S.16/02-03

Scottish Public Services Ombudsman Act 2002

Report by the Scottish Public Services Ombudsman
of an investigation into a complaint against:

Renfrewshire Emergency Medical Service (REMS)

Complaint as put to the Ombudsman

1. In this report I refer to the complainant as Mr G and to his wife as Mrs G. The account of the complaint provided by Mr G was that at about 6.00 am on 13 August 2001, he telephoned the GP deputising service, REMS, on behalf of his wife. Mrs G had been unwell with sickness, diarrhoea and pain since midnight on 11 August. Mr G spoke to a General Practitioner (the GP) and explained his wife's symptoms. The GP told him that it appeared that Mrs G was suffering from food poisoning and gave advice that she should take a painkiller containing codeine which could be obtained from a pharmacy. The GP also suggested that Mr G could take a specimen of diarrhoea to Mrs G's family GP (the second GP) for analysis. Mrs G's condition continued to deteriorate and Mr G's daughter-in-law telephoned the second GP at 2.30 pm to request a home visit. The second GP visited Mrs G after evening surgery at about 5.30 to 5.45 pm and arranged an urgent admission to hospital. An emergency operation was performed on Mrs G at 9.30 pm. Mrs G died at 2.47 am on 14 August. The causes of death entered on the death certificate included generalised peritonitis (inflammation of the lining of the abdominal cavity), perforated duodenal ulcer (an ulcer of the first part of the small intestine) and peripheral vascular disease (narrowing of the arteries causing reduced blood flow). Mr G complained to REMS that the GP should have made a home visit and that he was wrong to have reached a diagnosis without examining Mrs G. Mr G was dissatisfied with the response to his complaint from REMS and that his subsequent request for an independent review was refused.

2. The complaints subject to investigation were that during the telephone call at 6.00 am on 13 August:

(a) The GP did not put himself in a position to make a diagnosis; and

(b) The GP did not offer a clinical assessment either at the primary care centre or at home.

Investigation

3. The statement of complaint for the investigation was issued on 23 July 2002. The GP's comments were obtained and relevant documents, including Mrs G's medical records, were examined. Oral evidence was taken from Mr G, the GP and REMS' Medical Director. Two professional assessors, both general practitioners, were appointed to advise on the clinical issues in this case and their report is produced in its entirety at paragraph 17 of this report. The transcript of the telephone conversation between Mr G and the GP is contained at annex A. I have not included in this report every detail investigated, but I am satisfied that no matter of significance has been overlooked.

Statutory background and Professional guidance

4. **The National Health Service (General Medical Services) (Scotland) Regulations 1995**, Schedule 1, Terms of Service for Doctors states:

> '11 (1) ... a doctor shall render to his patients all necessary and appropriate personal medical services of the type usually provided by general medical practitioners.
>
> '(2) The services which a doctor is required ... to render shall include:
>
> '... (c) offering to patients consultations and, where appropriate, physical examinations for the purpose of identifying, or reducing the risk of, disease or injury;
>
> '... (e) arranging for the referral of patients, as appropriate ...'.

5. **Guidance from the General Medical Council** entitled 'Good Medical Practice', in the edition published in July 1998, describes good clinical care as including:

'... an adequate assessment of the patient's condition, based on the history and clinical signs including, where necessary, an appropriate examination;

'providing or arranging investigations or treatment where necessary;

'referring the patient to another practitioner, when indicated ...'.

Mr G's evidence

6. **Mr G** said that in general, Mrs G kept very good health and hardly ever attended the second GP. She was not one to complain and would never mention when she felt ill. During the day on Saturday 11 August she behaved normally and gave no indication that she was ill. She arranged a family meal and baked a cake. Mrs G went to bed at 9.00 pm, which was unusually early for her and might have been the first sign that something was wrong. Mr G was disturbed by Mrs G when she returned to bed about midnight after having been sick. On Sunday, Mrs G stayed in bed all day apart from about an hour. She told Mr G that it felt as though she was suffering from flu. She had nothing to eat throughout the day and only drank cups of tea. Mr G offered to contact the surgery, but she said not to bother. Mrs G took two paracetamol tablets. In the early hours of Monday morning, Mrs G felt no better. She complained of cramp, she was sweating, she had not eaten since about 6.00 pm on Saturday and had had only about one hour's sleep. Mr G told her that he was going to contact a doctor and this time she did not object.

