OFFICIAL REPORT
AITHISG OIFIGEIL

Public Petitions Committee

Thursday 22 October 2020

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 22 October 2020

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PUBLIC PETITIONS COMMITTEE
17th Meeting 2020, Session 5

CONVENER

*Johann Lamont (Glasgow) (Lab)

DEPUTY CONVENER

*Gail Ross (Caithness, Sutherland and Ross) (SNP)

COMMITTEE MEMBERS

*Maurice Corry (West Scotland) (Con)
*Tom Mason (North East Scotland) (Con)
*David Torrance (Kirkcaldy) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jackson Carlaw (Eastwood) (Con)
Neil Findlay (Lothian) (Lab)
Dr Dionysios Veronikis (Center for Vaginal Surgery and Urogynecology)

CLERK TO THE COMMITTEE

Lynn Russell

LOCATION

Virtual Meeting

Scottish Parliament

Public Petitions Committee

Thursday 22 October 2020

[The Convener opened the meeting at 13:30]

Continued Petition

Polypropylene Mesh Medical Devices (PE1517)

The Convener (Johann Lamont): Welcome, everyone, to the 17th meeting in 2020 of the Public Petitions Committee. The meeting is being held virtually.

The only item on our agenda is consideration of continued petition PE1517, on polypropylene mesh medical devices, which has been lodged by Elaine Holmes and Olive McIlroy on behalf of the Scottish mesh survivors hear our voice campaign.

We are joined by Neil Findlay MSP and Jackson Carlaw MSP, both of whom have a long-standing interest in, and commitment to, addressing the issues that are highlighted in the petition.

The petition calls on the Scottish Government to suspend use of polypropylene transvaginal mesh procedures; to initiate a public inquiry and/or comprehensive independent research to evaluate the safety of mesh devices using all available evidence, including evidence from around the world; to introduce mandatory reporting by health professionals of all adverse incidents; to set up a Scottish transvaginal mesh implant register, with a view to linking it to national and international registers; to introduce a uniform approach of fully informed consent across Scotland's health boards; and to write to the Medicines and Healthcare products Regulatory Agency, asking it to reclassify TVM devices with heightened-alert status to reflect on-going concerns worldwide.

The committee was grateful, following consideration of the petition on 3 September, to receive a written submission from Dr Dionysios Veronikis, who is the director of female pelvic medicine and reconstructive surgery at the Center for Vaginal Surgery and Urogynecology in St Louis, Missouri. Following that submission, the committee agreed to invite Dr Veronikis to give oral evidence.

We are delighted to welcome Dr Veronikis to our virtual meeting. We are conscious of the pressure on his time and appreciate the time that he is giving to us, and we hope that we can use it as productively as possible. We recognise that there is a world out there for Dr Veronikis that goes way beyond our committee.

I invite Dr Veronikis to provide an opening statement before we move to questions.

Dr Dionysios Veronikis (Center for Vaginal Surgery and Urogynecology): Thank you for inviting me to speak to the Public Petitions Committee. It is an honour and a privilege, and I appreciate your giving me 10 minutes to make a statement.

I am a surgeon, not a politician, so I am in unfamiliar territory this afternoon. Many communications have arisen from my interactions with Scotland, and I cannot possibly reference all of them today. However, I believe my account to be fair and accurate.

Mesh-injured women who contemplate undergoing mesh removal surgery do not do so lightly. Surgeries on women following partial mesh removals can be the most difficult gynaecological operations.

Mesh-injured women are in pain and distress, and need transparent medical care. I have successfully removed thousands of mesh implants—slings, prolapse mesh, rectopexy mesh and sacrocolpopexy mesh. For more than 20 years, I have been a surgeon of last resort for women who seek other choices or options, and for women who have had partial removals of mesh by other surgeons and are still in pain. Annually, I perform more than 600 surgeries.

I want to talk about the Scotland offer. When the Scottish Government appointed Terry O'Kelly in June 2019, I worked under the assumption that urgency on the mesh-injured women situation was foremost in everyone's mind. The goal of the project was to provide surgical help for the mesh-injured women; training local surgeons would be a by-product of helping those women.

On paper, it appeared that everything was in place to make a success of the project. I was assured that Scotland's medical community wanted to work together, with me, to make the project happen. Team Scotland was backed by the First Minister, the Cabinet Secretary for Health and Sport, the chief medical officer and the assigned lead mesh-removal surgeons, with all the influence and power of those officers. Yet, here we are today. No members of that team have been able to complete the regulatory process and no document has ever been issued that could be considered a letter of intent or an employment contract.

In early November 2019, in St Louis, the then CMO promised me that the regulatory process would be completed within a month of her return. She stated that sponsors had to be obstetrics and

gynaecology specialists. Although CMO Calderwood is a consultant obstetrician and gynaecologist and could have endorsed my application, she stated that it would be better if that came from the lead clinician, who was Karen Guerrero. CMO Calderwood assured me that she would provide the necessary sponsorships, letters and employment contract.

In return, and on the condition that the regulatory process be completed, I agreed in principle to visit Scotland in spring 2020, primarily to review patient files, schedule surgery and start the project of caring for the women. There is correspondence that includes the detail of possible itineraries that were discussed, but there was never any agreement that I would visit Scotland before the General Medical Council's regulatory process had been completed: there was no misunderstanding about that. Only when that crucial step had been completed would I finally have been able to make what I hoped would be the first of multiple extended journeys to Scotland to care for and operate on mesh-injured women.

On returning to Scotland from St Louis, CMO Calderwood shifted the goalposts. She asked me to fly to Scotland in spring 2020 to attend an educational event. That request came one day after I had been contacted by Mr Chris Harding, the mesh spokesman for the British Association of Urological Surgeons, who indicated that he had pitched the idea to CMO Calderwood. She contacted me the next day and stated that it was her idea. When I questioned her as to why she was adding that element to the itinerary, she said that it was about sponsorship and requested that I engage with the attendees and ask for their support to sponsor my GMC application. In short, the Scottish team's medical members would not be endorsing the GMC application.

I clearly communicated to CMO Calderwood that in no circumstances would I fly to Scotland before completion of the GMC application. The more I communicated that position, the more CMO Calderwood glossed over the problem. She continued to send letters with plans for a visit in spring 2020. I read in the press and in the Scottish Parliament's official record about my visit in spring 2020. That was barren ground. I was bitterly disappointed for the mesh-injured women, and not only those in Scotland.

