Scottish Parliament Region: Lothian

Case 200501210: Lothian NHS Board

Summary of Investigation

Category

Health: Out-of-Hours Services, Clinical Diagnosis

Overview

The complainant (Miss C) complained that Lothian NHS Board (the Board) failed to provide the necessary out-of-hours care to her fiancé (referred to in this report as Mr A) on the night of the 26 and 27 April 2004, contributing to his death from acute haemorrhagic pancreatitis on 27 April 2004.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) GP 2 failed to make an appropriate differential diagnosis of Mr A's medical condition (*not upheld*);

(b) the telephone receptionist failed to record and pass on all the symptoms described to him by Miss C (*upheld*);

(c) GP 3 failed to take a comprehensive medical history (*upheld*);

(d) GP 3 failed to give appropriate advice about paracetamol (*not upheld*); and

(e) the out-of-hours service failed to respond appropriately to Miss C's complaint (*upheld*).

Redress and recommendation

The Ombudsman recommends that the Board:

(i) use the events of this complaint as part of future training for out-of-hours staff to reiterate the importance of good communication skills; and

(ii) (as the successor organisation) apologise to Miss C for the failure to properly handle her complaint in accordance with the regulations.

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. On 5 August 2005 the Ombudsman received a complaint from a woman (referred to in this report as Miss C). Miss C complained that Lothian NHS Board (the Board) failed to provide the necessary out-of-hours care to her fiancé (referred to in this report as Mr A) on the night of the 26 and 27 April 2004, contributing to his death from acute haemorrhagic pancreatitis on 27 April 2004.

2. Miss C initially raised her concerns with the out-of-hours service and GPs involved in Mr A's care that night. Miss C received written responses from the GPs. The Procurator Fiscal Service considered whether to recommend that a Fatal Accident Inquiry should be convened to consider the events surrounding Mr A's sudden death. Miss C did not pursue her complaint further pending the decision of the Crown Office. It was decided not to hold a Fatal Accident Inquiry (although this situation may change). Miss C referred the matter to Lothian NHS Board in July 2005. As it was now more than six months since Mr A's death (the time limit for accepting complaints under the NHS complaints system) the Board contacted the Ombudsman's office and it was agreed, in consultation with Miss C, that the Ombudsman's office would consider Miss C's complaint.

3. The complaints from Miss C which I have investigated concerned:

(a) the failure of GP 2 to make an appropriate differential diagnosis of Mr A's medical condition;
(b) the failure of the telephone receptionist to record and pass on all the symptoms described to him by Miss C;
(c) the failure of GP 3 to take a comprehensive medical history;
(d) the failure of GP 3 to give appropriate advice about paracetamol; and
(e) the out-of-hours service failure to respond appropriately to Miss C's complaint.

Investigation

4. Investigation of this complaint involved meeting with Miss C, several discussions with staff at NHS Lothian, reviewing Mr A's GP records, obtaining the opinion of a Medical Adviser (referred to in this report as the Adviser), reading the documentation provided by the Procurator Fiscal's office (including telephone transcripts and statements from the parties involved) and reading the

report of an expert GP Assessor (referred to as the Assessor) obtained by the Procurator Fiscal's office. Miss C, the Board, GP 2 and GP 3 all had an opportunity to comment on the draft report. Following receipt of the draft report the Board provided further information with respect to the new out-of-hours services in the Board's geographical area. Through their representative at the Medical and Dental Defence Union of Scotland (MDDUS), GP 2 and GP 3 disputed a number of the findings and conclusions of the draft report, particularly with respect to the operation of out-of-hours services. As a consequence of the disputed matters further advice was sought from the Adviser and an additional Specialist Adviser (referred to as the Specialist Adviser) was asked to review the complaint and interviewed GP 2, GP 3 and Miss C. Following this a revised draft of the report was issued. A summary of terms used is contained in Annex 1. A glossary of medical terms is contained in Annex 2. A transcript of GP 3's telephone call with Mr A is contained in Annex 3.

5. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Miss C, the Board, GP 2 and GP 3 were given an opportunity to comment on both the original and revised draft of this report.

Administrative background to this complaint

6. At the time of these events out-of-hours GP services were provided in different ways throughout Scotland. Within NHS Lothian the service was predominantly delivered by a number of area-specific services provided by local GPs who had grouped together to offer out-of-hours services for the GP practices in their area. Often these were the GPs already working in the local practices. These services operated under a contract with the local GPs who were at that point obliged to provide out-of-hours services for their patients - either directly or indirectly through such groups. This was the system in operation at the time of these events.

