Payment and Mean and Median Delay Between Incident and Payment by State, 2005 and Cumulative Through 2005 - Physicians*
National Practitioner Data Bank (September 1, 1990 - December 31, 2005)

State	Payment Amounts						Delay Between Incident and Payment			
	2005 Only			Cumulative through 2005			2005 Only		Cumulative through 2005	
	Mean Payment	Median Payment	Rank of 2004 Median Payment***	Mean Payment	Median Payment	Rank of Cumulative Median Payment***	Mean Delay Between Incident and Payment (Years)	Median Delay Between Incident and Payment (Years)	Mean Delay Between Incident and Payment (Years)	Median Delay Between Incident and Payment (Years)
Alabama	\$256,056	\$135,000	35	\$347,642	\$150,000	6	4.26	4.17	4.29	3.98
Alaska	\$533,524	\$257,950	5	\$253,354	\$100,000	23	3.82	3.76	3.90	3.60
Arizona	\$304,851	\$192,500	17	\$241,319	\$117,769	22	3.84	3.57	3.85	3.38
Arkansas	\$311,623	\$176,188	22	\$205,727	\$100,000	23	4.07	3.62	3.55	3.15
California	\$210,060	\$70,000	49	\$140,332	\$50,000	50	3.28	2.67	3.32	2.78
Colorado	\$277,620	\$125,000	37	\$198,147	\$75,000	43	3.87	3.39	3.44	3.04
Connecticut	\$735,569	\$375,000	1	\$394,723	\$174,299	5	5.42	4.88	5.43	5.28
Delaware	\$456,677	\$231,250	12	\$277,431	\$122,500	19	3.68	3.50	4.44	4.11
District of Columbia	\$367,541	\$250,000	8	\$400,729	\$200,000	1	4.11	3.50	4.70	3.99
Florida**	\$240,256	\$175,000	23	\$232,514	\$150,000	6	4.10	3.91	3.99	3.50
Georgia	\$337,322	\$175,000	23	\$306,705	\$150,000	6	4.49	3.90	3.77	3.39
Hawaii	\$577,834	\$250,000	8	\$301,110	\$100,000	23	3.94	3.66	4.02	3.81
Idaho	\$190,122	\$100,000	42	\$218,698	\$74,500	49	4.69	4.20	3.69	3.27
Illinois	\$510,668	\$356,482	2	\$353,615	\$200,000	1	5.42	5.01	5.70	5.15
Indiana**	\$271,139	\$150,000	30	\$179,520	\$75,000	42	6.15	5.83	5.59	5.22
Iowa	\$199,179	\$125,000	37	\$197,860	\$80,000	39	3.72	3.26	3.33	3.12
Kansas**	\$156,552	\$158,444	29	\$161,912	\$118,491	21	3.66	3.40	3.96	3.33
Kentucky	\$234,316	\$100,000	42	\$189,332	\$75,000	43	4.84	4.20	4.14	3.51
Louisiana**	\$181,897	\$100,000	42	\$146,965	\$90,013	36	5.67	4.94	5.20	4.66
Maine	\$239,414	\$190,150	18	\$263,003	\$150,000	6	3.75	3.62	4.09	3.72
Maryland	\$371,299	\$255,000	6	\$271,368	\$150,000	6	4.00	3.83	4.56	4.17
Massachusetts	\$476,428	\$265,000	6	\$329,596	\$187,500	4	6.16	5.99	5.95	5.65
Michigan	\$134,837	\$97,500	46	\$107,919	\$75,000	43	4.40	3.90	4.33	3.64
Minnesota	\$449,819	\$198,000	14	\$217,600	\$80,000	39	3.56	3.12	3.23	2.85
Mississippi	\$199,155	\$84,500	47	\$216,889	\$100,000	23	4.64	3.99	4.21	3.83
Missouri	\$303,064	\$197,500	15	\$229,578	\$120,000	20	4.57	4.13	4.46	3.87
Montana	\$269,141	\$170,000	26	\$180,186	\$75,000	43	3.66	3.18	4.20	3.69
Nebraska**	\$98,998	\$59,618	51	\$135,277	\$82,500	38	4.53	4.57	4.07	3.81
Nevada	\$245,924	\$150,000	30	\$272,883	\$125,000	15	4.91	4.59	4.52	4.25
New Hampshire	\$358,224	\$250,000	8	\$267,462	\$150,000	6	4.27	4.03	4.70	4.13
New Jersey	\$374,247	\$290,000	4	\$282,780	\$150,000	6	5.88	5.10	6.08	5.12
New Mexico**	\$239,150	\$150,000	30	\$154,374	\$100,000	23	3.68	3.22	3.81	3.37
New York	\$390,602	\$250,000	8	\$293,423	\$150,000	6	5.56	4.98	6.70	5.81
North Carolina	\$308,528	\$167,550	27	\$271,015	\$125,000	15	4.62	4.02	3.87	3.50
North Dakota	\$254,147	\$175,000	23	\$200,062	\$85,000	36	3.54	3.28	3.42	3.21
Ohio	\$305,501	\$187,500	19	\$247,122	\$100,000	23	4.31	3.72	4.31	3.53
Oklahoma	\$243,224	\$107,500	40	\$253,335	\$95,000	34	4.29	3.80	3.95	3.42
Oregon	\$314,973	\$150,000	30	\$225,150	\$98,950	33	3.20	3.07	3.41	3.03
Pennsylvania**	\$346,832	\$300,000	3	\$245,389	\$192,652	3	5.87	5.12	5.90	5.43
Rhode Island	\$362,268	\$182,500	21	\$277,458	\$125,000	15	6.08	6.28	6.17	5.87
South Carolina**	\$167,587	\$100,000	42	\$193,603	\$100,000	23	4.58	4.28	4.59	4.16
South Dakota	\$268,200	\$107,500	40	\$218,856	\$75,000	43	4.51	3.63	3.59	3.22
Tennessee	\$254,960	\$130,000	36	\$224,553	\$98,969	32	3.73	3.38	3.73	3.24
Texas	\$191,060	\$150,000	30	\$195,283	\$100,000	23	3.70	3.33	3.81	3.39
Utah	\$153,393	\$62,500	50	\$157,213	\$50,000	50	3.89	3.34	3.62	3.32
Vermont	\$161,478	\$82,500	48	\$149,647	\$75,000	43	4.17	4.18	4.32	4.06
Virginia	\$353,882	\$225,000	13	\$221,893	\$125,000	15	3.78	3.30	3.82	3.27
Washington	\$331,034	\$187,500	19	\$223,179	\$85,000	36	3.88	3.74	4.25	3.66
West Virginia	\$231,753	\$125,000	37	\$219,658	\$100,000	23	5.06	4.25	5.31	4.15
Wisconsin**	\$370,236	\$185,000	28	\$331,414	\$145,000	14	4.06	3.73	4.76	4.18
Wyoming	\$290,464	\$193,750	16	\$180,489	\$79,584	41	3.89	3.07	3.26	3.01
All Jurisdictions***	\$294,153	\$174,569		\$229,944	\$100,000		4.66	4.13	4.75	4.04

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

* The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents.

