

MEDICAL MALPRACTICE CLAIMS STUDY



ILLINOIS DEPARTMENT OF INSURANCE

June 2011

Pat Quinn
Governor

Michael T. McRaith
Director



Illinois Department of Insurance

PAT QUINN
Governor

MICHAEL T. McRAITH
Director

June 3, 2011

Via Hand Delivery

The Honorable Pat Quinn
Governor
207 State Capitol
Springfield, IL 62706

The Honorable John J. Cullerton
President
Illinois Senate
401 State Capitol
Springfield, IL 62706

The Honorable Michael J. Madigan
Speaker
Illinois House
420 State Capitol
Springfield, IL 62706

Re: 2011 Medical Malpractice Claims Report.

Dear Governor Quinn, President Cullerton, and Speaker Madigan:

Pursuant to Section 155.19 of the Illinois Insurance Code (215 ILCS 5/155.19), the Department hereby releases the 2011 Medical Malpractice Claims Report. This Report compiles medical malpractice claims information filed with the Department by insurers that did or do provide medical malpractice coverage in Illinois.

Very Truly Yours,

Michael T. McRaith
Director

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Introduction

Section 155.19 of the Illinois Insurance Code requires licensed insurance companies to report closed Illinois medical liability claims to the Illinois Department of Insurance (Department), and requires the Director to release statistical reports based on the reported data.

The study is based on reported medical malpractice claims closed between January 1, 2005, and December 31, 2008.

This study provides an analysis of the following areas:

- Number of claims and indemnity payments per claim– the number of claims closed during any given year, the percentage that are closed with an indemnity payment, and the mean and median indemnity payment per claim.
- Defense Counsel Payment – Mean and median fees paid by an insurance company to an attorney to defend a claim, for claims with and without an indemnity payment.
- Claim duration – Mean and median duration between an injury, notification of the insurer, and closing of the claim.
- Injury Severity – Frequency of claims for varying levels of injury severity, the percentage of such claims closed with an indemnity payment, and the mean and median indemnity payment per claim.
- Specialty of treating physician – Frequency of claims against different specialists, the percentage that are closed with an indemnity payment, and the mean and median indemnity payment per claim.
- Regional analysis – Analysis by region of frequency of claims, the percentage that are closed with an indemnity payment, and the mean and median indemnity payment per claim.

All figures in this report are in 2008\$.

The study was prepared by Professor David Hyman of the University of Illinois.

Limitations

When reviewing this report, the reader should keep in mind the following limitations of the underlying data and the final report:

- Results in this report cannot be compared to previous reports – This report is not comparable to any of the Department’s earlier medical malpractice reports for several reasons, including: (1) the figures in this report are inflation-adjusted, while figures in earlier reports are not; and (2) changes in the methodology of collecting, compiling, and analyzing the data. Prior studies have not been revised or updated. Readers should not draw any conclusions because of differences between the figures reported in this report and in prior reports.
- Report does not evaluate medical liability insurance rates – This report is limited to the closed claims reported to the Department. It does not attempt to evaluate past or current medical liability insurance rates, nor is it predictive of future trends in medical liability insurance rates.
- Report provides only a partial analysis of the overall Illinois medical liability insurance marketplace – This report provides only a partial analysis of the Illinois medical liability insurance marketplace for several reasons:
 - Data pertains to claims closed against physicians and surgeons only. This report does not analyze closed claim information for other health care providers such as nurses, hospitals, clinics, or corporations.
 - Report does not provide information about the number of active insurers writing medical liability insurance for physicians and surgeons and whether that number has increased or decreased over the report period, or whether insurers have made business decisions to increase or decrease their medical liability writings in certain classifications and/or territories.
- Data may contain anomalies – The Department makes every possible effort to ensure the accuracy, consistency, and completeness of the data. The Department provides all insurers with the same set of instructions and filing requirements, and Department personnel attempt to follow up on incomplete reports or anomalies in data. However, the accuracy of the report still depends largely on the accuracy of the data reported by insurers. Individual insurers and individual data entry personnel employed by those insurers may interpret data fields differently. As a result, errors and inconsistencies may still occur. The Department cannot verify the accuracy of certain claim data reported and must rely solely on the accuracy of the reporting insurer.

Attached as Appendix A is a list of the information provided by reporting insurers to the Department. An on-line version of the information may be found at <http://www.ilga.gov/commission/jcar/admincode/050/05000928ZZ9999bR.html>.

- Data does not distinguish between policies and coverage amounts – The report does not analyze the data by type of policy (*e.g.* primary or excess, prior acts or extended reporting period coverage), limits of insurance purchased, or size of deductibles to determine whether these factors affect the frequency or severity of claims.
- Data is reported separately for each insured physician or surgeon – If a claim is made against more than one physician or surgeon for the same incident, the data is reported separately by each insurer for each defendant. This report treats each such report as a discrete claim/dispute. This method effectively over-states the frequency of disputes/cases (viewed from the perspective of the plaintiff), but more accurately reflects the frequency of claiming (from the perspective of defendants).
- Report does not include information about open claims - This report analyzes only closed claims. Any claims that are still open, such as claims that are in settlement negotiations or on trial, are not included in this study.
- Specialties are Aggregated - Individual insurers code the specialty of defendant physicians, and the nature of the claim (*i.e.*, Radiology – diagnostic – no surgery, and Radiology – diagnostic – minor surgery). To simplify comparison of claim patterns across specialties, this report combines all claims involving the same specialty. *See* Appendix B.

Executive Summary

Note: All observations apply only to the period covered by this report (2005-2008). All dollar figures are inflation adjusted, and are in 2008\$. Every reference to claims refers only to closed claims.

Number of Claims

- The total number of claims was 7,260, of which there were 1,217 (17%) indemnity payments.
- The percentage of claims with an indemnity payment in any given year ranged from 13% to 18%.
- There was a decline in the number of claims per year, both paid and unpaid. For example, in 2005, there were 2,475 claims, with 443 indemnity payments. In 2008, there were 1,246 claims, with 211 indemnity payments.

Indemnity Payments

- Mean indemnity payments for claims in which there was a payment ranged from \$558,655 in 2007 to \$654,009 in 2005.
- Median indemnity payments for claims in which there was a payment ranged from \$415,369 in 2007 to \$534,188 in 2006.
- There was a total of \$762,848,581 in indemnity payments, ranging from \$289,725,854 in 2005 to \$103,351,138 in 2007.

Defense Counsel Payment

- Legal fees were incurred in 68% of all closed claims, and 89% of claims with a positive indemnity payment.
- Mean legal fees were \$35,543 in cases without an indemnity payment, and \$63,145 in cases with an indemnity payment.
- Median legal fees were \$21,241 in cases without an indemnity payment, and \$45,799 in cases with an indemnity payment.
- There was a total of \$205,148,374 in payments to defense counsel for legal fees.

Claim Duration

- Mean duration from injury to closure was 5.01 years, increasing from 4.7 years in 2005 to 5.25 years in 2008.
- Median duration from injury to closure was 4.65 years, increasing from 4.31 years in 2005 to 4.98 years in 2008.

Injury Severity

- Death cases accounted for 39% of all claims, and 38% of all paid claims.
- More severe injuries generally had higher mean and median indemnity payments, except for death claims.

Type of Medical Specialty

- Four specialties (surgery other than obstetric, internal medicine, obstetrics & gynecology, and family physicians/general practitioners) accounted for 62% of claims, and 65% of total indemnity payments.
- Surgery (other than obstetric) accounted for 28% of all claims, 27% of paid claims, and 29% of total indemnity payments.

Claims by Region of State

- Five counties (Cook, Madison, McHenry, St. Clair and Will Counties) accounted for 55% of claims, 53% of paid claims, and 55% of total indemnity payments.

