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Medical Act and Negligence: Ethical Concerns

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Abstract

To all doctors, Medical ethics must be in support of every medical action. Nowadays, ethics in medicine is an elective topic in college curricula, and therefore, unknown, forgotten or poorly learned in detriment of patient care and their wellbeing. Medical care lacking in ethics generates mistakes derived from lack of skill, negligence or recklessness. These are exacerbated by the lack of training and/or overconfidence, which at first glance can appear to be commonplace and even normal, and thus, resulting in medical malpractice. We must return to humanistic medicine. Combat medical mercantilism at the cost of the patients, and recover the social position that medicine has held with the utmost respect for centuries.

Keywords: medical ethics, medical act

1. Introduction

In memory of my unforgettable wife Dra. Laura Elena Mancilla RIP

The purpose of this document is for professors, general, specialists, subspecialists and medical trainers, to make a thorough insight of the grave deficiencies that the medical act has before a healthy or ill patient. We will start by defining the medical acts as every action executed by the doctor before the patient from the moment they seek to be treated.

The medical act must be surrounded by the medical ethics and this is based on the moral values and principles that define what is done right or not under the use of reason (ethics) and rule our conduct for the benefit of the patient (medical ethics). This principle called deontological are benevolence, equity, autonomy, confidentiality, respect, dignity, solidarity, honesty, loyalty, and justice and every doctor has the responsibility to apply them with humanism, knowledge, and experience at all times during the medical act. All these, taking into account that the ultimate purpose of the doctor is to provide quality in the medical attention with a humanistic sense (granting appropriate medical attention to the patient, pursuant to medical knowledge and applicable ethic principles, which allow the satisfaction of their medical needs and expectations), knowing that the medical responsibilities are aimed on the prevention, diagnosis, treatment, control, curing, palliation of the problem, or moral support when none of the above is possible in order to facilitate a dignified death. The patient's expectations value each one of the components of the medical act, that translate in to a professional, humane, and assertive treatment and also valuing the institutional capacity where this attention is given [1].

Thus, we can say that the medical act so practiced is a Good Practice or *Lex Artis*, and the medical act that does not comply with the requirements is called *Malpractice* and is identified frequently drawn from one or more unjustified errors, therefore it implies fault, and medical liability. Here we highlight negligence, incompetence, reckless incompetence, and willful misconduct. The justified or excusable errors are not deemed malpractice but the result of the continuous risk in the decision making even when they are adequate and that might arise from intolerances, allergies, over-infections, side and adverse effects, etc. The doctors are not infallible nor make willful mistakes.

Negligence: lack of the required precautions and attention; when in spite of having the knowledge, it is not applied and causes damage. Incompetence: Lack of skills and experience of technical and practical knowledge; acting without having the knowledge and causing damage. Reckless incompetence: taking unnecessary risks caused by the lack of knowledge. Willful misconduct: Scheme to cause damage. It is always sanctionable because it consciously breaches the law [2, 3].

When the actions become repetitive in the same place, by the same doctor, before the same patient, the need and importance of having mechanisms that allow to perform an evaluation process of the medical act arises, in order to identify if the clinical practice and the complete analysis rendered correct and complete diagnosis and treatment processes, based on the knowledge of the feelings of the patient and not only in the encyclopedic knowledge of medicine or the isolated analysis of the requested studies, additionally to the experience and empathy, if it was performed under continuous and adequate supervision, with explicit and precise instructions, and starting from the identification of the fact that there was a diagnosis and if it was correct, if the secondary effects and complications that might damage the patient were expressly explained, as well as the short and long term prognosis, and especially if every step of the medical act was taken with dignity and wellbeing.

This concern takes us to claim that the doctors in formation must retake the professional ethics as a way of personal life in order to give health and wellbeing, to their main objective, the patient. To achieve this, they need to exercise their profession with medical ethics, so tampered nowadays. Luckily there are many of us working towards that objective. But the road to the patient's wellbeing is filled with obstacles, or simply shortened because of mistakes arising from inexperience, negligence, or incompetence, covered by the lack of training, the excess confidence, or just for executing medical acts lacking ethics and humanism that may seem normal at plain sight, but giving rise to medical malpractice.

