

Geriatric Medicine:

A selection of Top Tips to get you started

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Six Random Thoughts...

1

Before doing any investigation, it is important to think why you are doing it and what you will do with the result. Scientific curiosity has no place!

2

Routine blood tests (especially on rehab wards) should be discouraged – they should only be done if clinical suspicion of abnormality. Studies have shown that 30-50% of inpatient lab testing is unnecessary.

3

Acopia is not a diagnosis! The inpatient mortality for patients carrying an admission “diagnosis” of “acopia” is higher than for a myocardial infarction!

4

There is a higher mortality associated with lower AMT scores than there is with higher NEWS scores – make sure you carry out a cognitive assessment on all general Geriatric patients. And remember that elderly patients may not trigger a higher NEWS score.

5

For confused patient, a collateral history is vital – it is important to determine if the patient has dementia, delirium, or both.

6

Chronic confusion screen bloods (B12, folate, TFTs) have no place in delirium. Neither does CT (unless focal signs): constipation is a commoner reason for confusion than stroke! And do check the Ca^{2++}



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- Produced by the **Bangor and Wrexham COTE teams** for our own new starters to the speciality and shared with you as #FOAMed. Let us know what else you'd like us to add for the 2nd edition!
- Contact us on Twitter: @WrexhamCOTE & @COTEBangor
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The concept of frailty

You already know what frail looks like - famously described in the second half of Shakespeare's Seven Ages of Man from As You Like It (catch it [here](#) with the fabulous Benedict Cumberbatch!) we can all see the difference between those amazing elderly people who are out, about, self-caring an active, and those who have slowed down and need an increasing amount of help.

A definition of frailty is:

“Frailty is characterised by a vulnerability to stressors which would not affect non-frail people. These stressors can range from a bereavement to septicaemia. These stressors can lead to a rapid decline in both functional status, and in some cases physiological deterioration. This decline may be reversible, but in many cases the person will not return to their baseline.”

In other words, when people with frailty become unwell, they are knocked further down than a non-frail person, may not recover to their baseline, and are more likely to die.

There are different Frailty score, but Rockwood's pictorial **Clinical Frailty Scale** is the simplest to learn and increasingly used in routine practice.

Clinical Frailty Scale*



1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.



2 Well – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.



3 Managing Well – People whose **medical problems are well controlled**, but are **not regularly active** beyond routine walking.



4 Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being “slowed up”, and/or being tired during the day.



5 Mildly Frail – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.



6 Moderately Frail – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.



7 Severely Frail – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).



8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.



9. Terminally Ill - Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise evidently frail**.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.

2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.



Frailty scores in everyday medicine

Top Tips when using frailty scores

- The patient's frailty score is what they are like when they are well, not when they are acutely unwell... try asking "what were you like 2 weeks ago"
- Patients with frailty are more likely to die when they become ill
- You *can* estimate a frailty score based on what relatives/carers describe to you
- Patients with frailty dip further when they are unwell, take longer to recover, and may not get back to their baseline function

Emerging evidence: a heads up

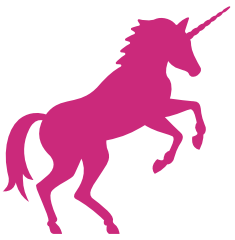
- There is emerging evidence (some of which is from work done in Bangor and Wrexham COTE & acute medicine departments - [click here](#) to see one of the papers) that the NEWS score and CFS - *used together* - can help to inform clinician thought process, priorities and decisions.
- For example, by early involvement of social assessments in patients with a NEWS of 0 but a frailty score of 5+ (as this is their most likely disposition).

		NEWS SCORE	
		0 to 4	5 or more
CLINICAL FRAILITY SCORE	0 to 4	<p>Aim to keep out of hospital. Seek ambulatory care alternatives to admission</p>	
	5+	<p>NEWS 0, CFS 5+: Is the problem more social than medical? Consider social services early: they're likely to be required for successful discharge</p>	<p>Ensure you have the "What Matters" conversation ASAP, in case the patient is approaching the end of life (but remember, many do get home and a DNACPR does not mean do not treat!).</p>

An unparalleled outdoor playground

SNOWDONIA

And it's on our doorstep. See p13.