7. Mr G telephoned REMS at 6.00 am because he thought that his wife required a home visit from a doctor. However, once he had described her symptoms to the GP, he felt reassured that his wife was not suffering from anything serious and that it was only food poisoning. After speaking to the GP, Mr G gave his wife another two paracetamol tablets. He contacted the surgery at about 8.30 am and arranged to pick up a prescription for co-codamol. He collected the prescription and returned home at 10.00 am. He gave his wife two co-codamol tablets and left for work at 12.45 pm and told her to take another two co-codamol tablets at 2.00 pm. At about 2.30 pm, Mr G's daughter-in-law contacted the surgery as Mrs G's condition had still

not improved and in fact the pain had worsened. The second GP arrived at the house about 5.30-5.45 pm and immediately arranged an emergency ambulance. Mr G said that the second GP told his daughter-in-law that he thought Mrs G had suffered an aneurysm [localised dilation of a blood vessel caused by a weakening of the walls] and that she needed an urgent operation but it might be too late. The ambulance arrived soon after with its blue lights flashing and siren blaring. When Mr G arrived at the hospital, a doctor told him that he should be prepared for some bad news. Mrs G needed an emergency operation but her condition had to be stabilised first. Mrs G was ready for theatre by 9.00 pm. At 2.00 am the surgeon came to speak to Mr G and told him that he was unable to save Mrs G, as he could not free a blood clot.

8. Mr G felt that the GP was wrong to have made his diagnosis by telephone. If he had needed extra information, he could either have asked to speak to Mrs G or made a home visit. Mr G believed that as the GP had given him the impression that Mrs G was not seriously ill, this stopped him from seeking alternative medical advice such as taking her direct to hospital. However, it appeared that the second GP knew straight away that something was seriously wrong and arranged an emergency admission. Mr G felt that if his wife had had a home visit at 6.30 am from the GP, instead of having to wait a further 12 hours, then that might have made a difference as to whether the hospital doctors could have saved her life.

<u>Documentary evidence</u>

9. The following are extracts from Mrs G's medical records.

13 August 2001

Extract from Call sheet compiled by REMS receptionist

'<u>Complaint:</u> since Sat[urday] vomit cramp'

Extract from Call sheet completed by the GP

'<u>Diagnosis and Treatment:</u> 36 hrs of constitutional upset with vomiting followed by diarrhoea and abd[ominal] cramps. Sounds like gastroenteritis or food poisoning. Advised re[garding] fluid balance and analgesia ie codeine based. Will try and get stool specimen to surgery

today. Will contact own doc[tor] if not slow improvement over next 12 hrs'

Extract from second GP's referral letter to the hospital
'This lady presents with 24 hr history of D & V [Diarrhoea and vomiting] but since 3 PM today developed pain in her r[ight] leg. O/E [on examination] distressed R[ight] leg immobile cold and pulseless L[eft] leg mobile cold and pulseless ... Heavy smoker 30-40 per day ... Her abdo[men] is distended ... but I cannot find an aneurysm ...'.

Evidence from the GP and REMS' Medical Director

10. **The GP** said that an overnight session at REMS starts at 12 midnight and finishes at 7.00 am the following morning. Between 6.00 pm and midnight, all calls are assessed by a nurse who would either provide advice, ask the patient to attend the centre for an assessment by the doctor, or arrange a home visit. Between 12 midnight and 7.00 am, there are two doctors on duty. One remains in the centre to triage telephone calls (the process of assessing priority and determining which calls can be dealt with by telephone advice, attendance at the primary care centre or by a home visit) and deal with patients who have been told to attend the centre. The other doctor is mobile to attend to home visits.