** 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.

*** One denotes the largest median payment; 51 denotes the lowest median payment.

**** The total includes reports for American Samoa, Guam, Northern Mariana Islands, Puerto Rico, U.S. Virgin Islands, and Armed Forces locations overseas (242 reports in 2005 and 2,447 reports cumulatively for payment amount and 2,422 reports cumulatively for delay between incident and payment); also included in the total are additional reports that lack information about the State (20 reports cumulatively for payment amount and 18 reports cumulatively for delay between incident and payment).

Table 14: Number, Percent Distribution, and Percent Change of Adverse Action and Medicare/Medicaid Exclusion Reports by Practitioner Type, Last Five Years and Cumulative Through 2005

National Practitioner Data Bank (September 1, 1990 - December 31, 2005)

Report Type	2001			2002			2003			2004			2005			Cumulative through 2005	
	Number	Percent	% Change 1999-2000	Number	Percent	% Change 2000-2001	Number	Percent	% Change 2001-2002	Number	Percent	% Change 2002-2003	Number	Percent	% Change 2003-2004	Number	Percent
State Licensure Total	3,146	43.6%	-26.3%	3,950	50.7%	25.6%	3,977	54.0%	0.7%	4,017	53.3%	1.0%	4,045	64.2%	0.7%	56,128	54.8%
Physicians*	2,580	35.7%	-21.6%	3,301	42.4%	27.9%	3,332	45.3%	0.9%	3,334	44.2%	0.1%	3,329	52.8%	-0.1%	45,375	44.3%
Dentists*	566	7.8%	-42.1%	649	8.3%	14.7%	645	8.8%	-0.6%	683	9.1%	5.9%	716	11.4%	4.8%	10,724	10.5%
Other Practitioners*	0	0.0%	0.0%	0	0.0%	...	0	0.0%	...	0	0.0%	...	0	0.0%	...	29	0.0%
Clinical Privilege Total	1,027	14.2%	-1.3%	962	12.4%	-6.3%	972	13.2%	1.0%	1,084	14.4%	11.5%	908	14.4%	-16.2%	14,311	14.0%
Physicians*	956	13.2%	-0.4%	905	11.6%	-5.3%	909	12.3%	0.4%	944	12.5%	3.9%	837	13.3%	-11.3%	13,471	13.2%
Dentists*	37	0.5%	54.2%	19	0.2%	-48.6%	20	0.3%	5.3%	90	1.2%	350.0%	19	0.3%	-78.9%	340	0.3%
Other Practitioners*	34	0.5%	-39.2%	38	0.5%	11.8%	43	0.6%	13.2%	50	0.7%	16.3%	52	0.8%	4.0%	500	0.5%
Professional Society Membership Total	33	0.5%	...	44	0.6%	33.3%	46	0.6%	...	47	0.6%	2.2%	68	1.1%	44.7%	589	0.6%
Physicians*	24	0.3%	...	38	0.5%	58.3%	46	0.6%	...	41	0.5%	-10.9%	42	0.7%	2.4%	517	0.5%
Dentists*	9	0.1%	...	6	0.1%	...	0	0.0%	...	6	0.1%	...	25	0.4%	...	71	0.1%
Other Practitioners*	0	0.0%	...	0	0.0%	...	0	0.0%	...	0	0.0%	...	1	0.0%	...	1	0.0%
DEA Total	9	0.1%	...	0	0.0%	...	54	0.7%	...	59	0.8%	...	20	0.3%	-66.1%	436	0.4%
Physicians*	9	0.1%	...	0	0.0%	...	46	0.6%	...	47	0.6%	...	19	0.3%	-59.6%	404	0.4%
Dentists*	0	0.0%	...	0	0.0%	...	5	0.1%	...	7	0.1%	...	1	0.0%	-85.7%	22	0.0%
Other Practitioners*	0	0.0%	...	0	0.0%	...	3	0.0%	...	5	0.1%	...	0	0.0%	-100.0%	10	0.0%
Medicare/Medicaid Exclusion Total**	3,007	41.6%	-56.1%	2,833	36.4%	-5.8%	2,312	31.4%	-18.4%	2,333	30.9%	0.9%	1,261	20.0%	-45.9%	30,899	30.2%
Physicians*	597	8.3%	-67.3%	412	5.3%	-31.0%	224	3.0%	-45.6%	177	2.3%	-21.0%	102	1.6%	-42.4%	6,645	6.5%
Dentists*	177	2.5%	-67.8%	130	1.7%	-26.6%	83	1.1%	-36.2%	85	1.1%	2.4%	44	0.7%	-48.2%	2,178	2.1%
Other Practitioners*	2,233	30.9%	-50.2%	2,291	29.4%	2.6%	2,005	27.2%	-12.5%	2,071	27.5%	3.3%	1,115	17.7%	-46.2%	22,076	21.6%
All Reports	7,222	100.0%	-40.6%	7,789	100.0%	7.9%	7,361	100.0%	-5.5%	7,540	100.0%	2.4%	6,302	100.0%	-16.4%	102,363	100.0%

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded. Percent changes that cannot be calculated because no reports were submitted during one of the specified years are indicated by "..."

* The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents. The "Dentists" category includes dentists and dental interns and residents. The "Other Practitioners" category includes other health care practitioners, non-health care 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. Exclusion Reports for non-health care practitioners are being removed from the NPDB.

Table 15: 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, 2005)

State	Number of Hospitals with "Active" NPDB Registrations	Number of "Active" Hospitals that Have Never Reported	Percent of Hospitals that Have Never Reported
Alabama	128	80	62.5%
Alaska	18	10	55.6%
Arizona	90	42	46.7%
Arkansas	106	59	55.7%
California	475	184	38.7%
Colorado	80	44	55.0%
Connecticut	45	15	33.3%
Delaware	10	3	30.0%
District of Columbia	15	4	37.5%
Florida	251	125	49.8%
Georgia	197	87	44.2%
Hawaii	28	16	57.1%
Idaho	49	31	63.3%
Illinois	224	91	40.6%
Indiana	154	75	48.7%
Iowa	122	80	65.6%
Kansas	157	111	70.7%
Kentucky	125	69	55.2%
Louisiana	238	177	74.4%
Maine	42	19	45.2%
Maryland	72	31	43.1%
Massachusetts	113	55	48.7%
Michigan	182	74	40.7%
Minnesota	140	93	66.4%
Mississippi	113	73	64.6%
Missouri	147	75	51.0%
Montana	53	36	67.9%
Nebraska	96	65	67.7%
Nevada	47	28	59.6%
New Hampshire	32	9	28.1%
New Jersey	115	41	35.7%
New Mexico	49	25	51.0%
New York	262	86	32.8%
North Carolina	140	70	50.0%
North Dakota	50	36	72.0%
Ohio	223	99	44.4%
Oklahoma	157	105	66.9%
Oregon	70	26	37.1%
Pennsylvania	274	124	45.3%
Rhode Island	15	4	26.7%
South Carolina	78	38	48.7%
South Dakota	58	44	75.9%
Tennessee	157	89	56.7%
Texas	554	364	63.9%
Utah	48	18	37.5%
Vermont	17	6	35.3%
Virginia	116	46	39.7%
Washington	96	39	40.6%
West Virginia	69	34	49.3%
Wisconsin	144	85	59.0%
Wyoming	27	19	70.4%
All Jurisdictions**	6,318	3,283	52.0%

* "Currently active" registered hospitals are those listed by the NPDB as having active status registrations on December 31, 2004. A few hospitals have more than one registration and are included more than once in this table. Non-Federal hospitals are hospitals not owned and operated by the Federal government.

