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ORIGINAL RESEARCH

Medical malpractice and diagnostic errors in emergency departments: the case of Turkey

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Abstract

Background: Emergency departments (EDs) operate 24/7, providing continuous healthcare services to individuals of all age groups and socioeconomic backgrounds. Physicians working in EDs often face high-pressure situations, requiring them to make rapid, high-stakes decisions for undifferentiated patients based on limited clinical information, which also increases their vulnerability to medical malpractice claims. This study aims to analyze malpractice cases involving negligent homicide in Turkish EDs by reviewing rulings from the Turkish Court of Cassation to identify the underlying causes and characteristics of such cases. **Methods**: A comprehensive search was conducted on the Turkish Court of Cassation's official website using the keywords "Emergency Department", "Emergency Medicine" and "Emergency Medical Intervention". The search yielded 11,131 results from a total of 9,154,439 judicial decisions. After reviewing cases between 2012 and 2024, 92 malpractice cases involving negligent homicide were included in the analysis. **Results**: The high judiciary upheld a guilty verdict against the physician in one out of every five malpractice cases related to negligent homicide. General practitioners were the most frequently implicated physicians, accounting for 41.3% of cases. The most common reason for malpractice claims was a "failure to conduct adequate medical evaluation" (58.1%). The gastrointestinal system was the most frequently involved medical category, with gastrointestinal bleeding or perforation identified in 15.2% of cases. **Conclusions**: EDs present a high-risk environment for malpractice claims involving negligent homicide. In Turkiye, EDs employ a substantial number of general practitioners alongside emergency medicine specialists, leading to a higher proportion of malpractice cases involving general practitioners. As demonstrated in this study, the failure to conduct an adequate medical evaluation remains the leading cause of malpractice claims. To mitigate these risks, it is essential to strengthen adherence to clinical practice guidelines and standardized protocols in both medical school and residency training.

Keywords

Emergency department; Medical malpractice; Negligent homicide; Diagnostic errors; Medical evaluation

1. Introduction

Emergency Medicine, as defined by the International Federation for Emergency Medicine, is a medical speciality that encompasses the knowledge and skills required for the prevention, diagnosis, treatment and management of acute and emergency conditions across all age groups, including both physical and psychological disorders [1]. Additionally, it involves expertise in pre-hospital and in-hospital emergency medical systems, addressing both surgical and internal conditions that pose a serious risk of death or threaten limb function [2].

In the United States, the American College of Emergency Physicians officially recognized Emergency Medicine as a speciality in 1968, with the first residency program established at the University of Cincinnati in 1970 [2]. Given the fast-paced and high-stakes nature of emergency medical practice, malpractice claims are common in emergency departments (EDs), where physicians are often forced to make rapid diagnostic and treatment decisions with little disease-related information as the patients are in critical conditions. A study analyzing 40,916 malpractice case files identified Emergency Medicine as the speciality most frequently involved in legal disputes among 25 medical specialities [3]. Furthermore, ED physicians are often the primary targets of malpractice claims [4]. Moreover, in case-based comparisons, diagnostic errors represent a significant challenge in emergency settings. While such errors occur in approximately 5% of outpatient cases, their incidence is markedly higher in EDs, reaching

12% [5]. Several studies have identified diagnostic errors and procedural deficiencies as leading contributors to malpractice claims in EDs [5–8]. Despite this, there is a notable lack of comprehensive research examining medical errors in Turkish EDs.

This study, therefore, aims to identify the causes and consequences of diagnostic errors associated with negligent homicide charges in Turkish EDs. By analyzing malpractice cases adjudicated by the Turkish Court of Cassation (Yargıtay), this study seeks to provide insights that may help raise awareness among emergency medicine specialists and healthcare professionals, ultimately contributing to improved clinical decision-making and patient safety.

2. Materials and methods

2.1 Study design and setting

This study utilized publicly available data from the official website of the Turkish Court of Cassation (https://karararama.yargitay.gov.tr/), the final appellate authority for decisions rendered by first-instance courts in Turkiye. In the Turkish legal system, lawsuits are initially adjudicated by first-instance courts, and parties can appeal these rulings, allowing for cassation applications. Then, the Court of Cassation, as the highest judicial authority, reviews these cases to assess their legal conformity.

