

Staying Out of Court

Statistics indicate that six out of ten physicians can expect to be involved in an incident or a malpractice suit at least once during their medical careers. But a patient complaint or even a medical error doesn't have to end up in a court battle. In some situations, a claim may not wind up in court, but may be settled by an equitable solution between the parties. In some cases, a plaintiff may drop his or her claim entirely.

With thoughtful responses and careful preparation, physicians can respond to complaints and handle negative outcomes and avoid legal action. And even if a suit is filed, physicians can opt for settlement.

When patients experience any problem, it is essential to communicate honestly with them and their families. Legal experts say that avoiding frustrated patients, or giving them explanations that they do not understand, increases the chances of being sued.

Physicians and their staffs should always be alert to situations that could turn into a serious patient problem or a potential lawsuit. When patients experience any problem, it is essential to communicate honestly with them and their families.

Legal experts say that avoiding frustrated patients, or giving them explanations that they do not understand, increases the chances of being sued.

Procrastination can aggravate an already bad situation. By not responding to concerns or by appearing evasive, physicians may boost anger levels. Malpractice insurance carriers outline specific notification duties in the event of a patient complaint or legal action. It is essential to know—and adhere to—these duties. Ignoring potential legal problems will not make them go away.

Signs of Trouble

In some cases, the first sign of trouble may come when patients inform staff that they are dissatisfied with the care provided, or that they experienced an undesirable result from a medical treatment. In other cases, the first indication may be when a regular patient abruptly cancels appointments and requests a copy of his or her medical records.

When patients become difficult to deal with or do not comply with instructions, it could be a sign of trouble ahead. In some circumstances, it may be advisable to stop providing care to those who fail either to follow up with referrals or medication instructions, to pay bills, or to show up for appointments. This decision should be approached with care, and patients must be notified in writing, either in a certified letter telling them of the dismissal or in a letter given to them when they arrive for their next appointment.

Sometimes the first sign of trouble comes through more official channels, such as a notice from the patient's health plan advising that it has received a grievance against a physician in the practice. The state licensing board may send notification that a patient has filed a complaint or that the board is conducting its own investigation into conduct or care provided.

A physician may receive a complaint letter from a patient or his or her attorney. This letter may allege negligence, a description of the injury, and a demand for compensation. In this case, the physician should immediately contact his or her professional liability insurer to plan next steps.

Creating an effective, consistent office policy for dealing with such matters can help improve patient relations and avoid legal action. The policy should designate someone on staff to make sure that verbal or written complaints are handled quickly. There should also be a backup person to handle this responsibility so that complaints or legal documents do not get stalled on the desk of someone who is away from the office.

The policy should also outline specific requirements for notifying the practice's malpractice insurance carrier. All details of any discussions with a patient who is not satisfied with care received should be documented in the patient's chart, indicating the date and describing the complaint. Discussions with the

insurer should also be documented, but in a separate file.

If a patient expresses dissatisfaction, the physician should listen carefully to his or her concerns. It is possible to be sympathetic or empathetic without placing blame. However, physicians should handle complaints regarding medical care themselves; other staff members should not address the medical aspects of a patient's complaint.

Physicians should take time to review the patient's medical record and determine exactly what took place before addressing the medical aspects of a situation. A thoughtful response from the physician can help put an end to a potential lawsuit. For example, Charles Utley, a surgical patient who was left with a

Physicians should take time to review the patient's medical record and determine exactly what took place before addressing the medical aspects of a situation. A thoughtful response from the physician can help put an end to a potential lawsuit. If handled properly, complaints and poor outcomes need not end up in court.

sponge in a body cavity, decided not to pursue litigation because his doctor and the hospital administrator took responsibility and apologized to him, according to the Joint Commission on Accreditation of Healthcare Organizations in its report "Health Care at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury." If handled properly, complaints and poor outcomes need not end up in court.

Notifying the Insurance Company

Most insurers prefer to review any written response to a patient complaint because it may be used as evidence if a lawsuit does occur. The insurer wants to make sure that nothing is said that might prove detrimental in a legal situation. In fact, sending a letter of apology or writing off a bill without first contacting the medical malpractice insurer could lead the insurer to deny coverage on the grounds that the physician prejudiced its ability to mount a vigorous defense, writes Kevin M. Quinley in his book *Bulletproofing Your Medical Practice*.

