C.O.M.E.T. – A novel educational method in clinical skills
From simulation to reality
Shibboleths of incompetence
Development of a clinical skills bus: making simulation mobile
“See one, do one, teach one!” – the uphill struggle for clinical skills acquisition
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The International Journal of Clinical Skills looks forward to contributing positively towards the training of all members of the healthcare profession.

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IJOCS - Volume 1 - Issue 1
Mission Statement

The clinical skills arena is an ever expanding field with an increasing wealth of knowledge; however there is no central resource for the sharing of evidence based research and information. The International Journal of Clinical Skills (IJOCS) is a peer reviewed International Journal, which will promote the sharing of information and evidence based research, as well as bringing together the clinical skills community.

The Journal aims to develop and maintain standards in research and practice, lay a platform for discussion and debate, and provide opportunity to present evidence based medicine and critical appraisal of research. Provision of this much needed resource for both students, teachers and healthcare professionals, will ultimately enhance patient care.

The IJOCS will be a regular publication, three times a year in the first instance, both online and in print. The implementation of the IJOCS website will provide a continual resource for daily use. Also, in conjunction with the ‘Clinical Skills Lab’, the IJOCS will allow access to an online database on over 200 clinical skills – launching in 2008.

A diverse range of reviewers support the Editorial Board, all of whom are leaders in their respective fields and the IJOCS prides itself on the quality of content. Contribution of original ideas, research, audit, policy, reviews, case reports and ‘Letters to the Editor’ are welcome from all those involved in this multidisciplinary field. Submissions are not limited to these specific publication types and your novel suggestions will be considered.

I wish to thank all those involved in the development of this unique venture – a Journal whose remit is highly significant to today’s needs.

Dr Humayun Ayub
Editor-in-Chief
International Journal of Clinical Skills

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International Journal of Clinical Skills  
– An exciting forum for clinical skills

There has been an explosion in the volume of medical information related to clinical skills, which are essential in our efforts to maintain optimal patient care. The International Journal of Clinical Skills (IJOCS) aims to disseminate this knowledge in an easily accessible form. This will not only enhance our attempts to provide a quality health service, possibly with some standardisation, but also provide a vehicle for teaching and learning, hence the Journal's motto – ‘docendo ac discendo’ (by teaching and by learning).

The IJOCS will not only serve as an avenue for publication of research papers, but will also act as a means of communication between clinical skills professionals at an international level. Consequently, those involved in the clinical skills field, can keep those in other countries informed of their activities, as well as offering best practice guidance.

Alongside this valuable publication, a continually evolving online database (‘Clinical Skills Lab’) will become available for students and teachers to access – this will hold extensive information on over 200 clinical skills. The Clinical Skills Lab will be regularly updated by all those involved in this field and provide a platform for discussion and debate.

The IJOCS also aims to present comment on items of specialist interest. For example, the current issue contains a paper by Professor Harold Ellis CBE, on ‘Medico-legal consequences in surgery due to inadequate training in anatomy’, and explores the potential niche for anatomical clinical skills training within the newly developed medical Foundation Years (F1 & F2). It is hoped readers will make use of the Journal to comment on matters such as this – and on others relating to the subject of clinical skills – by means of ‘Letters to the Editor’, research based evidence and shared practice.

In order for IJOCS to become an exciting forum for clinical skills, the Journal welcomes submission of innovative research, papers, reviews and case reports. Of course, submissions are not only limited to these specific publication types and your innovative ideas would be greatly welcome by the Editor.

I am confident that IJOCS will be appreciated by a variety of health care professionals, at an international level. It promises to be representative of an ever expanding field, and with the support of all those able to contribute, it will, without doubt become increasingly influential.

I wish those responsible for the production of the International Journal of Clinical Skills, the success which their initiative deserves.

Professor The Lord McColl of Dulwich CBE  
September 2007
Medico-legal consequences in surgery due to inadequate training in anatomy*

You do not need to be a member of the medical profession to be aware of the frightening increase in medico-legal claims against surgeons in the U.K. Indeed, it seems that every day some newspaper has a report of some new and sensational ‘surgical disaster’. The hard facts speak for themselves. A report from the National Audit Office showed that the bill for medical negligence faced by the NHS in 2000 amounted to £2.6 billion, double the amount paid out in 1997\(^1\), and this figure is now well above £3 billion. This report also pointed out that the rate of new claims per thousand consultant episodes rose by an incredible sevenfold between 1995-6 and 1999-2000. Part of this phenomenon is the increasing expectations of patients and their families. Anything short of a perfect result may be queried. A minor superficial wound infection following life-saving emergency surgery for faecal peritonitis in an elderly, immuno-compromised patient may be followed by a visit to the solicitor.

