ORIGINAL ARTICLE

A retrospective forensic analysis of medical malpractice allegations related to thoracic surgery in Türkiye

İbrahim Güneş,[1] Caner Beşkoç,[1] Eren Erdoğdu,[2] Salih Duman,[2] Murat Kara,[2] Berker Özkan[2]

[1]Counsil Of Forensic Medicine, İstanbul-*Türkiye*

[2]Department of Thoracic Surgery, İstanbul University Faculty of Medicine, İstanbul-*Türkiye*

ABSTRACT

BACKGROUND: Medical malpractice refers to harm caused to patients during the delivery of healthcare services due to negligence, misapplication, or failure to provide appropriate treatment by healthcare professionals. In recent years, a notable increase in medical malpractice lawsuits has been observed both nationally and internationally. Surgeons, in particular, are more frequently subject to such lawsuits, as complex surgeries carry a higher risk of adverse effects and complications. Thoracic surgery ranks among the specialties with the highest number of malpractice claims. Understanding the causes and distribution of these lawsuits can contribute to the prevention of malpractice in this field.

METHODS: We retrospectively evaluated 118 cases of alleged medical malpractice in thoracic surgery by the Council of Forensic Medicine. Data collected included sociodemographic characteristics, medical records, other healthcare professionals involved, the institutions and departments in question, relevant specialties, and causes of death, where applicable.

RESULTS: Of the 118 cases, 76 (64.4%) involved male patients and 42 (35.6%) female patients, with a mean age of 43.2±20.5 years. Tertiary healthcare institutions accounted for the majority of allegations (58.5%). Non-traumatic conditions were the reason for admission in 61 cases (51.7%), while traffic accidents were the most common trauma-related cause (25 cases, 43.9%). Medical malpractice was confirmed in 11 cases (9.3%), while six were considered assessable. Diagnostic errors were the most common stage at which malpractice occurred, identified in five cases (45.5%). Pneumothorax was the most frequent diagnosis (29 cases, 24.6%), and tube thoracostomy was the most commonly performed surgical procedure (31 cases, 26.2%). Medical malpractice was identified in 3 out of 6 cases (50%) managed in outpatient clinics. Among the three cases involving procedural misconduct, malpractice was confirmed in two (66.6%).

CONCLUSION: This study is the first in the literature to specifically analyze medical malpractice cases related to thoracic surgery. In specialties where complex procedures are common, such as thoracic surgery, malpractice allegations may arise not only from surgical interventions but also from diagnostic and follow-up processes. To reduce the risk of malpractice lawsuits, it is essential to emphasize continuous education on current best practices, ensure thorough documentation, obtain informed consent, promote shared decision-making, and provide ongoing training for thoracic surgeons in both their professional duties and legal responsibilities.

Keywords: Thoracic surgery; medical malpractice; malpractice lawsuit; patient safety.

INTRODUCTION

Medical malpractice refers to incidents resulting from negligent actions or omissions by healthcare professionals during the provision of medical services. At the 44th General Assembly of the World Medical Association in 1992, medical malpractice was defined as: "harm caused by a physician's failure to apply standard practices, lack of skill, or omission of treatment".[1,2] Globally, an increase in malpractice claims related to medical errors has been observed.[3,4] From a legal standpoint,

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Address for correspondence: Eren Erdoğdu

Department of Thoracic Surgery, İstanbul University Faculty of Medicine, İstanbul, Türkiye

E-mail: eren.erdogdu@istanbul.edu.tr

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for healthcare professionals to be held liable, there must be a causal relationship between the harm suffered and the professional's negligent act.[5] It is of utmost importance for healthcare professionals to have a comprehensive understanding of their professional responsibilities, relevant legal regulations, and the approaches of legal authorities. This knowledge is essential not only for preventing medical malpractice but also for effectively managing any incidents that may arise.[6]

The success of surgical specialties relies on skill, experience, a competent team, and adequate equipment. As technology advances, new medical and surgical procedures have become more widespread, which has led to an increase in errors and complications due to insufficient knowledge, skill, or experience in evolving techniques.[7]

