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Jury Trial Outcomes for Medical Malpractice Cases Involving Pulmonary Embolism

By Frank Griffin, M.D., J.D.*

Insight into jury trial outcomes in complex medical malpractice cases is valuable for advising clients, making settlement decisions, and evaluating medical malpractice policy. Pulmonary embolism (“PE”)—basically a blood clot blocking an artery in the lungs—is a complex, sometimes controversial, and often fatal medical problem that frequently leads to potential allegations of medical malpractice. PE is the third most common cause of cardiovascular death in the United States, behind heart attack and stroke.¹ Specifically, between 60,000 and 200,000 Americans die annually from PE² resulting in up to 22,000 to 74,000 prospective medical malpractice claims.³ Therefore, it is not surprising that a Google search

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³ The exact number of PE-related deaths annually in the United States is uncertain and likely underestimated. CENTERS FOR DISEASE CONTROL AND PREVENTION (hereinafter “CDC”), Venous Thromboembolism: Data and Statistics, http://www.cdc.gov/nchddvd/dvt/data.html (noting that “(e)stimates suggest that 60,000 to 100,000 Americans die of DVT/PE” annually); S.B. Smith et. al., Early Anticoagulation is associated with Reduced Mortality for Acute Pulmonary Embolism, 137(6) Chest 1382 (2010) (noting that pulmonary embolism “account(s) for 50,000 to 200,000 deaths annually”). See also A.J. Burge et. al., Increased diagnosis of pulmonary embolism without a corresponding decline in mortality during the CT era, 63(4) CLIN. RADIOL. 381 (2008); C. Becattini and G. Agnelli, Acute pulmonary embolism: Risk stratification in the emergency department, 2(2) INTERN. EMERG. MED. 119 (2007); The Task Force for the Diagnosis and Management of Acute Pulmonary Embolism of the European Society of Cardiology, Guidelines on the diagnosis and management of acute pulmonary embolism, 29(18) EUR. HEART J. 2276 (2008).

³ F. Matsen et al., Lessons Regarding the Safety of Orthopaedic Patient Care An Analysis of Four Hundred and Sixty-Four Closed Malpractice Claims, 95A(4) J. BONE JOINT SURG. AM. e20
using the term “Pulmonary Embolism Lawyer” yields thousands of results. This study examines how juries assign blame in medical malpractice cases where PE is the primary diagnosis at issue.

II. Methods/Procedure

Medical malpractice jury trials involving plaintiffs (or plaintiffs’ decedents) whose primary diagnosis was PE were sought for analysis. A Westlaw™ search using the search term “pulmonary embol!,” the connector “and,” and the search term “malpractice” was conducted on June 22, 2014. The search yielded a total of 722 “cases,” including 571 state court “cases” and 151 federal court “cases.” The opinions for these 722 “cases” were filtered by the author for cases that went to a jury and that involved patients with PE as the primary diagnosis supporting the litigation. Summary judgments, bench trials, interlocutory orders, and any other non-jury trial “cases” were excluded. In addition, cases where pulmonary embolus was not the primary reason for litigation were excluded. Seventy-one cases involving 79 doctors in 27 states qualified for the study. For each case, a data sheet was generated by the author by reviewing the facts given in the judicial opinion. The data was then compiled into a table and analyzed.

(2) (2013) (reporting 3.7 malpractice claims per 10 adverse events, and applying here by considering 60,000 to 200,000 pulmonary embolisms as “adverse events”).

4 Specifically, one hundred and sixty-four thousand (164,000) results were reported with the Google search (Search conducted on 8/23/16).

5 See Appendix A for a list of the cases (noting that one case, Hall v. Frankel, 190 P.3d 852 (2008), was counted as two separate cases because the jury found for one doctor (the pulmonologist) and against the other doctor (the orthopedist) in the same case).

