

CASEBOOK

FINDING COMMON GROUND

HOW MEDIATION COULD RESOLVE
STRESSFUL, COSTLY CLAIMS

PAGE 8



From the case files.....

ANTIBIOTIC ALLEGATIONS

Was a GP negligent for not prescribing antibiotics?

A DELAYED DIAGNOSIS

Persistent abdominal symptoms but what was missed?

AN ELUSIVE FOREIGN BODY

A child, a plastic toy – and pneumonia?



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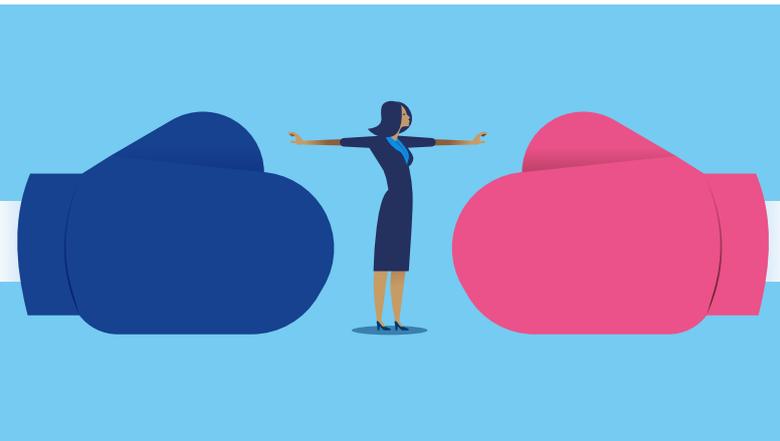
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WHAT'S INSIDE...



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EDITORIAL TEAM

Dr Marika Davies
EDITOR-IN-CHIEF



Gareth Gillespie
EDITOR



Dr Graham Howarth
EDITORIAL CONSULTANT



Dr Volker Hitzeroth
EDITORIAL CONSULTANT



PRODUCTION

Philip Walker Production Manager

Emma Senior Corporate Design Manager

TU Ink Print

CASE REPORT WRITERS

Dr Clare Devlin



Dr Anna Fox



Dr Emma Green



Dr Monica Lalanda



Dr Gordon McDavid



Dr Janet Page



Dr Rafael Sadaba



Dr Ellen Welch



Dr Philip White



New Annual Report from MPS

MPS's Annual Report and Accounts 2016 is now available on our website.

The report contains MPS's full financial statements, together with our strategic report, report of the Council and statements by Kay-tee Khaw (Chairman of the Council), Simon Kayll (Chief Executive) and Howard Kew (Executive Director – Finance and Risk).

In previous years, MPS has posted a summary version of our Annual Report to all members worldwide. Following feedback from members, the report will no longer be posted out and, instead, will be published in full on our website each year, representing a cost saving for members.

To view the 2016 Annual Report, please visit the About section of www.medicalprotection.org.

Please address all correspondence to:

Casebook Editor
Medical Protection
Victoria House
2 Victoria Place
Leeds LS11 5AE
United Kingdom

casebook@medicalprotection.org



WELCOME

Dr Marika Davies
EDITOR-IN-CHIEF



Of all the factors that come to mind when thinking about claims for clinical negligence, the various associated costs and the considerable stress and anxiety for affected clinicians are two that stand out.

Mistakes in medicine may never go away, but the adversarial nature of seeking any resulting redress certainly shouldn't be a given. That is why, in this edition of *Casebook*, we look at a possible alternative means of resolving patient–doctor conflict in the wake of an adverse incident: mediation.

As a process involving an impartial participant facilitating discussions between the two opposing parties, mediation is by definition a potential route towards a civilised, amicable and conciliatory resolution. This can reduce what are often severe levels of worry for both sides, and of course help to drive down those ever-increasing legal costs.

Away from claims, here at Medical Protection our medicolegal advice team manages many other types of cases that you, our members, can become involved in. This wide variety of cases isn't always reflected in *Casebook*, where traditionally we have devoted much of the focus to clinical negligence claims, perhaps because of the sheer costs that are often associated with them.

Claims form around 20% of our caseload at Medical Protection, with the rest comprised of advice and assistance with report writing, complaints, HPCSA complaints, inquests, employer disciplinarys on clinical issues and police investigations. From this edition on, the *Casebook* team will be working hard to bring you case reports from these different areas of medicolegal jeopardy, painting a more complete picture of the modern landscape in which you practise and the range of services available to you as a Medical Protection member.

Whatever the category of medicolegal issue, it is likely that expert evidence from a specifically instructed witness will be needed. This vital part of many types of medicolegal procedure comes complete with its own strict set of requirements and guidelines – and anyone interested in this complex but rewarding line of work would do well to read our comprehensive article on page 6.

As ever, there is our usual CPD questionnaire at the back of this edition. I hope you enjoy this edition of *Casebook* – please do get in touch with your views and comments.

Dr Marika Davies
Editor-in-Chief
marika.davies@medicalprotection.org



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BUDDING EXPERT WITNESSES, STEP THIS WAY

Ashley Dee, Medical Protection claims lead for Southern Africa, explains the crucial role of expert witnesses in complaints and claims – and why we are always looking to expand our pool in this area

READ THIS ARTICLE TO:



- ✓ Understand the crucial role of expert witnesses
- ✓ Learn how you can get involved in expert witness work

It should not come as a surprise that HPCSA complaints and clinical negligence claims largely turn on the expert evidence. Experts are a critical part of investigating and defending these types of cases, and this work is incredibly important to both Medical Protection and our members.

It can be rewarding and interesting work, but it is also demanding: experts need to appreciate the commitment involved and to understand the high standards expected – in terms of report writing, preparation and giving evidence at court or a hearing.

This article highlights how to avoid some of the common pitfalls – and is written after seeing cases quite literally fall apart at the 11th hour, due to U-turns by experts or poor expert preparation or performance.

ACCEPTING INSTRUCTIONS

You do not have to agree to act as an expert if asked; you should not do so if you feel that you are not sufficiently experienced in the subject matter to express an informed opinion, or if you have a conflict (or potential conflict) of interest and/or cannot express an objective opinion.