For this study, a keyword-based search was conducted on the Court of Cassation's website using the terms "Emergency Department", "Emergency Medicine" and "Emergency Medical Intervention". From a total of 9,154,439 judicial decisions available in the database, 11,131 results were identified based on these keywords. After a detailed review, 92 malpractice cases involving negligent homicide, dated between 2012 and 2024, met the inclusion criteria and were analyzed.

2.2 Legal framework and judicial process for negligent homicide cases in Turkey

In Turkiye, medical malpractice cases involving offenses such as involuntary manslaughter can be initiated by the patient's family. Since crimes of this nature fall under criminal law, the state may also intervene to safeguard public rights and ensure the prosecution of the accused. According to the Turkish Penal Code, involuntary manslaughter is classified as a criminal offense, allowing for the initiation of a public lawsuit. Thus, in cases where a patient dies, the victim's family can file a lawsuit against the responsible party, and the state may also independently initiate and oversee the criminal proceedings.

The judicial process for negligent homicide and medical malpractice cases follows a structured legal framework. Initially, these cases are adjudicated by first-instance courts, which may include criminal courts depending on the nature of the alleged offense. If a party disagrees with the court's ruling, they have the right to appeal the decision. Additionally, Turkiye has implemented a mediation system designed to facilitate alternative dispute resolution methods before litigation to reduce the judicial workload and promote amicable settlements, particularly in civil cases.

In medical malpractice cases, the Turkish Ministry of Health plays an important role in conducting a preliminary review to assess whether negligence or malpractice has occurred. The findings of this review are compiled into an official report, which serves as a key reference for the legal authorities handling the case. If the case involves a patient's death, it may be subject to further judicial review by the Court of Cassation (Yargıtay), which functions as the final appellate authority. Yargıtay's role is to ensure that legal principles are correctly applied and that judicial decisions conform to established legal norms.

2.3 Statistical analysis

Data analysis was performed using IBM SPSS Statistics software version 22.0 (IBM Co., Armonk, NY, USA). Categorical variables are summarized using frequencies, percentages and counts. Comparisons of categorical data were conducted using the Chi-square test. A p-value of less than 0.05 was considered statistically significant.

3. Results

A search was conducted on the official website of the Turkish Court of Cassation (https://karararama.yargitay.gov.tr/) using the keywords "Emergency Department", "Emergency Medicine" and "Emergency Medical Intervention". This search retrieved 11,131 decisions from a total of 9,154,439 Court of Cassation rulings. Following a detailed review, 92 malpractice cases related to negligent homicide were included in the study.

Among these 92 cases, 34 (37%) first-instance court rulings determined that malpractice had occurred due to a crime or error, while 58 (63%) concluded that no malpractice was present. The Court of Cassation confirmed 38% (n = 35) of these decisions and overturned 62% (n = 57). Overall, we observed that one in every five malpractice cases involving negligent homicide resulted in a confirmed guilty verdict against the physician. The changes between first-instance court rulings and the Court of Cassation decisions are summarized in Table 1. A significant finding was that in 79.4% (n = 27) of cases where the first-instance court ruled that malpractice had occurred due to a crime or error, the Court of Cassation later overturned the decision ($p = 0.008$).

The Court of Cassation overturned rulings for various reasons. In 38.6% (n = 22) of cases, the decision was reversed due to the need for further judicial review following incomplete investigations. In 33.4% (n = 19) of cases, misclassification of the crime necessitated a reconsideration of the legal charges. In 22.8% (n = 13) of cases, acquittals were issued for negligent homicide; however, the findings indicated duty neglect rather than a criminal act. In 3.5% (n = 2) of cases, incorrect conviction decisions were identified, while in 1.7% (n = 1) of cases, incorrect findings of no malpractice due to crime or error led to a reversal.

The medical causes underlying these lawsuits are categorized in Table 2. The most frequently cited cause was gastrointestinal system hemorrhage or perforation, accounting for 15.2% (n = 14) of cases. The second most common cause, observed in 12% (n = 11) of cases, involved intracranial hem-

TABLE 1. Changes between first-instance court and court of cassation decisions.

First-instance Court Rulings	Court of Cassation Decisions	
	Confirmed, n (%)	Reversal, n (%)
No malpractice due to crime/error	28 (48.3)	30 (51.7)
Malpractice due to crime/error	7 (20.6)	27 (79.4)

TABLE 2. Systematic categorization of medical causes in malpractice lawsuits.