This is why, the specialized and sub-specialized doctors must reevaluate our actions before the patient; the medical malpractice has caused that in the past years, our roll as doctors has changed before the society, and our ethical behavior with *lex artis*, has been transferred to the personal and commercial ethics, the encyclopedic knowledge to diagnose with laboratory and cabinet studies more sophisticated and expensive and to give therapies for diseases without contemplating the patient as the center of everything and as a human being.

To exercise medicine with *lex artis*, we want to make the following observations and recommendations:

1. The doctors educate ourselves to prevent diseases and in its case, try to cure them, avoid complications, and premature death from the disease or from complications from such, favoring the recovery and rehabilitation for the family and social reintegration, always applying the best diagnostic and therapeutic strategies, with the least expense and the maximum benefit [4, 5] complying with the following responsibilities:

a) Acknowledging that their patient is a human being, such as them, that by falling ill, they are living with a crisis of pain, anguish, fear, confusion, uncertainty, and are asking for help; b) disposition to listen and act with empathy (asses in order to understand the disease and suffering of a patient “putting themselves in their shoes”); c) having sufficient medical and scientific knowledge and being an expert in the field; d) being aware of their deficiencies, abilities, and skills; e) accepting the need for training and updating; evaluating and contrasting their real skills with other doctors and in different educational and working sites; f) knowing how to talk and inform patients in the same communication channel and language, in a simple, direct, and explicit manner about every aspect related to their health or disease; g) asking in a timely manner for the help, opinion, or official valuation from their peers when we cannot make a diagnosis with certainty; h) highlighting the medical ethics and the human values as a way of life and work exercising respect, discipline, responsibility, timeliness, honorability, honesty, integrity, education, love, and passion; i) fostering the wellbeing; j) not trying to get rich at the expense of your patients; j) honoring the profession with your actions; k) educating and transforming your patients and alumnus; l) professing humanism in your daily life, towards excellence, exercising assertive medicine and not in a defensive way that damages the doctor, the patient, and the institutions; m) using the medical file as a working tool to record all your medical actions, because when there are explicable or inexplicable mistakes; unconformities, and claims against the doctor might arise, in the midst of pain and resentment caused by the grieve of the family members, the instigation of lawyers, plus the media that makes a windfall from another’s misfortune, the doctor is degraded to the level of a criminal by all the aforementioned and even the judges, that without any knowledge on the subject feel capable to comment and make medical conclusions and issue despicable sentences against us. A well-documented clinical file will then become a valuable tool in the defense before this scenario [6, 7].

2. In the climax of scientific development and technology applied in the medical field, the medical education at medicine schools prioritize the medical clinic subjects and minimize or exclude the hours of ethics and bioethics and in general, the psycho-social sciences from the curriculum design. The clinical rotations of the medicine students in the teaching hospitals are anxiously awaited and it is here when the young students are seduced and/or confirm their dreams of making a medical specialty, they are impressed by the medical personalities that are their teachers and that exercise their profession, with or without ethics, in the midst of the advanced diagnosis and treatment studies so that when they are done with their studies they can join medical residencies, which is often hard to achieve.

