

AIM

ANAESTHETISTS IN MANAGEMENT

Autumn Issue

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A Message from the chair.....

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Dr Pamela Bell

Welcome to another AIM newsletter. Every year AIM contributes to the Association of Anaesthetists of Great Britain and Ireland 'Seminars at 21 Portland Place'. This year the seminar, following feedback from members, covered issues such as training to be a manager, the implications of the European Working Time Directive for anaesthetic departments and how briefing and debriefing can con-

tribute to patient safety in theatre. The afternoon session dealt with the importance of caring for your staff, and dealing with underperforming colleagues. In the final session, Dr Stuart Davies related



AAGBI, 21 Portland Place,
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the issues arising from an accidental death under anaesthesia; not least how the department cared for and supported the anaesthetist concerned through the vicissitudes of enquiries and trials.

For those of you who were unable to attend, I hope that this newsletter will update you on these important matters. To those who did attend, my thanks

for your contributions to some enlightening discussions, making it a most useful day for everyone. To all the speakers, my appreciation of the hours of preparation and the quality of presentations on the day, and last but by no means least to Ramana Alladi, our education lead for ensuring that we had a very successful day.

AIM is holding a lecture session at the AAGBI Annual Congress in Liverpool on Wednesday 23rd September; I hope to see many of you there. A remainder also of our own Annual Conference at the Royal College of Anaesthetists on Monday 9th November – some places are still available, but early registration is recommended.

Pamela F Bell
Chair

Editors note.....

It has been truly delightful to edit the 8th AIM Newsletter, this edition highlights the important aspects of managing the Anaesthetic workforce. It includes abstracts from various committee members and others involved directly in workforce management at local and national level. Hope you find this edition an entertaining read, I am grateful

for your input and continued support, please continue to encourage others to join our specialty society of Anaesthetists In Management.

I look forward to meet you in November at Royal College Of Anaesthetists for Annual Conference focusing on Quality and

Risk, Trainee essay competition, Poster presentations and much more.....

Asha Chhatwani
University Hospital Coventry
and Warwickshire
Walsgrave, Coventry

Briefing & Debriefing for Patient Safety

Presented by Dr Adrian Hobbs

In this presentation, Dr Adrian Hobbs illustrated, with the use of video clips, the problems that arise when members of theatre staff fail to communicate adequately. Using examples gleaned through conversations with various theatre team members in his trust, he produced a video of situations which arise in theatres throughout the country and are familiar to us all – the list overrunning, lack of essential equipment, lack of suitably experienced staff, failure to recognise when the surgeon is experiencing technical difficulties and failure to take responsibility for the performance of the team.

He then addressed the ways in which briefing and debriefing the theatre team can improve patient safety and job satisfaction for the team. His first video clip dealt with the scenario of the overrunning list – the surgeon wishes to finish the list (task-orientated), the scrub nurse is about to finish her shift (time-orientated) and the anaesthetist is also somewhat time-orientated and has 'delayed the list' by taking too long in the anaesthetic room (teaching and siting an epidural – this results in conflict which could have been prevented by better planning. The clip illustrates a lack of leadership in the team, hostile and rhetorical questioning and a lack of constructive communication.

The WHO Surgical Safety Checklist has been shown to reduce morbidity and mortality in a global population (complications down from 11%-7% and deaths from 1.5%-0.8% in over 3000 cases pre and post introduction of the checklist over 4 hospital from high income countries and 4 hospitals in low/medium income countries). However when the data from the high income countries is considered, although the reduction in complications is similar, the reduction in mortality is not marked (0.8%-0.6%) and day surgery tends to skew the

figures.

Dr Hobbs then discussed the factors underpinning several major disasters of the 1980's including the Chernobyl nuclear explosion where safety checks were run at night following a daytime power cut when appropriately trained safety staff were not on duty (Hospital at Night), the Challenger space shuttle disaster (managers not heeding concerns of technical staff), the sinking of the Herald of Free Enterprise (ETWD, Systems, monitors), the Piper Alpha explosion (safer systems, briefing, command chain) and the Kegworth air crash (silos, cognitive capacity, new technology). In all of these situations non-technical skills (human factors) played a significant part.

