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A Peer Reviewed International Journal for the Advancement of Clinical Skills - 'docendo ac discendo' - 'by teaching and learning'



In this issue:

Studying living anatomy: the use of portable ultrasound Clinical reasoning and interactive board-games Inter-professional simulation

Communicating with confused elderly patients The African Working Time Directive

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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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Foreword

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Since its inception, the International Journal of Clinical Skills (IJOCS) has provided a unique platform for the teaching and learning of clinical skills in a variety of healthcare disciplines. It has become a well established peer reviewed Journal publishing a diverse range of clinical skills articles.

The Editorial Board consists of people active in the field of clinical skills teaching and this is reflected in the journals philosophy to encourage sharing of ideas and practice. Pertinent contributions aim to meet the current needs of researchers and practitioners.

Clinical skills teaching is going through a definite 'growth spurt' at present with increasingly responsive models, manikins and e-learning programmes - not dismissing financial investment that comes along with this. High quality clinical simulation is becoming more sophisticated as a teaching and learning methodology. The need to equip health professionals with the skills and competencies to improve patient-safety is one of the drivers behind this growth. However, alongside the purchase of the 'Sim'-men/women/babies and linked e-learning, let's not forget the importance of personal

interactions through faculty support, i.e. experienced clinical teachers. In addition, simulated patients and the delivery of interprofessional sessions, bring clinical simulation closer to the realms of reality and validity, for both undergraduate and postgraduate health professionals.

The use of simulated patients, relatives and carers is well established in clinical communication education. More recently, additional interesting and innovative approaches to clinical communication teaching are in various stages of substantive core curricula and special study activity across medical schools in the UK.

The IJOCS is now established in the world of clinical skills publications by providing a niche specific arena that welcomes quality research, thereby promoting excellence in healthcare internationally. The wide range of papers covering research, discourse and reflection in clinical education and practice, plus the inclusivity of interprofessional approaches in one publication, raises the validity of this journal. There remains room for research based evidence to support teaching and practice of patient-centred clinical learning. The IJOCS welcomes additions to the literature that encourage critical debate.

Without doubt, the International Journal of Clinical Skills has continued to exceed its original ambitions and I wish it growing success.

Time Cill

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The African Working Time Directive: a comparison of logbooks

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Abstract

Introduction: There are current concerns regarding the implementation of the European Working Time Directive (EWTD) and the quality and quantity of surgical training in the UK. Some UK junior surgical trainees are travelling abroad to gain surgical experience in a new environment. This study highlights the difference between the surgical logbooks of four UK orthopaedic trainees who worked in Ngwelezane Hospital, South Africa, and compared the training to the national average of orthopaedic trainees in the UK.

Results: On average, a trainee in South Africa is involved in 448 orthopaedic trauma operations in one year, compared to a total of 841 operations for trainees completing six years in the UK. Trainees in South Africa performed more operations, including external fixation, intramedullary nailing and tendon repairs, in one year than a trainee in the UK performed in a total of six years.

Conclusion: This study highlights that there are significant opportunities for training abroad in certain recognised institutions, and with concerns over the quality and quantity of training in the UK, recognised training abroad maybe a valid consideration.

Introduction

Surgical training in the United Kingdom (UK) is currently under going significant change. The implementation of the European Working Time Directive (EWTD) has reduced the number of hours a trainee surgeon can work to 48 hours per week from 1st August 2009. This has led to serious concerns regarding the quality and quantity of training across all surgical specialities [1 - 4].

Furthermore, the impact of Modernising Medical Careers (MMC) on the training of junior doctors has yet to be fully assessed. A recent study, however, indicates junior anaesthetists are now performing fewer cases since MMC began [5].

Surgical logbooks are used to record trainee activity in theatre and the eLogbook (an online logbook available at www. elogbook.org) [6] is widely used and is regarded as a highly sensitive barometer of the training experience of UK surgical trainees [7].

An analysis of orthopaedic surgical training using the eLogbook highlighted some deficiencies in current training opportunities, particularly in complex surgical cases. It recommended the focus should be placed on maximising theatre exposure and that senior trainees should be performing, or training junior colleagues, rather than assisting in routine trauma surgery [8].

Trainee surgeons are increasingly looking for opportunities abroad to gain experience, either at the beginning of their surgical training or towards the end of their higher surgical training scheme. Comparisons of orthopaedic training systems in English speaking countries highlight the differences in hours per week worked by trainees (USA – 80 hours, Australia – 85 hours) [9], but the training opportunities in South Africa have never been analysed.

