nationally to support development elsewhere. Of course, one size will not fit all and some areas, notably Scotland and perhaps the South West of England, will be better served by local general surgeons continuing to undertake the GPS. In such centres, training adult general surgery trainees to undertake GPS is a logical step. Provision should be made to enable any general surgeons who may choose to undertake this work to get the training they require in their local DGHs.

What is clear is that strong and decisive leadership is required in order that we can make use of the limited time available to plan the workforce that will be needed, put in place the necessary training systems and agree funding streams for new appointments. Accurate data will be necessary to allow correct decisions to be made. We feel discussions should be taking place between all the specialties involved, particularly between paediatric and general surgeons and we would welcome the opportunity to contribute to these discussions as future consultant paediatric surgeons.

References

1. Gomez K *et al.* *Survey of paediatric surgery in Wales*. Presented at ASGBI Annual Scientific Meeting, Manchester, April 2007.
2. British Association of Paediatric Surgeons. *Reconfiguration in Paediatric Surgery*. London: BAPS, 2003.

AUTHOR'S RESPONSE

doi 10.1308/003588409X359178

JONATHAN PYE

Association of Surgeons of Great Britain and Ireland, The Royal College of Surgeons of England, London, UK

CORRESPONDENCE TO

Jonathan K Pye, Honorary Secretary, Association of Surgeons of Great Britain and Ireland, The Royal College of Surgeons of England, 35–43 Lincoln's Inn Fields, London WC2A 3PE, UK
E: jk.pye@zen.co.uk

I thank Yardley and colleagues for their interest in my paper on the future provision of general paediatric surgery. They have correctly identified that the problem has appeared in a gradual, unplanned fashion and that if it continues will not be welcomed by anyone. Their proposed solution, however, does not recognise some of the practical realities that will prevent a single provider of GPS being the answer.

Hub-and-spoke already exists as part of the provision of care. The majority is currently provided by appropriately trained general surgeons and urologists. At recent meetings of BAPS/APA and ASGBI, both in the first half of May 2008, this subject was discussed at length. There was unanimity on the fact that a problem is approaching, and that provision of care should be given locally wherever possible. The mechanism of that provision was not put in place, because it was recognised that there is no simple

solution. The problems are 3-fold. First, the volume of work is such that it cannot all be absorbed into the tertiary centres; therefore, paediatric surgeons would have to travel to the DGH. If a paediatric surgeon decided to just do GPS (as suggested by Yardley and colleagues), there is an insufficient volume of GPS work in any individual DGH to give a full week's job plan. Also, the geography, if an individual were to be employed by more than one trust, is such that much travelling would be required. In many parts of the UK, excluding the remote and rural scenario referred to, DGHs are frequently many miles apart. This constant travelling would make for a poor working life for an individual and is thus less attractive than is implied. Second, the expansion of paediatric surgeons called for by Yardley and colleagues is not a realistic proposition in the current political climate. Finally, as alluded to in their letter, the emergencies are still left unprovided for. Whilst the volume of these is relatively small, the cases that require observation is rather greater, and these children are rarely 'ill', but need treatment. Where would the children be observed, and by whom? Also, it seems unreasonable to ask parents and children to travel many miles for a minor abscess to be drained, when the capability is surely available locally.

All are agreed that safe, local care should be maintained wherever possible. The reality is that this will be provided by a variety of 'types' of surgeon. The key here is not really 'who' does it, but that this problem is pushed up the agenda of trusts and SHAs so that appropriate solutions can be put in place region by region. The essential requirement here is to establish training for sufficient individuals so that safe, local provision of care can be maintained. Agreements are needed between tertiary centres and DGHs to establish a sensible network of care. The training committees for both general surgery and urology as well as paediatric surgery need to have discussions so that a sensible training arrangement can be put in place to allow GPS to continue to be provided close to the patient.

COMMENT ON

doi 10.1308/003588409X359141

A Day, M Sayegh. Infacol to reduce the bubble effect at endoscopic ultrasonography. *Ann R Coll Surg Engl* 2008; **90**: 347

doi 10.1308/003588408X358747

Swallow the medicine

J THOMAS

Dept of General Surgery, Watford General Hospital, Watford, UK

CORRESPONDENCE TO

J Thomas, Department of General Surgery, Watford General Hospital, Vicarage Road, Watford WD18 0HB, UK.
E: john.meyrick-thomas@whht.nhs.uk

Even easier is for the patient to swallow a dropperfull (0.5 ml) of Infacol® (Forest Laboratories UK Ltd, Bexley, Kent, UK) in 10 ml

water prior to the procedure – a practice that I employ routinely prior to diagnostic endoscopy to avoid bubbling of the duodeno-antral bile reflux that may otherwise impair thorough mucosal inspection. It is cheap and (when patients are told that it is infant gripewater and the strawberries before the local anaesthetic banana) it is cheerful!