Cognitive skills, such as situation awareness, decision making and conflict resolution, and social skills, such as communication team working and leadership and followership are all needed to prevent errors. It is about what is right, not who is right. It is important to maintain perspective – anaesthesia in an ASA1 patient is ultra safe with risks similar to the nuclear industry, railways and commercial large-jet aviation. However surgery increases the risk to that of road safety. The question of who leads the theatre team was then raised; illustrated by another video clip.

Older anaesthetists present agreed that it used to be the theatre sister – now perhaps it is the doctor – perhaps it should be the person who has task knowledge, who trades task knowledge for social leadership. If this knowledge is distributed amongst the team then leadership is also distributed – a heterarchy, not a hierarchy. Everyone is capable of leadership if situationally aware – this is the benefit of briefing. The ideal theatre team would be led by a 'wheelwright' in a heterarchy of constructive followers who feel able to offer construc-

tive dissent when required.

The 'Call X-ray' clip illustrated the point – everyone could have recognised the need for an intra-operative X-ray and a brief at the start of the list could have reduced delays. The surgeon may have displayed poor leadership, but the scrub nurse could have called for a brief to consider contingencies.

Situational awareness, or shared mental models, is only possible if team members are briefed and totally proficient (i.e. their cognitive capacity is not overloaded). They need to feel important to the success of the task and work in a flat hierarchy, so that they can speak up. Their contributions need to be recognised.

A final video clip illustrated a model brief. Lasting just 1 minute 42 seconds it enabled the team to establish shared mental models, discover potential problems and develop contingency plans. In this example it was lead by the scrub nurse – however all members of the team had constructive ideas and a good working atmosphere was established.

As with any change, briefing has its detractors. Reasons for not briefing were cited as lack of leader enthusiasm, time restrictions, difficulty co-ordinating staff, other pressing commitments and priorities, and junior staff not feeling empowered to ask for briefs. Dr Hobbs suggested that successful briefing depends on communication occurring at an appropriate time, avoiding interpersonal/hierarchy barriers, being clear and concise and feedback should be encouraged.

In summary, briefing establishes a team, initiates open communication, establishes situational awareness, raises issues relating to patient, equipment, liaison, needs to cover time and training and should continue throughout the list.



Delegates at the Seminar



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Briefing & Debriefing

Summarised by
Dr Pamela F Bell (Belfast) Chair AIM

A debrief is necessary to thank team members, reflect and learn and issues raised at debriefing must be resolved by the team and the theatre management.

Dr Hobbs described a number of different types of briefing including horizon briefing by a stable team a week before the list – lasting 30 minutes – allows for forward planning of complex procedures; a functional checklist before the list starts – 3-5 minutes – allows a quick check of major issues; the team building format, with everyone together before the list is good for ad hoc teams, permitting discussion of who is on the team/patient issues/equipment issues – this takes about 10 minutes; cumulative check per case using the WHO checklist permits new team members to be briefed and others to be updated on progress on matters raised earlier (e.g. results of pre-op blood tests). Using a facilitator (for example a theatre nurse for 6 months part-time to gather data, stimulate and support the introduction of briefing and to share what is happening with other teams has been a successful exercise.

To summarise the briefing section of his presentation, Dr Hobbs reiterated its benefits. It helps to establish a team from a disparate group of individuals; it initiates open communication and establishes situational awareness; issues concerning the patients, equipment, and

liaison are addressed. To be successful it must deal with the thorny problems of time and training and it must continue throughout the list.

What then is the role of debriefing and how should it be achieved? The role of debriefing is to learn the lessons and reflect upon what went well, what was challenging, how well did the team communicate and did all share an understanding of the cases, was time an issue, did briefing help and what, if any, other issues arose. As with briefing, this can be captured using a formal check list, however it may also be achieved by recording critical incidents and other



issues for review – possibly during sewing up of the final case, by using a credit card checklist or by having a roving debrief.

Debriefing should be a time to reflect and learn and a time to say thank you to the team. It is essential that issues raised during the debrief are resolved by the team and by the theatre management if

enthusiasm for debriefing is to be maintained.