7. In April 2004 a new General Medical Service (GMS) contract was introduced which changed the requirements for provision of out-of-hours services, allowing GPs to opt-out of responsibility for providing or obtaining such services for their patients. Lothian NHS Board (through their Community and Primary Care Division) took over this responsibility from all GPs in the region in October 2004 and now provides the service in conjunction with NHS 24.

8. The out-of-hours service involved in these events in April 2004 no longer exists and NHS Lothian have taken over responsibility for the service. The issues raised are of relevance to the current out-of-hours service. I have, therefore, considered Lothian NHS Board to be the relevant authority for this complaint and advised the Board accordingly.

Medical Background to this complaint

9. Mr A had a history of liver problems and problems relating to alcohol misuse. He had a duodenal ulcer and enlarged veins in the gullet caused by the liver problem. The reason for death is recorded on the death certificate as 'acute haemorrhagic pancreatitis'. This is a rare variant of acute pancreatitis. Symptoms of acute pancreatitis commonly include upper or central abdominal pain which can have a gradual or severe onset, vomiting and fever. Pain is usually eased by sitting. The signs of the disease can be mild even in a serious case and include a raised pulse, jaundice, shock and tenderness of the abdomen. Most cases of acute pancreatitis settle but 20% are severe and the overall death rate is between 5% and 10%. There are around 10,000 cases of acute pancreatitis a year in the UK. Around 80% of the cases in Britain are associated with excessive alcohol intake or gallstones.

Investigation and findings of fact

10. Mr A and Miss C spoke with the out-of-hours service on four occasions between 20:05 on 26 April 2004 and 04:21 on 27 April 2004 either over the telephone or in person. On the first three occasions they reported the onset and progression of symptoms, speaking each time to different doctor (referred to in this report as GPs 1, 2 and 3). On the final occasion they requested an ambulance be called as a doctor was not able to attend due to another emergency. In the event Miss C called for an ambulance herself at 04:25 (approximately) on 27 April 2004. Mr A arrived at the Royal Infirmary of Edinburgh at 05:06 on 27 April 2004. Sadly Mr A went into cardiac arrest and despite resuscitation attempts was declared dead at 06:13 on 27 April 2004.

(a) GP 2 failed to make an appropriate differential diagnosis of Mr A's medical condition

11. Miss C and Mr A returned from a holiday abroad on 24 April 2004. Late in the afternoon of 26 April 2004 Mr A developed symptoms of abdominal pain and vomiting. In the early evening Miss C contacted Mr A's GP and was eventually referred to the out-of-hours service for the area closest to her home (which was outside the usual geographical area for Mr A's GP practice). The call to the out-

of-hours service was returned by GP 1 as triage doctor. Both Miss C and Mr A spoke with GP 1 at around 20:15 on 26 April 20004. Mr A informed GP 1 that he had been unwell for the past two days with sickness and diarrhoea and a continually painful stomach which worsened when he vomited. GP 1 noted Mr A had recently returned from Spain, had a liver problem and a known alcohol problem. Mr A informed GP 1 he took propanolol daily. GP 1 told Mr A she would arrange for a doctor to come out.

12. GP 2 attended at Miss C's home at 20:35 on 26 April 2004. He discussed Mr A's symptoms and past medical history with him. The call sheet used by GP 2 records Mr A's history of liver and alcohol problems and notes the enlarged veins in the gullet. He noted that Mr A was 'shivery at times' (this may indicate fever). He did not record Mr A's temperature. He noted Mr A's pulse to be 92 beats per minute (the normal rate for an adult is 72) and his blood pressure as 140/80 (this is normal). His physical examination noted Mr A had a distended stomach, tender upper central abdomen, a much enlarged liver and that his eyes were jaundiced. He noted a diagnosis of gastroenteritis. He gave Mr A an injection of an anti-emetic (to ease the vomiting) and advised him to call back again if the pain worsened.

13. Both the Assessor and the Adviser have commented that given Mr A's known medical history and these presenting symptoms; diagnoses other than gastroenteritis should have been considered. In particular the Adviser said that the distended stomach, jaundice, the site of the abdominal pain and the enlarged liver combined with the known alcohol related problems and the possibility of fever should have given rise to serious consideration of a disease process such as pancreatitis.