Table 1: Claim Frequency and Indemnity Payments by Year

Year	No. of Claims	% with Positive Payment	Mean Indemnity Payment	Median Indemnity Payment	Total Indemnity Payment
2005	2,475	18%	\$654,009	\$441,014	\$289,725,854
2006	2,070	18%	\$639,519	\$534,188	\$241,738,144
2007	1,469	13%	\$558,655	\$415,369	\$103,351,138
2008	1,246	17%	\$606,794	\$416,662	\$128,033,450
Total	7,260	17%	\$626,827	\$454,060	\$762,848,581

Table 2: Defense Counsel Payment by Year (in Claims with Positive Defense Counsel Payment)

Year	Total			Claims with Positive Indemnity Payment			Claims with Zero Indemnity Payment		
	No. of Claims	Mean	Median	No. of Claims	Mean Defense Counsel Payment	Median Defense Counsel Payment	No. of Claims	Mean Defense Counsel Payment	Median Defense Counsel Payment
2005	1,811	\$37,028	\$23,327	396	\$53,457	\$42,283	1,415	\$32,430	\$18,160
2006	1,672	\$42,565	\$25,647	340	\$71,201	\$50,224	1,332	\$35,256	\$21,070
2007	643	\$45,313	\$28,262	156	\$64,351	\$41,220	487	\$39,215	\$23,639
2008	804	\$46,997	\$31,384	192	\$67,880	\$54,356	612	\$40,445	\$26,583
Total	4,930	\$41,612	\$26,165	1,084	\$63,145	\$45,799	3,846	\$35,543	\$21,241

Table 3: Claim Duration by Year

		2005	2006	2007	2008	Total
Date of Injury ~ Date Reported to Insurer	Mean	2.03	2.07	2.02	2.03	2.04
	Median	2.02	2.02	2.02	2.02	2.02
Date Reported ~ Date of Closure	Mean	2.67	3.04	3.16	3.21	2.97
	Median	2.31	2.82	2.95	3.01	2.70
Date of Injury ~ Date of Closure	Mean	4.70	5.11	5.18	5.25	5.01
	Median	4.31	4.70	4.94	4.98	4.65

Insurers are required to code the severity of injury for each closed claim according to the categories established and defined by the Department. The specific categories are:

- Emotional only – fright, no physical damage;
- Insignificant Temporary – lacerations, contusions, minor scars, rash; no delay;
- Minor Temporary – infections, mis-set fracture, fall in hospital; recovery delay;
- Major Temporary – burns, surgical material left, drug side effect, brain damage; recovery delay;
- Minor Permanent – loss of fingers, loss or damage to organs; includes non-disabling injuries;
- Significant Permanent – deafness, loss of limb, loss of eye, loss of one kidney or lung;
- Major Permanent – paraplegia, blindness, loss of two limbs, brain damage;
- Grave Permanent – quadriplegia, severe brain damage, lifelong care or fatal prognosis;
- Death.

Table 4A: Claiming Patterns by Severity of Injury and Year

Severity of Injury Code	2005		2006		2007		2008		Total	
	No. of Claims	% Paid	No. of Claims	% Paid	No. of Claims	% Paid	No. of Claims	% Paid	No. of Claims	% Paid
Emotional Only	34	15%	32	16%	24	4%	13	8%	103	12%
Temporary - Insignificant	34	9%	29	3%	17	18%	31	10%	111	9%
Temporary - Minor	122	13%	136	12%	113	13%	114	15%	485	13%
Temporary - Major	600	9%	446	12%	286	7%	153	15%	1,485	10%
Permanent - Minor	262	24%	205	25%	149	18%	154	19%	770	22%
Permanent - Significant	274	19%	217	25%	137	13%	139	17%	767	19%
Permanent - Major	182	29%	139	24%	78	23%	78	27%	477	26%
Permanent - Grave	73	38%	70	37%	44	30%	40	25%	227	34%
Death	894	19%	794	18%	621	11%	524	16%	2,833	16%
NA			2	0%					2	0%
Total	2,475	18%	2,070	18%	1,469	13%	1,246	17%	7,260	17%

Table 4B: Indemnity Payment by Severity of Injury and Year

Severity of Injury Code	2005		2006		2007		2008		Total	
	Mean Indemnity Payment	Median Indemnity Payment	Mean Indemnity Payment	Median Indemnity Payment	Mean Indemnity Payment	Median Indemnity Payment	Mean Indemnity Payment	Median Indemnity Payment	Mean Indemnity Payment	Median Indemnity Payment
Emotional Only	\$71,720	\$27,563	\$362,958	\$122,863	\$15,576	\$15,576	\$3,000	\$3,000	\$182,664	\$31,009
Temporary - Insignificant	\$722,161	\$165,380	\$9,348	\$9,348	\$35,411	\$20,768	\$105,833	\$25,000	\$259,956	\$22,884
Temporary - Minor	\$340,503	\$145,189	\$132,712	\$45,406	\$144,329	\$41,537	\$278,285	\$250,000	\$226,050	\$81,409
Temporary - Major	\$281,794	\$165,380	\$380,926	\$267,094	\$443,109	\$295,950	\$363,794	\$300,000	\$351,784	\$267,094
Permanent - Minor	\$345,551	\$220,507	\$331,600	\$160,256	\$329,645	\$233,645	\$832,960	\$230,000	\$424,853	\$220,507
Permanent - Significant	\$655,190	\$551,268	\$637,994	\$560,898	\$613,156	\$467,290	\$777,449	\$750,000	\$662,908	\$551,268
Permanent - Major	\$1,007,022	\$1,047,409	\$1,310,336	\$908,120	\$896,968	\$804,777	\$787,698	\$900,000	\$1,034,624	\$961,539
Permanent - Grave	\$1,465,598	\$937,156	\$1,016,191	\$1,068,376	\$1,353,348	\$1,028,037	\$872,500	\$1,000,000	\$1,217,873	\$1,000,000
Death	\$685,416	\$496,141	\$692,551	\$641,026	\$551,927	\$519,211	\$559,977	\$470,000	\$645,366	\$519,211
NA										
Total	\$654,009	\$441,014	\$639,519	\$534,188	\$558,655	\$415,369	\$606,794	\$416,662	\$626,827	\$454,060

Table 5: Claiming Patterns by Specialty and Year

Specialty: 2005	N	% of All Claims (2005)	% Paid	Mean Payout	Median Payout	Total Payout
Surgery - other than obstetrics	674	27.2%	16.6%	\$595,337	\$399,669	\$66,677,811
Internal Medicine	309	12.5%	16.5%	\$542,836	\$441,014	\$27,684,674
Obstetrics and Gynecology	309	12.5%	26.5%	\$865,468	\$551,268	\$70,968,386
Other	234	9.5%	20.1%	\$542,932	\$311,466	\$25,517,831
Family Physicians or General Practitioners	169	6.8%	16.6%	\$603,451	\$606,395	\$16,896,637
Radiology	150	6.1%	14.7%	\$471,350	\$413,451	\$10,369,717
Cardiovascular Disease	113	4.6%	14.2%	\$571,618	\$513,782	\$9,145,901
Emergency Medicine	108	4.4%	18.5%	\$484,362	\$330,761	\$9,687,246
Anesthesiology	95	3.8%	23.2%	\$1,197,691	\$826,902	\$26,349,207
Gastroenterology	68	2.7%	10.3%	\$821,651	\$551,268	\$5,751,562
Pediatrics	66	2.7%	19.7%	\$615,865	\$551,268	\$8,006,248
Pulmonary Diseases	45	1.8%	4.4%	\$441,014	\$441,014	\$882,028
Neurology	43	1.7%	20.9%	\$632,315	\$496,141	\$5,690,840
Psychiatry	32	1.3%	28.1%	\$314,100	\$275,634	\$2,826,901
Nephrology	31	1.3%	6.5%	\$532,892	\$532,893	\$1,065,785
Hematology/Oncology	29	1.2%	3.4%	\$2,205,071	\$2,205,072	\$2,205,071
Total	2475	100.0%	17.9%	\$654,009	\$441,014	\$289,725,845