The magic of the Medication Review

Polypharmacy causes a lot of problems with frail patients. With this in mind, it is vital that when you are reviewing patients that you perform a wholistic medication review.

Specific events that should always prompt a medication review:

- Falls
- Immobility
- Confusion
- Functional decline

A starting point to this is talking to the patient and asking what their goals are. A lot of medications we use are with the aim of prolonging life – this is often not the patient's priority, many would prioritise quality of life. Despite this, 70% of patients leave hospital on more medication than they came in on.

Some of the best tools for medication reviews:

- START/STOPP
- IMPE

Some dos and don'ts of de-prescribing

Do discuss changes to medications with patients and their families (especially if they lack capacity - the patient, that is, not the families)

Do review PPIs and the indication – PPIs carry and 89% increase in pneumonia in dementia, and a significant increase in *C. diff* risk

Do review antihypertensives – for patients with impaired cognition or impaired ADLs (i.e. frail) at baseline, lowest mortality is with a blood pressure of 160-180 mmHg systolic

Do not aim for tight glycaemic control in type 2 diabetes – aim for a BM of 10-20 without symptoms (and remember a HbA1C below 50 is too low).

Don't routinely prescribe statins for patients >80 with MI/IHD – no significant effect on long term survival.

Don't de-prescribe cholinesterase inhibitors in advanced dementia unless in the imminently terminal stage or bradycardia – worsens cognition and neuropsychiatric symptoms.

Do not routinely prescribe anti-psychotics or sedatives to patients with dementia or

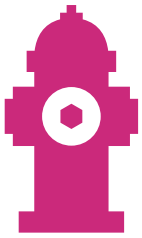
delirium: increased mortality and few benefit (<1 in 5 patients with dementia) so these drugs should only be used for patients who are at risk to themselves or others. Shouting out/ climbing out of bed does not count! This may be suggested by psychiatry liaison, if you are unsure discuss this with a senior

Do not routinely prescribe beta blockers post-MI in care home residents – there's no improvement in mortality and they increase functional decline *except* in the presence of heart failure

Do think about NNT (see Polypharmacy app)

Pharmacists - your allies

- Make use of your pharmacists - they're likely to know a lot more than new prescribers!
- Communicate clearly if you are stopping or withholding medications, so that the drug reconciliation pharmacist (or patients/carers) don't put them all back again!



Waterworks

Catheters

Where possible catheter use should be minimised in frail patients.

When a patient comes in with a catheter (especially with a catheter-associated UTI, CAUTI) the indication for the catheter should be checked and it should be removed if possible.

If a catheter is inserted on admission it should be removed ASAP – preferably after ensuring a patient is opening their bowels well.

NEVER ask for a urine dip to confirm a CAUTI – it will be positive (you can still culture for sensitivity if clinically a UTI)

Constipation is one of the commonest causes of urinary retention in women and failed TWOCs – with this in mind, make sure patients have been opening their bowels regularly before attempting a TWOC.

If a patient is confused and has a catheter ensure they are on a leg bag – it is much less likely to be ripped out!

Where there is a CAUTI the catheter must be changed after starting antibiotics.

UTIs

Ref: SIGN guidelines with formatting partly sourced from guidance issued by Doncaster & Bassetlaw Teaching Hospitals

Smell of urine, positive urine dipstick, positive urine culture and pyuria are **not** automatically signs of a UTI. These need correlating with the clinical picture (i.e. symptoms).

- The incidence of asymptomatic bacteria in women living in care homes is >50%
- The number needed to *harm* for treating asymptomatic bacteria is 3

Be a urosceptic

- Only treat if there are at least 2 symptoms of UTI (or if there are signs of infection and no other source evident)
- Send an MSU, ideally before antibiotics commence
- Consider oral antibiotics if your patient is not septic, and use the shortest possible course of antibiotics: stop the antibiotics if the MSU comes back negative!
- Treat with narrow-spectrum antibiotics based on sensitivities where possible

Not sure if it's a UTI or not? try to hold your nerve?

- If your patient isn't acutely septic, consider not treating and monitoring instead:
- Recheck bloods, monitor temperature
- Review if persisting/change in symptoms
- Get a collateral history: is the confusion new?



