

Special Report on Medical Malpractice Payments

Overview of Medical Malpractice Payments Reported to the Massachusetts Board of Registration in Medicine 1990 through 1999

Commonwealth of Massachusetts Board of Registration in Medicine

Peter N. Madras, MD
Chairman

Arnold S. Relman, MD
Physician Member

Dorothy Keville
Public Member

Peter Gelhaar, JD
Vice-Chairman

Mary Anna Sullivan, MD
Physician Member

Nishan Kechejian, MD *
Physician Member

Rafik Attia, MD
Board Secretary

Martin Crane, MD
Physician Member

Walter Prince, JD
Public Member*

* *Members who retired from the Board during 2000*

CONTENTS

<i>Introduction</i> _____	<i>Error! Bookmark not defined.</i>
<i>Statutory Authority</i> _____	3
<i>The Issues</i> _____	5
<i>Malpractice Paid Claims in Massachusetts, 1990 – 1999</i> _____	11
The population _____	11
Paid Claims _____	11
Malpractice Paid Claims by Year, 1990 – 1999 _____	11
Paid claims by individual amount _____	12
Distribution of physicians with paid claims by specialty _____	13
Distribution of Physicians with Paid Claims by Specialty and Gender _____	16
Distribution of Physicians with Paid Claims by Foreign or Domestic Medical Education	19
<i>Conclusions</i> _____	21

Introduction

Truth in all its kinds is most difficult to win; and truth in medicine is the most difficult of all.
Peter Mere Latham, 1789 – 1875, Physician

Amid the tedium of every legislative session there are usually a few truly shining moments. Occasionally among these is an initiative so thoughtful, and so important, as to rise to a level of true historic significance. One of the latter surely was the Medical Malpractice Act of 1986. Faced with a huge and costly increase in medical malpractice claims in Massachusetts, the legislature sought for some means to stem the tide of red ink, and to address the underlying causes of the problem.

No legislative body can aspire to affect directly the mechanism of an issue so complex and vexing as medical malpractice. Nevertheless, a legislative body can, and in this case did, aspire to leadership on a particular question. In 1986 the Massachusetts Legislature, both by statute and by implication, provided leadership and direction on the question of dealing with the causes and costs of medical malpractice within the State.

The Board of Registration in Medicine was selected to be a prime mover in tackling this problem, and was armed by statute with the authority to collect information on malpractice payments made in Massachusetts. While this was far from the only provision of the act, it was one of the most important. Implicit in this statutory authority was a requirement to convert information in the form of the mandated reports into an unprecedented knowledge of the problems which the act seeks to address. There is no virtue in the mere collection of information for its own sake. Information is the raw material from which a foundation of knowledge is built, and on such a foundation are sound solutions constructed.

While the collection of information is a long way from the application of a solution, it is the necessary first step in the process. Pursuant to its statutory obligations the Board has methodically collected the required information, and has incorporated the routine review of malpractice information into its day to day operations. All incoming reports are evaluated for substandard care components, and investigations are opened and prosecutions pursued where appropriate.

As of January 1, 2000, the Board has collected malpractice payment information for approximately 14 years. The growing body of statistical information available has become significant in depth and breadth. This is especially true for the period January 1, 1990 through January 1, 2000. By 1990, the collection process had matured to the point where reporting compliance and reliability were very high, and they have remained so ever since. The data collected for this period is assessed as accurate and comprehensive.

Few subjects addressed by the Board of Registration in Medicine are of a more contentious nature than the issue of medical malpractice and its relationship, if any, to quality of care. The subject of malpractice outcomes is of visceral interest to just about every segment of our citizenry, from the press and the public, to physicians and attorney's whose practice is centered on malpractice litigation.

In the ten years from January 1, 1990, to December 31, 1999, the Board's records indicate that over \$800,000,000 was paid to plaintiffs and their attorneys as a result of judgments or settlements in malpractice cases in Massachusetts alone. This amount represents about \$135.00 for every man, woman, and child in the Commonwealth. It also represents an annual industry amounting to almost \$30,000,000 for plaintiff's attorneys in this state alone.

In 1986 the Board of Registration in Medicine was granted statutory authority as described below to collect statistics on malpractice outcomes in Massachusetts. This report is an abstract of the information collected under that authority for one segment of the data; paid claims.

Statutory Authority

Prepared by Susan M. Berg, J.D.

Data Repository Attorney

Massachusetts Board of Registration in Medicine

The majority of the mandated reports submitted to the Massachusetts Board of Registration in Medicine's Data Repository fall into five categories: license renewal applications, court reports, closed claim information, disciplinary action reports, and information reported by health care providers about their peers. Most of these reporting obligations were established by the Medical Malpractice Act of 1986, and the regulations promulgated thereunder.

Statutory authority for the collection and storage of these various reports is derived from Massachusetts General Laws (G.L.) Chapter 112, §5, which provides, in part:

There shall be established within the board of registration in medicine a data repository which will be responsible for the compilation of all data required under sections five A through five J, inclusive, and any other law or regulation which requires that information be reported to the board.

G.L. Chapter 112, §5C requires closed claim reports to be filed by insurers and risk management organizations which provide professional liability protection for physicians. Any claim or action for damages for personal injuries alleged to have been caused by error, omission, or negligence in the performance of professional services must be filed within 30 days of a 1) final judgment, 2) settlement, or 3) final disposition not resulting in payment. Each report must include the following:

- name, address, specialty, and policy number of the physician
- name, address, and age of the claimant/plaintiff , nature and substance of claim
- date and place of incident leading to claim
- amounts paid, and date and manner of disposition, judgment, or settlement

- date and reason for final disposition, if no judgment or settlement
- any additional information the board shall require

Pursuant to G.L. Chapter 112, §5E, any physician without professional liability insurance must report every settlement or arbitration award of a claim or action for damages related to his or her practice of medicine. The report must be made within 30 days of a written settlement agreement or within 30 days of service of the arbitration award on all parties.

(Please note: pursuant to 243 CMR 2.07(16), a physician who does not have professional liability insurance must obtain a bond or letter of credit, unless he or she falls into one of three exceptions.)

The Federal Health Care Quality Improvement Act of 1986 established a National Practitioner Data Bank (NPDB) to collect adverse information about physicians and other health care providers. Regulations implementing this act were codified in Chapter 45 of the Code of Federal Regulations (CFR) part 60.

45 CFR 60.7 mandates reporting by "[e]ach person or entity...which makes a payment under an insurance policy, self-insurance, or otherwise, for the benefit of a physician...in settlement of or in satisfaction in whole or in part of a claim or a judgment against such a physician...for medical malpractice." A copy of the report sent to the NPDB must be forwarded to the licensing board in the state where the alleged act or omission took place.

The Issues

The accuracy and overall quality of any statistical data is affected by the number of sources of submission, the complexity of the reporting requirement, and the diligence of the record keeping. The Board receives malpractice reports from multiple sources. Of these sources the least numerous with the most straightforward reporting process is the malpractice insurance providers. Since they are few in number, and since the reporting requirement is straightforward, and since the maintenance of the data by the Board's data repository is conscientious, the data is of uniform high quality.