It is expected that a certain number of medical malpractice allegations will follow surgical procedures. Studies show that such allegations are more commonly encountered in specialties such as Obstetrics and Gynecology, Emergency Medicine, General Surgery, and Orthopedics.[8] In a study conducted by Seabury S. et al.[9] In the United States, involving 40,916 physicians, the specialties most frequently subject to complaints were reported as Neurosurgery, Thoracic Surgery, Cardiovascular Surgery, Plastic and Reconstructive Surgery, Orthopedics and Traumatology, General Surgery, and Obstetrics and Gynecology. Thoracic surgery ranked third, after Orthopedics and Traumatology, and General Surgery, in terms of being found liable.[8]

In this study, we aimed to conduct a detailed analysis of medical malpractice allegations in the field of thoracic surgery by examining the distribution of cases and evaluating whether this distribution varies across different types of hospitals. Additionally, we investigated whether malpractice rates differ based on the frequency of operative and non-operative procedures, as well as across diagnostic, treatment, and follow-up processes. Another goal of our study was to offer insights into potential preventive measures based on our findings, thereby contributing to improved patient safety and guiding healthcare professionals on how to reduce the risk of malpractice allegations.

MATERIALS AND METHODS

We conducted a retrospective evaluation of cases involving allegations of medical malpractice in the field of thoracic surgery. These cases were reviewed by the 1st, 2nd, 7th, and 8th Specialty Boards of the Council of Forensic Medicine over a five-year period, from January 2016 to December 2020. The study was approved by the Education and Scientific Research Commission of the Council of Forensic Medicine, with decision number 25189509/2020/864.

We included 188 cases in the analysis. Sociodemographic characteristics such as the age and gender of the patients were recorded. Medical records were analyzed based on the nature of complaints, clinical diagnoses, surgical interventions performed, and treatment approaches adopted. Additionally, we examined the type of healthcare institution where the incident occurred and identified the specific department where the alleged malpractice took place, including the emergency room, outpatient clinic, general ward, operating room, or intensive care unit.

We also assessed the roles of the healthcare professionals involved, including surgeons and associated medical staff, as well as the participation of other related specialties in each case. In cases where death occurred, the cause of death was documented. Data were analyzed using SPSS 25.0 statistical software (IBM Corp., Armonk, NY, USA). Categorical variables were evaluated using the Chi-square test to identify significant associations. In cases where sample sizes were small or the assumptions for the Chi-square test were not met, Fisher's exact test was used. This comprehensive statistical approach ensured a thorough and reliable analysis of the data, allowing for the identification of patterns and trends related to medical malpractice in thoracic surgery.

RESULTS

Of the 118 cases related to medical malpractice in the field of thoracic surgery, 76 (64.4%) involved male patients and 42 (35.6%) involved female patients. The mean age was 43.2±20.5 years. When categorized by age groups, 12 cases (10.2%) were between 0-18 years, 45 cases (38.1%) between 19-40 years, 31 cases (26.3%) between 41-64 years, and 30 cases (25.4%) were 65 years or older.

When healthcare institutions under complaint were classified as either public or private hospitals, 105 cases (89%) involved public hospitals, while 13 cases (11%) involved private hospitals. Among these institutions, 49 cases (41.5%) occurred in secondary-level hospitals, and 69 cases (58.5%) in tertiary-level hospitals.

At initial admission, 61 cases (51.7%) presented for non-traumatic reasons, while 57 cases (48.3%) were trauma-related. Among the 57 trauma cases, the causes were as follows: traffic accidents in 25 cases (43.9%), falls in 14 cases (24.6%), sharp or penetrating injuries in seven cases (12.2%), assault in four cases (7.0%), iatrogenic trauma from intramuscular injection in four cases (7.0%), entrapment under rubble in two cases (3.5%), and firearm injury in one case (1.8%).