Medical Cause	n (%)
Gastrointestinal system hemorrhage/perforation	14 (15.2)
Brain hemorrhage/spinal cord injury	11 (12.0)
Myocardial infarction	10 (10.9)
Pulmonary edema/infection, aspiration pneumonia	10 (10.9)
General body trauma/traumatic bone fractures and resulting complications	10 (10.9)
Cause of death undetermined	10 (10.9)
Sepsis	9 (9.8)
Meningitis/encephalitis	4 (4.3)
Metabolic conditions (diabetic ketoacidosis, hypoglycemia, *etc*.)	3 (3.3)
Aortic dissection	3 (3.3)
Neonatal hypoxia	3 (3.3)
Intoxication (*e.g.*, mushrooms, alcohol)	2 (2.2)
Hemopneumothorax	2 (2.2)
Tetanus	1 (1.1)

orrhage or spinal cord injury within the field of neurosurgery.

A total of 126 healthcare personnel were charged across the 92 malpractice cases. In 75% (n = 69) of cases, a single healthcare worker was implicated, while in 25% (n = 23) of cases, multiple healthcare professionals were involved. The distribution of the most frequently prosecuted healthcare personnel is presented in Table 3. General practitioners were the most commonly implicated physicians, accounting for 41.3% (n = 52) of cases.

Regarding the nature of criminal charges, 26.1% (n = 24) of cases involved multiple allegations, whereas 73.9% (n = 68) were based on a single allegation. Across the 92 cases reviewed, a total of 117 distinct charges were identified. The most frequent charge was inadequate medical assessment, representing 58.1% of all charges. Additional details on the distribution of charges are provided in Table 4.

4. Discussion

EDs are essential components of healthcare systems, providing continuous, 24-hour care to patients of all ages and socioeconomic backgrounds. Emergency medicine is characterized by high-risk decision-making under conditions of uncertainty, often with limited clinical information and undifferentiated patients [4, 9]. As a result, emergency physicians frequently make critical decisions in high-pressure environments. The overcrowding of both EDs and hospitals further exacerbates these challenges, contributing to the increased risk of adverse outcomes and potential legal consequences [4, 9].

Jena *et al*. [3] reported that more than 75% of emergency physicians will face malpractice lawsuits at some point in their careers. While most physicians are likely to encounter at least one medical malpractice lawsuit over their professional lifetime, various factors related to emergency medicine practice and its unique environment significantly increase the legal risks for emergency practitioners. By the time they reach 55 years of age, 68% of emergency physicians will have been sued [10, 11], suggesting that the likelihood of facing a lawsuit correlates with the duration of time spent working in the ED. Efforts to reduce malpractice claims have included quality improvement initiatives, particularly through the training and employment of emergency medicine specialists. In the Netherlands, the integration of emergency medicine specialists into healthcare systems has been associated with a reduction in malpractice claims following ED visits [7], with a similar trend also observed in Japan [5].

In Turkiye, emergency medicine speciality training was introduced in 1993; however, there are still more general practitioners than emergency medicine specialists in the current EDs [2]. General practitioners in Turkiye are responsible for managing a wide range of cases in EDs, including making diagnostic and treatment decisions, consulting specialists and requesting additional evaluations. The high proportion of general practitioners among defendants in malpractice cases suggests that emergency medicine specialization may serve as a protective factor against legal liability, rather than simply the duration of professional experience. Since our study did not include data on the professional experience of the defendants, we cannot assess the impact of years of practice on malpractice risk. However, our findings suggest that competency gained

TABLE 3. Types of healthcare workers sued.

Healthcare Worker	n = 126 (%)*
General Practitioner, n (%)	52 (41.3)
General Surgery Specialist, n (%)	15 (11.9)
Internal Medicine Specialist, n (%)	11 (8.7)
Neurosurgery Specialist, n (%)	8 (6.3)
Pediatrics Specialist, n (%)	7 (5.6)
Orthopedics Specialist, n (%)	5 (3.9)
Obstetrics and Gynecology Specialist, n (%)	5 (3.9)
Emergency Medicine Specialist, n (%)	3 (2.4)
Neurology Specialist, n (%)	3 (2.4)
Cardiology Specialist, n (%)	3 (2.4)
Urology Specialist, n (%)	3 (2.4)
Auxiliary Healthcare Personnel (Nurse, *etc.*), n (%)	3 (2.4)
Anesthesiology Specialist, n (%)	2 (1.6)
Thoracic Surgery Specialist, n (%)	2 (1.6)
Cardiovascular Surgery Specialist, n (%)	2 (1.6)
Pulmonology Specialist, n (%)	1 (0.8)
Pediatric Surgery Specialist, n (%)	1 (0.8)

**In a single allegation, multiple individuals may be involved.*

TABLE 4. Reasons for allegations in medical malpractice cases.