Unfortunately, the wheels of justice are slow. Years can elapse between the incident or incidents which underlay a malpractice suit and the final resolution of the issue.

Nevertheless because of the high quality of the data collected on paid claims, it is at present the "gold standard" by which to evaluate the role of medical malpractice in the life of the Commonwealth. No other data offers an equal opportunity to gain a clear perspective on the issues involved in the system of medical malpractice adjudication in Massachusetts.

It is the intent of this report to evaluate, that is to measure, the occurrence and characteristics of medical malpractice in the Commonwealth during the ten year period from January 1, 1990, to December 31, 1999.

Nevertheless it would be disingenuous to do so without providing some context for the issues which afflict the present system of medical malpractice.

One of the most evident features of the present system of adjudicating malpractice claims is that there is no direct discernible "cause and effect" link between the occurrence of a paid malpractice claim and the proper practice of medicine. This is true in no other area of the Board's mandated reports. Hospital discipline reports which touch upon patient care issues are linked directly and unambiguously to quality of care. Board discipline for substandard care is also by definition linked to quality of care. Criminal convictions involving practitioners may bear clearly upon a physician's fitness to practice medicine. However it is the studied opinion of the clinical investigators who review malpractice cases and judgments that such outcomes may or may not reflect substandard care.

Medical outcomes may have truly tragic results. Children or the elderly may suffer horrible injury or death as the unintended result of a medical procedure. These unintended results may originate from a preventable error, or from one that is not preventable. They may originate from simple culpable negligence, or from an unforeseeable circumstance or circumstances beyond the reasonable control of any individual. The system of tribunal review of a malpractice suit is intended to weed out those cases that are without merit, nevertheless the standard of such a review is not intended to be conclusive. The judgment of a malpractice case is made ultimately by a jury, or by the economics of the insurance industry in the event of a settlement. In neither case is the outcome the result of a deliberate and dispassionate clinical professional evaluation on the merits

Unfortunately the malpractice arena is not one ruled by clinical dispassion. Quite the opposite is true. It is an arena cloaked in the stately ritual and demeanor of court proceedings, but filled with all of the intense confrontational passion arising from grievous injury and a sense of injustice, often on both sides of the question.

It would be inhumanely unreasonable to forbid a juror from being affected by the suffering of parents deprived of a beloved child, or of siblings deprived of a parent, or anyone deprived of a loved one, or to be unmoved by a horrible and highly visible injury, regardless of how that injury occurred. Who will take responsibility for the continuing care of someone deprived of the ability to care for themselves? Who will mitigate the suffering of a grieving parent or loved one? Will a compassionate juror sometimes be inclined to ignore culpability in the interest of some compensation for a victim? Will an insurance company often seek pure justice when its actuaries tell it that it is more economic to settle a case than to pursue it?

Whatever side of the questions posed above one may avow, clearly there is a great deal more at play here than simple medical competence.

A reasonable test of the numbers buttresses the conclusion that a direct one-to-one relationship between a paid malpractice claim and medical competence is not supported. We apply the same standards of licensure to all practitioners. While this doesn't necessarily result in a uniformity of competence from practitioner to practitioner, and while it is also true that some specialties are more apt to be involved in patient injuries than others, it does imply that across the entire population of physicians we can expect a relatively consistent level of

competence, and that we could reasonably expect to encounter some consistency in the numbers. However, as the paid claim numbers demonstrate, we do not see consistency across the whole population. If we examine the specialty populations for the ten years 1990 – 1999 for those specialties with an aggregate total of 100 or more practitioners during the period, we can get a sense of the distribution of paid claims.

Malpractice Payments by Medical Specialty (1990 - 1999)

Specialty	<u>Aggregate Population</u>	<u>Physicians making payments</u>	<u>Number of suits</u>	<u>Likelihood of paid claim</u>
Gynecology	223	62	96	27.80%
Obstetrics and Gynecology	1363	300	461	22.01%
Neurological Surgery	240	45	66	18.75%
Otorhinolaryngology/Otolaryngology	110	18	22	16.36%
Urology	237	36	40	15.19%
Otorhinolaryngology	171	25	28	14.62%
Orthopedic Surgery	1162	158	249	13.60%
General Surgery	1358	180	231	13.25%
Plastic Surgery	303	35	47	11.55%
Urological Surgery	202	22	26	10.89%
Thoracic Surgery	134	14	14	10.45%
Vascular Surgery	143	13	13	9.09%
Emergency Medicine	1232	90	107	7.31%
Diagnostic Radiology	1352	92	109	6.80%
Cardiovascular Surgery	153	10	10	6.54%
Family Practice	1541	98	109	6.36%
Therapeutic Radiology	111	6	6	5.41%
Dermatology	524	28	37	5.34%
Radiology	474	25	29	5.27%
General Practice	541	28	31	5.18%
Gastroenterology	454	23	23	5.07%
Other Specialty	286	13	25	4.55%
Endocrinology	304	13	15	4.28%
Internal Medicine	6893	287	312	4.16%
Neurology	819	34	38	4.15%
Rheumatology	197	8	9	4.06%
Ophthalmology	1079	41	48	3.80%
Anesthesiology	2201	82	89	3.73%
Pathology	529	19	20	3.59%
Nephrology	252	9	9	3.57%
Child Neurology	113	4	4	3.54%
Cardiovascular Diseases	1211	42	48	3.47%
Geriatrics	123	4	5	3.25%
Occupational Medicine	193	6	7	3.11%
Anatomic Pathology	422	13	16	3.08%
Psychiatry	3379	102	134	3.02%
Pulmonary Diseases	412	12	13	2.91%

Pediatric Hematology-Oncology	108	3	4	2.78%
Pediatrics	2618	72	79	2.75%
Pediatric Cardiology	110	3	4	2.73%
Infectious Diseases	308	7	7	2.27%
Oncology	373	8	8	2.14%
Neonatal-Perinatal Medicine	162	3	3	1.85%
Allergy and Immunology	117	2	2	1.71%
Radiation Oncology	134	2	2	1.49%
Physical Medicine & Rehabilitation	350	5	5	1.43%
Hematology	290	2	2	0.69%
Child Psychiatry	329	1	1	0.30%

Clearly some specialties have substantially greater exposure to financial penalty than others, as illustrated by these numbers. It is also clear that the arena of malpractice adjudication is not one where simple judgments about competence can be made based solely on the financial outcomes. A single large payment representing a single lapse in an otherwise outstanding career can easily overshadow a pattern of smaller payments which arise from a more systemic problem within a medical practice.

Nevertheless, despite the fact that the evidence does not support the acceptance of a paid malpractice claim as prima facie evidence of substandard care, it would be a mistake to assume that no connection exists. The numbers clearly do support the conclusion that, while still not rising to the level of cause and effect, such a connection does exist. One of the most striking features of this data is the relatively large number of practitioners who have a single paid claim, versus the very few who have multiple paid claims.

