SYMPOSIUM CLINICAL ETHICS IN THE PRACTICE OF GYNECOLOGY AND OBSTETRICS

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Symposium Clinical Ethics in the Practice of Gynecology and Obstetrics

Simposio Ética clínica en la práctica ginecobstétrica

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Prologue to the Symposium

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This is the third ethics symposium published by the Peruvian Journal of Gynecology and Obstetrics (RPGO) in the last 11 years, given the importance of this discipline for medical practice, especially for the gynecologist-obstetrician[1,2]. Because of the topic's transcendence, the Peruvian Society of Gynecology and Obstetrics (SPGO) hosted an event in 2009, highlighting various issues in sexual and reproductive health ethics[3]. That same year, the Society participated in a Values Clarification Workshop in Trinidad, Bolivia[4].

While it is true that scientific knowledge and skills are key to the physician's training, the ethical component has a central role. Since the beginning of medicine, it is said that Hippocrates coined the idea "first do no harm" (primum non nocere), in the same way that he recognized professional secrecy as a must in the doctor-patient relationship[5]. The practice of medical paternalism was standard for a long time, until ideologies began to change by the mid-twentieth century.

After World War II, the Nuremberg trials (1947) incorporated the person's right to autonomy to decide about diagnostics, therapeutics and experimental medicine[5]. Later, the World Medical Association issued the Declaration of Helsinki, which recognizes the right of persons to receive qualified medical attention and the importance of Ethics Committees[6].

Potter, a pathologist, initiated a radical change in the ethical doctrine with his publication "Bioethics, the science of survival"[7]. In response to alleged abuses by medical practitioners towards their patients, the Congress of the United States of America created a special committee that, in 1978, wrote the Belmont report, where they recognized three bioethical principles: autonomy, beneficence and justice[8]; the following year, the principle of non-maleficence, proposed in the publication by Beauchamp and Childress, was also included[9]. This is the origin of Principlism in Bioethics. The criticism to this initial set of principles caused other principles to be progressively added.

As we can see, the ethical framework of medical paternalism transformed into an ethical framework based on individual rights, where the principles of bioethics take place. Within this framework, the International Conference on Population and Development, held in Cairo, recognized Sexual and Reproductive Rights[10], which were reiterated at the following year's conference in Beijing[11].

In Peru, the General Health Law of 1997 recognizes the individual right to autonomy, medical confidentiality, conscientious objection and some aspects in sexual and reproductive health[12]. In the same way, medical and other institutions have developed activities recognizing sexual and reproductive rights, particularly in their ethical dimension.

Within this framework, the SPOG and, specifically, the Editorial Board of the Peruvian Journal of Gynecology and Obstetrics, following the doctrinaire and theoretical aspects of medical ethics, have developed this symposium, proposing a reflection around allegations of ethical misconduct against some physicians.

For this, we have chosen cases from ethical files, with knowledge and oral approval by the president of the Ethics Committee and the Dean of the III Regional Council of the Peruvian Medical Association (CMP). We provide a summary of the facts, protecting the anonymity of those involved and the institutions where they occurred. These cases were presented to four prestigious physicians who did not belong to the specialty of gynecology and obstetrics, to avoid biases. The first of them elaborated on general issues about medical ethics and the responsibility of ethics committees, and the other three colleagues commented each of the cases from their perspective, building upon the Code of Ethics and Deontology of the Peruvian Medical Association[13].

On behalf of the Editorial Committee of the RPGO, we express our deep appreciation to our invited guests to this Symposium. We leave to you the reading of this document, which will surely be useful to your medical practice.

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The ethical responsibility of the physician

Alfonso Mendoza F.

I. Ethics and moral

The moral dimension is a characteristic aspect of human beings[1]. Life in community, life itself, would not be possible if its people did not follow rules regulating their interactions. Resulting in habits and customs of a collectivity in a determined time, these rules change and evolve influenced by variations of various factors, from the weather to the questioning and criticism that may appear within the same community.

Ethics is the science of moral action. It examines the morality of human actions[2], as well as the will for goodness that gives meaning to the human praxis. In other words, ethics seeks to identify the criteria by which an action can be classified as good. Ethics does not dictate what is good, but how an action can be considered good. Despite these differences and because both words name the same concept (ethos in Greek and mores in Latin), some people use both terms indistinctively[3].

II. Medical ethics and Bioethics

As with other professions, medical ethics are applied ethics. Due to this, the Code of Ethics and Deontology of the Peruvian Medical Association[4] highlights in its declaration of principles that "the goal of medicine is to respect life and achieve the highest quality of life", and that its actions "are based on recognizing the dignity, autonomy and integrity of people". The declaration also notes that "medical ethics guide the behavior of physicians toward good, righteousness, ideals and excellence", and that the deontological rules of the medical order "establish what physicians should and should not do" in their relationships with one another and with their patients. The statement finally adds that "following this guidance and rules guarantees an autonomous, integral and dignified professional exercise [...] in the framework of respect toward patient rights".

The development of science and technology has, in general, expanded the role of medicine and physicians. However, this technological adventure has not evolved along with an ethical reflection, thus endangering the sustainability of life. Bioethics emerged in response to this. Since Potter introduced the term, according to Martínez[5], "it became a space for social and multidisciplinary reflection regarding the use of scientific and technological development in nature and in people's lives", so that conduits and criteria that channel technological development are established "to protect the dignity of people and of what society deems as valuable".

In the year 2000, the Peruvian Medical Association incorporated into its Code developments such as the bioethical principles, patient rights and the social responsibility shared by physician, society and State, with the aim to ensure people's right to health. The Association also promoted training in the principles and methods of clinical bioethics, while organizing actions in support of quality and safety improvement in patient care and prevention of adverse events.

III. Ethics committees

The medical act is highly complex; part of our duty as physicians is to consider patient values and rights within our decision-making process. One important expression of this is the informed consent. On the other hand, values may often conflict in various clinical situations, so procedures that identify the most adequate solution for each case become necessary.

This is the reason for being of Bioethics Committees, which include health care ethics and research ethics committees, among others.