How to diagnose a UTI

At least two of the following symptoms

- Dysuria
- urinary urgency
- Urinary frequency
- New incontinence
- Rigors
- Fever or hypothermia
- Flank pain
- Superpubic pain
- Haematuria
- New or worsening confusion (see below)

or

Evidence of pyrexia, hypothermia, abnormal WCC or CRP

AND

No alternative cause for these

Ref: SIGN guidelines with formatting partly sourced from guidance issued by Doncaster & Bassetlaw Teaching Hospitals



Confusion - what does it mean?

New/worsening confusion might be due to infection, but may also be due to constipation, urinary retention, dehydration, medication or just the change in environment.



Constipation: if you don't check, you won't find it...

If you're tempted to diagnose a UTI because of increasing confusion, remember the old adage that "if you don't put your finger in it, you'll put your foot in it". Do that PR. Don't poison your patient with unnecessary antibiotics - they are *not* harmless!

Patients with Parkinson's Disease

PD patients need special attention. If they miss their usual PD drugs they can come to catastrophic harm or even die. Then there are many other drugs you may be tempted to prescribe (e.g. cyclizine, prochlorperazine, haloperidol, metoclopramide) which can also cause catastrophic harm.

- Treat PD drugs like you would insulin and steroids: They Must Not Be Missed.
- Take a careful drug history, and prescribe usual medication accurately and promptly.
- If the patient is NBM or can't swallow, they may need an NG tube and to be converted to a dispersible or liquid preparation.

Liaise with a PD specialist at the earliest opportunity (PD consultant, nurse specialist or pharmacist)

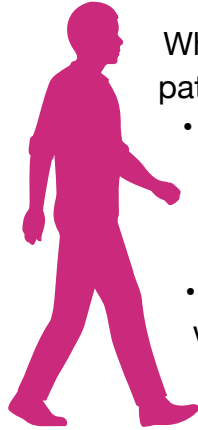
Use www.parkinsonscalculator.com



End PJ Paralysis

Deconditioning is a big problem in hospital inpatients. It is well known that a week in bed results in a 10% loss of muscle mass, and a 14% loss in aerobic capacity. In patients that are just about maintaining their independence at home this can often be the difference between returning home or needing 24-hour care, sometimes for the rest of their lives. Other studies have shown that “ambulant” patients spend less than 3% of their time standing or walking whilst in hospital.

It is vital we try to keep our patients mobile whilst in hospital wherever we



can. There is a lot to be said for the stigma around hospitalisation: as soon as patients come into hospital they are put into their pyjamas and they become a patient.

Wherever possible we need to encourage our patients to mobilise:

- Encourage patients to never stay in bed when they can sit out (confers a lower risk of hospital acquired pneumonia)
- Walk to the bathroom when they can.
- Encourage relatives to walk with patients when they come in to visit

Falls

A diagnosis of “Fall ?Cause” means a thorough assessment hasn't taken place – a fall is a presenting complaint, **NOT** a diagnosis.

- A clear history of the fall that precipitated your contact with the patient (as well as any previous falls) is vital.
- For patients that fall on the wards you should have to complete a post-falls review sticker the next day to look for the cause.
- Always consider postural hypotension in unexplained falls (present in 40% of cases) especially when the patient cannot provide an accurate account.
- When asking a patient about their “dizziness” always get them to characterise it – BPPV is common.

A **focused medication review** in patients that are falling is vital.

- Antidepressants are more strongly linked to falls than benzodiazepines or anti-hypertensives.

- All patients who fall should have a FRAX score and osteoporosis treatment should be considered.
- Many elderly people who fall are uninjured, but the potential for serious (and potential fatal) injuries must be actively considered.

A word about injuries

- A fall from standing height in a frail patient can be equivalent to a fitter person being hit by a car
- Half of elderly patients who fall down the stairs have major trauma - they need handling as such, usually including CT.
- Always think about potential injuries, including the c-spine & chest.
- Ask for help where you are unsure.
- Patients who have painful hips or cannot walk after a fall *must* have hip/pelvis x-rays as appropriate.



Delirium

- There are two main types of delirium: hypoactive and hyperactive.
- Hypoactive delirium is frequently missed and confers a higher mortality.

DELIRIUM DETECTION

Asking these two simple questions:

1. months of the year backwards
 2. what day of the week is it
- ... is 93% sensitive and 64% specific for detecting delirium.

