ORIGINAL ARTICLE

Forensic analysis of medical malpractice claims in major joint dislocations: retrospective analysis of 64 cases

Yusuf Atan,[1,2] Muhammed Fatih Yaman,[2] İbrahim Uzunlu,[3] Hüseyin Çağrı Şahin,[2] Muhammed Oduncu,[2] Mehmet Ali Yıldız,[4] Mustafa Bilal Ceylan,[2] Serkan Bayram,[5]

[1]Department of Forensic Medicine, Bilecik Şeyh Edebali University, Bilecik-*Türkiye*
[2]Council of Forensic Medicine, Ministry of Justice, İstanbul-*Türkiye*
[3]Department of Orthopedics and Traumatology, İstanbul Medeniyet University, İstanbul-*Türkiye*
[4]Council of Forensic Medicine, Alanya Directorate, Antalya-*Türkiye*
[5]Department of Orthopedics and Traumatology, İstanbul University, İstanbul Faculty of Medicine, İstanbul-*Türkiye*

ABSTRACT

BACKGROUND: The objective of this study was to examine the characteristics of medical malpractice claims related to major joint dislocation cases.

METHODS: Our database was used in the study to analyze major dislocation cases involving medical malpractice that were closed between 2018 and 2024. A complete and detailed dataset was collected for each case. This included information such as patients' demographics (age and sex), the specific anatomical location of the dislocation (ankle, knee, hip, wrist, elbow, shoulder, and acromioclavicular joint), the underlying cause of the dislocation, rationales for the claim, complications, and unique characteristics of each case.

RESULTS: This retrospective study analyzed 64 cases of major joint dislocation referred to the Council of Forensic Medicine between 2018 and 2024. The mean age of patients was 30.21±15.3 years, with 60.9% being male and 39.1% being female. Upper extremity dislocations accounted for 78.1% of cases, with the elbow being the most common site. Patients were treated at university hospitals (12.5%), education and research hospitals (57.8%), and private hospitals (29.7%). Complications were observed in 46 patients (71.8%), with restricted joint mobility being the most common complication. The most prevalent complaint was delayed diagnosis (37.5%), followed by inappropriate postoperative management and negligence. The board deemed 35.9% of cases as malpractice, with a significant association between conservative treatment and malpractice. In 22 cases with malpractice rulings, the physician was deemed culpable, whereas in one case, malpractice was assigned to a healthcare worker.

CONCLUSION: The primary causes of malpractice claims in major joint dislocation cases were delayed diagnosis and inadequate postoperative care. Conservative treatment was associated with high rates of medical malpractice. To reduce the risk of medical malpractice, it is necessary to standardize early diagnosis methods and ensure comprehensive postoperative follow-up.

Keywords: Emergency orthopedics; joint dislocation; malpractice; shoulder; upper extremity.

INTRODUCTION

Large joint dislocations frequently occur in emergency orthopaedics, often arising in conjunction with other injuries.[1] In cases of significant joint dislocation, early intervention is paramount, as there is potential for concomitant damage to blood vessels and nerves.[2] Although their frequency varies according to joint type, age group, and mechanism of trauma, major joint dislocations (of the shoulder, elbow, hip, and knee) are relatively common among orthopaedic emergen-

Cite this article as: Atan Y, Yaman MF, Uzunlu İ, Şahin HÇ, Oduncu M, Yıldız MA et al. Forensic analysis of medical malpractice claims in major joint dislocations: retrospective analysis of 64 cases. Ulus Travma Acil Cerrahi Derg 2026;32:1243-1249.

Address for correspondence: Serkan Bayram
Department of Orthopedics and Traumatology, İstanbul University, İstanbul Faculty of Medicine, İstanbul, Türkiye
E-mail: dr.serkanbayram89@gmail.com

Ulus Travma Acil Cerrahi Derg 2026;32(10):1243-1249 DOI: 10.14744/tjtes.2026.25500
Submitted: 10.01.2026 Revised: 06.05.2026 Accepted: 15.06.2026 Published: 06.10.2026
OPEN ACCESS This is an open access article under the CC BY-NC license (http://creativecommons.org/licenses/by-nc/4.0/).