However, a report from the Medical Defence Union (MDU) of claims made against it\(^2\) showed that the most common reason for compensation pay-outs in General and Vascular Surgery, amounting to 32% of the claims, was for ‘damage to underlying structures’ - a figure similar to that noted in an eight year review published in 1998. What is ‘damage to underlying structures’ in a surgical operation? - in the majority of cases this means some anatomical error or even disaster. Let me give some examples from three types of surgical procedures:

1) In varicose vein surgery - the commonest operation in vascular surgery - the sural nerve may be injured divided or ligated when operating on the short saphenous vein behind the knee, or the saphenous nerve damaged as it lies adjacent to the long saphenous vein along the lower leg; in both instances the patient is left with numbness, pain and paraesthesia in the leg. At the groin, the femoral vein may be inadvertently cut, tied, divided or even stripped in mistake for the overlying great saphenous vein - indeed, the femoral artery itself has been injured in this operation, with disastrous consequences.

2) Laparoscopic surgery is now commonly employed for cholecystectomy and for gynaecological abdominal procedures. Both require a detailed knowledge of anatomy and anatomical variations. Injuries to the common bile duct will require major and complex reconstructive surgery, while injury to one or both ureters are the gynaecologist’s nightmare. A recent report\(^3\) from the Medical Protection Society (MPS) of the 247 claims it dealt with related to laparoscopic surgery between 2000 and 2005, showed that 47% of these were due to ‘damage to adjacent structures’ - e.g. common bile duct, ureters, bladder and uterus, while a further 14% were due to ‘vascular damage’.

3) A common operation delegated to junior staff is a simple biopsy of a lump in the neck. However, failure to appreciate the complex anatomy (and its variations) of this region may result in division of the mandibular branch of the facial nerve, with consequent paralysis of the lower lip, damage to the accessory nerve, with an unsightly and uncomfortable shoulder drop, or injury to major blood vessels, especially an anomalous superficial jugular vein.

My reason for having chosen these three examples is because the MDU report quoted above, also showed that varicose vein surgery was the most common procedure for general and vascular surgery claims, at 17%, followed by ‘local excision of tumour’ at just over 12% and cholecystectomy at just under 12% of the total claims.

When I took the old Primary FRCS examination, at the start of my surgical training in 1949, the Anatomy component comprised a tough essay paper, followed by two searching oral examinations on dissections, osteology and surface anatomy, as well as a practical histology test. All this has long been swept away.

*(Based on a paper given at the Royal College of Surgeons symposium on Anatomy teaching, 20 March, 2007).
Moreover, in many medical schools. Anatomy has all but disappeared from the undergraduate curriculum and something like half the dissecting rooms have closed. Today, there may be a few MCQ questions in the entry Part 1 and 2 MRCS examination, and the candidate’s Anatomy is not properly tested until the exit Part 3 MRCS, when there is a 10 minute oral in Surgical Anatomy. I have sat in on this examination several times and many of the candidates, (who, of course, fail), show a dangerous ignorance of Anatomy. To go back to my early examples, they cannot find the great saphenous vein, or the ureter, or the accessory nerve in the neck! What is the solution?4.

A potential taxi driver is not let loose on the streets of London until he has passed his ‘Knowledge’ of the Anatomy of the streets of the metropolis. So our young surgeons must be taught and tested on their Surgical Anatomy at the beginning, not the end, of their training. There must be compulsory courses - preferably full time, or else day release- based in Anatomy departments, with access to dissection, osteology, surface anatomy and imaging anatomy. Surgeons must use the operating theatre to teach living anatomy to their assistants. The important post of Anatomy Demonstrator should be recognised as a valuable component of a four month slot in the current F1 or F2 training programme.

Once this is achieved, not only shall we produce better trained surgeons but also less work for the courts in dealing with claims due to ‘injuries to adjacent structures’ - so often a euphemism for Anatomical Ignorance.

References
2) Goodwin, H. Litigation and surgical practice in the UK Brit. J. Surg. 2000; 87: 977 - 9,
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The Clinical Skills Lab database will comprise information on over 200 clinical skills, broadly separated into:

- History taking skills
- Communication skills
- Clinical examination/interpretation skills
- Practical skills

Not only will this valuable resource provide material to students as a learning tool and revision aid, for example, OSCEs, it will also offer educational materials for teachers from all disciplines, allowing some standardisation of practice. The Clinical Skills community will also be encouraged to contribute, making this database interactive.

CSL is Launching in April 2008 – view sample material at [www.ijocs.org](http://www.ijocs.org) and take advantage of a 50% discounted rate if booked prior to 1st March 2008 (enter promotional code **CSL63R** at registration)