14. In his written response to Miss C, GP 2 stated that he was fully aware of Mr A's medical history. He considered his physical findings (set out in paragraph 12 and 13) were consistent with chronic excessive alcohol consumption and that Mr A's pulse and blood pressure were satisfactory. GP 2 concluded that Mr A's symptoms and signs were entirely in keeping with gastroenteritis. He offered to meet with Miss C to discuss matters further.

15. In response to the draft report GP 2 commented that he had considered a number of other diagnoses including liver disease but ruled this out. GP 2 also noted that he had taken considerable steps to discuss this case with colleagues and consider his actions at peer review and remained of the view that the

actions he took were appropriate in the circumstances.

16. In discussion with the Specialist Adviser, GP 2 described Mr A as appearing shy and embarrassed about discussing his alcohol intake. GP 2 stated that Mr A had described his alcohol intake as 'not great'. GP 2 also described Mr A's pain as colicky although this is not noted on the contemporaneous record. Miss C disagrees with this description of Mr A who she considered to be well aware of his alcohol problems and always candid in discussing it with doctors; he would not have described his alcohol intake as 'not great' (Mr A advised GP 2 that it was 60 units a week, correcting the note made by GP 1 of 60 units per day).

17. The Specialist Adviser told me that GPs working in out-of-hours services are attempting to answer a number of key questions. Firstly, is the patient seriously ill or not? Secondly, does the patient require hospital admission or not, and finally does a patient require immediate treatment or can that wait until routine daytime services re-open? Making a definitive diagnosis is not an absolute requirement of doctors working out-of-hours particularly when they do not have access to the whole general practitioner record or benefit from having met the patient before.

18. The Specialist Adviser's view was that GP 2's history taking, clinical examination and assessment were of a standard generally expected of a general practitioner presented with the same set of circumstances. The Specialist Adviser concluded that GP 2's plan to alleviate the vomiting and to use time as a further diagnostic tool reflects the usual practice of general practitioners working in an out-of-hours setting. He also noted that GP 2 had given appropriate advice to call again if the pain worsened or if there was gastrointestinal bleeding. The Specialist Adviser considered that GP 2's working diagnosis of gastroenteritis was appropriate.

(a) Conclusion

19. The medical evidence I have seen is that while Mr A did have a number of symptoms suggestive of gastroenteritis, there were other significant presenting symptoms (jaundice, distended abdomen, site of the abdominal pain and liver enlargement) which were not pre-eminently suggestive of gastroenteritis and could have given rise to consideration of other conditions. These symptoms combined with the known medical history and the patient's description of his recent alcohol intake might have alerted GP 2 to a broader range of diagnostic

possibilities than that indicated by the contemporaneous medical record. I acknowledge GP 2's view that he did consider other possible diagnoses and that some notes were made to this effect in the contemporaneous medical record. I note too the view of the Specialist Adviser that gastroenteritis was a reasonable working diagnosis when combined, as it was, with instructions to call back if the situation changed for the worse. The advice I have received is that while it may be that another GP may have come to a different view and taken different action that does not mean that GP 2 acted unreasonably. I am also conscious of the Specialist Adviser's comments regarding the role of the out-of-hours doctor as distinct from the regular GP.

20. It is important to note that neither Miss C or any of the advisers involved in this complaint consider that GP 2 should have diagnosed acute pancreatitis. The question is whether Mr A's symptoms and known medical history should have raised with GP 2 suspicion of a more sinister problem to an extent that made arranging an immediate in-patient admission appropriate. While several doctors have reviewed the events of this complaint there is no consensus as to the clinically correct action. GP 2 has said he considered other more serious possibilities and none of the advice I have seen suggests otherwise. Based on this advice I conclude that GP 2 did not fail to make an appropriate differential diagnosis and I do not uphold this aspect of the complaint.

(b) The telephone receptionist failed to record and pass on all the symptoms described to him by Miss C

21. The transcripts of the telephone calls record that Miss C called at 03:14 on 27 April 2004. Miss C stated that Mr A's stomach pains were worse and he now had shallow breathing. This was repeated a few moments later and Miss C added that he had a rapid pulse. The receptionist stated he was writing the information down.

22. The call sheet used by GP 3 contains typed details referring to the earlier call sheet used by GP 1 and GP 2 for medical history. It also states 'friend calling, patient has intracable [sic] stomach pains'.

