ORIGINAL ARTICLE

Evaluation of medical malpractice claims in thoracic surgery

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ABSTRACT

BACKGROUND: Medical malpractice occurs in cases, where a patient experiences damage as a result of the doctor's deviation from the standard practice or care. As in all medical specialties, thoracic surgeons may face medical malpractice claims.

METHODS: Among the files reviewed by the First Board of Specialization of the Council of Forensic Medicine between January 01, 2010, and December 21, 2015, cases with malpractice allegations against thoracic surgeons were analyzed retrospectively.

RESULTS: Fifty-nine of the cases were male (72.8%), and 22 were female (27.2%). The mean age was 51.13±18.97 years, and the most common age range was >60 years (n=35, 43.2%). Medical malpractice was confirmed in 11 (13.6%) of the cases. A diagnostic error was the most common cause of error (n=7, 63.6%), and the most common cause of a diagnostic error was failure to diagnose a condition on time (n=4, 36.4%). The most frequent diagnosis was "injuries due to trauma" (n=54, 66.7%), followed by lung cancer (n=9, 11.1%). It was found that 80.2% (n=65) of the doctors intervened with the patient as a consultant. Complications developed in 48 (59.3%) of the cases. The most common complication was pneumonia (n=7, 14.6%).

CONCLUSION: This was the first study in Turkey that included cases of medical malpractice claims that involved thoracic surgeons. We think that examining cases with medical malpractice claims will help physicians not only better understand the characteristics of malpractice claims but also develop strategies to prevent malpractice claims.

Keywords: Diagnose; forensic medicine; malpractice; thoracic surgery.

INTRODUCTION

Medical malpractice occurs in cases where damage develops in a patient as a result of a doctor's deviation from the standard practice or care.[1] The surgical specialties are at a higher risk for medical malpractice claims than any other areas of specialization.[2,3] Today, young doctors do not prefer surgical branches in their professional careers due to the high risk of malpractice together with long and exhausting working hours.[4] The time spent on defense due to lawsuits and the emotional burden that these lawsuits can have on surgeons may also affect their medical practice; some physicians have abandoned surgery completely after cases resulting in compensation.[5] To reduce and prevent medical malpractice claims that may cause serious consequences for physicians, cases with medical malpractice claims should be closely analyzed. Unfortunately, few studies published in Turkey have raised awareness about thoracic surgeons and medical malpractice. The purpose of this study was to evaluate thoracic surgery cases that resulted in death, where medical malpractice claims were filed to increase the awareness of thoracic surgeons about cases with alleged medical malpractice.

MATERIALS AND METHODS

Sampling

Medical malpractice claims that were filed in thoracic surgery cases that resulted in death were retrospectively analyzed from among the report archives of the First Board of Special-

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ization of the Council of Forensic Medicine between January 01, 2010, and December 31, 2015.

Diagnostic Methods

The First Forensic Medicine Specialization Board of the Forensic Medicine Institute acts as an expert on cases with medical malpractice claims that resulted in death and were filed by judicial authorities. The board consists of a chairman and ten members (two forensic medicine specialists, one pathologist, one internist, one cardiologist, one general surgeon, one neurosurgeon, one anesthetist, one gynecologist, and one pediatrician). In addition, members from different medical specialties (such as thoracic surgery) may be appointed to the board. After the case reaches the board, it is examined by the rapporteur. If there are any deficiencies in the file, a letter is written to the judicial authority requesting any necessary information. If the file is complete, the rapporteur evaluates statements from the victims, accused doctors, and witnesses; all medical documents, surgery notes, epicrisis reports, observation documents, and radiological examination documents and images; autopsy reports; and photographs. The prepared report is then presented to the chairman and members of the board, and a final report is prepared and sent to the court detailing whether the physician has been determined to be at fault.

Data Collection and Implementation

While the data were being recorded, the following parameters were scrutinized: The gender and age of the cases, the healthcare organization visited, the reason for the visit to the hospital, the academic title of the physician, the clinical diagnosis, medical and/or surgical treatments performed, and any emergency-elective interventions, whether the death was traumatic or natural, the presence and type of any complications, and the phase in which confirmed malpractice was occured. The present study was a retrospective study that included no identifying data or human/animal subjects, so informed consent was not required. All study procedures were performed after obtaining the scientific and ethical approval of the Ministry of Justice Council of Forensic Medicine dated February 23, 2016, No.21589509/77 and in accordance with the 1964 Declaration of Helsinki including its later amendments.