NORCAL Mutual Insurance Company, a California-based, doctor-owned malpractice insurance company, advises its policyholders to contact the company the moment a physician thinks

a claim may be forthcoming—in other words, before a complaint has been filed. This gives the company a chance to begin evaluating the incident immediately. NORCAL’s claims department will ask for a copy of the medical records and a narrative so that it can start reviewing the medical care the patient received.

When notifying the insurer of a claim, provide as much information as possible, such as the name of the patient, the circumstances surrounding the claim, and any information about the patient’s medical care handled by another physician or clinic. Most malpractice insurance policies require physicians to immediately send the carrier copies of any demands, notices, summonses, or legal papers in connection with a claim or suit. “Wise

Handling Complaints

If not handled properly, complaints can lead to more serious problems, even litigation. Effectively handling patient complaints offers everyone an opportunity to improve the way your practice works.

Medical practices should have policies and procedures that outline how to handle complaints from patients. The policy should include some method to document verbal complaints. The name of the patient should be written down, along with the date the patient called with or personally registered the complaint, exactly what the complaint entailed, the physicians or staff member’s response, and the response of the patient. It’s a good idea to review all complaints each month. If you find a particular complaint pattern emerging, such as patients say they have to wait too long to see the doctor, you may want to take steps to change the way you schedule appointments.

Here is a sample policy for handling complaints from the Texas Medical Association’s *Medical Office Policy and Procedure Manual*:

How to Handle Patient Complaints*

Complaints may arise under a variety of circumstances in any clinical setting. Your staff’s best course of action is a coherent, concise response that preserves patient confidence and satisfaction, as follows:

■ **Listen:** Stop what you are doing, and give your undivided attention to the patient. If you are on the phone, make appropriate responses so the patient knows you are listening. Do not argue with the patient or interrupt with explanations. Listen without attributing fault.

physicians establish a strict standard that any lawsuit will be reported to their insurance company within twenty-four hours of their receipt,” writes Mr. Quinley. Be sure to send these letters by certified mail, with a return-receipt requested.

Maintaining thorough medical records that accurately reflect the care of each patient is vital, especially in the event of legal action. Serious errors or omissions in the documentation will have a negative impact on the defense of any malpractice claim. When talking with an attorney about legal action, the physician should inform him or her if there may be documentation problems in the medical records.

On the other hand, medical experts warn against including

- **Empathize:** Place yourself in the patient’s place. Offer a statement of empathy (e.g., “I’m sorry that ...,” or “I understand that ...”). Do so without agreeing to guilt on your part or on behalf of the practice. Extend understanding without agreement.

- **Inquire:** Gain as much information as you can about the problem. This will help you decide the best way to handle the complaint. Be sure the patient knows you take his or her concern seriously.

- **Act:** Suggest solutions you can perform. Get the patient’s approval on the recommended action (e.g., “I will contact ... and ask her to get back to you”). If no immediate action is apparent, assure the patient that an appropriate manager will be informed and that he or she can expect a response.

- **Conclude:** Thank the patient for taking time to notify you of the complaint. Stress that patient satisfaction is a critical component of quality patient care in your practice.

- **Document:** Give any patient and/or family member with a complaint an opportunity to document it. Create a simple form that contains the patient’s name and date of the complaint, the patient’s statement of the problem, the staff member’s statement or response, a description of the action taken, and the staff member’s signature with a date.

The form both assures patients that their complaints are taken seriously and provides documentation that can help forestall potential problems and educate staff on how to prevent future similar complaints.

**First published by the Texas Medical Association, copyright ©2005. Reprinted with permission.*

superfluous information or personal opinions in a patient's medical record. Such information may actually work against you in

Deciding to settle is not necessarily an admission of wrongdoing, nor does it mean that the physician was at fault for the poor outcome that the patient experienced. But, Dr. Zurad points out, if you decide not to defend the case, you will lose the opportunity to tell your side of the story.

a malpractice case when the records are reviewed by a plaintiff's attorney. When documenting a record, avoid personal abbreviations, never squeeze words into a line, and never leave blank spaces. Every entry in the record should include a complete date—month, day, year, and time. It is unethical and illegal to predate or backdate an entry in the medical

record. Be sure that entries are authenticated by the author, typically by a written signature.