cies. Major joint dislocations are most prevalent in the shoulder joint among adults, constituting approximately 50–60% of all such dislocations, with an annual incidence ranging from 17 to 25 cases per 100,000 individuals.[3] However, other major joint dislocations are also frequently observed in orthopaedic emergencies and may result in significant morbidity and mortality.[4]

Trauma surgery is widely regarded as a specialized field that is susceptible to a high incidence of legal action, largely attributable to the potential for complications arising from both the diagnostic process and therapeutic interventions.[5] Emergency orthopaedic procedures represent a clinical area in which the risk of malpractice is high.[6] This is due to the need for rapid decision-making and the critical importance of time. Conditions such as traumatic fractures, major joint dislocations, open wounds, and compartment syndrome can result in permanent disability or death if diagnosis is delayed or intervention is inadequate.[7] Previous studies have reported cases of malpractice in orthopaedic procedures involving bone fractures.[8] However, research in this area remains limited, and no studies have examined malpractice cases involving major joint dislocations, which are considered orthopaedic emergencies.

The present study examined malpractice cases involving major joint dislocations in emergency orthopaedics based on the following factors: case characteristics, hospital type (public or private), affected anatomical region, clinical outcomes, and final forensic medical decisions (confirmation or denial of malpractice).

MATERIALS AND METHODS

This study utilized a retrospective analysis to examine cases of patients referred to the 7th Specialized Board of Forensic Medicine for the assessment of malpractice claims between 2018 and 2024 following a diagnosis of major joint dislocation in the orthopaedic emergency department. In order to accomplish this objective, the National Judicial Network Information System (UYAP) was utilized. This is the data entry platform of the Institute of Forensic Medicine and a resource employed by all entities within the justice system and the courts. Through its use, a thorough analysis of all medical malpractice cases involving closed traumatic dislocations of major joints was performed. As the data utilized in this study were entirely anonymized, no further agreement was necessary from either the defendant or the claimant. The study was approved by the Ethics Committee of İstanbul University, İstanbul Faculty of Medicine (Date: 24.04.2026, Decision No: 2026/861).

A database was utilized as a repository for a vast array of court records on cases submitted to courts or arbitration by judges and attorneys. To facilitate further in-depth investigation, each case in our database incorporated detailed summaries, court documents (including expert witness reports), and details about the plaintiffs and defendants. In most cases, radiological images were available as references. Following approval by the Scientific Board of the Council of Forensic Medicine (Date: 18.02.2025, Decision No: 2025/158), the malpractice specialization committee in our country utilized our database to investigate medical malpractice cases.

The inclusion criteria were major joint dislocation, traumatic origin, age >12 months, and complete available data. The exclusion criteria included open fracture–traumatic dislocation and missing data. Within the UYAP system, joint dislocation-related inquiries were conducted, and the resulting data were subsequently filtered using the joint dislocation criteria. A subsequent search was performed using the following keywords: "fracture-dislocation of large joint," "joint dislocation," "shoulder dislocation," "knee joint dislocation," "hip dislocation," "ankle joint dislocation," "elbow joint dislocation," "wrist dislocation," "acromioclavicular joint dislocation," and "acute large joint dislocation."

Following the legal proceedings, the relevant section of the Institute of Forensic Medicine was required to undertake a detailed examination of each case. This included information such as patient demographics (age and sex), the specific anatomical location of the dislocation (ankle, knee, hip, wrist, elbow, shoulder, and acromioclavicular), the underlying cause of the dislocation, rationales for the claim, complications, and the unique characteristics of each case. The cases examined for major joint dislocation injuries were categorized as follows: joint dislocation alone, dislocation with fracture, soft tissue injury, vascular injury, and nerve injury.

Healthcare services in this country are predominantly provided by two sectors: public and private hospitals. Patients receiving treatment at state hospitals are not subject to financial responsibilities; however, those receiving treatment at private hospitals must pay the associated expenses themselves. Public hospitals can be further classified as institutions dedicated to research and education or those affiliated with universities. The duration of hospital stay, need for surgical intervention, and interval between trauma and surgery were determined through a review of medical records.

The mechanisms of major joint dislocations were categorized into four groups: traffic accidents, work accidents, falls, and spontaneous dislocations. Traffic accidents were further categorized into three groups: accidents occurring outside the vehicle, accidents occurring inside the vehicle, and motor vehicle accidents. In cases involving injuries sustained during traffic accidents inside a vehicle, patients were categorized as drivers, front passengers, or rear passengers.