What were the problems? There were several indications that there was a great willingness to delay real progress in the project. Phase 1 was June to September 2019. In June 2019, when the project started with Mr O'Kelly, who was appointed by the Cabinet Secretary for Health and Sport, I knew that I would be in Europe for the International Continence Society's meeting in September. Mr O'Kelly had initially extended to me an invitation to visit Scotland when I was in Europe. However, things changed. He stipulated that the Scottish team must visit me at the Mercy hospital in St Louis. With good grace, I accepted and accommodated a visit that was organised for July, but the team cancelled. The grounds that were given were that Karen Guerrero was not sure of her commitment to the project and had childcare issues during the summer.

I then received an urgent request from Mr O'Kelly to organise a visit in August 2019. I made arrangements once again, but days before the visit the team cancelled due to schedule clashes. When the team cancelled in August 2019, I reminded Mr O'Kelly that I would be in Gothenburg at the ICS conference from 3 to 6 September, and then in the United Kingdom. He suggested that he might visit me and another surgeon in Gothenburg. No further invitation to visit Scotland was extended to me, and since that time I have had no further communication from Mr O'Kelly.

I will mention two issues of note. I was not aware that any Scottish team members would be at the ICS meeting in Gothenburg. During the meeting, a prominent US colleague approached me and stated that the Scottish clinicians at the ICS meeting needed his help in relation to mesh removal, and that he had informed them that I was the best person to help them. That US colleague sent emails introducing me to the Scotland team and attempted to arrange a visit for the team to meet me in St Louis.

In any case, had the team visited me in St Louis in July—or, indeed, in August—I could have visited Scotland in September, when I would be in the UK, and started the process, and I could even have stayed longer, if needed. That made perfect sense to me. However, the surgeons were not on board with the project, despite all the reassurances that I had been given. At that juncture, I withdrew from the project.

In October 2019, I agreed to return to the project following a brief conversation with the First Minister of Scotland. That was at the direction of CMO Calderwood. The Scotland team eventually visited me in early November. I hosted CMO Calderwood, the two lead mesh clinicians, a member of the nursing staff and a member of the physical therapy team. They arrived at my office at 11 am on Thursday 7 November 2019 and departed at 11 am on Friday 8 November. I remain of the opinion that the Scottish team's 24-hour trip to St Louis was not an essential part of the project.

When CMO Calderwood left St Louis, it was made clear to me that she would ensure that the regulatory process would be completed, as she stated, within a month. When she returned to Scotland, she did a U-turn on that agreement. She made the unreasonable request that the spring

2020 visit would be used as an opportunity for me to canvass and acquire sponsorship from attendees of the educational symposium.

Mr Harding notified me that he was in discussions with CMO Calderwood about the symposium. Again, I do not know what CMO Calderwood communicated to the cabinet secretary, to the First Minister, to her successor interim CMO Gregor Smith, or to Mr Harding. I know the sequence of events that were promised, the first of which was completion of the GMC process.

Any suggestion to the mesh-injured women that I was arriving in spring 2020 was not transparent. First, at no point did I agree to CMO Calderwood's suggestion that I attend the symposium. I made it clear, in no uncertain terms, that I would not canvass anyone, ever, for sponsorship. Secondly, even if CMO Calderwood had delivered her promise, the purpose of the visit in spring 2020 would not have been to commence any care or surgical treatment for the mesh-injured women. I could have been in Scotland in September 2019.

In conclusion, my involvement in the project is flavoured by delay and what appeared to be a war of attrition. Whatever the motivations, the outcome demonstrated to me that there was no sense of urgency in delivering the project to help the mesh-injured women.

I am happy to answer any questions.

The Convener: Thank you very much for that helpful statement. I think that it is one that the committee will have heard with some concern, in relation to the delays. In my view, even the suggestion that you should come to an event to look for support is astonishing.

I have one question to ask before I move on to my colleagues. The petitioners have repeatedly urged the Scottish Government to engage with you because they have great faith in your skill and in the treatment that you have been giving to mesh-injured women. One of the issues is that women consider that the profession did not believe them when they commented on the pain that they were suffering. Can you explain what you are doing at your clinic that is so different to what other surgeons are doing?

Dr Veronikis: I listen to the patients. I ask them when the pain started, how it started and where is it located. The trajectory of the slings follows a specific path, with small variations, depending on the type of sling and the woman's pelvis. The pain is not only in the middle; it is on the left and on the right. It is in multiple areas. Removing only a piece of the mesh is not helpful at all, and actually makes it much more difficult to help the women later.

Gail Ross (Caithness, Sutherland and Ross) (SNP): In your written submission and your opening statement, you explained that you offered to come to Scotland with the intention of helping the women. Can you explain what that work would have involved? Would it have involved you initially operating on some patients then passing that role to surgeons whom you would have trained? Were there any agreements on what you would do? Did you ever get that far?

Dr Veronikis: No—it never really got that far. As a surgeon, I take for granted some things about caring for women. It always starts with their history and a physical in order that I understand their complaints. Then, I discuss with them what is reasonable and what is available. I have a transparent discussion about how the illness could be treated.

My understanding is that the women who were suffering or were injured from mesh surgeries would have undergone surgery under me. I was okay with having surgeons observing me, but I have spent my lifetime mastering, refining and continuing to polish my skills through tens of thousands of hours in the operating room to develop techniques and instruments, which I am happy to share.

However, it is not something that can be learned in a day or a week—it is not a case of "See one, do one". A transobturator sling can be a TVTO—tension-free vaginal tape obturator—a MonArc, an Aris, an Obtryx halo, an Align curve or an Obtryx curve, and they have variations. They behave differently post-implantation, they have different colours and they curl differently. There are many things that need to be learned, and the learning curve is steep. I suggested to Mr O'Kelly that I would make an initial trip, as part of which I would schedule some surgeries and find the appropriate operating room time. Subsequently, I would travel back and forth, and would train whoever had the requisite skills.

13:45

Gail Ross: The Scottish Government has offered the survivors extended involvement with the surgeons that initially implanted the mesh. Can you understand the survivors' reluctance—I suppose that that is the word—to continue any kind of medical treatment or even dialogue with those surgeons? I think that there has been a huge breakdown in trust.

Dr Veronikis: Trust is very fragile, is it not? From literature and my practice, I know that women do not return to the surgeon who operated on them when there is a complication from a hysterectomy or a mesh product. When women perceive that they are not being listened to or are

not being given the choices that they want—women have choices—they move on to the next surgeon. As they move on, they acquire more knowledge, do more research and become more aware of what is available to them. Generally, the meshes that I remove have been implanted by other surgeons, not by me. It should be a woman's choice to seek out whomever she wishes to be her surgeon or her doctor.

Gail Ross: Given that there is a small pool of surgeons to call on in Scotland, the survivors have no choice but to contact someone like you, who has not dealt with them before.