** The total includes hospitals in American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and U.S. Virgin Islands (50 hospitals with active registrations, 34 hospitals which have never reported).

Table 16: Clinical Privileges Reports and Ratio of Adverse Clinical Privileges Reports to Adverse In-State Licensure Reports by State - Physicians*
National Practitioner Data Bank (September 1, 1990 - December 31, 2005)

State	Number of Clinical Privileges Reports*	Number of Clinical Privileges Reports Adverse to the Practitioner**	Number of Licensure Reports Adverse to the Practitioner for In-State Physicians	Ratio of Clinical Privileges Reports Adverse to the Practitioner to In-State Licensure Reports Adverse to the Practitioner
Alabama	172	157	378	0.42
Alaska	28	24	115	0.21
Arizona	405	366	1,046	0.36
Arkansas	128	115	190	0.61
California	1,607	1,491	3,462	0.43
Colorado	244	230	975	0.24
Connecticut	87	84	418	0.20
Delaware	35	32	29	1.10
District of Columbia	49	45	46	0.83
Florida	694	635	1,562	0.41
Georgia	429	402	811	0.50
Hawaii	59	54	36	1.50
Idaho	61	52	82	0.63
Illinois	359	333	811	0.41
Indiana	299	274	202	1.36
Iowa	122	110	379	0.29
Kansas	211	197	192	1.03
Kentucky	185	174	591	0.29
Louisiana	166	168	442	0.38
Maine	64	61	156	0.39
Maryland	311	290	844	0.34
Massachusetts	522	464	670	0.69
Michigan	448	413	1,265	0.33
Minnesota	191	176	329	0.53
Mississippi	88	84	336	0.25
Missouri	232	217	556	0.39
Montana	56	49	103	0.48
Nebraska	122	112	79	1.42
Nevada	198	167	113	1.48
New Hampshire	68	63	117	0.54
New Jersey	391	355	953	0.37
New Mexico	75	70	82	0.85
New York	944	869	2,071	0.42
North Carolina	252	228	333	0.68
North Dakota	44	41	102	0.40
Ohio	583	538	1,836	0.29
Oklahoma	218	204	532	0.38
Oregon	166	154	517	0.30
Pennsylvania	499	464	632	0.73
Rhode Island	76	71	122	0.58
South Carolina	187	168	331	0.51
South Dakota	27	26	31	0.84
Tennessee	256	236	361	0.65
Texas	903	830	1,940	0.43
Utah	94	91	177	0.51
Vermont	43	36	91	0.40
Virginia	297	271	1,081	0.25
Washington	314	285	534	0.53
West Virginia	113	100	401	0.25
Wisconsin	221	198	263	0.70
Wyoming	25	24	52	0.46
All Jurisdictions***	13,471	12,372	28,808	0.43

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded. Clinical Privileges Reports were attributed to States based on the physician's reported work State. If work State was not included in a report, home State was used. Licensure Reports were considered to be for In-State physicians if the State of the board taking a reported action was the same as the State of the clinical privileges action as described above.

* The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents.

** "Clinical Privileges Reports" include truly adverse actions (e.g., revocations, probations, suspensions, reprimands, etc.) as well as reportable "adverse actions" which are not adverse to the practitioner (e.g., restorations and reinstatements). "Reports Adverse to the Practitioner" exclude restorations, reinstatements, etc.

*** The total includes reports for American Samoa, Guam, Northern Mariana Islands, Puerto Rico, U.S. Virgin Islands, and Armed Forces locations overseas (55 Clinical Privileges Reports; 48 adverse Clinical Privileges Reports, and 11 adverse Licensure Reports); additional reports that lack information about the State are also included in the total (20 Clinical Privileges Reports, 17 adverse Clinical Privileges Reports).

Table 17: Licensure Actions by State, Cumulative Through 2005 - Physicians*
National Practitioner Data Bank (September 1, 1990 - December 31, 2005)

State	Number of Licensur Reports	Number of Licensur Reports Adverse to Practitioner**	Percent of Licensur Actions Adverse to Practitioner	Number of Licensur Reports Adverse to the Practitioner for In-State Physicians***	Percent of Licensur Action Reports Adverse to the Practitioner for In-State Physicians
Alabama	619	513	82.9%	378	73.7%
Alaska	197	181	91.9%	115	63.5%
Arizona	1,395	1,215	87.1%	1,046	86.1%
Arkansas	254	226	89.0%	190	84.1%
California	5,386	4,594	85.3%	3,462	75.4%
Colorado	1,289	1,152	89.4%	975	84.6%
Connecticut	539	519	96.3%	418	80.5%
Delaware	61	51	83.6%	29	56.9%
District of Columbia	189	178	88.0%	46	60.6%
Florida	2,135	1,826	85.5%	1,562	85.5%
Georgia	1,160	1,045	90.1%	811	77.6%
Hawaii	102	95	93.1%	36	37.9%
Idaho	150	129	86.0%	82	63.6%
Illinois	1,289	1,010	78.4%	811	80.3%
Indiana	391	340	87.0%	202	53.4%
Iowa	741	652	88.0%	379	58.1%
Kansas	282	238	84.4%	192	80.7%
Kentucky	877	736	83.9%	591	80.3%
Louisiana	718	569	77.9%	442	79.1%
Maine	247	215	87.0%	156	72.6%
Maryland	1,180	1,059	89.7%	844	79.7%
Massachusetts	906	850	93.8%	670	78.8%
Michigan	1,950	1,686	86.5%	1,265	75.0%
Minnesota	572	457	79.9%	329	72.0%
Mississippi	490	431	89.8%	306	76.0%
Missouri	950	856	90.1%	556	65.0%
Montana	166	152	91.6%	103	67.8%
Nebraska	117	113	96.6%	79	69.9%
Nevada	173	172	99.4%	113	65.7%
New Hampshire	158	153	96.8%	117	76.5%
New Jersey	1,663	1,403	84.4%	953	67.9%
New Mexico	121	102	84.3%	82	80.4%
New York	4,111	4,087	99.4%	2,071	50.7%
North Carolina	613	499	81.4%	333	66.7%
North Dakota	237	174	73.4%	102	58.6%
Ohio	3,040	2,368	77.9%	1,836	77.5%
Oklahoma	725	628	86.6%	532	84.7%
Oregon	635	573	90.2%	517	90.2%
Pennsylvania	1,474	1,368	92.8%	632	46.2%
Rhode Island	178	168	94.4%	122	72.6%
South Carolina	545	406	74.5%	331	81.5%
South Dakota	59	56	94.9%	31	55.4%
Tennessee	564	485	86.0%	361	74.4%
Texas	2,505	2,188	87.3%	1,940	88.7%
Utah	306	234	76.5%	177	75.6%
Vermont	155	141	91.0%	91	64.5%
Virginia	1,701	1,494	87.8%	1,081	72.4%
Washington	848	703	82.9%	534	76.0%
West Virginia	676	540	79.9%	401	74.3%
Wisconsin	449	360	84.6%	283	74.5%
Wyoming	84	75	89.3%	52	69.3%
All Jurisdictions	45,375	39,488	87.0%	28,808	73.0%

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded. Licensure Reports were attributed to States based on the State of the reporting licensing board.