3. Now, let us focus in the public service in Mexico where millions of patients are treated, in most cases from the middle and lower class and the workload increases in the attention of emergencies, consults, and hospitalization. Let us suppose that 20 patients are treated in a family medicine consult, dedicating 6 minutes per patient for the information, exploration, issuance of laboratory, admission, and prescription requests. This time conditions a scares communication and does not allow for empathy, there are only brief questions and answers, without the patient feeling conformable or even being able to ask what they have and how the given treatments work, nor the doctor having the time or desire to do so. The work is deficient and fast, because there are other tasks to complete. Depending on the level of attention, the doctors are, most of the times, the residents being supervised or not by the attending doctor. And that is how they learn, without anyone telling them what is well done and what

is not. The great teaching hospitals, that are highly specialized, use advanced scientific and technological tools, new and expensive medicine and therapeutic schemes at the reach of a limited group of patients, those who have weird or complicated diseases, or those that are a public health issue (that even so, they exceed the capacity for attention of the units). The doctors exceeded by the patients in public medicine are the same ones that work in private medicine that will treat patients with more resources able to pay the exorbitant costs of their treatment whether in a doctor's office or in the hospital. The high quality and expensive medical attention is limited to the few patients that are trapped in social security (SS) in the various specialty clinics (most of the time for occupancy) or to the patients with high economic resources capable of paying for their treatment on a direct manner or by mayor medical expenses insurance policies that are another factor that intervenes in this mechanism [7].

4. And up to this point, the doctors have not yet received training in humanistic medicine, are still acting with the ethics that they have molded thought the years, piling up knowledge and personal experience, sometimes being a true reflection of their teachers that carry out the medical act on the path of personal ethics or convenience, in which they act convinced that what they are doing is right because it is convenient to them, leaving aside the humanist ethics in which this reflection is based upon for their personal benefit as well as for the patient's.

To continue with the problem, the public and private treatment define the patient as an object and not as an ill human being, and the health worker is thus, a public servant or a service renderer or provider (the medical attention, whatever it may be, in transformed into a service). A service is rendered to make a diagnosis of something and not of a disease in an ill person. They make a budget to fix your broken car and if you can afford it, you fix it, and if not, you leave it as is until it stops working. That is the exercise of medicine in a public and private level, splashed with great scientific and technological advances, the doctor slowly starts losing their doctor-patient relationship, and substitutes a good interrogation and exploration with lab and cabinet exams, that make the service and the attention more costly and delay the early diagnosis and the timely treatment. In private medicine, the doctors are encouraged to admit more patients and ask for more studies to keep the economy in hospitals, or to face the increase of the lease in their offices or being expelled from the medical group. The medicine is commercialized and many times it becomes fraudulent [8].

The malpractice has given rise to more indictments and medical detentions that damage the physical, moral, social, and professional integrity of the doctor, which warns us to review the environment of our medical actions, asses how we are failing and not only to protest against the judicialization of the wrongful medical act without explanation.

5. We will now submit to your consideration some cases (the first one unabridged for a better analysis) in which you can assess the medical action:

2. Case 1

Woman of 65 years with a background of abdominal pain in meso and epigastrium, mild to severe, inexplicable, during 20 years, associated with hypergastrinemia never above 500 picograms per milliliter, reason for which a sub total pancreatectomy is performed in a public institution, leaving behind only the head of the pancreas; no macroscopic tumor was removed nor were microscopic tumors detected. As of this