Dr Veronikis: That is true.

The Convener: David Torrance will ask the next question.

David Torrance (Kirkcaldy) (SNP): Good morning, Dr Verofnikis. Thank you for giving up your time to give evidence to the committee today.

The petitioners have explained that the most-used mesh device in Scotland is the TVTO device. They believe that, when removing those devices, surgeons in Scotland are mostly doing so vaginally. In your opinion, can mesh devices be successfully and safely removed vaginally?

Dr Veronikis: No.

David Torrance: That was a brief answer.

Dr Veronikis: Well, it is really that simple. The trajectory of a transobturator sling—whether it be a TVTO or another device—is under the urethra. It then perforates the side wall muscles—the obturator muscles—which are lateral rotators of the hip. That is why these women have hip pain: the mesh adheres to the bone and limits the normal function of those muscles. It then passes through the entire abductor musculature. So, removing that portion under the urethra, in the vagina, does nothing. Honestly, if they did a tiny little partial, that would be better than if someone did a bigger partial that removed the mesh all the way out to the muscles. The problem is that the mesh adheres to the bone and then limits the function of normal musculature.

There is no way on God's green earth that an entire transobturator sling can ever be removed only through the vagina. It requires an incision in the skin lateral to the vulva to identify the end of the mesh in the musculature. There are two techniques that can be used. One involves cutting the muscles, taking them off the pubic bone and trying to reattach them. However, as any surgeon knows, muscles are hard to sew. Therefore, there is a second technique, which I innovated, which does not cut the muscles. Once you find the mesh, which can be very testing, you have to trace it down very specifically and take it off the bone on the groin side—the muscle side—and then on the vaginal side, and remove it. Depending on the variation of the woman's pelvis, it can be very difficult to find the mesh in the groin. That is why partials are so bad. If the sling is intact, the surgeon can get guidance to trace it from the vaginal side to the bone, identify the trajectory and remove it.

I hope that that simple explanation was brief yet detailed enough to explain the complexities of the implant and why nobody should be putting in any implants if they cannot absolutely manage any associated complications and provide comprehensive treatment to any patient, whether it be a woman or a man, undergoing any surgery.

David Torrance: Thank you for your answer.

Gail Ross: I have a couple of questions on the back of that explanation. Do you think that TVTO devices are useful at all? If so, in what circumstances should they be used? Do you think that they are being overused here?

Dr Veronikis: I do not think that they are useful. They were innovated in 2003 simply because surgeons were having a hard time doing a retropubic sling, which are the original slings, made out of fascia, that were described by von Giordano in 1907. Through the years, the technology evolved.

Retropubic slings emulate normal anatomy. Transobturator slings were innovated for those surgeons who had difficulty doing retropubic slings. They do not follow a normal anatomic trajectory or emulate normal anatomy. Women have variations in their pelvis and their vaginal sulcus—under the urethra, the sulcus dips up—but the mesh follows a straight line, which creates a band effect. A scientific paper said that up to 80 per cent of transobturator slings have a band that is palpated on clinical examination. The conclusion of the study was that they do not know the significance of that. Another paper, by Chauhan, said that 25 per cent of women undergoing a transobturator sling procedure have de novo pain with intimacy. I do not know any woman who would exchange a little bit of leaking, or a lot of leaking, for a 25 per cent chance of pain with intimacy.

If you fast forward 17 years from the initial procedure, you now have an implant in a woman that cannot be removed easily or safely without drastic consequences such as cutting the muscles, which may never be able to be reattached successfully. In my opinion, there was and is no place for transobturator slings.

Gail Ross: So, the TVTO device was created to benefit surgeons because it was easier than another method, rather than to benefit patients.

Dr Veronikis: I think that that point could be held to be arguable by those who carry out the procedure. There was a good rate of success with retropubic slings, but the complexities of that procedure mandated the creation of another technique. In my opinion, the surgeons who were unable to do the retropubic sling procedure should perhaps have referred those patients to someone who had higher volumes of patients requiring that procedure. The literature clearly states that high-volume surgeons have better outcomes. I think that my mother or my aunt deserves the benefit of a high-volume surgeon who carries out that procedure all the time.

Gail Ross: How would you approach surgery on a patient who had undergone partial removal?

Dr Veronikis: The first thing that I do is look at the implant operative report. I try to acquire an implant log that tells me what implant I am looking for. It is common for any implant to be called a TVT. For some reason, that has become the generic term, but it is like saying, "I drive a car"—just as there are different cars, there are different implants.

Sometimes the implant operative report is very replete. If there is a photograph, I try to get it; if there is a pathology report, I try to get it. We published a poster stating that the medium length of a transobturator tape sling is approximately 22cm. The sling is 44cm when it is implanted, and it is cut at the edges, to create a length of 22cm. Documentation telling me how much was removed gives me an idea of where to look for the mesh. If 2cm was removed, the mesh should be to the left and right of the urethra. The problem comes when it is 3cm, 4cm or 5cm. Women have different pelvises and, if the patient is a smaller woman with a narrower pelvis, that mesh is going to be further out in the obturator muscles. That is where the problem arises. That mesh retracts and is glossed over with scar tissue. That means that I then need to make selective cuts into the woman's obturator musculature, through the vagina, to try to look for fibre or to palpate scar tissue. Depending on where the mesh was placed and what the woman's pelvis is like, it can be much more traumatic to find the end of a cut piece of mesh than to find an intact mesh that I could trace. I might spend up to 30 or 40 minutes trying to find the end of a severed piece of mesh.

I believe that, eventually, the medical community will agree that, if anyone who has a TOT sling has problems, the entire sling should be removed in one surgery.

Gail Ross: Are there any situations in which partial removal would be the preferred course of treatment? If so, what happens with the mesh that remains in the body in the long term?

Dr Veronikis: In my opinion, there are no such situations. Let me explain why. If a woman has a sling, whatever that sling is, and the only symptom that exists is what we call incomplete empty—there is a little retention, they are not emptying their bladder, they are getting bladder infections or they are experiencing urgency—which happens with all slings, even an autologous sling that is made from her own body, a division of the sling is indicated. However, you must understand that, if you have an exposure—a little snip—that is the tip of the iceberg. These implants are in the vaginal wall—they are exposed in the vaginal wall. As an example of what I am talking about, imagine that you are walking on a lake in winter. The edge of the lake is frozen, but, as you get to the middle, the ice gets thin. Where the mesh is exposed, the vaginal wall gets very thin. If you trim part of it, it may come back, and the tissue on top of the sling cannot be pulled together with sutures. What happens then is that the exposure is bigger. If you remove any amount of the sling—even if you divide it—it may not work as well. If you remove 1cm of the sling and the woman has incontinence, when you undertake the second operation to go back and fix her, you will run into the implant.

