

**MEDICAL MALPRACTICE CLAIMS INVESTIGATED BY
THE MEDICOLEGAL CONSULTATION CENTER,
TANTA UNIVERSITY, EGYPT (2008-2015)**

BY

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ABSTRACT

Medical malpractice is defined as lack of reasonable care and skills or negligence on the part of a medical practitioner in the treatment of a patient whereby the health or life of a patient is endangered. This study aimed to throw light on medical malpractice claims investigated by the Medicolegal Consultation Center (MLCC), Tanta University in order to understand the underlying causes of their events which is crucial to prevent their occurrence in the future. Characteristics of defendant physicians (gender, qualifications and specialty) were tabulated. Locations of health care settings were checked up. The causes of claims and the outcomes of the cases were graded (death, permanent infirmity or complications), then judgment on cases as positive or negative for malpractice was done based on several criteria. The studied claims showed that 88.2 % of defendant physicians were males. It was found that 47.1 % of defendant physicians were consultants, 35.3% were specialists, 5.9% were residents and the whole medical team was accused in 11.8% of the cases. Different specialties were claimed in this study; 23.5% of them were gynecologists and 17.6% were general surgeons. It was found that private hospitals and clinics were presented by 41.18%. Death was the outcome of 29.41% of the studied claims and 35.29% of the cases ended with permanent infirmities, also 35.29% ended with complications. Positive claims for malpractice were 23.53%, while 76.47% were negative for malpractice. The present study concluded that detailed investigation of medical malpractice claims revealed important data and offered an opportunity to physicians to benefit from previous recorded medical errors to be avoided.

Keywords: *Medical, malpractice, errors, claims, defense, consultation, centers.*

INTRODUCTION

Many patients suffer preventable harm

from medical treatment during their admission to hospital (Kohn et al., 1999). Estimates of the frequent and severe pre-

ventable patient harm from medical treatment vary among the research studies throughout the world. Most of them agree that approximately 10% of all hospital admissions are associated with complications. The specific reported rates are United Kingdom 10.8%, New Zealand 10.7%, Australia 16.6%, Canada 7.5%, and USA 2.9–17.7% (Ibrahim et al., 2009).

Professional negligence refers to an act or a lack there of considered inconsistent with the professional standard maintained by reasonable, similarly trained representatives of that profession. Malpractice is the term that has evolved in civil law and has become synonymous with professional negligence. In a claim of medical malpractice, the patient is called the "plaintiff" and the doctor the "defendant". A plaintiff is asserting that his or her physician(s) failed to act within an accepted medical standard and that this failure caused directly an injury to the plaintiff (Lyons et al., 2005; Mello et al., 2010).

In all negligence claims, the plaintiff must prove by a preponderance of the evidence the presence of four elements. These elements are: (1) that a duty existed toward the plaintiff by the defendant, (2) that the defendant breached that duty, (3) that the plaintiff suffered an injury, and (4) that the breach of duty directly caused the plaintiff's injury. The physician–patient relationship is a contract, ei-

ther written expressly or implied through the actions of the physician, whereby the physician agrees to treat the patient. The creation of this relationship does not require the exchange of anything of value. Thus, even if the physician gives free medical advice or renders treatment free of charge, a physician–patient relationship may exist (Lyons et al., 2005).

Different medical specialties have greatly different risks. Obstetrics, anesthesia, neurosurgery, plastic surgery and emergency medicine are being highly vulnerable (Mello et al., 2010). Estimates of many studies about patient safety suggest that one half to two thirds of inpatient complications are attributable to surgical care (Gawande et al., 1999; Thomas, et al., 2000; Bruce et al., 2001).

Injuries caused by medical interventions have received widespread importance in the public, probably due to damages that may occur in the form of direct damages including lost earnings, medical expenses and future medical and rehabilitation costs or indirect damages that include pain and emotional distress, and many others (Stuach, 2009).