6 See Appendix B1 and B2.

7 See Appendix A.
III. Results

A. Overview of the Data

In ninety-three percent (66/71) of the cases, the patient who was the subject of the lawsuit died of the PE. In the five nonfatal cases, two involved cardiac arrests related to PE, and three were based on the PE alone. Seventy of the 71 cases were appealed. Seventy-nine percent (56/71) of the cases included in this study were reported, while twenty-one percent (15/71) were published by Westlaw™ but not reported.⁸

B. Outcome of the Trial by Jury and Appeal

Defendants won sixty-nine percent (49/71), and plaintiffs won thirty-one percent (22/71) of the cases. On appeal, 31% (22/71) were reversed with the rate of reversal similar for plaintiff verdicts (7/22; 31.8%) and defense verdicts (15/49; 30.6%). In 2016 dollars,⁹ jury awards in favor of the plaintiff ranged from $156,196 to $20,241,695 with a median of $1,048,114 and a mean of $2,458,575 for the twenty cases in which the verdict amount was disclosed in the opinion; the verdict amount was not disclosed in two opinions. In states with more than five cases included, doctors won 100% of the cases in Ohio (8/8), but only 56% in Illinois (5/9).

C. Outcome by Medical Specialty

The outcomes varied between medical specialties. Emergency medicine doctors were at the highest risk for an adverse outcome winning only 11.1% (1/9) of their PE cases. On the other end of the spectrum, OB/Gyn doctors and medical subspecialists (cardiology, pulmonology and neurology) were least likely to lose prevailing 90% of the time. In between the extremes,

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surgical specialists (general surgeons, orthopedic surgeons, cardiothoracic surgeons, and obstetrician/gynecologists) won 78.9% (26/33), and primary care physicians (family practice and internal medicine doctors) won 65.2% (15/23). If emergency medicine doctors’ cases are eliminated from the study, doctors overall won 77.4% (48/62).

D. Outcome Based Upon Diagnostic Error

Doctors won 100% (7/7 cases) of cases when the PE was diagnosed immediately upon presentation of the patient. Doctors won 92% (23/25) of cases where the patient first presented with sudden death. In contrast, doctors only won 48.4% (15/31) of cases where the PE was initially misdiagnosed. When the doctor misdiagnosed the PE as pneumonia, the plaintiff had a 50% (3/6) chance of winning. The largest verdict, $20,241,695, involved a case where the patient died of PE when the treatment (heparin) of the known PE was stopped by a young doctor-in-training (intern) to get a radiographic study (angiogram) with the supervising doctors denying at trial giving the intern permission to order the stoppage. When this single case is removed from the study, the mean jury award drops to $1,522,621 for the remaining 70 cases.

The second largest award, $6,350,715, was in a case where the PE was misdiagnosed for 75 days before the patient finally succumbed. In two cases, the doctor misdiagnosed the PE as hyperventilation and recommended a brown paper bag as treatment resulting jury verdicts for the plaintiff in both cases with an average award for the plaintiff of $2,623,072.

E. Outcome Based Upon the Patient’s Presenting Symptoms

When the patient did not initially complain of the most common symptoms associated with PE (shortness of breath, chest pain, hemoptysis, and/or cough), the doctor prevailed 83.9%

(26/31) of the time. Doctors won 92% (23/25) of cases where the patient first presented with sudden death without warning. In contrast, when the patient presented with primarily shortness of breath (“SOB”), doctors won only 47.1% (8/17). When the SOB was combined with other symptoms, the doctor won 83.3% (10/12). When chest pain alone was present, doctors won 80% (4/5) and won even more often, 92.3%, when chest pain was combined with other symptoms.

IV. Discussion

A. EMERGENCY MEDICINE DOCTORS ARE UNIQUELY VULNERABLE TO PLAINTIFF JURY VERDICTS IN MEDICAL MALPRACTICE CLAIMS RELATED TO PULMONARY EMBOLUS.

Emergency medicine (EM) specialty physicians are particularly vulnerable to adverse jury verdicts in PE-related medical malpractice cases. In this study, the EM doctor prevailed only 11% (1/9) of the time whereas all other specialties combined won 77% (48/62) of their cases (P < 0.05). The literature suggests that doctors generally win 79.6% of medical malpractice cases that go to trial, which is similar to the win rate of the combined population of doctors in this study minus the EM doctors.