The best chance for a cure—this is documented in the literature—is with the first sling. So, if a woman has a sling, how do you bring her back to the first sling? You do it by removing and clearing that tissue, letting it heal, and almost starting over.

I have tried all of these things. I have spent my days doing what I like to do most, which is to care for women in the operating room. That is what I am good at. When women have asked me to do everything in the one surgery, I have tried to do so, but the outcomes are not the same. There is literature to support the view that a second sling does not work as well as the first one at one setting. I have good success if I remove the implant and allow the tissue to heal. Ironically—we presented a poster on this—when you do a complete removal, half the women do not leak. I think that that is because of the scarring that ensues.

Gail Ross: Can you give us an overview of how much of your work is mesh removal rather than mesh insertion?

Dr Veronikis: More than half my practice is managing complications of mesh implantation. I am a gynaecological surgeon. I predominantly do vaginal surgery. I take care of prolapse, fistulas, recurrent prolapse, urinary incontinence and faecal incontinence. I only offer retropubic slings, and I offer three types of them. I offer a sling from their own body and I offer a biologic sling, and, for the sake of completeness and transparency, I mention polypropylene slings. Women only

choose polypropylene slings when it is the only option that they want.

Gail Ross: Thank you.

14:00

The Convener: I am struck by the challenge that the medical process presents for women and your description of the consequence of that is powerful.

I want to take you back briefly to how the Scottish Government has treated you. The mesh scandal has unfolded over time. A lot of people have perceived you as someone who would be able to help address the concerns and find a way forward. You have already outlined quite troubling communications between you and the Government. Do you think that, at any point, the communications with you were serious, or were barriers being constructed to your coming to and helping us in Scotland?

Dr Veronikis: The communications seemed serious in the beginning, when Mr O'Kelly tried to schedule a visit, but it became apparent that matters were just not going to progress.

One thing that I never want to take away from my patients is hope. I never want to give false hope, either, and I have maintained during this entire time that I do not want that for the women of Scotland. I moved away from the project because I felt that the women were getting false hope—they were hoping that a resolution would come soon and it just did not seem like that was happening.

There was an opportunity when I was in Europe. I do not know whether, other than those from Mr O'Kelly, the communications were ever serious.

The Convener: Were any alternatives discussed? There was a suggestion that you would come here, but it seems as though that was not a serious proposal. Was it ever suggested that videoconferencing could be used to allow you to observe and advise surgeons in theatre? Was anything like that considered?

Dr Veronikis: No.

The Convener: Okay. I move to Tom Mason.

Tom Mason (North East Scotland) (Con): We need to clarify what has been going on. In your written submission, you stated that you required sponsorship from Scotland as part of the General Medical Council's eminent visiting surgeon scheme. What does the scheme require?

Dr Veronikis: I was a visiting surgeon to the United Kingdom in 1998, when I operated in London. The process was easy. Perhaps things have changed. My understanding is that the scheme requires a sponsor and a contract from the national health service. Neither of those aspects is truly under my control.

Tom Mason: Okay. Our understanding is that such programmes and knowledge exchanges occur regularly. How many exchange visits have you participated in, either to other countries or to other areas in the USA?

Dr Veronikis: Prior to 2000, I visited Spain, Italy and the United Kingdom. Since about 2000, I have dedicated my time to polishing, mastering and teaching surgery. I was the director of the ob-gyn residency programme, which required me to be in the US. Since then, I have not gone anywhere else.

Tom Mason: Have many surgeons come to your practice in St Louis to learn from you?

Dr Veronikis: Yes.

Tom Mason: How many, approximately?

Dr Veronikis: Easily 50.

Tom Mason: So, you are used to that.

Dr Veronikis: Yes, sir.

Tom Mason: Thank you.

The Convener: I call Maurice Corry.

Maurice Corry (West Scotland) (Con): Thank you very much indeed for appearing before us today, Dr Veronikis. In your written submission, you state that you have withdrawn your offer in frustration at the lack of action from the Scottish Government. Have Scottish ministers or officials ever explicitly said no to your offer, or is the lack of progress an implicit rejection of your offer?

Dr Veronikis: It is the latter.

Maurice Corry: Right; okay. Do you consider that there has been any resistance from the Scottish medical fraternity to your proposal and, indeed, involvement in Scotland?

Dr Veronikis: I believe so. Early on, I had a conversation with Mr O'Kelly in which all the clinicians were on the phone. In subsequent discussions with Mr O'Kelly, he stated that one of the clinicians was not on board—she was unsure of the consequences or about my involvement, and so on.

I gave an unselfish offer to help women—that is all that it really was. No one needed to be threatened. I would have cared for the women and trained the doctors who could be trained. I told Mr O'Kelly that not everyone can or should be a mesh removal surgeon. Mesh removal requires surgeons with the finest technique and the most experience who are able to grasp new techniques of surgery.

Maurice Corry: Basically, you feel that there was resistance.

Dr Veronikis: Yes, sir.

The Convener: I call Tom Mason.

Tom Mason: We understand that Dr Calderwood, the then chief medical officer, accompanied by a clinical team, met you to observe you and your colleagues at your practice. In your written submission, you state that, following the visit, you were hopeful that the proposed project would materialise. Did Dr Calderwood give you any indication that there was a problem with achieving that objective?

Dr Veronikis: No. Actually, she said that she could make the application happen within a month.

Tom Mason: In your submission, you highlight that Dr Calderwood suggested that you attend a symposium in Scotland to

"'work' the crowd for a sponsor."

Can you explain what that symposium was, and what you were invited to do? In addition, given what occurred after her visit, do you think that the visit from Dr Calderwood and the clinical team was a genuine attempt to move the situation on, or was it a gesture to placate the mesh campaigners?

Dr Veronikis: I am not sure that I understood the latter part of that question. Would you be kind enough to repeat it?

Tom Mason: Yes. Dr Calderwood suggested that you should come to the symposium in order to

"'work' the crowd for a sponsor."

Given what occurred after that, do you think that that was done for a bit of hype, and that the visit to you and the suggestions that were made were not done in good faith and were dishonest?

Dr Veronikis: I would think so. When CMO Calderwood and I sat down together, it felt genuine. I was reassured, I was trusting and I felt hopeful. I agreed to come to Scotland.

I did not understand the symposium concept. If I was there, I would have been happy to bring my hard drive, which I did when the Scotland team visited me, to show unedited videos, pictures and techniques of thousands of mesh removal surgeries to the clinicians I would be working with.