Selecting an Attorney

If you have medical malpractice coverage and follow your policy's requirements, your carrier retains counsel for you when a lawsuit is filed and takes care of the legal fees. If you want a voice in selecting the attorney who will represent you, tell your carrier immediately.

A physician may decide to obtain his or her own lawyers in addition to the counsel whom the carrier retains. These additional legal fees become the physician's responsibility, but they may prove well worth the expense if, for example, your personal assets are at stake, or if there is a likelihood of a verdict that will exceed policy coverage limits. Physicians may choose to hire their own lawyers if they believe they are not getting effective legal assistance from the attorney selected by the carrier. (However, in most cases, the carrier will name a new attorney if the physician finds that he or she cannot work with the one originally selected.)

To find a top-notch attorney who has experience with medical malpractice lawsuits, check with colleagues and the hospital with which you are affiliated for recommendations. But do not discuss the specifics of your case in these conversations. Any discussions other than those with your attorney or your spouse can

be discovered by the plaintiff's lawyer, causing your colleagues or friends to be called in to testify about what you told them.

When to Settle and When to Fight

Deciding whether to settle or fight a malpractice lawsuit is never easy. There are risks and benefits for each decision, and these must be weighed carefully before deciding on a specific course of action.

In a settlement, the defendant and the plaintiff agree to end the dispute and not go to trial. The physician's insurance carrier and attorney discuss settlement options with the plaintiff and his or her attorney. If the parties come to a formal settlement, the resulting document will cover the various terms that they agree to, which may include the stipulation that the physician does not admit negligence. A judge may

If a physician decides to fight, he or she must be willing to commit the time to what is likely to be a long-drawn-out trial. Typically a case that goes to trial can take four to eight years. "Physicians have to be willing to sit down with their attorney and spend time educating the defense team about the medicine that is involved in the case," says Dr. Zurad.

execute the order of non-suit in response to the motion to settle. In the event of a settlement, information about the case is reported by the insurance carrier to the federal government's National Practitioner Data Bank. (For more about the National Practitioner Data Bank, see below.)

If the case goes to trial, the plaintiff must prove that the care delivered was substandard; that the injury suffered was a direct result of a medically negligent act, omission, or error; and that the claimed damages stem from that injury. Juries tend to be tough on malpractice plaintiffs, according to Michelle M. Mello, J.D., Ph.D., associate professor of health policy and law at the Harvard School of Public Health. In her recent testimony before the House Committee on Energy and Commerce Subcommittee on Health, Dr. Mello pointed out that plaintiffs lose about four in five trials.

Before deciding whether to settle or go to trial in a specific case, the defense team should outline the risks and benefits of each course of action. Dr. Edward G. Zurad, a family physician

in solo practice in Tunkhannock, Pa., speaks from experience on the subject, having been involved in a malpractice lawsuit that lasted six years. He points out that settle-versus-trial is rarely a clear-cut decision.

If a physician practices in a community where trial publicity and the facts surrounding the case may be devastating, one should certainly consider settling the case, he says, adding that deciding to settle is not necessarily an admission of wrongdoing, nor does it mean that the physician was at fault for the poor outcome that the patient experienced. But, he points out, if you decide not to defend the

Another factor to consider is whether the case has a “smoking gun” that will almost certainly mean that the doctor will lose if he or she goes to trial. Legal experts maintain that alteration of the medical record will hamper any chance to defend the claim.

case, you will lose the opportunity to tell your side of the story.

Sometimes a plaintiff’s attorney will try to force a settlement by including punitive damages in the claim. The idea may be to intimidate the defendant physician into settling in order to preserve his or her personal assets, he says. “To request punitive damages, the plaintiff must assert the actions of the defendant physician were careless and wanton and that these actions were directly connected to the injury which is alleged,” he explains.