Over the past few years, some UK trainees have travelled to South Africa to increase their surgical exposure and experience. Ngwelezane Hospital, a 550 bed district general hospital and tertiary referral centre in the heart of rural KwaZulu-Natal, has been a popular destination for many of these UK trainees. Published descriptive reports by UK doctors who have worked at this hospital in the past describe the learning opportunities to have been very favourable [10, 11].

The aim of this study is to compare the surgical opportunities for UK orthopaedic trainees travelling to this hospital in South Africa and discuss opportunities for working in South Africa as part of recognised UK higher surgical training in trauma and orthopaedic surgery.

Methods

We collected and analysed the orthopaedic logbooks of four UK orthopaedic trainees (SN, JAA, TN, AH) who worked in the orthopaedic department at Ngwelezane Hospital ranging from a period of 9 months to 16 months between 2004 and 2009, and compared them with the average orthopaedic trainee experience in the UK. Three trainees had already completed their MRCS examinations (SN, JAA, TN) and one had finished the foundation programme (AH).

Three of the trainees (SN, JAA, AH) had completed their logbook with eLogbook and one with an excel spreadsheet (TN). Dr Paul Rollinson FRCS, an experienced British trained orthopaedic surgeon who has worked in the Ngwelezane Hospital for over 20 years, runs the Department as the Chief Specialist in Orthopaedics. He provided the supervision and training of all four trainees.

The working hours in the department are from 0800 to 1700 on weekdays (with a suitable one hour break) and a 1:5 on-call rota is implemented. This comprises of one weekday on-call of a complete 24 hour shift followed by the afternoon off on the following day. Weekend shifts were split into working one 24 hour shift on a Saturday and one on a Sunday (during separate weekends) once a month. Therefore during a normal working week (with no weekend duties), the average working week was 52 hours. If a weekend shift was covered, this became a 76 hour week.

Only orthopaedic trauma cases were included in this study, thereby excluding infective cases (incision and drainage of abscess, sequestrectomy), elective cases (predominantly paediatric orthopaedic surgery) and general surgical cases (predominantly laparotomies). Wound management, including debridement, fasciocutaneous flaps and split skin grafts were included.

The mean number of individual operations each month was calculated for each trainee; an average year's logbook was calculated based on these figures. Comparisons were then made with the data published from the recent analysis of trauma experience in the UK using the eLogbook [8].

Results

All trainees reported a good level of supervision and never felt out of their depth. The vast majority of the cases performed with no supervision were actually in a parallel theatre with immediate consultant assistance available if necessary.

A total of 1918 operations were recorded over a period of 51 working months at an average of 37.61 cases per month. The trainee assisted in 24% of these operations and was supervised in 20% (Figure 1).

Figure 1: Breakdown of surgical cases by level of supervision



The trauma caseload was large and variable. The most common operation was intramedullary nailing of the femur followed by manipulation of paediatric supracondylar fractures of the humerus.

In an average 12 month period, it was calculated a trainee would be involved in 448 operations; assisting in 110, performing 328 and teaching 13 (Table 1). Table I: An average trainee's orthopaedic trauma logbook summary based on 12 months at Ngwelezane Hospital, South Africa

	Assisted	OP	Taught	Total
Cervical spine*	3	4	0	7
Intracapsular hip fracture	5	8	I	14
Extracapsular hip fracture	3	10	0	13
External fixation	П	12	0	23
Intramedullary nail (femur, tibia, humerus)	16	48	0	64
Distal femur ORIF	4	4	0	8
Tibial plateau ORIF	3	3	0	6
Ankle MUA	3	17	0	20
ORIF ankle	6	8	0	14
Elbow supracondylar (childhood)	6	22	0	28
TBW (olecranon / patella)	2	6	0	8
MUA ± K-wire wrist	3	32	I	36
ORIF forearm	8	13	0	21
Tendon repair: flexors	3	17	0	20
Tendon repair: extensors	2	10	0	12
Split skin graft	3	14	I	18
Wound debridement	2	25	0	27
Fasciocutaneous flap	2	4	0	6
Nerve repair	2	7	0	9
Amputations	I	7	0	8
Other	22	57	7	86
Total	110	328	10	448

Figures rounded to the nearest whole number.