On the concept of me coming to a symposium to ask people in the crowd, "Would you please kindly sponsor me?", I am sorry, but I just cannot do that.

Tom Mason: Okay; thank you very much.

The Convener: On that previous point, would it be fair to say that any suggestion that you should come and, basically, work a crowd was insulting?

Dr Veronikis: Yes.

The Convener: Am I allowed to be insulted on your behalf?

Dr Veronikis: Certainly.

The Convener: In all your work, has any other group of people come to you and said, "We recognise your expertise. Do you want to come to see whether we can get folk to fund your work?"

Dr Veronikis: No. I would not agree to that.

The Convener: Okay; thank you very much. I call David Torrance next.

David Torrance: You mentioned that you had visited Italy and Spain to perform mesh removals. What steps did you have to take to meet doctor/surgeon regulatory requirements for those nations?

Dr Veronikis: I did not do much—I submitted my curriculum vitae and medical licence; the sponsoring institution did everything.

The Convener: I call Neil Findlay, who, as I mentioned earlier, has a long-standing interest in the issues highlighted in the petition.

Neil Findlay (Lothian) (Lab): Will you compare and contrast the mesh removal surgery that you do with what you have observed about the surgery that has been carried out on Scottish patients who have travelled to the US for you to carry out additional surgery on them?

Dr Veronikis: The women from Scotland whom I have had the privilege of caring for basically had a partial removal under the urethra transvaginally, with the two ends of the mesh remaining in the obturator and adductor muscles. Almost all the women I cared for were in that identical situation in which only the centre portion was removed. Removing the centre portion does not relieve groin pain, which relates to the obturator and adductor muscles.

Neil Findlay: I understand that you use a scanning technique to identify the mesh—

Dr Veronikis: I am sorry—I use a what?

Neil Findlay: You use a scanning technique—you scan the patient to identify and trace the mesh. Is that correct?

Dr Veronikis: No, sir, that is not correct; I do not use any scanning techniques. My treatment is based on surgical acumen, an understanding of female pelvic anatomy and an understanding of the implants and knowing where they are. I do not waste patient time or increase costs by carrying out scanning that provides nothing.

Neil Findlay: Thank you; that is helpful.

I have been involved throughout this issue, and I have been extremely frustrated by what has

happened over the piece. We could cover many issues, including what happened and who was at fault. However, the most important aspect is that we get the best treatment that we can for women who have been mesh injured. It is obvious to me that there were deliberate acts by vested interests in Scotland to prevent you from coming here—I am absolutely convinced of that. How do we get the best treatment for the women whose lives have been destroyed by mesh but who hope that they can have a full mesh removal, so that that horrific product can be removed from their body? Can we do that by ensuring that the women are sent to you, and that the Government covers the cost? In terms of your coming to Scotland, is there no way back? I know that you are committed to helping the women. How do we do that?

14:15

Dr Veronikis: That has plagued my offer to come to Scotland. My offer was so that the women would not have to spend their life savings, sell their homes, borrow money or do whatever they needed to do to get to me.

Since June 2019, the situation has escalated in so many ways. I must tell you that I feel uncomfortable with everything that has happened. I do not know how I would be perceived if I came to Scotland. I know how I have been perceived. I do not know how I could possibly work with a medical team in a hospital given that almost the entire population of Scotland knows what has transpired. I do not think that my coming to Scotland can be on the table.

Can the women come to me? They certainly can, and many women do. I regret that not all the women can. As I have stated, I have dedicated my career and life to doing this surgery—it is what I do best. I operate five days a week, and I will continue to do that. I would be delighted to help the women but, at this juncture, they would have to find someone with my skill set or come to me.

Neil Findlay: There is an alternative to that: the Government has said that it is setting up a specialist centre for mesh removal, and the women will be referred to it. Given what you have seen of the previous treatment received by the women on whom you have operated, is it your view that the treatment at the mesh centre will improve their condition or make it worse?

Dr Veronikis: I do not know what the mesh centre will involve, although I assume that it will involve physical therapy. There is no data to suggest that that is helpful for those with a mesh implant. Think about what you would do about anything else in your body. Say that you have a piece of dust in your eye. You do not rub it; you leave it alone until it comes out. Physical therapy after removal might be beneficial, and I suggest that to my patients.

You can see how women from Scotland whom I have operated on have done. They have had a partial removal. They are still in pain, but they are doing better.

I do not know what the mesh centre will involve. I do not know how the staff have acquired their skill set. One thing that I do in order to be transparent is to take a picture of every removal and I give it to the patient. They have been through such a journey with mesh that that provides closure for them. I learned that practice from obstetrics: when a mom lost a child, you put the child in her arms to provide closure for her.

The women have been on such an arduous journey, so I take a picture to show that all the mesh is out. Women are strong. They can deal with whatever pain they may have. Usually, they all do better once they know that the mesh is out.

I do not know what the mesh centre involves, I do not know what skill set the staff have and I do not know what protocols they have. Therefore, I cannot comment on whether the women would be better off.

Neil Findlay: You question the skill set of those at the centre; many of us have also questioned the skill set of the surgeons. If you were setting up a new service, would you recruit people to it who had been part of the initial implantation process?

Dr Veronikis: As I have mentioned, there are publications and literature that state that women do not want to go back to the same doctor; they move on. It is rare for any woman to hold a grudge against her doctor; they simply want to move on and get different care from someone else.

When I was in discussion with Mr O'Kelly, I mentioned that I give pictures to each patient and asked him whether he could send me a few pictures of the full removals carried out by the surgeons I would be working with. I never received those.

If anyone with a good skill set was looking to improve it, I would want to see what they were doing and how I could help train them to get better. I would want them to show me their previous 10 mesh removals. I could look at those and tell you whether it was a partial or complete removal, because I have removed thousands of implants.

Neil Findlay: What is your view on the ethics of cases in which patients have been advised that they have had a full mesh removal but find out that they have had only a partial mesh removal?

Dr Veronikis: That is where trust is lost and there may not be proper transparency. That is not ethical.

Patients do okay. If a patient is told that there is a piece of mesh on a major blood vessel that could not be removed and what the consequence would have been if it were removed, the patient will invariably say, "Thank you for not doing that."

If someone knowingly states that there has been a full mesh removal, has knowingly cut it at two points with scissors and said in their mind that there has been a full removal from the vagina, but implies to the patient that there has been a full removal so that the patient thinks that her entire mesh is out, that is not right.

Neil Findlay: Thank you.

Jackson Carlaw (Eastwood) (Con): Good afternoon, Dr Veronikis. It is a pleasure to engage with you.

