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THE MOYNIHAN ACADEMY
PURSUIT OF SURGICAL EXCELLENCE

ASGBI
Association of Surgeons of Great Britain and Ireland

The Moynihan's Academy Newsletter - January 2026

Welcome to the first edition in 2026 of The Moynihan's Academy newsletter.

Follow us on Instagram @asgbi_ma, X @ASGBI_MA, LinkedIn @The Moynihan Academy and on WhatsApp for updates and registration links for our planned events.

Presidential Update

Jared Wohlgemut, The Moynihan Academy President

We hope you have had a wonderful time with family and loved ones during the Christmas and New Year's holiday season. We at the MA have enjoyed reflecting on the past year's achievements and are looking forward to what 2026 has to offer.

In 2025, we organised a sold-out MA Masterclass event in Birmingham. Feedback has been immensely positive, especially the FRCS viva skills sessions.

In 2026, we are working diligently to offer MA members excellent surgical opportunities. Thinking of coming to the ASIT conference in Manchester? We will lead a pre-conference ASiT trauma course, which has been hugely successful in previous years. This year, we will add thoracotomy skills to the already amazing programme.

Following this, we look forward to the highly anticipated ASGBI congress in Brighton. Come check out the incredible sessions, practical skills, breakfast sessions and we can't wait until the social events!

Aside from these big events, there will be multiple webinars, podcasts, social media, newsletters, and possibly even a one-day practical session under planning. Can't wait to see you there!

There are many ways to engage with The Moynihan Academy:

Monday MRCS

Weekly MRCS MCQs to help trainees build exam confidence and maintain steady revision habits.

Friday FRCS

Every Friday we post FRCS-style questions to support senior trainees preparing for the fellowship exam.

Wednesday Wellbeing & Medical Student Wednesdays

These run on an alternating schedule:

Wellbeing Wednesday – practical wellbeing advice, tips, and webinars to promote a healthier surgical life.

Medical Student Wednesday – guidance for medical students who wish to begin a surgical career, including study tips and early exposure opportunities.

What else do we share?

Alongside our weekly themes, we regularly post about:

Important national audits

Masterclasses and teaching events

Moynihan Academy and ASGBI updates

RCSEd webinar adverts

FRCS webinar series announcements

Highlights from partner surgical associations

We are active on Twitter, LinkedIn, and Instagram, and we welcome everyone interested in surgery, education, and wellbeing to join our growing community.

Have ideas or suggestions?

We would love to hear from you — please message us on any of our platforms. Your feedback helps us improve and continue delivering valuable content.

Watch this space for more great content and collaborations.

SAS Update

Ralph Obure, MA SAS Lead

High-yield tips to get your portfolio pathway application on track

I was fortunate to catch up with Mr Gaurav Kulkarni, a newly appointed Consultant Abdominal Wall and Colorectal Surgeon based in York, for a brief chat about his key takeaways on entering the Specialist Register via the portfolio pathway.

Mr Kulkarni's meticulous approach is clearly not limited to developing abdominal wall planes in theatre but is a way of life — demonstrated by his extensive academic work and diligent portfolio submission, earning CESR within 8 months of submission and without needing a review. His achievements have been impossible to overlook, and he has been invited to speak at various important meetings including the ASGBI Annual Congress in Edinburgh. Despite his impressive journey, he maintains an easy-going and approachable demeanour and is always happy to share from his experiences. We had a great chat, and I have distilled his high-yield tips below.

1. **Expect the unexpected — adapt early and adjust your plans.**

The CESR pathway was revised to the current portfolio pathway three months before I had planned to submit. My target was February 2024; however, in November 2023 the pathway changed. This meant going back to the specialty-specific guidance (which I had to read three times). Some key differences

forced me to delay my submission to March 2024.

2. Have reliable tools to permanently redact patient information.

I realised late that the redactions I was making were not permanent. You need either a paid PDF-editing tool or a MacBook to ensure irreversible redaction. I subsequently had to redo all the redactions, and despite this, two of the 300 were still not permanent! The GMC advisor spotted them, and I had to complete a GDPR/confidentiality course and provide a reflection.