11. The GP explained that all calls to REMS are answered by a receptionist whose role is to obtain basic information such as the patient's name, age, address and details of the problem. The receptionist does not triage the telephone call. As the caller is on the telephone, the receptionist enters details on a computer screen (paragraph 9). The receptionist would then ask the caller to hold, and he/she would speak to the centre doctor. The centre doctor would then access the computer screen which had been completed by the receptionist. It is possible that the receptionist might have a brief word with the doctor but usually the call is transferred straight through to the doctor. The doctor would read the details input by the receptionist and speak to the caller. The doctor then completes further details on the screen (paragraph 9) such as a diagnosis and the action taken. The following morning, between 9 am and 10 am, a print-out containing details of the telephone call is faxed to the patient's GP surgery.

12. The GP was aware from reading the transcript of Mr G's telephone call, that he had asked the receptionist for a home visit for Mrs G. This request would not necessarily be passed on from the receptionist to the doctor. The GP believed that most people who telephone the Emergency Service usually ask for a home visit. This used to be the normal practice a few years ago when almost all telephone calls received a home visit. However, now telephone calls are triaged to ensure that appropriate action is taken. That could result in a home visit or attendance at the centre or simply advice if that was all that was required.

13. The GP thought that he had asked Mr G sufficient questions to obtain a history of the symptoms which led to his diagnosis that Mrs G was suffering from gastroenteritis (an acute inflammation of the lining of the stomach and intestines that has various causes, including food poisoning). The reported symptoms of a 30 hour history of stomach cramps, (Note: the entry in the call sheet completed by the GP was 36 hour history), diarrhoea and vomiting were consistent with his diagnosis. He thought that Mr G was a good and reliable witness who had provided a reasonable history and it did not appear from the tone of his voice that there was something seriously wrong. The GP had assumed that as the conversation with Mr G involved vomiting and diarrhoea then the cramps which Mr G had mentioned were stomach cramps. He did not consider that Mrs G might have had leg cramps. The GP did not ask whether Mrs G's pain was intermittent or persistent or its exact location as he assumed that it would be severe and intermittent as would be expected in a patient suffering from food poisoning. The GP thought that the use of the word 'cramps' implies intermittent, colicky pains which are usually severe.

14. The GP said that he possibly could have asked Mr G if there had been signs of blood in Mrs G's vomit or diarrhoea. Although, he would normally rely on the caller to volunteer that kind of information. However, even if Mr G had mentioned that there were signs of blood in Mrs G's diarrhoea, the GP did not think that it would have affected his diagnosis. The GP did not ask Mr G about his wife's age but he thought that he had gleaned from his conversation with him that his wife was not elderly. He would have been more aware for the need for a home visit if the patient was aged over 65 years or a young child.

15. The GP felt that with hindsight, perhaps he could have asked Mr G additional questions, but he did not think that his diagnosis would have altered. His usual practice is to tell the caller/patient to telephone REMS again if their condition deteriorated. He did not ask Mr G to telephone again because the second GP would have resumed responsibility for Mrs G 45 minutes later. The GP thought that Mrs G's condition would show signs of improvement later that day and that he had provided Mr G with appropriate advice, such as obtaining co-codamol or anadin extra from a pharmacist and that he should take a specimen of Mrs G's diarrhoea to the second GP for analysis. He did not think that an assessment at the centre or a home visit was required at that time. The GP felt that Mrs G's condition must have deteriorated later that day. He was aware that Mrs G's death certificate gave the cause of death as generalised peritonitis and perforated duodenal ulcer. However, the symptoms which Mr G reported did not sound like symptoms of a perforated ulcer.

16. The **Medical Director** said that the role of the receptionist was to obtain identification details from the caller. The receptionist would also ask for the reason why the caller was contacting REMS. The receptionist would not ask clinical questions as either the triage nurse or the centre doctor would cover this. The Medical Director felt that the receptionist had obtained sufficient contact details before transferring the call to the GP. He noted that there was no indication that the receptionist had told the GP that Mr G had requested a home visit. However, even if a home visit had been requested, this would not have affected the priority given to the call. It would be up to the centre doctor to make a decision on whether a home visit was required. It was the role of the centre doctor to speak to the caller and to decide on the next course of action.

