# Citizen Participation and Public Petitions Committee

# 13th Meeting, 2022 (Session 6), Wednesday 28 September 2022

# PE1865: Suspend all surgical mesh and fixation devices

# Note by the Clerk

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| **Lodged on** | 17 May 2021 |
| **Petitioner** | Roseanna Clarkin and Lauren McDougall |
| **Petition summary** | Calling on the Scottish Parliament to urge the Scottish Government to suspend the use of all surgical mesh and fixation devices while—<br>• a review of all surgical procedures which use polyester, polypropylene or titanium is carried out; and<br>• guidelines for the surgical use of mesh are established. |
| **Webpage** | https://petitions.parliament.scot/petitions/PE1865 |

## Introduction

1. The Committee last considered this petition at its meeting on 8 June 2022, where it heard evidence from Maree Todd, Minister for Public Health, Women's Health and Sport, Professor Sir Gregor Smith, Chief Medical Officer, and Terry O'Kelly, Senior Medical Advisor. At that meeting the Committee agreed to agreed to consider the evidence heard at a future meeting.

2. The petition summary is included in **Annexe A.**

3. The Official Report of the Committee's last consideration of this petition is at **Annexe B**. The Official Report of the Committee's meeting on 12 May 2022, where it heard from Dr Fernando Spencer Netto, Shouldice Hospital, can be found in **Annexe C.**

4. The Committee has received new responses from the Petitioner, and James Young which are set out in **Annexe D**.

5. Written submissions received prior to the Committee's last consideration can be found on the petition's webpage.

6. Further background information about this petition can be found in the SPICe briefing for this petition. In addition to the briefing on this petition, SPICe have also published a blog on the use of surgical mesh and its complications, which is available here.

7. The Scottish Government's initial position on this petition can be found on the petition's webpage.

## Action

The Committee is invited to consider what action it wishes to take.

**Clerk to the Committee**

# Annexe A

# PE1865: Suspend all surgical mesh and fixation devices

## Petitioner

Roseanna Clarkin and Lauren McDougall

## Date lodged

17 May 2021

## Petition summary

Calling on the Scottish Parliament to urge the Scottish Government to suspend the use of all surgical mesh and fixation devices while—

- a review of all surgical procedures which use polyester, polypropylene or titanium is carried out; and
- guidelines for the surgical use of mesh are established.

## Previous action

I have been in contact with my MSP, and Scottish Government officials who advised that the concerns of hernia and other mesh survivors would be heard along with those of TVT and pelvic mesh survivors. They never were.

I also met with the Cabinet Secretary for Health and Sport.

## Background information

Information on polypropylene and polyester mesh and stitches clearly states the potential complications of their use and titanium protacks carry a cancer warning.

We understand mesh must be used in life or death situations, but we want to ensure that—

- mesh is only used when essential;
- patients have alternatives to mesh; and
- mesh is only used with the fully informed consent of the patient.

We want the use of mesh devices and stitches to be suspended while a review of all surgical procedures which implant any form of polyester, polypropylene or titanium products – for example hernia mesh, rectomesh, mesh used in hysterectomies – is carried out and guidelines for the use of surgical mesh are established.

We are also calling for suspension of the use of titanium protacks that are used with hernia mesh, as these carry a cancer warning.

While we recognise and support women with TVT or pelvic mesh implants, the mesh that we are talking about is not the same. It is put into the body differently and used for different purposes.

# Annexe B

## Extract from Official Report of last consideration of PE1865 on 8 June 2022

**The Convener**: We have a number of interesting evidence sessions this morning, the first of which is on continued petition PE1865. It seems that the committee has been preoccupied with that petition for coming up to a decade. It almost feels like 10 meetings and 10 years of this important issue.

The petition, which was lodged by Roseanna Clarkin and Lauren McDougall, calls on the Scottish Parliament to urge the Scottish Government to suspend the use of all surgical mesh and fixation devices while a review of all surgical procedures that use polyester, polypropylene or titanium is carried out, and while guidelines for the surgical use of mesh are established.

We have previously met the Minister for Public Health, Women's Health and Sport, Maree Todd. I welcome her again and thank her for attending. We are also delighted to have with us the chief medical officer, Professor Sir Gregor Smith. Terry O'Kelly is back with us, but online. I say good morning to him as well.

We previously considered the petition in an online meeting in which we took evidence from Dr Fernando Spencer Netto of Shouldice hospital in Canada. A number of questions arise from all the evidence that we have heard.

As we have gone along, we have had a lot of evidence that many people have benefited from mesh as a treatment for hernias. However, I will start with a couple of back questions, as this might be the last time that we cover mesh in quite such wide detail.

In relation to the Transvaginal Mesh Removal (Cost Reimbursement) (Scotland) Act 2022, there have been some reports that we are still trying to negotiate—

**The Minister for Public Health, Women's Health and Sport (Maree Todd):** Convener, I have an opening statement, if you would like to hear it.

**The Convener:** I very much would. Thank you.

**Maree Todd:** It might set the context and answer some of the questions that you are keen to put to me.

**The Convener:** Excellent. Thank you very much.

**Maree Todd:** Thank you for inviting me and giving me the opportunity to return to this important topic.

I am pleased to say that we have made significant progress in our action on transvaginal mesh. We have established a national service for the management of mesh complications, and women have options with regard to their treatment, which can be undertaken in Scotland or elsewhere in the United Kingdom and with an independent provider if desired.

Most recently, the Transvaginal Mesh Removal (Cost Reimbursement) (Scotland) Act 2022 was introduced, and the associated scheme opened on 6 June—just this Monday. The contract with Spire Healthcare has been concluded, and arrangements are being made for the first patients to attend for surgery. Meanwhile, discussions with Dr Veronikis are progressing.

I am mindful of the concerns that have been raised by campaigners over the years about the use of mesh in other sites, such as in hernia repair. That is what I will focus on. I am sorry to hear of any instance of complications and the adverse effect that they have had on individual patients and their wider families.

As members know, the Scottish Health Technologies Group has looked into the use of mesh in hernia repair and published two reports on the subject, one of which was published shortly after my previous committee appearance. Those reports, which are based on current published evidence, support the continued use of mesh in a variety of abdominal wall and groin herniae. That is, of course, subject to all the tenets of realistic medicine: ensuring shared decision making and informed consent with knowledge of the benefits, risks, alternative measures and the possibility of doing nothing.

We have discussed the findings of those reports with professional bodies, including the royal colleges and the British Hernia Society, and we will continue to work with them on that important issue. Work is also going on to establish the medical device information system—MDIS—which will provide important surveillance and outcome information.

Since I last appeared before the committee, the chief medical officer has—in December 2021—written to board chief executives and medical directors to draw their attention to the SHTG report. In the letter, the CMO asked health boards to consider the availability of non-mesh surgery, how best to address skill gaps, if they exist, and the development of broader clinical networks for the management of complex cases. The actions resulting from that will be discussed at a meeting of the Scottish Association of Medical Directors in August.

I know that the committee has received a report from Shouldice hospital in Canada. Although the results reported are notable, it is important to remember that Shouldice hospital is a specialist centre dedicated to natural tissue repair and that it operates in a healthcare system that is very different from the national health service in Scotland. For that reason, the report should not be considered in isolation; rather, it needs to be considered in the context of the wider available evidence.

As I have said before in front of the committee, there are, of course, still some gynaecology procedures for which the use of mesh has not been halted. In those circumstances, there is a high vigilance protocol in place across NHS Scotland. It is important to remember that some of those procedures are complex and long established with few, if any, viable alternatives. Therefore, to suspend the use of mesh would leave a cohort of people with limited or no treatment options.

I reassure committee members, as well as the campaigners who lodged the petition, that the Government is absolutely committed to ensuring that everyone with mesh complications gets the care and treatment that they need.

I look forward to answering any questions that members have on the matter.

**The Convener:** Thank you, minister. That is very helpful.

The evidence that we have heard on the second area of mesh concern supports the view that there are nuances that mean that the way in which we might progress in future is different from the prognosis in relation to the transvaginal mesh campaign.

You mentioned the continuing conversations with Dr Veronikis. “Negotiations continue” has been the situation for as long as I can recall—in fact, I might even have been a list MSP when we first heard that said. I recognise that there is a commercial interest in the Missouri facility that Dr Veronikis operates, and I know that, at times, the conversations have been strained. However, inherent in the 2022 act is a belief that the facility would be one of the identified options and that something would be concluded with it. Therefore, naturally enough, expectations are raised that something will be forthcoming that can assist women in the near future. Some people will have thought that it would be even sooner than now. Is it difficult to say where we are in those negotiations and how they are proceeding?

**Maree Todd:** No. I have to commend NHS National Services Scotland, which is pursuing the conclusion of that contract. It is very close to finalising that. I know that it is frustrating but, if we stop and reflect on the differences in the medical and legal systems in the two countries, we see that it is understandable that there has been a deal of to-ing and fro-ing. However, I am confident that everything is being done to conclude that contract, and I hope to be able to update Parliament on it soon.

**The Convener:** Thank you, minister. I have one further follow-up question.

We have discussed the nuances in relation to hernia mesh. At times, it seems that the issue has been the need for a proper explanation of options to patients. That is one of the aspects that Professor Alison Britton is looking at in her casework review with regard to the way in which women progressing through the transvaginal hernia mesh issue have been treated. Her inquiry has been going on for some time; a month or so ago, I asked a question about it in Parliament. I wonder whether you are able to offer any update on where we are with the review, as some of what Professor

Britton may report might be of interest with regard to the need for patients to be properly notified and made aware of the options that are available to them.