3. Support and mentorship are the cheat code.

I've been extremely fortunate to work with supportive trainers who went above and beyond for my application. I sat the FRCS while at Kettering General Hospital, and I owe much of this success to the support from the clinical director and clinical lead. During my fellowship at Broomfield Hospital, consultants who had never supported CESR applications before still made the effort to help me.

Without support, completing a strong application is incredibly difficult. Many components — MSFs, CEXCs, PBAs, CBDs — all require timely colleague input within four weeks.

4. Harness the power of incremental gains.

The portfolio pathway is compartmentalised and can be broken down into manageable goals. The philosophy of small, consistent daily progress works. Each day, ask yourself:
"What can I do today — even something small — that moves me closer to CESR?"
These small steps keep you motivated and "in the game".

5. A prospective online portfolio is worth more than gold.

Keeping WBAs, MCRs, and evidence on ISCP or another platform provides timestamped, credible, prospective documentation. Paper applications are risky and far less persuasive. Discuss your plans with consultants early so they can support the MCR process.

If I had to give one tip: embrace incremental gains and remain grounded — you are one of many working toward this, not a superstar simply because of years of experience.

6. A burden shared is a burden halved.

Although I didn't personally benefit from this, having a CESR buddy can be invaluable for motivation and accountability. Attending meetings like ASGBI Congress or Moynihan Academy EGS days is a great way to network and meet others at a similar stage.

Mr Kulkarni has also kindly shared a checklist he created for anyone working on the portfolio pathway in general surgery with an interest in colorectal surgery (see QR code below).

An online recording of his full presentation is available on the:
NHS England National Online Training Programme (NOTP) website:

https://pgvle.co.uk/course/view.php?id=485

Papers of the Month

with Georgios Geropoulos, MA Research Lead

Cholecystectomy is a common abdominal operation, yet it remains a procedure where “routine” can rapidly become hazardous. The stakes are high: bile duct injury (BDI) is uncommon but devastating, and the situations that drive difficulty (inflammation, scarring, aberrant anatomy, cirrhosis, Mirizzi, fistulae, malignancy concerns) are exactly the settings where cognitive and technical errors compound. This JAMA Surgery clinical review is essentially a safety manual for when the critical view of safety (CVS) is hard—or impossible—to obtain, and it argues that the safest surgeon is the one who recognizes the inflection point early and transitions to a bailout strategy before the dangerous dissection happens.

The Difficult Cholecystectomy

Villani V, Kao LS, Fong Y. JAMA Surgery 2025

DOI: 10.1001/jamasurg.2025.4199

Question

In patients at risk for—or found to have—a difficult cholecystectomy, what preoperative predictors and

intraoperative strategies (including adjunct imaging and bailout options) best reduce the risk of severe bilio-vascular injury when CVS cannot be safely achieved?

Findings

1) Predicting difficulty starts before the first port: Key patient- and disease-level predictors include obesity, higher ASA class, prior abdominal operations, cirrhosis/portal hypertension, acute cholecystitis severity, and CBD stones. Imaging features associated with difficulty include gallbladder wall thickening, pericholecystic fluid, impacted neck stone, and CBD dilation/stones.

2) Timing matters: “cooling off” is not the safety panacea it once seemed. The review supports early intervention (often framed as within ~72 hours of presentation) rather than delayed surgery, noting guideline-level recommendations that early approaches tend to reduce serious adverse events and shorten overall resource use; if early surgery isn’t feasible, delaying beyond ~6 weeks is favoured over an “intermediate” window.

3) CVS remains the standard—but persistence in hostile anatomy is a known trap. The paper reiterates CVS as the preferred method of duct identification (over infundibular techniques), highlights the value of deliberate “reorientation” (eg, backing the camera out, “waving the flag”), and recommends an intraoperative pause/time-out before clipping/cutting.