- Mortality increases by 11% for every 48 hours that it isn't recognised.
- Delirium can be prevented in 1/3 of cases (each ward move increases the risk of delirium by 5-10%)
- Be aware that sometimes patients that are "poor historians" have inattention related to hypoactive delirium.
- >50% of patients remember being delirious, it is very distressing, and some even can get PTSD from it. Explanation and reassurance is very important.

DELIRIUM DETECTION

Picking at bedclothes or the air in front of them (carphologia or floccilation if you're interested!) are pathognomonic for delirium.

4AT

Assessment test for delirium & cognitive impairment

Patient name: _____
Date of birth: _____
Patient number: _____
Date: _____ Time: _____
Tester: _____

[1] ALERTNESS
This probing patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Choose the patient, if asking, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.

Normal (fully alert, but not agitated, throughout assessment)
Mild sleepiness for <10 seconds after waking, when normal
Clearly abnormal

CIRCLE

0
1
2
3
4

[2] AMT4
Age, date of birth, place (name of the hospital or building), current year.

No mistakes
1 mistake
2 or more mistakes/unintelligible

0
1
2

[3] ATTENTION
Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.

Months of the year backwards

Achieves 7 months or more correctly
Starts but misses >7 months (refuses to start)
Unintelligible (cannot start because unwell, drowsy, inattentive)

0
1
2

[4] ACUTE CHANGE OR FLUCTUATING COURSE
Evidence of significant change or fluctuation in attention, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs

No
Yes

0
1
2

4 or above possible delirium or cognitive impairment
3: delirium or severe cognitive impairment unlikely but delirium still possible if [4] information incomplete

4AT SCORE

GUIDANCE NOTES
The 4AT is a screening instrument designed for rapid initial assessment of delirium and cognitive impairment. A score of 4 or more suggests delirium but is not diagnostic; more detailed assessment of mental status may be required to reach a diagnosis. A score of 1-3 suggests cognitive impairment and more detailed cognitive testing and interview history-taking are required. A score of 0 does not rule out delirium or cognitive impairment; more detailed testing may be required depending on the clinical context, time of day, one knowledge of the patient, other staff who know the patient (eg. ward nurses), GP notes, case notes, carers. The tester should take account of communication difficulties (hearing impairment, aphasia, lack of common language) when carrying out the test and interpreting the score.

Alertness: Altered level of alertness is very likely to be delirium in general hospital settings. If the patient shows significant altered alertness during the bedside assessment, score 1 for this item. **AMT4 (Abbreviated Mental Test - 4):** This score can be extracted from items in the AMT4 if the latter is done immediately before. **Acute Change or Fluctuating Course:** delirium can occur without delirium in some cases of dementia, but marked fluctuation usually indicates delirium. To help rule out hallucinations and/or paranoid thoughts ask the patient questions such as: "Are you concerned about anything going on here?" "Do you feel frightened by anything or anyone?" "Have you been seeing or hearing anything unusual?"

© 2011 by the Royal Free Hospital

Review these things every day to reduce risk of delirium:

- Hydration status
- Bowel habit (a PR in delirium is often indicated)
- Pain review
- Check hearing/visual aids are present and working

The 4AT Assessment test for delirium and cognitive impairment is simple to use and rapidly gaining popularity.

[Download it here.](#)



Dementia

- Reduced oral intake is one of the later signs of dementia – if dehydration is the only pathology in the absence of infection, delirium etc then careful thought should be given regarding the appropriateness of non-oral hydration.
- This may be the end stage of dementia and a conservative, palliative approach should be considered in conjunction with the next of kin.



Capacity & Agitation

You will frequently be asked to assess the mental capacity of our patients. Capacity is decision and time specific – this is something that is often misunderstood. It may fluctuate and this needs to be taken into consideration.

To say that somebody has capacity to make a decision they need to be able to:

- Understand information pertaining to the decision
- Retain it long enough to make a decision
- Be able to weigh up the information and come to a decision
- Be able to communicate the decision back

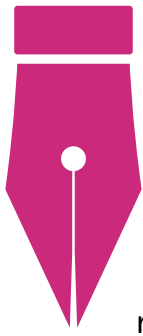
This should be recorded on a Mental Capacity form. These are **decision specific** but can include the ability to decline medical treatment or leave the ward. N.B. if we would stop the patient from leaving the ward if they tried they should have a DOLS (Deprivation of Liberties safeguard) completed.