The most common diagnoses were pneumothorax and lung mass, each observed in 10 cases (8.5%), followed by rib fracture in six cases (5%), pleural effusion in six cases (5%), hemothorax in six cases (5%). Pneumomediastinum was reported in four cases (3.4%), mediastinal lymphadenopathy in four cases (3.4%), and hemopneumothorax in four cases (3.4%). Foreign body aspiration was identified in three cases (2.5%), as was bronchiectasis in three cases (2.5%). Mediastinitis occurred in two cases (1.7%), emphysema in two cases (1.7%), tracheal stenosis in two cases (1.7%), and sharp or penetrat-

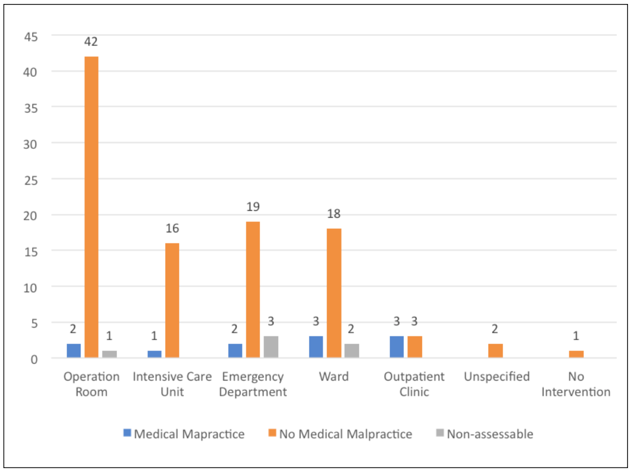

Figure 1. Distribution of medical malpractice cases regarding intervention units.

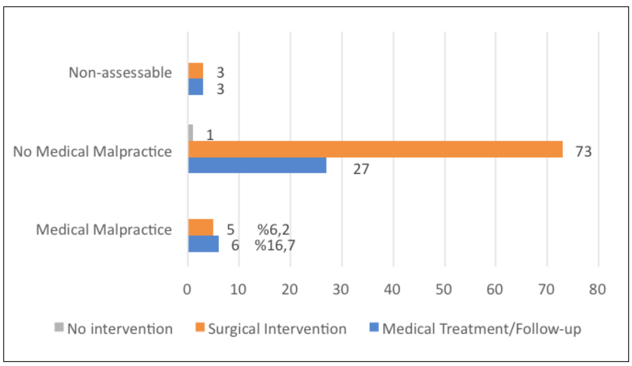

Figure 2. Medical malpractice allegations regarding treatment type.

ing trauma in two cases (1.7%). The following diagnoses were each observed in one case (0.8%): atelectasis, thoracic outlet syndrome, mediastinal mass, tracheoesophageal fistula, pneumonia, esophageal diverticulum, pectus carinatum, axillary hyperhidrosis, blunt object contact, blunt head and chest trauma, parapneumonic effusion, foreign body in soft tissue, catheter requirement, endobronchial lesion, and nausea-vomiting. In two cases (1.7%), no diagnosis was made by the thoracic surgeon, and in 36 cases (30.5%), multiple diagnoses were reported.

When cases were evaluated based on the units where interventions were performed, 45 cases (38.1%) took place in the operating room, 24 cases (20.3%) in the emergency department, 23 cases (19.5%) in the ward, 17 cases (14.4%) in the intensive care unit, and six cases (5%) in the outpatient clinic. In two cases (1.7%), the intervention unit was not specified, and in one case (0.8%), no intervention was performed, only a medical report was issued. Medical malpractice was identified in three cases (50%) managed in the outpatient clinic, three cases (13.0%) in the ward, two cases (8.3%) in the emergency department, one case (5.9%) in the intensive care unit, and two cases (4.4%) in the operating room. Analysis of the relationship between the intervention unit and the occurrence of medical malpractice showed that the malpractice rate was significantly higher in cases managed in the outpatient clinic (p=0.21) (Fig. 1).