moment, hypothyroid crisis, hypothyroidism, rheumatoid arthritis, detection of anti-thyroid antibodies, to mention the most important and those that required hospital services. The patient continues with the abdominal pain, and still in pain and without any advancements, she attends another health institute where she is diagnosed by endoscopic means with atrophic chronic gastritis and finding antibodies anti-parietal cells in the stomach, adding to the diagnosis from the same studies, gastric polyps and neuroendocrine tumors in different years, resolved by extirpation. The endoscopic exam was made every one or two years or as per the request of the patient because of the continuance of the symptomatology. Fast forward to three years ago, and the pain continues, adding halitosis, heaviness sensation, and postprandial abdominal bloating, abdominal distention, and mild to moderate gastroesophageal reflux (RGE). Eight months ago, we add bad digestion, nausea, and post prandial vomiting, so as per the insistence of the patient (hereinafter called ROMA) a new endoscopy is performed referring to a great amount of dense food residue in the stomach rendering the study impossible, programing a new study for the following week, prescribing a soft and liquid diet of 24 hours prior to the study. ROMA, at that time, had a month and a half tolerating only 30 to 40 ml of liquid diet four or five times a day according to her tolerance, suspended every time by intense nausea and constant moderate reflux. The endoscopic study is suspended once more due to a great amount of gastric residue arguing that ROMA has not been duly prepared, rescheduling it for the following week. For this reason, a private cabinet performs an ultrasound and an abdominal tomography that finds a very distended gastric chamber at the expense, presumably, of nutritional material, and of the water flow, and contrast medium, they cannot see the pylorus, but they can see an increase in the thickness of the gastric antrum wall, establishing the diagnosis of gastric obstruction or pyloric syndrome. With this results she goes to the institution for the programed study, with those results they perform a vacuum of the gastric content referring once again to a poor preparation for the performance of the study, reporting verbally and surely by the expert (the same one that has performed the studies in this time table), again an atrophic of chronic atrophic gastritis without any other associated or visualized pathology due to the fact that the endoscopy was not able to pass thought the pylorus, sending her for a gastroenterology assessment. The patient insists that a programmed and complete gastric lavage is performed, for an endoscopic study with ultrasound that has been programed and suspended twice, the doctor refuses and with a doctors' consensus by phone, the hospitalization is requested knowing that there are no available beds. It is important to highlight that the diagnosis of the consult never elaborated diagnosis of suspicion of cancer, nor multidisciplinary evaluation were performed in the many years of studies. The treatment for the discomfort of the patient was purely symptomatic the whole time, and in this 20 years of evolution, the abdomen was explored by the clinic only three times and in every semimanual or annual visit for the control of her specialist doctor, she was seen by different resident doctors that were not aware of the case, without the presence of the base doctor.

COMMENT.

ROMA with 20 years of evolution always interested in her health and wellbeing, always attending to doctors seeking attention, diagnosis, and treatment. It calls our attention that during this time after dozens of consults almost nobody was interested to perform a full physical exploration, correlate symptoms, physical findings, laboratory and cabinet studies, and on top of that it was impossible because the doctors were different, new, in training for being teaching institutions, inexperienced in the field of skills, and with scarce supervision. When there were inter-consulting services, each one attended the affected organ or system and of course, there were never multisystemic assessments or consults to help ROMA who was seen during 20 years without the doctor

in charge of assessing her thinking to make analysis and scrupulous, clinical, lab, and cabinet correlations to go beyond the ignored hypergastrinemia, an immune chronic atrophic gastritis, and even less to comment that with someone of the same service or of the gastroenterology service in order to help the patient. Sadly, for the doctor of gastroenterology and other interconsultant services a case that was so painful, rude, and chronic did NOT stand out in a prestigious teaching institution, even when the patient seeks direct and urgent attention, in the end, losing wellbeing and dignity on top of her health before the collective indifference.

The medical act must be performed with professional and medical ethics, and here is evident, the lack of respect towards the patient, of medical consciousness, of empathy for the patient, of training, of supervision, total indifference to the suffering and needs of the patient, and what makes it worst, the medical action that must be credited with the application of knowledge, abilities, skills that give experience and wisdom to the service renderer, here we could see a lack of these abilities. Ignoring ROMA with loss of weight for an obstructive syndrome and the inability to eat, additionally to the cause of the problem, turns the medical act to medical negligence, for omission, carelessness, incompetence, arrogance, excess of confidence, actions that take the patient to unnecessary risks for her health or even death, as in this case, which turns these acts in a crime against health, in a medical conditioned crime due to a total lack of professional ethics [9].