Treatment was classified as either conservative or surgical. The specialties subject to malpractice claims included orthopaedic surgeons, nurses, and healthcare personnel. The professional seniority of physicians facing allegations of medical malpractice was categorized as follows: professor/associate professor, attending surgeon, senior resident, and junior resident. In this study, additional injuries sustained by the patient

Table 1. Demographic data of patients with joint dislocation

n=64	Patients with Joint Dislocation	
	Mean±SD	Min-Max
Age, years	30.21±15.3	16 months-65 years
Gender, Female/Male	25 / 39	
Dislocation joint		
Acromioclavicular, n	2	
Shoulder, n	21	
Elbow, n	24	
Wrist, n	3	
Hip, n	4	
Knee, n	6	
Ankle, n	4	
Additional injury		
Isolated dislocation	25 (39.1%)	
Fracture dislocation	28 (43.8%)	
Soft tissue injury	5 (7.8%)	
Nerve injury	3 (4.7%)	
Vascular injury	3 (4.7%)	
Mechanism of dislocation		
Traffic accident	9 (14.1%)	
Work accident	2 (3.1%)	
Fall	47 (73.4%)	
Spontaneous	6 (9.4%)	
Malpractice litigation against		
Medical Doctor	62 (96.9%)	
Healthcare professional	2 (3.1%)	
Treatment		
Conservative	27 (42.2%)	
Surgery	37 (57.8%)	
Degree of seniority of doctors		
Professor-Associate professor	8 (12.5%)	
Attending surgeon	53 (82.8%)	
Senior resident doctor	3 /4.7%)	
Junior resident doctor	-	
Hospital		
University Hospital	8 (12.5%)	
Education-Research Hospital	37 (57.8%)	
Private Hospital	19 (29.7%)	
Complication, Yes/No	46/18	

cohort were also evaluated. The following types of complications were examined: delayed or failed diagnosis, negligence, surgical error, excessive or inappropriate surgery, inadequate surgery, postoperative management errors, and healthcare system errors.

Statistical Analyses

Statistical analysis was conducted using the IBM Statistical Package for Social Sciences Statistics for Windows version 29.0 (IBM Corp., Armonk, NY, USA). Dispersion parameters (mean or median, standard deviation, minimum, and maximum) were used for quantitative data in descriptive analyses, whereas percentages were used for qualitative data. For quantitative data with a normal distribution, the Student's t-test was used for comparisons. Qualitative variables were compared using Pearson's chi-square test, Fisher's exact test, and the Fisher–Freeman–Halton test. The threshold for statistical significance was set at $p<0.05$.

RESULTS

A total of 64 medical malpractice claims pertaining to cases of large joint dislocations were documented. The mean age was 30.21±15.3 years (range, 16 months–65 years), with 39 (60.9%) subjects identified as male and 25 (39.1%) as female. The analysis revealed that 78.1% of joint dislocations occurred in the upper extremities. The distribution of acromioclavicular, shoulder, elbow, and wrist joint dislocations was as follows: 2, 21, 24, and 3 cases, respectively. In the lower extremities, four cases were identified in the hip joint, six in the knee joint, and four in the ankle joint (Fig. 1). The demographic data of the patients are presented in Table 1.

Of the patients, 12.5% received treatment at a university hospital, 57.8% at an education and research hospital, and 29.7% at private hospitals. Complications were observed in 46 patients (71.8%), most of whom had restricted joint mobility. The most prevalent complaint was delayed diagnosis, accounting for 37.5% of cases. This was followed by inappropriate postoperative management and negligence. The distribution of the complaints is shown in Table 2.

A total of 23 cases (35.9%) were deemed instances of mal-

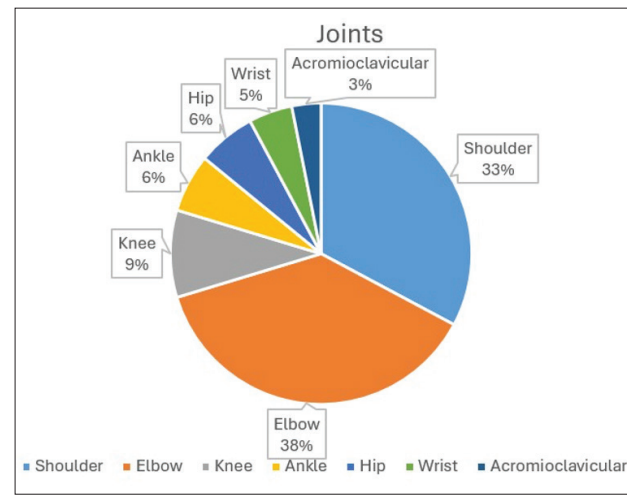

Figure 1. The visual representation of the data illustrates the location of the major joint dislocation.