Surgical and/or interventional procedures were performed in 81 cases (68.7%), while medical treatment or follow-up alone was carried out in 36 cases (30.5%). In one case (0.8%), no treatment was provided, and only a medical board report was issued (Fig. 2).

In 88 cases (74.5%), complaints were filed against thoracic surgeons in conjunction with physicians from other specialties. In 34 cases (38.6%), complaints involved more than two specialties. Among the additional specialties implicated, complaints were filed against anesthesiologists in eight cases (6.8%), emergency medicine specialists in seven cases (6%), neurosurgeons in six cases (5.1%), general surgeons in five cases (4.2%), orthopedic surgeons in five cases (4.2%), pulmonologists in three cases (2.5%), general practitioners in three cases (2.5%), and otolaryngologists in three cases (2.5%). No significant association was found between the occurrence of medical malpractice and the involvement of physicians from other specialties alongside thoracic surgeons (p=0.71) (Fig. 3).

Among the additional healthcare professionals implicated alongside physicians (n=33, 28.0%), hospital management was the most frequently cited, with 22 cases (18.6%), followed by nurses in six cases (5.1%) and anesthetic technicians in three cases (2.5%). No significant difference was observed between the presence of medical malpractice and the involvement of other healthcare personnel alongside thoracic surgeons (p=0.493) (Fig. 4).

The most common allegation was incorrect treatment, reported in 49 cases (41.5%), followed by negligence in 20 cases (17%) and misdiagnosis or failure to diagnose in 17 cases (14.4%). In eight cases (6.7%), the reason for the complaint could not be determined due to insufficient information. When evaluating the cases by complaint category, medical malpractice was identified in three cases (6.1%) of incorrect treatment, two cases (66.6%) of procedural misconduct, one case (33.3%) involving infection, two cases (20%) of prema-

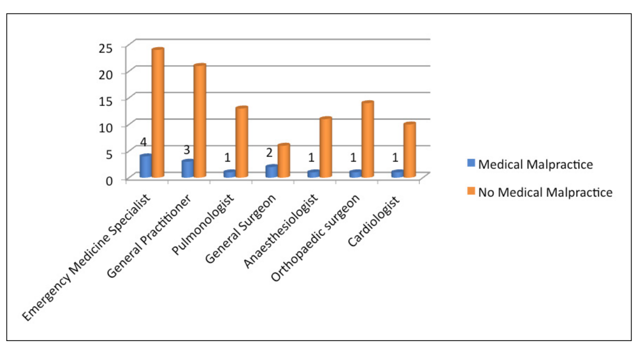

Figure 3. Distribution of medical malpractice allegations against other specialties alongside thoracic surgery.

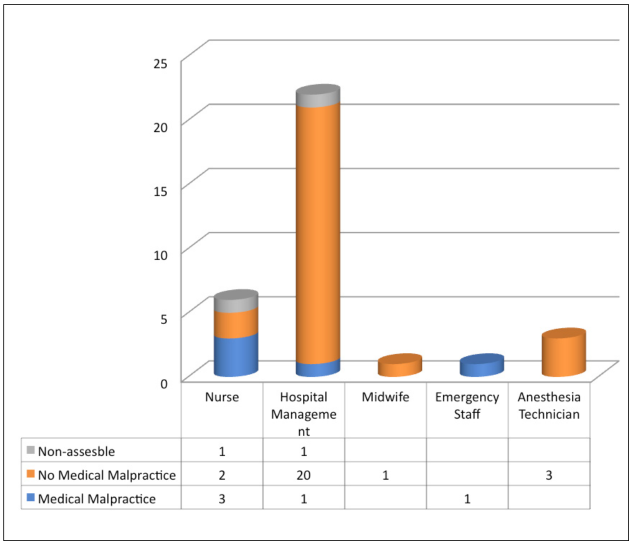

Figure 4. Distribution of medical malpractice allegations against other healthcare personnel.

ture discharge, two cases (11.8%) of misdiagnosis or failure to diagnose, and one case (5%) of negligence (Table 1).