Two of the women whom you have helped are constituents of mine. Lorna Farrell lives just a few doors down from me, and Elaine Holmes, who is one of the petitioners, lives about a mile in that direction, behind my back. I know that their lives have been transformed by the work that you have done and I thank you for everything that you have done for women in Scotland.

What you outlined at the start and what chimed with me—I hope that this question is not too convoluted—was essentially a professionally organised obstruction to your involvement and it seems that Catherine Calderwood became complicit in that at some point.

I recall the start of the process back in 2013, when the committee considered the matter. Elaine Holmes and others were told by professionals in Scotland that they had a psychological problem and that the pain that they thought that they were experiencing was really in their minds—that it was not a genuine physical expression of pain. It seemed to me that, throughout the process, a lack of ability to deal with the issue underpinned a reluctance of the profession in Scotland to allow you to participate.

I was struck by an expression that you used earlier. You said that the operation is not a "See one, do one" type of operation. Is it possible that the profession thought that it was such an operation and that you might come here and be able to show in 5 minutes what could be done? You explained earlier that that is not possible, but is it possible that the profession thought that that is what could be done? Is it possible that the professionals in Scotland decided that they did not like the idea of your being involved in a more proactive, longer-term capacity because that would question their ability to undertake operations in the short term and that it suited them more to frustrate that process and to carry on with whatever alternatives they think that they can perform?

Dr Veronikis: I think so. The mesh centres were going up, so I would agree with that.

To put things into perspective, conservatively a transobturator sling can be placed in 20 to 30 minutes. It takes me over two hours to remove one, millimetre by millimetre, without cutting the muscles. As I mentioned earlier, TVTO is very common. In some ways, it is easier to remove and in some ways it is harder to remove, but it is clear that it is different from the Coloplast Aris sling, the Obtryx slings and the Align slings. It is not a matter of "See one, do one". There is a learning curve for a transobturator removal, and it is the hardest of all gynaecological operations.

We do not really study that area of the human body in medical school. I had to go back to cadavers and talk to multiple orthopaedic surgeons as I was developing the technique. I have refined it, because I have done hundreds upon hundreds of those operations, but they are still difficult for me. Last week, I spent six hours removing two TVTOs in a 38-year-old woman who had one placed at age 31 and a second placed at age 38.

It takes dedication, devotion and discipline, and it takes time. You need to know that you are not going to stop and that you are going to do the right thing. It is not "See one, do one"; it might be "See 50 and do one."

Jackson Carlaw: I know from the women themselves that some of them were told that they had had a full mesh removal but, when they went to see you, it became perfectly apparent that they had not. Grimly, it is almost described in centimetres what more has been found and that it has been possible to remove. The issue is a huge one, and not just in the countries that we have discussed—for example, it is also an issue in Australia. I wonder whether women from places other than Scotland have come to you in the United States for treatment.

You talked about the future of the opportunity for you to come here. Many of us thought that that would happen and that your expertise would underpin the centre for excellence that is to be established in Scotland. I do not know what excellence it will now be based on. I am tempted to beg you to reconsider, but you seemed quite firm in your view on that.

Since there are women here in pain who need to have hope, what now is on offer to them? It is for us as politicians to argue that the Scottish Government should fund women to come to you. Are there surgeons of a new generation here who

could serve with you in the United States and be trained in order to bring that experience and excellence to Scotland in due course? I recognise that you are not a politician and that that is not your expertise, but what can we as politicians argue should happen here that will benefit the women as we go forward? Too many of them still remain who have seen what others have achieved and who hope that that is still an option for them.

Dr Veronikis: There need to be transparent standards of excellence and detailed operator reports. Every piece of mesh that is taken out should be sent to pathology, with documented pictures on what was removed. There will be people on the planet who can do it, but it must be proved that it can be done safely and effectively, and that requires commitment. No matter what you do—whether you play a sport or you are a politician, a surgeon or a mechanic—it requires commitment, devotion and transparency about what can be done and what you can do, and the intent that you will continue to strive to do the best that you possibly can.

As I mentioned, patients are understanding. If I did my absolute best, but I could not get a piece out of the tendon, I think that any woman would understand that and would say, "Thank you for not cutting my tendon." They might or might not have pain there, but I did not cut their tendon.

I do not know how to train someone. I have a partner who I trained, and I have other residents whom I teach vaginal surgery, although they do not all remove mesh. Surgery is an apprenticeship. You need to work with someone who can quickly elevate and refine your skill set, because that is what patients need. They do not need someone learning slowly and getting complications.

As I have told my young partner, a community pays a price for a surgeon. A surgeon practices on the community and will get some complications, but we hope that the surgeon will be able to learn from those and will serve his or her community better over time. As I said, that takes dedication. Not everyone can publish papers and give speeches. Someone needs to be in the operating room teaching and performing surgery.

14:30

Jackson Carlaw: You have engaged with the health secretary and directly with the First Minister. When the First Minister addressed the issue most recently, she again told the Parliament that she was prepared to intervene. Is there anything further that she could say or do that would give you any further confidence?

Dr Veronikis: I do not know how I would work in the system with everything as it is at this point. When I first talked to Mr O'Kelly, he told me that, in the United Kingdom and Scotland, people worked in teams and that I would be put in a team, and so on. With everything that has happened, I do not want to keep giving women false hope. We have been at this for almost 18 months now. In the time that I have spent engaging, I could probably have operated on 50 women.

Jackson Carlaw: Thank you.

Gail Ross: The evidence that you have given is sobering, and I again thank you very much.

Various members have asked questions of the Scottish Government in the chamber, including Neil Findlay and Jackson Carlaw, who are not members of the committee but who join us today, and Alex Neil, who was due to join us today but unfortunately could not.

The Scottish Government is still saying that the offer is still open. What is your message to the Scottish Government? What steps does it now need to take for the survivors? After all the effort that they have put in to getting you over here, they will be hugely disappointed. It will be quite devastating for the survivors who are watching to hear what you have said in your evidence today. What is your message to them, Dr Veronikis?

Dr Veronikis: I have never had an offer from the Scottish Government. I made an offer, unselfishly, to come and operate. I said, "Give me an operating room, six days a week, and I'll be able to deal with three to four cases a day, depending on the number of rooms." That was the offer. I cannot just show up in Scotland and say, "Here I am—I'm ready to do surgery." There are processes, regulations, licences and GMC regulation. The Scottish Government has never made an offer. I have never had a letter of intent. There has never been a contract. It was my offer to help so that the women would not have to use their life savings, as they told me that they would have to, sell their homes or borrow from their relatives. That is my answer to your first question.