You may have a conflict of interest if you:

- Have been involved in the patient's treatment
- Are a friend and/or close colleague of the clinician being investigated
- Are friends/family with the patient
- Have accepted instructions to provide a report for one of the parties (eg, the patient or another defendant).

If you do agree to proceed, your agreement creates a contract. As with any contract you need to be sure of the terms, particularly as to the identity of the other contracting party (client or attorney), timing for your input, and, importantly, the specific issue(s) on which you are asked to provide your opinion.

YOUR FEE

The expert should specify their fee structure and rates (including court attendance and cancellation fees) at the outset and ensure these are accepted by the instructing party.

SCOPE OF OPINION

Generally an expert is asked to provide an opinion in one of four possible categories:

Negligence

Did the clinician fail to exercise the degree of skill and care that a reasonable practitioner of that experience/specialty would have exercised in the same circumstances? The degree of skill and care to be expected of a reasonable practitioner in the same circumstances must be logical and stand up to scrutiny.

Causation

Did any failures identified above probably (greater than 50%) cause or contribute to some injury, damage, harm or loss for the patient?

Apportionment

If there are several care providers, you may be asked for your view on appropriate apportionment (as a percentage) between the various parties.

Condition and prognosis and/or life expectancy

This usually requires an assessment of the patient in person, as well as a review of the clinical records.

For all of the above, you will be expected to provide relevant references from any scientific literature at the time you provide your report.

EXISTING INVESTIGATIONS

An expert may be the subject of regulatory or disciplinary problems or complaints – if so, this should be disclosed to an instructing attorney at the outset or as soon as they arise.

POINTS TO NOTE

- **Due to the crucial role of experts in investigating and defending claims and HPCSA complaints, Medical Protection is always keen to hear from clinicians who are interested in expert witness work, so get in touch at southafrica@medicalprotection.org.**
- **Acting as an expert is an important and challenging role – don't underestimate the time commitment.**
- **Read papers and instructions thoroughly; ask questions if anything is unclear – and provide an open, honest and objective opinion.**

YOUR REPORT

Experts instructed by Medical Protection are provided with guidance on report-writing – these should be read fully and carefully. When you receive the documents, inform your instructing attorney if there are further records/information you need to provide a meaningful opinion. Do not start your report until the further information has been provided, unless your instructing attorney tells you otherwise.

Generally, your report should:

- Be clear, laid out in a sensible, logical order and free of spelling and grammar errors
- Summarise the facts/history/chronology and identify the information from which those facts are taken
- Highlight any conflicting facts/ discrepancies between records
- Provide a clear opinion – based on the legal test for negligence and causation summarised above – as to whether there were shortcomings in the care provided and whether these caused or contributed to the patient's outcome
- Not sit on the fence. Whilst experts should not stray outside their area of expertise, the court will need to determine the issue on the balance of probabilities – ie, was it more likely than not? Experts should base their opinion – and reach a conclusion – on the same basis
- Address the specific questions asked by your instructing attorneys
- Be honest and objective – if the claim is indefensible, say so. As an independent expert, you are commenting on what the reasonable practitioner would (or should) have done in the same circumstances.

Remember – whilst you are being instructed and paid by one of the parties to the claim, you are preparing your opinion for the court. Your role is to assist the court.

Send your report to your instructing attorney.

SCOPE OF YOUR EXPERTISE

You should remain sufficiently experienced in the relevant area of medicine to give an authoritative view. The HPCSA would likely take seriously a complaint that an expert expressed opinion beyond the scope of his expertise.

WITHDRAWAL OF YOUR SERVICES

You are entitled to withdraw your services as an expert if you wish. You can be criticised for doing so, if you do so in breach of your contractual obligations, or you do not have good reason, particularly if you withdraw at a late stage.

IMPARTIALITY

Your role is to present the court with your impartial opinion, soundly based. You must, at all costs, not be persuaded, or tempted, to withhold material information in order to maintain your initial opinion.

There is no immunity for experts in South Africa. If an expert acts in a way which is negligent, then they can be sued.

MEETINGS BETWEEN EXPERTS

You may be required to discuss the differences of opinion between you and other experts of the same discipline after you have seen their reports. These discussions may be in person or by telephone and are usually arranged by you direct. You will be required to produce for the court a note of the discussion.

GIVING EVIDENCE

The simple rule is to listen to the specific question and, after reflecting on it, answer it succinctly and honestly.

THINGS TO AVOID

- Do not rush or be rushed. Answer in your own time.
- Do not try to answer a question if you do not know the answer. Say you do not know.
- Do not try to anticipate questions or try to fend off a question before it has been asked. Stick to the questions asked.
- Do not stick to your opinion if, in the course of giving evidence, you change it. Be sure of your reasons for changing.

INTERESTED IN WORKING AS AN EXPERT WITNESS?

Medical Protection runs training workshops in locations around South Africa – visit medicalprotection.org for the latest details

FINDING COMMON GROUND

READ THIS ARTICLE TO: 

- ✓ Learn about an alternative to litigation
- ✓ Discover the benefits of mediation



Being the subject of a clinical negligence claim is often a costly, time-consuming and stressful experience. Fortunately, an alternative approach exists: mediation. Medical Protection senior content editor *Gareth Gillespie* looks at this less adversarial and potentially cheaper method of solving disputes

For doctors, litigation means anything from stress and anxiety to financial hardship and a damaged reputation. Using an impartial, independent third party to strive for conciliation rather than combat can help to reduce the likelihood of these problems occurring, which is why mediation may be an attractive alternative.

Although there is no guarantee that conflict will be entirely avoided, mediation can offer an unbiased and impartial third party who is dedicated to bringing two disputing parties into an agreement. There is no enforced outcome and the mediator does not impose his/her views on either party.

The procedure works by giving potential claimants the opportunity to discuss their cases with hospitals, or individuals within healthcare, without having to initiate a claim, or even when litigation proceedings have been commenced. A code of strict confidence surrounds all communications that take place in the meetings.

THE BENEFITS

The South African Association of Mediators (SAAM), a professional association for mediators in South Africa, says in its blog that “the time has come for alternative dispute resolution (ADR) to take root in SA’s civil and commercial dispute resolution spheres”. It also adds:

“The characteristics of processes such as mediation are speed, cost-effectiveness and mutually acceptable outcomes.