In light of this, ROMA seeks alternative solutions and is hospitalized in the institutions where she was affiliated, at that time she had not been feeding, had lost 12 kg of weight, tolerating only scarce suspended liquids due to the sensation of satiety, nausea, and persistent reflux only reduced by abundant voluntary vomiting of abundant and fetid content. Once hospitalized and one week after her last endoscopy, a gastric lavage is performed for 24 hours as well as a pan endoscopy with ultrasound that informs of a mucous of gastric antrum very thickened and swollen almost 3 times the normal standard up to the pylorus, which is impermeable, with a macroscopic image very suggestive of linitis plastica. The trans ultrasound reports no invasion of extra gastric and extra abdominal organs. ROMA is programmed to an exploring laparotomy, finding the stomach very increased in size, indurated almost completely, of antrum towards the pylorus, with invasion to the first portion of the duodenum, bile ducts and implantations in the epiploon. The surgeons refer that with carcinomatosis there is no indication of gastrectomy and only a gastro jejunum anastomosis is performed to promote feeding and closed, informing ROMA that she has a surgical diagnosis of gastric adenocarcinoma in state 4b type linitis plastica. The biopsy taken a few days before reports cells in sealing rim characteristic of the linitis plastica [10].

COMMENT.

The correct management function and the empathy of her doctors allow ROMA to be hospitalized in the second mentioned institution and subject to immediate testing, which allowed that four days after her admission a suspicious endoscopic diagnosis was made, and a surgery programmed one week after her admission.

The deficient management work of the first hospital institution and the lack of medical ethics in her doctors reflects the mentioned mishaps and radically contrasts with the fact that within a week, the diagnostic appreciation of years with chronic atrophic gastritis changed abruptly to a linitis plastica [11, 12], that even though it is in fact strange and hard to diagnose when the patient is not studied, ROMA has been studied for 20 years and dozens of digestive tract endoscopies were performed, with clinical evidence of a gastric disease more complex than a gastritis and was ignored and rejected for studies in several opportunities when her manifestations became evident of gastric obstruction, inability to eat, and weight loss during the last two months to begin with, that should be cause for alarm for any self-respecting doctor, but here, the medical negligence and the great lack of professionalism and professional responsibility, became

a constant in the negligent and reckless medical act and the lack of expertise of at least the endoscopies and gastroenterology services, that were aware of the grave problems of ROMA and finally agreed not to treat her as an emergency as it was merited, but instead to indicate hospitalization when they knew there were no beds available nor there would be in a near future and that would inevitably harm the patient.

The medical teams of the second institution acted promptly to try to solve a medical emergency and within a week they were operating the patient [13]. Unfortunately, the cancer was very advanced without expectations of medical and surgical treatment, except to favor ROMA to help her eat for 3 months, before the second obstruction. Great difference between the duties and action between one institution and the other one, as well as in their medical teams. Great difference in the professional exercise and the execution of the medical act with and without medical ethics.

Two months after the surgery, when the oral tolerance at home was of half servings, in fifths, with good tolerance, they assess, at the oncology hospital of the second institution, already immerse in the pandemic with great occupancy of patients in waiting rooms and medical offices, indicating oral chemotherapy (it is important to comment that there was no physical exams and a they documented a weight loss of 12 kg, with normal lab studies and a tomographic study that was poorly performed and very poorly interpreted). (It was said that for stratification she was not a candidate for any surgical medical treatment). The treatment causes the diminishment of oral tolerance, nausea, vomiting, loss of and extra 4 kg of weight in two weeks, so the patient suspends the treatment voluntarily and before the fear and great risk of contagion of coronavirus she stops attending the institution. As of that moment, the problems worsen, presenting low oral tolerance, with exclusive liquid diet and deterioration of her general condition, even though the lab tests are normal and there is no invasion to other extra-gastric and extra-abdominal organs in the new contrasted tomography performed in particular, although there was persistence of the gastric findings.

COMMENT.

Once again, the negligence (the convenience, need, and consequences of an alternative oral chemotherapy in a patient in terminal phase with oral tolerance were not deeply analyzed), the inexperience (lack of clinical capacity, experience, and knowledge led to a wrongful medical act) and the recklessness (indicating drugs without explanation and damaging to the patient) made the appearance in another group of oncology doctors during pandemic times. Not to even mention the high occupancy of patients in COVID times in the oncology hospital...