Statistical Analysis

The Statistical Package for the Social Sciences 21.0 (Armonk, NY) statistics program was used for the data analysis in this study. Descriptive statistics were presented as the frequency, percentage, mean (mean), standard deviation, minimum, and maximum values. Fisher's exact test was used for the comparison of qualitative data, along with descriptive statistical methods. The significance level was accepted as $p<0.05$.

RESULTS

This study included 81 cases: Fifty-nine of the cases were male (72.8%), 22 were female (27.2%). The mean age is 51.13±18.97. The most common age range is over the age 60 (n=35, 43.2%), followed by 40–59 years (n=28, 34.6%), 18–39 years (n=13, 16%), and 0–17 years (n=5, 6.2%). Medical malpractice was confirmed in 11 (13.6%) of the cases. Eighty-nine doctors (three resident, 77 medical specialist, two asistant professor, two associate professor, and five professor) charged with malpractice allegations. When the distribution of the involved hospitals where these incidents took place was examined, it was determined that the most frequent treatment occurred at state hospitals (n=49, 60.5%), followed by education and research hospitals (n=15, 18.5%), university hospitals (n=10, 12.3%), and private hospitals (n=7, 8.6%).

In the 11 cases where medical malpractice was confirmed by the board, the most common cause of error was diagnostic error (n=7, 63.6%). The most common cause of diagnostic error was failure to diagnose on time (n=4, 36.4%) (Table 1).

Forensic examinations indicated that 54 (66.7%) of the cases were traumatic deaths, while 27 (33.3%) were deaths from natural causes. When the disease diagnoses of the cases were examined, the most frequent diagnosis was "injuries due to trauma" (n=54, 66.7%), followed by lung cancer (n=9, 11.1%) (Table 2).

The first intervention performed by thoracic surgeons frequently occurs in the emergency department (n=59, 72.8%). Of all 81 cases evaluated in this study, 31 (38.3%) underwent surgical treatment, and while 50 received medical treatment. Surgery was performed under emergency conditions in 17 (54.8%) of the 31 cases who underwent surgery and under elective conditions in the remaining 14 (45.2%) patients. No statistically significant difference in medical malpractice rates was found between surgical interventions performed on an emergent basis and elective interventions ($p>0.05$) (Table 3).

Table 1. Distribution of error types in malpractice cases

Classification of medical errors	n	%
Diagnostic error		
Not being able to diagnose on time	4	36.4
Not requesting necessary medical workup and graphies 18–39 years	1	9.1
Not requesting consultations	2	18.2
Treatment error		
Incomplete treatment	1	9.1
Breach of duty		
Causing negligence/breach of duty by not going to the hospital	3	27.2
Total	11	100

Table 2. Distribution of primary disease diagnoses and complication diagnoses

	n	%
Primary disease diagnosis		
Trauma	54	66.7
Lung cancer	9	11.1
Foreign body aspiration	3	3.7
Coronary artery disease	2	2.4
Others*	13	16.1
Total	81	100
Complication diagnosis		
Pneumonia	7	14.6
Pneumothorax	4	8.2
Bleeding	3	6.2
Sepsis	3	6.2
Bradycardia, hypotension	3	6.2
Acute respiratory distress syndrome	2	4.2
Esophageal performance	2	4.2
Pleural effusion	2	4.2
Pulmonary embolism	2	4.2
Vertebra metastasis	2	4.2
Tracheoesophageal fistula	2	4.2
Massive hemothorax	2	4.2
Acute renal failure	2	4.2
Others†	12	25
Total	48	100

*Soft tissue infection, bronchopneumonia, interstitial lung disease, subdiaphragmatic abscess, tuberculosis, massive pleural effusion, tracheal cancer, esophageal stenosis, epilepsy, brain tumor, nematic myelopathy, chronic bronchitis, breast cancer.
†Aspiration pneumonia, atelectasis, fat embolism, abscess, thromboembolism, pleuritis, peritonitis, mesenteric ischemia, myocardial infarction, cerebrovascular event, diaphragm rupture, vena cava superior rupture.