**Maree Todd:** Absolutely. The review is now well under way. It was established following the serious concerns that were raised by some of the women about whether their case records accurately reflected the treatment that they had received. It is expected to conclude later this year.

In Scotland, we have a system that is based on realistic medicine—I am sure that Professor Sir Gregor Smith will want to come in on this. We want all patients, at all times, to be well informed and to be part of the decision-making process. We use the acronym BRAN to remind everybody who is involved to consider the benefits, risks and alternatives, whether the intervention is needed now, and what will happen if we do nothing. That type of conversation is vitally important when people are considering surgery.

There is no risk-free option when someone has a hernia, and it is important that people are well able to ask questions about, and understand, the proposed treatment—not just the risks in general, but how those risks apply to them—in order to make a fully informed decision on how they want to proceed.

I will let Gregor Smith say more on that.

**Professor Sir Gregor Smith (Scottish Government):** Shared decision making is at the heart of the relationship between people who receive care and those who provide it. With regard to realistic medicine, when we began to have a conversation with the profession in late 2015, we saw that there was a need to promote a better approach to shared decision making. Personalised care has been right at the heart of realistic medicine, as we try to create a much more equal relationship between patients and providers of care.

Since that point in time, the shared decision-making approach has—I would say—been whole-heartedly embraced by the profession. It has been supported very much through the work that we have participated in with the General Medical Council on refreshing the ethical and legal obligations around consent. In addition, it has also been greatly supported by our education establishments at the undergraduate and postgraduate levels, through NHS Education for Scotland, with several modules that promote the essence of shared decision making.

The four questions that the minister outlined, which are known by the acronym BRAN—the benefits, risks and alternatives, and what would happen if we did nothing—are now at the heart of consultations. We have them as part of the NHS Near Me electronic platform, which has been used extensively over the past two years and has now increased its presence across the country. They are also part of the letters that we send to out-patients. In those letters, we encourage patients to engage with the clinical team and to use the BRAN questions to ensure that they

explore those concepts, so that, when they arrive at a decision, it is well informed and underpinned by consent that can be said to be informed. We know that, if that conversation has happened fully, it is associated with much lower levels of treatment regret afterwards.

**The Convener:** I think that the evolution of that exchange and how shared decision making has materially progressed are great. Such a process was historically meant to be in place, but we discovered, in exploring the transvaginal mesh issue, that it was not really in place. If that change has happened, it is a very positive development.

I should say, Mr O'Kelly, that we have a very good video feed for you, so if at any time you feel that you would like to say something, you can just raise a hand and I will know immediately that you are trying to come in. You should not feel that you have to do anything more—I can see you well.

Minister, on the last occasion we met, you said that it would be very difficult to quantify the extent to which there was a valid underpinning for the petitioners' concerns, because there was no basis for evidence gathering that would allow for a material judgment to be made about the extent to which any experience was real. Has any thought been given to undertaking some sort of limited sampling or anything like that, just to get an understanding of how many people may be experiencing genuine post-hernia mesh complications?

**Maree Todd:** I am not sure that I entirely understand your question, convener. Do you mean a sampling of records or of data? There is a recognition that, where medical devices in particular are used, they need to be more traceable. More clarity is needed on which devices were used where, and we need a system of retrieval in place. We are working closely with the United Kingdom Government on that aspect, so that, in future—I guess this answers your question, as we found ourselves in a situation in which it was quite difficult for us to tell precisely what had happened—that data should be gathered much more routinely. Where there are issues with a product, it should be perfectly straightforward to find out where that product has been used, and there should be a strong audit trail in a patient's notes.

**Alexander Stewart (Mid Scotland and Fife) (Con):** Minister, you talked about the risks and the benefits, but, in all this, the word "complications" seems to be the problem. Many individuals have given us their testimony that they took the information that they received in good faith and went through the process but then, three, four or five years on, their situation became so difficult that they ended up with a real problem. You talked about consent in the process, but communication is an issue. I believe that anyone who goes in and gets medical support and advice will take it on board, but they may not realise what complications could occur perhaps three, four or five years later, and the damage that could be done.

We have seen the same thing with the hernia situation. People believed, in good faith, that having the mesh put in was the right thing to do because that is what they were advised to do at the time, but it ended up not being the right thing, and that has put them in a really difficult and dangerous situation.

It would be good to get clarity as to how that aspect is communicated, in order to ensure that individuals make the right choices and are not steamrollered by a doctor or clinician who says, “We believe that this is the best treatment for you.” People take such advice in good faith, but, years later, as I said, they may find that that treatment should not have happened.

**Maree Todd:** I see that Mr O’Kelly is raising his hand—I am sure that he is very keen to contribute, as a practising surgeon who has to go through such issues with patients time and time again, day in and day out.

You are absolutely on the button, Mr Stewart—it is really important that these decisions are shared, and that is what we are talking about with regard to realistic medicine. We are moving away from what has happened in the past, when we had a paternalistic style of medicine. Back then, the doctor was all-powerful and told the patient what to do, and their advice was almost always taken as law. We now recognise that health is much better when it is delivered in a shared way. People are much more likely to attain good health if the decision making is shared.

The individual has to be party to a decision, and they must be able to discuss it with their clinician. As I said, that discussion should cover not just the general risks, but how those risks apply to that person as an individual. It should be a very individual discussion, and a patient should feel that, instead of having to access the internet in order to find and assess the data themselves, they can, as they make their decision, talk to their own health professional and have the risks explained as those risks apply to them specifically.

Patients are often in a very difficult situation in which there is no risk-free option. If someone has a hernia, continuing to live with it is not a comfortable situation for them to be in, but the options for treating it are never going to be risk free. As you said, an honest, transparent and well-documented discussion about those risks is a very important part of the process.

Secondly, you raised the point that there is sometimes a sense that people are not listened to. As a politician, I—and we all, as politicians—probably hear about that more than it actually happens, through a select few, or even many, stories. We hear from people who have been to see their health professional and have felt that their concerns have been dismissed or their health problems minimised. Again, we are working hard to improve that situation so that people, when they present to a healthcare professional—often, five years on, it will not be the same surgeon who operated on them—will receive a response that is more empathetic and understanding. We want to ensure that they are suitably directed to people who

might be able to help them to disentangle whether what they are experiencing is related to the surgery that they have had.

I am sure that Mr O'Kelly will want to come in at this point.

**The Convener:** Yes—I think that Mr O'Kelly would like to contribute.

Good morning, Mr O'Kelly—over to you.

**Terry O'Kelly (Scottish Government):** Good morning to you, convener, and to the committee. I may well have raised my hand too early. It involves a very good explanation of—[Inaudible.]

The issue of complications is difficult. In explaining complications, we do not want to flood patients with data and cause anguish or a feeling that something dreadful is inevitably going to happen, given all the things that can happen. Within that, we need to try to allay their fears. Although the risks are relatively small in that they may affect less than 5 per cent or 2 per cent of people, for the person whom the complication affects it is not a negative concept. In that case, there is not a risk of less than 1 per cent—it is a 100 per cent risk, because it has happened to them. There is a notion of the importance of trying to ensure that patients understand the nature of the risk to which they are exposing themselves.

We know, from the work that has gone on around realistic medicine, that health literacy in Scotland is by no means ideal. There is a need, therefore, for clinicians to spend time with patients to ensure not only that they have given them the information, but that it has been assimilated and truly understood. In that respect, it is always a good idea to check and to ask patients to attend with a supporter or advocate if required, particularly when one is engaging in a more invasive and perhaps more risky procedure. That is very important—it is probably the crucial point.

Another important point to consider takes me back to the comments from Donald Rumsfeld, which members may remember. There are the knowns—we know the complications and we have looked at them—and there are the known unknowns: we cannot tell people about what is going to happen in 10 years, because the products have not been available for that period of time and we do not know what the outcome is going to be, so there is a risk there.

However, as Donald Rumsfeld said, there are also the unknown unknowns, and those are the ones that always catch us out. I am not suggesting at all that my colleagues have, in the past, always dressed themselves in glory, but we now need to recognise that we have to be absolutely honest with patients. We need to say that we do not know what is going to happen in 10 years' time, because a particular device, product or drug has not been available for that length of time, so it is impossible for us to know. We have to tell the patient that, nevertheless, we recognise that, at that moment, given our experience of the timeframes, something

will be of benefit to them. We can say to them, “These are the reasons and the risks that we know of, these are the alternatives, and this is what might happen if we do nothing.”

There is quite a lot there—for the patient who is sitting in a doctor’s surgery, that is quite a lot to take on board. However, as Gregor Smith said, an important aspect is not only the questions, but flattening the hierarchy. We need to have the right attitude and give the patient the right environment, which is one in which they feel able to speak up and ask questions.

**Alexander Stewart:** Following on from the comments from both the minister and Mr O’Kelly, do we have some understanding of mesh itself? Different types of mesh may well undergo different processes. How have we been investigating and taking steps to analyse some of the mesh products themselves, to look at what defects they might have?

Has the Government, or have clinicians themselves, had a look at any of the history to find out whether there are defects that occur with specific types of mesh products, which might be more susceptible or more problematic for individuals? If we are aware that certain products might be more susceptible than others, that might reassure people in the future that the mesh that is being put in will be better, because it is not of a type that has a track record of causing issues in the past.

Minister, perhaps you can answer first.

**Maree Todd:** I will let Mr O’Kelly answer the bulk of that question. He can certainly give you a picture of what clinicians are doing to understand those issues. As with medicines, it is possible to do randomised controlled trials with these medical devices in order to learn more about them. It is also possible, as the unit in Canada has done, to collect anecdotal and observational evidence. That happens on an on-going basis in this area of medicine as in any other.