Healthcare ethics committees are multidisciplinary teams composed of physicians, nurses, social workers and non-specialized people from both sexes. Ideally, at least one of the members should have training in bioethics. These committees are not legal organizations and their function is to analyze, balance and evaluate moral problems proposed by physicians regarding a case; as a result of their discussion, the course of action that preserves the most important value or values is suggested. In this way, it reinforces adequate decision making while emphasizing that medical actions always imply values, which cannot be ignored if one strives for a professional practice marked by excellence and respect towards dignity and human rights. While commit-

tees' resolutions are not binding and do not substitute a court of justice, Gracia points out that (6), if a healthcare ethics committee "makes a decision after mature reflection, it is unlikely that the judge, should it be the case, would not assume said decision as their own".

IV. The importance of the method

Drane[7] remarks that medical ethics deals with situations that imply some difficulty, so an adequate strategy and method are required. The method provides a framework for discussing from several viewpoints, in response to our plural society, where people adhere to different moral systems. Nevertheless, he clarifies, the method does not guarantee infallibility. In any case, a committee can prevent grave mistakes.

To illustrate the importance of the method, we will consider Gracia's course of thought in his analysis of deliberation[8], based on Aristotelian Ethics, which lies at the core of the ontological or principlist method, which will serve as an illustration of the importance of the method.

According to Gracia, deliberation "is reasoning before making practical decisions and aims to know if something concrete can and must be done". Deliberation stems from principles, so it should use speculative reasoning; however, since it has to assess particular situations, it uses practical reasoning. This type of reasoning is characterized by the prudent consideration of the circumstances surrounding the evaluated situation. The stark degree of uncertainty of this situation explains why, despite rigorous logical reasoning, deliberation by different groups may reach different, even opposing conclusions within the same moral system.

An example is the famous case of "Baby M" from the US, in 1987. A couple had a baby through heterologous insemination and a substitute mother who ultimately declined to give up the newborn after delivery. The case reached the Supreme Court of the state of New Jersey. While we will not develop the topic, we will only mention that the Vatican, through the Congregation for the Doctrine of Faith, stated that the natural order of divine creation should be respected, and that since this order implies the direct sexual union of man and woman without interposition of any artificial medium, assisted reproduction techniques should be considered disordered or bad. This position is considered valid even for homologous insemination and the use of contraception methods.

Gracia also presents a Jesuit priest, Gafo, who justifies the "disorder" that the technique introduces into marital relations as follows: "This is not an impersonal procreation way, but a technological resource within the community of love and life inherent to the couple. The technical act of insemination must be seen in the light of the couple's love and selflessness..." Beyond the case of Baby M, which has multiple moral problems, Gafo justifies the use of this technique in the aforementioned occasions with solid arguments of reason.

V. The ethical responsibility of the physician

The medical profession, which formerly used to receive a sort of judicial impunity, has transformed into one of the most regulated professions by the state, enforced through the Civil and Criminal Codes, administrative regulations, consumer rights and the Code of Ethics and Deontology of the Peruvian Medical Association. Physicians are held accountable for their actions in the light of these norms.

The doctrine of human rights and the principles of bioethics have determined that today, as part of the professional exercise, patient rights have to be conscientiously protected, as well as the rights of all the people implied in the relationship health system-user. If these rights were violated, the professional could be even tried by a court.

Malpractice suits have increased, generating a defensive attitude in physicians that has not only failed to improve healthcare, but has worsened it. On the other hand, as noted by Gracia, "judges have to ask physicians to decide whether an act has been negligent or not; if cases return to the medical field, maybe they should not have left it in the first place".

The Peruvian Medical Association (PMA) has an auditing role upon the professional behavior of its members, and the law grants it sanctioning power. If a member were accused of having allegedly violated the PMA's deontological rules, and the preliminary investigation found evidence of

this, they could undergo an ethical disciplinary procedure, which has a special regulation in the VII Section of the PMA Code (articles 110 to 160). These rules apply to all members of the order, without affecting the disposition of civil and criminal law, and the corresponding administrative policies. The ethical procedure applies foundations similar to those of judicial procedures: presumption of innocence, secrecy, right to appeal, and a properly motivated acquittal or condemning decision.

Evaluating a deontological case also requires a rigorous method, which starts by identifying the main problem and the circumstances where this alleged infringement happens. This requires analyzing the charges and disclaimers, and contrasting the physician's behavior with the Code's rules and the objective duty of care when negligence, imprudence or lack of skill are suspected. Often, it must also consider legal aspects. To define the different moments of the ethical procedure, we recommend reviewing the aforementioned articles of the PMA's Code of Ethics.

Finally, we stress that many of the investigated complaints at the PMA are related with the medical act, alleged negligence in diagnostic and treatment procedures, and tensions and accusations between physicians. Probably, many of these problems could be prevented by strengthening the doctor-patient relationship, by carefully applying the informed consent and, especially regarding adverse events, by equipping health services with the necessary resources for a better organization and function, while introducing and reinforcing healthcare quality assurance systems and prevention of adverse events. Another critical point for preventing these problems is medical schools emphasizing the ethical commitment of our profession as a means to articulate the technical-scientific competence with values of excellence, altruism, responsibility and respect to the dignity and fundamental rights of the person[9,10].

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Presentation of Cases

Summary of case 1

Complainant: Mrs. XX

Defendant: Dr. YY (Gynecologist-Obstetrician)

Context: Medical appointment in Gynecology/ Obstetrics, in a health center

Summary of the complaint

Mrs. XX, a patient, files a complaint to the Peruvian Medical Association (PMA) for physical and sexual assault by Dr. YY during a clinical appointment, on January 16, 2018. The patient screamed and received help from the police and the municipal police, who ultimately took her and the physician to the police station. The case was forwarded to the prosecutor's office.

Summary of the defendant's defense

The defendant presents arguments and documentary evidence, as well as a CD with pictures and videos.

According to his defense, the complainant assaulted him psychologically and physically because he did not agree to provide a prescription for tramadol and benzodiazepine. The pictures and video show the assault and that the complainant threats the physician. The events take place in front of the center's security guard. Agents of the municipal police and the police are called in; the policeman decides to take both to the police station. Mrs. XX reports in the police station and in the prosecutor's office that the physician tried to rape her. During the audience with the prosecutor, the complainant is informed that her account of the facts has contradictions. Medical examination of the complainant reports no external lesions. The court dismisses Mrs. XX's allegation.