My answer to your question about my message to those women is that I have never given them false hope. I have always tried to make sure that they understood, as I did, that there was hope, but I have never given them any false hope. I have always been transparent.

Gail Ross: Thank you so much.

The Convener: Tom Mason has some questions, after which we will move to summing up.

Tom Mason: If arrangements were made for Scottish patients to come to you in the US, how rapidly could you accommodate them? You said that you could deal with four or five cases at a time in the UK. If the patients came to you, could you

deal with them at the same rate, or more quickly or more slowly? Obviously, that would depend on your schedule.

Dr Veronikis: I would limit it to three mesh removals per day, especially when transobturator tape is involved. The average time is two to two and a half hours, but it can take longer than that. I would be able to do three surgeries per day. Are you asking how soon could I do that?

Tom Mason: Yes—how soon and how fast.

Dr Veronikis: I am scheduling surgery in December.

Tom Mason: Okay.

The Convener: Thank you very much for that.

I have one last question. I think that you speak powerfully to the women who have suffered. I can understand why they have put so much faith in you. Your honesty is very powerful when you say that you are not giving them false hope.

Is there a point at which mesh-injured women will not be able to be operated on? Is there a limit to the timescale within which women will be able to be helped? I do not mean in practical terms—that is, whether the Scottish Government will change its mind—but in clinical terms. Is there a point at which, clinically, it will not be possible?

Dr Veronikis: It is not a chronological limitation. If the women have partial after partial after partial, you reach a point at which it might not be feasible any more to do anything without creating even more scarring and injury.

If someone were to perform a very good partial vaginally and one attempted partial in the groin, that would leave a section of mesh in the groin. Although I have been successful in such cases, I can see situations in which multiple revisions of mesh prolapse implants would make it impossible to do any more.

The Convener: Thank you for that. We have come to the end of our questions. We appreciate the time that you have given us and the seriousness of your responses.

We will now move on to a discussion of what to do next with the petition. I am conscious of your time, and that you may want to leave before the end of our meeting. Do you have any final comments?

Dr Veronikis: No. Thank you for the opportunity to speak to you today. I applaud your sincerity. It is one thing to stop the utilisation of mesh, but it is another thing to go back and help these women, so I very much applaud your efforts.

The Convener: Thank you, again, for your time and your commitment. I think that I speak for the committee when I say that we regret that what has been a genuine offer has got caught up in bureaucracy, which serves you and the women ill.

If you would like to leave the meeting now, you may do so. I appreciate that you have a busy day ahead of you. Thank you once again for all that you have done for us today. Your contribution has provoked a lot of thought.

We will now turn to comments from the committee members, as well as Jackson Carlaw and Neil Findlay. We will not get agreement on what we want to do next—we will decide on that at a later date.

David Torrance: I want to put on record my thanks to Dr Veronikis for the evidence that he has given. We have heard a great deal today, and I think that it would be best to digest it for a while and discuss it at another committee meeting.

Tom Mason: I have a motto in life: when all else fails, try honesty. Dr Veronikis has been honest and open about his opinion, which is much appreciated and very refreshing. I hope that the implications of his words will influence the situation as we come to make our decisions, and that we can make progress in helping these women, who have been suffering greatly.

Maurice Corry: I entirely endorse what David Torrance and Tom Mason have said. I was struck by the honesty of Dr Veronikis and I am delighted that he was able to join us.

The way in which he has been treated is quite shocking, in some instances. I recommend that we discuss the issues more fully at another meeting.

Neil Findlay: Dr Veronikis is an extremely credible witness. He did not give the impression that he was looking to deflect any questions; he took everything head on. That is much to his credit.

There are a number of things that we can do. My priority is less to rake over old coals, although those questions still need to be asked and answered, than it is to ask what we are going to do in relation to the treatment of these women. That is the absolute priority.

If I were to ask the committee to do anything, it would be to write to the Government and say that—I do not know whether committee members feel this way, but I certainly do—the proposal to set up the regional mesh removal centre in Glasgow is not credible for the women who have been injured, particularly for those who require full mesh removal, and that the Government should agree to pay for the women to have mesh removal carried out by Dr Veronikis. A considerable amount of money is being spent on the centre. If the centre is set up but people do not use it, we

will end up wasting money for a poorer result. The committee should investigate that option.

In relation to the other part of this matter—how this happened, and who did what where and when—I think that there are people who need to come before the committee. Potentially, that would be the former chief medical officer, who I believe is still a senior member of the NHS in Scotland, and some of the senior surgeons identified as those who took part in the visit to Dr Veronikis's hospital. I think that they have questions to answer.

Jackson Carlaw: I will make a couple of points, convener. When I look at the content of the petition, I see that quite a lot of the evidence that we took from Dr Veronikis is additional to its focus. The petition calls for the initiation of a public inquiry, mandatory reporting, the setting up of a mesh implant register and writing to the MHRA. I very much trust that the committee is pursuing those objectives.

Today, I learned that the process of mesh removal is even more complicated than I had understood it to be. Until now, I had thought that having Dr Veronikis practise in the UK would help to educate and inform a body of clinicians who might have been able to progress that work in Scotland in the future. However, the point that was made about the "see one, do one" approach and the fact that the association of dedicated clinicians would be required over quite a long time before they had that expertise must be considered, because it is very much at the heart of what the options are before us for women who are suffering today.

That leads me more than I had hoped it would towards the conclusion that the only viable option for many of the women, if they choose to have it, is to go to Dr Veronikis in America. Therefore, Parliament might have to coalesce around the idea of the Government making available a formal fund to make that possible.

Asking women to fund the treatment themselves is an invidious option. I had hoped that that might be only for the minority, but I am driven more to the view that, if Dr Veronikis is not available to operate here—I might still want the First Minister to have another go at arranging that, and ask the committee to urge her to do that—it does not seem that we will be able to train people to carry out whole mesh removals any time soon. I think that we need to ask Parliament to ask the Government to fund that, and for that to become a formal policy.

Gail Ross: I have to say that, in the short time that I have been with the Public Petitions Committee, that was one of the most informative evidence sessions I have taken part in. I certainly learned a lot more about the topic. I agree that we should definitely further investigate the matter at a future meeting.

I thank Neil Findlay and Jackson Carlaw for coming along to the meeting and sweeping up at the end with some probing questions. There is still a lot to do on the petition, as some points have not yet been addressed.

I agree that there is no point in setting up a centre with the surgeons who have already performed the operation if the women are not going to use such a centre. That is the bottom line. It is disappointing to hear that the very profession that let the women down in the first place is letting them down all over again. It is a national shame.

