Q. You will receive the ESSO Medal tomorrow for your outstanding contribution to surgical oncology: which one do you consider as the most remarkable achievement in your career?

- **NOH:** Whatever achievements have come my way are due to opportunity and the collegiality of others. Being a medical doctor is a privilege. Being the Head of a University Department of Surgery for 30 years conferred the profound twin responsibilities of enhancing standards of clinical care and of influencing the education of medical students. Clinical research is an intrinsic component of each of these obligations. The development of an Academic Department of Surgery allowed me to play an active role in preparing national programmes for liver transplantation and for cancer care, in developing guidelines for breast cancer services, both for screening and symptomatic, and in assisting government in implementing these policies. To have a busy clinical and academic commitment, together with a busy operative schedule provided is a wonderful combination.

Q. Were you inspired by anyone when you decided to start this profession?

- **NOH:** My parents, my siblings, my wife and children influenced me greatly by their strong commitment to voluntary public service. I was also fortunate to work with inspiring surgical leaders during my training in Ireland and in London.

Q. How are selected the Niall O’Higgins Award winners selected during the ESSO Congress?

- **NOH:** All medical personnel involved in the training of medical specialists should encourage, support and cherish doctors in training. This award was established to acknowledge the efforts and enthusiasm of trainee surgical oncologists. The Scientific Committee chooses the best papers based on the evaluation of abstracts. My function is to try to identify the best presentation based on the value of the hypothesis and the quality of the methodology, analysis of results, and the presentation.

Q. What are in your opinion the main disparities as concerns the quality of cancer surgery across European countries?

- **NOH:** The standard of cancer care throughout the European Union is variable, not only among the Member States but from region to region within States and even within hospitals. Abundant evidence is available on this point and acknowledgement of this fact is an important step towards improvement. Access to good quality care is also a major issue.

Q. What factor would be key to overcome inequalities?

- **NOH:** Clinical and administrative guidelines, capable of being brought up to date regularly in the light of advances, should be adopted in each Member State. Clearly responsibility for the health service is a matter for each country but adoption of evidence-based guidelines would raise standards rapidly. Implementation of standards is often politically difficult and courage on the part of public representatives is needed. However, members of the public understand that cancer services, when delivered in a small number of specialist centres, provide an advantage both in survival and quality of life. The argument is irrefutable; questions remain about the political will.

**Research Expertise**

Q. As former President of FECS/ECCO, what is your vision of multidisciplinarity in the management of cancers?
Multidisciplinarity is often misunderstood. In oncology it involves a meeting among experts (medical oncologists, surgical oncologists, radiation oncologists, radiologists and pathologists and others), preferably in the same location to discuss the best management of individual patients. Such meetings should also be multiprofessional, thus involving nurses, physiotherapists, social workers and allied professions so important in determining the best care for the management of the individual patient. This arrangement is quite different from sequential opinions of specialists about patients. In brief, it involves all actors to be on stage together at the same time so that useful interactive dialogue can occur. Such an arrangement is not always easy to put in place but it is indispensable for contemporary cancer care.

Q. From your extensive experience, how would you evaluate the quality of surgeon-patient communication?

Patients should be involved in the decision-making process about their own management. Time spent in discussing options of treatment with each patient and their family members or supporters is of inestimable value, avoiding confusion and misunderstanding about what is often a complex pathway of care. I do not mean that patients should be given a range of options and asked to make a decision about their own treatment. It involves dialogue and understanding. Sometimes it is as important to understand what kind of patient has the disease as to it is to understand what disease the patient has. In University College Dublin, where I was privileged to be Head of the Department of Surgery for over 30 years one of our mantra was “We treat not just cancer, we treat people.” What is good for the many may not be good for the one. Such dialogue may involve several discussions. When patients understand and agree with the plan action, management is facilitated and difficulties in communication minimised.

I have mentioned earlier what a privilege it is to be a doctor. It is an amazing experience to appreciate what the human frame can support and the human spirit can endure.