“The most obvious advantage is the speed with which the mediation process can be convened and concluded. Between 70% and 80% of commercial disputes mediated in London each year are settled in one to two days, and a further 10% to 15% within a few weeks. This is usually achieved at a significantly reduced cost and without further damaging relationships already under strain.

“If anything, the case for ADR is even stronger in SA, where access to justice is out of the reach of most citizens and many businesses.”¹

The Department of Justice and Constitutional Development lists numerous potential benefits of choosing mediation:

- “It offers speedy resolution of disputes
- It is considerably cheaper than litigation
- It provides a win-win situation for both parties in a dispute
- The process is flexible and avoids technicalities
- It is a voluntary process
- It promotes reconciliation
- Parties can use their own languages.”²

THE PROCESS

Typically, mediation involves a series of meetings – usually during one day – that mix open and private discussions. The process then remains flexible enough for the mediator to look at the situation and plan meetings to suit participants – essentially, in a way that allows for constructive dialogue. Either party is also free to leave the mediation process at any time until an agreement is reached. Any agreement is put into writing, signed and made legally binding. The opening statements see the mediator drill down into the needs of both parties and the obstacles standing in the way of resolution.

Dr Graham Howarth, head of medical services (Southern Africa) at Medical Protection, says that the skill of the mediator lies in their ability to get to the heart of the real issues of a dispute, as these issues are rarely those that are contained in the court documents.

Dr Howarth adds: “Mediation is an inquisitorial – as opposed to adversarial – process, as it deals with needs rather than rights. The parties to the dispute are at the heart of it, not the lawyers. It also takes place in a safe environment, away from a public forum like open court.

“Furthermore, it offers the opportunity for something very powerful indeed – an apology to the patient, or at least an acknowledgment of harm caused. And as this apology or acknowledgment is given face to face, in private, it does not have to be seen as an acceptance of guilt. Explanations can be offered, which by its very nature the court process does not allow. It is also often cathartic to the doctor who wishes to apologise.”

At Medical Protection, we are always keen to explore mediation and other alternative dispute resolutions as options, particularly as we have years of experience in mediation across our caseload worldwide. Indeed, we welcome any mechanism that facilitates the early resolution of meritorious claims. This is in the best interests of patients, their families and healthcare professionals.

1. www.saam.org.za/news/36-sa-ripe-for-alternative-dispute-resolution-to-take-root (accessed 10 August 2017)
2. www.justice.gov.za/mediation/mediation.html (accessed 10 August 2017)

CASE STUDY

A claim was being brought by the parents of a married woman, on her behalf, for injuries sustained during a medical procedure. She suffered significant brain damage, was in a persistent vegetative state (PVS) and was being cared for in a hospice: her needs were so specialised, the charitable hospice had set up a specific care regime for her, which was bespoke.

The parents wanted the hospital to pay compensation to set up the same regime in her home or provide an indemnity that if ever the hospice was to refuse to continue to provide the care, the hospital would set up the same regime elsewhere for her. Alternatively, they wanted to receive sufficient money to set the system up themselves; this would have been very expensive to set up and run. They also wanted a review of the processes that had led to the injury, and had suggestions for improvement themselves.

The daughter and her husband had a close loving relationship prior to the injury, but the husband had not become involved in the litigation.

At mediation it was discovered in confidence that the parents refused to accept that the woman was in a complete PVS; the mother, particularly, could not accept her daughter was demonstrating reflex responses only.

The husband did accept that she was in PVS. He also recounted that, during the marriage, he and his wife had discussed what each would want to happen in those circumstances. She had expressed a definite wish not to live and he described vividly her view that it would be a living hell. Hence the husband did not want to pursue a situation where her life was prolonged.

During the mediation, the mediator was able to deal with the enormously sensitive issue of whether or not the woman was in non-reversible PVS and what realistically could be achieved for her. He was also able to deal with what the parents needed to be able to come to terms with that fact (the medical evidence was compelling). Issues that the parents' own lawyers could not deal with were aired by the mediator.

The mediator also managed to persuade the hospital representative to face the parents and apologise to them and the husband for what had happened, and to look at the photographs of their daughter/wife in the days before the injury, laughing at a party. This was for them an acknowledgement of what she had lost.

The matter was resolved to both parties' satisfaction, and to the satisfaction of the husband. Although the resolution is confidential, it is one that the court could not have ordered as it was not within its power to do so. It did not just involve a payment of money.

This is an actual MPS case, with facts changed to preserve confidentiality.

LIVING UP TO EXPECTATIONS

A surgeon fails to inform a patient about a complication that may have occurred during the operation

Author: Dr Rafael Sadaba, cardiac surgeon

Mr G was a 62-year-old office worker; he was overweight (BMI 29) and suffered from exercise-related angina. Mr G had several risk factors for ischaemic heart disease including smoking, diabetes mellitus and hypercholesterolaemia. Following a positive exercise test, a coronary angiography confirmed triple vessel coronary artery disease with a left ventricular ejection fraction of 45%. He was referred to Dr F, a consultant cardiothoracic surgeon, for consideration of coronary artery bypass graft (CABG) surgery.

Based on his symptoms and the severity of his coronary artery disease, Dr F strongly advised Mr G to undergo surgery on both prognostic and symptomatic grounds. He also explained the risks of the operation, stating that the risk of death was below 3%. In view of the seriousness of his condition, Mr G accepted he required CABG. He was strongly advised by Dr F to stop smoking and lose weight before the operation.

Mr G underwent an uneventful triple bypass. Dr F documented the use of bilateral internal mammary artery and saphenous vein grafts. Following surgery, Mr G made a good recovery, although a control chest x-ray showed an elevation of the right hemidiaphragm. Dr F decided not to share this finding with Mr G in order to avoid giving him unnecessary reasons for concern. Mr G was eventually discharged home on the seventh postoperative day, having made a good recovery.

Six weeks later, Mr G attended clinic for a postoperative surgical review. He mentioned that he was angina-free but complained of dyspnoea on moderate exertion. Dr F put this down to the fact that Mr G was still recovering from the operation and said that "things would get better soon". Mr G was discharged from the clinic back to the care of his own GP.