Dr. YY also presents copies of other complaints filed against the patient.

Comment by Dr. Marta Rondón

Analysis

In this case, we have a patient who reports a gynecologist-obstetrician for alleged rape. The circumstances of her account are confusing. What was the symptom that motivated the appointment? Why was she attended by a gynecologist-obstetrician? Where was the office's support staff? What was the security guard's reaction?

Women who suffer from substance abuse are particularly vulnerable regarding the respect and protection of their rights, including the right to health.

Benzodiazepine use starts by a medical prescription and is maintained by the government's incapacity to regulate pharmacies.

Women who consume addictive substances are exposed to violence in an almost linear way, especially through sexual abuse in their childhood and adolescence. The patient in this case could have been a victim of sexual violence. Thus, physicians and legal and protection services need to improve their approach to these women.

While we may consider that the effect of addiction on the central nervous system compromises the woman's autonomy, it is our moral obligation to act in the benefit of the patient in terms that she can understand, beyond the interests of the health center, physician, or society as a whole.

Additionally, we have to consider the great power inequalities at play against the patient: the physician is imbued in authority and knowledge, so he can deny the prescription, with cameras, videos and a security guard to his disposition. He is also assisted by the police when facing this woman, who has a disease that interferes with her capacity to negotiate her demands and control her impulsivity.

When a woman complains about sexual violence, it is our duty to listen to her and lend credibility to her claim. While it is possible that, in this case, the patient lied about the attempted abuse, this is generally not the case. It is very abusive to disqualify a woman's complaint because she has a mental disorder (i.e. substance abuse) and it sadly reflects a frequent practice in the health community worldwide.

In the case we examine, the healthcare provided was not adequate: there was no support staff nor relatives to accompany the appointment,

but the security guard; the attending physician did not succeed in empathizing with the woman and failed to build a cordial relationship of mutual trust that would have prompted an appropriate transfer; finally, the interaction resulted in a scandal (a trauma for the patient) that even revisited the patient's past (previous complaints). All this hurts the patient's dignity. On the other hand, the patient's lawyer did not present former complaints against the physician, nor evidence of any sexual violence incidents in the establishment.

Finally, the patient did not receive all the care she needed: referral to a mental health professional specializing in addiction.

Conclusion

In this case, the patient did not receive an ethically adequate attention.

The solution given to this conflict is based on an "acute ethics" reasoning, used in situations where the chance for a mutually respectful conversation has been lost. Thus, it is decided to file a complaint against the woman and abandon her, without providing the adequate care, while protecting the physician from the allegation of sexual misconduct. The messages for physicians and patients are terribly wrong and discouraging:

1. Women are not believed because they are lying drug addicts

2. Women do not complain because they will be stopped by the security guard and the policeman

3. Women with a mental disorder are defenseless against the health system

"Preventive ethics" are an opposite way to resolve an ethical conflict. Here, patient consent and negotiation are a continuous process, and "respectful persuasion" is a clinical strategy one may recur to if necessary. These actions and frequently consulting an ethics committee, are intended to prevent acute ethical conflicts.

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Comment by Dr. Alfredo Benavides Zúñiga

Analysis

According to the PMA's Code, any natural or legal person or institution may present complaints against members regarding alleged assault for the corresponding process in the Peruvian Medical Association. In the absence of any of them, the procedure may take place ex officio.

In this case, the complaint was filed by a citizen. Such situations are referred to in the article 5 of the Code of the PMA. The complainant is a patient who was attended in a health center, with an apparent conflict between the complainant and the physician, requiring participation of the security guard and the police, ensuing a criminal lawsuit and an ethical complaint.

The complainant accuses the doctor of alleged attempted physical and sexual assault, which led to the transport of both complainant and physician to the police station; afterwards, the patient was derived to the public prosecutor and subject to a medical-legal assessment. The latter reports no physical evidence of lesions or acts related with sexual violence in the patient.

In this case, the physician states that the patient filed a complaint because he did not agree to give her a prescription for tramadol and benzodiazepines. The Committee will investigate the physician's knowledge and participation regarding these statements and will determine if there is a relation between the drugs that the patient had asked for and her behavior, and if these drugs have caused any mental disorder in the patient.

In this stage, the Committee will interview the respondent physician about the circumstances of the medical act, focusing on the age, conditions, history and mental state of the patient during the attention. The physician must explain if the drugs could have altered her emotional state.

The physician will define the circumstances of the appointment, especially why he attended a female patient without having another person, relative or administrative, to accompany the act. This is necessary to prevent a sexual connotation from being added to this situation. The subsequent medical examination performed on the patient revealed no evidence of physical or sexual assault.

The interview to the complainant evaluates the consistency of the arguments she presented, considering characteristics such as further information about the appointment, her personal history and comorbidities. For the sake of objectivity, the complainant may be required to obtain a copy of her clinical documents, such as the clinical history, as established by the Code.

The committee members will consider the lack of direct witnesses to determine if the information given by the complainant and the respondent can be true. The concept "word against word" invalidates both statements as true. The recording presented by the complainant could be an element of proof that contains circumstantial evidence in her favor, which the Committee did not deem important in order to make a decision.

The responding physician presented past allegations by the complainant against other doctors, suggesting that this is a pattern in the relationships she establishes with her attending physicians, which could make the case for a psychological disorder or belligerent personality. Finally, it should be investigated if she uses addictive psychotropic drugs for medical purposes, such as treating mental diseases.

Conclusion

This case deals with conflicts that frequently cause allegations regarding the medical act. These conflicts often reflect a lack of empathy in healthcare providers, whose care is considered discordant with the patient's wishes.

First, the patient filed a complaint of being allegedly assaulted by her attending physician during an appointment. The physician, in his defense, responded that the patient suffered from an emotional dysfunction possibly caused by the use of benzodiazepines and tramadol. He also presented similar past complaints by the same patient against other physicians. The patient-doctor relationship was not achieved, and there was no empathic understanding compatible with quality care provided by the physician. It is indispensable to protect the ethical and moral integrity of the members of the order when there is no evidence against them.

The accusation of sexual assault could be dismissed based on the medical-legal examination finding no physical nor genital lesions in the patient.