4) Conversion to open isn’t failure—but it’s not automatically “easier,” either. Conversion is positioned as situation-dependent (eg, uncontrolled bleeding, fistulae, Mirizzi, suspected malignancy), and the authors explicitly note that inability to obtain CVS alone is not necessarily an indication for open conversion unless the surgeon is choosing an open subtotal approach.

5) If a bile duct injury is suspected: stop, drain, get help, don’t “hero-repair.” A clear safety message: pause, avoid making things worse, seek hepatobiliary expertise if possible, and consider wide drainage as a temporizing strategy when definitive repair isn’t appropriate in that moment.

Take Away Points

When cholecystectomy is difficult, the safest move is often not to “push through” the hepatocystic triangle: prioritize achieving (and documenting) the critical view of safety, use adjunct imaging early if anatomy is unclear, and have a low threshold for bailout strategies (fundus-first, subtotal cholecystectomy, or cholecystostomy) rather than persisting with hazardous dissection. Conversion to open can be appropriate but isn’t inherently safer unless it enables a controlled bailout, and if a bile duct injury is suspected, the key is to stop, drain, and seek expert help rather than attempting a risky repair in the moment.

Trauma Update

with Ellie Smith, MA Trauma Lead

Changing experience of Trauma – The Rise of the Silver Trauma

For years the view of the “classic” trauma patient has been the same: a young man in his teens or early twenties, either the victim of a violent attack or injured as a result of misadventure following a high-energy mechanism such as a road traffic collision. This picture has changed dramatically over the last few decades, with the rise of the “Silver Trauma” population of patients.

The term silver trauma refers to patients who are over the age of 65 and have been subjected to a traumatic injury. It is used to identify those patients whose mechanism of injury might appear minor, such as a fall from standing, but who due to their pre-existing physiology can still sustain serious injuries. The rise of these patients is seen throughout the western world. One study noted that over a 16 year period, the proportion of trauma patients over the age of 60 admitted to a major trauma centres across Germany, Austria and Switzerland rose from 23% to 40%. Another study looking at similar hospitals in USA found a comparable increase. The growth in the silver trauma population brings its own set of challenges and has a significant impact on healthcare system.

Primary Survey

During the initiation assessment and management of the silver trauma patients it is important to recognize that although they might not have a “significant” mechanism of injury following even a minor injury is high. Care needs to be taken during the initial ATLS “A to E” assessment. For example, careful consideration needs to be made in regard to cervical spine immobilization. Elderly patients can have underlying degenerative changes that would may make standard immobilization uncomfortable or inappropriate. If a cervical spine injury is identified, protecting patient from further neurological injury should take the patients pre-injury neck position into consideration.

The usual signs of significant haemorrhage may not present as clearly in the elderly population. Patients taking beta-blockers are unable to mount the usual compensatory tachycardia seen following haemorrhage. Those with pre-existing left ventricular systolic dysfunction will have less reserve to respond to any significant haemorrhage. It is also important to remember patients with untreated pre-existing hypertension can appear normotensive when haemorrhaging. In addition, many older patients are on anticoagulant medications, putting them at higher risk of haemorrhage and close monitoring of clotting and potential reversal may be required.

The assessment of disability in these patients can also be challenging. Confusions may be attributed to

pre-existing cognitive impairment when it may represent a manifestation of serious intracranial injury. A low threshold for neuro-imaging is therefore essential and clinicians should avoid assuming that altered mental statues is baseline without objective evidence.

⏳ During Admission

Analgesia in elderly patients requires careful consideration. The presence of multiple co-morbidities and the associated polypharmacy increases the risk of drug interaction and adverse effects. The use of opioids is linked to rise in delirium, however inadequate pain control is also a risk factor for delirium development. An appropriate balance must therefore be achieved. In addition, pre-existing chronic kidney disease is common in this population group and can result in reduced clearance of opioid medications, further increasing the risk of toxicity.
Trauma patients are traditionally admitted under a surgical team, but the complex pre-existing co-morbidities in the silver trauma population can present significant management challenges. In contrast, patients with neck of femur fractures have long benefited from both initial assessment at admission as well as ongoing involvement throughout admission from an ortho-geriatrics team, a model now mandated by both NICE and the British Geriatrics Society. Many hospitals have begun to involve geriatric teams in the assessment and management of these silver trauma patients. The input of the geriatric team forms an important part of the multidisciplinary approach required to optimize outcomes in this vulnerable group.