23. In her letter to GP 3 written on 9 June 2004, Miss C questioned whether GP 3 had been informed that Mr A had shallow breathing and a rapid pulse and, if not, what his actions would have been had he known. GP 3 responded that he did not know this information and had he known he would have investigated further over the telephone but could not say without such further investigation if

he would have altered his course of action.

24. In his letter to Miss C of 2 June 2004, GP 3 (who was also Medical Director of the out-of-hours service) advised Miss C that he was reviewing matters with the receptionist on duty on 27 April 2004 and that NHS 24 would soon be taking over the service.

25. The Adviser stated that he could not see any evidence that the receptionist had passed on the further information provided by Miss C. He considered these were important clinical indicators and highlight a problem of the use of telephone diagnosis.

26. In response to the draft report the Board have told me that this case has been reviewed by Lothian Unscheduled Care. In addition this case was used as an example in an Education meeting in May 2006 organised by Lothian Unscheduled Care.

(b) Conclusion

27. The evidence I have seen suggests that the receptionist did not accurately or completely pass on all the relevant clinical information provided by Miss C. I, therefore, uphold this aspect of the complaint.

(b) Recommendation

28. As the particular out-of-hours service no longer exists the Ombudsman has no direct recommendation to make with regard to this failure. However, the failure identified in this report is a matter of concern and relevance to all out-of-hours services. The Ombudsman, therefore, commends NHS Lothian for the actions it has taken and plans to take in respect of this complaint and has no further recommendation to make.

(c) Failure by GP 3 to take a comprehensive medical history

29. Miss C called the out-of-hours service again at 03:14 on 27 April 2004. She expressed concern that despite following GP 2's advice, Mr A continued to be very unwell and was now having difficulty breathing and had a rapid pulse. The receptionist took the details and said a doctor would call. GP 3 telephoned at 03:25 on 27 April 2004 (see Annex 3). He had GP 1 and GP 2's notes with him. He spoke with Mr A who described an increase in pain. The phone call was interrupted early on in the conversation when the line became disconnected. GP 3 called back immediately. Neither GP 3 nor Mr A made

mention of the breathlessness or rapid pulse (see complaint (b)). GP 3 spoke with Miss C at the end of the call and advised Miss C to call back again if things didn't improve.

30. Both the Assessor and the Adviser stated that given the change in Mr A's symptoms in their view the appropriate decision would have been to make a further home visit or hospital referral. The Adviser noted that GP 3 did not appear to have been given all the relevant information by the receptionist (see complaint (b)), but considered this information could have been obtained by a better history taking. He also commented that Miss C, who was clearly capable of giving a good account, was expressing anxiety over Mr A's continued illness, this was the third medical contact and several hours had passed with no improvement.

31. GP 3 commented that he had undertaken to review the events in question with a number of colleagues and during peer review, and considered his actions were in-line with those of his peers. In response to Miss C's original complaint GP 3 stated that while he had not been informed by the receptionist of the change in symptoms, he could not say for certain that even if he had known this he would have altered his actions as he had found Mr A to be conversing fluently and a rapid pulse would not have been inconsistent with a diagnosis of gastroenteritis. In discussion later with the Specialist Adviser GP3 indicated that if he had been provided with the extra information about Mr A's pulse and breathing then the most likely option was that he would have visited him again.

32. I have referred to the views of the Specialist Adviser generally about out-of-hours services in paragraph 17. With reference to the actions of GP 3, the Specialist Adviser noted that GP 3 was of the view that he had reached his own conclusion as to the working diagnosis of gastroenteritis and not simply followed that of GP 2. The Specialist Adviser noted that GP 3 was not made aware of the rapid pulse and shallow breathing that can indicate a patient is suffering from a potentially serious illness. He concluded that whether the presentation of these symptoms would have influenced the outcome was a matter of conjecture but that in his view most General Practitioners would recognise the potential serious nature of these signs and when taken with the rest of the history, would reach a conclusion that a further face-to-face consultation was advisable.

33. The Specialist Adviser noted that GP 3 had informed him that he had

undertaken a review of his consultation using a validated assessment tool and considered his telephone consultation with Mr A had been of an appropriate standard. The Specialist Adviser commented that having himself taught groups of GP Registrars consultation skills over a number of years, he considered that GP 3's consultation did raise a number of issues as there was evidence of the over use of direct and leading questions around the nature of Mr A's pain and the reason for the medication already taken by Mr A. However, the Specialist Adviser concluded that on balance he did not believe these issues had a significant bearing on the consultation.