ROMA is still desperate because she cannot eat, and nobody is helping her. She consults two prestigious oncologists in a private hospital. One, after hearing the case by phone, orders to start triple chemotherapy without specifying drugs, effects, and when he was asked about this, he answered... What do you prefer, cancer or the effects of the chemotherapy? and by phone, requests for a budget. Another one, in a face to face visit and also without exploring or touching the abdomen recommends starting triple chemotherapy (both doctors are from the same public assistance institution). Afterwards, an oncology surgeon after knowing about the case and without exploring the patient, asks: Why did you come to see mee? What do you want me to do for you? Without further explanation he offers to perform a gastrostomy for drainage and a jejunostomy. Up to this point, none of the three doctors offered nutritional therapy in spite of the evident malnourishment of ROMA nor offered drug therapy for the pain that was on the rise. ROMA did not like like the lack of empathy and dehumanized attitude of the doctors and did not go back to them. She was conscious of her diagnosis and prognosis, as well as of these new complication of a possible intestinal tumoral invasion, because she could

feel a big and painful tumor that increased in size in the upper part of the abdomen that was rapidly increasing. The clinical evidence of obstruction was corroborated in a different institute with a pan endoscopy and the placement of an orogas-trojejunal trilumen tube, so they try to feed her for two weeks with specialized diets, without success, having a gastric loss always similar to the oral intake. She is reassessed by fluoroscopy, the placement of a tube that was angled and corrected, recommending not changing and continuing the feeding scheme.

COMMENT.

To the prior findings, a new cancer is added in the medical act, the commercial exercise of medicine, where it is more important to charge chemotherapy services without professional assessments, without regard of the clinical state of the patient, the state of malnourishment and diminishment of physical capacities, because there was no clinical exercise, than helping to alleviate the suffering and procuring the wellbeing in the disease of the patients. Something appalling at least in this school of oncology doctors that contaminate the good medical act of the majority. As reproachable is this as another oncology surgeon doctor, once aware of the case, asking ROMA; why did you come to me and what do you want me to do for you? Offensive questions to the intelligence and dignity of the patient that, seeking for help, finds the doctor asking her to tell him what to do. The lack of professional ethics with all its sad consequences. In the desperation and suffering the trips to attention centers continue every time more painful and filled with difficulties and ROME finds humanitarian and uninterested answer for help when a tube of trilumen is placed to favor her nourishment. The doctors still have souls. Unfortunately the intestine obstruction was causing harm making the whole feeding process and marking the immediate future of ROMA.

Immediately after, she is assessed by an oncology surgeon, one of the few that in this story is capable of being empathic with ROMA, treating her in a human manner and after a full evaluation with physical exploration including rectal tact where he corroborates intestinal pastrones and contemplating her terrible general and nutritional conditions, that was almost unable to move by herself and unable to speak on top of the advanced state of the tumor, indicates her to stoop seeking therapeutic palliative alternatives, that her and her family had done enough and all that was humanly possible and that she should be treated solely for algology and palliative medicine to mitigate her suffering and give dignity to her life, that she had to go home and not move anymore. It is important to say that ROMA was a retired doctor and that she seeks and asked for specialists in alternative medicine, private algologists, nutritionists since her discharge from the surgery and her husband tended after her at home during her last seven months of her life, he and family members searched for drugs and specialized nutritional supplements. All made more difficult by the ghost of the pandemic and the collapse of medical services [14], where the high occupancy of hospital services, distant or absent doctors, or those interested in the profit, that are only thinking of themselves not in the patient, new and unsalvageable administrative procedures, change of attention on the hospitals and transformation into COVID hospitals, inability to perform multidisciplinary assessments that were required seeking a complete focus of the problem, many months, maybe years, with a complicated and terminal cancer, situation that was never addressed by the consulting doctors.

The patient dies of starvation [15] in her home because of the inability to feed herself and due to the impossibility of hospitalization for the risk of infection or coronavirus and five months after her diagnosis, from a tumor invasion to the intestine with obstruction.