Among the alleged cases, 78 (66.1%) resulted in death, while 40 cases (33.9%) were non-fatal. Of the 40 non-fatal cases, no specific harm was identified in 21 cases; organ and/or tissue loss was reported in seven cases; neurological sequelae were observed in five cases; final status examinations were not conducted in four cases; and drop foot, limb amputation, and organ function loss were reported in one case each.

The Council of Forensic Medicine concluded that no medical malpractice was present in 101 cases (85.6%), while medical malpractice was confirmed in 11 cases (9.3%). In six cases (5%), no opinion could be issued due to missing medical documentation (n=5) or contradictions in the statements provided (n=1).

In the 11 cases where medical malpractice was confirmed, diagnostic failures were the most common, identified in five cases (45.5%), followed by treatment failures in three cases (27.2%) and follow-up failures in another three cases (27.2%). The most frequently observed failures were premature discharge and failure to request necessary tests, each found in three cases (27.2%). Other errors included failure to request a consultation in two cases (18.2%), delayed treatment in one case (9.1%), faulty procedure in one case (9.1%), and incomplete treatment in one case (9.1%).

DISCUSSION

This study represents a unique effort to comprehensively analyze allegations of medical malpractice in the field of thoracic surgery, addressing a notable gap in literature. It offers a detailed evaluation of malpractice case distribution, differences related to the frequency of operative versus non-operative procedures, and the variables contributing to diagnostic, treatment, and follow-up errors. By examining malpractice rates across different levels of healthcare institutions and exploring potential preventive strategies, this study makes a contribution to healthcare policy and patient safety initiatives. The findings of this study not only highlight the professional responsibilities of healthcare providers in thoracic surgery but also provide a foundation for future improvement strategies.

The average age of 43.2 years and the predominance of male patients in cases involving allegations of medical malpractice in thoracic surgery are consistent with findings in the literature. This may be attributed to the fact that men are generally more active in the workforce and that this age group is more prone to thoracic trauma and related diseases.[10,11]

The majority of cases involved public hospitals, where a higher incidence of medical malpractice was observed. This may be due to several factors, including the larger patient volume in public hospitals, limited time allocated per patient during consultations, and generally less favorable working conditions compared to private hospitals.

Table 1. Distribution of medical malpractice allegations by reason for complaint

Reason for Complaint	Total	Medical Malpractice	No Medical Malpractice	Non-Assessable
Incorrect Treatment	49 (41.5)	3 (6.2)	45 (91.8)	1 (2)
Negligence (Stage Not Specified)	20 (17)	1 (5)	19 (95)	0
Misdiagnosis/Missed Diagnosis	17 (14.4)	2 (11.8)	15 (88.2)	3 (17.6)
Premature Discharge	10 (8.5)	2 (20)	6 (60)	2 (20)
Insufficient Follow-Up	6 (5.1)	0	6 (100)	0
Infection	3 (2.5)	1 (33.3)	2 (66.7)	0
Irregularity	3 (2.5)	2 (66.6)	1 (33.3)	0
Referral Mistake	2 (1.7)	0	2 (100)	0
Unspecified	8 (6.8)	0	8 (100)	0
Total	118	11 (9.3)	101 (85.6)	6 (5.1)

The most common intrathoracic findings in thoracic trauma are hemothorax, pneumothorax, and hemopneumothorax.[12,13] Rib fractures are also frequently reported in traumatic cases, occurring in over 50% of instances.[14] Similarly, in this study, and in line with the literature, pneumothorax was the most common diagnosis, identified in 29 cases, followed by rib fractures.

In all three cases (100%) managed in outpatient clinics, medical malpractice was identified. Malpractice was also found in three cases (13.0%) managed in wards, two cases (8.3%) in emergency departments, one case (5.9%) in intensive care units, and two cases (4.4%) in operating rooms. Additionally, medical malpractice was identified in six of the 81 cases involving surgical and/or interventional procedures, and in five of the 36 cases managed with medical treatment and follow-up. These findings underscore the need for vigilance regarding medical malpractice, regardless of whether surgical intervention is involved.