The shortness of breath persisted during the next few months and Mr G mentioned this to his cardiologist, Dr T. Dr T reviewed the chest x-rays and arranged an echocardiogram, which showed a poor left ventricular function with significant dyskinesia in the inferior and lateral walls of the left ventricle. Pulmonary function test showed a mild reduction in total lung capacity. A chest fluoroscopy test revealed paralysis of the right hemidiaphragm. The final diagnosis was right phrenic nerve palsy secondary to surgical damage.

Mr G made a claim against Dr F because of the damage to his right phrenic nerve during the operation. The case was defended successfully, based on the facts that damage to the right phrenic nerve is a rare, but known, complication of right mammary artery harvesting and that his deteriorated heart function, rather than the paralysed diaphragm, was the likely cause of his breathlessness.

Learning points

- Dr F was not open about the complication; he should have warned Mr G as soon as it happened, as part of the ongoing consenting process. If he had disclosed the complication and explained why it had occurred, the claim may never have arisen.
- The HPCSA states you must be open and honest with patients if things go wrong.
- Patients should not be given false expectations. Surgical procedures do not always result in a complete cure, but can slow down deterioration and reduce the risks of serious complications. In this case, Mr G was led to believe that the operation would rid him of all his angina and dyspnoea.
- Surgical complications are not necessarily a result of medical negligence. However, when these do occur, giving an open clear explanation to the patient of the possible causes and consequences decreases the likelihood of complaints and claims.



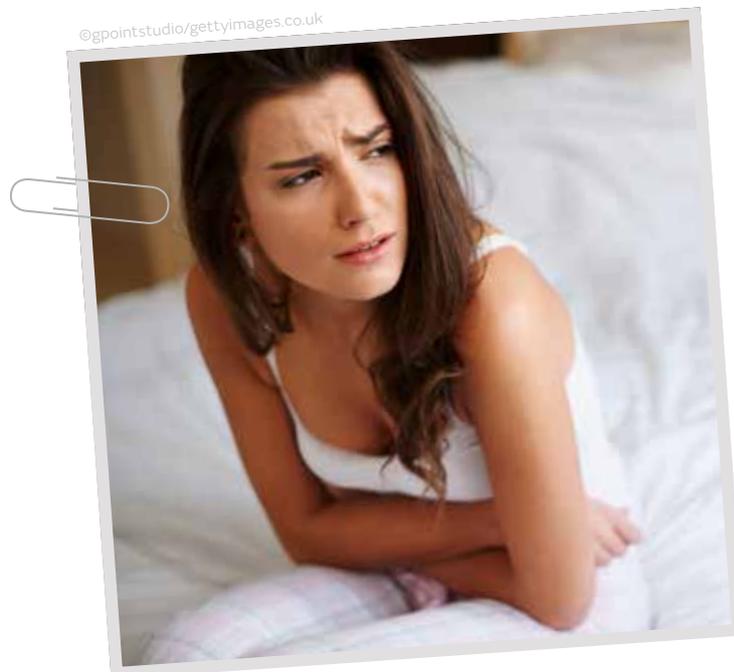
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DELAYED DIAGNOSIS

A patient repeatedly attends the surgery over a number of years with persistent abdominal symptoms

Author: Dr Ellen Welch, GP

@gpointstudio/gettyimages.co.uk



Mrs F, a 30-year-old housewife, visited her GP, Dr O, with a four-week history of diarrhoea. Dr O arranged a stool sample for microscopy and culture (which was negative) and prescribed codeine. Four months later, Mrs F was still having diarrhoea, especially after meals, and she had started to notice some weight loss. She returned to the surgery and this time saw Dr P, who examined her and found nothing remarkable, but decided to refer her to gastroenterology in view of her persistent symptoms.

Mrs F was seen four months later by a gastroenterologist, who attributed her symptoms to irritable bowel syndrome (IBS). She underwent a sigmoidoscopy which revealed no changes, and was diagnosed with functional bowel disease.

Four years later, Mrs F developed difficulty passing stools after the birth of her second child. She was referred back to the gastroenterologist and underwent a further sigmoidoscopy, which revealed no abnormalities. She was referred for pelvic floor physiotherapy.

Two years later, Mrs F returned to her GP and consulted Dr G with the sensation of a lump in her rectum preventing her from defecating. She reported incomplete bowel emptying and the need to manually evacuate. She was referred back to the gastroenterologist, who arranged a barium enema, which was reported as normal.

Three months later, Mrs F visited the practice again with a two-week history of diarrhoea and abdominal cramps. Dr B saw her on this occasion and diagnosed her with possible gastroenteritis. He arranged a stool culture, coeliac screen and routine bloods.

Mrs F returned a week later for follow-up with Dr Y, reporting ongoing diarrhoea with no rectal bleeding. Dr Y noted the recent normal barium enema and sigmoidoscopy and normal stool culture. The blood tests remained pending so Dr Y sent Mrs F to hospital to get them done. The results for the coeliac screen were normal.

Another three months later, Mrs F was still symptomatic and attended Dr P with diarrhoea and bloating. No abnormalities were found on abdominal and PR examination. Dr P diagnosed IBS and prescribed amitriptyline.

Over the next three weeks, frustrated at the lack of resolution of her symptoms, Mrs F had several GP appointments with Dr G, Dr P, Dr O, Dr B and Dr Y. She was referred for a colonoscopy and pelvic ultrasound – all of which were normal. She was referred to a colorectal surgeon and a family history of pancreatic insufficiency was discussed during the outpatient appointment. Faecal elastase confirmed pancreatic insufficiency and a CT abdomen revealed obstructing pancreatic duct calculi. She underwent ERCP and Frey's procedure, which failed to resolve her symptoms and, at the time of the claim, Mrs F was considering a total pancreatectomy.

A claim was brought against Dr P, Dr Y and Dr O, for failing to take into account Mrs F's family history of chronic pancreatitis and arranging a specialist referral and follow-up investigations.

EXPERT OPINION

On the basis of the medical records and the evidence provided by the doctors involved, the GP expert was supportive of Dr P, Dr Y and Dr O. Given that Mrs F did not mention her family history of chronic pancreatitis, there was no reason to suspect pancreatic insufficiency as a cause for her symptoms. The claim subsequently discontinued.

Learning points

- Where patients are repeat attenders with ongoing symptoms, it is important to consider alternative causes for their symptoms.
- Careful documentation of consultations is imperative and greatly assists when defending claims.
- Where patients are repeat attenders, it is important to consider all past consultations, particularly if patients do not see the same practitioner each time, to ensure that continuity of care is not impacted.