Due to their pre-existing physiology and complex medical needs, many silver trauma patients require enhanced clinical and multidisciplinary management. In response, teams across the country are developing new models, such as frailty intervention teams and dedicated silver trauma clinics, to adapt the assessment and treatment of elderly trauma patients within systems originally designed for younger populations. These Silver Trauma patients will often require a substantial healthcare resources, including prolonged hospital admissions, input from multiple medical and therapy specialities, and gonging care following discharge. Effective care planning must therefore extend beyond acute hospital management to include early consideration of rehabilitation and social care needs.

EGS Hot Topics

with Georgios Karagiannidis, MA EGS Lead

Evidence-Based Algorithm for Small Bowel Obstruction (SBO): A Pragmatic Guide for Emergency Surgeons.

Livingston DH, et al. (2025)
Evidence-based, cost-effective management of small bowel obstruction: An algorithm of the Journal of Trauma and Acute Care Surgery emergency general surgery algorithms work group
Journal of Trauma and Acute Care Surgery, Vol. 99(5)

https://doi.org/10.1097/TA.0000000000004790

Question

What is the optimal, evidence-based approach to diagnosing and managing adult patients with small bowel obstruction (SBO) in the emergency setting?

Findings

This expert consensus paper, developed by the Journal of Trauma and Acute Care Surgery EGS

Algorithms Group, synthesises decades of evidence into a structured, bedside-relevant algorithm for managing SBO.

Key takeaways include:

- CT with IV contrast is the diagnostic gold standard—plain films are outdated due to low specificity and poor utility in identifying ischemia or closed-loop obstruction.
- Emergency surgery is indicated in ~20% of patients—particularly those with peritonitis, hemodynamic instability, or ischemic signs on CT.
- In stable patients, begin with non-operative management (NOM): IV fluids + NG decompression.
- Use of water-soluble contrast studies (WSCS) (e.g., Gastrografin) between 6–24 hours improves clinical decision-making and reduces time to surgery and hospital stay, especially if contrast fails to reach the cecum within 24h.
- Minimally invasive surgery (MIS) is increasingly safe and effective for selected patients. Evidence suggests laparoscopy can lower LOS and complications if used judiciously in non-peritonitic patients with ≤2 prior laparotomies.
- SBO in the “virgin abdomen” is often still adhesive; non-operative management is reasonable unless signs suggest otherwise.

Take Away Points

This updated SBO algorithm is highly relevant to EGS practice. It reinforces a balanced, patient-specific approach—leveraging early CT, avoiding unnecessary surgery, and recognising when surgical delay may increase risk.

Two clinical pearls to remember:
1) Don’t wait beyond 72h to decide — use contrast studies to guide early.
2) Don’t discount laparoscopy — with the right setup, it’s not just feasible, but favourable.