When the physician's role in patient care was examined, it was found that 80.2% (n=65) of the accused doctors intervened as a consultant, and 19.8% (n=16) were the primary attending physician. There was no significant difference between the consultant physician and the responsible physician in terms of their medical malpractice rates (p>0.05) (Table 3).

Complications developed in 48 (59.3%) of the cases during their treatment course. The most common complication was pneumonia (n=7, 14.6%) (Table 2). No statistically significant difference was found between the development of complications and medical malpractice rates (p>0.05) (Table 3).

DISCUSSION

In Turkish studies, the overwhelming majority of cases that are associated with alleged medical malpractice lawsuits are filed by male patients.[6,7] In the present study, most cases (72.8%) were also male. In Turkey, the incidents that cause medical malpractice claims frequently occur at state hospitals.[6,8,9] In the present study, 60.5% of the cases were treated at a state hospital.

Because the physicians that care for emergent patients often do not have sufficient information about the patient when treatment begins, they are very likely to encounter medical malpractice claims due to the need to make quick decisions in an acute situation, the limited time allocated to patients and their relatives, and the discontinuous patient–doctor relationship.[10] In the present study, thoracic surgeons often performed the first intervention in the emergency department (n=59, 72.8%).

Surgical intervention has been carried out in the vast majority of cases of medical malpractice claims that are filed against doctors from surgical specialties.[6,7,9] However, patients who undergo a nonsurgical medical treatment reportedly have a statistically significantly higher incidence of encountering a medical error compared to patients treated with surgery.

Table 3. The relationship between medical malpractice and medical conditions

		Medical malpractice		Test value	p*
		No	Yes		
		n (%)	n (%)		
Physician	Primary responsible	14 (17.3)	2 (2.5)	0.02	1.000
	Consultant	56 (69.1)	9 (11.1)		
Surgery	Emergency	14 (45.2)	3 (9.6)	2.735	0.232
	Elective	14 (45.2)	0(0)		
Complication	Yes	39 (48.1)	9 (11.1)	2.368	0.185
	No	31 (38.3)	2 (2.5)		

*Fisher's Exact Test.

[6,7] Surgical procedures performed under emergent conditions may seem to be more prone to error, but the literature indicates otherwise. Emergency surgery was carried out in 54.3% of cases that filed medical malpractice claims; these patients underwent surgical interventions in the general surgery department, but no significant relationship was identified between emergent and elective surgical intervention and medical errors.[6] Only 38.3% (n=31) of the patients in the present study underwent a surgical intervention. No statistically significant difference was found between surgical interventions performed under emergent and elective conditions according to medical malpractice (p>0.05) (Table 3). However, it was quite remarkable that none of the cases who underwent elective surgical intervention had any malpractice, and 17.6% (n=3) of the cases treated with emergency surgery had confirmed medical malpractice.

Doctors may often solicit ideas and suggestions from their colleagues in other specialties about their patient's follow-up or treatment, and they can modify the patient's treatment plan based on these consultations. Although the primary treatment responsibility lies with the attending physician, consulting physicians also have a responsibility to report their opinions about the patient and to provide the most appropriate treatment recommendations to the attending physician in a comprehensive verbal and written form.[11] In the present study, 80.2% (n=65) of the thoracic surgeons accused of malpractice examined the patient as a consulting physician.

Trauma cases have a reputation for being at high risk of becoming involved with malpractice claims.[12] One study found that 16.6% of cases with medical malpractice claims in the general surgery specialty were traumatic cases.[7] In the general surgery specialty, this rate was 32.3% in cases with medical malpractice claims that resulted in death.[6] In another study that involved 275 neurosurgical medical malpractice claims, 17.5% of the cases were trauma cases.[13] In this present study, 54 (66.7%) of the cases were found to be traumatic forensic deaths, while 27 (33.3%) were ruled as natural death. While 18.5% of the cases who died as a result of trauma were determined to have medical malpractice, this rate was only 4.7% in cases where the patient died from natural death causes. This situation demonstrates that in trauma cases, medical malpractice rate is about four times more than in cases, where the patient dies from natural causes; doctors would be prudent to exercise great caution in these cases.