34. In his letter to Miss C, GP 3 commented that when he spoke with Mr A his concern was that Mr A might have bleeding from the veins of his gullet – a problem which was secondary to Mr A's liver problem. He concluded that he still considered his diagnosis of gastroenteritis to be reasonable. He stated that diarrhoea is not a usual symptom of pancreatitis and he had not seen this presentation in 12 years of practice (this was subsequently corrected during the investigation of this complaint to 16 years).

35. Annex 3 contains a transcript of GP 3's telephone call with Mr A. The Assessor, the Adviser and the Specialist Adviser expressed concern that the changes reported to the receptionist prior to this call were significant and should have resulted in either a home visit or referral to hospital. I have reviewed the telephone call in light of the concerns and considered why GP 3 did not obtain all the relevant information from that conversation. A transcript does not give a complete picture of the telephone call as it does not indicate where emphasis or pause occur in conversation and as such a certain amount of caution is needed in reviewing the text alone. However, I note that on several occasions GP 3 asked a series of questions without giving opportunity for separate answers. Mr A makes a number of statements which are at least in part contradictory and often does not provide the information needed to answer the question asked. These confusions or omissions are not always addressed by subsequent questions from GP 3.

(c) Conclusion

36. GP 3's telephone conversation with Mr A concentrated on the pain symptoms and relieving these (see Annex 3). GP 3 failed to identify that the call had been prompted by a concern that there had been a change in Mr A's symptoms. The medical advice I have seen is that these potential developing symptoms were significant and would have prompted a change in plan (either a

visit or hospitalisation). The doctors who have reviewed this case have expressed concern at GP 3's questioning of Mr A and I share this concern. I consider that GP 3 failed to elicit important information from Mr A during the course of his telephone consultation. I recognise though that this was aggravated by the incomplete information made available to him by the receptionist and the break in the transmission of the telephone call (see complaint (b)). I note GP 3's current view that such information may have altered his actions and the Specialist Adviser who considered such additional symptoms would cause most GPs to undertake a home visit.

37. I consider that it was the responsibility of GP 3 to ensure he obtained any relevant information during his telephone consultation and I conclude that he failed to do so. I, therefore, uphold this aspect of the complaint. I note and commend the actions GP 3 has already taken to review his involvement in the events of that evening.

(c) Recommendation

38. In light of the action already undertaken by GP 3 the Ombudsman has no further recommendation to make with respect to GP 3 but recommends that the Board use the events of this complaint as part of future training for out-of-hours staff to reiterate the vital importance of communication skills in telephone consultations.

(d) A failure by GP 3 to attend to Mr A and give appropriate advice about paracetamol

39. GP 3 asked Mr A if he had taken anything for the pain and specifically mentioned paracetamol. Mr A indicated he didn't think that he should take paracetamol and that he had had liver problems in the past. GP 3 then spoke with Miss C and asked if Mr A had taken any pain relief. Miss C indicated that he had not. She mentioned that she had Ibuprofen but that this stated it was not suitable for ulcers. GP 3 advised Miss C to give Mr A a couple of paracetamol and specifically stated 'paracetamol is safe to give'.

40. The Adviser said the prescribing of paracetamol to a patient with known liver disease and jaundice is not good practice. The *British National Formulary* (BNF - the guide to prescribing used by all GPs) indicates that paracetamol should be used with caution in patients with liver disease. The BNF also indicates that when used in conjunction with the drug which GP2 gave Mr A to inhibit vomiting, paracetamol absorption is increased – thus increasing the risk

for a patient with ongoing liver disease.

41. Following sight of the draft report GP 3 commented that he had discussed his actions with a number of colleagues and specifically raised the question of the use of paracetamol with a Consultant Hepatologist who had advised him that paracetamol is in fact the analgesic of choice in alcohol liver disease. I sought the further advice of a pharmaceutical and a hepatology specialist who both advised that there is no ideal drug in this situation and that paracetamol in ordinary doses may be the most appropriate analgesic. However, the Advisers also stated that they did not consider it good practice to prescribe paracetamol in this situation without a full examination of the patient. GP 3 advised me that he was satisfied that Mr A had very recently undergone a physical examination by GP 2 and, therefore, felt paracetamol was safe to prescribe.