* Application of tongs / MUA / anterior fixation

OP - Operation performed with or without trainer present in theatre ORIF - Open reduction, internal fixation

MUA - Manipulation under anaesthesia

TBW - Tension band wiring

Based on national annual figures for the average surgical trainee in the UK, in the full 6 years of training, a trainee would be involved in a total of 841 cases [8]. This is less than double the workload of one year of surgical training in Ngwelezane Hospital, South Africa.

Comparing specific operations, one year in South Africa is comparable to the full training of 6 years in the UK for certain operations (Table 2). Of note, the trainees in South Africa had more exposure to external fixators, intramedullary nailing, tendon repairs and paediatric supracondylar humerus fractures.

Table 2: Comparison of an orthopaedic trainee's operative caseload for 1 year in South Africa, compared to 6 years in the UK

	South Africa	United Kingdom			
	Over I year	Over 6 years			
	Total (Assisted, OP & Taught)	Assisted	OP	Taught	Total (Assisted, OP & Taught)
Intracapsular hip	14	7	65	10	82
Extracapsular hip	13	4	56	12	72
External fixators	23	5	12	0	17
ORIF ankle	14	7	47	4	58
Tendon repairs	32	5	18	0	23
TBW (olecranon / patella)	9	2	13	0	15
Intramedullary nail	64	10	38	0	48
MUA +/- K-wire wrist	36	3	74	7	84
ORIF forearm	21	8	30	1	39
Elbow supracondylar (children)	28	3	10	I	14
All Trauma	448	141	643	57	84 I

Figures rounded to the nearest whole number.

In an average year within the UK, the numbers of intracapsular and extracapsular hip fractures, as well as ankle fixation, were lower than that of one year in South Africa, but the differences were not as great as other procedures (Figure 2).

Figure 2: A comparison of an average year working as a trainee in South Africa, compared to working an average year in the UK



Discussion

This study is the first of its kind, comparing surgical logbooks of trainees in the UK with those of UK trainees in South Africa. The results highlight a significant difference in training opportunities for orthopaedic trainees in trauma procedures between South Africa and the UK.

Although this study is only highlighting the experience of four trainees of varying degrees of experience in one South African hospital, the stark comparison of theatre exposure highlights the possibilities that are present abroad. There are opportunities for gaining significant surgical experience overseas that perhaps should be considered for training our future surgeons. With the EWTD now enforced, it is anticipated that this difference in exposure to theatre time may well actually increase.

This study is limited in that there is no direct comparison between actual working times and shift patterns performed by the surgeons in Ngwelezane Hospital and the orthopaedic trainees working in the UK. The logbooks of the UK trainees were analyzed [9] on a national website [6] with no data on how many hours each of the UK trainees were working during this period. However, since the implementation of the EWTD on 1st August 2009, with a limit of a 48 hour working week, it is clear that the surgeons training at Ngwelezane Hospital are working longer, with over 60 hours per week. This study considered only one hospital and therefore it cannot be assumed all centres in South Africa provide similar experiences.

Although this data does not consider elective procedures, it is expected that trainees in South Africa would gain wider experience in elective cases. The prevalence of HIV and TB in the general South African population gives the added opportunity of exposing the trainee to a large quantity of bone and joint sepsis, with trainees performing many cases of joint washouts, incision and drainage of abscesses and sequestrectomies. At the Ngwelezane Hospital there is a good exposure to emergency general surgical procedures, including laparotomies and thoracotomies, and also to paediatric orthopaedics, with a large club foot clinic and regular deformity correcting operations, all which were not included in the data analysis.

Any surgical training requires a structured academic approach, and the experience at Ngwelezane Hospital includes regular weekly hospital and departmental presentations, as well as structured teaching ward rounds. There is ample opportunity for research, for example, recent research work has included bone and joint sepsis, Blount's disease and open fractures associated with HIV [12]; one trainee (JAA) completed an MD whilst working in the hospital. The overall setup of the institution is therefore focused on training junior surgeons academically, as well as practically, whilst providing safe quality patient care.

If UK orthopaedic trainees are to improve their surgical training and experience, this study highlights there maybe valid evidence that their working patterns should not be completely restricted by the EWTD and improved shift systems focussed on operating time should be implemented. With the current concerns over the EWTD and surgical training within the UK, this study suggests that there maybe opportunities for orthopaedic trainees to continue part of their training in internationally approved centres and overcome some of the concerns regarding adequate training of the UK's future orthopaedic surgeons.

Declarations

The authors have no financial or other interests to declare in relation to this paper.

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