Emergency medicine doctors seem to be held to higher standards than other doctors because EM doctors who misdiagnose the patient also lose much more frequently than other doctors who misdiagnose. When other types of doctors initially misdiagnose the patient’s PE as something else, the doctors still win the case 61% (14/23) of the time. In contrast, EM doctors only win 12.5% (1/8) of cases where misdiagnosis occurred. In one case, the EM doctor lost even though the patient coded (lost heart rate and blood pressure) within 2.25 hours of

presentation making causation questionable since the average time to diagnosis was 2.4 hours at the Mayo Clinic in one study and since treatment prior to diagnosis can be dangerous in some situations.\textsuperscript{14} Some guidelines recommend starting treatment prior to diagnosis when the clinical suspicion of PE is high,\textsuperscript{15} but some doctors believe that this may not be the most prudent course in spite of the guidelines.\textsuperscript{16}

Juries seem to be expecting more from EM doctors perhaps believing the patient has presented with symptoms that the patient believed (correctly here) were “emergent,” but the EM doctor arguably failed to recognize the emergency (“arguably” because sometimes the EM doctor admitted the patient with another urgent diagnosis like pneumonia). It is easy for a layperson to imagine the distress he or she would feel if he/she or a loved one went to the emergency room in distress and expected proper treatment, but the EM doctor failed to make the diagnosis resulting in death or severe complication. However, is this really a fair and just outcome?


\textsuperscript{15} Smith, supra note 2, at 1383 (citing Torbicki, \textit{supra} note 1; D. Charlebois et al., \textit{Early recognition of pulmonary embolism: the key to lowering mortality}, 20(4) J. CARDIOVASC. NURS. 254 (2005); American College of Chest Physicians, \textit{Anti-thrombotic therapy for venous thromboembolic disease: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (8th Edition)}, 133(6) CHEST 454S (2008).)

\textsuperscript{16} \textit{Id.}
Causation is likely where the heart of these cases lies. Did the EM doctor’s failure to diagnose actually and proximately cause the death/complication? Early administration of heparin reduces the risk of death associated with PE.\textsuperscript{17} Diagnosis of PE in the emergency department reduces the risk of death (mortality) compared to those diagnosed later.\textsuperscript{18} However, PE is not fatal in 95\% of ambulatory patients…even when misdiagnosed.\textsuperscript{19} So, did the EM doctor really “cause” the death or was the missed diagnosis more of a “loss-of-chance”? 

The plaintiff’s best argument is probably that the EM doctor’s failure to diagnose increased the risk of in-hospital death almost five-fold (from 1.4\% if diagnosed in the ED to 6.7\% if diagnosed later) and risk of death within 30 days over three-fold (from 4.4\% to 15.3\%).\textsuperscript{20} Using this logic, the plaintiff can argue that the patient was three to five times more likely to die (depending upon the timing of death) due to the EM doctor’s missed opportunity than if the EM doctor had made the diagnosis. This may be enough to convince juries beyond the preponderance of the evidence standard.

On the other hand, the defense can argue that the doctor’s misdiagnosis only reduced the patient’s odds of survival during hospitalization by 5.5\% (6.7 minus 1.4) and during the following 30 days by 9.9\% (15.3 minus 4.4), which is more in line with a “loss of chance” than actual causation.\textsuperscript{21} In addition to the doctor’s misdiagnosis, other factors may play a role in

\textsuperscript{17} See Smith, supra note 2, at 1382; see also D.W. Barritt and S.C. Jordan, Anticoagulant drugs in the treatment of pulmonary embolism: A controlled trial, 1(7138) LANCET 1309 (1960).
\textsuperscript{18} See Smith, supra note 2, at 1383; see also J.A. Kline et al., Prospective study of the clinical features and outcomes of emergency department patients with delayed diagnosis of pulmonary embolism, 14(7) ACAD. EMERG. MED. 592 (2007).
\textsuperscript{19} K. Calder et al., The Mortality of Untreated Pulmonary Embolism in Emergency Department Patients, 45 ANNALS EMERG. MED. 302 (2005).
\textsuperscript{20} Smith, supra note 2.
\textsuperscript{21} Id.
mortality including a history of cancer, chronic obstructive pulmonary disease (“COPD”), and older age. Some studies have also suggested that cardiovascular disease and hemodynamic instability are predictive of mortality. In addition, some authors argue that PE is over-diagnosed and over-treated with adverse results related to overtreatment. Thus, the defense may be able to successfully argue that the plaintiff has not met its burden regarding actual causation since the patient’s other diseases and simple probability may have contributed to the outcome and the doctor may have been justified in hesitating in coming up with the diagnosis.