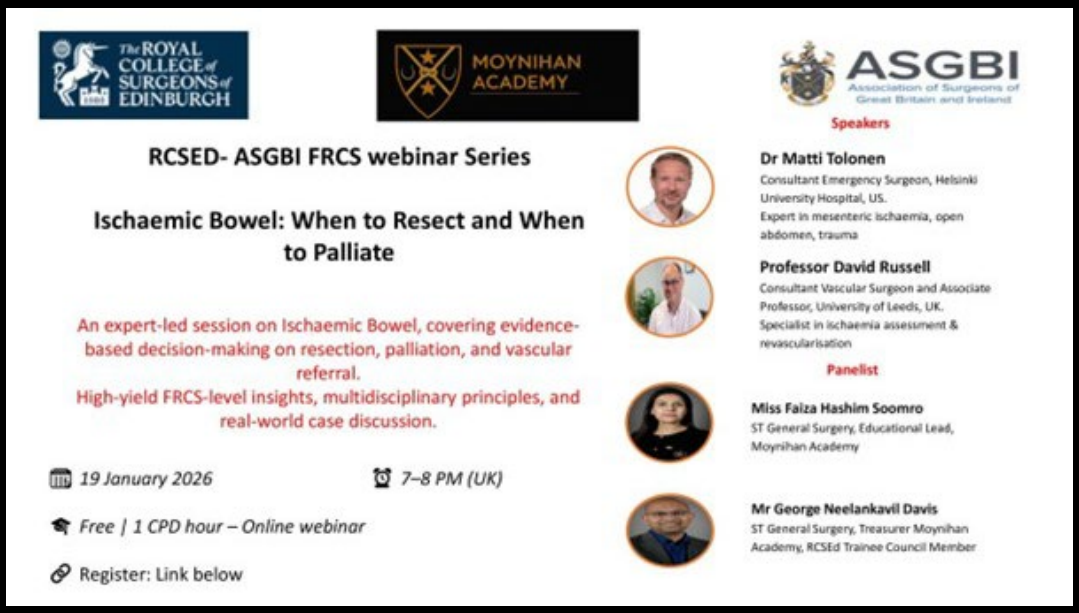
Latest in Surgical Education

with Faiza Soomro, MA Educational Lead

Upcoming Moynihan Academy Events

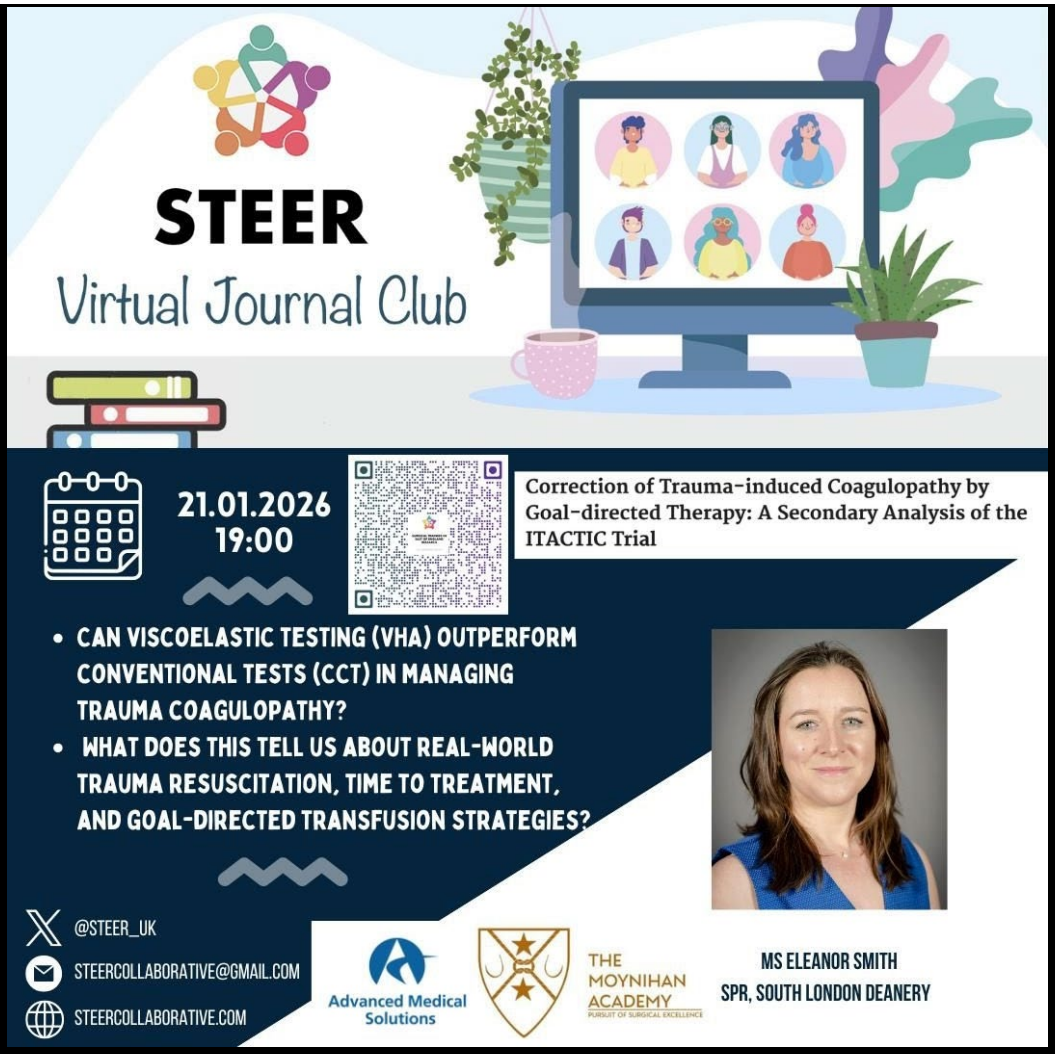
19th Jan 2026: MA & RCSEd Webinar on “Ischaemic Bowel - When to resect, when to palliate”