* The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents.

** "Licensure Reports" include truly adverse actions (e.g., revocations, probations, suspensions, reprimands, etc.) as well as reportable "adverse actions" which are not adverse to the practitioner (e.g., restorations and reinstatements). Reports "Adverse to the Practitioner" exclude restorations, reinstatements, etc.

*** The total includes reports for American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands (13 licensure actions, 13 adverse licensure actions, and 11 adverse licensure actions for in-State physicians). Licensure reports were considered to be for In-State physicians if the State of the board taking a reported action was the same as the reported work State of the physician. If work State was not included in a report, home State was used.

Table 18: Licensure Actions by State, Cumulative Through 2005 - Dentists*
National Practitioner Data Bank (September 1, 1990 - December 31, 2005)

State	Number of Licensure Actions*	Number of Licensure Actions Adverse to Practitioner**	Percent of Licensure Actions Adverse to the Practitioner	Number of Licensure Actions Adverse to the Practitioner for In-State Dentists***	Percent of Licensure Actions Adverse to the Practitioner for In-State Dentists
Alabama	137	136	99.3%	133	97.8%
Alaska	51	49	96.1%	46	93.9%
Arizona	825	820	99.4%	789	96.2%
Arkansas	43	38	88.4%	38	100.0%
California	476	469	98.5%	445	94.9%
Colorado	570	565	99.1%	522	92.4%
Connecticut	171	163	95.3%	151	92.6%
Delaware	2	2	100.0%	2	100.0%
District of Columbia	2	2	100.0%	2	100.0%
Florida	536	487	90.9%	468	96.1%
Georgia	192	192	100.0%	186	96.9%
Hawaii	8	8	100.0%	6	75.0%
Idaho	19	19	100.0%	18	94.7%
Illinois	525	376	71.5%	349	92.8%
Indiana	86	55	83.3%	47	85.5%
Iowa	211	196	92.9%	143	73.0%
Kansas	36	36	100.0%	34	94.4%
Kentucky	112	109	97.3%	105	96.3%
Louisiana	146	142	97.3%	137	96.5%
Maine	60	60	100.0%	54	90.0%
Maryland	308	240	77.9%	216	90.0%
Massachusetts	158	149	94.3%	135	90.6%
Michigan	592	512	86.5%	457	89.3%
Minnesota	206	163	79.1%	159	97.5%
Mississippi	59	57	96.6%	54	94.7%
Missouri	174	171	98.3%	150	87.7%
Montana	26	25	96.2%	20	80.0%
Nebraska	56	53	94.6%	44	83.0%
Nevada	43	40	93.0%	37	92.5%
New Hampshire	35	35	100.0%	33	94.3%
New Jersey	308	278	90.3%	263	94.6%
New Mexico	13	12	92.3%	11	91.7%
New York	608	605	99.5%	537	88.8%
North Carolina	328	321	97.9%	311	96.9%
North Dakota	2	2	100.0%	2	100.0%
Ohio	654	629	96.2%	617	98.1%
Oklahoma	109	108	99.1%	105	97.2%
Oregon	324	323	99.7%	302	93.5%
Pennsylvania	223	215	96.4%	160	74.4%
Rhode Island	18	18	100.0%	15	83.3%
South Carolina	109	104	95.4%	101	97.1%
South Dakota	3	3	100.0%	3	100.0%
Tennessee	192	174	90.6%	165	94.8%
Texas	463	459	99.1%	456	99.3%
Utah	107	84	78.5%	74	88.1%
Vermont	21	19	90.5%	14	73.7%
Virginia	795	750	94.3%	687	91.6%
Washington	373	356	95.4%	322	90.4%
West Virginia	25	24	96.0%	21	87.5%
Wisconsin	194	173	89.2%	160	92.5%
Wyoming	6	6	100.0%	6	100.0%
All Jurisdictions	10,724	10,035	93.6%	9,315	92.8%

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded. Licensure Reports were attributed to States based on the State of the reporting licensing board.

*The "Dentists" category includes dental residents.

** "Licensure Reports" include truly adverse actions (e.g., revocations, probations, suspensions, reprimands, etc.) as well as reportable "adverse actions" which are not adverse to the practitioner (e.g., restorations and reinstatements). Reports "Adverse to the Practitioner" exclude restorations, reinstatements, etc.

*** The total includes reports for American Samoa, Guam, Northern Mariana Islands, Puerto Rico, U.S. Virgin Islands, and Armed Forces locations overseas (3 licensure actions, 3 adverse licensure actions, and 3 adverse licensure actions for in-State physicians). Licensure reports were considered to be for In-State physicians if the State of the board taking a reported action was the same as the reported work State of the physician. If work State was not included in a report, home State was used.

Table 19: Relationship Between Frequency of Medical Malpractice Payment Reports, Adverse Action Reports,* and Medicare/Medicaid Exclusion Reports -- Physicians
National Practitioner Data Bank (September 1, 1990 - December 31, 2005)**

Number of Medical Malpractice Payment Reports	Number of Physicians with Specified Number of Malpractice Payment Reports	Number of Physicians with Specified Number of Medical Malpractice Payment Reports Also Having One or More Adverse Action Reports Other than Exclusions***		Number of Physicians with Specified Number of Medical Malpractice Payment Reports Also Having One or More Medicare/Medicaid Exclusion Reports	
		Number	Percent	Number	Percent
1	94,332	4,357	4.6%	691	0.7%
2	28,128	1,908	6.8%	300	1.1%
3	9,452	870	9.2%	147	1.6%
4	4,055	477	11.8%	67	1.7%
5	1,772	251	14.2%	43	2.4%
6	888	139	15.7%	28	3.2%
7	485	80	16.5%	18	3.7%
8	287	64	22.3%	12	4.2%
9	179	46	25.7%	4	2.2%
10 or More	481	161	33.5%	40	8.3%
Total	140,059	8,353	6.0%	1,350	1.0%

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

* "Adverse Action Reports" are as defined in footnote 1 on page 6 of this report, except that in this table Exclusion Reports are reported separately from other Adverse Action Reports.

** The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents.

*** For example, 94,332 physicians have one Medical Malpractice Payment Report in the NPDB; of these physicians, 4,357 have one or more adverse action reports (4.6%) and 89,975 (95.4%) have no Adverse Action Reports, not including Exclusion Reports. Similarly, of the 94,332 physicians with one Medical Malpractice Payment Report, 691 (0.7%) have one exclusion report and 93,641 (99.3%) have no Exclusion Reports.