Different Judicial Systems around the world exist in many countries to investigate malpractice claims. In Egypt, Law No. 96 for year 1952 organized the work of expert witnesses in front of courts. All

malpractice cases are reported to local attorney and referred to Medicolegal Department, Ministry of Justice for expert opinion (Sherief et al., 2005).

The defendant may counter with expert testimony and evidence either provides that there was no breach of duty or demonstrates that, even if there was breach of duty, it did not cause the injury or the damages which the plaintiff complains (Lyons et al., 2005). In Egypt, this expert testimony may be offered by Committee of Medical Ethics in the Egyptian Medical Syndicate, or by medicolegal consultation centers whether university centers or private centers.

The Medicolegal Consultation Center (MLCC) in the Faculty of Medicine, Tanta University founded that received different types of claims since 2008 was including multiple malpractice claims. Determination of a verdict is based on three or four Forensic Medicine professors committee to each claim. In case of medical malpractice claims, the committee reviewers have accessed the full claim records since the standard of care, professional and patient culpability and any other circumstances are taken into account before reporting the decision. Then, the committee reviews the claim and reaches to a consensus.

Files of the medical malpractice claims represent a potentially valuable source of

information on medical errors. Hence, the purpose of the current work is to throw light on medical malpractice claims investigated by the Medicolegal Consultation Center, Tanta University in order to understand the underlying causes of their events.

SUBJECTS AND METHODS

All cases presented to the Medicolegal Consultation Center (MLCC) in the Faculty of Medicine, Tanta University since its foundation have been reviewed. Out of them, medical malpractice claims have been further investigated.

Characteristics of defendant physicians (gender, qualifications and specialty) were tabulated. Causes of the claims and location of health care settings were checked up and the outcomes of the cases were graded (death, permanent infirmity or disease). The final results of medical malpractice claims "positive or negative" were grouped in a result chart. Criteria for judgment were based on the following factors (modified from Ahmed et al., 2007; Azab, 2013).

Positive cases for malpractice

1. Not taking adequate measures to prevent or treat complications.
2. Grave mistake.
3. Inadequate follow-up.
4. Wrong diagnosis.

5. Improper performance of the procedure.

Negative cases for malpractice

1. Error could not be evidenced.

2. Inevitable complication.

3. No direct causal relationship between error and injury.

4. Damage occurred due to patient's primary condition.

5. No damage.

6. Patient shared in the responsibility.

Privacy of the data of all cases in the claims was assured by coding, and authorized consent from the administrative board of the Medicolegal Consultation Center - Forensic Medicine and Toxicology Department was taken. Approval from the Research Ethics Committee in Tanta Faculty of Medicine was taken before starting the research.

RESULTS

The present study investigated all cases presented to the Medicolegal Consultation Center (MLCC) in the Faculty of Medicine, Tanta University since its foundation in July 2008 till December 2015.

A total of 131 cases were presented to the center during this period, 17 cases (12.97%) were for malpractice claims.

Detailed investigation of medical malpractice claims revealed that 15 (88.2 %) of

the defendant physicians were males. Regarding the qualifications of the defendant physicians, eight (47.1 %) of defendant physicians were consultants, six (35.3%) were specialists, one (5.9 %) was a resident and in two cases (11.8%) the whole medical team was accused. Gynecologists were accused in four cases (23.5%), general surgeons in three cases (17.6%), anesthetists in two cases (11.8%), and orthopedic surgeons in two cases (11.8%). Plastic surgeons, cardiothoracic surgeons, neurosurgeons, ophthalmologists and dermatologists were accused in a single case for each. In 15 cases (88.2%) there was a single defendant physician, while in two cases (11.8%) the whole medical team was accused. Location of health care settings was checked up and it was found that university hospitals and general hospitals were presented by 23.53% for each. Private hospitals and clinics were presented by 41.18%, while 12.5% of the studied claims came from both general and private hospitals. Characteristics of physicians and location of health care setting are illustrated in table (1) and figure (2).