I go back to your concern about how we find out about different types of mesh and which types may have defects. The Cumberlege report focused on the regulation of medical devices, and it found the UK environment wanting in that regard. As a Government, we are absolutely committed to taking forward the recommendations that were made by Baroness Cumberlege and her team, and we have made significant progress on them since the report was published, last year.

**Alexander Stewart:** Mr O’Kelly, do you want to answer some of that question?

**Terry O’Kelly:** The base material, polypropylene, has been used in surgery for 80 years—I think that it was introduced at the time of the second world war, or perhaps just afterwards. It has been found to be very safe and effective, and it is well tolerated by patients. In vascular surgery, in particular, it is the product of choice. We have learned over time that there have been no major safety issues raised with its use as a suture material.

Mesh itself has evolved over time. The Medicines and Healthcare products Regulatory Agency has looked at hernia mesh. I know that there have been issues with MHRA representatives sitting in front of this committee, but the mesh has been scrutinised very carefully, as the committee will appreciate, both in this country and by similar organisations abroad, such as the Food and Drug Administration in the States. It is recognised that mesh is an implanted product, and it is important that patients understand that, but there does not seem to be an intrinsic issue with the product itself. There are some reports in the press and the published literature of patients having some reactions, but those are very rare.

Given the number of meshes that are used each year and the period of time for which they have been used, going back to the late 1980s, we see very few patients—or, rather, a very low percentage of patients—coming back. As these procedures are common, even rates of less than 1 per cent will mean that a number of patients will appear to have problems related to their surgery. Yes, they have a foreign body—-the mesh—inside them, but it is not necessarily the mesh itself that will be the problem. Modern mesh construction is probably as good as we are going to get it; the base material allows for the ingrowth of fibrous material and scar tissue, which causes a fibrous scar and strengthens repair. Problems can occur over time with shrinkage or contraction of the fibrous scar, which can in turn lead to other problems. It is important that the mesh is inserted in a tension-free fashion so that there is a lesser possibility that it will cause injury. It is also important that, if it is used in a position where the bowel might come into contact with it, steps are taken to avoid that as much as possible.

**Alexander Stewart:** We have heard that, in some situations, individuals had one mesh for a hernia put in but it had to be removed; they then had a second one put in and, since the second attempt, things have been better. They have not experienced the same complications since the first mesh was removed and the second one was implanted. Is there evidence, in your experience or that of others, of that happening when one mesh is removed and then replaced with a new one? Is it common or just an ad hoc situation that occurs with certain individuals?

**Terry O’Kelly:** I suspect that that is an ad hoc situation; I do not know the individual circumstances relating to the case that you cite. If, let us say, a mesh was put in and it was too tight—which can happen, as it is a technical exercise—the answer might be to remove that mesh and put in a tension-free mesh. It is possible that, if the mesh is inserted and held in place by sutures, a suture could entrap a nerve—it is very likely that one would not be able to see that at the time. Physically removing the foreign body from the vicinity of the nerve might alleviate the patient’s symptoms, but it might be necessary to remove the mesh to do that.

In the case that you described, it may be that the second mesh that was inserted was self-adhering or was inserted and held in place with tissue glue. There may be other such reasons. Why, in a car, does something not work, but, when you get it

changed, it then works? It will be difficult to know precisely what the issue was in every circumstance, but such a situation is not common.

**The Convener:** Minister, to go back to the Cumberlege report, I note that this committee was alert to the shortcomings surrounding the MRHA regimen, and I think that all parties in this Parliament endorsed the report's recommendations. Did I understand you to say that you believe that the discussions that are taking place in relation to the report are constructive and are progressing to a positive outcome?

**Maree Todd:** We in the Scottish Government are certainly working with the report and taking positive steps. There is still work to be done to ensure that patients' voices are heard and listened to—that is why we proposed a patient safety commissioner in our programme for government; it was also a manifesto commitment. We consulted on that recently. The consultation has now closed, and we recently published a report that provided an analysis of the results. We are going to take that into account as we continue to work with patients and experts to develop the commissioner role. We are keen to do that in Scotland, and we are keen to deliver what patients are asking for on that front.

With regard to UK-wide discussions with the MHRA, there has been slow progress—as has often been the case over the past couple of years—which is understandable, given the situation that we are in. Nevertheless, we are pretty keen to pick that up as a priority and to make UK-wide progress on these issues.

**The Convener:** MHRA regulation is reserved, but I think that there was a very strong feeling across all parties in this Parliament that, wherever support could be given to efforts that the Scottish Government was making to progress issues around the regulation of these devices, it would be forthcoming. I am sure that all parties are still willing and able to offer whatever support the Government feels that it might need if it is struggling to make the progress that we all want to see.

**Maree Todd:** I will bear that in mind, convener, and I will take up your offer if necessary.

**Paul Sweeney (Glasgow) (Lab):** I thank the witnesses for their contributions so far, which have been very interesting. I have some questions around mesh removal procedures and protocols. We have had a number of written submissions from members of the public—patients—who have experienced adverse outcomes and complications. Martin O'Neill commented that his life is improving now that he has had the mesh removed. He said:

"I'm still mesh afflicted due to the device being left so long in my body that pain and damage is permanent. BUT I have hope. It's out! There is at least a possibility of me doing something with life rather than taking pills that don't allow basic functioning, coupled with pain that still doesn't stop sleepless nights and an overwhelming sense of wanting to die than live in that horror of pain that mesh causes."

In other cases, individuals were told by surgeons that the mesh was too enmeshed in their body to be removed without causing serious consequences such as the loss of their rectum or testicles. Individuals have resorted to private surgery to get the mesh removed, with some even travelling abroad to do so.

In another written submission, Carole Coutts described difficulties in getting her mesh removed on the NHS in Scotland. She said:

“My GP ... discussed my case with other GPs. She said none of them knew much about mesh.?She tried referring me to the Scottish Complex Mesh Surgical Service”—

which is a service for women who are considering specialist surgical mesh removal—

“and I also emailed them”

as a patient.

“They refused my referral as they only accept gynaecological referrals.”

In 2018, your predecessor as chief medical officer wrote to the health board medical doctors in Scotland on the use of mesh in sites other than the vagina. In that letter, she said:

“The management of patients with mesh-related complications must follow agreed pathways which should involve a multi-disciplinary team of clinicians with appropriate skills and experience.”

In the light of all that, can you talk us through the “agreed pathways” for non-gynaecological “mesh-related complications” that your predecessor referred to in 2018? Do you believe that those pathways are operating as they should?

**Professor Sir Gregor Smith:** When the stories and the terrible symptoms that some are suffering as a consequence of some types of surgery are recounted, as you have recounted them, it is always very difficult, and you cannot help but be moved by their experience.

Terry O’Kelly will be able to say a little bit about the detail of some of the pathways, but you are absolutely right to suggest that we have created an expectation in boards that they should be developing pathways that not only offer alternatives to mesh surgery for patients who would prefer to explore other options but allow people who might have complications necessitating further revision surgery to explore that in a place of a specialist nature.

Each health board has what are called exceptional referral protocols. What happens just now—and, indeed, what has happened for many years—is that, where particular specialist services that require a high degree of competency are not available in a

local board area, local staff are able through the exceptional referral protocol to refer outside that board to places that can provide them, either in another area in Scotland or even beyond Scottish borders. That has traditionally been one of the ways of trying to deal with this issue. Many surgeons in Scotland have a high level of competency in addressing some of the issues that you have described, particularly at the more complex end of mesh removal, but I would like to see greater consistency across Scotland in developing more localised services to provide that type of care. Indeed, that is why my predecessor and I have written to health boards.

As I have said, Mr O'Kelly might be able to say a little bit more about progress in that respect. We have heard that, later this year, there will be more detailed discussions with the Scottish Association of NHS Medical Directors on the progress that has been made following the letter that was sent to them towards the end of 2021—in December, I think.

**Terry O'Kelly:** I just want to make a couple of points. First, it is not only for the clinician to recognise the need for a second opinion—it is actually the patient's right. If they are not receiving information or opinions that they are satisfied with, they should be able to ask to see somebody for a second opinion themselves. As a practising surgeon, I think that there is a great deal of security in asking somebody else to review a case; it helps not only me but the patient, and it is something that we need to support.

Pathways are germane to each circumstance. Because the hernias and complications that have occurred are not that common, the mesh procedures will be bespoke. It is important that care is individualised so that it is very much centred on the particular patient.

It is also important that clinicians form networks. That is certainly the case in my own health board area. Networks need support—especially administratively. It is essential that any conversations that occur are recorded and discussed with patients and that the outcomes of all deliberations are entered into the electronic patient record that will go forward in perpetuity. A bit of work still needs to be done to ensure that such a process is embedded into the work of every health board in Scotland.

With regard to private healthcare, it is a real shame that there is still a perception that, if I pay for something, I will get it done better. State services are often provided by the same people. We need to be able to provide exemplary care within our national health service for all patients, and I think that we are all committed to doing that.

**The Convener:** Mr Sweeney, do you want to come in? Mr O'Kelly has slightly anticipated the question that we might have asked.

**Paul Sweeney:** Thank you for that contribution. The point about there being such a small number of cases in the national scale of things requires us to reflect on how

best to address it. The pathways perhaps need consideration of how we might establish learning curves so that defects can be addressed by a network of people who are robustly capable of doing it rather than it being a lottery.

Could the NHS consider establishing a protocol for investigating such cases so that it could understand, for example, why someone has gone for a private surgical solution, what the outcome was and what could have happened differently? Is there a way of addressing the concerns that are expressed in the patients' submissions that we have received, such as by conducting a deeper analysis of what has gone wrong in their journey to identify whether there are opportunities for improvement?