ANTIBIOTIC ALLEGATIONS

A patient alleges her GP was negligent for failure to prescribe antibiotics

Author: Dr Clare Devlin, medical claims adviser at Medical Protection

Miss G, 23, presented to GP Dr Q with a four-day history of fever, cough and green/brown sputum. On examination, she was afebrile with no chest signs except expiratory wheeze.

Dr Q's clinical impression was of a viral infection. The clinical findings were supported by the fact that Miss G was on day four of a five-day course of amoxicillin, prescribed by her dentist, which had not produced an improvement in her symptoms.

Given the history and examination findings, Dr Q did not feel Miss G required a further course of antibiotics; in any event, Miss G was already receiving the correct antibiotic and course duration, as set out in guidelines for empirical cover of low risk community-acquired pneumonia.

Dr Q advised Miss G about viral infection, and performed appropriate safety-netting with instructions in the event of the symptoms worsening, new symptoms developing or a failure to improve.

Miss G did not re-present to Dr Q, but did see other doctors when her cough failed to improve, and she received further courses of antibiotics at this point. She later fractured a rib during a bout of coughing, but made a full recovery.

Miss G made a claim against Dr Q, alleging a failure to prescribe any or an adequate dosage of antibiotics to treat the symptoms of fever and productive cough. She also alleged there was a failure to advise against continuing amoxicillin, which allegedly had not been prescribed for Miss G's symptoms and which had only one more day left of the course, and finally alleged that her chronic cough led to her rib fracture.

EXPERT OPINION

In this case, Medical Protection was able to serve a robust defence denying liability, based on our legal team's assessment and the quality of Dr Q's medical records, supplemented by a helpful detailed account provided by Dr Q.

This approach by Medical Protection enabled the claim to be dealt with rapidly, without the need to instruct an independent expert witness or generate expenditure on an expert report.

The defence served by Medical Protection highlighted the appropriate history and examination performed by Dr Q and the lack of clinical indication for antibiotics. It also explained that Miss G was already on first-line empirical antibiotic treatment, started by another clinician for a different problem, and that advice to stop the course a day early would not have been appropriate because incomplete antibiotic courses promote the growing problem of antibiotic resistance.

Learning points

- On receiving a letter of claim, members may be shocked and aggrieved to see allegations that are factually incorrect and may in addition be medically misconceived. In this case, we see contradictory allegations, where Dr Q is simultaneously being criticised for failing to stop an antibiotic and for failure to prescribe an antibiotic.
- Medical Protection is accustomed to allegations of this nature and takes care to address them fully, with a comprehensive rebuttal of all factual and clinical inaccuracies. In this we are greatly assisted by thorough accounts of incidents from our members, and especially quality documentation in the form of contemporaneous medical records.



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A CASE OF MISTAKEN HAEMORRHOIDS

A patient presents with symptoms of haemorrhoids but is it something more sinister?

Author: Dr Emma Green, medical claims adviser at Medical Protection

Mr F, a 33-year-old policeman, attended his GP, Dr B, with a six-month history of abdominal pain and rectal bleeding. The abdominal pain had become more constant over the preceding few weeks and laxatives reportedly eased the pain; the pain had eased on the day of the consultation. The blood was bright red in the toilet bowl and on the stool and paper, there was no mucous in the stool and no family history of cancer. Dr B documented no weight loss or joint pains. A telephone consultation earlier the same day, with another GP, had referred to Mr F “straining” to pass his stool.

The examination revealed a soft abdomen with slight lower abdominal tenderness. There were no masses and no organomegaly, and a rectal examination revealed an empty rectum with no masses.

Given the age of the patient and the description of the blood, Dr B felt this was most likely haemorrhoids secondary to constipation, which was being eased by the laxatives. He advised further laxatives, blood tests to look for inflammatory bowel disease and for Mr F to return in four weeks, if no better.

Mr F did not attend for blood tests nor did he return to see Dr B. One year later he was admitted to hospital and diagnosed with metastatic colorectal cancer, from which he died within a year.

A claim was made against Dr B by Mr F’s family, alleging he was negligent in diagnosing haemorrhoids when these were not visualised, instead of referring to secondary care for further assessment. It was alleged that these failures resulted in a 12-month delay in diagnosis and a nine-month reduction in life expectancy.

EXPERT OPINION

A GP expert considered that the history of straining with fresh red blood on defecation would be consistent with a diagnosis of haemorrhoids. The recorded history in the records was felt to be detailed enough to support Dr B and his logical reasoning that constipation was the most likely cause of the abdominal pain, the improvement with laxatives and the straining to pass stool. The blood tests and safety netting were also considered appropriate and it was felt there was no breach of duty. In addition the expert was supportive of the diagnosis of haemorrhoids in the absence of visualisation, noting that haemorrhoids are frequently not palpated but diagnosed following a history consistent with them that lacks features suggesting something more sinister.

An expert oncologist instructed in the case did not support the claim that Mr F would have survived for a further nine months had the tumour been diagnosed earlier.

Medical Protection served a robust defence denying both breach of duty and causation and the claim was discontinued against Dr B.

Learning points

- Record-keeping was the most important aspect in defending this case. Important positive findings and relevant negatives should be recorded to enable a clear logical reasoning to be followed.
- Rectal examination should always be performed in patients presenting with rectal bleeding. When a patient declines this examination, it should be clearly documented that they are aware of the implications this could have on diagnosis.
- Although uncommon, malignancy can be a cause of rectal bleeding in younger patient groups.



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A PAIN IN THE KNEE

An 11-year-old girl repeatedly attends her GP complaining of knee pain

Author: Dr Janet Page, medical claims adviser at Medical Protection



@kwanchachaudorn/gettyimages.co.uk

Miss F, an overweight 11-year-old, attended her GP, Dr A, complaining of knee pain and clicking for two months following a twisting injury whilst playing tennis.

Examination was unremarkable, with straight-leg raising to 90 degrees and a full range of movement in the knee. Dr A treated with simple analgesia and arranged for an x-ray of the knee the following week. The x-ray was normal and Miss F was advised to see her GP for review.