Characteristics of patients regarding their age and gender were outlined in table (2) where 11 of patients (64.7%) were females and six (35.29%) were males. Ages of patients ranged from seven months to 60 years, (median 25 years).

In 13 cases (76.5%), the claim was filed

at MLCC by physicians, three cases (17.6%) were filed by patients, and one case (5.88%) was filed by the husband of the patient (who was the counter-party in the claim in front of the court).

Medical outcomes of the studied claims and criteria for judgment were outlined in table (3) for cases positive of malpractice and table (4) for cases negative of malpractice.

In MLCC investigation, judgment on cases as positive based on the following criteria: not taking adequate measures to prevent or treat complications, grave mistake and inadequate follow-up and wrong diagnosis. Each criterion was presented by 5.88 %. On the other hand, judgment on cases as negative for malpractice was based on the following criteria: claimed error could not be evidenced (5.88 %), inevitable complication (35.29 %), no direct causal relationship between error and injury

(29.41 %), damage occurred due to patient's primary condition (17.65 %), no damage (17.65 %) and the patient shared in the responsibility (29.41 %) as shown in table (5).

The frequency and percentage of medical outcomes and results of investigations of claims by MLCC are illustrated in table (6) and figure (3), where death was the outcome of five studied claims (29.41 %), six cases (35.29 %) ended with permanent infirmities, and six cases (35.29 %) ended with complications. Thirteen claims (76.47 %) were negative to malpractice by MLCC investigation, and reports were issued combating previous reports by Medico-legal Departments, Ministry of justice (MDMJ). On the other hand, four claims (23.53 %) were positive for malpractice by MLCC investigation and didn't issue reports as the results agreed with the reports of MDMJ.

Table (1) : Frequency and percentage of characters of physicians (gender, qualifications, specialty and number of defendant physicians) and location of health care setting (n=17).

Characteristic parameters		Frequency (n=17)	%
Gender	Males	15	88.2
	Females	2	11.8
Qualifications	Consultant	8	47.1
	Specialist	6	35.3
	Resident	1	5.9
	Medical Team	2	11.8
Specialty	Gynecology & obstetrics	4	23.5
	General surgery	3	17.6
	Anesthesia	2	11.8
	Orthopedics	2	11.8
	Plastic surgery	1	5.9
	Neurosurgery	1	5.9
	Cardiothoracic	1	5.9
	Ophthalmology	1	5.9
	ENT	1	5.9
	Dermatology	1	5.9
Number of defendant physicians	Single physician	15	88.2
	Multiple physicians	2	11.8
Location of health care setting	University hospital	4	23.53
	General hospital	4	23.53
	Private hospitals & clinics	7	41.18
	Both general and private hospitals	2	11.76

n: number, %: percentage.

Table (2) : Characteristics of patients: sex and age.

Sex	n	%
Male	6	35.3
Female	11	64.7
Age		
Min.	7 months	
Max.	60 years	
Median	25 years	

n: number, %: percentage.

Table (3) : Medical outcomes of cases positive for malpractice and criteria of judgment out of all studied claims (n= 4).

Case Number	Filed by	Medical Outcome	Criteria of judgment
1	Physician	Death	▪ Inadequate follow up
2	Husband of the patient	Complication	▪ Wrong diagnosis
3	Patient	Permanent infirmity	▪ Grave mistake
4	Physician	Death	▪ Not taking adequate measures to prevent complication. ▪ Wrong technique

Table (4) : Medical outcomes of cases negative for malpractice and criteria of judgment out of all studied claims (n= 13).