**Professor Sir Gregor Smith:** Audit is an incredibly important part of learning in medicine or surgery. The ability to reflect on practice and to obtain evidence of how practice has affected people and the outcomes that they have experienced—whether those are positive or, as has happened on the occasions that we are considering, negative—relies on the availability of good data. Some of the issues that we have heard about today—such as the scan for safety approaches, where we are able to have much greater information about the types of devices or materials that are used in different types of surgery—help us to better understand, over time, and through that data, the outcomes that people are experiencing.

Where care transcends the division between the NHS and private facilities it sometimes becomes a little more difficult to obtain such data and to be able to use it in a way that allows proper understanding. However, the point that you make is still critical. We rely on using such data to be able to understand the outcomes that are associated with it. The new protocols that will come into play will allow us to do that an awful lot better in the future.

**Paul Sweeney:** Okay. Thank you very much. I want to follow up on an instance that was mentioned earlier. It is in one of the submissions from a patient. The national complex mesh removal surgical service in Scotland accepts only gynaecological referrals. Why cannot patients who wish to have other types of surgical mesh removed utilise that service? Why is it restricted in that way?

**Professor Sir Gregor Smith:** Mr O'Kelly might want to add more to what I am about to say. The service has been set up with surgeons whose focus of training has been the urogynaecological use of mesh. Because that is so specialised and highly specific it would not be appropriate for them to look at the use of mesh in other sites—it is very site specific.

**Terry O'Kelly:** The centre was set up specifically for the purpose of managing complications from the use of urogynaecological mesh. There is a multidisciplinary team that consists of urogynaecologists, a urologist and colorectal surgeons.

If it is not yet doing so, the group will, over time, take on the burden of dealing with rectopexy mesh, which is very specialised and crosses the boundary between

urogynaecology and colorectal surgery, at the interface between the last part of the large bowel and gynaecological structures such as the vagina. That is certainly the way in which such management procedures will proceed in England.

The centre has not been constructed to deal with other forms of mesh surgery. The clinicians are certainly available to be consulted, but they are not taking referrals for non-pelvic gynaecological mesh surgery, as I have described. That is appropriate for that particular centre.

**The Convener:** I want to touch on the final area to which you alluded in your opening statement, minister, which is the evidence that we received from and the subsequent oral testimony of Dr Spencer Netto from Shouldice hospital in Canada. David Torrance will lead our questions on that.

**David Torrance (Kirkcaldy) (SNP):** Good morning. In his evidence, Dr Spencer Netto highlighted how successful Shouldice hospital had been with natural tissue repairs, which have resulted in a low recurrence of hernias. How do pre-operative preparation and post-operative care for hernia repair surgery in Scotland differ from the steps undertaken in that hospital?

**Maree Todd:** It is probably worth going to Mr O'Kelly on that question. As I understand it, Shouldice has a very specialised unit and patients there are somewhat pre-selected. It is therefore not a population that would be reflective of the general population who seek surgery in Scotland. That aside, its results are impressive and we are very interested in the work that is being done over in Canada. However, as I understand it, if we were to compare the population who use the unit in Canada with that seeking hernia repair in Scotland, there might be significant differences, for example in terms of obesity or ambulation.

I will hand over to Mr O'Kelly, who will be able to give you a better explanation.

**Terry O'Kelly:** The results and outcomes at Shouldice are very impressive. However, it has said that the relative contraindications and risks with regard to successful surgery are smoking; obesity; diabetes and other pre-existing conditions; the quality of the underlying structures; and the size of the defect. We do not have a great deal of control over some of the aspects that Mr Torrance mentioned in his question, but the build-up to surgery—or prehabilitation, which I think he might be alluding to—could have a significant role in getting patients fitter for surgery by getting them to stop smoking, increase their exercise levels if they can, lose weight, reduce alcohol consumption and so on. All those things are beneficial for patients and we aim to promote them. If surgery is then conducted in a "get it right first time" manner, patients will be in good shape and will benefit not only from the surgery itself but from post-operative mobilisation and return to normal activities at an earlier stage. There are lessons to be learned from the experience of Shouldice and measures that we can apply to improve the lot of patients who are having surgery in this country.

**David Torrance:** There are very strict criteria at Shouldice hospital, especially on patient weight loss. In fact, Dr Spencer Netto told the committee that some of its patients have to lose between 50 and 100 pounds before the hospital will even see them before going ahead with a natural repair. Could such criteria be brought into play here? Would it be acceptable to do so?

**Terry O'Kelly:** This is very difficult—are we going to deny patients access to surgery if we believe that they are overweight? I suspect that that would be a subject for parliamentary debate. The other issue is around what problem the hernia is causing. Is it a strangulated hernia? Do we need to engage in life-saving surgery? Is it preventing them from working? We also know that, when patients are a certain size, losing weight becomes almost impossible without some other medical intervention, particularly if they are diabetic.

These are theoretical issues that are profound and worthy of consideration, but you may also have an opinion on that, which might be better than mine.

**Professor Sir Gregor Smith:** You have raised a very interesting ethical dilemma and it is one that many clinicians would feel uncomfortable with. I feel uncomfortable even talking about it just now. The restriction of access to treatment because of personal criteria is something that many clinicians feel deeply uncomfortable with, particularly when a health need lies at the bottom of it.

However, if we turn this concept around a little bit and look at how we can work with patients on education in relation to the concept of risk, we can then begin to explore an area where there is mutual benefit. It is about trying to encapsulate the risk of certain personal characteristics for people before they enter all sorts of treatment where risk is increased because of those personal characteristics.

The term "prehabilitation" is becoming more familiar to us all: using education, we can work with patients so that they can prepare themselves for surgery in a way that helps to reduce that risk. That is part of the conversation that we spoke about earlier when we spoke about the benefits, risks and alternatives and what happens if we do nothing.

We know that there are many approaches that we can take with patients to discuss that and to work with them. The two most obvious things to talk about are being overweight and being a smoker. Weight loss before surgery is a good thing if you are overweight. It does not matter what type of surgery you are undergoing—if you are more obese, greater risks are associated with surgery and general anaesthesia as a consequence of that. We know that, with abdominal surgeries specifically, such as hernia repairs, being more obese is associated with slightly poorer outcomes. It is a similar case with smoking.

Knowing those characteristics, you can then describe risk in different terms to those individuals. You can begin to calibrate risk for them. They will have their own level of

tolerance to risk and they can then make their own judgment and say, “If I go forward and have this treatment that I really want and need to have, these are the things that I can do and can take personal responsibility for to contribute to better outcomes.” However, I think that many people would feel very uncomfortable about methods of restricting access to surgery, particularly when people are experiencing a lot of discomfort.

**David Torrance:** Are the skills in natural tissue hernia repair techniques being lost in Scotland in favour of teaching surgeons mesh repairs? Could more surgeons in Scotland be receiving training in natural tissue methods?

**Maree Todd:** Mr O’Kelly will want to come in on this but, as I understand it, there is real interest in improving the expertise within Scotland in natural tissue repair and they are looking at centres that use those techniques in Europe—just because of the ease and practicalities of links with Europe versus links with North America.

I will let Mr O’Kelly tell you a little bit more about that.

**Terry O’Kelly:** The Shouldice submission said that mesh surgical training is seen as being easier to teach and that is why that aspect of training was germane to training in Scotland. That is a bit disingenuous. There has been an emphasis on mesh training and mesh surgery because of its proven efficacy as revealed in the Scottish Health Technologies Group report.

That said, we need to offer patients choice—that is very important—and there will be some for whom mesh is not appropriate. With each health board, it is critical that, when appropriate, patients have access to non-mesh surgery, which might be provided by their health board or by another health board somewhere else in Scotland.

I cannot tell you how many surgeons we would need to train, but I think that it would be more than one. One of the discussions that we will have when we meet the Scottish Association of Medical Directors will be about the provision of training, and access to training, for colleagues who wish to do it. In my health board, one of my colleagues is keen to take that forward. He has started to make contacts, and he will probably travel with one of the surgeons from NHS Lothian. However, it will not be sufficient for one person in my board to have the necessary training; we need at least two people. The situation will depend on demand.

It is important that individual surgeons will not be performing one procedure per year. There will need to be a sufficient volume for the process to be effective and efficient. Colleagues will need to buddy up—certainly at the start—to make sure that the numbers are correct and that they refresh their skills through practice. One of the successes of Shouldice is that the surgeons there perform 600 or 700 procedures per year. That is 15 to 20 procedures per week, taking into account leave and one

thing and another. Doing the same thing every day enables you to become very proficient. That is something that we also need to—[Inaudible.]

**David Torrance:** The example of Shouldice hospital demonstrates the success of a specialised hernia repair unit. Would it be possible to have such a centre in Scotland, taking into account the criteria that would need to be met in order to have such a success rate?

**Maree Todd:** I understand why you ask that question. I know from debates that have taken place in my constituency that there is a real tension between accessing healthcare as close to home as possible and being able to access national expertise when that is required. I get many more expressions of concern from constituents who have to travel within the constituency to access care than I do from people who want to travel to benefit from specialist expertise.

In NHS Scotland, the way we tend to work is that it should be possible for people to access routine care as close to home as possible. There are lots of good reasons for that. From the point of view of not just the medical model of health but the biopsychosocial model of health, with routine procedures it is important that people are treated close to home, have support around them and are able to recover well within their family and their community.

However, with particularly challenging or complex procedures, we need to build in expertise. We will have to work in a networked way across Scotland to deliver that. We have said that there are challenges with volume. If people are to train in natural tissue repair, they will have to see enough people to maintain that training. We will certainly consider what is the best model for Scotland but, at the moment, I am not minded to reconstruct the unit in Canada here in Scotland.