Miss F next attended the practice seven weeks later, when she was seen by Dr B. She was complaining of pain in the right groin, which was worse on walking or standing. Dr B recorded in her notes that it was “probably muscle strain or too much pressure on hip joint because of her weight”. She prescribed diclofenac.

Five days later, Miss F attended the emergency department (ED) at the local hospital complaining of a painful right hip with difficulty walking. A diagnosis of ligament sprain was made.

Two days later, Miss F again attended the practice and was seen by Dr C. Examination revealed reduced range of movement in the right hip. Dr C arranged a routine appointment for a hip x-ray for the following week.

The day before the appointment, Miss F attended the ED in severe pain. Hip movements, particularly flexion and internal rotation, were noted to be limited. The diagnosis of slipped femoral capital epiphysis was confirmed on x-ray and classified as “mild” (less than 30 degrees). Miss F subsequently underwent pinning of the epiphysis.

Over the course of the next few years, Miss F attended her GP and an orthopaedic surgeon on multiple occasions, complaining of intermittent hip pain. Her weight continued to rise and at age 15 her BMI was 41.4. MRI of the hip three years later showed deformity of the right hip with a CAM abnormality (bony deformity of femoral head resulting in femoro-acetabular impingement) and degenerative changes. The features were reported as being consistent with an angle of displacement of 50 degrees (severe slippage).

A claim was brought against Dr A alone, alleging a failure to recognise or appreciate that pain in the knee could be referred pain from the hip, failure to examine the hip and failure to refer for x-ray of the hip. It was additionally alleged that, because of Dr A’s failures, Miss F suffered premature osteoarthritis and was likely to require a primary hip replacement in her late 30s, and two further revisions in her lifetime.

EXPERT OPINION

Medical Protection sought opinion from a GP expert. The expert was critical of Dr A, stating that a reasonably competent general practitioner would know that a slipped upper femoral capital epiphysis (SUFE) is more common in adolescents who are overweight. He also opined that a reasonably competent GP being presented with an overweight adolescent complaining of knee pain should have been aware that this may have been referred pain from the hip. In these circumstances the GP should have carried out an examination of the hip and, if any abnormality had been found, should have considered the possibility of slipped upper femoral capital epiphysis and referred the claimant for an x-ray.

The expert said that there was also a failure by Dr A, and subsequently Dr B, to consider the diagnosis and to carry out an appropriate examination of the hip. For the same reason, the expert was also critical of the care provided by the ED doctors and of Dr C for failing to make an urgent referral to hospital the same day.

Based on the critical expert opinion, the case was deemed indefensible and was settled on behalf of Dr A for a moderate sum, with a contribution from Dr B and the hospital.

Learning points

- SUFE is more common in obese adolescents (particularly boys) and may present following an acute, minor injury.
- Pain may be poorly localised. Pathology in the hip can present as referred pain to the knee; hence a full assessment of the joints on either side of the affected joint should be undertaken.
- There may be an associated limp with out-toeing of the affected limb.
- Diagnosis is confirmed on x-ray, which may require a “frog lateral” view for confirmation.

CAUGHT BY CONSENT

A private neurosurgeon faces questions regarding consent

Author: Dr Philip White, medical claims adviser at Medical Protection

Mrs P, a 40-year-old nurse who lived in the platteland, attended her GP complaining of back pain and was prescribed simple analgesia. After a month, the pain was no better so she consulted a neurosurgeon in a nearby city, Dr S, who advised conservative measures.

One month later, Mrs P phoned Dr S to tell him her back pain had not improved and that she now had left-sided sciatica. This was confirmed by her GP, who arranged an MRI scan, which showed the disc bulge responsible for it. Overall, her condition was worse and she had been off work for over a month.

As Mrs P now had sciatica, Dr S felt that a microdiscectomy was a reasonable approach. He discussed the options with her over the phone, and explained the operation and its pros and cons. Dr S did record the phone call in the medical records, but did not state exactly what was discussed. Mrs P was happy to proceed and so the operation was arranged. Dr S wrote a letter to the GP informing him of the plan.

Dr S next saw Mrs P on the day of the operation as she was brought in to be anaesthetised. He had a brief conversation with her, confirming that she was happy to go ahead and that she had no questions. She then signed the consent form, which listed none of the pros and cons of the operation.

The operation was straightforward and there were no observed complications. However, two months after the operation Mrs P felt that her pain was worse, and she had genital numbness and urinary symptoms. Her urodynamic investigations were normal but she was numb in the S3 dermatome.

Mrs P brought a claim against Dr S, alleging that he had taken inadequate consent and had not informed her that the operation could make her pain worse. She also alleged that the operation had been negligently performed, damaging the left L5 root and the S2 and S3 roots bilaterally.



EXPERT OPINION

Medical Protection sought expert opinion from a neurosurgeon. The expert advised that although the consent form was inadequate, the overall consenting process, including the phone consultation and the brief discussion on the day of the operation, was just about acceptable.

The expert also opined that it was very unlikely that an experienced neurosurgeon, such as Dr S, would have damaged the nerves without noticing and recording it. He noted that there was no suggestion of nerve damage in the immediate postoperative period and suggested that deterioration occurring two months after the operation was more suggestive of a chronic pain syndrome.

The case was deemed defensible and taken to trial. The judge concluded that there had been no negligence during the operation, but that Dr S had taken inadequate consent. The ruling stated that Mrs P had not been warned of a 5% risk that the surgery could make her back pain worse and, if she had been, she would not have gone ahead. Mrs P was awarded a moderate sum.

Learning points

- Being cognisant of the National Health Act, doctors must take reasonable steps to ensure that patients are aware of any risks that are material to them and of any reasonable alternative or variant treatments.
- In deciding whether a risk is material, doctors should consider whether a reasonable person in the patient's position would be likely to attach significance to the risk.
- It is important to make a record of the consent discussion in the patient's notes, including key points raised and hard copies or web links of any further information provided. This is in addition to the consent form.
- It is also important to document the indications for surgery.

COMPLICATIONS OF NITROFURANTOIN

A patient on long-term medication begins to feel short of breath

Author: Dr Anna Fox, GP



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Mrs D was a 70-year-old retired teacher who had struggled with recurrent UTIs. Urologists had advised her to take antibiotics in the long term as a prophylactic measure and advised alternating between trimethoprim and nitrofurantoin.

