"Our world is about to suffer a catastrophe if a well-thought action is not taken soon" A. Einstein.

Bioethics and a professional conduct

The osteoarthrosis [OA] is the most common joint disease. It is the most frequent cause of osteomuscular disability in developing, and one of the most frequent reasons of limited disability caused by the daily life of adults in general. Although [OA] may affect any joint of the body, the most frequently affected is the knee followed by the hip. The effects of arthrosis in the lower extremities include a reduced mobility and the corresponding loss of independence, as well as an increase of health care needs. OA of the hip has been identified as one of the most important causes of pain that weaken people. The two main categories of hip OA are primary OA (also called idiopathic) and secondary hip OA (result from a defined disorder) [1,2]. Although the ratio of each category is still controversial, the primary hip OA is believed to be the most common one. OA is generally considered as a multifactorial disease involving the interaction of systemic risk factors (for example age, sex, level of hormones, genetics, and nutrition), intrinsic risk factors (for example anatomical variants, muscular weakness, lack of alignment, and joint laxity), and extrinsic risk factors (for example repetitive physical activities and obesity). The risk factors for the progression of hip arthrosis are similar to those associated to prevalence and include systemic factors (metabolic, hormonal, genetic, age, sex), biomechanical factors (mechanic workload), body mass index, acetabular dysplasia, and gravity stress radiographs [1,2].

The coxarthrosis or hip arthrosis is a degenerative disorder of the joint cartilage and its underlying bone that may affect one or both hip joints. It is a common joint disease among the elderly. It is recognized as one of the main causes of pain, disability and social expenditure, and it represents an important problem for public health care around the world [1,3].

The diagnosis of hip arthrosis is based on clinical criteria consisting on hip pain, degeneration of joints confirmed by X-Ray studies. Only hip pain is not a sufficient factor to indicate OA as the majority of people who complain about it do not show clinical nor X-Ray evidence; and not everyone with evidence that confirm the disorder have hip pain. Several systems that study the prevalence of morphological changes of joints have been used through time, and they are roughly comparable. However, there is no gold standard method to mark the X-Ray evidence of hip OA. The first standardized system was suggested by Kellgren and Lawrence (K & L -score) in 1957. Late, their criteria were accepted as a diagnosis method by the World Health Organization. Revisions to this work have tried to tackle some issues about the validity of the original grading system, mainly related to the relative important presence of osteophytes to define OA. Some people think that osteophytes are a natural phenomenon of the bone related to age and remodeling of joints, therefore they should not contribute to the diagnosis of the pathology. Others suggest that the presence of osteophytes is the most specific criteria that leads to the diagnosis of [OA], and are as sensitive as the criteria of narrowing of joints space, above all for hip OA. At least, other 10 X-Ray grading systems for hip OA have been developed since the early '80s. These systems cover almost the same X-Ray characteristics, but some are relatively more important than others. Because the majority of people with X-Ray evidence of hip OA are symptom free, definitions of alternative cases have been suggested [2,3,4,5].

Primitive coxarthrosis is produced in a normal hip, in a person of more than 60 years old and it represents 40% of all coxarthrosis cases.

Secondary coxarthrosis is produced in a hip with dysplasia (with an anatomic malformation), in a younger person and it represents 60% all coxarthrosis cases.

Morphological anomalies are, therefore, the main risk factor of coxarthrosis.

However, we must not forget the excess of weight (overweight and obesity), trauma injuries and micro trauma injuries of contact sports. The professional behavior is included in the concept of bioethics and it is the responsibility and commitment of the health care professional to search for the well-being, therefore, for the recovery of the patient's health [3,4,5].

Presentation of the clinical case

Female patient of 48 years old, single, being revised for having pain in the left pelvic member, discomfort in the left extremity at the level of coxofemoral joint. The patient refers that she has not been under medical evaluation before because of her job. She started having discomfort in that area since April 16, 2013. Because of her work, she came to medical evaluation until May 2 on that same year. She says that she related this pain to sciatic nerve. She was on a job trip and when she was coming back to Irapurato, while arriving to Guadalajara on May 2, 2013 she went the Hospital of Zapopan, Jalisco, Mexico where she got medical care from an specialist in traumatology who analyzed her story and started to evaluate her. The doctor indicated X-Ray studies. After revising such studies, the diagnosis was left coxarthrosis, and the patient was also informed that she was not a candidate for surgery.

She mentions that while she was under observation, receiving an endovenous treatment, the traumatologist leaves and a resident stays with her. This resident asks her questions about her condition and without having enough information about it he starts doing stretching movements and abruptly moving her left pelvic extremity. She refers that while the physician was doing, she Heard something "cracked" she felt the physician was "breaking her bone". This caused her intense pain, evaluated in EVA7, also causing more pain and difficulty to stand up. The patient says that some minutes after the pain due to those movements, they indicated medical discharge as well as the intake of painkillers and anti-inflammatories.