The physicians most frequently implicated alongside thoracic surgeons were general practitioners and emergency medicine specialists. These physicians often serve as the initial point of contact in traumatic cases, which are commonly managed in emergency departments. Their key responsibilities include consulting with relevant specialists and/or referring patients to other medical facilities. Given these responsibilities, combined with the demanding working conditions in emergency departments, it is unsurprising that they rank among the most frequently accused in malpractice allegations.

Aside from physicians, complaints were most commonly directed at hospital management, followed by nurses and anesthesia technicians. Since healthcare is a collaborative and multidisciplinary service, it is common for lawsuits to involve multiple healthcare professionals who are part of the patient's care process. Therefore, the importance of physicians and other healthcare professionals working collaboratively in patient management, treatment, and follow-up becomes even more evident in the context of such cases.

As observed in our study, medical malpractice can occur at any stage of the healthcare process.[15] It is essential for physicians, particularly those in surgical specialties, to exercise the utmost care throughout the entire continuum of diagnosis, treatment, and follow-up.

In surgical specialties, the risk of death following interventional procedures is higher compared to other clinical disciplines, and complications are often unpredictable. Furthermore, patients may suffer permanent harm. This highlights the need for thorough planning and meticulous attention before, during, and after surgical procedures. The objective should not only be to successfully perform the surgery but also to manage the entire medical process effectively.[16,17] While surgical procedures are often the first to come to mind in discussions of potential medical malpractice in surgical fields, it is important to recognize that non-surgical processes also carry a considerable risk in this regard.[18]

Recently, with the rise in medical malpractice allegations both in our country and globally, the practice of defensive medicine has become increasingly common among physicians. This has also led to a growing reluctance to pursue surgical specialties.[19] Studies on medical malpractice can help identify the stages of the medical process where errors are most likely to occur and play a crucial role in raising awareness to reduce reliance on defensive medicine. Rather than resorting to defensive practices, such as ordering excessive tests or unnecessary procedures to avoid potential errors, it is more effective to inform patients about the risks and rationale behind diagnostic and treatment decisions. Obtaining informed consent and engaging in shared decision-making when multiple diagnostic or treatment options exist are essential. Equally important is the proper documentation of these processes. While such documentation offers greater legal protection for healthcare professionals, studies have shown that it does not necessarily reduce the number of malpractice lawsuits.[20]

The most frequently identified errors identified diagnostic errors. These typically result from physicians having limited time with patients, often due to challenging working conditions, and from communication gaps with other specialists. We believe that improving working conditions and providing targeted training on effective communication and interdepartmental consultations can help prevent a significant number of these errors. Additionally, supporting retraining programs for physicians with identified knowledge or skill deficiencies may contribute to reducing the incidence of medical malpractice.[21]

In our study, medical malpractice cases related to thoracic surgery that were reviewed by the Council of Forensic Medicine over a five-year period were evaluated, and medical malpractice was identified in 9.3% of the cases. However, this study reflects only a portion of the overall landscape. To gain a more comprehensive understanding, it is essential to conduct regular, annual evaluations and to determine the annual rates of medical malpractice and complications across all medical specialties.[22]

CONCLUSION

Thoracic surgeons carry ethical, professional, and legal responsibilities throughout the entire continuum of patient care, including diagnosis, treatment, and follow-up. From the initial examination through to treatment, discharge, and subsequent follow-up, it is essential that the highest level of care and attention is maintained. To prevent potential legal issues in the future, physicians must ensure that comprehensive medical records are accurately maintained and securely stored for each patient. Moreover, it is crucial that thoracic surgeons receive ongoing training in their professional and legal responsibilities following graduation. This training may be conducted within their institutions, through external programs, or through self-directed learning.

Ethics Committee Approval: This study was approved by the the Education and Scientific Research Commission of the Council of Forensic Medicine (Date: 10.09.2020, Decision No: 25189509/2020/864).

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Conflict of Interest: None declared.