Table 20: Relationship Between Frequency of Adverse Action Reports*, Medical Malpractice Payment Reports, and Medicare/Medicaid Exclusion Reports -- Physicians
National Practitioner Data Bank (September 1, 1990 - December 31, 2005)**

Number of Adverse Action Reports for Each Physician	Number of Physicians with Specified Number of Adverse Action Reports (including Exclusions)*	Number of Physicians with Specified Number of Adverse Action Reports Having One or More Medical Malpractice Payment Reports***		Number of Physicians with Specified Number of Adverse Action Reports Having One or More Medicare/Medicaid Exclusion Reports	
		Number	Percent	Number	Percent
1	10,423	3,689	35.4%	1,005	9.6%
2	6,442	2,361	36.7%	1,555	24.1%
3	3,037	1,103	36.3%	919	30.3%
4	1,609	636	39.5%	607	37.7%
5	907	329	36.3%	353	38.9%
6	500	185	37.0%	232	46.4%
7	320	124	38.8%	152	47.5%
8	170	77	45.3%	76	44.7%
9	88	28	31.8%	53	60.2%
10 or More	198	76	38.4%	110	55.6%
Total	23,694	8,608	36.3%	5,062	21.4%

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

* "Adverse Action Reports" in this column are as defined in footnote 1 on page 6 of this report. This definition includes Medicare/Medicaid Exclusion Reports, which are also counted separately in the last column.

** The "Physicians" category includes allopathic (M.D.) physicians, allopathic interns and residents, osteopathic (D.O.) physicians, and osteopathic interns and residents.

*** For example, 10,423 physicians have one Adverse Action Report in the NPDB; of these physicians, 3,689 have one or more Medical Malpractice Payment Reports (35.4%) and 6,734 (64.6%) have no Medical Malpractice Payment Reports. Similarly, of the 10,423 physicians with one Adverse Action Report, 1,005 (9.6%) have one Exclusion Report and 9,418 (90.4%) have no Exclusion Reports. Note that for the 1,005 physicians with one Adverse Action Report and one Exclusion Report, the Exclusion Report is their only Adverse Action Report.

Table 21: Practitioners with Reports
National Practitioner Data Bank (September 1, 1990 -
December 31, 2005)

Practitioner Type	Number of Practitioners with Reports	Number of Reports*	Reports per Practitioner
Acupuncturists	91	94	1.03
Chiropractors	6,359	7,896	1.24
Counselors	606	673	1.11
Dental Assistants, Technicians, Hygienists	30	30	1.00
Dentists and Dental Residents	30,299	49,933	1.65
Denturists	10	10	1.00
Dieticians	9	9	1.00
Emergency Medical Practitioners	126	128	1.02
Homeopaths and Naturopaths	11	11	1.00
Medical Assistants	26	28	1.08
Nurses and Nursing-related Practitioners	19,918	21,125	1.06
Occupational Therapists and Related Practitioners	70	72	1.03
Optical-related Practitioners	618	741	1.20
Pharmacists and Pharmacy Assistants	2,457	2,810	1.14
Physical Therapists and Related Practitioners	832	868	1.04
Physician Assistants	1,132	1,267	1.12
Physicians (M.D., D.O. and Interns and Residents)	157,914	291,185	1.84
Podiatrists and Podiatric-related Practitioners	4,121	6,965	1.69
Prosthetists	5	5	1.00
Psychiatric Technicians and Aides	8	9	1.13
Psychology-related Practitioners	1,243	1,540	1.24
Respiratory Therapists and Related Practitioners	37	38	1.03
Social Workers	185	202	1.09
Speech and Language-related Practitioners	45	49	1.09
Technologists	170	174	1.02
Other Health Care Practitioners	8	8	1.00
Other Individuals	12	14	1.17
Unspecified or Unknown	325	336	1.03
All Types	226,667	386,210	1.70

This table includes only disclosable reports in the NPDB as of the end of the current year. Voided reports have been excluded.

* "Number of Reports" include Medical Malpractice Payment Reports, Adverse State Licensure Action Reports, Clinical Privileges 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.

**Table 22: Number, Percent, and Percent Change in Queries and Queries Matched, Last Five Years and Cumulative Through 2005
National Practitioner Data Bank (September 1, 1990 - December 31, 2005)**

Query Type	2001	2002	2003	2004	2005	Cumulative
ENTITY QUERIES*						
Total Entity Queries	3,231,086	3,254,506	3,214,081	3,448,514	3,503,922	38,962,333
Queries Percent Increase/Decrease from Previous Year	2.4%	0.7%	-1.2%	7.3%	1.6%	n/a
Matched Queries	428,440	439,793	440,830	484,040	491,945	4,571,240
Percent Matched	13.3%	13.5%	13.7%	14.0%	14.0%	11.7%
Matches Percent Increase/Decrease from Previous Year	14.6%	2.6%	0.2%	9.8%	1.6%	n/a
SELF-QUERIES						
Total Practitioner Self-Queries	36,608	37,804	42,214	47,948	52,041	555,978
Self-Queries Percent Increase/Decrease from Previous Year	-24.2%	3.3%	11.7%	13.6%	8.5%	n/a
Matched Self-Queries	3,293	3,763	4,174	4,823	5,487	48,414
Self-Queries Percent Matched	9.0%	10.0%	9.9%	10.1%	10.5%	8.7%
Matches Percent Increase/Decrease from Previous Year	-23.3%	14.3%	10.9%	15.5%	13.8%	n/a
TOTAL QUERIES (ENTITY AND SELF)	3,267,694	3,292,310	3,256,295	3,496,462	3,555,963	39,518,311
TOTAL MATCHED (ENTITY AND SELF)	431,733	443,556	445,004	488,863	497,432	4,619,654
TOTAL PERCENT MATCHED (ENTITY AND SELF)	13.2%	13.5%	13.7%	14.0%	14.0%	11.7%

* "Entity queries" include practitioner self-queries submitted electronically by entities for practitioners in 1999 and 2000.

**Table 23: Queries by Type of Querying Entity, Last Five Years and Cumulative Through 2005
National Practitioner Data Bank (September 1, 1990 - December 31, 2005)**

Entity Type*	2001			2002			2003		
	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	5,773	1,118,008	34.6%	5,826	1,119,594	34.4%	5,869	1,139,537	35.5%
Voluntary Queriers									
State Licensing Board	72	14,260	0.4%	71	15,490	0.5%	79	14,122	0.4%
Managed Care Organizations	1,138	1,645,973	50.9%	1,051	1,637,311	50.3%	980	1,556,736	48.4%
Professional Societies	68	6,835	0.2%	68	6,168	0.2%	66	7,692	0.2%
Other Health Care Entities	3,414	446,010	13.8%	3,816	475,943	14.6%	4,440	495,994	15.4%
Total Voluntary Queriers	4,692	2,113,078	65.4%	5,006	2,134,912	65.6%	5,565	2,074,544	64.5%
Total**	10,465	3,231,086	100.0%	10,832	3,254,506	100.0%	11,434	3,214,081	100.0%

Entity Type*	2004			2005			Cumulative through 2005		
	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	5,943	1,186,018	34.4%	5,945	1,214,636	34.7%	8,022	15,331,665	39.3%
Voluntary Queriers									
State Licensing Board	84	17,092	0.5%	91	18,259	0.5%	163	170,176	0.4%
Managed Care Organizations	941	1,689,004	49.0%	940	1,669,692	47.7%	2,116	18,061,994	46.4%
Professional Societies	70	6,497	0.2%	71	8,982	0.3%	211	103,740	0.3%
Other Health Care Entities	5,235	549,903	15.9%	5,802	592,353	16.9%	9,397	5,294,758	13.6%
Total Voluntary Queriers	6,330	2,262,496	65.6%	6,904	2,289,286	65.3%	11,887	23,630,668	60.7%
Total**	12,273	3,448,514	100.0%	12,849	3,503,922	100.0%	19,909	38,962,333	100.0%

* "Entity Type" is based on how an entity was registered on the last day of 2005 and may be different from previous years. Thus, the number of queriers for each entity type also may vary slightly from the number shown in annual reports for previous years. A single entity may have more than one registration at a time or over the years.