Reasons for Allegations	n = 117 (%)*
Inadequate medical assessment	68 (58.1)
Failure to request or refer for necessary consultations	26 (22.2)
Referral without meeting appropriate transfer conditions	9 (7.7)
Failure to respond to emergency consultation calls	6 (5.1)
Failure to perform emergency surgery	5 (4.3)
Inadequate performance of emergency surgery	3 (2.6)

**In a single case, multiple allegations may be included.*

through emergency medicine specialization may reduce malpractice susceptibility. In this regard, Tyczynska *et al*. [12] highlighted that training on avoiding malpractice claims is minimally incorporated into medical school and residency curricula, and that mentorship during specialty training may play a significant role in equipping emergency medicine specialists with the necessary skills to mitigate legal risks.

In the Netherlands, 228 malpractice cases were reviewed over a 16-year period, in Japan, 108 malpractice cases were examined over 56 years [5, 7], and in Turkiye, 92 malpractice cases with high court rulings were recorded over the past decade. These differences may be attributed to several factors, including variations in emergency medical practice models and legal frameworks. The Anglo-American and Franco-German models of emergency medicine differ in their clinical approaches, while the legal systems governing malpractice cases also vary. The Civil Law System (Romano-Germanic legal system) and the Common Law System (Anglo-Saxon legal system) provide distinct judicial mechanisms for evaluating medical negligence. In Turkiye, emergency medicine follows the Anglo-American model, whereas the legal framework is based on the Romano-Germanic legal system. Although medical and legal systems differ across countries, the intersection of medicine and law has become increasingly complex, requiring more sophisticated approaches to investigate and evaluate medical negligence. This evolving field, commonly referred to as medical law or health law, has gained significant attention due to various factors influencing medical malpractice litigation. Advances in medical technology, increased public awareness of patient rights, and the continuous development of healthcare-related legal frameworks have contributed to a growing need for expert forensic analysis in alleged malpractice cases. The expansion of forensic medicine in the context of medical malpractice, as well as the increasing prominence of health law and medical law, reflects both the evolving nature of healthcare services and shifting societal expectations. These changes highlight the need for rigorous scientific research to ensure fair and accurate assessments of malpractice claims. As this field continues to develop, a more detailed examination of malpractice in EDs would be essential to improve patient

safety, refine legal processes, and enhance professional accountability in emergency medicine.

Previous research highlights trauma, particularly intracranial hemorrhage, as the leading cause, while infections as more prevalent in non-trauma medical malpractice cases [5]. Similarly, in a systematic review by Newman-Toker *et al.* [13], the top 15 clinical conditions associated with severe harm due to misdiagnosis were identified. These conditions, ranked in order, include stroke, myocardial infarction, aortic aneurysm and dissection, spinal cord compression and injury, venous thromboembolism, meningitis and encephalitis (tied for sixth place), sepsis (tied for sixth place), lung cancer, traumatic brain injury and traumatic intracranial hemorrhage, arterial thromboembolism, spinal and intracranial abscess, cardiac arrhythmia, pneumonia, gastrointestinal perforation and rupture and intestinal obstruction [13]. Poyorena *et al.* [8] analyzed 60 malpractice cases in EDs and found that the most common clinical issues involved infectious diseases and neurological conditions. Additionally, cardiac conditions, including acute myocardial infarction, cardiorespiratory arrest and other cardiovascular diseases, along with fractures, are considered among the highest-risk diagnoses for malpractice claims [6, 14]. While meningitis was previously the leading cause of malpractice cases in pediatric patients, recent studies indicate that cardiac conditions now pose the highest malpractice risk in this population [10, 15]. Although our study did not categorize cases by patient age, the distribution of malpractice cases aligns with findings in the existing literature. The most frequently cited causes of malpractice cases were gastrointestinal system hemorrhage or perforation (15.2%), brain hemorrhage or spinal cord injury (12%), followed by myocardial infarction, trauma and related conditions.