"Incorrect application, incorrect technique, failure to recognize the complication, forgetting a foreign body, incorrect management, unnecessary procedure, operation of the wrong body part, lack/failure in informed consent, failure to perform the procedure, and delay in implementation" are the ten most common causes of medical malpractice that result in compensation in surgical specialties.[3] A study involving 58,158 surgical medical malpractice cases found that 41.8% of the cases received paid compensation.[14] Regenbogen et al.[15] reported that 52% of the cases with surgical medical practice error claims included technical errors, and the most common reasons for technical errors were injury of internal organs or other anatomical structures as a result of an accident or a lack of judgment and knowledge. In Turkey, the most common reasons for medical malpractice in the branch of general surgery are incomplete evaluation before and after surgery and misdiagnoses.[9] In the study of Üzün et al.,[6] the most frequent mistakes made in the branch of general surgery were caused by deficiencies in the treatment process (47.8%). In this study, we found that medical malpractice was reported in 11 (13.6%) of the cases by the Board of Specialization, and the most common reason for reporting medical malpractice by the Board of Specialization was a diagnostic error (n=7, 63.6%) (Table 1). The Board of Specialization decided that the medical procedure performed in 86.4% of the cases was appropriate. In other words, 86.4% of the physicians accused of medical malpractice were accused of unfair reasons. Since medical malpractice lawsuits continue for many years and have serious negative effects on physicians, it is obvious that new legal arrangements should be prepared for medical malpractice lawsuits.

It is claimed that trauma patients have a low risk of filing a real malpractice lawsuit.[16] Trauma surgeons are significantly more at risk in terms of unwanted patient complaints than surgeons in other specialties, but this risk is likely due to the small number of trauma surgeons and not associated with the field itself.[17] Trauma and injury patients constitute 22–36% of cases in Turkey, in which general surgeons are found guilty of medical malpractice.[6,9] In the present study, trauma and injuries (n=54, 66.7%) were the most common cause for medical malpractice claims among primary diagnoses made at healthcare institutions (Table 2). In addition, 90.1% of the cases in which the thoracic surgeon was found to have committed medical malpractice were trauma and injury patients.

The goal of treatment in trauma patients is to identify the injuries as soon as possible and begin treatment.[18] Delays in diagnosis are associated with high morbidity and mortality rates, which lead to longer hospital stays and high health costs.[18–22] In trauma patients, 19–23.3% of the diagnoses that could not be made on time are clinically significant injuries,[20] and 56.3% of the factors that cause missed diagnoses in multiple trauma cases are preventable.[21] In our trauma cases where thoracic surgeons were determined to have committed medical malpractice (n=10), the most common reason for a misdiagnosis was the inability to diagnose on time (n=4, 40%). Repeated clinical evaluations during the follow-up process after the first emergent intervention play an important role in the detection of missed diagnoses.[19–21] New complaints observed in the patient, especially during the follow-up period, may be closely related to a possibly missed diagnosis.[23]

Failure to diagnose an issue on time (80%) is the most common reason for that patients sue doctors who treat lung

cancer patients (80%), followed by errors in surgery and chemotherapy (7%) and a false positive diagnosis of lung cancer (7%).[24] In a study that included 583 diagnostic errors made by 310 clinicians, lung cancer (3.9%) was the third most frequently missed diagnosis after pulmonary embolism and drug reaction.[25] In addition, primary care physicians and radiologists have a higher risk of being sued for malpractice claims related to lung cancer, while this risk is lower for thoracic surgeons who operate on lung cancer patients.[24] In this study, the second most common diagnosis associated with medical malpractice claims was lung cancer (n=9, 11.1%) (Table 2).

While the complication rate of surgeries was 9.1% in 1990 in the United States, this rate had increased to 83.6% in 2012.[26] The most common postoperative pulmonary complications that occur after thoracic surgery are pneumonia and atelectasis. Postoperative pulmonary complications are responsible for 80% of deaths that take place after thoracic surgery.[27] In this study, 59.3% (n=48) of cases developed complications and the most common complication was pneumonia (Table 2). No statistically significant difference was found between the development of complications and the medical malpractice rates ($p>0.05$) (Table 3). This trend indicates that thoracic surgeons are successful in recognizing and managing complications related to the thoracic diseases and treatments.