What are the barriers to the successful implementation of briefing and debriefing? Some medical staff find it unnecessary and time wasting and have described it as 'tree hugging'. In teams where there is a steep hierarchy or low morale there may be reluctance to ask for a brief, there may be reluctance to lead a brief and in a physically widespread unit it may be difficult to co-ordinate the time and the task. There may be lack of motivation to brief because of time, staff availability and lack of tenacity, however Dr Hobbs pointed out that it is when time is short and staff under pressure that briefing is most useful.

In the Royal Cornwall Hospitals Trust the solutions to these barriers lay in starting with the checklist forms, proceeding with implementation even if the surgeon and anaesthetists did not attend, reporting back on progress through audit meetings, reminding and rewarding staff for compliance and tenacity. They have been sustained by early positive gains – as one theatre team member said 'Starting a list without a Theatre Team Review Meeting is like driving your car without a seat belt'.

Training to be a Manager ... Presented by Dr Pamela Bell

Summarised by Dr Asha Chhatwani, Consultant Anaesthetist, Coventry

Dr Bell's presentation focused on how the management training can be started early and further built up to be more efficient, more effective and more responsive. The general management training usually starts as senior trainee, rota-maker, as junior representative at anaesthetic division, junior BMA rep or as GAT committee member, all these roles provide doctors an opportunity to take part in influencing the way in which care is delivered.

There is no substitute for learning by doing, and active experience should be sought from the beginning by participating in seminars, workshops, discussions, presenting business case, chairing a meeting or being beside someone and

learning and more formal Management courses

Dr Bell then mentioned about specific management courses like MBA that would help to further the general skills, increase self confidence and could change career direction, as there are government initiatives encouraging medics to be the Chief Executives. There are lots of ways to do MBA - online, distance learning, full or part time with some available funding from employers.

The emphasis is on MBA that offers more transferable skills for Healthcare. There are various Darzi Fellowships / Projects available to improve the Quality of Care in NHS – Team working, Leader-

ship Development, safety improvement project, Data collection and analysis, etc that are available in modular training from Leeds University. Such fellowships would require support from Med Director or an independent coach from management field. For members at Trust Board level there are more focused programmes from King's Fund, BAMB and AIM society that also provide with various publications, newsletters and updated information via websites. Management websites:

www.aimgbi.org, www.aagbi.org,
www.rcoa.ac.uk, www.bamm.co.uk,
www.kingsfund.org.uk,
www.mbaworld.com, www.bps.org.uk,
www.uklifecoaching.org



Dr Diana Dickson
Consultant Anaesthetist
Leeds

“performance after a 24 hour shift is impaired to the same extent as having a blood alcohol of 0.1%”

Caring For Your Staff

Presented by Dr Diana Dickson - Leeds

Dr Dickson gave a very exciting and informative presentation on Caring for the staff to maintain a stable workforce. Caring implies physical, mental, emotional welfare of staff members. Caring and mentoring relationship results in increased productivity. The consequences of not caring are sick leave, interpersonal disputes and the staff often would feel unappreciated and exploited. Caring could be provided in different roles – as Parental, in the form of Mentoring and Communal within the organization

In order to deliver care remain in contact with as many workforce as possible, know the undercurrent feelings of staff and look for any health problems and behaviour associated with stress and emotional distress. If there are physical health problems encourage registration with GP, give time off to get treatment, maintain contact with employee while they are off sick, keep a track with regard to their illness, organize staged return to work.

As a manager encourage Healthy Behaviour – healthy eating, exercise, work-life balance, encourage attitudes which would improve mental as well as physical health.

Mental Health Problems are more likely to occur in an organization that is under threat or pressure. The vast majority of mental health problems can be successfully managed if identified early. Often the common causes of stress are – Lack of predictability and control at work, difficult interpersonal relationships with seniors, colleagues, nurses, too much work / difficult work, fear of failure and litigation, life changes and personal / financial problems resulting in various psychological effects - depression, anxiety, aggression, poor judgement and concentration with the end result of impaired ability to function

How do we spot a doctor in difficulty? Usually this would be apparent from their behaviour, the work or relationships at

work will suffer, some become very quiet signaling danger and others may become aggressive or emotionally distressed

How to help colleague under stress? Stress management skills....

Communication: Encourage colleague to communicate with individuals involved early and sensitively, involve others as required. Handle aggression assertively

Conflict management skills: Identify potential problems and individuals with problems.