Table 2. The main reasons for medical malpractice claims that come about after a joint dislocation

Reason for litigation	Total defendant (n=64)
Delay in diagnosis/Failure to diagnosis	24 (37.5%)
Negligence	12 (18.8%)
Surgical error	11 (17.2%)
Excessive or inappropriate treatment	2 (3.1%)
Inadequate surgery	2 (3.1%)
Inappropriate postoperative management	13 (20.3%)

practice by the board. Patients with and without malpractice were compared in Table 3. A detailed examination of the data revealed no statistically significant differences between the parameters examined in cases where malpractice was detected and those where it was not, with the exception of the treatment method. Cases in which malpractice was detected were treated conservatively. Among the 23 malpractice cases, 13 involved delayed diagnosis, four involved negligence, one involved surgical error, and five involved inappropriate post-operative management. Following a thorough examination of the 23 malpractice cases, it was determined that 22 involved medical doctors and one involved a healthcare professional.

Table 3. Comparison of clinical characteristics between cases with malpractice and without malpractice

	Cases with no malpractice (n: 41)		Cases with identified malpractice (n: 23)		
	Mean±SD	Min–Max	Mean±SD	Min–Max	p
Age, years	29.3±14.2	16 months – 54	31.6±17.3	4–65	0.597
Gender, Male/Female	25/16		14/9		0.993
Joints					
Acromioclavicular	2		0		0.927
Shoulder	14		7		
Elbow	15		9		
Wrist	2		1		
Hip	2		2		
Knee	4		2		
Ankle	2		2		
Hospital					
University	5		3		0.987
Education-research	24		13		
Private	12		7		
Trauma					
Traffic accident	7		2		
Work accident	2		0		0.291
Fall	27		20		
Spontaneous	5		1		
Degree of seniority of doctors					
Professor-Associate professor	5		3		
Attending surgeon	35		18		0.515
Senior resident doctor	1		2		
Junior resident doctor	-				
Treatment, Conservative/Surgery	12/29		15/8		0.005*
Complication Yes/No	27/14		19/4		0.153

DISCUSSION

In orthopaedic traumatology, a subspecialty of trauma, incidences of medical negligence are frequently documented, typically arising from patients sustaining high-energy injuries, technical inadequacies in emergency departments, or inadequate emergency care. A considerable body of research has been conducted on this subject, revealing that allegations of medical malpractice in trauma surgery predominantly pertain to diagnostic errors, inadequate surgical planning, and insufficient postoperative care.[8] Of the 10,900 claims received by the NHS in 2023–2024, orthopaedic surgery accounted for 10.8%, establishing it as one of the most frequently involved specialties. This figure represents a 12% decline compared with the rate recorded during 2019–2020.[9,10] However, trauma departments remain among the settings where malpractice cases are most likely to occur due to the high workload and fatigue among healthcare workers. The severity of damage is not directly correlated with the probability of litigation in the emergency department. It is evident that cases involving relatively mild permanent and partial disabilities are more likely to result in legal action. Agout et al.[11] reported that, following a 10-year archive review, 51,582 surgical procedures were performed, of which only 71 resulted in malpractice lawsuits. Of the 71 cases reported in that study, 52.1% were categorized as trauma surgery cases. Over a period of seven years, an evaluation of trauma cases within the Council of Forensic Medicine was conducted, resulting in the identification of 64 instances that led to malpractice lawsuits attributable to joint dislocation.