The fact that the judicial process still continues should not affect the possibility of filing the ethical process at the PMA. Finally, given that there is no evidence of infringement on the articles of the Code of Ethics of the Peruvian Medical Association, the Committee for Surveillance in Ethics and Deontology will return the case to the Regional Council for its archiving.

Comment by Dr. Eleazar Aliaga Viera

Analysis

First, one should ask what prompted the patient to schedule an appointment. It was a grave error by the physician to be alone with the patient; having an accompanying person is particularly important when a male physician attends female patients. In this case, due to the contradictions in the patient's statement, it is probable that the judicial process did not proceed. Nevertheless, we quote the articles from the Code of Surveillance in Ethics and Deontology of the PMA relevant to this case. The patient could accuse the physician for not performing the scheduled evaluation and for unwelcome touching and acts against public morals.

Conclusion

I consider that, in this case, the articles 58 and 63, section i of the Code of Ethics of the Peruvian Medical Association have been infringed.

First section: about the ethical principles in medicine

Title I: declaration of principles

Numeral 1. The role of Medical Ethics and Deontology

Art. 58. The physician has to be alert to the affective intensity that appears when caring for a patient; it is their duty to protect their patient and themselves from the risk of initiating a sentimental or sexual relationship with them.

Art. 63. The physician must respect patient rights, using the most appropriate media to ensure them or their reestablishing, if these had been infringed. The patient has the right to:

Respect for their intimacy and decency, with the power to authorize or not the presence of people who are not directly involved in their attention, without detriment to the care they receive.

Summary of case 2

Complainant: III Regional Council, Peruvian Medical Association (CRIII CMP)

Defendant: Dr. ZZ (Anesthesiologist)

Involved parties: CRIII CMP and physician

Complaint: Providing medical care and medical certificates for diseases outside her scope of practice

Summary of the complaint

On February 19, 2018, the Public Prosecutor sent a letter to the National Dean of the Peruvian Medical Association (CMP) regarding an arbitration process where he was representing the Peruvian state, in dispute with three persons who claimed to be unable to work at an altitude higher than 3 500 masl, based on medical certificates diagnosing the following conditions: asymptomatic second-degree heart block, mild to moderate pulmonary fibrosis of unknown origin and pneumoconiosis. The Public Prosecutor asked the CMP to determine which medical specialty is required to give these certificates. The Dean responded with the corresponding specialists on March 15, 2018.

On March 23, 2018, the Public Prosecutor asked the Dean of the CMP if it is within the scope of practice of an anesthesiologist to diagnose these diseases. If not, he required the CMP to proceed with the corresponding process.

On April 4, 2018, the Dean presented the case to the CRIII for it to determine the course of action.

On May 18, 2018, the Secretary of the CRIII sent the findings to the Ethical Surveillance Committee for it to determine if it was appropriate to begin an ethics investigation against Dr. ZZ.

On June 25, 2018, Dr. AA informed the Dean of the CRIII that the Ethical Surveillance Committee had decided to begin an ex officio investigation against Dr. ZZ; this was approved by the CRIII.

Summary of the respondant's statement

On August 10, 2018, Dr. ZZ presented her written statement to the CRIII. Here, she claimed to have seen the patients as a general physician upon their request. She formulated the presumptive diagnoses in the certificates and recommended the patients to visit the corresponding specialist. In this statement, she claims that she did not know the certificates would be part of a judicial proceeding with our State.

Comment – dr. Marta rondón rondón

Analysis

Article 96 of the Code of Ethics and Deontology of the Peruvian Medical Association states that "the certificate is a medical-legal document. The physician must write it in a clear and precise manner, including the purpose it is intended for. The physician should not issue a certificate attesting a medical act that was not performed, nor expressing false, inaccurate or biased information."

If the colleague had not established what the certificate was going to be used for, she worked with an incomplete story, lacking sufficient data to issue a medical certificate, which is a medical-legal document.

On the other hand, article 20 clearly states that a physician should not provide care outside their scope of practice, unless it is an emergency, or in the absence of another specialist, or upon express request by the patient.

If the patients had expressly requested that Dr. ZZ attended them, the principle of beneficence compels us to at least tell the patient about the medical specialty that can best resolve their discomfort or demands (in this case, a certificate); in other words, a pulmonologist.

The principle of justice has been violated in this case: the right to a medical certificate supporting medical leave should be available to all who need one. On the contrary, by issuing inappropriate certificates, the colleague privileges her patients, or damages them with a document of questionable validity. The hypothetical right of these patients to health protection from hypoxia would have been protected better if the anesthesiologist had referred them to a pulmonologist.

Conclusion

We can assume that the colleague did not act with due diligence. It is important to anticipate the possible repercussions of medical acts and behave ourselves in accordance with the current code.

Comment - dr. Alfredo Benavides Zuñiga

Analysis

One of the most used documents in the patient-doctor relationship is the medical certificate, issued by the medical professional as an evidence of a deteriorated health state for third parties, especially the employer, to justify work absence. However, it covers many situations and receives various names, such as health certificate, certificate of temporary inability to work and private medical certificate, depending on the place and person who issues it. Complaints related to ethical transgressions regarding medical certificates are an important problem in the CMP's record.

This case is an ex officio complaint presented by the National Council of the Peruvian Medical Association (CMP) to the III Regional Council (CRIII) upon learning about a process started by another organization at the Public Prosecutor office against an anesthesiologist of the jurisdiction, for issuing health certificates that were questioned and investigated by the judiciary. This is in accordance with the following articles in the current statute of the CMP: article 132 about ex officio complaints, article 48.18 about the National Council's competence, and article 72.2, on initiating a disciplinary ethics process.

The Public Prosecutor deems the diagnoses prescribed in the medical certificates by the accused physician as inaccurate in the occupational context. The processes, namely a cardiac disease (asymptomatic second-degree heart block) and respiratory diseases (fibrosis and pneumoconiosis), are conditions with a long period of premorbidity that require clinical examinations and tests that should be performed by cardiovascular specialists, a pulmonologist or an occupational physician.

The importance of a qualified specialized opinion in the healthcare process is clearly established in the Code of Ethics of the CMP, chapter 3: regarding specialized work. Article 20 guarantees the suitability of the professional act and its impact on the patient's wellbeing, considering its ethical, legal and occupational consequences, as well as other aspects in Peruvian society.