COMMENT ON

doi 10.1308/003588408X2806008

VA Pandey, JHN Wolfe, SA Black, M Cairois, CD Liapis, D Bergqvist. Self-assessment of technical skills in surgery: the need for expert feedback. *Ann R Coll Surg Engl* 2008; **90**: 286–90

doi 10.1308/003588409X359187

Simulators in self-assessment

JK SMITH, B BAXENDALE, E FERGUSON, CA MAXWELL-ARMSTRONG
Department of Surgery, Queen's Medical Centre, Nottingham
University Hospitals, Nottingham, UK

CORRESPONDENCE TO

CA Maxwell-Armstrong, Consultant Colorectal Surgeon, Queen's Medical Centre Campus, Nottingham University Hospitals, Derby Road, Nottingham NG7 2UH, UK
E: charles.maxwell-armstrong@nuh.nhs.uk

This article is highly interesting as its findings mirror our own research into non-technical skills. Evaluating ward-based surgical peri-operative management is an important but neglected area in surgery, which is amenable to simulation techniques.^{2,3}

At our institution, realistic specialist registrar, ward-based scenarios have been developed using the METI HPS adult mannequin. Common peri-operative complications, such as cardiovascular problems may be simulated. In our study, pairs of specialist general surgical registrars worked together for 10–15 min. This allows assessment of decision-making, team-work, leadership and organisational skills by experienced consultants, other specialist registrars and by the participants themselves.

Our participant analysis has identified good correlation between the consultant and peer assessments of performance (Pearson rank correlation 0.514; $P = 0.05$). However, as discussed in this article, significant correlation was not found between self and consultant or peer assessments. Reported self-assessment did not correspond to year of training as an indirect marker of experience. A trend was found for those who scored above or below average by their peers to under or over score their own performance, respectively.

Together, these articles offer caution to self-assessment of abilities. Employing expert feedback in training, and specifically when using ward-based and practical skill simulations, is essential.

References

- McQuillan P, Pilkington S, Allan A, Taylor B, Short A, Morgan G *et al.* Confidential inquiry into quality of care before admission to intensive care. *BMJ* 1998; **316**: 1853–8 [Erratum in *BMJ* 1998; **317**: 631].
- Marshall RL, Smith JS, Gorman PJ, Krummel TM, Haluck RS, Cooney RN. Use of a human patient simulator in the development of resident trauma management skills. *J Trauma* 2001; **51**: 17–21.
- Schwid HA, Rooke GA, Carline J, Steadman RH, Murray WB, Olympio M *et al.* and Anesthesia Simulator Research Consortium. Evaluation of anesthesia residents using mannequin-based simulation: a multiinstitutional study. *Anesthesiology* 2002; **97**: 1434–44.

COMMENT ON

doi 10.1308/003588408X285685

B Campbell. Home-made, adapted and modified devices in surgical practice. *Ann R Coll Surg Engl* 2008; **90**: 251–2

doi 10.1308/003588409X359150

Innovation in surgery

CHARLES A WILLIS-OWEN
Orthopaedics and Trauma Department, Northwick Park Hospital,
Harrow, Middlesex, UK

CORRESPONDENCE TO

Charles A Willis-Owen, Orthopaedics and Trauma Department, Northwick Park Hospital, Watford Road, Harrow, Middlesex HA1 3UJ, UK. E: cawillisowen@hotmail.com

The comprehensive and enlightening editorial by Professor Campbell left me with a number of questions. As a keen innovator, I had not given much thought to the risks of litigation.

The summary of the relevant regulatory advice was clear, comprehensive and useful. Nevertheless, the MDA/MHRA regulations are subject to interpretation and appear vague and unhelpful. For example, does blunt dissection with scissors constitute 'off label' use as they are designed for cutting? Is it no longer acceptable to use a DCS implant to fix a subtrochanteric femoral fracture in the light of much more expensive intramedullary nails marketed for this fracture pattern? The list of example is endless, and ranges from what many would consider to be standard practice, to what some may consider to be quite out of the ordinary.

The notion that commercially available alternatives must be used if they exist has enormous cost implications; indeed, I am sure a fortune could be made converting many of the innovations seen in the 'Technical Tips' section of the *Annals* into purpose-made devices.

I feel this matter should prompt debate, and perhaps we can produce somewhat clearer standards before one poor surgeon is quoted these vague MDA/MHRA regulations in court.