Case Number	Filed by	Medical Outcome	Criteria for judgment
5	Patient	Complication	• Inevitable complication • No damage
6	Medical team	Permanent infirmity	• Damage occurred due to patient primary condition • Patient shared in responsibility
7	Patient	Complication	• Inevitable rare complication
8	Physician	Patient died	• Damage occurred due to patient primary condition • Patient shared in responsibility (taking banned drugs and without medical supervision)
9	Physician	Patient died	• Damage occurred due to patient primary condition
10	Physician	Complication	• Inevitable complication • No direct causal relationship between the operation and the end result • Patient shared in responsibility • No damage
11	Physician	Permanent infirmity	• Patient shared in responsibility
12	Physician	Complication	• No direct causal relationship between the cesarean section. and the complication • Claimed error could not be evidenced • Inevitable complication after the second operation. • No damage
13	Lawyer of the university on behalf of the medical team	Permanent infirmity	• No direct causal relationship between the operation and the end result. • Patient shared in responsibility
14	Physician	Complication	• No direct causal relationship between the procedure and the end result.
15	Physician	Patient died	• No direct causal relationship between the operation and the end result
16	Physician	Permanent infirmity	• Inevitable complication
17	Physician	Permanent infirmity	• Inevitable complication. • Patient shared in responsibility

Table (5) : Criteria for judgment in positive and negative cases for malpractice:

Result	Criteria for judgment	n	%*	%**
Positive cases for malpractice (n=4)	▪ Not taking adequate measures to prevent or treat complications	1	25	5.88
	▪ Grave mistake	1	25	5.88
	▪ Inadequate follow-up	1	25	5.88
	▪ Wrong Diagnosis	1	25	5.88
	▪ Improper performance of the procedure	1	25	5.88
Negative cases for malpractice (n=13)	• Claimed error could not be evidenced	1	7.69	5.88
	• Inevitable complication	6	46.15	35.29
	• No direct causal relationship between error and injury	5	38.46	29.41
	• Damage occurred due to patient's primary condition	3	23.07	17.65
	• No damage	3	23.07	17.65
	• Patient shared in the responsibility	6	46.15	35.29

n: number, %: percentage, *percentage calculated on number of cases within the group [positive (n=4) or negative (n=13) for malpractice] and may be more than 100% as the judgment may be based on more than one criterion, **percentage calculated on total number of cases n=17 and may be more than 100% as the judgment may be based on more than one criterion.

Table (6) : Frequency and percentage of medical outcomes of the cases and results of claims investigation (n= 17).

Result of claim investigation Medical Outcome	Positive		Negative		Total	
	n	%*	n	%*	n	%*
Death	2	11.76	3	17.65	5	29.41
Permanent infirmity	1	5.88	5	29.41	6	35.29
Complication	1	5.88	5	29.41	6	35.29
Total	4	23.53	13	76.47	17	100

n: number,%: *percentage calculation based on the total number of cases (n=17).