In a population of physicians approaching 30,000, only 105 had more than two paid claims. These physicians, who represent about 5% of the population with a paid claim on record, and 1/3 of one percent of the total population of physicians, account for almost 16% of the dollars paid. Their payments totaled \$127,042,873 over ten years.

Moreover physicians with more than two paid claims tend to be seriously problematic in other areas. The 105 physicians with 3 or more paid claims also have records including 334 open or closed complaints, 99 hospital discipline reports, 25 Board disciplinary actions, and 16 complaints from health care professionals or reports from government or law enforcement agencies (5D/5F reports).

In summary, the following conclusions are reasonable:

- The existence of a single paid claim, or even two, on a physician's record is not prima facie evidence of either professional misconduct or substandard care.
- Medical malpractice adjudication is not a system wherein medical practice is subject to sound professional or clinical scrutiny, and the claim reports which arise from payments made as a result of this process require considerable additional professional examination before they can be used as a basis for disciplinary action.
- Physicians with more than two paid claims, however, do represent a population which warrants scrutiny. These physicians have tended to be problematic in other areas as well. However, because of the excruciatingly long time required to adjudicate a malpractice case, most of these physicians already have drawn attention to themselves through other mechanisms before their malpractice histories become evident. Nevertheless, physicians acquiring a third malpractice paid claim should be (and are) flagged as soon as the report is received.
- Even if a clinical review of cases involving physicians with a history of multiple paid claims produces no compelling evidence of substandard care, these physicians represent a business problem of serious proportions and significant cost. If the problem isn't substandard care, what is it? While "following the dollars" may not be a recipe for reducing substandard care, it would be consistent with addressing the other significant component of medical malpractice, i.e. the costs involved, all of which are absorbed ultimately by the consumer in the form of rising health care costs.

As a key component of our civil justice system the mechanism by which we adjudicate medical malpractice fails to provide comprehensive justice, and it does so at a staggering cost. It was the intent of the legislature in 1986 to find ways to make the system more effective and less costly. The mandated collection of this data and the implementation of an innovative Patient Care Assessment program in Massachusetts were part of that effort. Great energy has been devoted to this effort by a range of public agencies and some strides have been made. While it is impossible to measure what the outcome would have been had no

effort been made, it is clear from examining these numbers that the situation is under management to the extent that it has not gotten appreciably worse than it was ten or fifteen years ago. With a steadily increasing population of physicians and health care consumers the incidence of malpractice paid claims has been relatively static.

Nevertheless this problem and its huge associated cost cannot be addressed in any fundamental way by focusing on the medical questions alone. In an arena where practitioners in one area of medical specialty are eight times more likely to pay a claim than those in another, where the actual adjudication of errors is a fraction of the incidence, and where the compensatory awards have the consistency of a lottery, it is not the management of the medical component alone which can effect any sort of fundamental change or improvement.

As medicine has become increasingly more complex, the medical profession has become, in the words of one of our most eminent physicians, "a universe of specialties". There is general acknowledgment that the broad sweep of modern medicine is growing beyond the ken of any one individual, and that to take full advantage of the burgeoning science and technology which supports medicine today individuals whose professional lives are devoted to the study and application of parts of the whole have become indispensable. Still, medicine is a business as well as a science. Clearly, many of the problems which arise in the area of medical malpractice have a genesis in something other than substandard care, and require a solution beyond the traditional regulatory remedy of disciplinary action.

Malpractice Paid Claims in Massachusetts, 1990 – 1999

The population

During the period from January 1, 1990 to December 31, 1999, the physician population in Massachusetts included 40,460 individual practitioners. The average calendar year physician population during the period was 24,579 practitioners.

The gender mix during this period averaged 74% male (18,188) and 26% female (6,391), with an aggregate population of 29,774 male practitioners and 10,686 female practitioners.

81% of this population graduated from U.S. or Canadian medical schools, while 19% graduated from international medical schools.

72% of this population was board certified in at least one specialty.

98% of this population were M.D.s, 2% were D.O.s

Paid Claims

During the period January 1, 1990 to December 31, 1999 2,183 practitioners paid \$814,376,266 in 2,766 malpractice claims.

Practitioners making payments amounted to 5% of the aggregate population, and 9% of the average population.

Practitioners with paid claims averaged 1.27 payments each.

The average payment for the period for a claim was \$294,423.81, and the average total paid by practitioners with at least one paid claim was \$373,053.72.

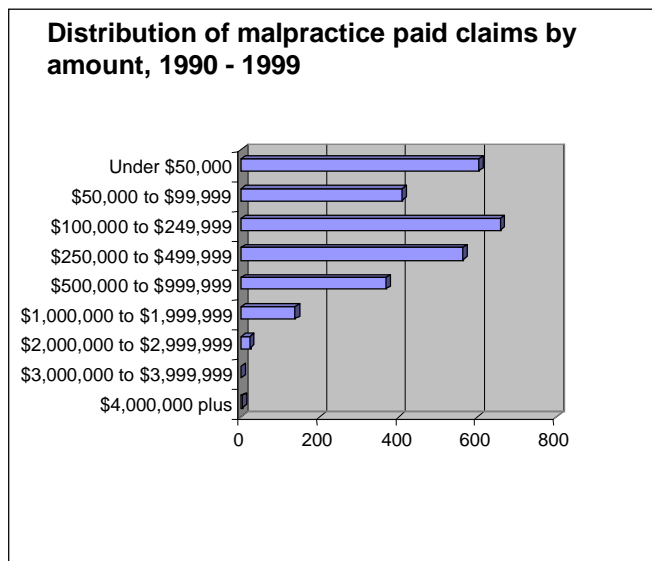
The largest single payment for the period was \$4,900,355 reported in 1997 by the insurance carrier for a surgeon specializing in Head and Neck Surgery.

Malpractice Paid Claims by Year, 1990 – 1999

Year	# Paid Claims	Total \$ Paid	Average \$ Payment
1990	188	\$44,519,732.00	\$236,807.09
1991	320	\$80,376,409.00	\$251,176.28
1992	295	\$74,303,392.00	\$251,875.91
1993	310	\$75,885,649.00	\$244,792.42
1994	244	\$61,688,987.00	\$252,823.72
1995	276	\$84,161,861.00	\$304,934.28
1996	277	\$85,274,271.00	\$307,849.35
1997	267	\$95,223,530.00	\$356,642.43
1998	280	\$94,199,278.00	\$336,425.99
1999	309	\$118,743,157.00	\$384,282.06
TOTAL	2766	\$814,376,266.00	\$294,423.81

Paid claims by individual amount

Range	Number	
\$4,000,000 plus	3	0.1085%
\$3,000,000 to \$3,999,999	1	0.0362%
\$2,000,000 to \$2,999,999	22	0.7954%
\$1,000,000 to \$1,999,999	137	4.9530%
\$500,000 to \$999,999	368	13.3044%
\$250,000 to \$499,999	564	20.3905%
\$100,000 to \$249,999	658	23.7889%
\$50,000 to \$99,999	408	14.7505%
Under \$50,000	605	21.8727%
Total	2766	100.0000%