Specialty: 2006	N	% of All Claims (2006)	% Paid	Mean Payout	Median Payout	Total Payout
Surgery - other than obstetrics	598	28.9%	19.4%	\$530,044	\$464,811	\$61,485,188
Internal Medicine	263	12.7%	16.0%	\$600,773	\$507,479	\$25,232,466
Obstetrics and Gynecology	239	11.5%	18.0%	\$956,436	\$614,316	\$41,126,776
Family Physicians or General Practitioners	193	9.3%	19.7%	\$655,444	\$534,188	\$24,906,873
Emergency Medicine	138	6.7%	18.1%	\$538,666	\$480,769	\$13,466,669
Other	123	5.9%	33.3%	\$619,781	\$427,350	\$25,411,026
Cardiovascular Disease	112	5.4%	10.7%	\$695,844	\$465,831	\$8,350,136
Radiology	101	4.9%	15.8%	\$746,193	\$948,184	\$11,939,103
Anesthesiology	81	3.9%	11.1%	\$872,567	\$961,539	\$7,853,111
Gastroenterology	56	2.7%	16.1%	\$661,799	\$801,282	\$5,956,196
Pediatrics	47	2.3%	14.9%	\$862,790	\$534,188	\$6,039,530
Psychiatry	39	1.9%	33.3%	\$456,783	\$534,188	\$5,938,188
Neurology	26	1.3%	11.5%	\$729,971	\$641,026	\$2,189,913
Pulmonary Diseases	22	1.1%	4.5%	\$373,931	\$373,932	\$373,931
Hematology/Oncology	19	0.9%	10.5%	\$614,316	\$614,316	\$1,228,632
Nephrology	13	0.6%	7.7%	\$240,384	\$240,385	\$240,384
Total	2070	100.0%	18.3%	\$639,519	\$534,188	\$241,738,122

Specialty: 2007	N	% of All Claims (2007)	% Paid	Mean Payout	Median Payout	Total Payout
Surgery - other than obstetrics	415	28.3%	16.1%	\$484,722	\$259,605	\$32,476,410
Internal Medicine	185	12.6%	11.9%	\$480,084	\$373,832	\$10,561,856
Obstetrics and Gynecology	178	12.1%	11.8%	\$889,880	\$838,791	\$18,687,493
Family Physicians or General Practitioners	135	9.2%	12.6%	\$707,027	\$778,816	\$12,019,463
Other	111	7.6%	10.8%	\$424,454	\$389,408	\$5,093,457
Radiology	103	7.0%	11.7%	\$361,067	\$277,778	\$4,332,814
Cardiovascular Disease	73	5.0%	11.0%	\$661,993	\$623,053	\$5,295,950
Emergency Medicine	52	3.5%	15.4%	\$577,622	\$708,723	\$4,620,976
Anesthesiology	45	3.1%	13.3%	\$748,528	\$830,737	\$4,491,173
Pediatrics	41	2.8%	17.1%	\$464,767	\$454,309	\$3,253,374
Gastroenterology	36	2.5%	2.8%	\$1,012,461	\$1,012,461	\$1,012,461
Pulmonary Diseases	31	2.1%	3.2%	\$519,210	\$519,211	\$519,210
Neurology	29	2.0%	3.4%	\$726,895	\$726,895	\$726,895
Psychiatry	14	1.0%	14.3%	\$129,802	\$129,803	\$259,605
Nephrology	13	0.9%	0.0%			
Hematology/Oncology	8	0.5%	0.0%			
Total	1469	100.0%	12.6%	\$558,655	\$415,369	\$103,351,137

Specialty: 2008	N	% of All Claims (2008)	% Paid	Mean Payout	Median Payout	Total Payout
Surgery - other than obstetrics	339	27.2%	18.3%	\$692,462	\$340,000	\$42,932,698
Internal Medicine	191	15.3%	10.5%	\$658,591	\$487,500	\$13,171,830
Obstetrics and Gynecology	157	12.6%	21.0%	\$538,466	\$441,329	\$17,769,396
Other	92	7.4%	13.0%	\$564,159	\$627,204	\$6,769,908
Family Physicians or General Practitioners	82	6.6%	24.4%	\$506,725	\$425,000	\$10,134,500
Emergency Medicine	75	6.0%	20.0%	\$754,839	\$400,000	\$11,322,593
Radiology	62	5.0%	17.7%	\$341,181	\$135,000	\$3,753,000
Cardiovascular Disease	53	4.3%	11.3%	\$674,438	\$902,064	\$4,046,628
Gastroenterology	44	3.5%	13.6%	\$451,620	\$325,000	\$2,709,725
Pediatrics	37	3.0%	27.0%	\$584,166	\$642,500	\$5,841,666
Anesthesiology	33	2.6%	36.4%	\$664,083	\$718,300	\$7,969,004
Pulmonary Diseases	27	2.2%	0.0%			
Nephrology	21	1.7%	0.0%			
Neurology	16	1.3%	12.5%	\$537,500	\$537,500	\$1,075,000
Psychiatry	11	0.9%	0.0%			
Hematology/Oncology	6	0.5%	33.3%	\$268,750	\$268,750	\$537,500
Total	1246	100.0%	16.9%	\$606,794	\$416,662	\$128,033,448

Specialty (2005-2008)	N	% of all claims	% Paid	Mean Payout	Median Payout	Total Payout
Surgery - other than obstetrics	2026	27.9%	17.6%	\$570,229	\$340,000	\$203,572,109
Internal Medicine	948	13.1%	14.2%	\$567,783	\$467,290	\$76,650,828
Obstetrics and Gynecology	883	12.2%	20.3%	\$829,899	\$550,000	\$148,552,053
Family Physicians or General Practitioners	579	8.0%	17.8%	\$620,946	\$534,188	\$63,957,474
Other	560	7.7%	20.0%	\$560,644	\$385,888	\$62,792,223
Radiology	416	5.7%	14.7%	\$498,272	\$413,451	\$30,394,635
Emergency Medicine	373	5.1%	18.2%	\$574,963	\$388,454	\$39,097,484
Cardiovascular Disease	351	4.8%	12.0%	\$639,014	\$561,200	\$26,838,616
Anesthesiology	254	3.5%	19.3%	\$952,295	\$826,902	\$46,662,496
Gastroenterology	204	2.8%	11.3%	\$670,867	\$551,268	\$15,429,945
Pediatrics	191	2.6%	19.4%	\$625,427	\$514,517	\$23,140,818
Pulmonary Diseases	125	1.7%	3.2%	\$443,792	\$441,014	\$1,775,171
Neurology	114	1.6%	13.2%	\$645,509	\$496,141	\$9,682,648
Psychiatry	96	1.3%	25.0%	\$376,028	\$319,184	\$9,024,695
Nephrology	78	1.1%	3.8%	\$435,389	\$330,761	\$1,306,169
Hematology/Oncology	62	0.9%	8.1%	\$794,240	\$400,000	\$3,971,204
Total	7260	100.0%	16.8%	\$626,827	\$454,060	\$762,848,568

Claims filed in Illinois are grouped into the following regions, based on the insured's location within the state:

- Region 1 – Cook, Madison, McHenry, St. Clair and Will counties
- Region 2 – DuPage, Kane and Lake counties
- Region 3 – Champaign, Jackson, Macon, Sangamon and Vermilion counties
- Region 4 – Remainder of State
- Out of State – Used when the injury occurred while the physician/surgeon was located in Illinois but, prior to reporting the closed claim information, the physician/surgeon moved out of Illinois.

Table 6A: Claim Frequency by Region

Region	2005		2006		2007		2008		Total	
	No. of Claims	% Paid	No. of Claims	% Paid	No. of Claims	% Paid	No. of Claims	% Paid	No. of Claims	% Paid
1	1,315	18%	1,096	17%	852	12%	704	17%	3,967	16%
2	634	15%	497	14%	208	11%	218	14%	1,557	14%
3	89	27%	74	28%	66	17%	38	16%	267	23%
4	313	17%	294	23%	294	14%	234	19%	1,135	18%
Out of State/UK	124	24%	109	28%	49	16%	52	19%	334	23%
Total	2,475	18%	2,070	18%	1,469	13%	1,246	17%	7,260	17%

Table 6B: Indemnity Payments by Region

Region	2005		2006		2007		2008		Total	
	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
1	\$635,312	\$441,014	\$678,184	\$492,541	\$611,264	\$460,147	\$633,835	\$450,000	\$643,655	\$468,578
2	\$612,939	\$551,268	\$615,198	\$587,607	\$562,261	\$519,211	\$527,087	\$400,000	\$596,358	\$545,755
3	\$471,850	\$303,197	\$762,889	\$801,282	\$402,997	\$373,832	\$309,500	\$337,500	\$542,501	\$379,860
4	\$1,024,910	\$441,014	\$508,294	\$419,338	\$457,479	\$311,527	\$487,342	\$425,000	\$624,576	\$389,408
Out of State/UK	\$437,716	\$339,030	\$662,297	\$480,769	\$610,073	\$649,014	\$1,248,000	\$800,000	\$645,654	\$434,182
Total	\$654,009	\$441,014	\$639,519	\$534,188	\$558,655	\$415,369	\$606,794	\$416,662	\$626,827	\$454,060