Where patients lack the capacity to refuse treatment it may be appropriate to give them medications covertly. This decision needs to be documented with a signature from a SpR or above, a pharmacist and a nurse.

**If this photo floats your boat,
perhaps it's time you moved to North Wales.**

**We have posts in COTE for post-CMT Clinical Fellows,
Consultants, and GPs. See page 13.**





Advanced Care Planning

Being admitted to hospital is greatly feared by elderly patients and with very good reason: some will never get back to their own home, and as the statistics in the box (right) show, admission really can be a harbinger of doom.

All of these statistics point to the importance of thinking of **ceilings of care** for all patients *especially* for the more frail. This should be discussed with the patient where possible. If they lack capacity to make decisions regarding their healthcare it should be discussed with their next of kin (remember to ask if anyone has Powers of Attorney for health & welfare) or an IMCA.

SOME STATISTICS

- 1/3 of inpatients in their 70s will die within one year.
- 1/2 of inpatients over 85s will die in the next year.
- 30 day mortality of care home resident admitted to hospital 30%
- 1/3 of patients with dementia admitted to hospital will not return home



#HaveTheConversation

Key issues to discuss:

- CPR status
- Escalation of care (e.g. would referral to HDU/ITU be appropriate?)
- Repeated courses of intravenous antibiotics in the end stages of life
- Whether re-admission to hospital following discharge/transfer to community hospital is appropriate
- Invasive investigations (inc blood tests)
- Artificial rehydration & artificial feeding

These decisions need to be considered on a case by case basis. **There is considerable evidence to say that elderly patients want to have these conversations**, healthcare professionals are not proactive enough in this regard.

Each decision is in isolation i.e. a DNACPR decision should *not* mean a patient is less likely to receive IV antibiotics.

Families and DNACPR discussions

Since the 2014 Tracey v. Cambridge University Hospitals NHS Trust case, the law is clear that DNACPR orders *must* be discussed with patients or their proxies, unless they've indicated they don't wish to be involved, or the discussion is likely to cause physical or psychological harm (NB - *not* "just" being upset). Patients who have no capacity and no family will need an IMCA to get involved in non-emergency DNACPR discussions. CPR is still a medical treatment that families/patients cannot demand, but ask for senior help if you feel a DNACPR is indicated and the family or patient do not.

You may be surprised at how matter of fact many elderly patients are when discussing that the end of their life is approaching... they have after all often been going to funerals for the past decade or two the way we went to weddings in our 20s!

**CPR is not a treatment
for Ordinary Dying**

ADVANCED CARE PLANNING & DNACPR DISCUSSIONS: Some suggestions that make things easier for everyone

- Make it routine. The more you have this conversation, the easier it becomes.
- **Ask in the social history** - after smoking/alcohol and before carers - “do you have any powers of attorney, Treatment Escalation Plans or DNACPR forms that I need to make a note of?”. The answer will usually be “no, what are they” and you have the perfect opening gambit to have a sensible discussion.
- If the patient looks upset or startled, then - assuming you don’t think they are at imminent risk of death - you can move swiftly on: “OK, we can have a chat about that later, but they are really important... now, on to who does the shopping...”
- Whether CPR (or any other escalation of treatment) is offered is a **medical decision**.
- It is not up to the family (or the patient, for that matter, though we take their view seriously). Make this very clear: “*your health is very precarious now, and when your heart eventually stops, we wouldn’t be able to start it again, so we should not try...there’s a form we need to complete to make sure that when your time eventually comes, you can pass away peacefully in your own bed*”.
- **Families need to know you are not asking their “permission” not to try to resuscitate mum or dad - some are very worried by this.**
- You can also try asking about “unwanted treatments”, at the point you are asking about allergies - “*are there any medicines you can’t have, or treatments you wouldn’t want?*”.
- Find phrases that work for you.