Distribution of physicians with paid claims by specialty

<u>Specialty</u>	<u>Population</u>	<u>With paid claims</u>	<u>%</u>
Facial Plastic Surgery	7	2	28.5714%
Gynecology	223	62	27.8027%
Obstetrics and Gynecology	1363	300	22.0103%
Neurological Surgery	240	45	18.7500%
Obstetrics	33	6	18.1818%
Otorhinolaryngology/Otolaryngology	110	18	16.3636%
Urology	237	36	15.1899%
Otorhinolaryngology	171	25	14.6199%
Surgical Oncology	7	1	14.2857%
Orthopedic Surgery	1162	158	13.5972%
General Surgery	1358	180	13.2548%
Abdominal Surgery	24	3	12.5000%
Plastic Surgery	303	35	11.5512%
Gynecological Oncology	45	5	11.1111%
Urological Surgery	202	22	10.8911%
Thoracic Surgery	134	14	10.4478%
Cardiothoracic Surgery	22	2	9.0909%
Genetics	11	1	9.0909%
Pediatric Allergy	11	1	9.0909%
Trauma Surgery	22	2	9.0909%
Vascular Surgery	143	13	9.0909%
Aerospace Medicine	24	2	8.3333%
Nutrition	26	2	7.6923%
Pediatric Surgery	68	5	7.3529%
Emergency Medicine	1232	90	7.3052%
Diagnostic Radiology	1352	92	6.8047%
Cardiovascular Surgery	153	10	6.5359%
Orthopedics (No Surgery)	62	4	6.4516%
Family Practice	1541	98	6.3595%
Head and Neck Surgery	18	1	5.5556%
Therapeutic Radiology	111	6	5.4054%
Dermatology	524	28	5.3435%
Radiology	474	25	5.2743%
Pediatric Critical Care Medicine	19	1	5.2632%
General Practice	541	28	5.1756%
Gastroenterology	454	23	5.0661%
Immunology	20	1	5.0000%
Colon and Rectal Surgery	42	2	4.7619%
Reproductive Endocrinology	43	2	4.6512%
Other Specialty	286	13	4.5455%
Otolaryngology	91	4	4.3956%
Endocrinology	304	13	4.2763%
Internal Medicine	6893	287	4.1636%
Neurology	819	34	4.1514%
Rheumatology	197	8	4.0609%
Ophthalmology	1079	41	3.7998%
Anesthesiology	2201	82	3.7256%
Pathology	529	19	3.5917%
Nephrology	252	9	3.5714%

<u>Specialty</u>	<u>Population</u>	<u>With paid claims</u>	<u>%</u>
Child Neurology	113	4	3.5398%
Cardiovascular Diseases	1211	42	3.4682%
Hand Surgery	61	2	3.2787%
Geriatrics	123	4	3.2520%
Occupational Medicine	193	6	3.1088%
Anatomic Pathology	422	13	3.0806%
Psychiatry	3379	102	3.0186%
Forensic Pathology	34	1	2.9412%
Pulmonary Diseases	412	12	2.9126%
Pediatric Hematology-Oncology	108	3	2.7778%
Pediatrics	2618	72	2.7502%
Pediatric Cardiology	110	3	2.7273%
Family/General Practice	40	1	2.5000%
Critical Care Medicine	87	2	2.2989%
Infectious Diseases	308	7	2.2727%
Oncology	373	8	2.1448%
Allergy	47	1	2.1277%
Neonatal-Perinatal Medicine	162	3	1.8519%
Allergy and Immunology	117	2	1.7094%
Radiation Oncology	134	2	1.4925%
Clinical Pathology	69	1	1.4493%
Physical Medicine & Rehabilitation	350	5	1.4286%
** No specialty listed **	3316	23	0.6936%
Hematology	290	2	0.6897%
Child Psychiatry	329	1	0.3040%
Addiction Medicine	1	0	0.0000%
Addiction Psychiatry	1	0	0.0000%
Adolescent Medicine	41	0	0.0000%
Adolescent Psychiatry	1	0	0.0000%
Bloodbanking	30	0	0.0000%
Chemical Pathology	5	0	0.0000%
Child/Adolescent Psychiatry	19	0	0.0000%
Clinical Pharmacology	7	0	0.0000%
Cosmetic Surgery	1	0	0.0000%
Cytopathology	5	0	0.0000%
Dermatopathology	22	0	0.0000%
Diabetes	59	0	0.0000%
Diagnostic Laboratory Immunology	1	0	0.0000%
Electrophysiology/Pacing	2	0	0.0000%
Forensic Medicine	1	0	0.0000%
Forensic Psychiatry	2	0	0.0000%
General Preventive Medicine	65	0	0.0000%
Geriatric Psychiatry	4	0	0.0000%
Hematology/Oncology	28	0	0.0000%
Legal Medicine	8	0	0.0000%
Maternal and Fetal Medicine	41	0	0.0000%
Medical Microbiology	5	0	0.0000%
Neoplastic Diseases	9	0	0.0000%
Neuropathology	26	0	0.0000%
Nuclear Medicine	77	0	0.0000%
Nuclear Radiology	3	0	0.0000%
Otology/Neurotology	1	0	0.0000%

<u>Specialty</u>	<u>Population</u>	<u>With paid claims</u>	<u>%</u>
Pain Management	12	0	0.0000%
Pediatric Emergency Medicine	24	0	0.0000%
Pediatric Endocrinology	47	0	0.0000%
Pediatric Gastroenterology	8	0	0.0000%
Pediatric Infectious Disease	3	0	0.0000%
Pediatric Nephrology	30	0	0.0000%
Pediatric Otolaryngology	2	0	0.0000%
Pediatric Pulmonology	39	0	0.0000%
Pediatric Radiology	65	0	0.0000%
Physiatry	9	0	0.0000%
Psychoanalysis	62	0	0.0000%
Public Health	73	0	0.0000%
Sports Medicine	1	0	0.0000%
Undersea Medicine	1	0	0.0000%
Unspecified Specialty	19	0	0.0000%
Vascular/Interventional Radiology	11	0	0.0000%
	40460	2183	5.3955%

Distribution of Physicians with Paid Claims by Specialty and Gender

Of the total physician population analyzed, 73.6% were male and 26.4% were female. For the population of physicians with paid claims, 88.3% were male and 11.7% were female. One area of significant difference between distribution of the physician population and likelihood of having a paid claim is seen in psychiatry. Women represent 31.7% of the physician population in this specialty, but only 9.8% of the population of psychiatrists with paid claims.