** Queries listed in this table include all queries submitted by entities, including practitioner self-queries submitted electronically as a service to practitioners by entities in 1999 and 2000.

**Table 24: Number of Entity Queries and Matched Entity Queries by Practitioner/Subject Type
National Practitioner Data Bank, 2005**

Practitioner/Subject Type	Number of Entity Queries, 2005	Percent of Total Entity Queries	Number of Entity Queries Matched, 2005	Percent of Entity Queries Matched	Practitioner/Subject Type (continued)	Number of Entity Queries, 2005	Percent of Total Entity Queries	Number of Entity Queries Matched, 2005	Percent of Entity Queries Matched
Accountant (see Note 1)	23	0.0%	3	13.0%	Nurse Midwife	8,678	0.2%	475	5.5%
Acupuncturist	3,291	0.1%	89	2.7%	Nurse Practitioner	70,171	2.0%	449	0.6%
Adult Care Facility Administrator (see Note 1)	60	0.0%	5	8.3%	Nurses Aide	574	0.0%	1	0.2%
Allopathic Physician Intern/Resident	13,924	0.4%	896	6.4%	Nutritionist	469	0.0%	1	0.2%
Allopathic Physician	2,265,069	65.2%	406,680	17.7%	Occupational Therapy Assistant	176	0.0%	2	1.1%
Art/Recreation Therapist	78	0.0%	0	0.0%	Occupational Therapist	10,627	0.3%	19	0.2%
Athletic Trainer (see Note 1)	134	0.0%	1	0.7%	Ocularist	57	0.0%	0	0.0%
Audiologists	5,280	0.2%	14	0.3%	Optician	463	0.0%	16	3.5%
Bookkeepers (see Note 1)	0	0.0%	0	---	Optometrist	72,138	2.1%	850	1.2%
Business Manager (see Note 1)	0	0.0%	0	---	Orthotics/Prosthetics Fitter	646	0.0%	5	0.8%
Business Owner (see Note 1)	2	0.0%	0	0.0%	Osteopathic Physician Intern/Resident	1,491	0.0%	61	4.1%
Certified Nurse Aide/Nursing Assistant (see Note 3)	97	0.0%	0	0.0%	Osteopathic Physician	139,637	4.0%	27,315	19.6%
Certified/Qualified Medication Aide (see Note 3)	3	0.0%	0	0.0%	Other Health Care Practitioner, Not Classified (see Note 1)	12,211	0.3%	153	1.3%
Chiropractor	85,460	2.4%	5,247	6.1%	Other Non-Practitioner Occupation, Not Classified (see Note 1)	2,841	0.1%	34	1.2%
Clinical Nurse Specialist (see Note 2)	1,385	0.0%	5	0.4%	Perfusionist (see Note 1)	1,584	0.0%	3	0.2%
Corporate Officer (see Note 1)	1	0.0%	0	0.0%	Pharmacist	1,867	0.1%	10	0.5%
Cytotechnologist (see Note 1)	35	0.0%	0	0.0%	Pharmacist, Nuclear	37	0.0%	4	10.8%
Dental Assistant	1,353	0.1%	3	0.2%	Pharmacy Assistant	886	0.0%	11	1.2%
Dental Hygienist	951	0.0%	3	0.3%	Pharmacy Intern (see Note 2)	20	0.0%	0	0.0%
Dental Resident	295	0.0%	14	4.7%	Pharmacy Technician (see Note 2)	210	0.0%	16	7.6%
Dentist	209,914	6.0%	33,689	16.0%	Physician Assistant, Allopathic	67,011	1.9%	849	1.3%
Denturist	42	0.0%	3	7.1%	Physician Assistant, Osteopathic	2,989	0.1%	60	2.0%
Dietician	2,488	0.1%	1	0.0%	Physical Therapy Assistant	431	0.0%	4	0.9%
EMT, Basic	125	0.0%	1	0.8%	Physical Therapist	55,492	1.6%	412	0.7%
EMT, Cardiac/Critical Care	21	0.0%	0	0.0%	Podiatric Assistant	174	0.0%	7	4.0%
EMT, Intermediate	14	0.0%	2	14.3%	Podiatrist	61,834	1.8%	12,864	20.8%
EMT, Paramedic	147	0.0%	1	0.7%	Professional Counselor, Substance Abuse	963	0.0%	1	0.1%
Health Care Aide/Direct Care Worker (see Note 3)	3	0.0%	0	0.0%	Professional Counselor, Alcohol	583	0.0%	1	0.2%
Hearing Aid/Instrument Specialist (see Note 3)	6	0.0%	0	0.0%	Professional Counselor, Family/Marriage (see Note 2)	5,964	0.2%	27	0.5%
Home Health Aide (Homemaker)	16	0.0%	1	6.3%	Professional Counselor	37,997	1.1%	57	0.2%
Homeopath	20	0.0%	0	0.0%	Psychiatric Technicians	231	0.0%	12	5.2%
Hospital Administrator (see Note 1)	4	0.0%	1	25.0%	Psychological Assistant, Associate, Examiner (see Note 2)	465	0.0%	1	0.2%
Insurance Agent (see Note 1)	1	0.0%	0	0.0%	Psychologist	86,802	2.5%	704	0.8%
Insurance Broker (see Note 1)	0	0.0%	0	---	Radiation Therapy Technologist	187	0.0%	1	0.5%
Long Term Care Facility Administrator (see Note 1)	1	0.0%	0	0.0%	Radiologic Technologists	865	0.0%	17	2.0%
LPN or Vocational Nurse	4,675	0.1%	14	0.3%	Rehabilitation Therapist	629	0.0%	1	0.2%
Marriage and Family Therapist (see Note 2)	12,423	0.4%	51	0.4%	Researcher, Clinical (see Note 1)	176	0.0%	0	0.0%
Massage Therapist	2,861	0.1%	5	0.2%	Respiratory Therapy Technician	69	0.0%	0	0.0%
Medical Assistant	1,523	0.0%	13	0.9%	Respiratory Therapist	368	0.0%	0	0.0%
Medical Technologist	1,112	0.0%	14	1.3%	RN (Professional) Nurses	64,134	1.8%	618	1.0%
Mental Health Counselor	19,399	0.6%	44	0.2%	Salesperson (see Note 1)	15	0.0%	1	6.7%
Midwife, Lay (Non-Nurse)	216	0.0%	6	2.8%	School Psychologist (see Note 2)	116	0.0%	1	0.9%
Naturopath	550	0.0%	2	0.4%	Social Worker, Clinical	96,201	2.7%	93	0.1%
Nuclear Med. Technologist	80	0.0%	2	2.5%	Speech/Language Pathologist	6,705	0.2%	3	0.0%
Nurse Anesthetist	35,038	1.0%	1,076	3.1%	All Types	3,503,922	100.0%	491,945	14.0%

Note 1: Category first available for reporting and querying on November 22, 1999.