While there are no precisions detailing the "ideal" model for a "particular" health certificate, the government organization SERVIR has recently issued the General Management guidance N° 015-GG-ESSALUD-2014, Regulations and Proceedings for the Emission, Registration and Control of medical certificates. This document asserts that the certificate is a document issued by physicians after an appointment upon the patient's request; it aims to inform the diagnoses, treatment and required rest period, to provide a license for incapacity caused by disease or common accident. The medical certificate has to provide the following: 1) full name of the patient; 2) descriptive diagnosis; 3) date of beginning and ending of the incapacity period; 4) date of issuing of the medical certificate; 5) signature of the health professional, consistent with RENIEC; 6) legible seal of the attending health professio-

nal; and, 7) in case it was issued overseas, it will need an endorsement or apostille by the corresponding consulate. Following these 7 simple requirements will prevent those issuing certificates from committing errors like those in the case reviewed.

Conclusion

According to the Royal Spanish Academy, the medical certificate is a document that guarantees the truth about a medical fact with judicial transcendence, regulated by sanitary statutes and of public order; in order words, it is of legal interest. The General Health Law 26842 has no definition for medical certificate. Nevertheless, it regulates it as a right and as an attribute of the professional practice of health, just like the medical act presented here, with important legal consequences.

The defendant physician issued certificates that were outside her scope of practice because her specialty is allegedly not linked to the diagnoses she listed; this occurred in a geographical area where there are other specialists of the diagnosed diseases. For these reasons, it is considered that the physician has infringed the Code of Ethics of the CMP, article 96 regarding the medical-legal certificate, and Chapter 3 regarding specialized work. Article 20 states that the physician must refrain from attending patients whose condition does not lie within their area of expertise or specialty, unless it is an emergency, or upon express request by the patient, or in the absence of the corresponding specialist.

The defendant's declaration is that she evaluated the 3 patients as a general physician upon their request, she reached the presumptive diagnoses noted in the certificates and recommended them to visit a specialist; she did not know that the certificates would be part of a judiciary process against the Peruvian State. The Code establishes in article 117 that claiming ignorance of the statutes of the CMP is unjustifiable.

Comment - Dr. Eleazar Aliaga Viera

Analysis

In this case, the physician issuing the medical certificates advising against working at high altitude is specialized in anesthesiology. According to her statement, she attended the patients upon their request; however, the diagnoses in the certificates (second-degree heart block, pulmonary fibrosis mild to moderate of unknown origin and pneumoconiosis) do not correspond to her specialty. The physician adds that she recommended the patients to visit a specialist.

In her statement, she also says that she did not know that the certificates would be used in a process against the Peruvian State.

Conclusion

In my opinion, in this case, the Code of Ethics and Deontology of the CMP has been infringed in the following items:

Section one: regarding the ethical principles of medicine

Title I: declaration of principles

Numeral 1. The role of Medical Ethics and Deontology

Numeral 7. The institutional and social compromise of the physician

Section two: regarding the deontology precepts in medical practice

Title I: Regarding The Medical Practice

Chapter 3. Specialized Work

Article 20. The physician must refrain from providing care for patients whose condition does not belong to their area of expertise or specialty, unless it is an emergency, or upon express request by the patient, or in the absence of another physician.

Title III: regarding medical documents

Chapter 2. About The Medical Certificate

Article 96. The certificate is a medical-legal document. The physician must write it in a clear and precise manner, including the purpose it is intended for. The physician should not issue a certificate attesting a medical act that was not performed, nor expressing false, inaccurate or biased information.

Summary of case 3

Complainant: Mrs. PP

Defendants: Dr. NN, Dr. MM

Parties involved: Postoperative patient and two physicians

Reason for the complaint: Alleged malpractice

Summary of the complaint

On August 14, 2018, Mrs. PP presented a written statement with the following facts:

1. On October 13, 2017, I underwent a myomectomy performed by Dr. NN and Dr. MM in a hospital. Due to an inexcusable mistake, they left a foreign body (gauze) inside. I was discharged two days later and told that the hysterectomy had been successful.

2. Unfortunately, a few days afterwards, I experienced severe pain in the operated area, fever and malaise; this led me to return to the hospital several times. I was readmitted on November 25 because liquid appeared in the surgical wound. On this occasion, several tests were taken: ultrasound, CT scan, bowel transit time, colonoscopy. Through these tests, a foreign body was detected. Upon pressure by my family and the media, I underwent a second surgery on December 21, where one meter of the small intestine and 10 cm of the large intestine were removed. Currently, my health is compromised, and I have to deal with important expenses.

3. Given this situation, I presented a complaint to the director of the hospital and the Office of the Ombudsman. I was able to obtain the audit report of my case, which identified several deficiencies. The differential diagnosis of foreign body was not considered despite the imaging reports from November 29 and November 30. The surgical team was composed of the surgeon (Dr. NN), an assisting physician who was not a specialist, and an instrumentalist who was not a nurse.

4. Based on the exposed, I can add that my health problems persist due to the negligence of the physicians who performed the hysterectomy; because of this, I request the corresponding disciplinary sanctions.

Her complaint includes:

- Criminal complaint against the physicians
- CD with images of the case
- Newspaper clipping
- Complaint to the Director of the Hospital
- Letter to the Office of the Ombudsman
- Copy of the medical audit report that mentions a finding of a foreign body in the second surgery (macerated 15 x 50 cm gauze). This finding was never communicated by the physicians to the patient

Summary of the defendants' response

1. **Response by Dr. MM**

On September 12, Dr. MM presents her written response, expressing the following:

On October 13, 2017, while being on call in the hospital, I was summoned to a gynecologic surgery that required a general surgeon because of an adverse event.

I went to the operating room, where Dr. NN, who was the main surgeon, informed me that he had found an 8 cm laceration in the serosal layer of the sigmoid colon, after liberating flanges and pelvic adhesions. I sutured the wound.

After suturing the serosal layer of the sigmoid colon, I examined the intestines and did not find any lesion. Throughout this procedure, I used a 50 x 50 cm dressing gauze, which I removed once my intervention was over. My participation lasted 15 minutes; after this, authorized by Dr. NN, I left the operating room.

I clarify that I was not part of the surgical team programmed for the hysterectomy. I only participated for a short time upon request by the attending surgeon, Dr. NN. I did not participate in the sponge count because I was not present before nor after the surgery.