Be assertive and empathic and help others adjust their belief and attitudes

Time management
Finally encourage and reward staff in dealing with challenges and allow flexible working where possible.

EUROPEAN WORK TIME DIRECTIVE:

Implications for Anaesthetic Departments

Presented by Dr James Watt

Dr James Watt opened his presentation by posing the question – By implementing the European Working Time Directive (EWTD) in our anaesthetic departments are we ‘Squaring the Circle? Or Circling the Drain?’ Following a brief review of EWTD, he explained the core aspects of its implications for anaesthetic departments and the impact that it has for manpower planning. He then suggested ways in which a department might cope with the introduction in August 2009 and illustrated this by outlining the effects of the introduction of EWTD in the North west Deanery in AUGUST 2008.

What is EWTD?

EWTD is health and safety legislation which has applied in the UK since October 1998. It limits the work for 1 employer to 48 hours per week, ensuring an 11-hour rest period in every 24 hours, a maximum of 8 hours working overnight, one day off in every 7 day period and a 20 minute break every 6 hours. It aims to limit the ability of the employer to exploit the employee and to reduce fatigue and the accidents that result. Rest is essential for physical and psychological well being. Tiredness has adverse effects in the central nervous and cardiovascular

systems and on the endocrine and immune systems. Dr Watts pointed out that performance after a 24 hour shift is impaired to the same extent as having a blood alcohol of 0.1%; the legal limit for driving in the UK being 0.08%. Lack of sleep increases the likelihood of errors, micro sleep etc

The ETWD has serious implications. The European Court of Justice rulings on the SIMAP and Jaeger cases means that all hours spent in hospital are working hours, whether the doctor is working or resting on the premises at the disposal of the employer.

Since 1989, when it was not uncommon for junior hospital doctors to work 120 hours per week, to 2009 where they should be working an average of 48 hours per week, there has been a 60% reduction in their working hours – in other words junior doctor capacity has reduced to 40% over 20 years. Currently the UK government is trying to extend the opt out, and the USA are trying to reduce resident hours to less than 80/week.

What are the medico legal implications?

In Regina v. Hart (2003), Gary Hart who has been awake all night surfing the internet, was sentenced to 5 years in prison for causing death by dangerous driving (10 counts) when he fell asleep at the wheel. This case highlighted one's personal responsibility to desist from working when sleep-deprived. R. V. Groves and Coates (2003) established employer liability for death by dangerous driving through permitting prolonged (20 hour) shift working, and in Eyres v. Atkinson's Kitchens and Bathrooms Ltd (2007) the employer was found responsible for the injury to the employee resulting from excessive working hours. Dr Watts pointed out that, so far, no doctor has been successfully prosecuted, however one has been found guilty of manslaughter for being recklessly negligent, so perhaps we should not be complacent.

How should the EWTD be tackled?

Dr Watts identified the problem of conforming to the EWTD as being a wicked one. That is one that cannot be solved by application of existing processes and cannot be fixed without altering the environment. He ran through the conflicting issues including financial (junior staff, targets, foundation status), staff (shift working unpopular, limited staff numbers) training (decreased skill and experience from shorter working/training hours, reduced access to training opportunities, different end product of training?) and service (who will fill the gap in staff grade and training posts, will elective or emergency work be prioritised, how will continuity of care be maintained, how will ser-

vices be modernised, developed and will some services be 'dumped?').

Can the problem be solved by manpower planning?

Can we work smarter/ differently? Can others do our work? Increasing the number of anaesthetists could be achieved by increasing medical school places or decreasing the length of training but the end product may be too inexperienced to be useful. Reducing the length of post graduate training means that the Certificate of Completion of Specialist Training becomes Certificate of Completion of Training with the establishment of a sub-consultant grade. Breaking the monopoly of medical anaesthetists by employing nurse anaesthetists/epiduralists, physicians assistants (anaesthesia), respiratory technicians etc begs the question as to whether these are really like-for-like replacements.