<u>Assessors' report</u>

17. I reproduce next, in its entirety, the report prepared by the professional assessors who were appointed to give advice on the complaint.

Report by the Professional Assessors to the Scottish Public Services Ombudsman of the clinical judgments of staff involved in the complaint made by Mr G

(i) *In considering this complaint we have been asked to comment on two specifics:*

(a) *The GP did not put himself in a position to make a diagnosis; and*

(b) *The GP did not offer a clinical assessment either at the primary care centre or at home.*

Documents Provided

(ii) *In producing this report we have taken into account documents provided to us by the Ombudsman's office:*

- *Clinical records (Hospital, GP surgery and REMS) for Mrs G*
- *Transcript of telephone call from Mr G to REMS on 13 August 2001*
- *Correspondence between Mr G and REMS regarding Mr G's complaint*
- *Mr G's letter dated 28 April 2002 to the Ombudsman*
- *Ombudsman's statement of complaint issued 23 July 2002*

(iii) *We also had notes of interviews with Mr G, the GP and the Medical Director which were carried out by the Ombudsman's investigating officer.*

Circumstances of the complaint

(iv) *Mrs G first became unwell on the night of Saturday 11 August 2001 when she vomited around midnight. She stayed in bed all Sunday, having nothing to eat and drinking only cups of tea. Early on Monday morning she felt no better and Mr G phoned REMS. He*

initially spoke to the receptionist who took some details before putting his call through to the GP , who was the doctor handling calls that night.

(v) *There then followed the telephone consultation from which the complaint arises.*

(vi) *After listening to some details of the complaint the GP diagnosed food poisoning and recommended that Mrs G be given a painkiller with codeine in it and suggested the symptoms should settle in the next twelve hours.*

(vii) *Mr G contacted the surgery at about 8.30 am and arranged to pick up a prescription for co-codamol. He gave his wife two co-codamol tablets and left for work at 12.45 pm.*

(viii) *At 2.30 pm Mr G's daughter-in-law contacted the surgery to say Mrs G's condition had worsened. The second GP said he would visit after the evening surgery.*

(ix) *The second GP arrived at approximately 5.45 pm and immediately arranged for Mrs G to be admitted to the hospital.*

(x) *Mrs G was taken to theatre at about 9.00 pm where she was found to have a perforated duodenal ulcer with generalised peritonitis, and a thrombosis of the aortic bifurcation.*

(xi) *The surgical team were unable to prevent Mrs G from dying at about 2.00 am on the 14 August.*

Review of the telephone call to REMS on the morning of 13 August

(xii) *Mr G initially asked the receptionist for a home visit to his wife but this was not passed to the GP and Mr G did not subsequently repeat the request in his conversation with the GP .*

(xiii) *The original request was for a home visit, so we need to establish whether the GP put himself in a position to make a sound decision*

not to see the patient. Patients do not have an absolute right to a home visit and the GP's Terms of Service make it clear that the decision is his. However, this decision must be based on adequate information received as a result of an appropriate history. It has been pointed out by the GP and by the Medical Director that this is a common request and carries no weight as the doctor assesses all cases on their merit and offers what he considers is appropriate care. However out of hours arrangements have been the norm for several years now and the expectation of a home visit every time has diminished, with the result that the request for a visit now carries some weight. It therefore should be passed on to the doctor.