Note 2: Category first available for reporting and querying on September 9, 2002.

Note 3: Category first available for reporting and querying on October 17, 2005.

Table 25: Self-Queries and Self-Queries Matched with Reports by Practitioner Type
National Practitioner Data Bank, 2005

Practitioner Type	Number of Self-Queries Processed Against NPDB Reports	Percent of Total Self-Queries	Number of Self-Queries that Matched At Least One NPDB Report	Percent of Self-Queries Matched with NPDB Reports
Accountant (see Note 1)	2	0.0%	0	0.0%
Acupuncturist	13	0.0%	0	0.0%
Adult Care Facility Administrator (see Note 1)	0	0.0%	0	0.0%
Allopathic Physician Intern/Resident	7,125	13.7%	40	0.6%
Allopathic Physician	31,004	59.6%	4,535	14.6%
Art/Recreation Therapist	0	0.0%	0	---
Athletic Trainer (see Note 1)	0	0.0%	0	---
Audiologists	4	0.0%	0	0.0%
Bookkeeper (see Note 1)	1	0.0%	0	0.0%
Business Manager (see Note 1)	2	0.0%	0	0.0%
Business Owner (see Note 1)	2	0.0%	0	0.0%
Certified Nurse Aide/Nursing Assistant (see Note 3)	2	0.0%	0	0.0%
Chiropractor	164	0.3%	17	10.4%
Clinical Nurse Specialist (see Note 2)	4	0.0%	0	0.0%
Corporate Officer (see Note 1)	1	0.0%	0	0.0%
Dental Assistant	10	0.0%	0	0.0%
Dental Hygienist	886	1.7%	0	0.0%
Dental Resident	70	0.1%	0	0.0%
Dentist	3,280	6.3%	356	10.9%
Dietician	29	0.1%	0	0.0%
EMT, Basic	480	0.9%	1	0.2%
EMT, Cardiac/Critical Care	1	0.0%	0	0.0%
EMT, Intermediate	10	0.0%	0	0.0%
EMT, Paramedic	73	0.1%	0	0.0%
Hospital Administrator (see Note 1)	0	0.0%	0	---
Insurance Agent (see Note 1)	5	0.0%	0	0.0%
Insurance Broker (see Note 1)	0	0.0%	0	---
Long Term Care Facility Administrator (see Note 1)	2	0.0%	0	0.0%
LPN or Vocational Nurse	44	0.1%	1	2.3%
Marriage and Family Therapist (see Note 2)	92	0.2%	1	1.1%
Massage Therapist	0	0.0%	0	---
Medical Assistant	12	0.0%	0	0.0%
Medical Technologist	2	0.0%	0	0.0%
Mental Health Counselor	225	0.4%	0	0.0%
Midwife, Lay (Non-Nurse)	0	0.0%	0	---
Naturopath	6	0.0%	0	0.0%
Nurse Anesthetist	258	0.5%	14	5.4%
Nurse Midwife	84	0.2%	4	4.8%
Nurse Practitioner	712	1.4%	9	1.3%
Nurses Aide	7	0.0%	0	0.0%
Nutritionist	5	0.0%	0	0.0%
Occupational Therapist	20	0.0%	0	0.0%
Occupational Therapy Assistant	1	0.0%	0	0.0%
Optometrist	150	0.3%	6	4.0%
Optician	1	0.0%	0	0.0%
Orthotics/Prosthetics Fitter	0	0.0%	0	---
Osteopathic Physician Intern/Resident	722	1.4%	4	0.6%
Osteopathic Physician	2402	4.6%	407	16.9%
Other Health Care Practitioner, Not Classified (see Note 1)	42	0.1%	1	2.4%
Other Non-Practitioner Occupation, Not Classified (see Note 1)	240	0.5%	2	0.8%
Perfusionist (see Note 1)	1	0.0%	0	0.0%
Pharmacist	91	0.2%	1	1.1%
Pharmacist, Nuclear	1	0.0%	0	0.0%
Pharmacy Assistant	4	0.0%	0	0.0%
Pharmacy Intern (see Note 2)	0	0.0%	0	---
Pharmacy Technician (see Note 2)	4	0.0%	0	0.0%
Physician Assistant, Allopathic	1073	2.1%	27	2.5%
Physician Assistant, Osteopathic	70	0.1%	0	0.0%
Physical Therapy Assistant	7	0.0%	0	0.0%
Physical Therapist	109	0.2%	1	0.9%
Podiatric Assistant	0	0.0%	0	---
Podiatrist	188	0.4%	36	19.1%
Professional Counselor, Substance Abuse	114	0.2%	1	0.9%
Professional Counselor, Alcohol	16	0.0%	0	0.0%
Professional Counselor, Family/Marriage (see Note 2)	21	0.0%	1	4.8%
Professional Counselor	422	0.8%	1	0.2%
Psychiatric Technicians	1	0.0%	0	0.0%
Psychological Assistant, Associate, Examiner (see Note 2)	1	0.0%	0	0.0%
Psychologist	277	0.5%	5	1.8%
Radiologic Technologists	4	0.0%	0	0.0%
Rehabilitation Therapist	1	0.0%	0	0.0%
Researcher, Clinical (see Note 1)	2	0.0%	0	0.0%
Respiratory Therapy Technician	16	0.0%	0	0.0%
Respiratory Therapist	176	0.3%	0	0.0%
RN (Professional) Nurses	598	1.1%	16	2.7%
Salesperson (see Note 1)	3	0.0%	0	0.0%
School Psychologist (see Note 2)	0	0.0%	0	---
Social Worker, Clinical	845	1.2%	0	0.0%
Speech/Language Pathologist	2	0.0%	0	0.0%
All Types	52,041	100.0%	5,487	10.5%

Note 1: Category first available for reporting and querying on November 22, 1999.

Note 2: Category first available for reporting and querying on September 9, 2002.

Note 3: Category first available for reporting and querying on October 17, 2005.

Table 26: Entities That Have Queried or Reported to the National Practitioner Data Bank (September 1, 1990 - December 31, 2005)

Entity Type	Active Status Registration on December 31, 2005	Active Registration Status At Any Time
Hospitals	6,556	8,042
State Licensing Boards	157	199
Managed Care Organizations	1,354	2,159
Professional Societies	139	227
Other Health Care Entities	7,971	9,485
Medical Malpractice Payers	442	823
Total	16,619	20,935

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 medical malpractice payments (e.g., hospitals and HMOs) are instructed to register as health care entities, not malpractice payers, and are not double counted if they registered only once.