COMMENT.

To close this very sad chapter, we find ROMA completely weakened by the disease, hit by the medical acts lacking of ethics, and favoring only in a few cases like the latter

where a group of doctors agreed to give ROMA a full assessment WITH PHYSICAL EXPLORATION, humanism and empathy, to convince her and her family that they had done everything that was humanly possible to help her, but that there were no probabilities for success. That the best was to rest at home aided by algology and palliative medicine to mitigate the suffering and wait for the end of her life. With this it is important to analyze a little bit the role of her husband, also a doctor, dedicated to complying every aspect of his wife's wishes. Here in that dedication to procure certainty in the diagnosis and palliating treatments aimed to mitigate her pain and suffering [16], the family member encounters the difficult situation of distinguish the very thin line that divides the therapeutic efforts from therapeutic cruelty, and even worse in case of a close family member. It was only this last assessment that made him see this thin line in order not to cross it.

As we can see in this type of rapid analysis, it is necessary to reconstruct the medical education in the social fields, ethics, and bioethics aimed to provide help, solution, and peace of mind to the patient. The social compromise of the doctor has been forgotten in favor of their economic benefit and not few times the work overload hinders the rational medical act and in other teaching institutions for doctors dedicated to providing encyclopedic education graduating doctors that diagnose lab and cabinet exams more and more sophisticated, when they are taught well, forgetting that in front and behind those studies there is a patient demanding for help for their sufferings. Another chapter to envision in full is the training of the doctors in medical schools where they are prepared to face a medical specialty in teaching hospitals, forgetting about the greater demand of attention at the first level of attention and forgetting specially the ethical formation of the doctors. We need to remember that our formation with moral principles, social values at home and in our family consolidate our ethical actions as individuals and we consolidate this with the formation in schools and hospitals. As in pediatrics THE KIDS LEARN WHAT THEY SEE... the adult doctors in formation also add the bad or good medical example to their professional actions in the future. If the teachers (and all the teachers mentioned herein) act with no professionalism and with personal ethics codes and not dedicated to impact in the wellbeing of the patient, the learning alumnus will learn the same mistakes and are and will become, the doctors that asses us and literally those we will face, like ROMA, when we fall ill.

3. Case 2

Male, 70 years old with background of systemic arterial hypertension of some years of evolution, apparently controlled, and smoking 10 cigarettes daily since he was young. The control drugs are unknown. He arrives from his work for lunch complaining of a terrible headache. He stands up suddenly saying he cannot stand the pain and loses consciousness.

He is taken to a private hospital received in the emergency room with a cardiopulmonary arrest. He receives CPR for 10 minutes, with the recovery of heart frequency but not automated breathing, keeping him intubated with ventilation assistance. With the suspicion of ICP and a deep secondary comma, they perform a CAT and pulmonary puncture and a diagnostic of grave subarachnoid hemorrhaging [17] WITH VENTRICULOMEGALY, and severe intercranial hypertension. 6 hours later he is declared brain dead. Even so, the family members were asked for authorization to perform an evacuation of the hemorrhaging without any explanations given and is subject to surgery with primary decompressive craniectomy. Inexplicably, the patient is pronounced dead after the surgery. The costs associated with the surgery were included in the invoice of the wife, also without further explanation [18].

COMMENT.

The patient arrives with cardiopulmonary arrest, secondary to a grave vascular cerebral probably hemorrhagic event. From 35 to 50% of the cases die before reaching the hospital. Once revived, a diagnosis is made of a subcarinal grave hemorrhaging with ventricular dilation and intercranial hypertension and braindead at 6 hours of live. The first critique of the case arises because a lumbar puncture was performed with the risk of worsening the bleeding of an extremely grave patient and by the conditions of his admission, with a very bad prognosis, with the hospital resource of a tomography (negligence, inexperience, and recklessness as medical acts committed at one moment) and the worst part, having already diagnosed with encephalic death, all medial heroic treatments should have been suspended and especially surgical, which lack therapeutic basis in a patient in those conditions (lack of medial professionalism, lack of medical ethics with unjustified therapeutic cruelty for the patient, absolute negligence and commercialization of the medicine for charging procedures in a patient declared with encephalic death which is an irreversible condition and therefore is not a candidate to be kept under vital support (unless he is an organ donor) and even less to be subject to surgical medical treatment).