(xiv) *The patient's age was not taken or recorded.*

(xv) *We feel that this is an important piece of information and that it should always be recorded and available to the doctor.*

(xvi) *Mr G then gave the receptionist a summary of his wife's condition, which the receptionist paraphrased on the call screen as 'since sat vom cramp'. He subsequently repeated the details almost word for word to the GP .*

(xvii) *The GP then asked Mr G if his wife had diarrhoea. When this was confirmed, the GP said it sounded that she had food poisoning. Mr G agreed that this was what he thought.*

(xviii) *At this point we feel the GP could usefully have asked a few more questions before reaching his conclusion. It would have been helpful to find out the position of the pain in the abdomen, whether there was blood in the diarrhoea, and the colour and frequency of the vomit. He points out in his defence that patients usually volunteer information on the last two questions but we feel it is unwise to always assume this.*

(xix) *The GP then gave a description of the likely course of food poisoning, suggesting it was likely to settle in 24 to 48 hours.*

(xx) *This by itself was an appropriate description of the illness.*

(xxi) *He then suggested that it would be helpful to collect a sample of the stool and give it to the second GP. In addition he suggested that treatment should be fasting with small amounts of clear liquids and something for the pain if the vomiting settled.*

(xxii) *This advice was perfectly appropriate for a diagnosis of food poisoning.*

(xxiii) *There followed a discussion of what would be a suitable painkiller. The GP said that something with codeine in it was a good treatment for the condition and disagreed with the suggestion of ibuprofen.*

(xxiv) *This was reasonable advice for the treatment of food poisoning.*

(xxv) *The GP concluded by saying that it would start to settle in the next 12 hours.*

Discussion of subsequent events

(xxvi) *While it is important that the GP 's actions should be judged solely on the context of the telephone consultation we feel it is necessary to pass comment on the subsequent events.*

(xxvii) *After the phone call Mr G contacted the surgery to arrange for a prescription for co-codamol and this was provided and two tablets were given to Mrs G at about 10.00 am.*

(xxviii) *Mr G's daughter-in-law contacted the surgery at 2.00 pm to request a home visit.*

(xxix) *It is clear that the diagnosis of Mrs G's condition was problematical. When the GP assessed the request for a home visit, his judgement at that time was that an urgent visit was not*

necessary. Her condition appears to have deteriorated during the afternoon.

(xxx) When the second GP visited at about 5.45 pm he could see that Mrs G was seriously ill but the nature of her illness was not clear to him. His referral letter indicates that he suspects an aneurysm but he mentions a distended abdomen.

(xxxi) On admission to the hospital the examining doctor in Accident & Emergency suspected a saddle embolus with a possibility of an ischaemic bowel.

(xxxii) The surgeon who performed the operation, in a letter to the second GP, expressed surprise that he had discovered a perforated Duodenal Ulcer at laparotomy.

(xxxiii) The fact that three doctors who examined Mrs G that day were unable to make the correct diagnosis indicates that hers was a far from straightforward case.

Conclusion

(xxxiv) This was a tragic and unusual case. We have been asked to comment on two aspects of the contact with the GP on the morning of 13 August. It is important that this event is treated on the evidence that was available at the time of the contact and not clouded by the subsequent events.

The GP did not put himself in a position to make a diagnosis

(xxxv) The crucial part of the contact was immediately after Mr G first spoke to the GP. It is our opinion that in not asking more questions regarding the details of Mrs G's illness, the GP did not put himself in a position to make a diagnosis.

(xxxvi) It is a matter of speculation as to whether better information would have led the GP to reach a different conclusion about Mrs G's condition. However, if he had taken a fuller history and not

depended so much on volunteered information, he could have put himself in a better position to make a decision.

The GP did not offer a clinical assessment at either the primary care centre or at home

(xxxvii) *Once the GP had come to the conclusion that the patient was suffering from food poisoning his advice was perfectly appropriate and one would not expect such an illness to require an assessment at either venue.*

Findings (a)

18. Mr G has said that he telephoned REMS to request a home visit for his wife. He gave a history that since midnight on Saturday she had been violently sick, she was in pain with cramps, she was sweating and could not eat or sleep. After speaking to the GP, Mr G was reassured that his wife was not suffering from a serious illness and that she had food poisoning. Mr G carried out the GP 's instructions and obtained a prescription for co-codamol from the practice. Mr G left for his work at 12.45 pm and his daughter-in-law contacted the surgery at 2.30 pm to report that Mrs G's condition had deteriorated. The second GP arrived at the house at about 5.30 pm and arranged for an emergency ambulance to take Mrs G to hospital but it was too late for doctors to save her life. Mr G said that the GP was wrong to reach his diagnosis by telephone and if the GP had required further information he could have asked to speak to Mrs G or arranged a home visit.