<u>Specialty</u>	<u>Total Population</u>	<u># Male</u>	<u>Male Pop %</u>	<u># Female</u>	<u>Female Pop %</u>	<u># with claims</u>	<u># Male</u>	<u>% Male</u>	<u># Female</u>	<u>% Female</u>
Internal Medicine	6893	4867	70.61%	2026	29.39%	287	253	88.15%	34	11.85%
Psychiatry	3379	2308	68.30%	1071	31.70%	102	92	90.20%	10	9.80%
** No specialty listed **	3316	2289	69.03%	1027	30.97%	23	18	78.26%	5	21.74%
Pediatrics	2618	1363	52.06%	1255	47.94%	72	52	72.22%	20	27.78%
Anesthesiology	2201	1674	76.06%	527	23.94%	82	68	82.93%	14	17.07%
Family Practice	1541	1036	67.23%	505	32.77%	98	88	89.80%	10	10.20%
Obstetrics and Gynecology	1363	793	58.18%	570	41.82%	300	222	74.00%	78	26.00%
General Surgery	1358	1176	86.60%	182	13.40%	180	172	95.56%	8	4.44%
Diagnostic Radiology	1352	1050	77.66%	302	22.34%	92	83	90.22%	9	9.78%
Emergency Medicine	1232	982	79.71%	250	20.29%	90	80	88.89%	10	11.11%
Cardiovascular Diseases	1211	1099	90.75%	112	9.25%	42	42	100.00%	0	0.00%
Orthopedic Surgery	1162	1115	95.96%	47	4.04%	158	154	97.47%	4	2.53%
Ophthalmology	1079	885	82.02%	194	17.98%	41	39	95.12%	2	4.88%
Neurology	819	647	79.00%	172	21.00%	34	32	94.12%	2	5.88%
General Practice	541	434	80.22%	107	19.78%	28	26	92.86%	2	7.14%
Pathology	529	365	69.00%	164	31.00%	19	17	89.47%	2	10.53%
Dermatology	524	344	65.65%	180	34.35%	28	26	92.86%	2	7.14%
Radiology	474	366	77.22%	108	22.78%	25	20	80.00%	5	20.00%
Gastroenterology	454	398	87.67%	56	12.33%	23	23	100.00%	0	0.00%
Anatomic Pathology	422	311	73.70%	111	26.30%	13	13	100.00%	0	0.00%
Pulmonary Diseases	412	348	84.47%	64	15.53%	12	12	100.00%	0	0.00%
Oncology	373	298	79.89%	75	20.11%	8	7	87.50%	1	12.50%
Physical Medicine & Rehabilitation	350	253	72.29%	97	27.71%	5	4	80.00%	1	20.00%
Child Psychiatry	329	207	62.92%	122	37.08%	1	1	100.00%	0	0.00%
Infectious Diseases	308	209	67.86%	99	32.14%	7	4	57.14%	3	42.86%
Endocrinology	304	209	68.75%	95	31.25%	13	10	76.92%	3	23.08%
Plastic Surgery	303	264	87.13%	39	12.87%	35	31	88.57%	4	11.43%
Hematology	290	217	74.83%	73	25.17%	2	2	100.00%	0	0.00%
Other Specialty	286	223	77.97%	63	22.03%	13	11	84.62%	2	15.38%
Nephrology	252	211	83.73%	41	16.27%	9	5	55.56%	4	44.44%
Neurological Surgery	240	230	95.83%	10	4.17%	45	44	97.78%	1	2.22%
Urology	237	230	97.05%	7	2.95%	36	35	97.22%	1	2.78%
Gynecology	223	172	77.13%	51	22.87%	62	55	88.71%	7	11.29%
Urological Surgery	202	194	96.04%	8	3.96%	22	22	100.00%	0	0.00%
Rheumatology	197	143	72.59%	54	27.41%	8	8	100.00%	0	0.00%
Occupational Medicine	193	151	78.24%	42	21.76%	6	6	100.00%	0	0.00%
Otorhinolaryngology	171	152	88.89%	19	11.11%	25	25	100.00%	0	0.00%
Neonatal-Perinatal Medicine	162	99	61.11%	63	38.89%	3	2	66.67%	1	33.33%
Cardiovascular Surgery	153	146	95.42%	7	4.58%	10	10	100.00%	0	0.00%
Vascular Surgery	143	137	95.80%	6	4.20%	13	13	100.00%	0	0.00%
Radiation Oncology	134	92	68.66%	42	31.34%	2	1	50.00%	1	50.00%

<u>Specialty</u>	<u>Population</u>	<u>Male</u>	<u>Pop %</u>	<u>Female</u>	<u>Pop %</u>	<u># with claims</u>	<u>Male</u>	<u>%</u>	<u>Female</u>	<u>%</u>
Thoracic Surgery	134	128	95.52%	6	4.48%	14	14	100.00%	0	0.00%
Geriatrics	123	83	67.48%	40	32.52%	4	2	50.00%	2	50.00%
Allergy and Immunology	117	100	85.47%	17	14.53%	2	2	100.00%	0	0.00%
Child Neurology	113	75	66.37%	38	33.63%	4	4	100.00%	0	0.00%
Therapeutic Radiology	111	92	82.88%	19	17.12%	6	6	100.00%	0	0.00%
Otorhinolaryngology/Otolaryngology	110	101	91.82%	9	8.18%	18	18	100.00%	0	0.00%
Pediatric Cardiology	110	84	76.36%	26	23.64%	3	2	66.67%	1	33.33%
Pediatric Hematology-Oncology	108	70	64.81%	38	35.19%	3	1	33.33%	2	66.67%
Otolaryngology	91	76	83.52%	15	16.48%	4	4	100.00%	0	0.00%
Critical Care Medicine	87	73	83.91%	14	16.09%	2	2	100.00%	0	0.00%
Nuclear Medicine	77	68	88.31%	9	11.69%	0	0	0.00%	0	0.00%
Public Health	73	54	73.97%	19	26.03%	0	0	0.00%	0	0.00%
Clinical Pathology	69	52	75.36%	17	24.64%	1	1	100.00%	0	0.00%
Pediatric Surgery	68	60	88.24%	8	11.76%	5	5	100.00%	0	0.00%
General Preventive Medicine	65	47	72.31%	18	27.69%	0	0	0.00%	0	0.00%
Pediatric Radiology	65	37	56.92%	28	43.08%	0	0	0.00%	0	0.00%
Orthopedics (No Surgery)	62	60	96.77%	2	3.23%	4	4	100.00%	0	0.00%
Psychoanalysis	62	44	70.97%	18	29.03%	0	0	0.00%	0	0.00%
Hand Surgery	61	58	95.08%	3	4.92%	2	2	100.00%	0	0.00%
Diabetes	59	49	83.05%	10	16.95%	0	0	0.00%	0	0.00%
Allergy	47	41	87.23%	6	12.77%	1	1	100.00%	0	0.00%
Pediatric Endocrinology	47	24	51.06%	23	48.94%	0	0	0.00%	0	0.00%
Gynecological Oncology	45	27	60.00%	18	40.00%	5	3	60.00%	2	40.00%
Reproductive Endocrinology	43	31	72.09%	12	27.91%	2	1	50.00%	1	50.00%
Colon and Rectal Surgery	42	38	90.48%	4	9.52%	2	2	100.00%	0	0.00%
Adolescent Medicine	41	12	29.27%	29	70.73%	0	0	0.00%	0	0.00%
Maternal and Fetal Medicine	41	23	56.10%	18	43.90%	0	0	0.00%	0	0.00%
Family/General Practice	40	35	87.50%	5	12.50%	1	1	100.00%	0	0.00%
Pediatric Pulmonology	39	20	51.28%	19	48.72%	0	0	0.00%	0	0.00%
Forensic Pathology	34	25	73.53%	9	26.47%	1	1	100.00%	0	0.00%
Obstetrics	33	25	75.76%	8	24.24%	6	5	83.33%	1	16.67%
Bloodbanking	30	21	70.00%	9	30.00%	0	0	0.00%	0	0.00%
Pediatric Nephrology	30	20	66.67%	10	33.33%	0	0	0.00%	0	0.00%
Hematology/Oncology	28	16	57.14%	12	42.86%	0	0	0.00%	0	0.00%
Neuropathology	26	20	76.92%	6	23.08%	0	0	0.00%	0	0.00%
Nutrition	26	20	76.92%	6	23.08%	2	2	100.00%	0	0.00%
Abdominal Surgery	24	22	91.67%	2	8.33%	3	3	100.00%	0	0.00%
Aerospace Medicine	24	23	95.83%	1	4.17%	2	2	100.00%	0	0.00%
Pediatric Emergency Medicine	24	11	45.83%	13	54.17%	0	0	0.00%	0	0.00%
Cardiothoracic Surgery	22	22	100.00%	0	0.00%	2	2	100.00%	0	0.00%
Dermatopathology	22	13	59.09%	9	40.91%	0	0	0.00%	0	0.00%
Trauma Surgery	22	21	95.45%	1	4.55%	2	2	100.00%	0	0.00%
Immunology	20	17	85.00%	3	15.00%	1	1	100.00%	0	0.00%
Child/Adolescent Psychiatry	19	9	47.37%	10	52.63%	0	0	0.00%	0	0.00%
Pediatric Critical Care Medicine	19	13	68.42%	6	31.58%	1	1	100.00%	0	0.00%
Unspecified Specialty	19	9	47.37%	10	52.63%	0	0	0.00%	0	0.00%