4. Case 3

The NICU of a hospital receives a concentration phone call regarding the arrival to a second tier hospital, of a patient pregnant with triplets, preeclampsia, and premature labor of 27 weeks of gestational age, the phone call is to request 3 places in the NICU that is at the time, at its maximum occupancy, without expectations of discharges in a week nor internal movements to free spaces. It is suggested to start specific treatment to the mother and transfer her urgently to an obstetrics and gynecological hospital with the capacity to provide assistance to the mother and to the newborns. Unfortunately the specific treatment is started, she is not transferred, and the birth occurs one week later, rendering 3 premature newborns with the need of neonatal intensive care unit assistance because of their prematurity and respiratory distress syndrome on top of complications for not reviving the adequate attention for having full occupancy and for not transferring them to a third tier attention or high specialty hospital and the newborns start dying with a difference of days before the impotence of the doctors and despair of the parents.

COMMENT.

The correct thing would have been to transfer the patient at risk of a premature labor in a timely manner to a unit with the adequate infrastructure for the attention of her problem and of the triplets at birth. Not doing so caused the death of the neonates that required assistance in an intensive care unit due to their base problems for being premature and the inherent complications to the inadequate treatment. In this case, there was medial institution liability, negligence for not doing what was supposed to, recklessness by taking decisions that put in high risk the lives of the patients clearly exemplifying a malpractice. What is evident in the case of the newborns is an absolute lack of prenatal control by the obstetrician to evaluate the state of mother's health or illness, of the product or products, and its channeling to specialized centers in case of finding pathologies that would rendered it necessary and consequently and the lack of communication between the obstetrician and the doctor who would attend the babies at birth. If the latter would have existed, together they could have made a diagnostic-therapeutic strategy to favor the adequate evolution of the pregnancy and a better birth. There are many problems that impact the pre-natal and post-natal periods; if the mother is under the legal age, if there is malnourishment, obesity, diabetes, hypertension, cardiac or renal

disease, multiple pregnancy, etc., prematurity, pulmonary, diaphragm, cardiac, and nervous system disease in the product, malformation or genopathies, etc. are problems that should be detected by the doctors who treat pregnant women, that are not necessarily obstetricians, and they should inform is to the doctor that receives the product, that is not necessarily a pediatrician or neonatologist [19, 20].

5. Final comment

Without the intention to demonize the doctors of these cases and in the understanding that we are only analyzing the medical action over the information given, it is clear that an emergency must be immediately treated to reduce suffering, pain, stabilizing, to make diagnosis, and decide the best therapeutic conduct pursuant to the expertise and skills of the doctor and the hospital infrastructure, and to the benefit of the patient in order to improve, cure, mitigate, or offer palliative care as the case may be.

There is doubt in the three mentioned cases whether the doctors that intervened were able, prepared, experimented, organized, with knowledge of the protocols, ethic, and if they made the best decisions for the benefit of the patient, but if the place where they are found does not have the resources and infrastructure required for treatment, there is institutional negligence. We can only state for a latter reading, that the reader makes and additional exercise assessing with their own judgment each of the cases and think what they would have done in each one to make a *lex artis*.

In the cited cases there are details that move the doubt on whether the medical act was the appropriate one and if, in ourselves, a bad decision is possible, even more in the patients and family members that are misinformed and miscounseled [21].

Lets go back to the humanistic medicine, lets fight medical commercialism at the cost of the patients and take back the well-respected social standing of centuries ago.

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