The most frequent allegations in malpractice cases pertaining to orthopaedic trauma are reported to originate from delayed diagnosis, surgical technique errors, and inadequate management of postoperative complications. Gathen et al.[12] conducted an extensive review of 230 cases in a study performed between 2000 and 2017. The researchers meticulously examined the legal database in their country to collect the data necessary for the study. Furthermore, a significant proportion of the plaintiffs in these 230 cases were female, constituting 56.8% of the total. The mean age of the plaintiffs was 44.6 years, with a standard deviation of±20.1 years. The complaints alleged that misdiagnosis (22.6%), inadequate nursing care (8.3%), and improper management (46.1%) were the primary causes. Ahmed et al.[8] evaluated 201 cases of fractures. The mean age of participants was 41 years. The study revealed that 64 cases (31.8%) involved diagnostic errors and 57 cases (28.4%) exhibited delays. Furthermore, an alleged treatment error was identified in 177 cases (88.1%). Cichos et al.[13] conducted a retrospective study on medical malpractice litigation involving orthopaedic surgeons between 1988 and 2013. In that study, over the course of 26 years, orthopaedic surgeons were the subject of 1,562 malpractice cases, 462 of which were reported to have been successful for plaintiffs. The most commonly litigated procedures were fracture fixation (363 cases), arthroplasty (290 cases), and spine surgery (231 cases); plaintiffs had the highest success rates with fasciotomy (48%), infection therapy (43%), and carpal tunnel release (37%). As demonstrated in that study, the highest average compensation amounts granted to plaintiffs were observed in the fields of paediatrics, spine surgery, and oncology. In our study, the most prevalent complaint was delayed diagnosis, accounting for 37.5% of cases. This was followed by inappropriate postoperative management and negligence.

The proportion of medical malpractice claims that result in favorable outcomes for defendants varies significantly.[14-16] Gidwani et al.[15] obtained data on 97 of 130 cases of alleged medical malpractice brought before the court system between 2004 and 2006. Interestingly, none of these patients proceeded to trial. A total of 55% of cases were withdrawn by the plaintiffs' attorneys, while the remaining 45% were settled out of court. This indicates that no cases were decided in favor of the defendant. Arif et al.[17] evaluated orthopaedic surgeons and non-orthopaedic practitioners involved in medical negligence lawsuits in 358 cases of acute compartment syndrome. In that study, settlements were reached in 67 cases (19%), the defendant was found to be at fault in 203 cases (57%), and the plaintiff was found to be at fault in 88 cases (25%). Furthermore, orthopaedic doctors were substantially more likely than non-orthopaedic physicians to be involved in cases where ACS resulted from fractures or surgery, as well as when the claim was based on alleged incorrect bracing or casting. In our study, malpractice was confirmed by the board in 35.9% of cases.

The length of a physician's professional tenure substantially affects the probability of facing malpractice claims. Empirical evidence suggests that cumulative risk increases with the duration of a physician's career, indicating that the likelihood of a doctor encountering litigation by the age of 65 increases to 75% in low-risk specialties and may approach 99% in high-risk specialties. In high-risk specialties, the probability of incurring damages rises from 33% at age 45 to 71% at age 65. This trend also applies to the risk of incurring damages.[18] The association between the duration of physicians' practice and malpractice claims is evaluated within the framework of defensive medical practices and the determination of legal liability, rather than merely the frequency of claims. Research suggests that physicians with less experience are more inclined to engage in defensive practices, such as ordering unnecessary tests or avoiding high-risk patients, to mitigate liability risks.[19] Conversely, this tendency diminishes as physicians gain greater expertise. When evaluating a physician's negligence in a malpractice claim, subjective factors such as experience, education, and skill level are considered. This suggests that the expected standards of care for more experienced physicians may differ from those applicable to newly qualified physicians. In our cohort of 64 cases, an analysis comparing instances of identified malpractice (n=23) with those without malpractice (n=41) in relation to physician seniority revealed

no statistically significant difference in malpractice incidence among professors/associate professors, specialist doctors, and junior doctors (p=0.515). This finding suggests that physician seniority does not independently influence the risk of medical malpractice.

Our study had several limitations. A notable limitation of this study is its retrospective nature, as it was based on the examination of existing case files. The absence of the ratio of malpractice cases related to joint dislocations to all emergency malpractice cases represents a significant limitation. A further limitation is the heterogeneity of the treatment modalities used for patients.