The patient was reoperated on December 21, 2017. This procedure consisted in a laparotomy, foreign body (textiloma) removal, abscess drainage, resection of fragments of ileum and colon, suturing of vesical wall, resection of the fistulous tract from intestine to skin, and colostomy.

2. **Response by Dr NN**

On September 17, 2018, Dr. NN presents the following written statement to the CMP:

The patient is a 38-year-old woman with history of 4 previous pelvic surgeries, diagnosed with uterine fibroid. She gave her informed consent and was programmed for an abdominal hysterectomy.

The surgical team was composed of Dr. NN, Dr. RR (a resident), Dr. SS as first assistant (a resident), TT as instrumentalist (a circulating nurse), and Dr. UU, anesthesiologist.

In the abdominal hysterectomy, we dissected multiple adhesions. The uterus was removed and an 8 cm laceration of the serous layer of the sigmoid colon was found. At this point, a new count of surgical material and gauzes was required; the gauzes were complete. The general surgeon on call was contacted; Dr. MM operated upon request and sutured the laceration of the serous layer of the sigmoid colon. Once the intervention was over, we made a new count of surgical material and gauzes, which the nurse reported as complete.

On November 25, 2017, the patient was readmitted to the Department of Gynecology due to a surgical wound infection and was then transferred to the Department of Surgery, where the following diagnoses were established: enterocutaneous fistula and surgical wound infection.

It is completely false that we left a foreign body (forgotten gauze) inside the patient. The surgeon in charge of the second intervention declared that he did not find any gauze.

The surgical schedule is made by the management of the Department of Gynecology and Obstetrics, which includes Human Resources.

The enterocutaneous fistula that the patient had two months later is of unknown origin; this condition should not affect the assessment of the surgery we performed.

I request that this complaint is closed, as well as the opportunity to present this situation to the Ethical and Deontology Surveillance Committee.

The gynecologist added documents from the clinical history including the operative report of the first intervention, the pathology report of the second operation, which describes a 60 cm long portion of small intestine, containing a granulomatous reaction to foreign body.

In the clinical audit, it is mentioned that during the second intervention, a foreign body, compatible with a 15 x 50 cm gauze, was found.

Comment - Dr. Marta Rondón Rondón

Analysis

In this case, the patient complains about a gynecological surgery complicated with an enterocutaneous fistula and a foreign body granuloma; said patient presents a criminal complaint against the surgeons who operated her in the first surgery. She underwent a second surgery, after seeking help in the media and even at the Office of the Ombudsman.

This is a scandal.

The responsible for the first surgery is obviously Dr. NN, who was the attending physician, obtains the informed consent and leads the surgical act. Dr. MM's participation is circumstantial and the accounts of both show that she did not forget the gauze.

Article 61 of the Code of Ethics and Deontology says: "The surgeon must program a surgery only when it is a necessary alternative, with a positive risk-benefit ratio and adhering to predefined institutional protocols or to lex artis."

In this sense, the management of the mandatory Surgical Safety Checklist seems to not have been correct because, despite what says Dr. NN (complete sponge count), a gauze was found.

In this case, we see the incapacity of a surgeon to admit an error and to correct it as soon as possible, in an attempt to avoid hurting the patient. This, in turn, only extends her suffering.

In other words, he violates the principle of non-maleficence, which is the minimum we expect from a physician.

His actions put his colleague MM in an unfair situation, because he is the one accountable for the surgery. The incongruence between the allegedly "complete" sponge count and the pathology finding of a gauze, informed by the audit report, does not imply that NN lied. We do not know how the checklist was managed, and the nurse could have made a mistake. Ultimately, the medical-legal professional in charge is Dr. NN.

In this case, the most serious flaw is that Dr. NN did not respond soon to the postoperative complaints of the patient, thus forcing her to go to the media. By doing this, he caused a social damage, contributing to the depreciation of the medical profession and health system in the eyes of the citizens.

The intervention of the Office of the Ombudsman can be interpreted as an incapacity or lack of will of the health center to protect the patient's rights over the convenience of the institution and the privileges of its members. These situations hurt the essential trust that, if one requires health services, these will be adequate and opportune.

An adversarial relationship between citizens and health system is highly unfavorable for the protection of the rights of both sides; besides, it hinders the implementation of preventive measures, as it has been seen these last weeks.

Conclusion

The patient's interest must be the first concern of the medical act.

The principle of non-maleficence is the minimum expected attitude from a physician. Unlike the principles of beneficence and autonomy, which belong to the private sphere, the principle of non-maleficence is public and mandatory and includes the prevention of damage or pain.

Comment – Dr. Alfredo Benavides Zuñiga

Analysis

In this case, the patient presenting the complaint underwent a gynecological intervention and developed an enterocutaneous fistula two months after the surgery. The results of the pathology report suggested the presence of a foreign body (gauze), which was confirmed in the subsequent pathology report.

The patient had been properly diagnosed and programmed for surgery with all corresponding pre-operative tests and informed consent; she also had a history of previous surgery. As stated by the operating gynecologist, in this programmed surgery, adhesions and an intestinal laceration were discovered. Upon finding the laceration, the gynecologist required the participation of the on-call surgeon, who, according to the report, assisted in the procedure by suturing the corresponding damaged organ. She left the room upon completion of this task. The reoperation, approximately two months later, was due to surgical wound infection and enterocutaneous fistula.

The patient, applying her citizen rights, presented on November 25, 2018, a complaint to the Medical Association, based on the premise that her readmission was a consequence of the previous operation. The Regional Council received the complaint against the gynecologist for complications after the elective hysterectomy he performed on October 13, 2017 (10 months before the complaint); this complaint presented as means of proof a copy of the patient's evaluations with consistent ultrasound, CT scan, bowel transit and colonoscopy, and a strong presumptive diagnosis of foreign body in the abdominal cavity. The complaint also included reports presented to the Director of the Hospital and to the Office of the Ombudsman, as well as an audit report pointing out several deficiencies that led to a reoperation on December 21, 2017.