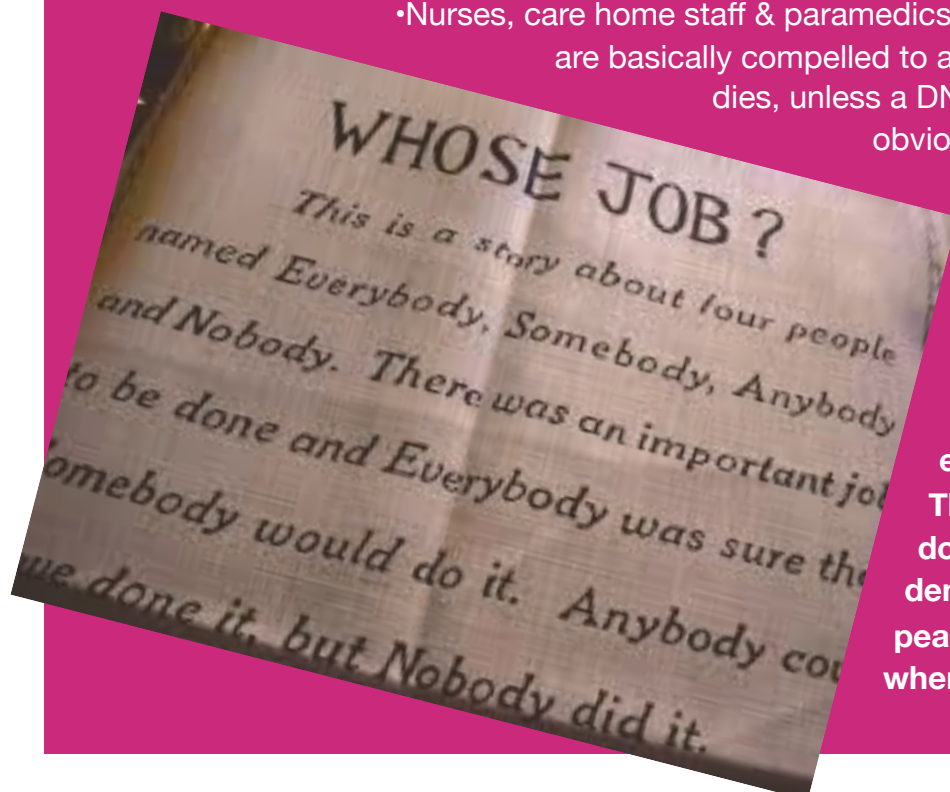
“CPR is a treatment for when your heart is the first thing to stop...”

- CPR is one of the miracles of modern medicine. In the right patients, it can literally bring the dead back to life. But CPR is intended for otherwise healthy people whose heart has suddenly stopped but when everything else in the body is working... not for when the heart has stopped because everything else in the body is either *not* working (when CPR doesn’t work), or is plain worn out. The latter is Ordinary Dying, and we should not be trying to stop it.
- The survival to discharge statistics for cardiac arrest in the elderly - especially those with comorbidities - are *extremely* poor. Most COTE patients need the protection of a DNACPR to prevent an undignified, futile and (sadly, but undeniably) brutal end to their lives.

• Nurses, care home staff & paramedics (and, increasingly, hospital staff) are basically compelled to attempt CPR on any patient who dies, unless a DNACPR is in place, however obviously inappropriate a resuscitation attempt is.

• Your patients need you to protect them from inappropriate, futile or unwanted CPR. In order to do so, you must talk to them.

• **NEVER assume that someone else will have the conversation. They might not, and so if you don’t do it either, your patient may be denied the right to slip away peacefully in his or her own bed when their life comes to an end.**





References and resources

<http://aeme.org.uk/> - Association for Elderly Medical Education – useful youtube videos and podcasts

www.bgs.org.uk – The British Geriatrics Society – free membership for F1 & F2 doctors