19. The GP has said that he thought that he had asked Mr G sufficient questions to arrive at his diagnosis that Mrs G was suffering from food poisoning. He did not ask for the location of Mrs G's pain and whether it was intermittent or persistent as he assumed that the pain would be severe and intermittent as would be expected with a patient with food poisoning. He did not ask whether there were signs of blood in her vomit or diarrhoea as he would normally rely on the caller to volunteer that information.

20. The assessors have pointed out that the only question the GP asked before reaching his diagnosis of food poisoning was whether Mrs G had had diarrhoea. They have taken the view that the GP could usefully have asked a few more questions before reaching his diagnosis. It would have been

helpful to find out the position of the pain in the abdomen, whether there was blood in the diarrhoea and the colour and frequency of the vomit. It would be unwise to expect the patient or caller to volunteer such information. The assessors conclude that by not asking more details of Mrs G's illness, the GP did not put himself in a position to make a diagnosis. The assessors have also said that even if the GP had asked additional questions, it would be a matter of speculation as to whether the additional information would have led the GP to reach a different diagnosis. It is also important to note that in the second GP's referral letter to the hospital (paragraph 9) that Mrs G had developed pain in her right leg from 3.00 pm. This indicated a change in Mrs G's condition which was not present at 6.00 am. Taking account of the advice which I have received, I too take the view that the GP should have asked more searching questions in an effort to support his diagnosis and I therefore uphold this aspect of the complaint.

Findings (b)

21. Mr G's main reason for telephoning REMS was to request a home visit for his wife. He told this to the receptionist but the request was not passed on to the GP . The GP said that historically, most callers to REMS usually ask for a home visit but that it is up to the doctor to decide whether a visit is appropriate. That is a view shared by the Medical Director. The assessors however, have explained that out of hours services have been the norm for a number of years and the expectation of a home visit every time has diminished, with the result that the request for a visit now carries some weight. I fully accept that it is up to the doctor to decide on whether a home visit is necessary. However, as it is the role of the receptionist to establish why the caller is contacting REMS, then I would expect that information, such as a request for a home visit, would be passed on to the doctor. I believe that for a caller to request a home visit, this indicates a degree of concern and as such, this should be addressed by a doctor. To that end, I **recommend** that REMS reviews their procedures in order that if a caller requests a home visit then that information is entered on the computer screen and is available for a doctor to consider. That said, the GP did not consider offering Mrs G a home visit or asking her to attend the centre as he thought his diagnosis of food poisoning was correct. The assessors are in agreement that such a diagnosis would not normally require an assessment at home or the primary care centre. However, this

investigation has found that the GP did not put himself in a position to make a diagnosis and his assessment of Mrs G was inadequate. Again, I have to point out that even if the GP had asked additional questions, it is not possible to say whether this would have made any difference to the outcome. However, I am critical that an assessment, either at home or at the primary care centre, did not take place and it is to this extent that I uphold the complaint.

Conclusion

22. I have set out my findings in paragraphs 18 - 21. REMS have asked me to convey to Mr G - as I do through this report - an apology for the shortcomings which have been identified and have agreed to act on my recommendation in paragraph 21.