<u>Specialty</u>	<u>Population</u>	<u>Male</u>	<u>Pop %</u>	<u>Female</u>	<u>Pop %</u>	<u># with claims</u>	<u>Male</u>	<u>%</u>	<u>Female</u>	<u>%</u>
Head and Neck Surgery	18	16	88.89%	2	11.11%	1	1	100.00%	0	0.00%
Pain Management	12	7	58.33%	5	41.67%	0	0	0.00%	0	0.00%
Genetics	11	6	54.55%	5	45.45%	1	1	100.00%	0	0.00%
Pediatric Allergy	11	8	72.73%	3	27.27%	1	1	100.00%	0	0.00%
Vascular/Interventional Radiology	11	9	81.82%	2	18.18%	0	0	0.00%	0	0.00%
Neoplastic Diseases	9	7	77.78%	2	22.22%	0	0	0.00%	0	0.00%
Physiatry	9	5	55.56%	4	44.44%	0	0	0.00%	0	0.00%
Legal Medicine	8	7	87.50%	1	12.50%	0	0	0.00%	0	0.00%
Pediatric Gastroenterology	8	5	62.50%	3	37.50%	0	0	0.00%	0	0.00%
Clinical Pharmacology	7	7	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Facial Plastic Surgery	7	7	100.00%	0	0.00%	2	2	100.00%	0	0.00%
Surgical Oncology	7	4	57.14%	3	42.86%	1	0	0.00%	1	100.00%
Chemical Pathology	5	4	80.00%	1	20.00%	0	0	0.00%	0	0.00%
Cytopathology	5	1	20.00%	4	80.00%	0	0	0.00%	0	0.00%
Medical Microbiology	5	4	80.00%	1	20.00%	0	0	0.00%	0	0.00%
Geriatric Psychiatry	4	4	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Nuclear Radiology	3	3	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Pediatric Infectious Disease	3	1	33.33%	2	66.67%	0	0	0.00%	0	0.00%
Electrophysiology/Pacing	2	2	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Forensic Psychiatry	2	2	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Pediatric Otolaryngology	2	1	50.00%	1	50.00%	0	0	0.00%	0	0.00%
Addiction Medicine	1	1	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Addiction Psychiatry	1	1	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Adolescent Psychiatry	1	1	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Cosmetic Surgery	1	1	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Diagnostic Laboratory Immunology	1	0	0.00%	1	100.00%	0	0	0.00%	0	0.00%
Forensic Medicine	1	1	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Otology/Neurotology	1	1	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Sports Medicine	1	1	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Undersea Medicine	1	1	100.00%	0	0.00%	0	0	0.00%	0	0.00%
	40460	29774	73.59%	10686	26.41%	2183	1927	88.27%	256	11.73%

Distribution of Physicians with Paid Claims by Foreign or Domestic Medical Education

Graduates of foreign medical schools represented 18% of the aggregate population during the period, and they represented about 18% of the population with claims. The only significant anomaly is in anesthesiology, where they were an anomalous 44% of the population with claims.

