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# Malpractice and system of expertise in anaesthetic procedures in Turkey

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**Abstract**

Deaths which occur during the administration of anaesthetics require medicolegal investigations. The objective of this study is to form a database for future comparisons related to anaesthetic-associated malpractice claims and also to investigate the system of expertise, pertaining to such procedures.

The decisions of the Supreme Health Council, whose expert opinion is requested by legal authorities (judges, prosecutors) for health workers brought to trial in a criminal court, were examined retrospectively over the period 1995–1999. In 21 (2.3%) of the 888 decision reports prepared by the council the team members (the anaesthologist, the anaesthetic assistant, the anaesthetic technician, the nurse) were directly interrogated. Data concerning these 21 council decisions were evaluated within the scope of this study.

It was found that 57% of the 21 decisions were related to medical procedures carried out in state hospitals. Of the 21 cases, 62% were males, 38% females. General anaesthesia was applied to 19 of the cases while one received regional (local) anaesthesia and one axillary blockade. Twenty died of complications associated with anaesthesia. Autopsy was performed on 11 (55%) of the dead. Health workers were found to have different degrees of liability in the 16 (76%) of the 21 decision reports.

In their medical practices, anaesthologists, like other specialists, are subject to legal procedures in the country where they perform their duties, to national and international principles of ethics, and to diagnostic and curative standards/procedures relevant to the scientific level of the country concerned. In anaesthetic malpractice claims, certain standards need to be followed in inquiries and approaches so as to determine the real reasons behind the disabilities and/or deaths which occur. In order that sound evaluations could be made in such cases, the experts as well as the system of expertise should be efficient and authorized.


*Keywords:* Anaesthesia; Malpractice; Medicolegal; The system of expertise

## 1. Introduction

The anaesthesia team can often be readily and usually unjustly blamed for deaths which occur during the administration of anaesthetics. Such deaths attract intense attention from the mass media as well as the general public [1–4].

The rates of anaesthetic-associated deaths may vary depending on study design, study period, study population and particularly what is understood from anaesthesia-associated deaths (0.05–10/10,000). It has been stated that the risk is increased in children, in infants under the age of 1 and in people over 65 [5–9]. Anaesthetic-associated mortality and anaesthetic contributory deaths have been studied exten-

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sively and in an increasing manner since 1950. It was stated that malpractice claims following the administration of anaesthetics were multifactorial and that errors of the personnel played a major role in many of them. Practical design of devices and ventilators as well as efficient monitoring has a great role in preventing errors, although they fail to prevent human errors completely [10–14].

Perioperative deaths necessitate medicolegal investigations in our country, as is the case in other countries [1–3,11,15–20]. Medicolegal evaluations of the medical malpractice claims in our country are initiated by the patient/relatives or legal authorities. Unfortunately, medical malpractice claims cannot be investigated within the framework of specific legal practices. Malpractice claims, which are considered criminal law suits, are assessed within the scope of ''causing death as a result of recklessness, carelessness, unskillfulness, failure to follow orders and directions; illegal conduct; and negligence'' [21].

In our country, suing for damages and opening a criminal suit is possible on grounds of medical malpractice claims. Legal authorities have to take medical expert opinion. Due to the fact that there are no expert institutions specifically dealing with medical malpractice in our country, choice of the medical expert (a specialist and/or a council) who has a great role in the assessment of malpractice claims, lies with the judge and/or the prosecutor [21,22]. The official body whose expert opinion needs to be taken in claims related to criminal law suits in Turkey is the Supreme Health Council (SHC), which is under the frame of the Ministry of Health [21,22].

The foundation of the SHC dates back to 1930. It has 16 members, five of whom are officials from the Ministry of Health (one jurist and four general directors). The remaining 11 members are physicians from different areas of specialization appointed by the Minister of Health for a period 1 year [22].

The council examines medical files sent by legal authorities only. The council make their assessments through careful examination of the medical records in those files. They later send the statements (reports) containing their opinions to the court. In practice, the opinions stated by this council directly affect the verdicts to be given by these courts.

This study aims to form a database for future comparisons in anaesthetic-associated malpractice claims and to examine the medical system of expertise in our country.

## 2. Methods

Decision reports related to criminal lawsuits for which expert opinions of the SHC requested were evaluated retrospectively for the years 1995–1999, and 888 decision reports related to various areas of specialization were examined over this period. In 21 (2.3%) of these decisions the anaesthesia team (the anaesthesiologist, the anaesthetic assistant, the anaesthetic technician, the nurse) were directly interrogated. These 21 decisions were then evaluated in detail. Findings reported in our study are obtained within the framework of factual evidence these decision reports contain. (In our country the anaesthesiologist is the person who is responsible for the preoperative assessment of the surgery room and the patient as well as the administration of anaesthetics. The anaesthetic assistant is an intern working under the supervision of the anaesthesiologist. The anaesthetic technician is an auxiliary health personnel working under the supervision of an anaesthesiologist or under a surgeon in institutions where there are no anaesthesiologists. The nurse is also an auxiliary health personnel who works under the supervision of an anaesthesiologist or surgeon.)

Data contained in these reports were then examined with respect to the health institution where the incident occurred, the distribution of the patients by respective clinical branches, the patients' age and sex, whether autopsy was performed, the difference in diagnosis before and after the autopsy, the distribution of liability on the part of the institution and liability percentage and causation laid on the health workers taking part in the attending team of anaesthetists.

### 2.1. Statistical analysis

The data obtained were evaluated on Stat Calculation Programme using the Fisher's exact test and Pearson's chi-square test.

## 3. Results

Twenty-one of the 888 decisions for which the SHC acted as an expert between the years 1995 and 1999 concerned the team of anaesthetists (Table 1). Of the 21 medical procedures, 12 (57%) were carried out in state hospitals (state-run hospitals), seven (33%) in private hospitals, and the remaining two (10%) in university hospitals. It was stated in the decisions that the highest numbers of erroneous procedures were carried out in state hospitals. The distribution of the decisions by the health institutions and the state of liability by the institution were shown in Fig. 1. There was no statistically significant difference (Fisher's exact test, $P = 1.00$) among the institutions where the anaesthetic was administered erroneously.

Of the 21 patients, six (28%) were from orthopaedics, five (23%) from general surgery and 10 (49%) from other clinics (Fig. 2). Also, 13 (62%) of the cases who were administered anaesthetics were males, and eight (38%) females. Nine cases were in the 0–18 age group, while the remaining 12 were in the 19–67 age group. Eight (38%) of the 21 cases underwent surgery after being examined by anaesthesiologists in the preoperative period, whereas 13 (62%) were operated on without being evaluated by anaesthesiologists for various reasons (such as the case