This study had strengths as well as weaknesses. First of all, the decisions provided regarding medical malpractice are only the decisions of an expert institution and do not represent the final decisions of the court. The inability to include the final decisions of the court was an important limitation. Since the Forensic Medicine Institute is not the only authority, the expert report given by the board can be appealed, and the judge is not required to comply with the expert's decision. Another limitation was the lack of information about the compensation amounts that the physicians had to pay as a result of the lawsuit. In addition, since our study included only cases that resulted in death, it cannot be said to adequately represent the entire sample. It is vital that future studies include cases from all over the country to provide important clues for thoracic surgeons about cases of alleged medical malpractice.

Conclusion

Despite these limitations, this was the first study in Turkey that included cases with medical malpractice claims filed against thoracic surgeons. We found that the first forensic medicine board reported that thoracic surgeons are involved in 13.6% of all medical malpractice cases. In other words, 86.4% of the physicians accused of medical malpractice were accused of unfair reasons. The most common reason for medical malpractice was a diagnostic error (n=7, 63.6%). The incident that was the subject of the complaint took place most frequently in a state hospital, and the specialist doctors were blamed most often. The most frequent diagnosis was "injuries due to trauma." Most of the accused doctors were asked by the attending physician to consult on the patients' case. Examining cases with medical malpractice claims will help physicians not only to better understand the characteristics of malpractice claims but also to develop strategies to prevent malpractice claims.

Ethics Committee Approval: This study was approved by the Ministry of Justice Council of Forensic Medicine Ethics Committee (Date: 23.02.2016, Decision No: 21589509/77).

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Conflict of Interest: None declared.

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ORİJİNAL ÇALIŞMA - *ÖZ*

Göğüs cerrahisinde tıbbi malpraktis iddialarının değerlendirilmesi

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AMAÇ: Tıbbi uygulama hatası, doktorun standart uygulama veya bakımdan sapması sonucunda hastada hasar oluşması durumunda ortaya çıkar. Tüm tıp dallarında olduğu gibi göğüs cerrahları da tıbbi uygulama hatası iddialarıyla karşı karşıya kalabilirler.
GEREÇ VE YÖNTEM: İstanbul Adli Tıp Kurumu Birinci İhtisas Dairesi tarafından 01/01/2010 -21/12/2015 tarihleri arasında karara bağlanan dosyalar arasında, göğüs cerrahları hakkında malpraktis iddiası bulunan olgular geriye dönük olarak analiz edilmiştir.
BULGULAR: Oguların 59'u erkek (%72.8), 22'si kadındı (%27.2). Ortalama yaş 51.13±18.97 ve en yaygın yaş aralığı 60'ın üzerindedir (n=35, %43.2). Tıbbi uygulama hatası 11 (%13.6) olguda doğrulanmıştır. Tanı hatası en yaygın hata nedeniydi (n=7, %63.6) ve tanı hatasının en yaygın nedeni zamanında tanı koyamamaktı (n=4, %36.4). En sık tanı "travmaya bağlı yaralanmalar" (n=54, %66.7), ardından akciğer kanseri (n=9, %11.1) idi. Doktorların %80.2'si (n=65) hastaya konsültan olarak müdahale etti. Olguların 48'inde (%59.3) komplikasyon gelişti. En sık görülen komplikasyon pnömoniydi (n=7, %14.6).
TARTIŞMA: Çalışmamız göğüs cerrahları ile ilgili tıbbi malpraktis iddialarını içeren Türkiye'deki ilk çalışmadır. Tıbbi uygulama hatası iddiaları olan olguların incelenmesinin, hekimlere yalnızca yanlış uygulama iddialarının özelliklerini daha iyi anlamalarına değil, aynı zamanda yanlış uygulama iddialarını önlemek için stratejiler geliştirmelerine de yardımcı olacağını düşünüyoruz.
Anahtar sözcükler: Adli tıp; göğüs cerrahisi; malpraktis; tanı.

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