I will hand over to Mr O'Kelly, who is keen to come in.

**The Convener:** We are quite short of time, and we still have a couple of questions to come.

**Terry O'Kelly:** With the creation of the national network of treatment and diagnostic centres, there will be some migration of patients in their locale to those facilities. That will provide an opportunity to concentrate colleagues who have particular expertise and interest in such fields. It may be that, as their careers develop, they will choose to have a more scheduled workload, instead of providing unscheduled care in the way they do at the moment. If they did more hernia lists, that would increase the numbers and would result in a move towards more of a Shouldice-type model. However, for most of our colleagues, I am not sure that doing one thing all the time is a very attractive way of spending their professional life.

**The Convener:** Thank you. We are very short of time now, although we are grateful for the time that you have given us. I invite Alexander Stewart and Paul Sweeney to

ask their supplementary questions, and then the minister can round up the discussion with any final comments in response.

**Alexander Stewart:** Minister, you touched on the need to try to create facilities to support individuals. Canada gives us a good example of what can be achieved. I appreciate that you want to ensure that medical support is given to individuals at the closest point, but some degree of specialisation may still be required, perhaps by creating a unit or expertise in the field for clinicians. That should be considered, as it could help to iron out some of the difficulties that we have seen. It would be good to get your views on that.

**Paul Sweeney:** I want to build on the point about the Scottish complex mesh surgical service being the opportunity to evolve the model. Given that there is such a small volume of defects in the national population base, combined with Scotland's relatively small geography and population base, the idea of a concentration of skills to deal with and rectify complex defects could provide a way to build the service to include some of the examples that Dr Spencer Netto has called for as key takeaways. Building that national centre would not be to say that everyone has to get a surgical mesh repair for a hernia in a national centre in Glasgow—for example, if they live in Lerwick. However, if there are complex or high-risk cases, that might be the most appropriate solution. Do you agree that we should look at that?

**Maree Todd:** Certainly. The Shouldice hospital deals with more routine operations and at quite high volume. In order to give people options in highly skilled and trained surgeons who are using those techniques, that is something that we need to explore on a national basis, although we can also build up local expertise.

I agree that there needs to be a national multidisciplinary team to look at those particularly complex cases. Clinicians from all over the country need to be able to access that expertise. It is difficult to understand how challenging it can be to communicate across boundaries in the NHS. That is a theme that comes up time and again. We are very keen to bust those boundaries to ensure that clinicians can access the expertise that they require for their patients, wherever they live in the country.

We are also mindful of developing systems that mean that patients, wherever they live, can access the right level of expertise. People in Lerwick are probably more comfortable with travelling than people on the mainland because they travel all the time. Patient choice needs to be part of it. We need to make shared decisions with patients about what is the best option for them.

**Professor Sir Gregor Smith:** One of the concepts that were explored in the extant clinical strategy for the country is the tension between competence for any given procedure or approach to care, and the volume of patients likely to be seen. There is a recognition that sometimes we need to look at ways where, nationally, we can

provide care for the low-volume procedures. All clinicians would sign up to that. However, there are different ways to achieve that.

Mr O'Kelly has spoken about the informal and formal networks that develop around care that can provide that highly specialised approach when it is required. That underpins much of our clinical strategy. Occasionally, there is a need to develop that further to create centres of excellence where there is a much more formalised structure and approach. The difficulty is gauging the best method to provide support to people when they need it.

**Terry O'Kelly:** That point is well made. An issue that Sir Gregor might want to take to the medical directors for discussion is how we can ensure that the best opinions and skills are applied when they are required, on all occasions. That means engagement between the board networks. The question is how we improve liaison and allow that cross-fertilisation of ideas.

**The Convener:** I do not know whether you saw any of our evidence session with the Shouldice hospital. I understand that there are questions of geography but, in principle, Dr Spencer Netto said that he would be very happy to facilitate any access to the expertise that they have developed with their clinicians to benefit Scotland's NHS, were that thought to be useful. They would be happy to explore that further if the Scottish Government wanted to pursue that.

I thank all three witnesses for giving evidence this morning.

10:35 Meeting suspended.

10:39 On resuming—

**The Convener**: I welcome everyone back. For confirmation, are members content to consider the evidence that we heard on the previous petition at a future meeting?

**Members** *indicated agreement*.

# Annexe C

## Extract from Official Report of consideration of PE1865 on 12 May 2022

**The Convener**: Good afternoon and welcome to this exceptional meeting of the Citizen Participation and Public Petitions Committee. This is the committee's eighth meeting in 2022.

We have only one agenda item, which is consideration of continued petition PE1865. The petition was lodged by Roseanna Clarkin, Lauren McDougall and Graham Robertson and calls on the Scottish Parliament to urge the Scottish Government to suspend the use of all surgical mesh and fixation devices while a review of all surgical procedures that use polyester, polypropylene or titanium is carried out, and while guidelines for the surgical use of mesh are established.

We last considered this petition on 2 February 2022, when we agreed to take evidence from the Shouldice hospital, in Canada, following representations that we received. We understand that it is the only licensed hospital in the world that is dedicated to repairing hernias, and it has been a supporter of natural tissue hernia repair for more than 75 years.

I am delighted to welcome Dr Fernando Spencer Netto, the chief surgeon at Shouldice hospital, and I thank him on behalf of the committee. Dr Spencer Netto joins us virtually—of course, all of us are appearing at this meeting virtually, so we are collectively all virtual.

We have an apology from Fergus Ewing MSP, who is unable to join us today.

Members would like to explore a number of questions with you, Dr Spencer Netto, so we will launch into that. However, I will begin by saying that Scotland has been very much at the forefront of the international discussion on transvaginal mesh repair procedures. Considerable angst and trauma was caused to an incalculable number of women, many of whom were told that they were imagining their suffering and that there was no option other than the mesh that had been fitted. In seeking to remedy that, the Scottish Parliament passed the Transvaginal Mesh Removal (Cost Reimbursement) (Scotland) Act 2022, which will facilitate women travelling to wherever specialist services are available for the removal of that mesh—including to the United States, where specialist services are available in Missouri.

Consequential to that, we have received this petition, which seeks to extend the interest in and potential impact of alternatives to mesh treatments in relation to hernias. The committee is incredibly intrigued and interested in experience from Shouldice hospital, so, by way of an introduction, could you tell us—and the many people who are watching today's meeting and who will be interested in the

discussion that we are about to have—about the work of your hospital, so that we can better understand it from your perspective as its chief surgeon?

**Dr Fernando Spencer Netto (Shouldice Hospital):** Thanks for having me here. It is a great opportunity to clarify some of your points. The first clarification is that the use of mesh may be very different from one area of the body to another, so whatever I address today will relate only to abdominal and groin hernias. I cannot say anything about vaginal mesh. I understand that it was a matter of discussion and that lots of gynaecologists think that it is related to the problems.

I do not know whether Shouldice hospital is the only one that is dedicated to hernias, but I know that it was the first. There are several clinics in the US that also do only hernias, but I do not know if they are considered hospitals.

We do about 6,000 to 6,500 procedures per year; it depends on the year—Covid meant that the number decreased a little bit in the past few years. I would say that we do 99 per cent of procedures without mesh, and we get good results. We deal mostly with hernias in the groin area, and mesh is used on a very small number of procedures in that area; it is used on less than one in 1,000 inguinal hernias. Our recurrence rate—which is given by auditors, not by us, through review of follow-on care of patients—is the lowest in the Ontario province by far; it is about three times lower than the hospital with the second-lowest rate of recurrence.

**The Convener:** I fully understand the difference, and that is why we are interested in pursuing information on hernias. It is quite different from transvaginal mesh, and the use of mesh in hernia repairs is far more widespread and has been done over a much longer period.

I am interested in your experience as someone from the leading hernia hospital in Canada. An issue that came across to us was that clinicians were opposed to the idea that there was an alternative treatment to vaginal mesh. You have obviously specialised in your process and can demonstrate that you have had excellent results. Is that widely accepted as a clinical practice by clinicians across Canada, or is there any resistance to the idea that there is an alternative to mesh as an appropriate route forward with hernia repair?

**Dr Spencer Netto:** [Inaudible.]—some evidence that there is a higher rate of complications than with tissue repair. It is relatively recent to this discussion.

Some time ago—it is still valid—the European Hernia Society said that the standard technique for groin hernia repair was to use mesh. We do not agree with the reason that it gives for saying that. It thinks that it is easier to teach new surgeons that procedure. That is the reason why the society says that that should be the standard or Initial approach.

There is a resistance in Canada and other parts of the world towards not using mesh. It is difficult to pinpoint one factor for why mesh became so widely used.

Physicians in other specialties are intrigued by or fascinated with new technologies and, if someone says that they have a mesh or different type of device that is a lot more resistant than human tissues, and if you have an opening, they seem intuitively to think that, if mesh resists more than human tissue, the repair will be more resistant if a mesh is used.

In laboratory studies, studies with animals and experimental studies, even in initial patient studies and follow-ups, it is difficult to pinpoint some of the complications that happened with mesh after the procedure. A few of the complications that happen with mesh are related and long term. For example, the mesh retracts and causes pain and sexual dysfunction and sometimes pain at movement. Probably the most important complication is pain related to inflammatory tissue that is around the mesh.

In general, I would say that, if well done, a hernia repair with mesh would be relatively efficient in regard to holding off the hernia but has other complications. It is also a lot simpler to do than a tissue repair as at Shouldice. That is where we do a reconstruction of the groin from the inner layer into the upper layer. It takes longer to train the surgeon and it takes longer for the surgeon to perform the procedure in comparison with an open mesh repair.