If a physician decides to fight, he or she must be willing to commit the time to what is likely to be a long-drawn-out trial. Typically a case that goes to trial can take four to eight years. “Physicians have to be willing to sit down with their attorney and spend time educating the defense team about the medicine that is involved in the case,” says Dr. Zurad. Preparation for trial becomes a very time-consuming endeavor. In Dr. Zurad’s case, he spent approximately 500 hours of uncompensated time getting ready and going through the trial. “Physicians have to be ready to invest a substantial portion of their lives in the case,” he adds.

Therefore, a major advantage to settling a case is saving a substantial amount of time. But for some physicians, their financial assets and reputation may be more important than the time saved by not defending the case.

Another factor to consider is whether the case has a “smoking

gun” that will almost certainly mean that the doctor will lose if he or she goes to trial. Legal experts maintain that alteration of the medical record will hamper any chance to defend the claim. In addition, if negligence has occurred, the defense attorney is likely to suggest that the doctor seek a settlement. The physician may also choose to settle if there has been a pattern of malpractice cases in the past.

Evaluating the Settlement

Before going to trial, the plaintiff may post a settlement demand. The physician and his or her attorney discuss that demand and determine whether it will be accepted. In some cases, a counteroffer will be made by the defense team, and often this counteroffer is not accepted by the plaintiff. Some insurance carriers may want physicians to settle and avoid trial. Before doing so, the physician, the carrier, and the physician’s attorney should answer a number of questions, including the following:

- How easily can the case be defended based on the clarity and quality of the medical records?
- How credible is the plaintiff?
- How effective are the plaintiff’s experts?
- Can the expert witnesses for the defense effectively rebut the plaintiff’s assertions?
- Can the defense attorney defend the facts in the case?
- Will the defense’s arguments in the case be understandable to the jurors?
- How credible is the doctor, and did he or she perform well during the deposition? How well is he or she likely to come across during the trial?
- What is the size of the claim measured by the seriousness of the injury? Will the doctor’s personal assets be at stake?
- Are punitive damages involved in the claim?

The physician should consider his or her own coping skills and tolerance levels for the stress of a trial. Some physicians will find the whole trial process intolerable, Dr. Zurad says, adding, “They cannot control their anger during the case and allow it to boil over into depositions, negotiations, and possibly the courtroom. In such a situation, settlement should be strongly considered.”

Other factors to consider are the jurisdiction (whether it is

friendly or not); the judge you are likely to get for the trial; the nature of the injury; and the sympathy factor for the patient. If a physician has hired his or her own attorney to provide independent legal advice, that lawyer should play a role in helping the doctor decide whether to settle or fight.

Insurance carriers of all varieties must look at the economics and the legal issues involved in defending a case. For-profit carriers, for example, may believe that going to trial would be too costly since most defense attorneys charge insurance carriers by the hour. In addition, expert witnesses are expensive, charging for their time plus fees for travel and other expenses. The carrier may believe that there is a reasonable probability that the physician will be personally liable for the claim.

In the end it is the job of the physician and attorney to determine how clear cut the lawsuit is and how definite the physician's liability is in the case. If the defense team determines that liability exists or that the case will be a difficult one to defend and may end up in a costly decision, it will probably advise the physician to settle the case and not pursue a trial.

Physician-owned insurance companies have a reputation for defending cases whenever possible and not settling simply to avoid the costs of litigation. These carriers believe that the best way to discourage unfounded malpractice suits is through vigorous defense. But taking this route may not always be possible.

In the end it is the job of the physician and attorney to determine how clear cut the lawsuit is and how definite the physician's liability is in the case. The physician plays a key role because he or she knows the entire medical record and laboratory information of the patient, says Dr. Zurad.

If the defense team determines that liability exists or that the case will be a difficult one to defend and may end up in a costly decision, it will probably advise the physician to settle the case and not pursue a trial. *The Physician Defendant—A Handbook*, a resource published by the State Volunteer Mutual Insurance Company (a Brentwood, Tenn.-based mutual insurance company that provides professional liability coverage to physicians), states: "Due to the unpredictable nature of malpractice liability, there is no set procedure that will guarantee that the decision to

settle or defend will be the right one.” Even so, the best-informed decision possible is likely to be made if the claim is evaluated objectively using the advice of an experienced team.

Dr. Zurad says that his defense team did in fact provide accurate advice concerning the decision to fight when he and several other doctors were sued by a patient who fell at a worksite. The suit, which included punitive damages not covered by malpractice insurance, was brought against him as well as the radiologist, the hospital, and the emergency department doctor. Because the settlement demand of \$6 million was considered excessively high by the defense team, the decision was made to forgo a settlement and defend the case. Dr. Zurad and the others won their case in 2002—six years after the claim was made by the plaintiff.

In addition to the attorney assigned to the case by his insurance carrier, Dr. Zurad hired a personal lawyer to help with the defense since his personal assets were at stake. He points out that such a step is customary when the amount sought by the plaintiff is higher than the coverage provided by a physician’s insurer. He adds that seeking large awards is a common tactic in states where there is no cap on punitive damages.

Reading the Fine Print

Before settling a case, you must determine what the various provisions of your insurance policy say about this. For example, if you have a consent-to-settle clause in your policy and decide to settle, in some situations you may be asked to sign an agreement to that fact.

Consent-to-settle clauses generally give physicians a voice in whether to settle. “Whether a physician must sign a specific agreement really depends on individual insurance company policies and practices,” says Kevin Quinley, author of *Bulletproofing Your Medical Practice*. In some cases, the physician may simply have to send a letter to the carrier indicating consent, while other carriers may require a specific form with their own specific wording, he explains.

When deciding whether to defend a case, it is prudent to check your policy for *hammer clauses* which may specify that all legal expenses above the settlement offer are the physician’s responsibility.

“This puts a lot of financial pressure on the policyholder to

consent to a settlement that they might otherwise not agree or consent to because it shifts the financial burden of the uncertainty for guessing wrong onto the policyholder,” says Mr. Quinley. The effect of such a clause is to convince the doctor that he should agree to settle the case regardless of its merits.

Some hammer clauses are worse than others. A *soft* or *modified hammer clause* specifies that the insurer is required to cover only a certain percentage of future defense and/or indemnity costs that exceed the amount of a settlement offer rejected by the insured. (Obviously, any type of hammer clause is unpopular among policyholders. For that reason insurance carriers who wish to make inroads into writing medical malpractice coverage will not include this type of clause in a policy, says Mr. Quinley.)

A cooperation clause may indicate that the insured physician must not admit liability to the injured party. Some health professionals have interpreted this to mean that if they disclose a medical error to a patient, they risk losing coverage for any malpractice case.

Malpractice insurance policies may also contain *cooperation clauses* that require physicians to cooperate with a carrier’s attempt to defend the insured against a claim. This essentially means that the physician must make a reasonable amount of time available to help with his or her defense by being available for the deposition, producing documents that are needed to evaluate the event, responding to subpoenas, appearing at the trial, and performing other tasks needed to defend the claim.

A cooperation clause may indicate that in order to maintain coverage, the insured physician must not admit liability to the injured party. Some health professionals have interpreted this to mean that if they disclose a medical error to a patient, they risk losing coverage for any malpractice case. However, legal experts maintain that this should not be the case.

“Any carrier who tries to contest coverage because of a physician’s apology on grounds of the cooperation clause, would be on shaky grounds unless there is specific language in the policy which says such comments might negate coverage,” explains Mr. Quinley.

The terms of settlement should be reviewed cautiously. These may include a *gag clause* that requires the confidential sequestering of all information related to the case. “A gag clause may not always be a necessary component of any settlement because for the most part physicians do not want to publicize this type of information,” says Mr. Quinley. In some situations, plaintiffs are happy to agree not to discuss the details of specific cases because they want to reach a settlement and receive compensation.

Critics of such provisions say that keeping settlements confidential does not help patients who may benefit from openness regarding negligence and other malpractice situations. “Building a culture of safety in medicine requires that physicians be

Practitioner Profiles

While it appears that Congress is unlikely to grant public access to information contained in the National Practitioner Data Base any time soon, some state have passed physician-profiling laws requiring state agencies to compile practice information on physicians. Generally, profiles consist of information such as the practitioner’s education and training, specialty, and hospital affiliations. Some states include malpractice claims experience in their profiles.

For example, the Massachusetts Board of Registration in Medicine (www.massmedboard.org) makes it possible for the public to access physician profiles online or by phone. These profiles give patients information about the education, training, and experience of all licensed physicians. In addition, the profiles provide information on malpractice claims paid in the past 10 years, as well as actions by hospitals to restrict privileges, and disciplinary actions taken by the board over the same period.

New York State has a Website (www.nydoctorprofile.com) that provides profiles for all licensed doctors of medicine who are registered to practice medicine in New York. The site includes information about the doctor’s medical education and legal action taken against the doctor. Physicians in New York are permitted to give extra information about their practice, such as community service activities or awards and a personal statement about any information included in the profile.

The Medical Board of California makes some information about physicians available to the public. This includes malpractice settle-

willing to share information about injuries with systems that can use it to learn about injury prevention,” Dr. Mello told the House Subcommittee on Health.

National Practitioner Data Bank

Settling a case is not without repercussions, says Dr. Zurad. For example, when a physician decides to settle instead of fighting, the information concerning the case is reported to the National Practitioner Data Bank (NPDB), a warning system that alerts users to a practitioner’s malpractice history.

Congress enacted legislation in 1986 under the Health Care Quality Improvement Act that led to the creation of the NPDB.

ments as well as any hospital disciplinary actions that resulted in the termination or revocation of the physician’s privileges to provide healthcare services at a healthcare facility. Some of the information may be obtained through the Board’s Website (www.medbd.ca.gov) or by requesting it by phone.

New Jersey’s Health Care Consumer Information Act became effective in June 2004. The statute requires that profile information about physicians in the state be maintained and that certain information be made available to the public. Some of the required information in the profiles includes the following:

- medical school attended and the year in which the medical degree was received
- location of office practice
- medical malpractice payments made in the last five years, including date, dollar amount, and type
- any current restrictions or limitations against the doctor’s New Jersey license

Patients can access a physician’s profile by going to www.njdoctorlist.com.

Georgia also enacted a patient right-to-know law, which requires the Composite State Board of Medical Examiners to create and maintain a profile on each physician licensed to practice medicine in the state. These profiles contain information on a doctor’s education, board certification, and years of experience as well as disciplinary actions taken by the board and certain malpractice judgments and settlements. (To access this information, go to www.medicalboard.state.ga.us.)

Lawmakers believed that the quality of medical care needed to be improved on a national scale by encouraging state licensing boards, hospitals, and other entities to identify and discipline providers who engage in unprofessional behavior. The NPDB identifies practitioners with a history of adverse actions and medical malpractice payments.

In some situations, insurance carriers may allow their insured physicians to see a working copy of the report before the final report is submitted to the NPDB. In fact, the data bank indicates that reporting entities may reduce the likelihood of a physician's disputing a report by consulting with the physician about the report prior to submitting it to the data bank.

It tracks licensure actions taken against physicians and dentists as well as mandatory professional review actions taken against them. This nationwide database provides the information upon request to hospitals, health plans, professional societies, and state licensing boards. One of the databank's principal objectives is to restrict the ability of incompetent physicians to move from state to state without

disclosure or discovery of their previous damaging or incompetent performance.

Organizations use information from the NPDB along with data from other sources when considering a practitioner for clinical privileges, employment, affiliation, or licensure, or when reviewing a practitioner's records. To receive the information, authorized organizations must officially query the data bank. In order to query the data bank, the organizations must be first registered with the data bank.

Managed-care organizations often require participating physicians to provide information concerning malpractice claim history as part of the credentialing process.

Hospitals also query staff physicians concerning their malpractice claims history. Staff privileges may be subject to revocation, restriction, or nonrenewal based on malpractice claims history. Hospitals take into account the number of claims that a physician has had over the course of his or her career, but these organizations also consider the nature of the physician's specialty. Several claims against physicians in high-risk specialties such as neurosurgery or obstetrics over a 20-year span may not

be seriously detrimental and may not be an indication of deficient medical care.

Other than these authorized requests, information in the data bank is confidential and cannot be disclosed to a medical malpractice insurer, defense attorney, or member of the general public.

In their book *Wall of Silence: The Untold Story of the Medical Mistakes That Kill and Injure Millions of Americans*, authors Rosemary Gibson and Janardan Prasad Singh point out that early versions of the legislation setting up NPDB “allowed the public to have access to the information, but lobbying by the American Medical Association led Congress to drop the provision granting public access.”

The reporting requirements and query rules of the NPDB are as follows:

■ **Medical malpractice carriers must report any payment resulting from a written claim or judgment.** Reports must be submitted to the NPDB and the appropriate state licensing board within 30 days of a payment. Failure to do so can result in a \$10,000 fine for each missing report. The reports are required to be submitted whether the matter was settled due to judgment, out-of-court settlement, or arbitration. Carriers are asked to provide a detailed narrative to describe the acts or omissions and injuries or illnesses on which the medical malpractice action or claim was based. Narratives cannot contain a patient’s name or names of other practitioners, plaintiffs, witnesses, or any other individuals involved in the case.

Note: In some situations, insurance carriers may allow their insured physicians to see a working copy of the report before the final report is submitted to the NPDB. In fact, the data bank indicates that reporting entities may reduce the likelihood of a physician’s disputing a report by consulting with the physician about the report prior to submitting it to the data bank.

■ **State licensing boards must report**

Do your patients have questions about Medicare Part D? We've got the answers in Your Guide to Medicare Part D from *Patient's Digest*. Go to www.doctorsdigest.net to download an executive summary that gives patients quick tips and instructions on how to get the free publication.

licensure disciplinary action based on reasons related to professional competence or conduct. Reports must be submitted to the NPDB within 30 days of the action. State boards can query the NPDB at any time.

■ **Hospitals and other healthcare facilities must report to the NPDB and the appropriate state licensing board any professional review actions within 15 days of the action based on the following reasons:**

- ✓ matters related to professional competence
- ✓ conduct that adversely affects clinical privileges for a period longer than 30 days
- ✓ voluntary surrender or restriction of clinical privileges while under, or to avoid, investigation

■ **Hospitals must query the NPDB when screening applicants for medical staff appointment or granting clinical privileges.** They also must query every two years to obtain information on healthcare practitioners on the medical staff or those who have clinical privileges. Hospitals are allowed to query at other times if they believe it is necessary.

■ **Professional societies must report to the NPDB professional review action based on reasons relating to professional competence or conduct that adversely affects membership.** Reports must be submitted to the NPDB and the appropriate state licensing board within 15 days of the action. Societies may query when screening an applicant for membership or affiliation and in support of professional review activity.

■ **The Department of Health and Human Services (HHS) Office of Inspector General must report exclusions from Medicaid/Medicare and other federal programs.** Exclusions are reported monthly.

Healthcare professionals are not eligible to initiate a report to the data bank. However, for a small fee they can query the NPDB for any information on file about themselves and take action to correct any erroneous information in the data bank. Physicians should review these reports for accuracy, including information about their current address and place of employment.

Once the data bank receives the properly signed and notarized self-query application, it takes approximately five to seven business days to process and mail the response. The response will

consist of either a notification that no information exists in the data bank or a copy of all reported information that has been submitted by reporting entities. Federal law expressly prohibits the data bank from sending query responses to a third party, such as a state board.

Reporting entities are responsible for the factual accuracy of the information they report. If any information in a report is not accurate, physicians should contact the reporting organization to request that it file a correction to the report. Doctors are also allowed to add a statement to their report at any time. These statements are limited to 2,000 characters, including spaces and punctuation. These statements cannot include any patient names. ISMIE Mutual Insurance Company encourages physicians to submit a reply to any reports submitted to the NPDB. This allows the insured an opportunity to explain the circumstances of the incident being reported. (For more on correcting erroneous information, go to www.npdb-hipdb.com/pubs/fs/Fact_Sheet-Self-Querying.pdf.)

While Congress has heard testimony concerning redesigning or replacing the NPDB, little action has taken place to date. A 2000 GAO report cited a number of problems with the data bank, including the underreporting of disciplinary actions. One suggestion offered to Congress is to create a centralized database that can capture important performance information about all licensed practitioners. For this to take place, the NPDB needs a significant overhaul, according to Margaret VanAmringe, vice president of public policy and government relations for the Joint Commission on Accreditation of Healthcare Organizations, in a statement before the House Committee on Energy and Commerce's hearings on innovation solutions to medical liability.