Interestingly, juries from two different states (IL, OH) with similar negligence standards—modified comparative fault—have markedly different results in the small number of PE cases available for comparison. In Ohio, doctors won 100% (8/8) of the cases, whereas in Illinois, doctors only won 55.6% (5/9). The laws in both states appear to be similar and interpreted similarly by the insurance industry. There are likely other factors at play here. In 2016, Illinois annually pays out $20.08 per capita ($258,191,000 total) in medical malpractice claims compared to $7.65 per capita ($88,787,000 total) in Ohio. Therefore, the differences in

22 Id. at 1388.
24 See supra note 14.
outcomes between the two states’ PE cases are likely due to differing ways of thinking about malpractice cases among jurors from the different states, and not due to differences in these two states’ laws.

**B. PERCEIVED SIMPLICITY OF DIAGNOSIS AND PRESENCE OF EMOTIONAL FACTORS LIKELY PLAY A ROLE IN PLAINTIFF JURY VERDICTS.**

When the doctor doesn’t have a chance to make the diagnosis (i.e., the patient just dies suddenly), the doctor almost always prevails. When the doctor faces a tough diagnostic dilemma, the doctor almost always prevails. However, when the diagnostic challenge appears simple—e.g., the patient only has symptoms related to lung problems—the doctor loses more often than not. Inflammatory, emotional factors—such as finger pointing by supervising doctors, failing to make the diagnosis for a prolonged period of time, or use of arguably dismissive treatments like breathing in a brown paper bag—lead to significantly higher jury awards.

Prior studies have shown that up to 95% of patients who die from PE do so before the diagnosis is made, so the majority of deaths from PE occur in untreated patients. Likewise, in this study, the patient often (25/71 cases; 35.2%) simply suddenly died before an opportunity was present for the doctor to make the diagnosis—even though in some cases the doctor may have had an opportunity to arguably prevent the PE with prophylaxis. Specifically, juries favored doctors in 92% (23/25) of cases where the patient presented with sudden death. This was true even though risk factors were present for PE that may have gone unrecognized by the doctor in prior interactions with the patient such as recent high risk surgical procedure, symptoms of blood clot in the leg, or prior history of blood clots. In fact, prophylaxis to prevent PE was virtually never mentioned in any of the cases as a part of the allegation of malpractice.

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27 Smith, supra note 2, 1382; see also, Torbicki, supra note 1; Goldhaber, supra note 23; Calder, supra note 19.
reported in the opinions. Because prophylaxis is often controversial and almost all doctors arguably use some type of prophylaxis—which may include prescription medications, early mobilization, ted hose, aspirin, calf pumps, etc.—it is not surprising that the courts largely ignored the issue when it came time for a decision.

The diagnostic challenge presented to the doctor appears to play a role in jury verdicts for PE cases. Doctors are more likely to lose when the presenting symptoms appeared to pose less of a diagnostic challenge. When the patient presented with a primary symptom of shortness of breath alone, plaintiffs prevailed in 53% (9/17) of cases. In contrast, when other symptoms accompanied the shortness of breath, the doctor won 83.3% of the cases (10/12). One study suggests that patients with more co-morbid conditions do indeed prove to be more of a diagnostic challenge for physicians because PE symptoms can be mistaken for coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease or other conditions.28 Here, the findings seem to indicate that the jury sees shortness of breath in isolation as a more simple sign of PE and is therefore less understanding when the physician fails to make the diagnosis and save the patient. On the other hand, when shortness of breath is combined with other symptoms that may mislead the physician to make an erroneous diagnosis or result in a complication or death of the patient, the jury is more likely to be forgiving of the doctor.