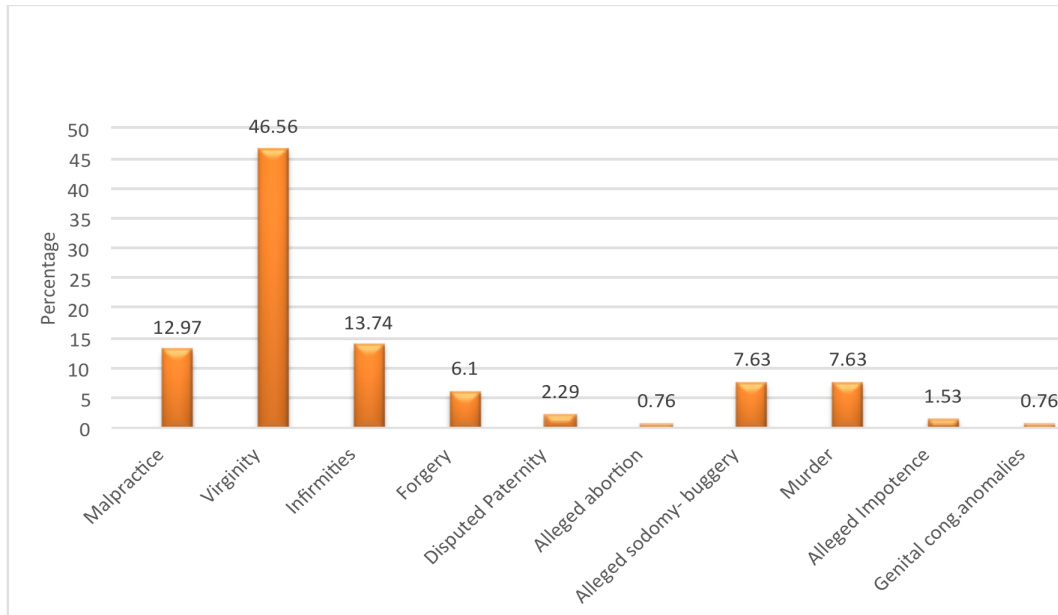


Figure (1) : Cases presented to Tanta Medicolegal Consultation Center 2008-2015 (n= 131).

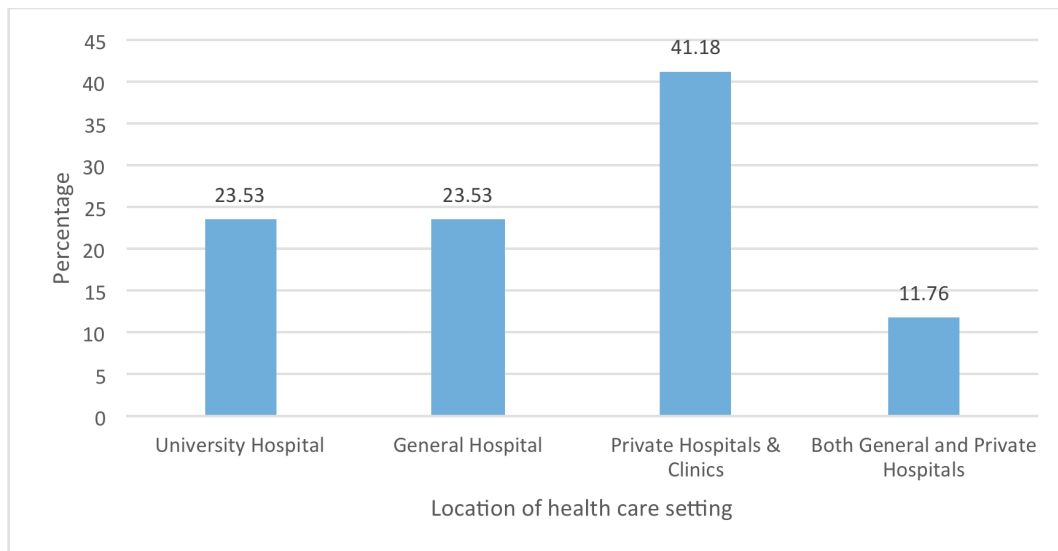


Figure (2) : Location of health care setting.

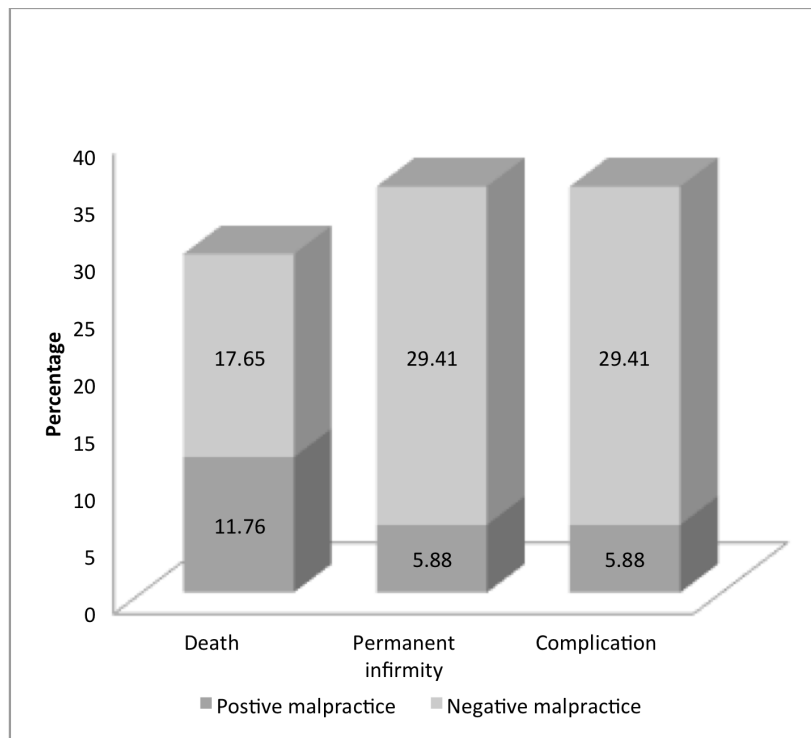


Figure (3) : Percentage of medical outcomes of the cases and results of claims investigation by MLCC (n= 17).

DISCUSSION

Medical malpractice is an underestimated world-wide problem of high relevance. It is often disregarded, although several approaches can be found to investigate and handle malpractice charges (Struve, 2004).

Malpractice claims represent financial burden that adversely affects health care system. Direct effect is litigation and settlement costs and indirect effect is unnecessary defensive medicine costs (Adamson et al., 1997). Hence, identifying etiologies of real or perceived adverse clinical events

and undesired outcomes is an important step in improving patient safety and reducing malpractice risks (White et al., 2005).

Files of medical malpractice claims represent a valuable source of information on medical errors. Therefore, greater understanding of the claims may highlight their causes and thus help to prevent them (Azab, 2013).

The present study aimed to throw light on medical malpractice claims investigated by the Medico Legal Consultation Center, Tanta University. In addition, to un-

derstand their underlying causes to prevent their occurrence in the future.

To the best of the available knowledge, this is the first study that investigates claims reaching Medicolegal Consultation Centers in Egypt. Till the beginning of the present study, 131 cases had reached Tanta Medicolegal Consultation Center. Out of them 17 cases (12.97 %) were malpractice claims.

This number of malpractice cases may appear as a small number of cases. However, these cases were previously evaluated as positive for malpractice by the Medicolegal Departments, Ministry of Justice. Furthermore, it is an optional right for accused defendant physician to counter the expert opinion of the Medicolegal Department, Ministry of Justice by an expert testimony.

In a comparable study, Fouad and Ali (2012) reported 23 positive malpractice claims out of 114 claims in Sharqia Governorate from 2007 to 2010. Where defendant physician(s) was/were found incompetent and/or negligent. Consistent with results gathered by Ahmed et al. (2007), where 22 cases were positive for malpractice out of 120 medical malpractice claims investigated by both Menoufia and Gharbia governorates (2002-2004). Azab (2013) revised 57 positive malpractice claims out of 91 claims investigated by the Commit-

tee of Medical Ethics in the Egyptian Medical Syndicate (2008-2009), Cairo.

Kane (2010) reported that claim frequency should not be used as an estimate of error rate or malpractice rate in medicine, as the majority of claims are dropped and an even larger percentage are closed without payment. However, Studdert et al. in (2006) reported that less than 15 % of patients who suffered a negligent injury filed a claim, and that negligence had occurred in only slightly over 15 % of filed claims.

In the present study, 88.2 % of defendant physicians were males, 11.8 % were females. Nearly the same percentages were reported by Azab (2013). Defendant physicians were consultant in 47 % of cases and specialists in 35.3 %. In the same time, the whole medical team represented 11.8 % and residents represented 5.9 %. A result that comes in line with Fouad and Ali (2012), who reported that the highest incidences of claims (43.85 %) was against highly qualified physicians, while the lowest incidence (19.29 %) was against physicians with diploma degree.

In the present study, 23.5 % of defendant physicians were gynecologists, 17.6 % were general surgeons, 11.8 % anesthesiologists, and 11.8 % Orthopedic. Cardiothoracic surgeons, neurosurgery, ophthalmology and dermatology specialties were

presented by 5.9 % for each. This is in agreement with comparable national and international studies where surgery and gynecology and obstetrics represent the most common specialties at risk of facing malpractice claims and proved positive malpractice.

For example, Azab (2013) registered obstetrics/gynecology as the most frequent specialty for defendant physicians (40.7 %), followed by surgery (24.2 %) then internal medicine (8.8 %). On the other hand, Fouad and Ali (2012) reported highest incidence of claims in general surgery (28.9 %), then orthopedics (25.44 %). The lowest incidences were in otolaryngology, emergency medicine, clinical pathology and cardiology (0.87 % for each).

Worldwide, nearly similar percentages were reported regarding type of specialty involved in Saudi Arabia (Alsaddique, 2004), Turkey (Gundogmus et al., 2005), Japan (Ehara, 2005), USA (Studdert et al., 2006), and with slight differences in Germany (Dettmeyer and Preuss, 2009).

Researchers have linked poor surgical outcomes to wide variety of factors including excessive workload (Sexton et al., 2000), lack of optimal technology (Gray, 2000), and inadequate hospital systems (Cole, 2000). In addition to low hospital volume for some operations (Birkmeyer et al., 2002), poor supervision of trainees

(Russell et al., 2003), emergency circumstances (Gawande et al., 2003), fatigue (Landrigan et al., 2004), time of day (Forster et al., 2004), poor staff communication (Davenport et al., 2007), and surgeon inexperience (Amato et al., 2013).

General and private hospitals and clinics are the location of health care settings in 37.5 % for each. University hospitals are the location of 12.5 % of the studied claims. In the same time 12.5 % of the claims come from both general and private hospitals. Fouad and Ali (2012) registered public hospitals in 52.63 %, followed by university hospitals (25.43 %), then private hospitals (12.28 %). Meanwhile, private clinics were included in 9.64 % of the claims. On the contrary, private health care sector was a more frequent location than the public healthcare sector as indicated by Azab (2013).

Females represent 64.7 % of plaintiffs and 35.29 % are males with age ranged from seven months to 60 years in the current study. Comparably, patients' age ranged from one day to 67 years according to Fouad and Ali (2012).

In the present study, death, permanent infirmities and complications occurred in 29.41 %, 35.29 % and 35.29 % of cases respectively. Such outcomes are more or less similar to those reported by Ahmed et al. (2007) in Menoufia, Gharbia and Sharqia

governorates. Nevertheless, death was the most frequent outcome (42% of the cases), followed by severe injuries (21 % of the cases) as reported by Azab (2013). Results reported by Fouad and Ali (2012) revealed that recovery in 35.08 % of cases, disfigurement in 1.76 % of cases and death was the final outcome in 20.2 % of cases.

In the present investigated claims, 23.53 % of cases are positive for malpractice, while 76.47 % of cases are negative. Judgment criteria for these cases as positive malpractice included inadequate follow up (where the patient left the intensive care unit soon after a major operation, case deteriorated and the patient died). In addition to inadequate measures to prevent complications and improper procedure performance (where the doctor did not secure bleeding points and did not put nasal packs after tonsillectomy. He could not control post-operative bleeding and re-admitted the patient to operation room then discharged him very soon. This patient died within few days post-operative after being unable to swallow any food and autopsy revealed excessive pharyngeal cautery).

Other causes for judgment of cases as positive malpractice are committing a grave mistake (the doctor did surgical dissection of whole breast tissue in young girl that ended up with retardation of breast growth) and wrong diagnosis

(where wrong diagnosis documented in a primary medicolegal report resulted in wrong accusation of husband of domestic violence).

Each one of positive malpractice judgment criteria is presented by 25 % (5.88 % of all cases). In a previous study by Ahmed et al. (2007), the most common fault in positive malpractice cases was failure of adequate measures to treat complications (31.8 % of positive cases). This is followed by leaving surgical instruments or towels (22.7 %) inside the abdomen then wrong technique of surgery (13.6 %). Results reported by Azab (2013) declared that improper procedure performance is the most frequent cause (21 %), followed by unethical conduct (19 %) and surgery in a non-equipped place (16 %).

On the other hand, judgment criteria for negative cases of malpractice are inevitable complication (46.15 %), no direct causal relationship between error and injury (38.46 %), patient shared in the responsibility (35.29 %), damage occurred due to patient's primary condition (23.07 %), no damage (23.07 %) and claimed error that could not be evidenced (7.69%). Judgment on one case may be based on several criteria. In a comparable study by Azab (2013), the same criteria were presented by 23 %, 19 %, 4.13 %, 8 %, 4 %, and 29 % respectively.

These criteria of judgment are of vast importance as they are the basis on which MLCC reports conflicted with MDMJ. They basically constitute the defenses of accused physicians and their probability should be well investigated and excluded before a final judgment is made on the case.

Most of the claims investigated by MLCC were filed by physicians (76.5 %). Nevertheless, patients (17.6 %) and even counter-parties in claims (5.88 %) benefit from MLCC services which proves its role in serving the whole community.

The present study concluded that detailed investigation of medical malpractice claims reveal important data and offers an opportunity for physicians to benefit from previous recorded medical errors to be avoided and at the same time offers better knowledge of their possible defense in case they are accused of medical malpractice.

Recommendations for physicians:

- 1- Physicians should document accurately each step of medical intervention.
- 2- Physicians should be aware of the common medical errors that could prove positive for malpractice.

Recommendations for patients:

1. Patients may share in the responsibility

of consecutive damage and they should not consume banned drugs or drugs without medical supervision.

2. Leaving the hospital without doctor's permission and without completing the needed treatment may result in a bad outcome.

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المشتركون في البحث

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يعرف سوء الممارسة الطبية بالتقصير في بذل الرعاية والمهارة المعقولة أو الإهمال من جانب الطبيب في علاج المريض حيث يتم تعريض صحته أو حياته للخطر.

الهدف من هذه الدراسة هو إلقاء الضوء على ادعاءات الممارسات الطبية الخاطئة التي تم فحصها في مركز الاستشارات الطبية الشرعية- كلية الطب- جامعة طنطا من أجل فهم الأسباب الكامنة وراء حدوثها لمنع وقوعها في المستقبل.

تم جدولة خصائص الأطباء المدعى عليهم من حيث (الجنس، المؤهل العلمي والتخصص)، والمكان الذي قُدمت به الرعاية الصحية. كما تم فحص أسباب القضايا، نتائج الممارسة الطبية (الوفاة أو العجز الدائم أو المضاعفات)، ثم الحكم على الحالات الإيجابية أو السلبية لسوء الممارسة الطبية وفق معايير محددة.

أظهرت الدراسة أن 88.2% من الأطباء المدعى عليهم من الأطباء و 11.8% منهم من الطبيبات، كما وجد أن 47.1% من الأطباء المدعى عليهم من فئة الاستشاريين، 35.3% من الأخصائيين، و 5.9% من الأطباء المقيمين، في حين اتهم الفريق الطبي بأكمله في 11.8% من الحالات. وقد شملت الإدعاءات مختلف التخصصات حيث وجد أن 23.5% كانوا من أطباء أمراض النساء والتوليد و 17.6% من أطباء الجراحة العامة. كما وجد أنه في 41.18% من الحالات تم تقديم الخدمة الصحية في المستشفيات والعيادات الخاصة، وأظهرت نتائج فحص القضايا أن 29.41% من القضايا انتهت بوفاة المريض، و 35.29% من الحالات انتهت بحدوث عاهة مستديمة، كما انتهت 35.29% من القضايا بحدوث مضاعفات. وأسفرت نتائج تقييم القضايا أن 23.53% من القضايا كانت إيجابية لسوء الممارسة الطبية، في حين أن 76.47% من القضايا كانت سلبية.