14:45

I take on board all the suggestions that Neil and Jackson made. Having had another look at the petition and, following our chat at the previous meeting about speaking to more medical professionals, I certainly would not dismiss the opportunity to get the Cabinet Secretary for Health and Sport and the former CMO in front of the committee again.

The Convener: Thank you, Gail. There were a lot of important suggestions there. As has happened many times before with different issues, we all recognise how powerful the issue is as we start exploring it. In the past, Jackson Carlaw and Neil Findlay have talked about it as a medical scandal, and it seems that the initial scandal continues to be compounded, which is a worry.

We need to look at why a minister said to Parliament that Dr Veronikis was still available when he had already said that he was not coming and, further, that he was not coming because of his treatment by the Scottish Government. I do not know about any other members, but I am utterly offended and insulted on his behalf at the idea that someone with such skill should be asked to come and work around to get some money. This is not a crowdfunder for a wee issue or someone's hobby horse. I was deeply troubled by that.

I think that we agree that we will continue with the petition and that we will discuss it again. There is work that the clerks can do ahead of us doing so, as there have been a number of productive meetings. We should write to the Scottish Government and ask whether any cost benefit analysis has been done on setting up a mesh centre when the women have already said that they will not use it. Has the Government looked at that in a hard way, which it has to do? There is no point in ticking a box if women do not have confidence in using such a service.

We should certainly write to the cabinet secretary—possibly ahead of another oral

evidence session with her—about the audit trail of what was said and done, and to ask the question that was asked of Dr Veronikis towards the end of the session: what are we saying to the women? What is now being offered to them? That is the direct challenge that Jackson Carlaw put. Would the cabinet secretary fund the women to go to America to have the treatment?

There is a case for us to hold another oral evidence session. We will get reactions to this evidence session and we should look at those of the petitioners, the cabinet secretary and the chief medical officer, who I presume can answer on behalf of the former CMO. There is a range of things that we can do, and I assume that colleagues agree to that.

I note that Neil Findlay wants to come back in. I will ask him to do so before we come to our final conclusions.

Neil Findlay: There are a couple of issues that the committee might want to clarify. I assume that the surgeons who have carried out so-called full mesh removals continue to offer that service. There are big question marks over what it is that they offer. Perhaps the committee could ask whether the service is still being offered and what the skill set is of the people who offer it.

Secondly, we heard Dr Veronikis say that, every time he does a removal, he photographs it and sends it for pathology and so on. Does that happen here? As far as I am aware, it does not, so there are technical questions around that, too.

My final point is that it might be worth asking the Government what it will do about the women who have been told that they have had a full mesh removal by surgeons practising in Scotland but who then find that they have not. Previously, I have asked the Government what it will do because, as far as I am concerned—Dr Veronikis has backed this up—what has happened to the women is extremely unethical.

The Convener: In the first instance, we will be looking for responses to today's session from the petitioners and from anyone else who wants to respond. We will also write to the cabinet secretary and ask the series of questions that have already been outlined, including the ones that Neil Findlay has identified.

We will ask the clerks to look at who we should write to about the technical questions relating to women being told that they are getting a full removal but, in fact, getting a partial one. Who is accountable for that? Where does that sit? Where is that skill set determined? The chief medical officer might have to respond to those questions, but we will ask the clerks to decide who to write to rather than making the wrong call right now.

Tom Mason: In the light of what you have said, with which I agree entirely, we should try to get the questions in two halves. One half should look forward and ask about what can be done now and rapidly. We should do that instead of mixing up those questions with those about the inquiry and what has gone wrong in the past. Otherwise, people will be defensive, which will not lead to a constructive way forward. We should try to separate the questions for clarity.

The Convener: I agree that the committee's consideration should be done in that way. I suspect that it is very difficult for the women to separate the two in that way, but you are absolutely right. There will be a point at which we will be able to ask the cabinet secretary why she came to Parliament and said that bringing Dr Veronikis over was still possible when he had already said no. He has given very powerful reasons why he has now desisted from being involved, and I do not think that any of the responsibility for that is attached to him at all.

I agree with Tom Mason that there are two areas of work. What are now the options for these women? Is the Jackson Carlaw option the only one that is available? Through the clerks, we can write to the cabinet secretary and ask those questions, and we can also write to the chief medical officer on the more technical stuff. Those questions could then go out to the profession. Dr Veronikis was explicit in saying that he does not regard it as ethical to say to women, or to create the expression, that a full removal has been done when, in fact, there has been only a partial removal—it could be considered full only using a very narrow definition.

It was mentioned in the run-up to the session that Dr Agur has given evidence previously, and it would be interesting to hear his response from what he heard today. That might guide some of the further action that we will take. There is no doubt that there will be further evidence sessions, but we want to ensure that we have done enough of the groundwork in gathering responses ahead of those sessions.

Are members content with that course of action? We will write to the cabinet secretary and the chief medical officer, and I will ask the clerks to provide guidance on any other medical professional groups to which we should write.

Jackson Carlaw: Is it possible for the clerks to ensure that the evidence session that we have just had is promoted actively on social media and that it is available to be accessed? You mentioned Wael Agur, and I do not know whether he was watching or not. If the fact that the committee has had this extraordinary session this afternoon could be actively promoted, and if a link could be

provided so that people can watch it, that would be very helpful.

The Convener: You might be aware that active work was done to promote the fact that the meeting was taking place, and that there was a lot of interest in it. We can ask the clerks to ensure that there is easy access to the recording of the session. I am struck by the fact that, in this day and age, it is actually much easier for the committee to hear from somebody such as Dr Veronikis than it would have been perceived to be, even six months ago.

I thank the clerks, who had a bit of work to do to bring the meeting together. I also thank the broadcasting team and of course all the members, who were willing to give up their recess. I know that you are all working anyway, but committees do not usually meet during recess, so we very much appreciate that. Jackson Carlaw is right that we want people to hear what has been said today. In particular, the petitioners will be looking to the committee's considerations. I am sure that what they have heard today will again be upsetting. I find it upsetting, but it will be much more upsetting for the women who are directly affected by the issues.

We are conscious of what has been said, and we recognise its significance. I again express our gratitude to Dr Veronikis for giving us his time at a particularly early point in the morning for him, when he is of course going off to do his important medical work. I again thank the clerks and the broadcasting team.

Clearly, there is a lot more for us to do. The committee has a heavy responsibility. Given the seriousness with which the matter has been addressed thus far by those who have engaged with the committee, we need to ensure that the matter is taken forward and that, as Dr Veronikis said, we give some hope to the women who have been treated so badly in the past.

I thank everyone for their attendance and I now close the meeting.

Meeting closed at 14:57.

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