CONCLUSION

The present study evaluated major joint dislocations, which are common in orthopaedic emergencies and associated with a high risk of malpractice claims. The data indicate that upper-extremity dislocations accounted for 78.1% of cases, with the elbow being the most common site of dislocation. The most prevalent complaint was delayed diagnosis, followed by inappropriate postoperative management. In 35.9% of cases, malpractice was confirmed, and conservative treatment was associated with a higher risk.

Ethics Committee Approval: This study was approved by Forensic Medicine Institution Scientific Board (Date: 18.02.2025, Decision No: 2025/158).

Peer-review: Externally peer-reviewed.

Authorship Contributions: Concept: S.B., M.F.Y., İ.U.; Design: S.B., Y.A.; Supervision: M.B.C., Y.A.; Materials: İ.U., M.O.; Data collection and/or processing: M.F.Y., H.Ç.Ş.; Literature review: H.Ç.Ş., S.B.. M.A.Y.; Writing: S.B., Y.A.; Critical review: M.B.C., Y.A.

Informed Consent: Retrospective study.

Conflict of Interest: None declared.

Financial Disclosure: The author declared that this study has received no financial support.

REFERENCES

1. Hindle P, Davidson EK, Biant LC, Court-Brown CM. Appendicular joint dislocations. Injury 2013;44:1022–7. [CrossRef]
2. Klein R, Laue F, Matthes G, Wölfl C. Notfallbehandlung von Luxationen großer Gelenke [Emergency treatment of dislocation of large joints]. Unfallchirurg 2021;124:391–406. [Article in German] [CrossRef]
3. Reiad TA, Peveri E, Dinh PV, Owens BD. Epidemiology of Shoulder Injuries Presenting to US Emergency Departments. Orthopedics 2025;48–e7. [CrossRef]
4. Lefebvre CW, Hartman ND, Glass C, Daubach E, Wodajo T, Hutchison B, Lance T, Prendergast NJ, Ashburn NP. Feasibility and efficacy of simulation training for joint dislocation management in residency. Am J Emerg Med 2025;94:50–4. [CrossRef]
5. Mouton J, Gauthé R, Ould-Slimane M, Bertiaux S, Putman S, Dujardin F. Litigation in orthopedic surgery: What can we do to prevent it? Systematic analysis of 126 legal actions involving four university hospitals in France. Orthop Traumatol Surg Res 2018;104:5–9. [CrossRef]
6. Gould MT, Langworthy MJ, Santore R, Provencher MT. An analysis of orthopaedic liability in the acute care setting. Clin Orthop Relat Res 2003;59–66. [CrossRef]
7. Rynecki ND, Coban D, Gantz O, Gupta R, Ayyaswami V, Prabhu AV, et al. Medical malpractice in orthopedic surgery: a westlaw-based demographic analysis. Orthopedics 2018;41–e20. [CrossRef]
8. Ahmed SA, DeFroda SF, Naqvi SJ, Eltorai AEM, Hartnett D, Ruddell JH, et al. Malpractice litigation following traumatic fracture. J Bone Joint Surg Am 2019;101. [CrossRef]
9. NHS Resolution's Annual report and accounts 2019/20, NHS Resolution (2020). Available at: https://resolution.nhs.uk/2020/07/16/nhs-resolutions-annual-report-and-accounts-2019-20/ Accessed September 29, 2026.
10. Annual report and accounts 2023/24 Advise / Resolve / Learn HC 73. Available at: https://resolution.nhs.uk/2020/07/16/nhs-resolutions-annual-report-and-accounts-2019-20/ Accessed September 29, 2026.
11. Agout C, Rosset P, Druon J, Brilhault J, Favard L. Epidemiology of malpractice claims in the orthopedic and trauma surgery department of a French teaching hospital: A 10-year retrospective study. Orthop Traumatol Surg Res 2018;104:11–5. [CrossRef]
12. Gathen M, Jaenisch M, Fuchs F, Weinhold L, Schmid M, Koob S, et al. Litigations in orthopedics and trauma surgery: reasons, dynamics, and profiles. Arch Orthop Trauma Surg 2022;142:3659–65. [CrossRef]
13. Cichos KH, Ewing MA, Sheppard ED, Fuchs C, McGwin G Jr, McMurtrie JT, et al. Trends and risk factors in orthopedic lawsuits: analysis of a national legal database. Orthopedics 2019;42–e7. [CrossRef]
14. Burns J, Shrader MW, Boan C, Belthur M. Characteristics of medical professional liability claims in pediatric orthopedics. J Patient Saf 2021;17–e96. [CrossRef]
15. Gidwani S, Zaidi SM, Bircher MD. Medical negligence in orthopaedic surgery: a review of 130 consecutive medical negligence reports. J Bone Joint Surg Br 2009;91:151–6. [CrossRef]
16. Ring J, Talbot C, Cross C, Hinduja K. NHSLA litigation in hip fractures: Lessons learnt from NHSLA data. Injury 2017;48:1853–7. [CrossRef]
17. Arif HA, Morales JA, Brito E, Moore ST, Lin CA. Litigation patterns of acute compartment syndrome: distinctions between orthopaedic and non-orthopaedic cases and factors predicting successful defense. J Bone Joint Surg Am 2025;107:1561–9. [CrossRef]
18. Jena AB, Seabury S, Lakdawalla D, Chandra A. Malpractice risk according to physician specialty. N Engl J Med 2011;365:629–36. [CrossRef]
19. Çağlayan Aygün G, Önder RT. Hekimlerin hukuki sorumluluğu bakımından defansif tıp uygulamaları. IMHFD 2024;9:73–108. [Article in Turkish] [CrossRef]