The introduction of the IOPA new consultant contract means that (assuming that each consultant works 5 'lists' and has 2.5SPAs there is a net 2 list per week loss (28%) compared to the pre 2003 contract. Unless there is pressure on the SPA time (reduction to 1) or more anaesthetists are employed it is not possible to meet service needs; so can we work smarter? Only anaesthetists can do anaesthetic tasks, but what has been the impact of Hospital at Night? Anaesthetists risk becoming the provider of last resort on cardiac arrest teams, care of the sick patient in the wards/A+E and the simple task service – erection of IV lines etc.

Dr Watts presented detailed evidence of how a consultant delivered elective and emergency anaesthetic service in a small trust with every consultant on a IOPA 2003 contract and assuming consultant and trainee numbers increase at the same rate as the past 8 years would have a shortfall of 210 PAs or 28 consultants by 2014. When a three layer resident consultant on-call pattern is considered this translates into a deficit of 44-48 consultants. When one considers the UKs 285 trusts, then 48 consultants per trust equates to 13,680 consultants and with current projected increases in manpower over the next 5 years of 10,536 there will

be a short fall nationally of 3,144 and this does not consider the impact of a mainly female workforce, part-time working and perhaps a different end product (the sub-consultant grade). Clearly the current consultant contract is not fit for purpose if current services are to be delivered.

The North West Deanery – EWTD compliant August 2008.

Dr Watts developed his presentation by explaining what happened when the North West Deanery went EWTD compliant in August last year. There were several deanery initiatives including overseas recruitment from EU and non-EU countries, there were recurrent monies (7Million) from the national fund to support the introduction of EWTD - the trust had to produce evidence that the money was used to support compliance and that new ways of working and novel posts were part of the solution. The Overseas Medical Training Initiative (overseas non-training trainees) was thought to upset the staff grade doctors.

There has also been service reconfiguration in the north west with changes to the services delivered at the two major acute hospitals. This has resulted in the loss of one trainee on call at one of the hospitals. In summary, Dr Watts felt that the main consequences of the EWTD nationally are recruitment of non-standard consultant by foundation trusts, increased attempts to recruit overseas doctors, pressure on SPAs, pressure on consultant to multi-task or work for free, increased pressure to deliver targets, increased pressure on departments to undertake non-anaesthetic work and, potentially, national renegotiation of the consultant contract and development of the sub-consultant grade. He concluded that EWTD is a 'wicked' problem that was unlikely to be solved by central initiatives but might be solved locally by asking the right questions about core services, staffing differently, the role of the consultant and controlling demand and rationalising supply.

**Summarised by Dr Pamela F Bell
Chair AIM
Belfast**

Dealing with underperforming colleague

Dr Catherine O'Dwyer, Lincoln

Dr O'Dwyer provided the audience with knowledge of dealing with poorly performing/ 'difficult' colleagues that so often prevents effective change for better patient care.

She emphasised failure to provide good clinical care or maintain proper relationships with patients and colleagues constitutes poor performance and as a Duty Of Care an appropriate action is required to avoid any patient harm and provide opportunities to colleague to improve the performance.



If concerns are serious, involve Clinical Director at an early stage, this enables the CD to see issues in perspective and range of options to be considered about how best to proceed

The standards of clinical care and professional conduct are set by GMC, PGMETB, Royal colleges, National organizations(NCAS) and reinforced through contracts of employment . The Professional Performance act enables GMC to assess formally doctor's clinical and professional performance, now it will be possible by Revalidation process.

Dr O'Dwyer mentioned various local regulatory processes to facilitate high standards of care – appraisal, team working, complaints procedures, NHS management and the role of trainers, college tutors, educational supervisors for trainees

Poor performance comes to light usually by concerns expressed by clinical and non clinical staff, complaints by patients and relatives, clinical governance, clinical audit, at appraisal, review of performance against job plan, litigations and allegations of negligence.

How to deal with poor performance?
5-part framework suggested

1. Action when a concern arises
2. Restriction of practice and exclusion
3. Conduct hearings and disciplinary matters
4. Procedures for dealing with issues of capability
5. Handling concerns about practitioner's health

What to do?