The **FRAX score** for osteoporosis risk

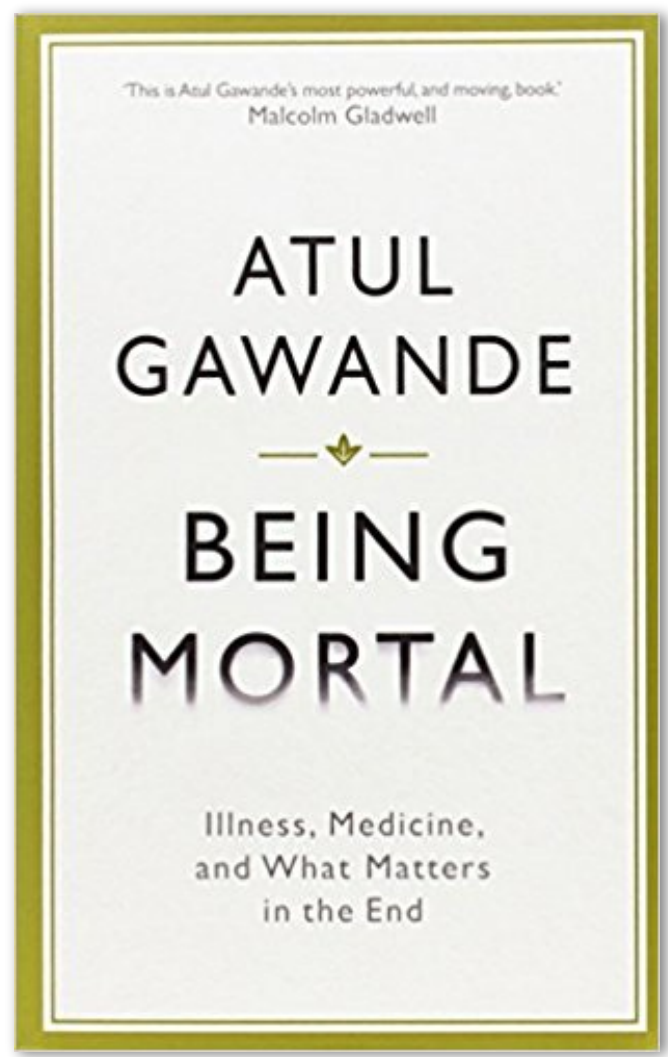
START/STOPP for medication reviews - this is the guidance from the Wirral.

IMPE for medication review - Health Foundation report

<http://thehearingaidpodcasts.org.uk/mdtea-2/> - MDTea produce podcasts about the multidisciplinary management of older patients

Being Mortal by Atul Guwande – a very good read for every doctor

The Other Side & The Bright Side by Kate Granger – written by a terminally ill geriatric medicine registrar who died in 2016, but not before founding the #hellomynameis movement





Join one of our teams!

WREXHAM, NORTH EAST WALES

MIDDLE GRADE CLINICAL FELLOWS

Wrexham's COTE team have some **fantastic middle-grade posts for post-CMT doctors** - the ideal posts to indulge in some CV buffing! Doctors in these roles are well supported, with an added bonus of 2-3 sessions per week that's all yours to undertake duties of your choosing, for example:

- ✳Supernumerary outpatient department clinics
- ✳Procedural experience in medical specialities
- ✳Audit and quality improvement projects
- ✳Medical education and simulation
- ✳Or come to us with an idea - if it benefits the local health economy as well as you, we can consider it!

CONSULTANT GERIATRICIANS

Wrexham is also on the look-out for additional **Consultant Geriatricians**, with posts available that can combine your choice of falls, frailty, general geriatrics and rehab.

For further information, contact Sara.Gerrie@wales.nhs.uk, or Dr Cameron Abbott (COTE Consultant) on Twitter at [@WrexhamCOTE](https://twitter.com/WrexhamCOTE)



Meanwhile, over in **Bangor** (North West Wales, between Snowdonia and the Isle of Anglesey) we are looking for a **Consultant Geriatrician with an interest in Stroke**, and an **ST3+ LAS or Clinical Fellow** to cover our registrar's maternity leave... we can create very attractive bespoke packages!

Flexible, bespoke portfolio GP posts also available.

We are also eyeing up our future direction of travel, and although our team has recently expanded significantly, if you are approaching CCT (or an established consultant Geriatrician considering a change of scene) please do get in touch for a chat. Our Movement Disorders service is pretty full, but we could make good use of most other varieties of **COTE consultant** in the medium term.

We specialise in flexible job plans and annualised rotas - and if you like mountains or beaches, this is a very nice (and affordable!) place to live!

Contact [Dr Salah Elghenzai](https://twitter.com/DrSalahElghenzai) or Tweet [@COTEBangor](https://twitter.com/COTEBangor). Do also visit www.COTEBangor.org for more info.