**The Convener:** I know that you are not seeking to draw parallels, but, from our experience, I think that the use of mesh in the transvaginal example was underpinned by issues of cost and the fact that it was a much simpler procedure than the alternative.

You referred to the European Hernia Society. The British Hernia Society, in expressing its scepticism and its justification for mesh as the principal and preferred route, says that the sutures that are required for the alternative—the tension-based repair procedure that you pioneer—are not resilient enough. How do you respond to that? How do you deal with that?

**Dr Spencer Netto:** That was based on studies from the 1980s and 1990s. Those looked at the molecular structure of hernia tissues in a patient that had hernias. Those people have a different disposition of the tissues. Their collagen is a little different. It is genetic most of the time, so it will not change. That compounded the use of mesh.

My response to that is our results. There are a few other things happening in the world. As you may know, the world is fighting an obesity surge. At Shouldice, if someone comes for an operation, we ask the patient to prepare themselves. Because we have good results and people want to have good results, we have the luxury of being able to ask them to lose weight; otherwise we cancel the procedures. If they smoke, we suggest that they stop, but they do not always stop and it is not a sine qua non for us. However, drugs and alcohol should be reduced for people to have an operation here. We are a fairly small hospital in regard to structure but, as we have a well-oiled machine, everything goes fine.

However, we have some requirements that sometimes an independent practitioner does not have. Let us say that a surgeon has a patient who is mildly obese, with a body mass index of 35. If an independent practitioner asks the patient to lose weight, so that they can do the surgery, the patient might go to another physician or surgeon. Because Shouldice has the structure and results to back us up, the patients want very much to have the repair here, so they will say, “I am going to do whatever they want.”

We do a few basic things to prepare patients for surgery. Because of many things, including commercial pressures, we need to have the patient’s weight down—if not, they are going to have to look for another practitioner. It might go in that direction.

It also counts that we just do hernias, so we are quite familiar with the area. I have always thought that, in a lot of areas of surgery—including trauma surgery and complex surgeries such as pancreatic cancer surgeries—patients do better if they go to reference centres, which do more cases per year. I think that it is the same thing with hernia. Because hernia is the most common surgery on the road for general surgery, I think that we should encourage the idea of centres of excellence, because their experience provides a counterbalance.

We also have a few requirements for the patient to undergo the operation. All those things make a difference, as you can see by the fact that, when our results are compared with those of other centres that do the Shouldice repair, our results are still better. That is said by independent investigators, not by us.

**The Convener:** Thank you; that is very helpful.

My colleague, David Torrance, will ask our fourth question, which explores the controlled trials and the low recurrence rates. He will ask a couple of questions that follow on from what you have just said.

**David Torrance (Kirkcaldy) (SNP):** Good afternoon from Scotland, Dr Spencer Netto. You have impressive results with regard to low recurrence of hernias. However, systematic reviews of randomised controlled trials, which are the gold standard for robust health intervention evidence, show that hernia recurrence rates are lower for mesh repairs than they are for non-mesh repairs. I know that that does not apply to you, so what are you doing that is different from what other hospitals are doing?

**Dr Spencer Netto:** Most of that difference is to do with our preparation of the patient. We get them to the correct weight and we control the comorbidities before the operation. However, we have been criticised because our results are too different from those of the other people that do the Shouldice repair around the world. We will

publish something about that in the near future. We control the patient prior to the operation—that is what we do that is different.

We also use a less aggressive method of anaesthesia; we use sedation and local anaesthesia for everyone. We do early ambulation, so patients start to walk on the same day that they have their condition seen to. We also do early rehabilitation, including an exercise programme that starts in the hospital. I think that, together, all those measures to prepare the patient contribute to their quick recovery; it is not just about the surgical technique and doing the stitches.

I do not know whether you have seen our facilities on our website. Shouldice is a little different from general hospitals; not everyone has the luxury of there being nice green fields outside. In the summer, the patients can walk around, which stimulates the ambulation that we want them to have in the post-operation period.

**David Torrance:** You apply selection criteria, such as weight loss, before admitting patients to Shouldice hospital. What is the rationale behind that? Are those selection criteria really important to your success rate?

**Dr Spencer Netto:** I think that they are. First, we are a small hospital, so we cannot take allcomers. We cannot take patients who might have more complex medical needs, such as those who might need back-up from cardiology or an intensive care unit. That is one aspect. That said, when our results are matched with those in other places in Ontario with regard to severity of disease in patients, they are still valid.

Regardless of groin hernia size, that is the main group of people whom we eventually do not take. However, if the patient in question is too obese and wants to undergo weight loss, that is okay. Sometimes there are patients who need to lose, say, 50 pounds; indeed, there have been patients who had to lose 100 pounds or more to have the operation. Sometimes we also change the estimated ideal weight a little bit.

One of the suitability criteria is the patient's medical condition. If they have a chronic condition, it needs to be stable before they can have the operation. With obesity, though, it is questionable whether we can do tissue repair, because the operation is a lot more difficult: the incision has to be bigger, the wound can get more infected, there can be more hematomas and, frequently, one complication will lead to another. That is why we always try to get patients to the correct weight. Unless some very specific things happen, most of them reach the correct weight—or at least get very close to it—and they have the operation. I am 100 per cent sure that that makes a difference to the final result for individual patients.

**David Torrance:** Thank you very much for that, but what I am trying to get on the record is whether you think that, if those criteria are not in place in a general hospital setting where repairs are being carried out, the procedure will not be as successful.

Are you saying that mesh repairs would not be suitable for the patients who do not meet the criteria?

**Dr Spencer Netto:** Yes. If patients do not meet the criteria for mesh repair, the results are worse. I have talked about groin hernias, but perhaps I should say a little about ventral hernias, including umbilical, epigastric and incisional hernias. It has been proven that, for that group, weight is the major factor in the recurrence of hernias, whether or not mesh has been used. That is well defined, and we therefore think that weight control is very important in hernia operations, unless it is an emergency case.

**David Torrance:** Thank you very much for that. I have no more questions, convener.

**The Convener:** Following on from that, I invite Paul Sweeney to reflect on what has been said so far and then to ask our next set of questions, as well as any question that might have occurred to him.

**Paul Sweeney (Glasgow) (Lab):** Thank you very much for taking part in our inquiry into the use of surgical mesh, Dr Spencer Netto. Chronic post-operative pain is clearly a substantial issue for many hernia repair patients, regardless of the type of repair that has been undertaken. What causes such pain?

**Dr Spencer Netto:** The definition of post-operative pain has changed a little bit: it now means having three months of continuous pain, but in the past it was defined as pain that disrupted activities for six or more months. As a result, we are now having to figure things out and redo our statistics—initially, though, the figure for those affected was 1 per cent.

What is not well defined are the variables. One significant variable with regard to mesh repairs relates to the fact that several nerves pass through the area in question. Fibrosis related either to the mesh or, indeed, to the surgery without mesh is one of the causes of those nerves becoming a little trapped, which causes pain.

There are a few cases in which we cannot detect the reason for the chronic pain. When the pain is caused by the nerves, we call it neuropathic pain, which is relatively easier to treat than nociceptive pain. We do not know the exact reasons for nociceptive pain, but we think that that involves damage to small nerve terminals that it is not possible to see with the naked eye. However, it can be very debilitating.

**Paul Sweeney:** Thank you for that overview. Systematic reviews comparing mesh and non-mesh repairs have found that post-operative complications, including the chronic pain that you define, are generally lower for mesh repairs. Why does the Shouldice hospital's written submission indicate an alternative view of the evidence? Can you explain why its written submission varies from the systematic reviews?

**Dr Spencer Netto:** Tissue mesh repairs are related to less chronic pain but, on the other hand, they are generally related to more recurrence. Recently, there was an

interesting publication relating to umbilical hernias that covered several thousand patients. It showed a 2 per cent recurrence of small hernias with tissue repair but just a 1 per cent occurrence of chronic pain; and a 1 per cent recurrence with mesh but a 3 per cent occurrence of chronic pain. In some cases, there is a trade-off, and you can incur a little bit more pain with the use of mesh. The incidence of chronic pain using mesh in the groin is a little bit higher, because there are nerves passing there, as I mentioned.

It is hard to control the pain. More research and understanding is required on the part of physicians. We know that remodelling of the area and addressing inflammation are important, but it is difficult to do that. We do that by addressing the range of motion very early on by using specific exercises that mobilise the joints—that is mainly for groin hernias. However that is not a perfect method. We need to understand more about that to make a formal recommendation but addressing the range of motion helps a lot.

Protecting the nerves is our policy—we do not cut the nerves to alleviate chronic pain, which other people do. Again, there is a trade-off between having a low incidence of chronic pain and a lack of sensation in an area. We think that it is better to preserve the nerve. We do not want to do something that is unnecessary in an operation. However, some people who use mesh use that strategy to avoid the patient feeling pain in the area.

**Paul Sweeney:** Thank you for that insight.

**The Convener:** One of the issues that we faced in Scotland in relation to the removal of mesh in the transvaginal area was that that operational procedure required a huge amount of skill. The glib view, before all this was examined properly, was that it might be possible for some clinicians from Scotland to simply sit in on a few procedures to gain the necessary skills. However, that did not prove to be the case, which is what led to the legislation in Scotland that is facilitating the transfer of women to wherever the skills exist.

In due course, we will have a meeting with the Scottish Government minister with responsibility for this issue. For the moment, though, Alexander Stewart will explore the potential transferability to Scotland of the skills and experience of the staff of the Shouldice hospital, and of its preferred model.