The procedure to be followed depends on the nature of concerns about poorly performing Anaesthetist:

Procedures to be followed within the trust:

Non specific concerns and patients may / not be immediately at risk :

Gather discreetly as much information as possible

Try to establish the facts

Anyone making an allegation against colleague must be prepared to support it in writing. Consult senior colleague before deciding how to proceed

If concerns appear to be well founded but not serious, than one or two colleagues can bring them informally to Dr's attention together with appropriate advice

If concerns are serious, involve Clinical Director at an early stage, this enables the CD to see issues in perspective and range of options to be considered about how best to proceed

Further advice can be obtained from RCOA, AAGBI, Sick Dr scheme, GMC.

Concerns where patients are at risk / local discussions have failed

CD and MD should be contacted urgently. NCAS should also be contacted if exclusion is being considered

MD may seek help from RCOA / AAGBI for procedure to be followed to provide impartial advice

CD may be asked to be the investi-

gating officer and provide the medical director with facts that would help the MD in proceeding further

Procedures outside a Trust
NCAS gives local case management advise to Trust in implementing the recommendations and for the candidate involved can avoid suspensions

NHS Ombudsman to assist in resolving the problem where the issues are not clear

GMC where local Trust action and NCAS advise has failed to resolve the problem or the problem is serious with wider implications

Finally keep records of everything: conversations, telephone calls, meetings interviews.

Establish facts, maintain openness with the colleague concerned to protect patients. Maintain standards and act justly

Maintain confidentiality until the enquiry is complete

In any large organization there remains a concern - How to deal with it is every clinical leader's fear that the opposition or obstruction of 'difficult' colleagues will stymie (Thwart) effective change - change that will ultimately benefit patients.

Giving attendees the necessary skills, knowledge and tools to deal effectively with their key problems, the aim of this seminar is to ensure that effective clinical change happens .

**Summarised by
Dr Asha Chhatwani
Consultant Anaesthetist,
Coventry**

An Anaesthetic Death

Presented by Dr Stuart Davies, Swansea.

Dr Davies discussed the facts surrounding a devastating incident that came to his attention in 2002, where a baby with pyloric stenosis died from a massive air embolus. The air had been intended as a suture line check (at the surgeon's request) via the in situ nasogastric tube. However, it was injected mistakenly into the intravenous line.

The intense efforts to resuscitate the baby were described, as were the honesty and courage of the primary anaesthetist involved in the case in his communication with the baby's parents.

Dr Davies gave a narrative account of subsequent events, which involved the local coroner, police and Criminal Prosecution Service. The unfortunate anaesthetist, who had a good reputation, was tried and acquitted of manslaughter two years

later; and had to attend a coroner's inquest two years after that, which corroborated the trial result. The lengthy processes involved in the official handling of such cases were highlighted, especially with reference to the emotional toll levied on all those involved.

Other organisations became involved: the GMC explored the anaesthetist's fitness to practise while awaiting the trial, no restrictions being put on his practice. The Royal Colleges (Physicians/Surgeons/Anaesthetists) undertook a review of the management of pyloric stenosis, which emphasised that the mutual compatibility of connectors between intravenous and nasogastric ports had been a significant contributory factor. In parallel to external investigations, the hospital where the incident took place undertook its own investigation, which resulted in different

connectors being introduced as a preventative measure.

The importance of frank, sensitive and supportive handling of the aftermath of a serious untoward incident was strongly emphasised, including the critical role demanded of the local department in providing debriefing and support for colleagues in need. Dr Davies directed the audience to sources of further information, including the AAGBI publication: *Catastrophes in Anaesthetic Practice – dealing with the aftermath* (2005).

**Summarised by
Dr Helen Hartley**

Have you booked your place yet?

AIM Conference

Title: Delivering Quality in Anaesthesia

9th November 2009

@

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CONFERENCE PROGRAMME

- **Defining Quality – Dr Liliane Field**
(MPS - Medical Protection Society)
- **Patient's Perspective of Quality – Mrs Anne Murray**
Chairman, Patient Liaison Group, RCoA
- **Motivation and Team Leadership**
Dr David Whitaker,
Consultant Anaesthetist,
Past President of the AAGBI
- **Right Patient and Right Care Environment**
Dr Paul Hughes
- **Presentation by the Prize Winner of the Essay Competition:**

“Ten ways of improving quality in the Anaesthetic Department”
- **Improving the image of the Department**
Dr David James
- **Safe Surgery – minimising human error in anaesthesia**
Dr Ellen O'dell MDU
(Medical Defence Union)