In addition, emotional factors may play a role in the size of jury awards. PE cases are generally more emotional than the average medical malpractice case. In this study, 93% (66/71) of the cases involved death of the patient, whereas only 22% of medical malpractice cases

28 Smith, supra note 2, at 1387.
generally involve death. In the case with the largest award, a doctor-in-training stopped the patient’s medication and all of the attending doctors supervising the young doctor denied authorizing the stoppage. The lack of supervision or the failure to take responsibility may have inflamed the jury. Similarly, in one case, the patient was misdiagnosed for 75 days, and the jury awarded $6,350,715. In two cases, the doctor misdiagnosed the pulmonary embolism as hyperventilation and had the patient breathe into a brown paper bag as treatment. The thought of a patient dying of PE being treated with such a seemingly dismissive treatment may have inflamed the jury resulting in an average award over two and a half times the median plaintiff award ($2,623,072 average for the paper bag cases versus $1,048,114 median).

C. WHEN THE DIAGNOSIS IS MADE IMMEDIATELY, THE DOCTOR WINS—BUT MISDIAGNOSIS LEADS TO FREQUENT PLAINTIFF VERDICTS.

Initial diagnosis is a key factor in the outcomes of jury trials for PE. When the doctor made the diagnosis immediately, the defense prevailed 100% of the time (7/7 cases). This is true even though treatment was delayed in some patients due to contraindications or other clinical concerns. In contrast, when the doctor misdiagnosed the patient or failed to make the diagnosis, the doctor lost 51.6% of the cases (16/31). The fact that doctors won 48.4% (15/31 cases) of misdiagnosis cases likely is related to the fact that the diagnosis can be difficult to make when the patient has multiple comorbidities or confusing symptoms—thus, misdiagnosis is not

29 C. Lee and R. LaFountain, NATIONAL CENTER FOR STATE COURTS, MEDICAL MALPRACTICE LITIGATION IN STATE COURTS, 6 (April 2011), http://www.courtstatistics.org/~/media/microsites/files/csp/highlights/18_1_medical_malpractice_in_state_courts.ashx.
30 Spyrka, supra note 10, at 804.
32 Supra note 11.
33 Smith, supra note 2.
necessarily outside the standard of care depending upon the symptoms present, tests ordered, and timing.

D. THIS STUDY LIKELY ACCURATELY REFLECTS THE OUTCOMES OF PULMONARY EMBOLISM CASES THAT GO TO JURY TRIAL.

The source of the data—judicial opinions—likely accurately reflects the courts’ and juries’ perceptions, even though it may not accurately reflect the medical record or facts. In some cases, the facts reported are medically inaccurate—e.g., the judge reported that one expert testified that heparin actually dissolves blood clots like PEs (i.e., it is thrombolytic)\(^{34}\) although heparin only prevents clot propagation and does not dissolve the clot.\(^{35}\) Whether the judge misheard or the expert was mistaken, the medical facts considered in the outcome were probably inaccurate.

In addition, it is very likely that judges overlook or fail to mention important clinical symptoms and may misstate precise timelines in the judicial opinions. However, the judicial opinion reflects what the judge took away from the expert testimony and medical record. Whether accurate or not, the facts presented in the opinion are the ones that the jury likely relied upon in making its decision. Therefore, this type of study may be a more accurate guide to jury verdicts than one in which an accurate medical record review is included. Given HIPAA, access, and expense issues, accurate medical record review in this type of study would be difficult, cost preclusive, and nearly impossible due to privacy issues.

The limited medical information in the judicial opinions was inadequate for the author to meet his goal of evaluating jury outcomes where prophylaxis may have been indicated. An attempt was made to assign Caprini risk values\textsuperscript{36} for PE to each patient, but the opinions were simply devoid of enough clinical information to make reliable assessments. Therefore, no conclusions were reached regarding the potential jury outcomes where the doctor failed to properly prophylactically treat the patient after a high risk procedure or where the patient had known risk factors for PE—except that the lack of judicial attention to this issue may be in line with the controversy that surrounds venous thromboembolic prophylaxis in general.

Even though these are mostly reported cases, the data still likely accurately reflect general PE jury outcomes since the reasons these cases were in the reporters are likely more related to legal issues than the underlying medical facts. The fact that the 79\% of the cases in this study (57/71) were published in a reporter may add some biases to the outcomes when compared to the average PE case since most PE cases are not published in reporters. Cases published in a reporter tend to be “of interest,” establish new law, criticize or question existing law, reverse a judgment, respond to a remand, or perhaps add other legal biases to the case selection.\textsuperscript{37} However, the decision to include a case in a reporter is likely more related to underlying issues of law, instead of the medical issues that are largely examined in this study. Still, in this study, doctors won 65\% (37/57) of reported cases versus 85.7\% (12/14) of unreported cases. Thus, if there is a bias here, favorable plaintiff verdicts may be over-estimated.