Sixteen months after commencing nitrofurantoin, Mrs D began to feel short of breath, especially when she was walking her dog. She was also feeling tired and generally unwell so she visited Dr W, her GP. Dr W documented a detailed history, noting that there was no orthopnoea, ankle swelling or palpitations. He also noted the absence of cough, wheeze or fever. Dr W referred back to a recent echocardiogram that was normal and mentioned that Mrs D was an ex-smoker. He conducted a thorough examination including satisfactory BP, pulse and oxygen saturation, and commented in the notes that Mrs D's chest had bilateral air entry with no crackles or wheeze and no dullness on percussion. Dr W stated that her heart sounds were normal and that there was no pitting oedema. He organised a CXR initially.

The CXR reported patchy peribronchial wall thickening and suggested a degree of heart failure. Dr W advised a trial of diuretics, which made no difference. Mrs D continued to feel short of breath and drained over the next few weeks. Gradually her breathlessness got worse and she noticed it even when she was sitting reading.

Four months later, Mrs D was admitted to hospital in respiratory failure. A high-resolution CT scan showed pulmonary fibrosis, with the likely diagnosis being subacute pneumonitis secondary to treatment with nitrofurantoin.

Within a month of withdrawal of nitrofurantoin she improved clinically, becoming less breathless, and her respiratory failure resolved. At a respiratory follow-up ten months later, she was found to be breathless after about 300 metres of walking and quite fatigued but able to do all her daily activities, including walking her dog.

Mrs D made a claim against Dr W. She alleged that he had failed to consider that the long-term use of nitrofurantoin may have caused her symptoms.

EXPERT OPINION

Medical Protection sought expert opinion from a clinical pharmacologist and a GP. The clinical pharmacologist referred to the relevant guidelines which stated on nitrofurantoin: *“Cautions: on long-term therapy, monitor liver function and monitor for pulmonary symptoms especially in the elderly (discontinue if deterioration in lung function).”*

She commented that although the guidance records the need to monitor periodically, the exact definition of “periodically” is not given. In her view, it should have been every six months.

The expert GP said that many doctors would be unaware of the need for monitoring and that it was probably rarely done in practice. However, he accepted that when prescribing an unfamiliar drug, a GP would need to check the relevant guidelines.

Medical Protection rigorously defended Dr W's actions, pointing out that he had seen Mrs D early in her clinical course, had documented a very thorough history and examination and made a reasonable initial management plan. As a result of this, the case against Dr W was dropped. However, the practice partners, who were indemnified by another organisation, faced a claim regarding the alleged lack of a practice system for monitoring for lung and liver complications in patients on long-term nitrofurantoin. This claim was settled with no contribution sought from Medical Protection.

Learning points

- Detailed contemporaneous notes assist in defending cases. GPs should document a thorough history and examination, including any negative findings.
- Medical Protection sees a number of claims regarding inadequate monitoring of long-term nitrofurantoin with patients developing hepatic or pulmonary complications. Many claims relate to inadequate practice systems for monitoring.
- To screen for hepatic complications, repeat prescribing of nitrofurantoin should generate liver function tests (LFTs), at least six monthly.
- To screen for pulmonary complications such as pulmonary fibrosis, doctors should advise patients starting on nitrofurantoin to attend urgently if they develop breathing problems. They could be reviewed for respiratory symptoms at the points of taking LFTs at least six monthly, with consideration of more frequent monitoring.

AN ELUSIVE FOREIGN BODY

A child suffers recurrent episodes of pneumonia following the inhalation of a plastic toy

Author: Dr Mónica Lalanda, emergency medicine physician



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Child H, a three-year-old boy, was brought into the emergency department (ED) of a private hospital by his mother, having inhaled or swallowed a little building brick. They brought a similar piece with them. Child H was seen by Dr W, who documented that he appeared well, with no signs of respiratory distress and a normal auscultation. Dr W arranged for him to have a chest x-ray, which both Dr W and a radiologist considered normal.

Two months later, Child H became unwell with a cough and a high temperature. His mother brought him to the ED where, following a chest x-ray, he was diagnosed with right lower lobe pneumonia. Child H's mother mentioned to Dr F – the doctor who saw them – that they had been to the ED not long ago after Child H “swallowed” a little toy. All this was documented.

During the next two years, Child H suffered recurrent episodes of pneumonia and attended the ED five times. He saw a different doctor on every occasion and had five more chest x-rays. All of them were reported as “right lower lobe pneumonia with collapse and some pleural fluid”. There were no indications in the ED cards to suggest that previous cards or x-rays were looked at.

In view of the recurrent chest infections, Child H's GP, Dr W, referred him to a paediatrician for further investigations. Paediatrician Dr Q saw Child H, looked at all the x-rays and became suspicious of the presence of a foreign body. An urgent bronchoscopy was organised and a large piece of plastic removed. Child H required further surgery as the foreign body had caused fibrosis of the pulmonary parenchyma, which required excision.

Child H's mother made a claim against the private hospital and all the hospital doctors involved during those two years.

EXPERT OPINION

The experts commented that “a case of a possible inhaled foreign body has to be followed up closely and even without a clear history of inhalation of a foreign body, this should be considered a possibility in cases of recurrent pneumonia in children with persistent x-ray changes”.

The case was deemed to be indefensible and was settled for a moderate amount.

Learning points

- Taking a good history can save a lot of mishaps in clinical practice; it is important to listen. Digging into the details of what happened to this child could have made it clear whether the foreign body was swallowed or inhaled. The sudden onset of respiratory difficulty, with coughing, stridor or wheezing, needs to be specifically investigated. If inhalation is suspected, careful follow-up is required to determine the need for a bronchoscopy.
- Many types of plastic are radiolucent and will not show up on an x-ray.
- Asking the radiographers to place an example of a foreign body, if brought in by the parents, next to the patient they are going to x-ray will easily determine whether it is a radio-opaque object or a radiolucent one.
- Previous attendances to the ED by children might be relevant in a significant number of cases. Hospital note-gathering systems may be helpful in picking up previous ED attendances. Reviewing old notes is therefore always important and might offer unexpected background to a new presentation.
- With modern computerised radiographic storing systems, there is little excuse not to look at previous x-rays. Both clinician and radiologist would have been alerted to the fact that the changes in the chest x-ray were chronic and would therefore be suspicious of a foreign body being present.