The physicians respond to these claims. Dr. MM, on-call surgeon on the day of the procedure, stated that her participation was required by the gynecologist during the surgery, complicated by

adhesions in the patient and an 8 cm laceration in the sigmoid colon. She performed the suture. Her participation lasted 15 minutes, after which she left the gynecologist with his team. Finally, the general surgeon clarifies that the patient was reoperated on December 21, 2017 by laparotomy, removal of foreign body (textiloma), resection of a fragment of ileum and colon, suture of vesical wall, fistulectomy and colostomy.

This statement provides further details. The patient was a 38-year-old woman with a history of undetermined pelvic surgery, programmed for myomectomy. The surgical team was comprised of medical staff and residents. The findings of the operative report describe an operative area complicated by multiple adhesions. During the hysterectomy, a surgical laceration in the serous layer of the sigmoid colon was detected; this laceration required the intervention of the surgeon on call, who successfully sutured it. The sponge count at the end of the surgery and the nurse report described the count as "complete". The responding gynecologist informs that he considers the enterocutaneous fistula to be "of unknown etiology", emphasizing as false the fact that a foreign body (gauze) had been detected.

An audit report mentions the existence of a foreign body compatible with a 15 x 50 cm operatory gauze.

On the matter of retained foreign bodies, specifically surgical gauze, some studies establish a time for diagnosis of one month after the initial abdominal open surgery. All reported cases required admission and reoperation, and had complications such as intestinal resection, enterocutaneous fistula, abscesses, reoperations and sepsis. This event can put patient safety at a higher risk by increasing the risk of morbidity and mortality, as well as costs, thus affecting the health system and the economy of patients and their families, beneficiaries of corporate institutions. The health staff must recognize it as a mistake and apologize directly to the patient; the hospital must pay for all the expenses. The hospital bearing the cost of this mistake promotes the integration of the event as a fracture of the system.

These events are underreported and their diagnosis is based on imaging, generally a simple X-ray; CT scan and ultrasound are confirmatory. Risk factors include emergency surgery, changes in the programmed surgical procedure and body mass index, the change of nursing staff during the surgery, fatigue of the team and surgical shift. A culture of surgical safety is fundamental; several publications about safety culture in the surgical team list inadequate communication and lack of protocols for sponge count as risk factors.

Rather than practical skills or resources at hand, a retained foreign body is the unwanted result of a process dependent of the surgeon's diligent care, according to many cases and the literature. The Code of Ethics of the CMP, Title I: Declaration of principles, establishes that, when providing healthcare, the responsibilities that the physician and health system must observe have to be linked to the conditions of certainty, as well as the means and resources that scientific medicine or lex artis calls for. They have the duty to perform the medical act in a diligent way. Meanwhile, the society and State are responsible of providing the best means and resources available for said purpose, in an equitable manner.

In this case, the evidence of the audit report mentioning a gauze has probative value for its existence and complications after the hysterectomy. Despite the nurses' sponge count in the operating room, the physician or the surgical team could have prevented the generation of damage. According to article 52, Chapter V: About attention and care of patients, this is an exclusive responsibility of the physician that cannot be delegated to other professionals when providing medical attention.

In the same way, one must consider that not all lesions from surgical procedures or medical activities are linked to medical errors. The main insight from this case is that, once committed, especially if some degree of medical responsibility is established, the error must be faced with integrity and transparency. This last comment is linked to the obligation of the physician to provide medical care, as established in the article 66 of the Code of Ethics that says "the physician must provide careful attention, taking the necessary time according to the nature of the clinical problem".

In the present case, the respondent systematically denies the presence of a gauze as the cause of the

complications (abscess, foreign body granulomas and iatrogenic colostomy), despite information suggesting the contrary. There is an ethical transgression of article 63, section d of Chapter 2: Regarding the respect for patient rights, which requires the physician to provide the patient with accurate, opportune and understandable information about their treatment.

80 to 90% of the cases of enterocutaneous fistula are postoperative, frequently after an urgency surgery. They are usually secondary to anastomosis dehiscence or intestinal lesions unnoticed during the first surgery. In this case, suturing the serous layer of the sigmoid colon could have been related to the complications, or at least have contributed to the retained gauze. In any case, the procedure should be considered as a less important factor, not as the main cause.

Conclusion

It is clear that there is a presumption of transgression of the Code of Ethics of the CMP in the Declaration of Principles of the Responsibilities in Health Care, numeral 6, in the article 52, related to the Medical Act, which states in section d the exclusive responsibility of the physician, and article 63, related to the Respect to Patient Rights, section d, which defends the patient right to obtain all the accurate and opportune information about their diagnosis, treatment and prognosis.

Comment – Dr. Eleazar Aliaga

Analysis

In light of the evident compromise of the patient and her tests, they should have acted fast and communicated the patient or the responsible person the possibility of complications derived from surgery, which every patient undergoing such a procedure is at risk for.

Besides, the intestinal laceration was already a complication, even requiring the presence of the surgeon on call. It should have been reported as such to the relatives or responsible person.

An aggravating factor is the fact that the audit report mentioned a 15 x 50 cm gauze inside the abdominal cavity, finding that was not communicated to the responsible relative.

In the defendants' responses, the doctor who intervened in the surgery states that she participated in the middle of the procedure, thus relieving herself from responsibility. Meanwhile, the responsible surgeon denies having left a foreign body, despite the existing evidence; according to him, the fistula and intestinal necrosis are of unknown etiology.

Conclusion

I consider that, in this case, the Code of Ethics and Deontology of the Peruvian Medical Association has been infringed in:

Section one: about the ethical principles in medicine

Title I: declaration of principles

Numeral 1. The role of Medical Ethics and Deontology

Numeral 2. The role of Medicine

Numeral 3. The ethical principles and values of medicine

Numeral 7. About the institutional and social compromise of the physician

Article 66. The physician must provide exhaustive, complete care to the patient, taking the necessary time according to the nature of the clinical problem. They must not act in a rushed and irresponsible way, at the expense of healthcare quality.

Article 68. The physician must explain the nature of their symptoms to the patient, or its possible or probable disease, until they have understood their clinical situation, following the principle of therapeutic privilege, which allows the physician to decide the pertinent restrictions. In case of patient incompetence, this information must be provided to the legally responsible person.

Final comment

Dr. Alfonso Mendoza Fernández

The cases have been analyzed by three professionals from different medical specialties with extensive experience in their respective

fields, which is desirable in a deontology committee, to which they contribute not only their knowledge but also with their own perspective, values and unique way to understand medical practice, which will enrich the indispensable discussion of each case.