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ORİJİNAL ÇALIŞMA - *ÖZ*

Türkiye'de göğüs cerrahisi ile ilgili tıbbi uygulama hatası iddialarının retrospektif analizi

AMAÇ: Tıbbi uygulama hatası, sağlık hizmetlerinin sunumu sırasında sağlık çalışanlarının ihmal, yanlış uygulama veya uygun tedavi sağlanamaması nedeniyle hastalara verilen zararı ifade eder. Hem ulusal hem de uluslararası düzeyde tıbbi uygulama hatası iddialarına dayalı davalarda kayda değer bir artış gözlemlenmiştir. Özellikle cerrahlar, karmaşık ameliyatların daha yüksek risk taşıması ve komplikasyonlara yol açması nedeniyle daha fazla tıbbi uygulama hatası davasına konu olmaktadır. Çalışmalar, göğüs cerrahisini tıbbi uygulama hatası iddialarının en fazla görüldüğü branşlar arasında üst sıralarda göstermektedir. Göğüs cerrahisinde tıbbi uygulama hatası davalarının nedenlerinin ve dağılımının belirlenmesi, bu tür hataların önlenmesine katkı sağlayacaktır.

GEREÇ VE YÖNTEM: Bu çalışmada, Adli Tıp Kurumu tarafından değerlendirilen göğüs cerrahisi branşına ait toplam 118 tıbbi uygulama hatası iddiası retrospektif olarak değerlendirilmiştir. Sosyodemografik veriler, tıbbi kayıtlar, şikayetçi olunan diğer sağlık çalışanları, olayın meydana geldiği sağlık kuruluşu ve birimler, ilgili branşlar ve ölüm sebebi kullanılarak analiz edilmiştir.

BULGULAR: 118 vakanın 76'sı (%64.4) erkek, 42'si (%35.6) kadın cinsiyette idi. Vakaların ortalama yaşı 43.2±20.5 olarak saptandı. Tıbbi uygulama hatası iddialarına konu olan sağlık birimlerine göre dağılımda ilk sırada 3. basamak sağlık kuruluşları (%58.5) yer almaktadır. Vakaların 61'inin (%51.7) travma dışı nedenlerle sağlık kuruluşuna başvurduğu ve travma şikayetiyle başvuranlarda en sık nedenin 25 (%43.9) vaka ile trafik kazası olduğu saptandı. Vakaların 11'inde (%9.3) tıbbi uygulama hatası olduğu görülmüştür. Tanı aşamasındaki hatalar 5 (%45.5) vaka ile ilk sıradadır. En sık tanı 29 vaka (%24.6) ile pnömotoraks, en sık yapılan cerrahi müdahale ise 31 vaka (%26.2) ile tüp torakostomidir. Poliklinikte müdahale edilen 3 vakada (%50) tıbbi uygulama hatası olduğu saptanmıştır. Usulsüzlük nedeniyle şikayetçi olunan 3 vakadan 2'sinde (%66.6) tıbbi uygulama hatası tespit edilmiştir.

SONUÇ: Bu çalışma, göğüs cerrahisine özgü tıbbi uygulama hatası davalarını analiz eden literatürdeki ilk çalışmadır. Karmaşık prosedürlerin yaygın olduğu branşlar, örneğin göğüs cerrahisi, malpraktis iddialarının yalnızca cerrahi müdahalelerle değil, aynı zamanda tanı ve takip süreçleriyle de ilgili olduğunu göstermektedir. Malpraktis davalarını azaltmak için sağlık çalışanlarına güncel en iyi uygulamalarla ilgili sürekli eğitimlerin verilmesi, uygun dokümantasyonun sağlanması, ortak karar verme süreçlerinin teşvik edilmesi ve göğüs cerrahlarının mesleki ve yasal sorumlulukları konusunda devamlı eğitim almalarının sağlanması gerekmektedir.

Anahtar sözcükler: Göğüs cerrahisi; tıbbi uygulama hatası; malpraktis davası; hasta güvenliği.

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