**Alexander Stewart (Mid Scotland and Fife) (Con):** As the convener has indicated, we are interested in finding out how surgeons in Scotland could learn from the skills, training and techniques that are used in the Shouldice hospital. What additional training and support would be required for them to fully understand what you are doing, so that they could use your approach to benefit patients in Scotland?

**Dr Spencer Netto:** That is a difficult question, because there are some cultural issues. If it was possible, a group of surgeons who were interested in doing, or being leaders in, hernia repairs could be selected to come here. Potentially, that could be done, although there would need to be conversations about that. People could watch what is done here and we could eventually send someone to provide guidance over there.

However, as I mentioned, if you develop policies for patients who undergo hernia operations, as we have done here, that might facilitate things. If a patient goes to surgeon A, who says that they need to lose weight, but then the patient goes to surgeon B, who does the operation, and there are eventually complications, that does not help too much. If you do the same procedure a lot of times, you will improve—that is a no-brainer. Those are some potential areas of development.

It is possible that techniques other than those used at Shouldice could be employed, too, in accordance with local training, or people could visit us to look at what we are doing to see whether it would be possible to incorporate the whole technique. We will have suggestions in that regard if you are interested in using the Shouldice technique. Some of us can spend some time helping with that.

**Alexander Stewart:** Surgeons in general hospitals are not as skilled in non-mesh techniques. Do you expect recurrence rates following non-mesh repairs to be higher than the rates for those who are treated at Shouldice hospital?

**Dr Spencer Netto:** Yes. I expect that to be the case if our guidelines are not followed. If they do not get the patients to lose weight, I would expect the rates to be higher. We just do that so that the skew increases a little. If there is a different situation with the groin that a colleague in another room knows about, we can call on that person.

**Alexander Stewart:** Would a ban of the use of mesh in hernia repairs be a good thing? Would that change some of the dynamics?

**Dr Spencer Netto:** In some situations, there is no possibility other than to close the opening with mesh. Sometimes, the hernias improve, and surgeons' knowledge of how to treat hernias also improves. The stats from today are probably very different from the stats on patients who were operated on five to 10 years ago. In relation to hernia repairs, it is not possible for there to be a ban, because, in some situations, using mesh is the only way to do a good repair.

**Alexander Stewart:** Thank you.

**Paul Sweeney:** In a previous evidence session, Dr Terry O'Kelly, a senior medical adviser to the Scottish Government, advised us that the Shouldice technique

“will not be applicable to non-inguinal hernias; it might also not be appropriate for patients with larger defects, or for very degenerative tissues.”—[Official Report, Citizen Participation and Public Petitions Committee, 6 October 2021; c 21.]

Do you agree with Dr O’Kelly’s assessment?

**Dr Spencer Netto:** Yes. The Shouldice technique is specifically for groin hernias—inguinal hernias—which account for 85 per cent of our patients. However, our general policies and methods relating to losing weight, early mobilisation and the least anaesthesia possible are for everyone. I agree with Dr O’Kelly in that regard.

**Paul Sweeney:** That is helpful.

**The Convener:** You just referred to the situation in which the use of mesh might still be appropriate. It occurs to me that the reason that mesh has been relied on by some is that the nature of the hernia suggests that the tissue walls are not sufficiently strong to withstand the subsequent pressure.

You have explained the preparatory criteria that you have for people you think it would be appropriate to operate on, but when it comes to—how can I put this?—what you find internally, are there times when you look at what is there and think, even though the patient has taken all the necessary action, the tissue wall might not be sufficiently strong to withstand the procedure? Does that happen from time to time, with the result that you have to fall back on an alternative?

**Dr Spencer Netto:** Yes, that happens, but it is not common. Recently—two years ago—we had a patient who was a young man in his 30s or 40s. There was no indication that there would be a problem, but the tissues just melted with the stitches, so we needed to use mesh.

That can happen with inguinal hernias, but it is a bit more common with other kinds of hernia. With inguinal hernias, it is really uncommon. Sometimes a person who has an inguinal hernia can have an associated femoral hernia. Because of the anatomy, those associated femoral hernias can be a little hard to deal with, so we sometimes use mesh.

**The Convener:** Out of interest, is there any difference with regard to the application of the procedure, the success rate and the outcomes, depending on sex? Does it matter whether the patient is a man or a woman, or is the procedure equally effective?

**Dr Spencer Netto:** Any repair of inguinal hernias is easier to do in females. Through the canal, there is a round ligament that we can section without problem. In males, we cannot do that, because if we do, we will kill the testicle. That might not be the best approach, because we do not want someone who comes in for a hernia repair to lose a testicle.

The opening that it is necessary to leave is a potential site of recurrence. We know that.

**The Convener:** With regard to that rather uncomfortable thought that you had in relation to men, does that happen from time to time?

**Dr Spencer Netto:** Yes.

**The Convener:** It does.

**Dr Spencer Netto:** There is a risk to the testicle in many hernia operations. The risk of losing a testicle is between 1:800 and 1:1,000. [Inaudible.]—use of mesh.

**The Convener:** The issue that we have had reported by so many people is what happens as a consequence of the use of mesh. In addition to my involvement in the whole question of mesh, I have been a member of the cross-party group on chronic pain. One of the obvious consequences of the use of mesh is the number of people who have presented, post-procedure, with life-crippling, intolerable pain. What is the post-operative life experience of the patients who undergo the procedure that you promulgate?

**Dr Spencer Netto:** We still have some patients with chronic pain—the figure is about 1 per cent. As I mentioned, it can sometimes be really hard to pinpoint exactly what the cause is. It is sometimes to do with characteristics related to the nerve. In such cases, there are specific medications that we can prescribe, and there are some procedures that we sometimes do, but sometimes it seems to be nociceptive pain. People in that position sometimes need to change profession, because they can no longer do heavy lifting. The incidence of chronic pain is a little bit lower with our procedure than it is with the use of mesh.

**The Convener:** That is very interesting.

**Dr Spencer Netto:** That is challenging for me and for the people who work here. It is a lot worse than a recurrence—we can fix recurrences. Chronic pain is a lot harder to fix; sometimes we can fix it and sometimes we cannot.

**The Convener:** I want to understand a couple of things in relation to healthcare systems in different places. First, how big a department is your facility, and how many procedures are you routinely expected to undertake?

**Dr Spencer Netto:** There are around 10 full-time surgeons; we may have a bit more because some are part time, but together we are 10 full time. The hospital has 89 beds, but patients do not go home immediately—on the same day—as happens in other hospitals; they have one or two days after surgery for rehab and pain control.

Most of our pain control is with anti-inflammatories and a normal period of analgesics. Five per cent of our patients receive opioids after surgery, and less than

1 per cent get an opioid prescription when leaving the hospital. Again, that is because of all the measures that we take.

**The Convener:** I want to understand one final thing. How is the procedure financed in the healthcare system in Canada? Obviously, we have a national health service here, so everything is part of a national healthcare plan, but in relation to the patients who present to you, what is the financial underpinning of the procedure that is undertaken?

**Dr Spencer Netto:** We are a privately administrated hospital, but we mostly see patients on the provincial health insurance plan, which is the Ontario health insurance plan. It pays for the hernia procedure.

**The Convener:** Is that a public plan?

**Dr Spencer Netto:** Yes.

**The Convener:** That is helpful.

**Dr Spencer Netto:** When patients come from other provinces in Canada, we find out from their provincial Government whether there is a difference in cost; if there is, they pay the difference. Sometimes it is more expensive than here, and they would pay the difference; sometimes it is cheaper. Patients who come from the outside world would pay for the surgery; they would pay out of their own pocket and may receive the cost back, depending on their insurance.

**The Convener:** In response to Alexander Stewart's earlier question, you very generously said that conversations could potentially take place in the event that there was interest in Scotland in trying to gain experience of all of this. If we raise that potential conversation in our evidence session with the Scottish Government minister who is responsible for this area of healthcare, what would be the appropriate way to explore that further? Would it be for the Scottish Government to make contact with Shouldice hospital to see whether a conversation could be initiated?

**Dr Spencer Netto:** It could be—that would be through Mr John Hughes. However, I do not know, because it has not been done before.

**The Convener:** I understand that.

**Dr Spencer Netto:** You need to figure out how it could be done. In relation to your previous question, which I kind of missed answering, we do around 25 to 30 patients per day on a regular day, which means around 500 to 600 per month and around 6,500 per year. Eighty-five per cent of those patients are inguinal hernia patients.

**The Convener:** That is a considerable complement.

As colleagues have no further questions to ask, I thank you very much for a fascinating opportunity. It is amazing what the world's worst pandemic has led us to

being able to explore across the world more easily, as we have become familiar with this virtual technology. Otherwise, it is not a conversation that we would have thought to have or been used to having.

On behalf of the committee, I am incredibly grateful to you for the time that you have given us and the evidence that you have presented.

Is there anything that you would like to say that we have not touched on?

**Dr Spencer Netto:** I thank you for the opportunity. My take-home message is that a centre for hernia repair makes sense, because hernias happen very frequently. It may vary a bit from what we do here, because of local characteristics, but that is okay; you need to see what works better for you. It may not always be the case that following the complete recipe that we follow would be good for you. The easiest way would be to find some leadership in hernia repair and start talking with them, and eventually you will have enough to completely dedicate a hospital unit or part of the hospital service to hernia repair.

**The Convener:** I thank you again for your good humour in dealing with us amateurs in this field of experience. We are very grateful.

That concludes our evidence session. For our next consideration of the petition, we will hear from the chief medical officer and the Minister for Public Health, Women's Health and Sport, Maree Todd.

