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

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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

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Simulators in self-assessment

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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.

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COMMENT ON

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

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Innovation in surgery

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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.