Case 1

In her analysis of the first case, Dr. Rondón points out that the physician did not establish an adequate patient-doctor relationship, and that he seems to assume the patient's complaint as true, emphasizing that it was a mistake to attend her without the presence of a relative or support staff. In the light of one of the statements presented by the respondent, who showed "copies of other complaints made against the complainant", Dr. Rondón notices: "unfortunately, the patient's lawyer did not present past complaints against the professional", even though nothing points towards the existence of said complaints.

It is true that many women in our country are subject to various forms of sexual abuse and psychological and physical violence; however, accusations of these are not necessarily true. Nevertheless, in a broader perspective, this hypothesis could be explored if there were signs of this kind of act.

Dr. Aliaga agrees with Dr. Rondón and proposes that the gynecologist-obstetrician has infringed articles 58 and 63 of the Code of Ethics and Deontology of the CMP. However, in the light of the data from the summary, it is not possible to accept the veracity of the patient's complaint. As such, a "sentimental or sexual relationship" with the patient (article 58) could not have happened, so we can at least question if her "intimacy and decency" were in fact disrespected (article 73 section i).

Dr. Benavides illustrates us about the importance of the method, and by developing his course of thought, shows us the value of each of the phases of this proceeding, starting by a detail-oriented examination of the facts – a fundamental aspect of the case study, for which one must analyze the clinical history, videos, reports, forensic examinations or audit reports, among other documents, besides the interviews to the involved parties. From this, the committee members propose hypotheses that are the base for the group discussion, considering arguments from both sides and concluding with a duly reasoned and sustained recommendation. This recommendation is then elevated to the higher instance, either the Regional or the National Council, according to the case; after this, the case can be archived or an ethics disciplinary procedure may be proposed, organized by the Committee of Contentious and Disciplinary Matters.

Dr. Benavides highlights that the complainant must present the proof or clues to sustain said complaint, because a testimony is not enough. In this case, the physician is the one who presents proof in his defense: photos and videos. Besides, the medical examination of the patient "found no external lesions", which may have led the Prosecutor to dismiss the complaint. Dr. Benavides reaches the same conclusion and proposes to archive the case.

Case 2

In this case, the three experts agree that Dr. ZZ did not act appropriately. According to Dr. Rondón, article 96 of the Code was infringed; this article clearly states that the medical certificate is a medical legal document that must include the purpose it is destined for, which implies a previous evaluation to obtain the corresponding information. Article 20 was also infringed; this article compels physicians to "not attend patients whose condition is outside their scope of practice", with obvious exceptions, not applicable in this case. For Dr. Rondón, the responding physician should have refrained herself from issuing the certificate and referred the patients to the corresponding specialists. Dr. Aliaga agrees with this.

Dr. Benavides not only agrees with his colleagues that Dr. ZZ infringed the aforementioned articles, but reminds us the articles in the statute stating that one of the functions of the CMP is to "absolve questions", such as the one formulated by the Public Prosecutor (article 48, section 48.18). This authorizes the Ethical and Deontology Surveillance Committee to "begin ethics disciplinary procedures against any member of the order" for infringing the Association's regulations: Statute, Rules, Code of Ethics and Deontology and others (article 72). Dr. Benavides also mentions the article by which the CMP has to complain ex officio in specific cases (article 132).

For Dr. Benavides, "there is sufficient evidence of ethical transgression of articles 96 and 29". Besides, he refers to the norms of the Civil Service National Authority (SERVIR) regarding certificates with the purpose of "license for incapacity caused by disease or accident", and lists the requirements that must be fulfilled in these cases, to prevent problems such as the one we comment.

Case 3

For Dr. Rondón, Dr. NN is responsible. He performed the first surgery, where the problem that gave rise to the complaint was generated. For her, this physician did not follow the lex artis (article 61), this is, he neglected the objective duty of care. Although the error was probably made by the nurse in charge of counting gauze, Dr. NN was leading the surgery and cannot exempt himself from the responsibility of said fault, which infringes the principle of non-maleficence.

For Dr. Aliaga, article 66 was infringed; this article decrees the duty of providing the patient "careful, exhaustive, complete attention", adding that the physician should have explained the patient about the nature of her symptoms (article 68). Evidently, this was not done, since it would have implied admitting a mistake. This aggravated the respondent's situation because errors can happen in the medical practice due to several circumstances, and both the institution and the professional have a moral and legal duty to repair the damage caused.

Dr. Benavides coincides with his colleagues. He mentions the Declaration of Principles of the Code of Ethics (Title I, section 6): "It is their responsibility to perform the medical act in a diligent way"; article 66, which was already mentioned; article 63, about the Respect to Patient Rights, section d, by not providing accurate and opportune information about the disease to the patient; and article 52, which points out that "the medical act is the exclusive competence and responsibility of the physician".

In this case, the evidence is overwhelming. The clinical manifestations and tests revealed the presence of a foreign body. In the second operation, that body was removed, something that Dr. NN denied in his response. Finally, we observe that the audit report informed the finding of a foreign body compatible with a 15 x 50 cm gauze, while the gauze that used Dr. MM was a 50 x 50 cm dressing gauze "that I removed when my intervention finished", as she said in her statement.

Dr. MM, the general surgeon, has no responsibility. She fulfilled the task she was asked to do.

This last case shows the complexity of the medical act and highlights the need to observe the health care provided by the staff when performing diagnostic or therapeutic procedures. It reveals the risks of the professional exercise of medicine, as well as possible adverse events. This is, for example, the origin of the surgical safety checklist and a series of actions oriented to prevent and solve adverse events, in order to protect the safety and quality of healthcare.

On the other hand, the study of each case is a serious challenge to the medical profession. Situations like these are around us and make us confront the problem of the truth. Here, I quote Changeux J.P. (El hombre de verdad, FCE, México, 2002): "What is truth? For Diderot and D'Alembert, it can be defined as 'a concordance between our judgement and what things are in reality' [...] However, isn't it true that people judge things based on their world perspective, on their internal dispositions?" Because of this we have to admit that, even when we try to judge a situation with the highest possible degree of objectivity, there will always be a margin of uncertainty, a place for questioning.