<u>Specialty</u>	<u>Pop</u>	<u>Domestic</u>	<u>Pop %</u>	<u>Foreign</u>	<u>Pop %</u>	<u>Pop with</u>	<u>DOM</u>	<u>%</u>	<u>Foreign</u>	<u>%</u>
						<u>Claims</u>				
Internal Medicine	6893	5398	78.31%	1495	21.69%	287	236	82.23%	51	17.77%
Psychiatry	3379	2760	81.68%	619	18.32%	102	84	82.35%	18	17.65%
** No specialty listed **	3316	2746	82.81%	570	17.19%	23	22	95.65%	1	4.35%
Pediatrics	2618	2140	81.74%	478	18.26%	72	63	87.50%	9	12.50%
Anesthesiology	2201	1501	68.20%	700	31.80%	82	46	56.10%	36	43.90%
Family Practice	1541	1338	86.83%	203	13.17%	98	83	84.69%	15	15.31%
Obstetrics and Gynecology	1363	1119	82.10%	244	17.90%	300	237	79.00%	63	21.00%
General Surgery	1358	1167	85.94%	191	14.06%	180	149	82.78%	31	17.22%
Diagnostic Radiology	1352	1163	86.02%	189	13.98%	92	77	83.70%	15	16.30%
Emergency Medicine	1232	1124	91.23%	108	8.77%	90	78	86.67%	12	13.33%
Cardiovascular Diseases	1211	932	76.96%	279	23.04%	42	32	76.19%	10	23.81%
Orthopedic Surgery	1162	1085	93.37%	77	6.63%	158	143	90.51%	15	9.49%
Ophthalmology	1079	982	91.01%	97	8.99%	41	36	87.80%	5	12.20%
Neurology	819	625	76.31%	194	23.69%	34	28	82.35%	6	17.65%
General Practice	541	368	68.02%	173	31.98%	28	18	64.29%	10	35.71%
Pathology	529	350	66.16%	179	33.84%	19	18	94.74%	1	5.26%
Dermatology	524	470	89.69%	54	10.31%	28	25	89.29%	3	10.71%
Radiology	474	394	83.12%	80	16.88%	25	19	76.00%	6	24.00%
Gastroenterology	454	354	77.97%	100	22.03%	23	20	86.96%	3	13.04%
Anatomic Pathology	422	282	66.82%	140	33.18%	13	10	76.92%	3	23.08%
Pulmonary Diseases	412	323	78.40%	89	21.60%	12	8	66.67%	4	33.33%
Oncology	373	336	90.08%	37	9.92%	8	8	100.00%	0	0.00%
Physical Medicine & Rehabilitation	350	249	71.14%	101	28.86%	5	3	60.00%	2	40.00%
Child Psychiatry	329	279	84.80%	50	15.20%	1	1	100.00%	0	0.00%
Infectious Diseases	308	274	88.96%	34	11.04%	7	5	71.43%	2	28.57%
Endocrinology	304	248	81.58%	56	18.42%	13	10	76.92%	3	23.08%
Plastic Surgery	303	271	89.44%	32	10.56%	35	30	85.71%	5	14.29%
Hematology	290	236	81.38%	54	18.62%	2	2	100.00%	0	0.00%
Other Specialty	286	252	88.11%	34	11.89%	13	10	76.92%	3	23.08%
Nephrology	252	189	75.00%	63	25.00%	9	6	66.67%	3	33.33%
Neurological Surgery	240	211	87.92%	29	12.08%	45	39	86.67%	6	13.33%
Urology	237	200	84.39%	37	15.61%	36	27	75.00%	9	25.00%
Gynecology	223	198	88.79%	25	11.21%	62	56	90.32%	6	9.68%
Urological Surgery	202	178	88.12%	24	11.88%	22	17	77.27%	5	22.73%
Rheumatology	197	177	89.85%	20	10.15%	8	7	87.50%	1	12.50%
Occupational Medicine	193	174	90.16%	19	9.84%	6	6	100.00%	0	0.00%
Otorhinolaryngology	171	142	83.04%	29	16.96%	25	19	76.00%	6	24.00%
Neonatal-Perinatal Medicine	162	119	73.46%	43	26.54%	3	2	66.67%	1	33.33%
Cardiovascular Surgery	153	115	75.16%	38	24.84%	10	9	90.00%	1	10.00%
Vascular Surgery	143	119	83.22%	24	16.78%	13	11	84.62%	2	15.38%
Radiation Oncology	134	111	82.84%	23	17.16%	2	2	100.00%	0	0.00%

Thoracic Surgery	134	105	78.36%	29	21.64%	14	10	71.43%	4	28.57%
<u>Specialty</u>	<u>Pop</u>	<u>Domestic</u>	<u>Pop %</u>	<u>Foreign</u>	<u>Pop %</u>	<u>Pop with</u>	<u>DOM</u>	<u>%</u>	<u>Foreign</u>	<u>%</u>
						<u>Claims</u>				
Geriatrics	123	99	80.49%	24	19.51%	4	3	75.00%	1	25.00%
Allergy and Immunology	117	89	76.07%	28	23.93%	2	2	100.00%	0	0.00%
Child Neurology	113	90	79.65%	23	20.35%	4	3	75.00%	1	25.00%
Therapeutic Radiology	111	85	76.58%	26	23.42%	6	5	83.33%	1	16.67%
Otorhinolaryngology/ Otolaryngology	110	87	79.09%	23	20.91%	18	16	88.89%	2	11.11%
Pediatric Cardiology	110	97	88.18%	13	11.82%	3	2	66.67%	1	33.33%
Pediatric Hematology-Oncology	108	97	89.81%	11	10.19%	3	2	66.67%	1	33.33%
Otolaryngology	91	78	85.71%	13	14.29%	4	4	100.00%	0	0.00%
Critical Care Medicine	87	67	77.01%	20	22.99%	2	1	50.00%	1	50.00%
Nuclear Medicine	77	47	61.04%	30	38.96%	0	0	0.00%	0	0.00%
Public Health	73	69	94.52%	4	5.48%	0	0	0.00%	0	0.00%
Clinical Pathology	69	46	66.67%	23	33.33%	1	1	100.00%	0	0.00%
Pediatric Surgery	68	61	89.71%	7	10.29%	5	4	80.00%	1	20.00%
General Preventive Medicine	65	55	84.62%	10	15.38%	0	0	0.00%	0	0.00%
Pediatric Radiology	65	60	92.31%	5	7.69%	0	0	0.00%	0	0.00%
Orthopedics (No Surgery)	62	57	91.94%	5	8.06%	4	4	100.00%	0	0.00%
Psychoanalysis	62	57	91.94%	5	8.06%	0	0	0.00%	0	0.00%
Hand Surgery	61	57	93.44%	4	6.56%	2	2	100.00%	0	0.00%
Diabetes	59	52	88.14%	7	11.86%	0	0	0.00%	0	0.00%
Allergy	47	38	80.85%	9	19.15%	1	0	0.00%	1	100.00%
Pediatric Endocrinology	47	38	80.85%	9	19.15%	0	0	0.00%	0	0.00%
Gynecological Oncology	45	42	93.33%	3	6.67%	5	5	100.00%	0	0.00%
Reproductive Endocrinology	43	37	86.05%	6	13.95%	2	2	100.00%	0	0.00%
Colon and Rectal Surgery	42	36	85.71%	6	14.29%	2	2	100.00%	0	0.00%
Adolescent Medicine	41	34	82.93%	7	17.07%	0	0	0.00%	0	0.00%
Maternal and Fetal Medicine	41	34	82.93%	7	17.07%	0	0	0.00%	0	0.00%
Family/General Practice	40	31	77.50%	9	22.50%	1	1	100.00%	0	0.00%
Pediatric Pulmonology	39	31	79.49%	8	20.51%	0	0	0.00%	0	0.00%
Forensic Pathology	34	25	73.53%	9	26.47%	1	0	0.00%	1	100.00%
Obstetrics	33	24	72.73%	9	27.27%	6	5	83.33%	1	16.67%
Bloodbanking	30	23	76.67%	7	23.33%	0	0	0.00%	0	0.00%
Pediatric Nephrology	30	19	63.33%	11	36.67%	0	0	0.00%	0	0.00%
Hematology/Oncology	28	22	78.57%	6	21.43%	0	0	0.00%	0	0.00%
Neuropathology	26	19	73.08%	7	26.92%	0	0	0.00%	0	0.00%
Nutrition	26	16	61.54%	10	38.46%	2	2	100.00%	0	0.00%
Abdominal Surgery	24	22	91.67%	2	8.33%	3	3	100.00%	0	0.00%
Aerospace Medicine	24	24	100.00%	0	0.00%	2	2	100.00%	0	0.00%
Pediatric Emergency Medicine	24	22	91.67%	2	8.33%	0	0	0.00%	0	0.00%
Cardiothoracic Surgery	22	20	90.91%	2	9.09%	2	2	100.00%	0	0.00%
Dermatopathology	22	17	77.27%	5	22.73%	0	0	0.00%	0	0.00%
Trauma Surgery	22	18	81.82%	4	18.18%	2	2	100.00%	0	0.00%
Immunology	20	17	85.00%	3	15.00%	1	1	100.00%	0	0.00%
Child/Adolescent Psychiatry	19	16	84.21%	3	15.79%	0	0	0.00%	0	0.00%
Pediatric Critical Care Medicine	19	14	73.68%	5	26.32%	1	1	100.00%	0	0.00%
Unspecified Specialty	19	13	68.42%	6	31.58%	0	0	0.00%	0	0.00%
Head and Neck Surgery	18	15	83.33%	3	16.67%	1	1	100.00%	0	0.00%
Pain Management	12	5	41.67%	7	58.33%	0	0	0.00%	0	0.00%