Q. In your opinion, which state-of-the-art technology will be key in the future of cancer surgery?

The technical advances in cancer surgery are astonishing. The development from (i) “open” surgery with extensive major operative incisions and scars to (ii) “keyhole” or laparoscopic surgery with several small puncture openings to (iii) robotic surgery with its enormous technical refinements has transformed cancer surgery and cancer treatment in general. The role of surgery in the future will be “less rather than more”, “selective” rather than “generic” and, above all, based on the biological properties of individual tumours. It will be refined and precisely focused on the individual patient and the individual tumour.

Surgery remains the primary and main treatment for solid tumours. However, there is a big difference between poor or mediocre surgery and good surgery, in terms of survival, recurrent disease and quality of life. The value of high quality surgery is not sufficiently appreciated, even among the oncology community. Quality of surgery has often been omitted in trials of adjuvant systemic post-surgical treatment and this represents a dangerous travesty of good treatment.

Radical or super-radical surgery has been superseded by biological refinements, based on the properties of the individual tumour. This conceptual transformation has led to safer techniques with less morbidity. Importantly, organs, often removed in the past in the interest of radical clearance of the tumour, can now be preserved with good function and with oncological safety.
Concerning breast cancer, the new information about the changing profile of the cancer cell as the disease progresses and the specific reaction to the cancer cell point to novel methods of controlling growth and spread of cancer. Understanding of the limitless potential of the human genome is bound to yield valuable information about the behaviour of cancer.

Q. What was the major challenge you encountered when you were President of ESSO?

- **NOH**: Necessity for political will, improved direct collaboration among cancer specialists, more open and swift sharing of scientific information in a transparent fashion and need for global vision about how solutions in prevention and treatment should be addressed. These principles were among those proposed and promoted by the Charter of Paris.

Q. You are currently developing a multidisciplinary training in oncology at the in EU level. Can you tell us more about this initiative?

- **NOH**: One of the obvious issues in the training of clinical cancer specialists is the lack of interdisciplinary training. Medical oncologists, surgical oncologists and radiation oncologists are trained separately with little or no cross-disciplinary training. Thus, training programmes, each discipline is excluded from a deep understanding of the potential and drawbacks of each of the others. Such lack of appreciation inevitably undermines mutual appreciation and restricts the value of the multidisciplinary meeting as a forum for true dialogue.

The idea of a degree of cross-disciplinary training is understood and widely accepted and should become the norm. Thus every trainee medical oncologist should spend some time in a surgical oncology and radiation oncology service, the radiation specialist should be affiliated to surgical oncology and medical oncology and the surgical cancer specialist should be assigned to a medical oncology and radiotherapy department as a mandatory component of training. The time spent in each of the other disciplines need not be long (perhaps a minimum of one month, depending on the structure of the training programme) and need not prolong the total duration of training. It could also be cost-neutral. Such an arrangement would inevitably result in true understanding of the specialties involved in cancer treatment and, more importantly, enhance the value of multidisciplinary meetings. A proposal to recommend interdisciplinary training as a mandatory component of training for clinical cancer specialists was considered by the Expert Group on Cancer Control of the European Commission. I am delighted to report that this proposal was unanimously approved and recommended by the Expert Group. This proposal in no way undermines the excellent global core curriculum drawn up by the European Society of Medical Oncology (ESMO) and the American Society of Clinical Oncology (ASCO), that developed by ESSO and its American counterpart, the Society of Surgical Oncology (SSO) nor the training curriculum devised by the European Society for the Radiotherapy and Oncology (ESTRO).

It is hoped that this recommendation can be officially endorsed by ESSO, ESMO and ESTRO and the UEMS in the months ahead and implemented by the oncology training organisations in each member state of the EU.

Q. What do you think is the major strength of ESSO as a society?

- **NOH**: The main strength of ESSO is its commitment to improve surgical management of patients with cancer. It seeks, not to undermine organ-specialists in surgical care but to emphasise that all surgeons treating cancer patients have training and understanding of the biology of cancer, oncological principles and a good knowledge of the scope, limitations and applications of the other modalities of cancer therapy. Its international representation
ensures its broad appeal. It is an inclusive, progressive, supportive and friendly organisation and I am proud to have been associated with it for several decades.