Graham Pettie
Senior Investigating Officer
duly authorised in accordance with
paragraph 11 of schedule 1 to the
Scottish Public Services Ombudsman Act 2002

February 2003

ANNEX A TO S.16/02-03

Transcript of conversations between the receptionist, Mr G and the GP on 13 August 2001 at 6.00 am

Receptionist	GP Emergency Service, which doctor are you calling?
Mr G	Yes, hello. I was wondering if I could possibly get a home visit for my wife?
Receptionist	I need to know who her GP is?
Mr G	Pardon?
Receptionist	I need to know who her GP is?
Mr G	Her GP is [GP details provided].
Receptionist	Home phone number?
Mr G	My home phone number is it?
Receptionist	Yes.
Mr G	[Home telephone number provided]
Receptionist	Patient's name?
Mr G	A.
Receptionist	First name?
Mr G	[First name provided]
Receptionist	What is the house number?

Mr G	[House number provided]
Receptionist	Who are you?
Mr G	Husband.
Receptionist	Your name is?
Mr G	[First name provided]
Receptionist	What is it that's wrong?
Mr G	Since Saturday night she has been really ill. First of all she has been violently sick and now she is in a lot of pain. She is now sweating, she can't sleep, she can't eat. I thought I might be able to hold on, but she is fairly ill.
Receptionist	Main door or a flat.
Mr G	It's a detached house, main door.
Receptionist	Can you hold the line for me?
The GP	Hello.
Mr G	Hello.
The GP	Yes, what can I do for you?
Mr G	It's my wife, she has been really ill since Saturday night. First of all she has been violently sick. Now she is in a lot of pain with cramp, she seems to be, she hasn't been able to eat, she can't sleep, she is sweating, she is

	taking cramps, she is really in a lot of pain, sort of thing.
The GP	Does she have any diarrhoea with it?
Mr G	She has had diarrhoea.
The GP	Yes, it sounds as if she has food poisoning, Mr G.
Mr G	Yes, that's what I thought.
The GP	Usually it depends on what type it is. Some of them go away fairly quickly within a day or two or some of them can last a bit longer and go on for about three or four days, but usually what happens you become unwell with a fever and then you start to get pains in your stomach, cramp pains, colic pains and usually it starts with vomiting and works its way down and you end up with diarrhoea and as I say it goes on for about a day or two or sometimes a bit longer, depending on which one of the bacteria it is that causes it. There is no sort of immediate cure for it or anything, usually we do recommend that people fast with it, you know.
Mr G	She can't eat anything.
The GP	That's right. Well I mean usually people feel unwell with it so they don't want to eat and by and large that's a good thing because if you feed it you are just keeping the thing going. Usually in the first instance we just recommend small amounts of clear fluid and usually the pain, the vomiting, the diarrhoea

	start to settle down within about 24-48 hours. So she has had it now for about 36 hours, I think, is that right? Saturday night you said.
Mr G	Yes.
The GP	So it should start to settle down quite quickly, probably a useful thing to do would be maybe to give your doctor a specimen of the diarrhoea and they will get it checked to see which one of the bacteria is causing it. There is one or two of them that are quite vicious and it can continue for four or five days and these are the ones at the end of the day tend to be treated, but in the early stages, in the first couple of days normally the treatment is fasting with small amounts of clear fluid and maybe something for the pain if the vomiting settles, you know.
Mr G	She has been taking some paracetamol.
The GP	That's kind of quite weak. You don't have anything stronger in the house? You don't have any co-codamol or anything?
Mr G	No.
The GP	Co-proxamol. That would be a wee bit stronger. You could probably get some of that from one of the pharmacies.
Mr G	What do you call it again?
The GP	Co-codamol, or something like anadin extra which is virtually the same as co-codamol. If

	she could take that for the pain. Something with codeine in it.
Mr G	What about ibuprofen?
The GP	No. I wouldn't take ibuprofen. I would take a painkiller with codeine in it. The chemist will give you one with codeine in it, because codeine quietens the bowel down and reduces cramps and things like that and reduces colic and stomach pains and things, so you could maybe get some of these in the meantime, but if you could get a specimen in to her doctor today, they will get it sent to the lab and they will check to see if she has a specific type of food poisoning. Okay. Carry on as you have been doing and hopefully it will start to settle down quite soon within the next 12 hours or so. Alright?
Mr G	Thank you for your help.
The GP	Right, cheerio now. Bye, bye.