ORİJİNAL ÇALIŞMA - *ÖZ*

Büyük eklem çıkıklarında tıbbi malpraktis davalarının adli analizi: 64 olgunun geriye dönük analizi

AMAÇ: Bu çalışmanın amacı, büyük eklem çıkığı olgularıyla ilgili tıbbi malpraktis davalarının özelliklerini incelemektir.
GEREÇ VE YÖNTEM: Çalışmada, 2018 ile 2024 yılları arasında sonuçlanan tıbbi malpraktis içeren büyük eklem çıkığı olgularını analiz etmek üzere veri tabanımız kullanılmıştır. Her olgu için eksiksiz ve ayrıntılı bir veri seti toplanmıştır. Bu veriler arasında hastaların demografik bilgileri (yaş ve cinsiyet), çıkığın anatomik konumu (ayak bileği, diz, kalça, el bileği, dirsek, omuz ve akromiyoklavikular eklem), çıkığın altta yatan nedeni, talebin gerekçeleri, olası komplikasyonlar ve her olgunun kendine özgü özellikleri yer almaktadır.
BULGULAR: Bu retrospektif çalışmada, 2018 ile 2024 yılları arasında Adli Tıp Kurumu'na sevk edilen 64 büyük eklem çıkığı olgusu analiz edildi. Hastaların ortalama yaşı 30.21±15.3 yıl idi ve %60.9'u erkek, %39.1'i kadın idi. Üst ekstremite çıkıkları olguların %78.1'ini oluşturuyordu ve en sık görülen bölge dirsek idi. Hastalar üniversite hastanelerinde (%12.5), eğitim ve araştırma hastanelerinde (%57.8) ve özel hastanelerde (%29.7) tedavi görmüştü. Kırkaltı hastada (%71.8) komplikasyon gözlendi ve en sık görülen komplikasyon eklem hareket kısıtlılığıydı. En yaygın şikayet gecikmiş tanı (%37.5) idi; bunu uygun olmayan postoperatif yönetim ve ihmal izledi. Kurul, olguların %35.9'unu malpraktis olarak değerlendirdi ve konservatif tedavi ile malpraktis arasında anlamlı bir ilişki olduğunu belirledi. Yirmi iki olguda tıbbi malpraktis kararında hekim suçlu bulunurken, bir olguda ise malpraktis bir sağlık çalışanına atfedildi.
SONUÇ: Büyük eklem çıkığı olgularında malpraktis davalarının başlıca nedenleri geç teşhis ve yetersiz ameliyat sonrası bakımdı. Konservatif tedavi, yüksek malpraktis oranlarıyla ilişkilendirildi. Tıbbi malpraktis riskini azaltmak için erken teşhis yöntemlerinin standartlaştırılması ve kapsamlı bir ameliyat sonrası takip yapılması gerekmektedir.

Anahtar sözcükler: Acil ortopedi; eklem çıkığı; malpraktis; omuz; üst ekstremite.

Ulus Travma Acil Cerrahi Derg 2026;32(10):1243-1249 DOI: 10.14744/tjtes.2026.25500