Certain preventable errors are consistently associated with malpractice lawsuits. An analysis of medical malpractice cases reveals that the most common source of error is a failure or disruption in the diagnostic process [8, 13]. A study conducted in Japan found that missed or incorrect diagnoses accounted for 86.5% of errors, while diagnostic delays were responsible for 13.5% [5]. In Turkiye, an analysis of high court (Court of Cassation) rulings related to malpractice in circumcision procedures identified negligence (43.3%), carelessness (20%), and faulty actions (20%) as the most frequent reasons for lawsuits [16]. In the present study, the most common cause of malpractice claims was inadequate medical evaluation. Errors at any stage of the physician-patient relationship, whether in diagnosis or treatment, may result in legal liability, even in ED settings. For malpractice to be legally established, four conditions must be met: (1) the physician has a professional duty to the patient, (2) the physician fails to fulfill that duty, (3) the patient suffers harm, and (4) the harm is a direct result of the physician's failure to meet their duty [17–20]. Fault during the diagnostic process may arise in several ways, including failure to conduct necessary tests or incomplete testing, failure to request appropriate consultations, and misinterpretation or incomplete evaluation of diagnostic data despite performing the required tests and consultations. Similarly, errors during the treatment phase may include inappropriate selection of tools and methods or incorrect application of medical principles. Physicians are expected to choose the safest and least harmful treatment methods whenever possible. However, in cases involving complex or life-threatening conditions, higher-risk interventions may be required. Adherence to established medical guidelines helps ensure that physicians apply recognized standards of care appropriately. In the United States, compliance with clinical practice guidelines, such as those issued by the Joint Commission on Accreditation of Healthcare Organizations or the Centers for Medicare & Medicaid Services, serves as an important reference for determining whether a physician has met the appropriate standard of care [11]. In Turkiye, national clinical guidelines, including those issued by the Ministry of Health and professional medical associations, are similarly designed to ensure the quality of care and minimize malpractice risks. While clinical practice guidelines (CPGs) are primarily developed to improve patient care, they are increasingly cited as evidence in malpractice litigation. Failure to adhere to CPGs has been recognized as a factor that may influence the outcome of malpractice lawsuits, reinforcing the need for physicians to remain updated on current guidelines to reduce legal risks [21].

This study has several limitations. First, although it represents the most comprehensive analysis of high court rulings in Turkiye, it only includes cases involving negligent homicide and does not account for other types of malpractice claims or out-of-court settlements. As a result, the extent to which settlements occur before malpractice claims reach litigation remains unclear. Second, differences in judicial decision-making processes between Turkiye's legal system and those of other countries with different legal frameworks make direct comparisons challenging. Third, the study does not provide information on the duration of legal proceedings, which limits the ability to assess the impact of prolonged litigation on healthcare professionals and institutions. Despite these limitations, this study is, to the best of our knowledge, the first and largest investigation of medical malpractice cases related to negligent homicide in EDs in Turkiye.

5. Conclusions

This study found that the high court upheld one in every five medical malpractice cases involving negligent homicide claims against physicians. Among malpractice cases arising in EDs, general practitioners were the most frequently sued healthcare professionals, and the most common cause of malpractice claims was medical evaluation deficiency, highlighting the critical role of accurate and thorough diagnostic assessments. To reduce the risk of malpractice, greater emphasis should be placed on adherence to clinical practice guidelines and standardized protocols in both medical school and residency training.

AVAILABILITY OF DATA AND MATERIALS

The data can be obtained publicly through the official website of the Court of Cassation (https://karararama.yargitay.gov.tr/) using the specified keywords. If desired, the results of the data analysis can also be shared.

AUTHOR CONTRIBUTIONS

HYB and UA—obtained and preprocessed the data, reviewed the results, provided interpretation of the analytical findings and drafting the manuscript. HYB—conducted the statistical analysis. Both authors contributed to the concept of the study, drafting of the manuscript, and provided edits to the manuscript.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

The rulings of the Court of Cassation are published with personal data protection measures in place and are based on publicly accessible records. Therefore, neither patient consent nor institutional review board approval was required for this study.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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