Figure 1: Claim Frequency and Percentage of Paid Claims by Year

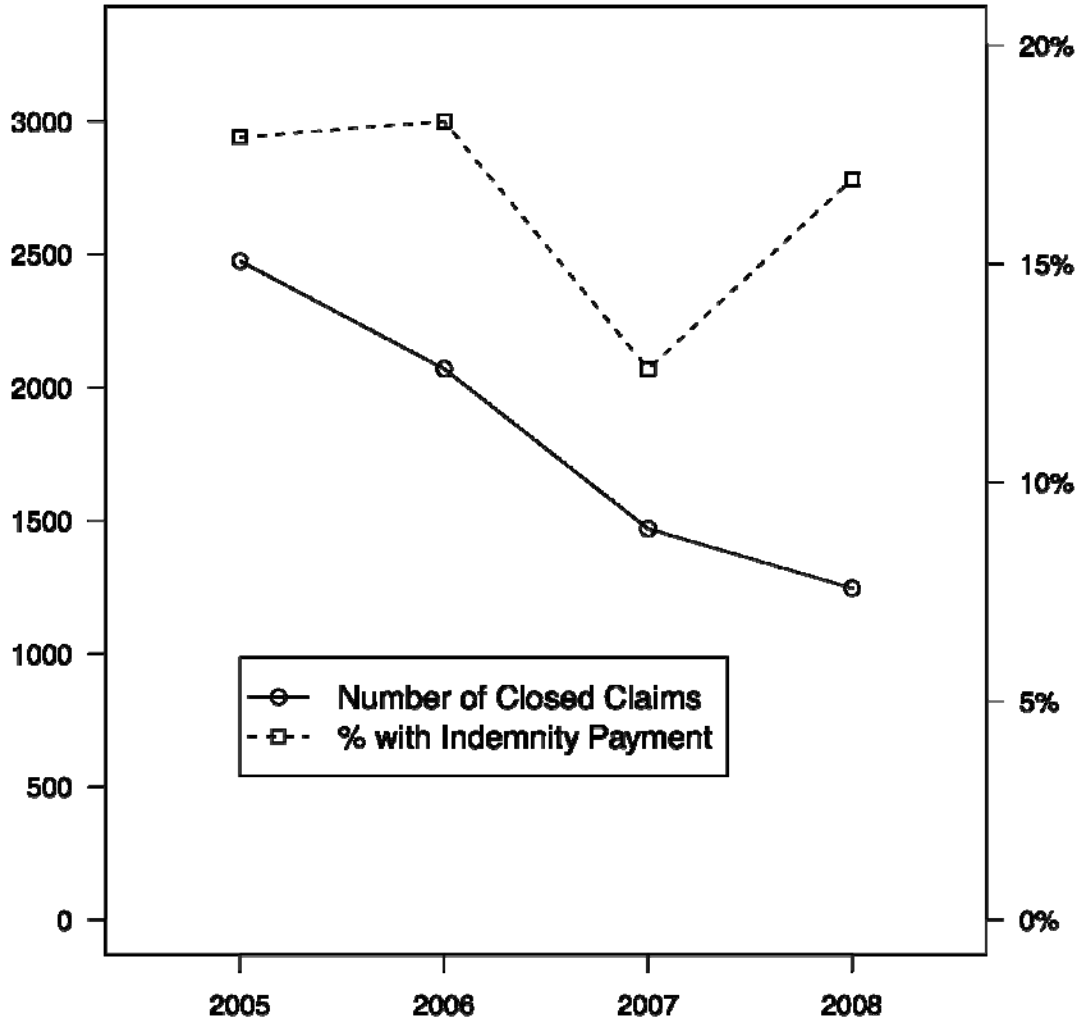


Figure 2: Mean and Median Indemnity Payment by Year

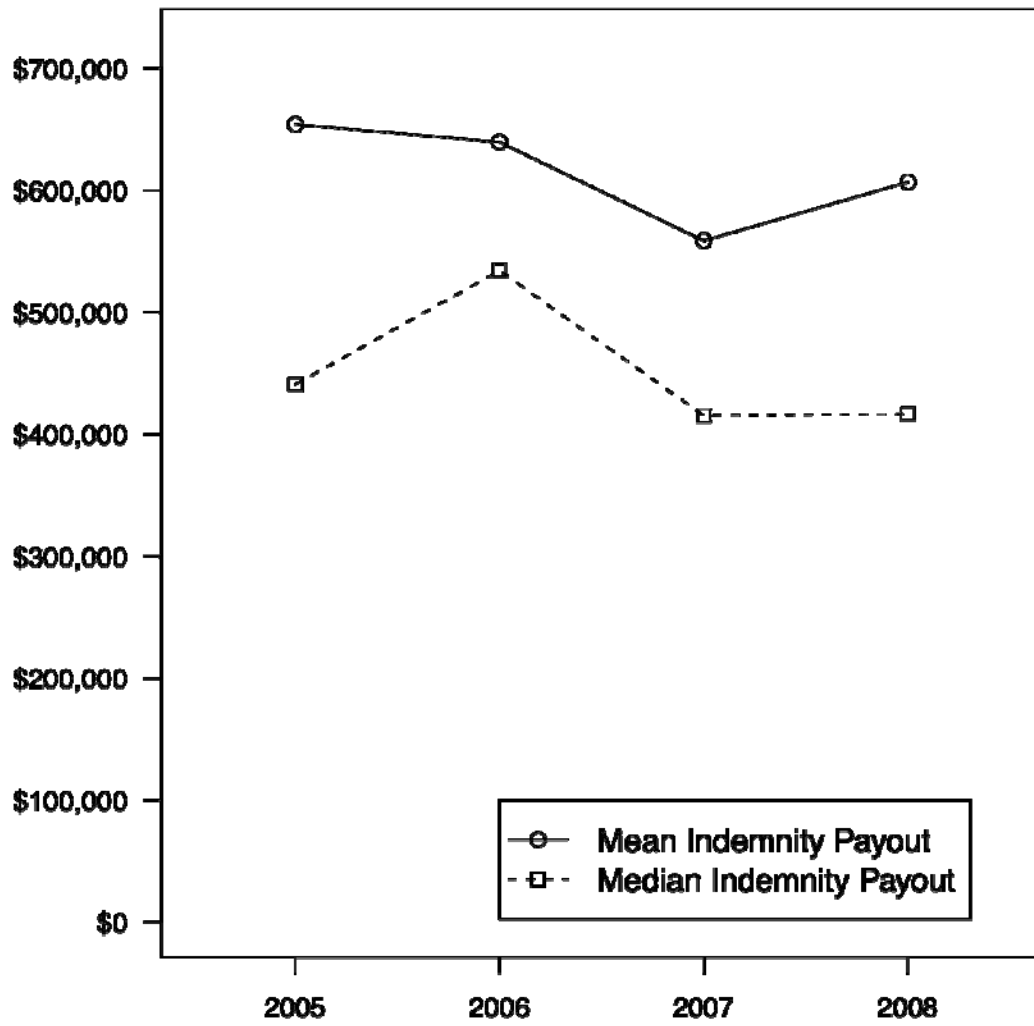


Figure 3: Mean and Median Defense Counsel Payment by Year

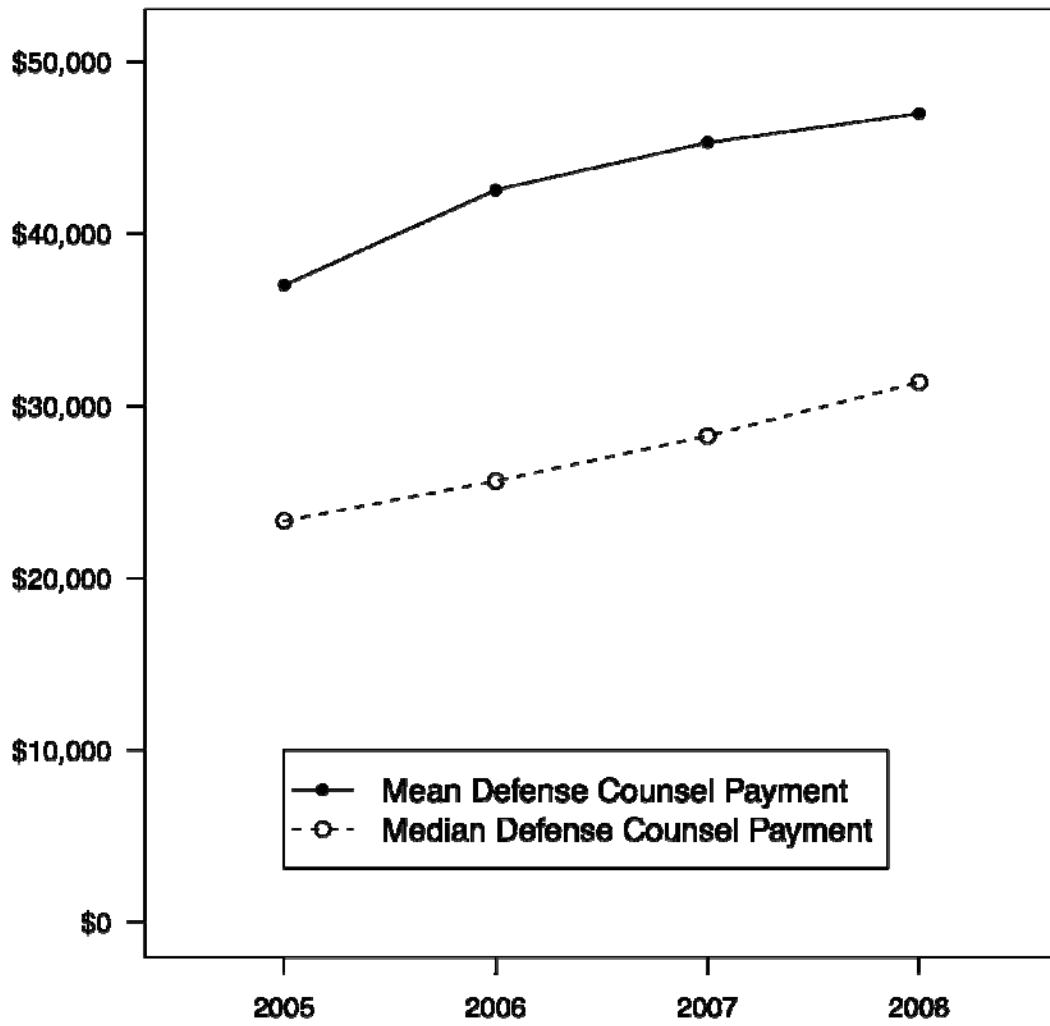
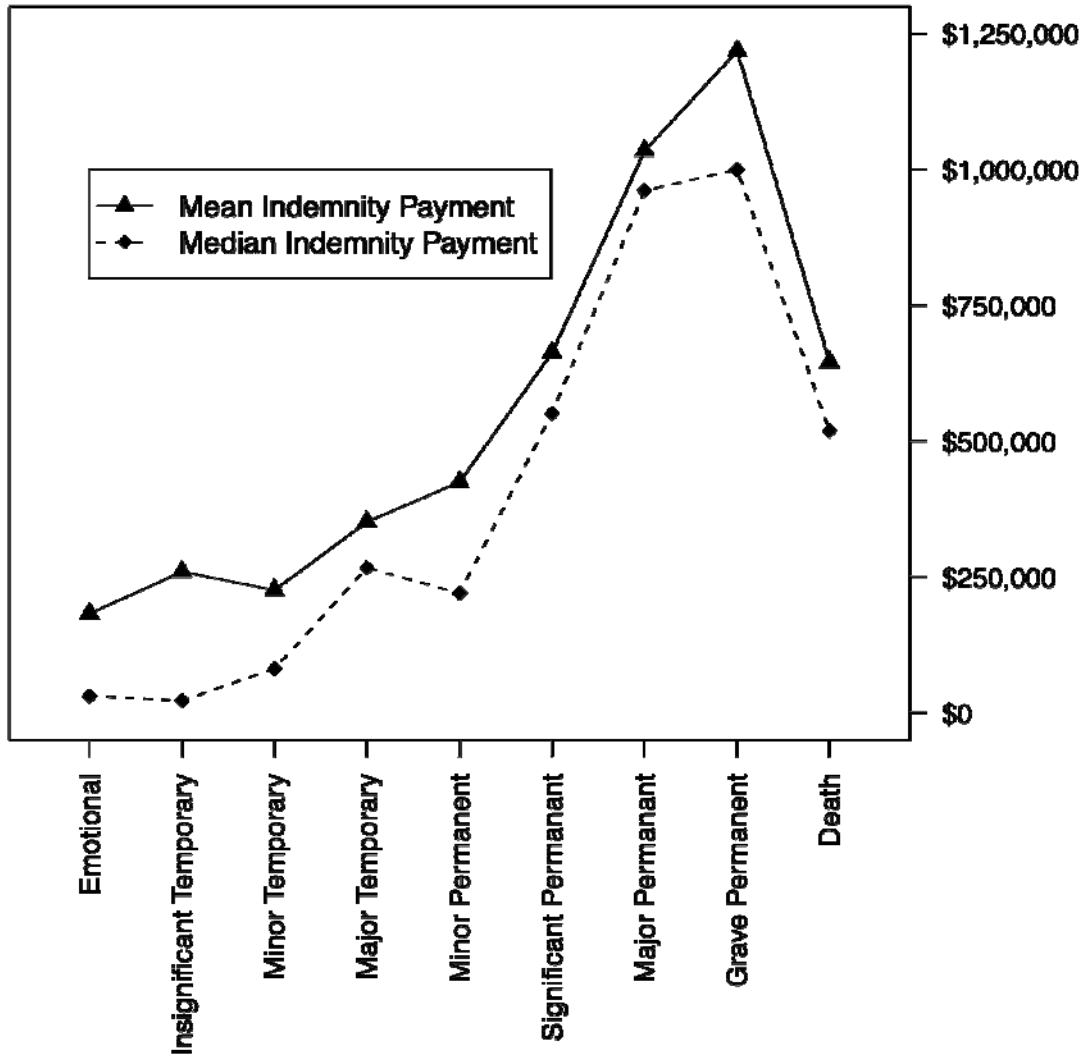


Figure 4: Mean and Median Indemnity Payments by Severity of Injury



Appendix A

TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF FINANCIAL AND PROFESSIONAL
REGULATION
SUBCHAPTER I: PROVISIONS APPLICABLE TO ALL COMPANIES
PART 928 MEDICAL MALPRACTICE DATA BASE
SECTION 928.EXHIBIT B ILLINOIS MEDICAL PROFESSIONAL LIABILITY
INSURANCE UNIFORM CLAIMS REPORT – REPORTING INSTRUCTIONS

Section 928.EXHIBIT B Illinois Medical Professional Liability Insurance Uniform
Claims Report – Reporting Instructions

To assist insurers and other reporting entities with electronic reporting, the Illinois Department of Financial and Professional Regulation-Division of Insurance (DOI) has created an electronic reporting application, which will be provided free of charge. Reporting entities will choose one of the two processes depending on how they prefer to file. One process will allow for data entry claim reporting and contain drop downs with choices. The other process will allow for batch reporting.

As required by Section 155.19 of the Insurance Code [215 ILCS 5/155.19] and 50 Ill. Adm. Code 928:

1. File all opened, closed, re-opened, and re-closed medical professional liability insurance claims and lawsuits, including any updates, with the DOI on a quarterly basis. For closed claims, include claims closed without payment. Insurance claim means a formal or written demand for compensation under a medical liability insurance policy relating to allegations of liability on the part of one or more providers for any act, error or omission in the rendering of, or failure to render, medical services for medically related injuries. Insurance claim includes any instance for which benefits or compensation are payable or eligible to be paid under any coverage under the policy. Lawsuit means a complaint filed in any court in this State alleging liability on the part of one or more providers for any act, error or omission in the rendering of, or failure to render, medical services for medically related injuries.
2. File separate reports for each defendant you insure. Each filing of a claim or lawsuit report shall be identified with a unique claim number. If more than one defendant/insured is associated with an incident, a unique claim number is required for each defendant/insured. If more than one claimant/injured party is associated with an incident, a unique claim number is required for each claimant/injured party. When there are multiple associated claims/lawsuits, report companion claim numbers in the other claims information section.
3. **RESPONSES TO ALL FIELDS ARE REQUIRED.** For open claim reports, complete Insurer Information through Contact Person Information. When updating reports, any information may be updated. For closed claim reports, all fields are required.