(d) Conclusion

42. GP 3 prescribed paracetamol knowing that Mr A had an active liver problem and previous liver damage. I accept the medical view that this was the in fact an appropriate option for pain relief and, therefore, it was reasonable practice to recommend it but note that GP 3 did not consider a home visit to be necessary prior to making such a recommendation. The medical advice I have received is that this was not good practice but I note GP 3's view that he was satisfied that GP 2 had recently undertaken such an examination.

43. I conclude that, on balance, the decision to prescribe paracetamol in the circumstances was reasonable. I do not uphold this complaint.

(e) The out-of-hours service failed to respond appropriately to Miss C's complaint

44. Miss C raised concerns in writing with the out-of-hours service on 25 May 2004. In this letter she expressed concern and dissatisfaction about aspects of Mr A's care and treatment. Miss C addressed her letter to a specific individual whom she believed to be responsible for complaints and asked for an inquiry to be conducted. She received a number of prompt written responses from GP 2 and GP 3 but no other comments or responses advising how her complaint was being dealt with and who else she might approach if she remained unhappy.

45. The guidance in the NHS complaints procedure for complaints concerning General Practitioners changed in April 2005. Before this it was expected that a

complaint would be acknowledged within two working days and fully responded to within ten working days in most circumstances. If it was not possible to reach a satisfactory conclusion by this means then the complainant had the opportunity to request an Independent Review of their complaint and ultimately ask the Ombudsman's office to consider the matter. There was an expectation that complainants would be advised of their rights by the general practice. This was the procedure in place when Miss C made her complaint. Since this time, Independent Review has been removed and complainants may now approach the Ombudsman's office on completion of local resolution; that is once they have received a response from the GP practice.

46. Miss C told me that no-one advised her of the existence of the complaints procedure and in particular no mention was made of Independent Review or the Ombudsman's office. Miss C acknowledged that GP 2 offered to meet with her but she considered such a meeting would be too distressful. Miss C stated that she felt no-one independent had reviewed her complaint as she had requested and she was always unclear as to the process for making a complaint.

(e) Conclusion

47. Both GP 2 and GP 3 sought to respond to the issues raised by Miss C. The out-of-hours service did not seek to make Miss C aware of the NHS complaints procedure or her rights to refer her complaint on. I uphold this aspect of the complaint.

(e) Recommendation

48. As the out-of-hours service no longer exists the Ombudsman recommends that NHS Lothian, as the successor organisation, apologise to Miss C for the failure to properly handle her complaint in accordance with the regulations.

49. NHS Lothian have accepted this recommendation and will issue an apology to Miss C on publication of this report.

23 May 2007

Annex 1

Explanation of abbreviations used

BNF	British National Formulary – the GPs' guide to prescribing
Differential diagnosis	a range of possible diagnoses based on the noted symptoms and medical history which also considers the probability and risk of any possible diagnosis
GP 1	the first GP to contact Mr A by telephone
GP 2	the GP who visited Mr A at home
GP 3	the second GP to talk to Mr A on the telephone
GMS	General Medical Services
Miss C	the complainant
Mr A	the aggrieved, Miss C's fiancé
The Board	Lothian NHS Board
The Assessor	A doctor who advised the Procurator Fiscal's office
The Adviser	A GP adviser to the Ombudsman
The Specialist Adviser	A specialist out-of-hours GP adviser to the Ombudsman

Annex 2

Glossary of terms

Acute (haemorrhagic) Pancreatitis	(bleeding caused by) severe inflammation of the pancreas
Gastroenteritis	Inflammation of the linings of the stomach and intestine

Annex 3

Transcript of Telephone Call between Mr A and GP 3

Time 03:25:02	
Miss C	Hello
GP 3	Hello, this is GP3 ringing for Mr A
Miss C:	Yes, this is his fiancée, (Miss C), would you like to speak to him personally?
GP 3:	Yes please
Miss C:	Yes, hold on, are you the triage doctor? Are you the chap who was out earlier?
GP 3:	No, I am a different doctor. I have his notes.
Miss C:	Hang on a sec.
Mr A:	Hi
GP 3:	Hello Mr A, it's GP 3, you've got abdominal pain, is that right?
Mr A:	Yes
GP 3:	Hello. Hello. Hello…(line dead)
Time 03:26:04	
GP3:	Hello, its GP3, where is the pain Mr A?
Mr A:	In the centre of my stomach.

GP3: In relation to your belly button – above your belly button?

Mr A: Around the belly button.

GP3: Around the belly button.

Mr A: Just above, it's better when I go to the toilet.