\textbf{V. Conclusion}


\textsuperscript{37} Platt, \textit{supra} note 8.
Pulmonary embolism often presents a difficult diagnostic challenge for doctors and juries alike. Juries hold emergency medicine doctors to higher standards than other doctors in management of acute PE such that EM doctors are uniquely vulnerable in PE medical malpractice claims. Juries are more likely to find in favor of the plaintiff when the presenting symptoms appear to more simply point to the diagnosis of PE and when emotional factors are in play. When the diagnosis of PE is made by the doctor immediately, the plaintiff is unlikely to prevail regardless of outcome. However, if the doctor initially misdiagnoses the PE, the plaintiff is more likely to win than lose. Doctors facing more difficult diagnostic challenges are often favored by juries, even when they make a diagnostic mistake. While this study is not perfect, it likely accurately reflects how juries assess pulmonary embolism medical malpractice claims.
### Appendix A: Data Table

| CH | PH  | DO | AT | PH | VA | CH | PH  | DO | AT | PH | VA | CH | PH  | DO | AT | PH | VA |
|----|-----|----|----|----|----|----|-----|----|----|----|----|----|-----|----|----|----|----|----|----|
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**Notes:**
- IL: Illinois Driver License
- CA: California Driver License
- M: Male
- F: Female
- White, Black, etc.: Race
- Brown, Blue, etc.: Eye Color
- Brown, Black, etc.: Hair Color
- 01/01/1980: Date of Birth
- 123456789: Driver Id
- 5'10" and 5'6": Height
- 170 lbs and 120 lbs: Weight
APPENDIX B1: DATASHEET FOR CASE COLLECTION (SURGICAL CASES)

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<th>Case Name:</th>
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<th>Plaintiff (Patient, estate, widow, etc.):</th>
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(1) Medical Specialty & Type of Surgical Procedure:

(2) Specialty of Physician Sued:

(3) Additional Risk Factors of Patient Mentioned in Opinion:

(4) Estimated Risk Class of Surgical Procedure/Patient (circle one)

HIGH | MEDIUM | LOW

(5) Type of Prophylaxis Rendered

NONE | MECHANICAL: | CHEMICAL: | OTHER: | CONTRAINDICATIONS?

(6) Time from Procedure until PE:

(7) Primary Symptom upon Presentation with PE (circle all that apply):

SHORTNESS OF BREATH | CHEST PAIN | COUGH HEMOPTYSIS | OTHER:

(8) Timeliness of PE Diagnosis (days after presentation):

(9) Outcome of Trial By Jury (circle prevailing party):

PLAINTIFF | DOCTOR

(10) Monetary Award Amount:

AMOUNT: | NOT APPLICABLE

(11) Court of Appeals’ Result:

AFFIRMED | REVERSED | REVERSED & REMANDED | OTHER:
APPENDIX B2: DATASHEET FOR CASE COLLECTION (NON-SURGICAL CASES)

GRiffin: Pulmonary Embolism Study: NON-Surgical Case Data Sheet

Case Name: State Law Applied: Date:
Complication (Death, MI, PE alone, etc.): Plaintiff (Patient, estate, widow, etc.):

(1) Specialty of Physician Sued:

(2) Additional Risk Factors of Patient Mentioned in Opinion:

(3) Primary Symptom upon Presentation with PE (circle all that apply):

SHORTNESS OF BREATH CHEST PAIN COUGHHEMOPTYSIS

OTHER:

(4) Timeliness of PE Diagnosis (days after presentation):

(5) Outcome of Trial By Jury (circle prevailing party):

PLAINTIFF DOCTOR

(6) Monetary Award Amount:

AMOUNT: NOT APPLICABLE

(7) Court of Appeals’ Result:

AFFIRMED REVERSED REVERSED & REMANDED

OTHER: