

ORIGINAL ARTICLE

Medicine Science 2025;14(4):1243-50

Comparison of forensic reports by non-forensic specialist physicians and forensic medicine experts

Tugba Ataseven¹, Ahmet Depreli², Kerim Aytar³, Siddika Gedik Depreli⁴¹Tokat State Hospital, Clinic of Forensic Medicine Tokat, Türkiye²Ministry of Justice, Council of Forensic Medicine, Tokat Forensic Medicine Branch Directorate, Tokat, Türkiye³Ministry of Justice, Council of Forensic Medicine, Diyarbakır Forensic Medicine Group Presidency, Diyarbakır, Türkiye⁴Tokat Provincial Health Directorate, Family Medicine Unit, Tokat, Türkiye

Received 18 March 2025; Accepted 30 October 2025

Available online 28 November 2025 with doi: 10.5455/medscience.2025.03.082

Content of this journal is licensed under a Creative Commons Attribution-NonCommercial-NonDerivatives 4.0 International License.



Abstract

This study aimed to identify the most common errors made by physicians who are not forensic medicine specialists while preparing forensic reports. The forensic investigation files of 2.321 cases for which a final report was requested between 2018 and 2022 at the Tokat Branch of the Council of Forensic Medicine were reviewed for this study. Among the examined cases, 178 (7.7 %) were aged < 18 years, while among adult cases, 782 (33.6%) were female and 1361 (58.6%) were male. Among all reports, 564 (24.2%) showed discrepancies in determining whether the injury could be classified as minor and treatable with a simple medical intervention. Additionally, 214 reports (9.2%) contained different conclusions regarding whether the injury could result in a life-threatening condition. The study concluded that physicians who are not forensic medicine specialists need to acquire more knowledge of forensic report preparation to ensure accuracy in forensic documentation and prevent disruptions in the judicial process.

Keywords: Forensic report, forensic medicine expert, forensic medicine

Introduction

Preparing medical reports for forensic cases is a vital responsibility, as it provides essential medical evidence. This duty is detailed in Article 280 of the Turkish Penal Code (TPC) No. 5237 [1].

Authorities typically approach the emergency departments of hospitals immediately after a forensic incident. Therefore, reports prepared by all physicians, especially those in the emergency department, are essential for the proper functioning of the judicial process. Lack of forensic medical knowledge, patient overload, stress, shift work, and long working hours can sometimes cause errors or omissions in reports written by physicians. Additionally, physicians may not always have sufficient time to properly evaluate the severity of the injury under the law [2,3].

Deficiencies in the initial report prepared after an injury can

negatively impact subsequent forensic investigation processes. Incorrect assessments regarding whether the injury results in a life-threatening injury (LTI) or whether it is mild enough to be addressed with basic medical treatment (BMT) can adversely affect the parties involved in the case during the judicial process [4-6]. For example, stating that an injury causes a life-threatening injury (LTI) in the case of an injury that does not result in such a condition may lead to the offense being removed from the category of crimes requiring a complaint, and it could result in the unnecessary arrest of the individual responsible for the injury. Such circumstances can prolong the judicial process and cause delays in the administration of justice [7].

This study aimed to identify the most common mistakes made by non-forensic specialist physicians when preparing forensic reports and to determine the most frequent situations in the conclusion section of medical documents that may cause contradictions in the judicial process.

CITATION

Ataseven T, Depreli A, Aytar K, Gedik Depreli S. Comparison of Forensic Reports by Non-forensic Specialist Physicians and Forensic Medicine Experts. Med Science. 2025;14(4):1243-50.



Corresponding Author: Tugba Ataseven, Tokat State Hospital, Clinic of Forensic Medicine Tokat, Türkiye
Email: dr.tugbaataseven@gmail.com

Material and Methods

Study Design and Settings

Our study is a descriptive archival study. Within the scope of the study, 2,321 criminal investigation files under the category of ‘Crimes Against Physical Integrity’ that occurred between 2018 and 2022 and required a definitive report were examined at the Tokat Forensic Medicine Branch. All cases were included in the study, and there were no exclusion criteria. In this context, the findings in the definitive medical reports prepared by forensic medicine experts were compared with those in the forensic reports prepared by other physicians.

Ethical approval for the study was obtained from the Non-Interventional Scientific Research Ethics Committee of Tokat Gaziosmanpaşa University Faculty of Medicine (approval number: E-15235480-050.04-572143). The study was conducted in accordance with the principles of the Helsinki Declaration and was approved by the Education and Scientific Research Commission of the Forensic Medicine Institution of the Ministry of Justice of the Republic of Turkey (approval number: 21589509/2022/176).

The "Guide for the Forensic Evaluation of Assault Crimes Defined in the Turkish Penal Code (TPC)" prepared in 2019 by the Forensic Medicine Department of the Ministry of Justice, the Forensic Medicine Specialists Association, and the Forensic Medicine Association, was used as a reference when providing opinions for the preparation of the definitive medical report [6].

Definitions

The concept of basic medical treatment (BMT) used in our study is defined in Article 86, Paragraph 2 of the Turkish Penal Code to denote the least severe category of injury [1]. A list of procedures falling within this scope has been compiled in the guide titled Forensic Evaluation of Assault Crimes Defined in the Turkish Penal Code, created in 2019. This list sets limits on which medical procedures will be considered basic medical treatment and also provides guidance on the conditions under which the physical effects of a traumatic event will be considered minor injuries. Similarly, Article 87(1) of the Turkish Penal Code (TCK) refers to the concept of life-threatening injury (LTI). This concept is understood to mean that the injury poses a threat to life, based on the objective medical consequences it has on the individual, even if recovery is achieved with or without treatment, without requiring the condition of death to have occurred. The concept of a permanent fixed scar (PFS) lesion, as defined in the same article of the law, is determined at least six months after the injury, in a well-lit environment, and at a distance that allows for social interaction between people. Lesions that cause permanent fixed scars must be easily noticeable at first glance under appropriate examination conditions [6].

Our study includes two separate groups of physicians: general practitioners and specialists, whose reports were evaluated for differences. General practitioners are physicians who, after completing their medical school education, provide primary

healthcare services with general medical knowledge and skills. Specialist physicians are physicians who, after graduating from medical school, have undergone specialist training in a relevant field of medicine and have acquired advanced diagnostic, treatment, and decision-making skills.

Results

A total of 2,321 criminal investigation files were examined in this study. Of the cases examined in the forensic reports, 7.7% (n=178) were under the age of 18, while 33.6% (n=782) of adults were female, and 58.6% (n=1361) were male. The general forensic forms in the files reviewed were prepared by general practitioners (GPs) or physicians who were not forensic medicine specialists.

Among all reports, it was observed that in 564 cases (24.2%), the result regarding whether the injury was mild enough to be addressed with basic medical treatment (BMT) changed, and in 214 cases (9.2%), the result regarding whether the injury caused a life-threatening injury (LTI) changed.

It was also observed that in 113 cases (4.86%), both the basic medical treatment (BMT) and life-threatening injury (LTI) results changed. In 43 cases (1.85%), there were deficiencies in bone fractures and permanent facial scars (PFS) (Figure 1).

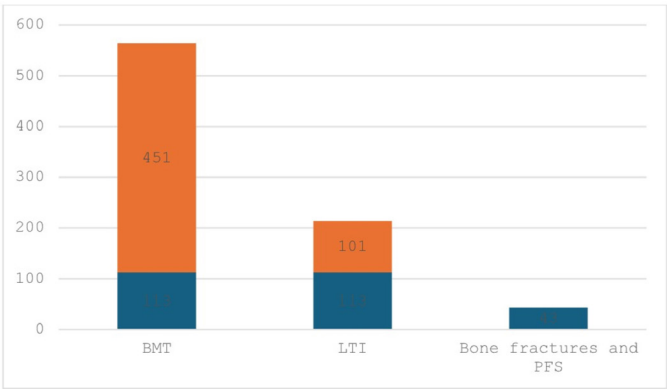


Figure 1. Distribution of issues with inconsistencies or deficiencies in general forensic reports by topic.

Each topic is explained with tables in its category, and cases that conflict with the results of simple medical intervention (SMI) are classified and presented in Table 1 along with the distribution of specialists and general practitioners. The distribution of 564 forensic cases in which the results differed according to whether the injury changed with SMI is shown in Table 1.

Although the injury was mild enough to be addressed with basic medical treatment (BMT), the reasons for the differences in the conclusions of the 564 cases where BMT (-) was stated in the general forensic examination form were categorized, and the results are presented in Table 2. Errors occurred in different subgroups when making the BMT decision for injuries with findings and symptoms in the head region (Table 2).

Although injuries that could not be treated with basic medical treatment (BMT) were detected, the most common injury type classified as treatable with BMT was bone fractures. In 117 cases (20.7%), although a bone fracture diagnosis was made, BMT (+) was applicable. The most common of these fractures was nasal bone fracture, which was found in 38 cases (6.73%). In 43 cases (7.6%), the forensic report initially stated that the injury was mild enough to be treated with BMT based on the existing information and findings; however, after the patient left due to referral or treatment refusal, it was determined that the injury was not mild enough to be treated with BMT. The most common cases were bone fractures, with 24 (4.2%) being bone fractures. Rib fractures in the chest region and nasal fractures in the facial region were diagnosed later, leading to a change in the BMT plan. The relevant basic descriptors are presented in Table 3.

We observed that 214 forensic reports (9.2%) had changed the life-threatening injury (LTI) outcome. More than half of these (129 cases, 60.2%) involved injuries that were initially assessed

as not life-threatening but were later determined to be life-threatening. The data showing the distribution of the reasons for incorrect decisions regarding life-threatening injuries are presented in Table 4.

It has been observed that there are 214 cases where, due to the mentioned injury, we determined that the life-threatening injury (LTI) was positive, but the general forensic examination form in the forensic investigation file concluded that there was no life-threatening injury. The reasons for the differences in the life-threatening nature of these cases are presented in Table 5.

A total of 20 (46.5%) forensic reports were found in which, despite the detection of fractures, it was stated that the fracture did not affect vital functions. Our department has requested that the discrepancy in these reports be corrected. In 7 (16.2%) cases, forensic reports indicated permanent facial scars (PFS) for acute lesions, such as ecchymotic lacerations, abrasions, and cuts on the face, without waiting for 6 months. These cases were determined by our department to have no PFS (Table 6).

Table 1. Cases where the result of basic medical treatment (BMT) changed

Type of BMT Result Discrepancy	Clinician Type	Number of Files (n)	Total (n=564)
Changing the result from BMT (+) to BMT (-)	GP	154	160 (28.3%)
	Spec.	6	
Changing the result from BMT (-) to BMT (+)	GP	253	298 (52.8%)
	Spec.	45	
Other situations related to BMT	GP	87	98 (17.3%)
	Spec.	11	
	GP	6	6 (1%)
	Spec.	0	
	GP	0	2 (0.35%)
	Spec.	2	

BMT (+): Mild enough to be addressed with basic medical treatment; BMT (-): Not mild enough to be addressed with basic medical treatment; Spec: Non-forensic specialist physicians; GP: General practitioner

Table 2. Reasons for declaring injuries that resulted in BMT (+) as BMT (-)

Category	Reason / Description	Number of Files (n)	Total (n=564)
Soft Tissue Damage	Isolated scalp subcutaneous hematoma - Contusion	59	83 (14.7%)
	Incised or sharp object injury (without factors aggravating the wound such as length, depth, muscle or nerve involvement)	23	
	Subcutaneous hematoma - Contusion in areas outside the head	1	
Pain	Headache	14	17 (3%)
	Pain felt in other areas	3	
Cases with results given based on suspicion before the diagnosis was confirmed	Suspected fracture	45	60 (10.6%)
	Pleural effusion (suspected hemothorax)	7	
	Suspected intracranial hemorrhage	4	
	Suspected pneumothorax	2	
	Suspected intra-abdominal hemorrhage or organ injury	2	

Note: The calculation of the ratio has been made by evaluating the 564 cases in which the BMT aspect changed.
BMT (+): Mild enough to be addressed with basic medical treatment; BMT (-): Not mild enough to be addressed with basic medical treatment

Table 3. Reasons for declaring injuries that resulted in BMT (-) as BMT (+)

Category	Reason / Description	Number of Files (n)	Total (n=564)
Presence of bone fracture or dislocation	Nasal Fracture	38	117 (20.7%)
	Rib Fracture	16	
	Phalanx Fracture	15	
	Metacarpal Fracture	14	
	Shoulder Dislocation	9	
	Frontal Bone Fracture	8	
	Humerus Fracture	6	
	Other ¹	11	
Skin, muscle tissue trauma	A single laceration or incision larger than 5 cm in the facial region.	48	83 (14.7%)
	Gunshot or sharp object injury causing muscle trauma	21	
	A total incision or laceration greater than 10 cm in the facial region	12	
	A single incision or laceration greater than 10 cm as a single lesion in areas of the body outside the head	2	
Later diagnosed or added medical conditions²	Rib fracture	11	24
	Nasal fracture	7	
	A bone fracture diagnosed later	Zygomatic bone fracture	2
		Phalanx fracture	2
		Frontal bone fracture	1
		Femur fracture	1
	Late diagnosis of brain hemorrhage, internal organ damage or bleeding	11	43 (7.6%)
	Late diagnosis of tympanic membrane rupture	6	
	Late-developed psychological disorders	2	
Cases where BMT (+) interpretation was made for the injury after recovery³	Bone fracture after recovery	15	26 (4.6%)
	Intracranial hemorrhage after recovery	9	
	Abdominal bleeding or internal organ injury after recovery	2	
Ear lesions	Tympanic membrane rupture	4	13 (2.3%)
	Hemotympanum	1	
	Laceration involving the cartilage of the ear helix	8	
Tooth fracture or subluxation			10 (1.7%)
Pulmonary contusion			3 (0.5%)
Intracranial hemorrhage			2 (0.3%)
Nerve injuries			1 (0.1%)

Note: The cases are expressed as a percentage within the 564 cases where the BMT issue changed;

BMT (+): Mild enough to be addressed with basic medical treatment; BMT (-): Not mild enough to be addressed with basic medical treatment; ¹: Other: 5 cases of scapula fracture, 4 cases of metatarsal bone fracture, 2 cases of femur fracture; ²: Cases where diagnoses were made by specialist physicians such as radiology specialists or orthopedists after referral or refusal of treatment, or diagnoses found in different hospitals after the preparation of the forensic report; ³: Sixteen cases, where the injury was deemed mild enough to be addressed with basic medical treatment due to recovery, were assessed by specialist physicians

Table 4. Situations where the life-threatening injury (LTI) outcome changed

Category / Description		Clinician Type	Number of Files (n)	Total (n=214)
Injuries that were Life-Threatening Injury (-) but were mistakenly assessed as Life-Threatening Injury (+).		GP	127	129 (60.2%)
		Spec.	2	
Injuries that were Life-Threatening Injury (+) but were mistakenly assessed as LTI (-)		GP	43	56 (26.1%)
		Spec.	13	
Other conditions related to LTI	Reports requiring more time for LTI assessment	GP	0	2 (0.9%)
		Spec.	2	
	Decision of LTI (-) despite the absence of signs of trauma or force	GP	6	6 (2.8%)
		Spec.	0	
	Reports with a decision of no need for evaluation despite the occurrence of an injury	GP	21	21 (9.8%)
		Spec.	0	
Total				214

LTI: Life-threatening injury; GP: General practitioner; Spec.: Non-forensic specialist physicians

Table 5. Reasons for the discrepancies in the LTI assessment

Injuries that were Life-Threatening Injury (+) but were mistakenly assessed as LTI (-)		n	n %
Conditions that could be diagnosed during follow-up 1			38 (17.7%)
Lung contusion			11 (5.1%)
Cases with a decision of LTI (-) after recovery	Cerebral hemorrhage after recovery	5	7 (3.2%)
	Abdominal organ injury after recovery	2	
Injuries that were Life-Threatening Injury (-) but were mistakenly assessed as Life-Threatening Injury (+)		n	n %
Bone Fracture	Humerus fracture	16	55 (25.7%)
	Spine fracture (isolated bone fracture without neurological deficit)	11	
	Facial bone fractures (without involvement of the skull base)	11	
	Isolated sternum fracture	6	
	Tibia-fibula fractures	4	
	Phalanx fracture	4	
	Femur fracture	3	
Subgaleal hematoma, scalp lesions and similar injuries.			35 (16.3%)
Penetrating muscle tissue injury with limited incision – GSW (gunshot wound)			23 (10.7%)
The decision to declare Life-Threatening Injury (+) based on suspicion before the diagnosis is confirmed.	Suspicion of vascular injury	8	16 (7.4%)
	Suspicion of brain hemorrhage	4	
	Suspicion of abdominal bleeding or internal organ injury	2	
	Suspicion of pneumothorax	2	
Other conditions related to LTI		n	n %
Reports where life-threatening injury assessment was deemed unnecessary despite the occurrence of an injury.	Soft Tissue Injury	17	21
	Pain and Tenderness	4	
Decision of life-threatening injury (-) despite the absence of signs of blunt force trauma.	No traumatic lesion and complaints such as pain or tenderness.	6	6
Reports where more time was required for the LTI assessment.	Soft Tissue Injury	2	2
Total			214 (100%)
LTI (-): Injury not causing life-threatening injury (LTI); LTI (+): Injury causing life-threatening injury (LTI);			
Note: The ratio is provided within the 214 cases where the Life-Threatening Injury (LTI) status has changed.			
¹ :Diagnoses identified in different hospitals after referral or treatment refusal following the preparation of the forensic report, or diagnoses made by a radiology specialist or consulting specialist after the forensic report was issued			

Table 6. Fracture and conditions related to permanent facial scars (PFS)

Assessment Category	Assessment Outcome	n (%)
Situations related to the assessment of the impact of fractures on vital functions.	Dislocation has no impact on vital functions.	4 (9.3%)
	Fracture has no impact on vital functions.	20 (46.5%)
	Fracture has an impact on vital functions, either 0 or 7 and above.	6 (13.9%)
Cases evaluated after recovery.	No fracture found after recovery.	6 (13.9%)
Cases where the opinion on PFS has changed.	Cases where it was stated that there were permanent facial scars (PFS) without waiting for 6 months, but the result was given as no PFS.	7 (16.2%)
Total		43 (100%)

During the review of 2321 forensic reports as part of the study, errors or omissions in injury descriptions identified through consultations, notes from specialist physicians at referral centers, and examinations of patients brought to our department shortly after the incident date have been listed in the table (Table 7).

The most common deficiency observed in the incorrect description of wound characteristics in the reviewed forensic reports was related to the localization of wounds, identified in 462 cases (19.9%). The top two issues within this group were the inability to determine whether the wound was within the

facial boundaries (n=202) and the description of the lesion using broad areas without clear anatomical orientation (n=180). Among the cases in which the localization was either poorly defined or completely overlooked, 382 (16.4%) were located in the facial region. In 1% of these cases (n=25), a decision was made that there was a positive result for permanent facial scarring. Incorrect classification of wound types (n=450) was the second most frequent issue, occurring in 19.3% of cases in which the wound characteristics were inaccurately described. Other findings related to this issue are presented in Table 7.

It was determined that in 450 (19.3%) forensic reports, the type of injury was either incorrectly or incompletely classified based on the forensic file containing follow-up documents and the examination conducted at the branch directorate near the date of the incident. The most frequent mistake was the use of different definitions instead of laceration. Another notable point is the classification of 46 acute wounds, including gunshot wounds, as "scar," thereby describing the existing injury as a chronic/old lesion. The identified incorrect usage of the injury types is shown in Table 8.

Table 7. Common errors and omissions in injury descriptions found in forensic reports

Wound Characteristics	Detailed Description	Number of Files (n)	Total (n=2321)
Lack of Localization Description	Cases where the injury's location within the facial boundaries was not specified	2202	462 (19.9%)
	Cases described with a broad area specified ¹	180	
	Cases where the broken tooth is not specified	37	
	Cases where it is not specified whether the ear cartilage is involved	24	
	Cases described in the wrong area ²	19	
Cases with incorrect wound type classification		450	450 (19.3%)
Wound size	Cases without size provided	232	417 (17.9%)
	Cases described approximately	123	
	Cases with incorrect measurements given	62	
Omissions in injury findings	Scrape, contusion, and laceration	164	252 (10.8%)
	Tooth fracture	57	
	Blunt force trauma/Sharp instrument wound	16	
	Gunshot wound	15	
Cases where the shape characteristics of the wound are not specified	Missing descriptive features such as wound shape (round, linear, etc.), edge characteristics (smoothly defined, etc.), tissue bridges, etc.	221	221 (9.5%)

¹ Example: "Stab Wound described as on the right side" was later clarified by the examination conducted at our branch, revealing that it was actually in the lower right quadrant of the abdomen. This refers to cases with unclear descriptions like this one.

² Cases where injuries on the thigh were described as on the leg, injuries on the forearm as on the arm, injuries on the leg as on the foot, or errors made regarding the right-left sides.

Table 8. Cases with incorrect or incomplete classification of wound type

Category	Incorrect Definition Used	Number of Files (n)	Total (n=450)
Definitions Used Instead of Laceration	Abrasion	29	382 (16.4%)
	Hematoma	2	
	Scar	16	
	Incision	324	
	Contusion	11	
Definitions Used Instead of Gunshot Wounds	Scar	17	26 (1.1%)
	Incision	9	
Definitions Used Instead of Abrasion	Laceration	15	15 (0.6%)
Definitions Used Instead of Stab or Cutting Tool Injuries	Incision	4	14 (0.6%)
	Laceration	4	
	Scar	6	
Definitions Used Instead of Contusion	Scar	7	7 (0.3%)
Definitions Used Instead of Incision	Lesion	3	6 (0.2%)
	Scratch	3	
Total			450

Discussion

Judicial authorities expect doctors to consider several important factors when preparing forensic reports. These factors include the accuracy of the information provided regarding whether the person is facing LTI, whether the injury can be treated with BMT, and whether the injury has caused a bone fracture. The guidelines on the provision of forensic medical services, published by the Ministry of Health's General Directorate of Primary Health Care Services September 22, 2005, under Circular No. 13292, summarize the key points to be considered in forensic reports. Furthermore, as a result of a joint study conducted in 2019 by the Ministry of Justice Forensic Medicine Institution, the Association of Forensic Medicine Specialists, and the Forensic Medicine Association, the 'Guidelines on the Forensic Assessment of Assault Crimes Defined in the Turkish Penal Code' was published and updated periodically.

When preparing a forensic report, failure to take this guide into account alongside the medical diagnosis and treatment process may lead to some errors and omissions that could disrupt the legal process [8]. In this study, when examining the files containing provisional medical reports sent to the Tokat Forensic Medicine Branch Directorate, it was observed that there were some significant differences between the forensic report results provided by doctors working in the emergency department and the results provided by the forensic medicine specialist after the same injury.

Incorrectly stating that an injury poses a life-threatening risk when it does not actually do so can lead to individuals being unjustly detained or receiving wrongful punishment. If individuals remain in prison because of a physician's incorrect forensic report, the doctor may face legal proceedings for both material and moral damages. Furthermore, such errors can cause inconsistencies, increasing the workload of courts and leading to delays in delivering justice to individuals.

In our study, the rate of cases reported as accidentally causing a life-threatening situation, despite the injury not posing a life-threatening risk, was found to be 60.2%, while the rate of cases reported as not causing a life-threatening situation, despite the injury posing a life-threatening risk, was found to be 26.1%. These findings indicate that life-threatening injury assessment is prone to error at a high rate in both directions. A review of the literature on the subject shows that the rate of detection of incorrect LTI decisions was reported as 6.48% by Çoltu et al., 4.7% by Çetin et al., and 13% by Serinken et al. [9-11]. These results are partially consistent with our study; however, we believe that the lower rates of incorrect assessment in the aforementioned studies compared to our study may be related to the nature of the study population, the level of experience of the physicians issuing the temporary medical reports, or changes over the years in the prevalence of defensive medicine practices among physicians.

In another study published in 2019, the success rate of the

reports evaluated within the scope of the study in detecting life-threatening clinical conditions was reported as 83.4%, and the success rate in detecting cases without life-threatening clinical conditions was reported as 85.5% [12]. While the high diagnostic accuracy in this study can be interpreted as a reflection of the clinical assessment-based decision-making mechanism, the high rate of erroneous reporting in our study highlights the difficulty in correctly interpreting clinical decisions and legal classifications when preparing forensic reports. Therefore, these differences identified in assessments of whether an injury poses a life-threatening risk indicate that physicians require standardized training in the preparation of forensic reports.

Failure to specify or incorrect reporting of the location of an injury in a forensic medical report prepared for an individual who has sought hospital treatment following an injury may lead to incorrect forensic medical interpretations and create the impression that there are inconsistencies in the statements made by the victim or defendant regarding the injury during the investigation. In such cases, where information about the existing wounds is lacking, it is difficult to establish a causal link with the injury. Sometimes this situation makes it difficult to reach the correct conclusion on issues such as determining the type of injury and the weapon used. The literature shows that there are studies identifying deficiencies caused by the failure to specify the injury site when preparing forensic reports [13-16]. For example, Yemenici and colleagues found that 46.1% of the forensic reports they examined did not provide a detailed description of the lesions included in the forensic reports. While Turla and colleagues reported that in 30.5% of cases with forensic reports, information on the presence of external traumatic lesions was not recorded in the report, and in 48.1% of cases where external lesions were indicated, the lesion description in the forensic report was not as detailed as it should have been [8,16]. In our study, the rate of non-reporting of injury findings was found to be 10.8%, and the rate of incorrect reporting of wound size was found to be 17.9%, which is consistent with similar studies previously conducted at different centres in Turkey.

In our study, it was observed that incorrect reports were issued for 17 forensic cases with only pain complaints and no medical lesions, stating that the injury was not mild enough to be classified as BMT. In 14 of these cases, only headache was detected. In 10.4% of the 83 forensic reports that incorrectly concluded BMT (-) due to soft tissue injury, it was stated that the injury was located in the head region. This situation is generally consistent with studies reporting that head and neck injuries are among the areas most frequently conflicting in BMT assessments [17]. Considering the vital importance of the head region, we believe that doctors' more defensive behaviour in cases involving injuries to this region may have contributed to the incorrect decision.

Conclusion

In conclusion, we believe that errors or omissions in the examined provisional forensic examination reports could be prevented

if existing guidelines were used in light of general medical knowledge. The persistence of errors and omissions may expose physicians to legal and criminal sanctions and may add further to the suffering caused by the injury. The persistence of errors and omissions may expose physicians to legal and criminal sanctions and may add further victimisation to the suffering caused by the injury. To minimise all these negative consequences, the duration of forensic medicine courses, which are currently crammed into a short period during medical education, needs to be increased. We believe that this approach can increase the likelihood of improving physicians' knowledge, attitudes, and behaviours regarding forensic case management. We believe that in-service training provided by forensic medicine specialists, regulated by the Ministry of Health, is of vital importance in keeping our colleagues who are currently practising medicine up to date on this subject and filling in any gaps in their knowledge.

Conflict of Interests

The authors declare that there is no conflict of interest in the study.

Financial Disclosure

The authors declare that they have received no financial support for the study.

Ethical Approval

Ethical approval for the study was obtained from the Non-Interventional Scientific Research Ethics Committee of Tokat Gaziosmanpaşa University Faculty of Medicine (approval number: E-15235480-050.04-572143). The study was conducted in accordance with the principles of the Helsinki Declaration and was approved by the Education and Scientific Research Commission of the Forensic Medicine Institution of the Ministry of Justice of the Republic of Turkey (approval number: 21589509/2022/176).

References

1. Turkish Penal Code (Law No. 5237), adopted on September 26, 2004, Official Gazette No. 25611 (Repeated), 12 October 2004, Article 280.
2. Serinken M, Çımrın AH, Ergör A, et al. Burnout syndrome and emergency department physicians. *J Community Physician*. 2002;17:358-65.
3. Kurtuluş A, Acar K, Boz B. Legal responsibilities of physicians. *Acad Design*. 2008;2:10-4.
4. Fedakar R, Aydin AH, Ercan I. A comparison of the "life-threatening injury" concept in the Turkish Penal Code and trauma scoring systems. *Ulus Emerg Surg*. 2007;13:192-8.
5. Yavuz MS, Aydın S. Forensic Cases and Reports in Primary Health Care. *Turk J Fam Med*. 2004;8:30-3.
6. Yavuz MF, Baştürk P, Yavuz MS, Yorulmaz C. Emergency room applications of forensic cases in Cerrahpaşa Medical School. *Turk J Forensic Sci*. 2002;1:21-6.
7. Çelik Y, Kılıboz T, Doğan B, Garbioğlu A, Şimşek Ü, Karbeyaz K. Evaluation of Forensic Reports in Terms of Life-Threatening Criteria. *Osmangazi Journal of Medicine*. 2021;43:308-17.
8. Turla A, Aydın B, Sataloğlu N. The mistakes and defects in the judicial reports prepared at emergency services. *Ulus Emerg Surg*. 2009;15:180-4.
9. Çoltu MA, Durak D, Fedakar R. Evaluation of forensic report forms organized in the Emergency Department of Uludağ University Medical Faculty. *J Forensic Med Bulletin*. 2000;5:36-40.
10. Çetin V, Fedakar R. Evaluation of forensic report forms organized in the Emergency Department of Uludağ University Medical Faculty between 1999 and 2001. In: 2nd Anatolian Forensic Sciences Congress Proceedings. Kayseri; 2003:17.
11. Serinken M, Türkçüer İ, Acar K, Özen M. Evaluation of medicolegal reports written by physicians in the emergency unit with regard to deficiencies and mistakes. *Ulus Emerg Surg*. 2011;17:23-8.
12. Akbaba M, Daş V, Asılbaş MK, et al. Are the judicial reports prepared in emergency services consistent with those prepared in forensic medicine department of a university hospital?. *Eurasian J Emerg Med*. 2019;18:79-85.
13. Koç S, Yorulmaz C. The legal responsibilities of physicians. In: Soysal Z, Çakalır C, eds. *Forensic Medicine*. Istanbul University Cerrahpaşa Medical Faculty Publications. 1999:45-60.
14. Bozkurt S, Daraoğlu V, Okumuş M, Savrun A, Karanfil R, Gök AA. Evaluation of judicial reports executed in the emergency service and identification of deficiencies. *J Clin Anal Med*. 2015;6:331-4.
15. Çetin ZE, Teyin A, Birben B, Çetin B, Şahiner GG, Hamamcı M. Evaluation of judicial reports prepared in the emergency department. *Bozok Med J*. 2018;8:34-40.
16. Yemenici S, Sayhan MB, Yılmaz A. Evaluation of medicolegal reports prepared in the emergency department. *J Harran Univ Med Fac*. 2017;14:179-86.
17. Akın U, Yılmaz Başer H. Comparison of forensic reports on the same forensic cases issued by the emergency department and forensic medicine polyclinic. *J. Exp. Clin. Med*. 2024; 41:112-8.