4. On the data entry process, drop downs are available for selecting codes for fields with an asterisk (*).
5. On the data entry process, incomplete filings cannot be saved – i.e., if you quit a filing before you have completed all required fields, you will not be able to save that incomplete filing.
6. Reports are due on a quarterly basis no later than 90 days after the quarter's end.

NOTE: If a company fails to submit accurate, timely, or complete reports, the Director may fine the company up to \$1000 for each offense. Each day during which a violation occurs constitutes a separate offense.

Insurer Information

- 1a. Insurer Name (not group name) (Maximum = 40 characters).
- 1b. Insurer 9-digit FEIN. Entities without a Federal Employer Identification Number (FEIN), contact the DOI for assigned number.

Initial Claim Information

- 2a. Claim ID. For each open claim report, assign a distinguishing claim number sufficient to enable DOI to track a particular claim over a period of years. On re-opened claims, use the same claim number as the original claim file that is being re-opened.
- 2b. Coverage Code.* Select the type of policy covering this claim. (1) Claims Made – Policy covers claim made during policy term regardless of when the incident occurred; (2) Prior Acts – Policy covers claim made during the policy term for events that occurred prior to the beginning of the policy term; (3) Occurrence – Policy covers claim that occurred during the policy term regardless of when the claim is presented; (4) Extended Reporting Period/Tail Coverage – Policy covers claim that occurred during the policy period but claim is made after the policy period ended.
- 2c. Date of Principal or Alleged Injury. (MM/DD/YYYY)
- 2d. Date Incident First Reported to Insurer. (MM/DD/YYYY) Date of alleged injury first reported to the insurer.
- 2e. Date Claim Opened by Insurer. (MM/DD/YYYY)
- 2f. Date Claim Re-Opened by Insurer. (MM/DD/YYYY)

2g. Date of Closure of Original Claim. (MM/DD/YYYY)

Insured Information

3a. Profession or Business Code.* (1) Physician or Surgeon*; (2) Hospital; (3) Nurse*; (4) Nursing Home; (5) Dentist*; (6) Pharmacy; (7) Optometrist*; (8) Chiropractor*; (9) Podiatrist/Chiropodist*; (10) Clinic/Corporation; (11) Other* – Employee (Maximum = 25 characters). A code with an asterisk (*) requires a "Type of Practice Code" as well.

3b. Type of Practice Code.* (1) Institutional, including Academic; (2) Professional Corporation, Partnership, or Group; (3) Self-Employed; (4) Hospital; (5) Nursing Home; (6) All Other Employees; (7) Intern or Resident.

3c. Insured's Name, including suffix such as MD, DO, etc.

3d. Insured's Illinois License Number. If unavailable, enter insured's Social Security Number. Enter FEIN for clinics and corporations.

3e. Insured's Date of Birth (MM/DD/YYYY). Not applicable to institution, group, or partnership.

3f. Five-digit ISO Specialty Code from Current ISO Common Statistical Base Classifications. Check annually with ISO for possible changes to specialty codes. Specialty code must be tied to the year the alleged injury occurred.

3g. Board Certified?* Y or N.
If Board Certified is answered with a "Y", Name of Board is required (Maximum = 25 characters).

3h. County of Insured's Principal Place of Practice for Rating Purposes.

Place of Injury Information

4a. Place Where Alleged Injury Occurred Code.* Enter only one. (1) Hospital Inpatient Facility*; (2) Emergency Room; (3) Hospital Outpatient Facility*; (4) Nursing Home*; (5) Physician's Office; (6) Patient's Home; (7) Other Outpatient Facility, including Clinics*; (X) Other* – describe place (Maximum = 25 characters). A code with an asterisk (*) requires a "Location Within Institution Code" as well.

4b. Location Within Institution Code.* (1) Patient's Room; (2) Labor/Delivery Room; (3) Operating Suite; (4) Recovery Room; (5) Critical Care Unit; (6) Special Procedure Room; (7) Nursery; (8) Radiology; (9) Physical Therapy Department; (X) Other – describe (Maximum = 25 characters).

4c. Name of Institution. (Maximum = 25 characters)

4d. County Where Alleged Injury Occurred.

Injured Person Information

5a. Injured Person's Name.

5b. Injured Person's Gender. M F

5c. Injured Person's Age Category.

5d. Injured Person's Social Security Number (for cross-tracking purposes only; information is kept confidential).

5e. County.

Other Claim Information

6a. Total Number of Defendants. Enter total number of persons or corporations that you insure that are involved in this claim.

6b. Companion Claim Number(s). Enter claim identification numbers for all claims against other defendants you insure that are involved in this claim. Space is limited to five separate claim numbers (Maximum = 35 characters each).

Contact Person Information

7a. Name of Person Responsible for Preparing this Report.

7b. Title of Person Responsible for Preparing this Report.

7c. Contact Person Name (if different than Name of Person Responsible for Preparing this Report).

7d. Contact Person Telephone Number.

7e. Contact Person Email Address.

Plaintiff Attorney Information

8a. Plaintiff Attorney's Name or Name of Law Firm.

8b. Plaintiff Attorney's Office City.

8c. Plaintiff's Attorney's Office State.*

Claim Data Information

9a. Nature and Substance of Claim. Give complete description of all actions and circumstances causing the claim, including allegations made by claimant. (Maximum = 250 characters)

9b. Act or Omission Codes Related to Claim.* Enter as many codes as needed. Use DOI 3-digit codes listed below. (1) Diagnosis Related; (2) Anesthesia Related; (3) Surgery Related; (4) Medication Related; (5) Intravenous and Blood Products Related; (6) Obstetrics Related; (7) Treatment Related; (8) Monitoring Related; (9) Biomedical Equipment/Product Medication Related; (10) Miscellaneous Related.

DOI 3-digit Act or Omission Code choices:

Diagnosis-Related

- 010 – Failure to Diagnose (e.g., concluding that patient has no disease or condition worthy of follow-up or observation)
- 020 – Wrong Diagnosis or Misdiagnosis (e.g., original diagnosis is incorrect)
- 030 – Improper Performance of Test
- 040 – Unnecessary Diagnostic Test
- 050 – Delay in Diagnosis
- 060 – Failure to Obtain Consent/Lack of Informed Consent
- 070 – Diagnosis Related – Not Otherwise Classified

Anesthesia-Related

- 110 – Failure to Complete Patient Assessment
- 120 – Failure to Monitor
- 130 – Failure to Test Equipment
- 140 – Improper Choice of Anesthesia Agent or Equipment
- 150 – Improper Technique/Induction
- 160 – Improper Equipment Use
- 170 – Improper Intubation
- 180 – Improper Positioning
- 185 – Failure to Obtain Consent/Lack of Informed Consent
- 190 – Anesthesia Related – Not Otherwise Classified

Surgery-Related

- 210 – Failure to Perform Surgery
- 220 – Improper Positioning
- 230 – Retained Foreign Body
- 240 – Wrong Body Part
- 250 – Improper Performance of Surgery
- 260 – Unnecessary Surgery
- 270 – Delay in Surgery
- 280 – Improper Management of Surgical Patient
- 285 – Failure to Obtain Consent/Lack of Informed Consent

290 – Surgery Related – Not Otherwise Classified

Medication-Related

- 305 – Failure to Order Appropriate Medication
- 310 – Wrong Medication Ordered
- 315 – Wrong Dosage Ordered of Correct Medication
- 320 – Failure to Instruct on Medication
- 325 – Improper Management of Medication Regimen
- 330 – Failure to Obtain Consent/Lack of Informed Consent
- 340 – Medication Error – Not Otherwise Classified
- 350 – Failure to Medicate
- 355 – Wrong Medication Administered
- 360 – Wrong Dosage Administered
- 365 – Wrong Patient
- 370 – Wrong Route
- 380 – Improper Technique/Induction
- 390 – Medication Administration Related – Not Otherwise Classified