# Annexe D

# Petitioner submission of 16 June 2022

## PE1865/HHHH – Suspend all surgical mesh and fixation devices

This is my submission based on the meeting held on Wednesday the 8th of June. Myself and Lauren weren't notified or given a chance to prepare anything ahead of this meeting. This was extremely disappointing for us.

Having watched the meeting back we want to thank the petition committee as they clearly have a good grasp of the mesh issues we all face and in the absence of instruction from us they nailed the points that are very important.

There are a few points we would like to make regarding the meeting.

The mention of Alison Britton doing case reviews we would like to try and meet with Alison as we do feel a lot of the reporting she will be doing will benefit us also.

We agree whole heartedly with the BRAN style of care that the government speak of. This is what should always have been in place and, in our view, it still currently isn't filtered right through yet. I know I'm a patient still going through the systems. I don't see it yet. We need to be given the best trained surgeons. We agree that no surgery is risk free but we should have the choice no matter what the surgeons opinion is. No 2 surgeons will have the same views just like politicians. We need that choice.

I also worked with NHS Education for Scotland to make the changes in the NHS regarding when things go wrong in the NHS. I attach a link to the study carried out by Jean McQueen and would draw the Committee's attention to the recommendations in Table 3 of this report. There is talk there are not enough hernia surgeries in a year to create a

centre for routine or complicated situations. The Scottish Government have based the current mesh centres on 600-800 woman with TVT/TVT mesh. Based on the figures just given to Paul Sweeney MSP by The Health Secretary (S6W-08789), from 2012 to 2021 the number of hernia mesh surgeries alone were 72,683. That's 7268 a year in Scotland. If the figures are correct, and 1 in every 10 people are affected by chronic pain as a result of their mesh surgery, that's 726 people a year. More than the numbers the Scottish Government set up the specialist mesh centre for gynaecological mesh. Why are the numbers of us affected not enough? The Scottish Government suggest we are a small minority. Not that small when it's severely affecting our lives. Also I am a hernia mesh patient who may lose my bowel due to mesh so I believe there is a cross over here for the mesh centre if it's going to include rectopexy meshies. This would give us a better chance to all specialists who deal with mesh complications if we could have the mesh centre utilised for all mesh. We have the foundation why not use it? There are no current pathways for any other meshies at the minute. I know I've battled for 8 years to find help.

Again there is not enough data collected even Dr Terry O'Kelly stated that Scottish Government/NHS Scotland don't know the full risks of these surgeries as they don't have 10 years of data. Short term they are happy to use it but long term when damage is done it's too hard to remove the device. This isn't acceptable.

The MHRA I have tried to work with, and sadly they aren't listening to us. They are failing us. They don't personally test devices they have a trust relationship with manufacturers trusting the devices that are being put through are as safe as they say they are. Very much like the FDA do. Through the 510K process if you can prove your device is like a device already on the market it is automatically passed, but wait aren't the devices before already failed and been removed from the market??? There is the issue. So I am all for Scotland regulating these devices and testing them. Then we know whole heartedly these would be safe to use and not based on trust from manufacturers. What about the trust between surgeon and patient? When a patient is saying they are suffering. We're dismissed as the surgeons believe in the process that is failing us. Too many failures.

Complications from mesh implants are not rare. It's the same material no matter where it is placed in the body. Its causing chronic, debilitating pain and autoimmune conditions. All the same. Use the data in front of you. We are your data. We are the evidence. What more do you need to see the damage? The Scottish Government/NHS Scotland say they use mesh as it's robust holds up. That's all well and good but what about the quality of life for us implanted with it? Again as Dr Spencer Netto from Shouldice said " we can fix reoccurance but pain we can't". No truer statement said. In my view, the quality of life should be factored in here instead of the science of a material. The Scottish Government can't deny that mesh is causing complications. They are putting us into minority groups. Mesh is mesh whether it is TVT/TVTO, hernia, rectopexy, hysterectomy, gallbladder, breast reconstruction or any new upcoming surgery. We are all mesh affected.

We ask for an independent review in Scotland of all mesh. Get the data. Put people first. Make it natural tissue repair first before mesh. We know mesh has to be used in life or death situations. Emergency situations. But give us natural tissue first. If someone is so against mesh then they will do all the can, i.e. weight etc to have this surgery. Give us the power back. I'd rather face 10 natural tissue repairs than 1 mesh repair. I live with mesh I know how damaging it is.

We ask you to listen to us. You talk about being listened to and supported? Our own government aren't listening. They are dismissing us. The government are keeping these issues going by not listening, by not making the changes. Please we ask allow us an independent review of all mesh.

# James Young submission of 17 June 2022

## PE1865/IIII: Suspend all surgical mesh and fixation devices

I am now a 58 year old gentleman whom on and around the year of 2013 had a mesh implanted into my right side groin.

Ever since this operation the mesh implant has cut into me and given me pain within my groin testy and right leg as little as three months after the device was implanted.

This pain is severe and can be quite debilitating, to say the least.

It causes pain in my right testicle as if it's being pulled or squeezed. Feels like someone pulling it to the side with a rope.

I was an active man, I was also a sexually active man, ever since this implant I have not had any sexual interactions with my wife for over 5 years and it has caused friction between us.

This mesh has destroyed my private life and my normal daily life.

I cannot ride my bike anymore nor can I sail my boat due to the pain and discomfort.

Boat has since been sold, my bike which is my pride and joy gets left in the driveway, it has not been ridden in some years.

Taking a walk in a daily basis is non-existent. Walking is something that is an achievement in of itself.

I have lost all of my self-confidence and want for life.

The depression and "hermit" lifestyle I have now adopted due to this mesh is nothing apart from disgusting, and doesn't fit.

I want to lie down and not wake up.

My right leg has shooting pains and twitches going up and down it.

My right testicle is constantly sore, this also has shooting type pains.

I can hardly sleep at night also due to this pain.

Medication seldom works to alleviate symptoms.

My mental health has taken a massive tumble.

I was a strong determined focussed man whom had a fire for life, but the mesh has killed that.

I was never told that mesh could cause problems.

I was told it would stop me getting a hernia.

When I signed my consent form I signed a form that didn't give me the full consent.

No one explained that mesh could do this.

I was told that it was safe to use, and that it had been tested in women and that it was safe.

It was a new thing for men and that it was going to protect me from further harm.

That has proven not to be the case.

Now I see that women are badly affected by surgical mesh.

I am a male whom is also badly affected by surgical mesh.

I would like to submit this to petition PE1865 under Roseanna Clarkin.

Thank you for your time.

# Petitioner submission of 5 September 2022

# PE1865/JJJJ: Suspend all surgical mesh and fixation devices

By pursuing this petition, we have sought the following:

- An independent review of all mesh and fixation devices.
  In our view, this would set the foundation for all future achievements. We believe that an independent review would bring to light the true extent of damage caused by mesh and enable progress to be made.

  The Committee may be interested to note a hernia mesh patient in the USA has recently been awarded several million dollars after

taking the mesh manufacturer to court. It was argued during the trial that the manufacturer had used non-medical grade polypropylene to make the mesh device, yet this device remains available on the market.

- Improved patient pathways.
  We want patient pathways with specialist surgeons who are aware of complications, how to properly insert mesh and who can remove mesh if this is needed. We want to see a choice of surgeries where natural tissue repair is offered first, and we want better aftercare.

    - Specialised Mesh Centre
      We would like a mesh centre with more surgeons trained in natural tissue repair. (How the Scottish Government can say there is no need for this as there are very few numbers amazes us, and we feel this is another attempt from the Government at stalling tactics).

      We are aware of a surgeon working in London who is a mesh specialist. This surgeon works privately and within the NHS doing removal and natural tissue repair, perhaps as he is closer to home, he would be a better candidate for assisting surgeons in Scotland. As the Scottish Government are not minded to develop a Shouldice type setting, maybe this surgeon offers an alternative option that could be provided via the current NHS system?

- Apology
  We want recognition and an apology from the Scottish Government.

  We feel the Scottish Government have completely ignored us over the past 8 years. We have campaigned alongside the transvaginal mesh women, the Government have spoken to us and were made aware of the issues with other mesh surgeries, but in our view they are still ignoring the issue.

- Compensation
  We want compensated for the quality of life we have lost as a result of operations carried out within our health care system.

> We have been damaged and feel that no-one is listening or even caring about us. We feel forgotten and left to the side. The woman with TVT mesh are no different from us, they have the same material inside them. Yes, placement is different, but how can it be recognised that transvaginal mesh has caused chronic pain, migration and auto-immune conditions in women, yet the concerns of patients with hernia, rectopexy and other meshes remain, in our view, ignored. If the Scottish Government were listening, they would understand it's not solely the placement of this device but also the material itself which causes issues. The Committee are aware from previous submissions to our petition that many mesh patients, myself included, have experienced chronic pain, migration of the mesh, and auto-immune conditions. Despite our experiences (and the medical evidence to support it), we do not feel the Scottish Government are taking our concerns seriously.

This is just what I would like to see happen under the petition.

I feel the Scottish Government have ignored me for 8 years, and the only way discussions are happening is through this petition. As petitioners, we feel there is more work to be done and would like to see the petition stay open so this can be continued.

We have 3 amazing MSPs helping and supporting us a lot, as well as amazing understanding from the petition committee. With this support, we are hoping there can be a parliamentary debate on the matter. We also hope to secure a meeting with the Cabinet Secretary for Health, Minister for Public Health, Women’s Health and Sport, and the Chief Medical Officer.

Given that the women with TVT are still struggling for healthcare within the centres that were provided for them, we feel it's also important this petition remains open to help support them. In our view, their voices still haven’t fully been heard. We always knew we would have to fight for better healthcare together under this petition. This petition is our last chance to get what we feel should have already been in place.