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REPORTED ABUSE

Thank you for the latest edition of *Casebook*. It is always informative, if sobering. I have a comment about one case report: the “Reported abuse” case.

The training that I have received on safeguarding guides me to report incidences of alleged abuse to my local safeguarding team without undertaking investigation or corroboration myself. If the abuse is clear and actual, the report should be direct to the police, or local sexual assault centre (SARC).

The reason for this has been explained as being twofold. Firstly, the safeguarding team is multidisciplinary and is able to undertake a more comprehensive investigation that will be robust in the face of a cross-examination, should it come to that. Secondly, the safeguarding team is privy to a wide range of information, so even small additions may be important.

Notwithstanding the fact that Mrs X told her GP that she had reported the allegation to the police, in this circumstance, as a GP I would have also reported the allegation to my local safeguarding team, informing Mrs X of this action, of course. I should have expected the teacher and Dr B to have done the same thing. I would not have checked with the school myself.

The expert for Mr X reported that Dr B failed to corroborate the allegation with the school. My training would suggest that the expert was wrong in making that comment. Perhaps an example of an expert opining beyond her/his area of expertise as considered in “A complicated claim”.

Whilst this is slightly outside the case, and you do make a general comment about our duty to act in the third learning point, I feel it is important to emphasise the critical nature of collaborative and consistent team working when it comes to safeguarding. All the investigations into failed cases have come to that conclusion. It needs to be reiterated until it is a reflex action across all of health and social care.

Dr Michael Innes

Response



Thank you for your correspondence – we are always pleased to hear from readers and welcome your comments on this case.

Our case reports are taken from different countries around the world where we represent members, and so local practices and policies can differ. However, I agree entirely with your comments on the importance of collaboration and team-working in these cases, as well as liaison with the safeguarding team where appropriate, which are valuable learning points.

NO NEWS IS NOT ALWAYS GOOD NEWS

The article on missed hip dysplasia states that Dr R was alleged to have failed to ensure the report made it to clinic. May I be clear? Is this a system error or is there a duty for Dr R to have phoned the abnormal result?

Incidentally, I don't think it is great journalism to illustrate a case of hip dysplasia with a radiograph of a normal hip.

Dr Jules Dyer

Response



Thank you for your email regarding the case report “No news is not always good news”, in the latest edition of *Casebook*.

The allegation that Dr R (the radiologist) failed to ensure that the report made it safely to the clinic was an allegation brought by the claimant (the parents) in this case. The claim was investigated and the hospital accepted that there had been “a clear administrative error” that allowed the system to file the report without it being sent to the clinical team for action. It would be a matter for an expert radiologist to comment on whether Dr R should have phoned the result or taken any other action. This wasn't explored in this particular case given the hospital's acceptance that there had been an administrative error.

I note your comment on the radiograph used to illustrate the case report. The pictures we use in *Casebook* are for illustrative purposes only and are not intended to be actual representations of the individual cases, and I do hope it did not detract from your learning or enjoyment of this case.



**We welcome all contributions to Over to you.
We reserve the right to edit submissions.**

**Please address correspondence to:
Casebook Editor, Medical Protection, Victoria
House, 2 Victoria Place, Leeds LS11 5AE, UK.
Email: casebook@medicalprotection.org**

CPD QUESTIONS

Volume 25, Issue 2

CPD accreditation by SAMA

To complete your CPD questionnaire please visit our online learning platform, Prism
Go to: medicalprotection.org/prism
After submission, you can check the answers and print your certificate.



- 1 When asked to be an expert witness, you should:
- a. Accept without hesitation
 - b. Accept, but only if you are friends with/related to the patient
 - c. Accept, knowing you can withdraw at any stage without being criticised
 - d. Accept, only if there is no conflict of interest, and you can give an informed, objective opinion

- 2 As an expert witness, you provide your opinion for:
- a. The court
 - b. Whoever is paying you
 - c. The patient
 - d. Whoever you think is in the right

- 3 An expert witness can be sued for negligence. Is this:
- a. True – there is no immunity for expert witnesses in South Africa
 - b. False – an expert witness cannot be negligent
 - c. False – expert witnesses can be negligent, but have special immunity

- 4 The benefits of mediation include:
- a. More money for lawyers
 - b. More chance of doctors escaping censure
 - c. A speedier, non-adversarial process
 - d. It forces everyone to use the same language

- 5 After a medical error, apologies to patients are:
- a. Dangerous – they are an admission of guilt
 - b. Wrong because they give patients too much power
 - c. The right thing to do – and it may reduce the chances of a claim or complaint
 - d. Irrelevant, as the error has already happened

- 6 Informed consent is:
- a. Ensuring all relevant forms are filled in and signed
 - b. Not important because, as an expert, the doctor will always know the best way to proceed
 - c. A two-way conversation between doctor and patient, where the patient is aware of the risks and any reasonable alternative or variant treatments
 - d. Has little or no impact on the potential outcome of a complaint or claim

- 7 Surgical complications are:
- a. Undoubtedly the result of medical negligence
 - b. Best kept hidden from the patient
 - c. Less likely to attract a claim or complaint, if they are explained and apologised for

- 8 The process of complete and accurate record-keeping is:
- a. Vital in the defence of clinical negligence claims
 - b. An administrative burden, best delegated to junior staff
 - c. A way of only recording basic details about a patient



- 9 When a patient repeatedly attends, it means:
- a. They are becoming problematic – you should refuse to see them
 - b. You should consider alternative causes for their symptoms, and review past consultations
 - c. They are hypochondriac – refer them to mental health services

- 10 When children repeatedly attend casualty, you should:
- a. Review previous attendances – there could be unexpected background to a new presentation
 - b. Show no particular concern – children are easily upset and claim they are unwell when they are not
 - c. Consider reporting the parents for wasting your time and resources

How to contact us

MEDICAL PROTECTION

info@medicalprotection.org

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MEDICOLEGAL ADVICE

Tel 0800 982 766

Fax 0800 982 768

medical.rsa@medicalprotection.org

MEMBERSHIP ENQUIRIES

Tel 0800 225 677

Fax 012 481 2061

mps@samedical.org