GP3: When you pass a bowel motion?

Mr A: Yes.

GP3: Pain coming and going? Any blood in the diarrhoea?

Mr A: No.

GP3: Have you been vomiting?

Mr A: Yes, but not since the injection, so that's all right.

GP3: OK. How often are you getting the diarrhoea?

Mr A: Once every 15 minutes.

GP3: And the pain eases when you pass the motion.

Mr A: That's right.

GP3: So the pain comes and goes?

Mr A: Yes, it tends to stay there quite a lot, does come and go, consistent.

GP3: And have you been drinking much?

Mr A: Last week, but not in the last two days.

GP3: Not in the last two days? The diarrhoea started when?

Mr A: Tea time tonight.

GP3: OK and you're just back from Spain – have you eaten anything unusual?

Mr A: Possibly, I think it's possibly food poisoning, but I don't know.

GP3: And so the pain builds up and then it settles down again?

Mr A: Yes, that's right.

GP3: OK. Are you drinking plenty of fluids?

Mr A: Yes, drinking plenty of water.

GP3: What are you taking for the pain?

Mr A: Nothing.

GP3: So you're not taking Paracetamol or anything?

Mr A: No, didn't want to play about with that.

GP3: What do you mean you don't want to play about with it?

Mr A: Well, I didn't know if it was going to do any good – I've had a bit of liver trouble in the past – I take Propranolol, but that's not for the liver, that's for the tubes.

GP3: The tubes?

Mr A: For eh, to thin my blood.

GP3: To thin your blood, the Propranolol?

Mr A: Yeah.

GP3: That's a beta blocker, it doesn't thin your blood, it slows down your heart rate.

Mr A: Right, well that's fine, that's what … yeah.

GP3: Is the Propranolol that you take for anxiety? Or high blood pressure?

Mr A: Yeah, I take that.

GP3: OK. Have you taken the Propranolol?

Mr A: Yes, I have.

GP3: OK, cos when the doctor saw you your abdomen was soft, he wasn't worried about a surgical cause.

Mr A: Eh, no.

GP3: You have Hepatitis, have you had Hepatitis before?

Mr A: I don't think so.

GP3: You saw (specialist heptology consultant), what did you see him for?

Mr A: Just a check up.

GP3: OK. But did he, there wasn't a question of Hepatitis then?

Mr A: Eh not that I know of, I don't know, I don't know Not that I know of..

GP3: OK. Can I speak to your partner for a second?

Mr A: Yes.

Miss C: Hello.

GP3: Hello, he hasn't taken anything for the pain?

Miss C: He hasn't taken anything because in the past he had an ulcer years ago and has had some liver compromise recently.

GP3: Right.

Miss C: I've got Ibuprofen which says don't take if you've got liver trouble and I've got something else which says don't take if you've ever had an ulcer, so that's why I felt I couldn't give him any of these things.

GP3: Well you can give him Paracetamol; Paracetamol is safe to give, ok?

Miss C: Right.

GP3: I would give him a couple of Paracetamol now. It seems to be, I mean, the doctor who saw him, GP2, felt it was Gastroenteritis.

Miss C: Right.

GP3: That would fit in with acute diarrhoea and vomiting. The medical Metoclopropramide will have settled the vomiting what nature's trying to get rid of is all the toxins and that's why you get the crampy abdominal pain. OK. So I would give him a couple of Paracetamol and that should kick in within an hour.

Miss C: OK.

GP3: The danger with Gastroenteritis is that if he keeps vomiting or the diarrhoea

Miss C: He will get de-hydrated.

GP3: De-hydrated, so you want him to drink Dioralyte.

Miss C: I've got some dio – oh what's it called?

GP3: Dioralyte?

Miss C: Yes.

GP3: Yes, that'll be alright to give him, it seems to be that the pain builds up when he gets diarrhoea and then it eases off again, that's the bowel in spasm. Now, when GP2 saw him, his abdomen was soft, so it's not a surgical thing like a twisted bowel or anything like that. There's no blood in it which is reassuring with Gastro but obviously that's the other thing you would want to look out for.

Miss C: Yes, I told him to watch for that.

GP3: OK. If you could give a couple of Paracetamol now and get him to take some of the Dioralyte and obviously just see how it goes, if things aren't any better, give me a ring back.

Miss C: OK, What's your number?

GP3: (number given).

Miss C: OK. Thank you very much for your help. Bye.

GP3: Bye.