not to illustrate the incidence of this type of lawsuit, but rather to provide a synopsis of common findings in cases that have been filed and this was accomplished.

Having said that, a deeper dive into these findings would be beneficial through provision of specific case citations and references from the cases. It would be interesting to get a feel for how many of those cases, if any, were appellate level, setting precedent for lower courts in terms of the rules of law implemented or elements to consider in determining an acceptable standard of care. As an appellate court ruling could overturn and set a new standard for previous rulings of lower courts, an understanding of the level and jurisdiction of the courts is helpful.

Further, it would also be helpful to have a table delineating the specific cases in the sampling considered for additional review, as cases are not always disposed of based

on the finding of issue alone. That is, a decision in favor of the plaintiff may or may not be solely due to a substantive finding of malpractice on part of the surgeon, but could rather be based on another aspect of care provided, another provider entirely, or a procedural issue with the filing of the suit itself, etc. In other words, it is not enough to simply state for which party the court found favorably. A consideration of why the court made its finding is necessary to get an accurate picture of the dynamics at play with this particular type of litigation. This information would provide greater direction to surgeons seeking to use these opinions to better protect themselves from legal action related to aortic dissections, further accomplishing the goal of the authors.

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See Article page 600.

Commentary: Ambushed by a snow leopard: Malpractice litigations involving aortic dissection

Stephanie L. Mick, MD, and Leonard N. Girardi, MD

When the Marfan Foundation established Aortic Disease Awareness Day in 2016, their leadership selected the snow leopard as the archetypal predator to represent aortic conditions: it is rare, silent, and difficult to find. With an incidence of approximately 7.7 cases/year per 100,000 population,¹ the human predator known as acute aortic dissection is an uncommon but lethal entity that commonly involves multiple organ systems. Its most common variant, acute type A dissection (ATAAD), can be challenging to diagnose, as malperfusion syndromes may mimic stroke, myocardial infarction, mesenteric ischemia, or threatened limb. The “Great Masquerader,” ATAAD often leads physicians down alternative diagnostic

Stephanie L. Mick, MD, and Leonard N. Girardi, MD

CENTRAL MESSAGE

In medical malpractice cases involving aortic dissection, the most common alleged bases of litigation were failure to diagnose (64.4%), delayed treatment (30.4%), and failure to test (28.1%).

and treatment pathways with catastrophic consequences. ATAAD ravages the aorta with a mortality of 1% per hour from onset to the time of operation. For those fortunate to get to operation, the mortality even within the experienced centers reporting to the International Registry of Aortic Dissection remains approximately 22%.² Is it any wonder why dissection is so strongly associated with medical malpractice litigation?^{3,4}

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In this issue of the *Journal*, Palaniappan and Sellke⁵ characterize the trends of malpractice litigations arising from aortic dissection over the past 25 years with the intent of educating the cardiothoracic community on the most common pitfalls leading to lawsuits. Within the online Westlaw legal research service,⁶ 135 cases were identified that made it to trial or documented settlement and analyzed to identify the most common allegations proceeding to litigation.

Although Westlaw is the most widely cited source for malpractice information, the authors readily acknowledge that its data are quite limited with respect to details of trials and resolution negotiations, with no information at all on the actual medicine. Realistically, the 135 cases at best represent less than 5% to 10% of all cases, as there is no tally for cases dismissed pretrial or resolved outside the legal system. This well-intended analysis unfortunately likely covers just “the tip of the iceberg” and therefore the possibilities for meaningful extrapolation are quite limited.

Despite the limitations, this work sheds some light on the larger trends in malpractice for dissection. The most common alleged bases of litigation were failure to diagnose (64.4%), delayed treatment (30.4%), and failure to test (28.1%). While testing for and diagnosing dissection are commonly outside the purview of surgeons, delay in treatment, the second most common alleged basis, is often within the cardiothoracic surgeon's control. Expedient transfer from the emergency

department to an operating room is now common practice and may mitigate a few of the issues related to delays. In terms of other possible measures to reduce the incidence of malpractice claims, the results also illustrate the importance of education of physicians who initially evaluate patients for dissection. Such education could include multidisciplinary Grand Rounds aimed at nonsurgical specialties and broad national education campaigns like Aortic Disease Awareness Day.

Just as for the prey of the snow leopard, quickly identifying and escaping this predator is the only way to survive. Brisk diagnosis and treatment are not only crucial keys for patient survival but also for minimization of potential legal liability.

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See Article page 600.

Commentary: Malpractice litigation and acute aortic dissection: What are the odds?

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CENTRAL MESSAGE

Good communication between ED physicians/primary care physicians and cardiovascular surgeons can minimize risk of litigations in cases of acute aortic dissections.

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