Intravenous & Blood Products-Related

- 410 – Failure to Monitor
- 420 – Wrong Solution
- 430 – Improper Performance
- 440 – I.V. Related – Not Otherwise Classified
- 450 – Failure to Ensure Contamination Free
- 460 – Wrong Type
- 470 – Improper Administration
- 480 – Failure to Obtain Consent/Lack of Informed Consent
- 490 – Blood Product Related – Not Otherwise Classified

Obstetrics-Related

- 505 – Failure to Manage Pregnancy
- 510 – Improper Choice of Delivery Method
- 520 – Improperly Performed Vaginal Delivery
- 530 – Improperly Performed C-Section
- 540 – Delay in Delivery (Induction or Surgery)
- 550 – Failure to Obtain Consent/Lack of Informed Consent
- 555 – Improperly Managed Labor – Not Otherwise Classified
- 560 – Delay in Treatment of Fetal Distress (i.e., identified but treated in untimely manner)
- 570 – Retained Foreign Body/Vaginal/Uterine
- 575 – Abandonment
- 580 – Wrongful Life/Birth
- 590 – Obstetrics Related – Not Otherwise Classified

Treatment-Related

- 610 – Failure to Treat

- 620 – Wrong Treatment/Procedure Performed
- 630 – Failure to Instruct Patient on Self-Care
- 640 – Improper Performance of Treatment/Practice
- 650 – Improper Management of Course of Treatment
- 660 – Unnecessary Treatment
- 665 – Delay in Treatment
- 670 – Premature End of Treatment (Also Abandonment)
- 675 – Failure to Supervise Treatment/Procedure
- 680 – Failure to Obtain Consent/Lack of Informed Consent
- 685 – Failure to Refer or Seek Consultation
- 690 – Treatment Related – Not Otherwise Classified

Monitoring-Related

- 710 – Failure to Monitor
- 720 – Failure to Respond to Patient
- 730 – Failure to Report on Patient Condition
- 790 – Monitoring Related – Not Otherwise Classified

Biomedical Equipment Product-Related

- 810 – Failure to Inspect/Monitor
- 820 – Improper Maintenance
- 830 – Improper Use
- 840 – Failure to Respond to Warning
- 850 – Failure to Instruct Patient on Use of Equipment/Product
- 860 – Malfunction/Failure
- 890 – Biomedical Equipment/Product-Related – Not Otherwise Classified

Miscellaneous-Related

- 920 – Failure to Protect Third Parties (e.g., failure to warn/protect from violent patient behavior)
- 930 – Breach of Confidentiality/Privacy
- 940 – Failure to Maintain Appropriate Infection Control
- 950 – Failure to Follow Institutional Policy or Procedure
- 960 – Other (Provide Detailed Description)
- 990 – Failure to Review Providing Performance

9c. Severity of Injury Code.

Select only one – Select code for principal injury if several injuries are involved.*

- 1) Emotional Only (e.g., fright, no physical damage)

Temporary:

- 2) Insignificant (e.g., lacerations, contusions, minor scars, rash; no delay)

- 3) Minor (e.g., infections, mis-set fracture, fall in hospital; recovery delayed)

- 4) Major (e.g., burns, surgical material left, drug side effect, brain damage; recovery delayed)

Permanent:

- 5) Minor (e.g., loss of fingers, loss or damage to organs; includes non-disabling injuries)
- 6) Significant (e.g., deafness, loss of limb, loss of eye, loss of one kidney or lung)
- 7) Major (e.g., paraplegia, blindness, loss of two limbs, brain damage)
- 8) Grave (e.g., quadriplegia, severe brain damage, lifelong care or fatal prognosis)
- 9) Death

9d. Date of Closure of Claim. (MM/DD/YYYY)

9e. Claim Disposition Code.* Enter code representing the final disposition of the claim. (1) Settled by Parties*; (2) Disposed of by a Court**; (3) Disposed of by Binding Arbitration***; (4) Suit Abandoned****; (5) Claim Abandoned.

A code with an (*) requires a "Settlement Code" as well.

A code with an (**) requires "Court Information" to be completed as well.

A code with an (***) requires a "Binding Arbitration Code" as well.

A code with an (****) requires a "County of Circuit Court" and "Docket Number" as well.

9f. Settlement Code.* (1) Before Filing Suit or Demanding Arbitration Hearing; (2) Before Trial or Hearing; (3) During Trial or Hearing; (4) After Trial or Hearing but Before Judgment or Decision/Award; (5) After Judgment or Decision but Before Appeal; (6) During Appeal; (7) After Appeal; (8) As a result of Review Panel or Non-Binding Arbitration**; (9) As a Result of Mediation; (10) As a Result of High/Low Settlement***.

A code with an (**) requires a "Review Panel or Non-Binding Arbitration Code" as well.

A code with an (***) requires all applicable "Court Information" except "Court Code".

9g. Review Panel or Non-Binding Arbitration Code.* (1) Finding for Plaintiff; (2) Finding for Defendant.

9h. Binding Arbitration Code* (1) Award for Plaintiff; (2) Award for Defendant.

Court Information

10a. Court Code.* (1) Directed Verdict for Plaintiff; (2) Directed Verdict for Defendant; (3) Judgment Notwithstanding Verdict for Plaintiff (judgment for defendant); (4) Judgment Notwithstanding Verdict for Defendant (judgment for plaintiff); (5) Judgment for Plaintiff; (6) Judgment for Defendant; (7) Decision for Plaintiff on Appeal; (8) Decision for Defendant on Appeal; (9) Voluntary Dismissal; (10) Involuntary Dismissal; (11) All Other Actions.

10b. County of Circuit Court.

10c. Docket Number.

10d. Amount Awarded by Circuit Court. (whole dollar amounts only)

10e. Date of Award. (MM/DD/YYYY)

10f. Was the Circuit Court decision appealed? Y or N
If "Y", Describe the Result of the Appeal. (Maximum = 25 characters)

10g. Describe any Other Post Trial Motions. (Maximum = 25 characters)

10h. Economic Damages. Amount of economic damages awarded by the court. This amount plus 10i. Non-economic Damages must equal 10d. Amount Awarded by Circuit Court. (whole dollar amounts only)

10i. Non-economic Damages. Amount of economic damages awarded by the court. This amount plus 10h. Economic Damages must equal 10d. Amount Awarded by Circuit Court. (whole dollar amounts only)

Claim Payment Information

11a. Total Direct Indemnity Paid/Payable by You Under this Policy on Behalf of this Insured/Defendant. Amount reported here shall be less than or equal to 10d. Amount Awarded by Circuit Court, if 10d. contains an amount greater than 0. (whole dollar amounts only)

11b. Economic Damages. If 9e. Claim Disposition Code is (2) Disposed of by a Court, enter the amount that was paid/payable by you for economic damages, as indicated by the court award. This amount plus 11c. Non-Economic Damages must equal amount reported in 11a. Total Direct Indemnity Paid/Payable by You Under this Policy on Behalf of this Insured/Defendant. (whole dollar amounts only)

11c. Non-Economic Damages. If 9e. Claim Disposition Code is (2) Disposed of by a Court, enter amount that was paid/payable by you for non-economic damages, as indicated by the court award. This amount plus 11b. Economic Damages must equal amount reported in 11a. Total Direct Indemnity Paid/Payable by You Under this Policy on Behalf of this Insured/Defendant. (whole dollar amounts only)

11d. Direct Loss Adjustment Expense Paid/Payable by You under this Policy to Defense Counsel. (whole dollar amounts only)

11e. All Other Allocated Loss Adjustment Expenses Paid/Payable by You for this Insured/Defendant for this claim, including filing fees, telephone charges, photocopy fees, expenses of defense counsel, etc. (whole dollar amounts only)

11f. Direct Indemnity Paid/Payable by You Under All Policies for this Insured/Defendant. (whole dollar amounts only)

11g. Other Indemnity Paid by or on Behalf of this Insured/Defendant. (whole dollar amounts only)

- D) Deductible(s) paid by insured/defendant for this claim under this policy;
- E) Indemnity paid under any excess limits policy issued by you;
- R) Amount paid by insured/defendant under self-insured retention;
- S) Amount you paid above any stop loss limit.

11h. Claimed Medical Expense. Amount of medical expense claimed by the plaintiff/injured party. (whole dollar amounts only)

11i. Claimed Wage Loss. Amount of wage loss claimed by the plaintiff/injured party. (whole dollar amounts only)"

(Source: Amended at 30 Ill. Reg. 19288, effective December 4, 2006)

Appendix B

Specialty	Description
Anesthesiology	Anesthesiology
	Anesthesiology - All Other
	Anesthesiology - All Other (DO)
	Anesthesiology - Pain Management
Cardiovascular Disease	Cardiac Surgery (Minor Risk Procedures, No Performing Major Surgery)
	Cardiovascular Disease (Specified Minor Risk Procedures)
	Cardiovascular Disease - minor surgery
	Cardiovascular Disease - minor surgery (DO)
	Cardiovascular Disease - no surgery
	Cardiovascular Disease - no surgery (DO)
Emergency Medicine	Emergency Medicine - including major surgery
	Emergency Medicine - including major surgery (DO)
	Emergency Medicine - no major surgery
	Emergency Medicine - no major surgery (DO)
Family Physicians or General Practitioners	Family Physicians or General Practitioners - minor surgery
	Family Physicians or General Practitioners - minor surgery (DO)
	Family Physicians or General Practitioners - no surgery
	Family Physicians or General Practitioners - no surgery (DO)
	Family Practice (Intermediate Risk Procedures Incl, If Applicable, Assisting In Surgery On Other Than Own Patients)
	Family Practice - minor surgery
	Family Practice - no surgery
	General Practice (Minor Risk Procedures)
	General Practice - no Surgery
Gastroenterology	Gastroenterology - no surgery
	Gastroenterology - minor surgery
	Gastroenterology - minor surgery (DO)
	Gastroenterology - no surgery (DO)
Hematology/Oncology	Hematology - minor surgery
	Hematology - no surgery
	Neoplastic Diseases - no surgery

	Oncology - no surgery
Internal Medicine	Internal Medicine - minor surgery
	Internal Medicine - minor surgery (DO)
	Internal Medicine - no surgery
	Internal Medicine - no surgery (DO)
Nephrology	Nephrology - minor surgery
	Nephrology - no surgery
Neurology	Neurology - including child - minor surgery
	Neurology - including child - no surgery - All Other
	Neurology - including child - no surgery - Pain Management
	Neurology - including child - no surgery - Physicians & Surgeons
	Neurology - including child - no surgery: All Other (DO)
	Neurosurgery (Minor Risk Procedures, No Performing Major Surgery)
	Neurosurgery (No Minor Risk Procedures, No Surgery)
Obstetrics and Gynecology	Gynecological Surgery
	Gynecology (No Surgery)
	Gynecology - minor surgery
	Gynecology - no surgery
	Gynecology - no surgery (DO)
	Obstetrics (Minor Risk Procedures, No Performing Major Surgery)
	Surgery - gynecology
	Surgery - obstetrics
	Surgery - obstetrics - gynecology
	Surgery - obstetrics - gynecology (DO)
Other	Additional Charges: Corporate or Partnership Liability
	Additional Charges: Employed Physicians or Surgeons
	Additional Charges: Employed Physicians or Surgeons Assistants
	Additional Charges: Radiation Therapy - by employed physicians or surgeons involved with major surgery
	Additional Charges: Shock Therapy - by insured physicians or surgeons involved with major surgery

Allergy/Immunology
Colon Surgery
Dentists - Engaged in oral surgery or operative dentistry on patients rendered unconscious through the administering of any anesthesia or analgesia
Dentists - N.O.C.
Dermatology - All Other
Dermatology - All Other (DO)
Dermatology - Clinical and Dermatological Immunology
Dermatology - minor surgery - Physicians & Surgeons
Dermatology - no surgery - Physicians & Surgeons
Employees Professional Liability: Chiropodists/Podiatrists Additional Charges: Employed Chiropodists/Podiatrists
Endocrinology - no surgery
Excess Insurance
Geriatrics - no surgery
Infectious Diseases - minor surgery
Infectious Diseases - no surgery
Intensive Care Medicine
Laryngology - no surgery
Legal or Forensic Medicine
Manipulator (DO)
Neonatal/Perinatal Medicine
Neonatalology
Nuclear Medicine (DO)
Occupational Medicine (No Minor Risk Procedures)
Ophthalmology - minor surgery
Ophthalmology - no surgery
Ophthalmology - no surgery (DO)
Orthopaedics (No Surgery)
Other
Other Health Care Facilities - Medical or X-Ray Laboratories
Other than Employees Professional Liability: Chiropodists/Podiatrists
Other than Employees Professional Liability: Psychologists

Otology minor surgery
Otorhinolaryngology (Incl Elective Cosmetic Plastic Surgery)
Otorhinolaryngology - minor surgery
Otorhinolaryngology - minor surgery (DO)
Otorhinolaryngology - no surgery
Outpatient Surgical Facilities
Pathology (No Minor Risk Procedures)
Pathology - All Other
Pathology - minor surgery
Pathology - no surgery - Physicians & Surgeons
Physiatry/Physical Medicine and Rehabilitation - Physicians & Surgeons
Physical Medicine and Rehabilitation - All Other
Physical Medicine and Rehabilitation - All Other (DO)
Physicians - No Surgery.
Physicians - minor surgery - N.O.C.
Physicians - no major surgery: Angiography, Arteriography, or Catheterization
Physicians - no major surgery: Angriography, Arteriography or Catheterization (DO)
Physicians - no major surgery: Colonoscopy, ERCP, or Radiopaque Dye
Physicians - no major surgery: Cryosurgery
Physicians - no major surgery: Cryosurgery (DO)
Physicians - no major surgery: Lasers used in Therapy or Radiation Therapy
Physicians - no major surgery: Needle Biopsy
Physicians - no major surgery: Radiopaque Dye - Injections into blood vessels, lymphatics, sinus tracts or fistulae.
Physicians - no surgery
Physicians - no surgery - N.O.C.
Physicians - no surgery - N.O.C. (DO)
Physicians or Surgeons Assistants
Preventive Medicine - no surgery - Occupational Medicine
Preventive Medicine - no surgery - Public/General Health Medicine
Retired Physicians or Surgeons
Rheumatology - no surgery

	Rheumatology - no surgery (DO)
	Pediatric - minor surgery (DO)
Pediatrics	Pediatric - no surgery (DO)
	Pediatrics - minor surgery
	Pediatrics - no surgery
	Psychiatry (Incl Electroshock Therapy - No Surgery)
Psychiatry	Psychiatry - All Other
	Psychiatry - including child - Physicians & Surgeons
	Psychiatry: All Other (DO)
	Pulmonary Diseases - no surgery
Pulmonary Diseases	Radiology - diagnostic - minor surgery
Radiology	Radiology - diagnostic - minor surgery (DO)
	Radiology - diagnostic - no surgery
	Radiology - diagnostic - no surgery (DO)
	Radiology - interventional
	Radiology - interventional (DO)
	Radiology - therapeutic - no surgery
	Radiology - therapeutic - no surgery (DO)
	Aerospace Medicine - Physicians & Surgeons
Surgery - other than obstetrics	General Surgery (Minor Risk Procedures, No Performing Major Surgery)
	Orthopaedic Surgery (Without Spinal Surgery or Chemonucleolysis)
	Physicians or Surgeons - major surgery. (Active Military)
	Surgery - Oncology (DO)
	Surgery - abdominal
	Surgery - cardiac
	Surgery - cardiovascular (DO)
	Surgery - cardiovascular disease
	Surgery - colon and rectal
	Surgery - gastroenterology
	Surgery - general - This classification does not apply to any family or general practitioner or to any specialist who occasionally performs major surgery.
	Surgery - general - This classification does not apply to any family or general practitioner or to any specialist who occasionally performs major surgery. (DO)

	Surgery - general practice or family practice
	Surgery - general practice or family practice - Osteopaths
	Surgery - hand
	Surgery - neurology - including Child (DO)
	Surgery - neurology - including child
	Surgery - oncology
	Surgery - ophthalmology
	Surgery - orthopedic
	Surgery - orthopedic (DO)
	Surgery - otorhinolaryngology
	Surgery - plastic - N.O.C.
	Surgery - plastic - N.O.C. (DO)
	Surgery - plastic - otorhinolaryngology
	Surgery - plastic - otorhinolaryngology (DO)
	Surgery - thoracic
	Surgery - traumatic
	Surgery - urological
	Surgery - urological (DO)
	Surgery - vascular