Table 27: Requests for Secretarial Review by Report Type, Last Five Years and Cumulative Through 2005
National Practitioner Data Bank (September 1, 1990 - December 31, 2005)

Category	2001			2002			2003		
	Number	Percent	% Change 2000-2001	Number	Percent	% Change 2002-2003	Number	Percent	% Change 2002-2003
Adverse Action Reports	59	67.0%	-20.3%	85	70.8%	44.1%	49	92.5%	-42.4%
State Licensure Actions	17	28.8%	-26.1%	18	21.2%	5.9%	13	26.5%	-27.8%
Clinical Privileges Actions	31	52.5%	-20.5%	58	68.2%	87.1%	33	67.3%	-43.1%
Professional Society Actions	1	1.7%	-50.0%	0	0.0%	-100.0%	2	4.1%	
Medicare/Medicaid Exclusions	10	16.9%	0.0%	9	10.6%	-10.0%	1	2.0%	-88.9%
Medical Malpractice Payment Reports	29	33.0%	-45.3%	35	29.2%	20.7%	4	7.5%	-88.6%
Total	88	100.0%	-30.7%	120	100.0%	36.4%	53	100.0%	-55.8%

Category	2004			2005			Cumulative	
	Number	Percent	% Change 2003-2004	Number	Percent	% Change 2004-2005	Number	Percent
Adverse Action Reports	52	76.5%	6.1%	46	79.3%	-11.5%	1131	64.08%
State Licensure Actions	10	19.2%	-23.1%	5	10.9%	-50.0%	336	29.7%
Clinical Privileges Actions	41	78.8%	24.2%	39	84.8%	-4.9%	744	65.8%
Professional Society Actions	0	0.0%	-100.0%	0	0.0%	--	18	1.6%
Medicare/Medicaid Exclusions	1	1.9%	0.0%	2	4.3%	100.0%	33	2.9%
Medical Malpractice Payment Reports	16	23.5%	300.0%	12	20.7%	-25.0%	634	35.9%
Total	68	100.0%	28.3%	58	100.0%	-14.7%	1,765	100.0%

Table 28: Distribution of Requests for Secretarial Review by Type of Outcome, Last Five Years and Cumulative Through 2005
National Practitioner Data Bank (September 1, 1990 - December 31, 2005)

Outcome	2001			2002			2003		
	Number	Percent	Percent of Resolved Requests	Number	Percent	Percent of Resolved Requests	Number	Percent	Percent of Resolved Requests
Request Closed by Intervening Action	5	5.7%	5.7%	13	10.8%	11.2%	14	26.4%	26.9%
Request Closed: Practitioner Did Not Pursue Review*	0	0.0%	0.0%	1	0.8%	0.9%	2	3.8%	3.8%
Request Outside Scope of Review (No Change in Report)	51	58.0%	58.0%	40	33.3%	34.5%	10	18.9%	19.2%
Secretary Changes Report	3	3.4%	3.4%	0	0.0%	0.0%	0	0.0%	0.0%
Secretary Maintains Report as Submitted	27	30.7%	30.7%	58	48.3%	50.0%	26	49.1%	50.0%
Secretary Voids Report	2	2.3%	2.3%	4	3.3%	3.4%	0	0.0%	0.0%
Unresolved as of December 31, 2005	0	0.0%	0.0%	4	3.3%	n/a	1	1.9%	n/a
Total	88	100.0%	100.0%	120	100.0%	100.0%	53	100.0%	100.0%

Outcome	2004			2005			Cumulative		
	Number	Percent	Percent of Resolved Requests	Number	Percent	Percent of Resolved Requests	Number	Percent	Percent of Resolved Requests
Request Closed by Intervening Action	16	23.5%	30.8%	11	19.0%	39.3%	139	7.9%	8.1%
Request Closed: Practitioner Did Not Pursue Review*	0	0.0%	0.0%	0	0.0%	0.0%	43	2.4%	2.5%
Request Outside Scope of Review (No Change in Report)	10	14.7%	19.2%	3	5.2%	10.7%	672	38.1%	39.3%
Secretary Changes Report	0	0.0%	0.0%	0	0.0%	0.0%	19	1.1%	1.1%
Secretary Maintains Report as Submitted	25	36.8%	48.1%	13	22.4%	46.4%	695	39.4%	40.6%
Secretary Voids Report	1	1.5%	1.9%	1	1.7%	3.6%	144	8.2%	8.4%
Unresolved as of December 31, 2005	16	23.5%	n/a	30	51.7%	n/a	53	3.0%	n/a
Total	68	100.0%	100.0%	58	100.0%	100.0%	1,765	100.0%	100.0%

This table shows, as of December 31, 2005, the outcomes of Secretarial Review requests based on the dates of requests for review. For undated requests, the date they were received by the Practitioner Data Banks Branch was used.

* "Request Closed: Practitioner Did Not Pursue Review" refers to cases which were closed because (1) the practitioner withdrew the request for Secretarial Review or (2) failed to submit required documentation after the case was elevated to Secretarial Review status. If the required documentation was not submitted prior to being elevated to Secretarial Review status, the case is not included in this table.

Table 29: Resolved Requests for Secretarial Review by Report and Outcome Types, Cumulative Through 2005
National Practitioner Data Bank (September 1, 1990 - December 31, 2005)

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	35	5.5%	34	10.1%	64	8.6%
Request Closed: Practitioner Did Not Pursue Review*	16	2.5%	11	3.3%	14	1.9%
Request Outside Scope of Review (No Change in Report)	352	55.6%	78	23.2%	218	29.3%
Secretary Changes Report	6	0.9%	8	2.4%	4	0.5%
Secretary Maintains Report as Submitted	183	28.9%	160	47.6%	337	45.2%
Secretary Voids Report	32	5.1%	40	11.9%	69	9.3%
Unresolved as of December 31, 2005	9	1.4%	5	1.5%	39	5.2%
Total	633	100.0%	336	100.0%	745	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	3	16.7%	3	9.1%	139	7.88%
Request Closed: Practitioner Did Not Pursue Review*	1	5.6%	1	3.0%	43	2.44%
Request Outside Scope of Review (No Change in Report)	5	27.8%	19	57.6%	672	38.07%
Secretary Changes Report	0	0.0%	1	3.0%	19	1.08%
Secretary Maintains Report as Submitted	6	33.3%	9	27.3%	695	39.38%
Secretary Voids Report	3	16.7%	0	0.0%	144	8.16%
Unresolved as of December 31, 2005	0	0.0%	0	0.0%	53	3.00%
Total	18	100.0%	33	100.0%	1,765	100.0%

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

* "Request Closed: Practitioner Did Not Pursue Review" refers to cases which were closed because (1) the practitioner withdrew the request for Secretarial Review or (2) failed to submit required documentation after the case was elevated to Secretarial Review status. If the required documentation was not submitted prior to being elevated to Secretarial Review status, the case is not included in this table.