<u>Specialty</u>	<u>Pop</u>	<u>Domestic</u>	<u>Pop %</u>	<u>Foreign</u>	<u>Pop %</u>	<u>Pop with</u>	<u>DOM</u>	<u>%</u>	<u>Foreign</u>	<u>%</u>
						<u>Claims</u>				
Genetics	11	8	72.73%	3	27.27%	1	0	0.00%	1	100.00%
Pediatric Allergy	11	9	81.82%	2	18.18%	1	0	0.00%	1	100.00%
Vascular/Interventional Radiology	11	10	90.91%	1	9.09%	0	0	0.00%	0	0.00%
Neoplastic Diseases	9	7	77.78%	2	22.22%	0	0	0.00%	0	0.00%
Physiatry	9	6	66.67%	3	33.33%	0	0	0.00%	0	0.00%
Legal Medicine	8	8	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Pediatric Gastroenterology	8	7	87.50%	1	12.50%	0	0	0.00%	0	0.00%
Clinical Pharmacology	7	5	71.43%	2	28.57%	0	0	0.00%	0	0.00%
Facial Plastic Surgery	7	7	100.00%	0	0.00%	2	2	100.00%	0	0.00%
Surgical Oncology	7	7	100.00%	0	0.00%	1	1	100.00%	0	0.00%
Chemical Pathology	5	4	80.00%	1	20.00%	0	0	0.00%	0	0.00%
Cytopathology	5	3	60.00%	2	40.00%	0	0	0.00%	0	0.00%
Medical Microbiology	5	2	40.00%	3	60.00%	0	0	0.00%	0	0.00%
Geriatric Psychiatry	4	1	25.00%	3	75.00%	0	0	0.00%	0	0.00%
Nuclear Radiology	3	3	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Pediatric Infectious Disease	3	2	66.67%	1	33.33%	0	0	0.00%	0	0.00%
Electrophysiology/Pacing	2	2	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Forensic Psychiatry	2	2	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Pediatric Otolaryngology	2	2	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Addiction Medicine	1	1	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Addiction Psychiatry	1	1	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Adolescent Psychiatry	1	1	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Cosmetic Surgery	1	1	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Diagnostic Laboratory	1	1	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Immunology										
Forensic Medicine	1	1	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Otology/Neurotology	1	1	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Sports Medicine	1	1	100.00%	0	0.00%	0	0	0.00%	0	0.00%
Undersea Medicine	1	1	100.00%	0	0.00%	0	0	0.00%	0	0.00%
	40460	32930	81.39%	7530	18.61%	2183	1793	82.13%	390	17.87%

Conclusions & Recommendations

Medical malpractice in Massachusetts is two distinct problems, not one.

The first of these is the potential for the actual existence of substandard patient care or negligence within an individual report which needs to be the target of the Board's investigatory and adjudicatory mechanism. The knowledge imparted by an examination of the body of mandated reports in the possession of the Board as a result of the Medical Malpractice Act of 1986 leads to the conclusion that every instance of medical malpractice needs to be investigated for evidence of actual substandard care or negligent practice. This is already the practice of the Board.

To compliment this practice, using the statistical information from the library of information available in the Board's mandated reports section (Data Repository), the Board should consider adding a dimension of risk management to the review process by defining a formal "envelope" of performance for the malpractice history of its licensees. This would help to focus the attention of the Board's staff on licensees whose performance is statistically anomalous, where the greatest risk presumably resides. This should in no way replace the case by case assessment now undertaken, but rather should be applied in a complimentary methodology designed to make the processing and review processes more efficient and productive. The consistent application of properly thought out guidelines would simply make the case review process less vulnerable to human error.

Nevertheless, no matter how diligent the review, traditional regulatory and enforcement action will never make a serious inroad into the second problem.

The second medical malpractice problem is in some ways more significant than the first. It is the sheer cost of malpractice litigation. On the surface the Board has little role to play in this, except as the repository of the data. Nevertheless, in fulfillment of the ultimate objective of the legislature, the Board's unique knowledge of the details of the cost problem position it as a potential prime mover. Unique among the potential contributors to a solution, the Board knows precisely where and with whom the problem lies.

It also knows that an exclusively disciplinary approach doesn't work. Of the 105 physicians who have three or more paid claims over the ten years in question, only 8 physicians were the target of a final action effectively terminating their practice in Massachusetts. Some might feel that this represents some deficiency in the system, but the clinicians who investigate these cases are well trained and diligent, and the Board's mandate is clear. Every case is reviewed carefully. Even a more stringent standard for prosecution is unlikely to alter the inescapable conclusion that this number represents a problem other than medical negligence. Too many of these cases have a problem other than substandard care or negligence in practice.

Until this area is addressed effectively, there is little likelihood of a meaningful reduction in the overall problem of medical malpractice.

What are the possibilities? Some physicians are poor communicators. Others are poor businessmen. Some are under pressure to take on more work than they can handle, or to take on work that they are ill equipped to handle. Add to this mix a smattering of overly aggressive attorneys and greedy litigants and the problem seems to begin to come into focus.

This problem is a prime candidate for outreach. Counseling for physicians on good business practices, and stress related counseling, *not targeted to all physicians, but to those most at risk*, is a potential area that should be investigated. The Board's role would be to provide an information base as to those individuals at highest risk to encounter malpractice problems for non-medical reasons. It might even be possible to structure a referral system, and even to seek a regulatory basis for such a system.

The key would be to develop a resource or resources targeted to the specific risk. Such a resource would be responsible not only for developing the counseling portion, but for acquiring an understanding of precisely where the most vulnerability resides, and developing appropriate curricula to deal with it. Outreach from this resource should be directed to physicians at risk, to the public, the legal profession, and the judiciary.

The one thing this aspect of the problem doesn't lack is the potential to develop funding. The 105 physicians most vulnerable to malpractice problems accounted for an average of \$12,000,000 each year for the ten years from 1990 – 1999. The malpractice payers, the

legislature, and the public would be well served by supporting such a targeted effort to effect a meaningful reduction of this cost.

Until we have a means to address the non-medical contributory elements to medical malpractice costs we will be addressing less than 10% of the whole problem. This is the knowledge we have acquired from that historic legislative initiative 15 years ago. What remains is the final piece of the puzzle. It is time to put that final piece in place and place our feet firmly on the road to a real reduction of medical malpractice costs in Massachusetts.