Register Here



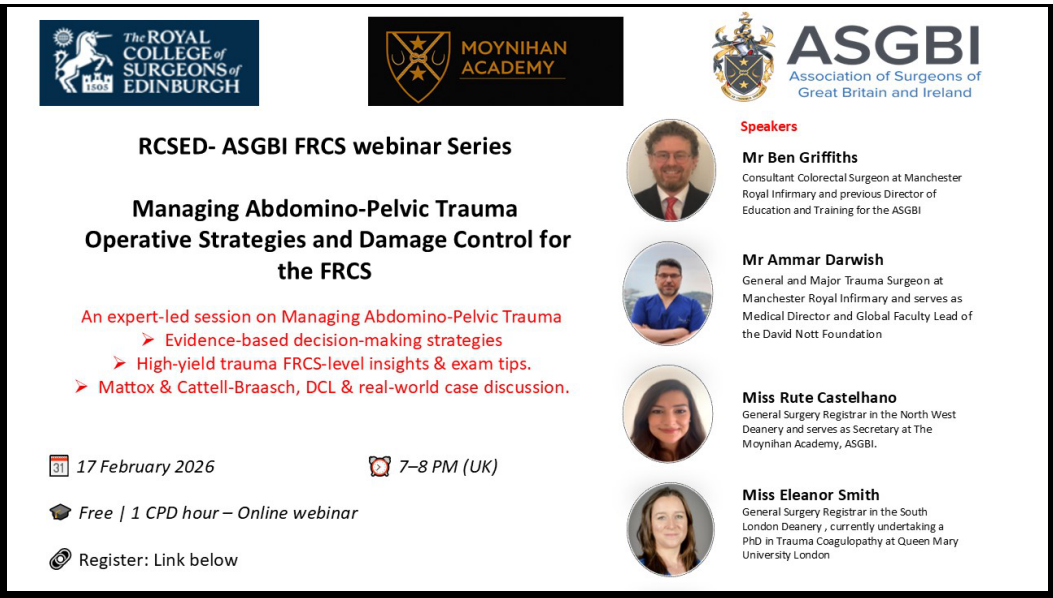
21st Jan 2026: STEER Virtual Journal Club

Register Here



17th Feb 2026: MA & RCSEd Webinar on “Managing Abdomino-Pelvic Trauma: Operative strategies and damage control for the FRCS”

Register Here



Further Upcoming Events

22nd - 23rd April 2026: Advanced Coloproctology Course (ACC)

Details Here

11th - 12th March 2026: European Society of Endoscopic Surgery (EAES) Intuitive Robotic Course

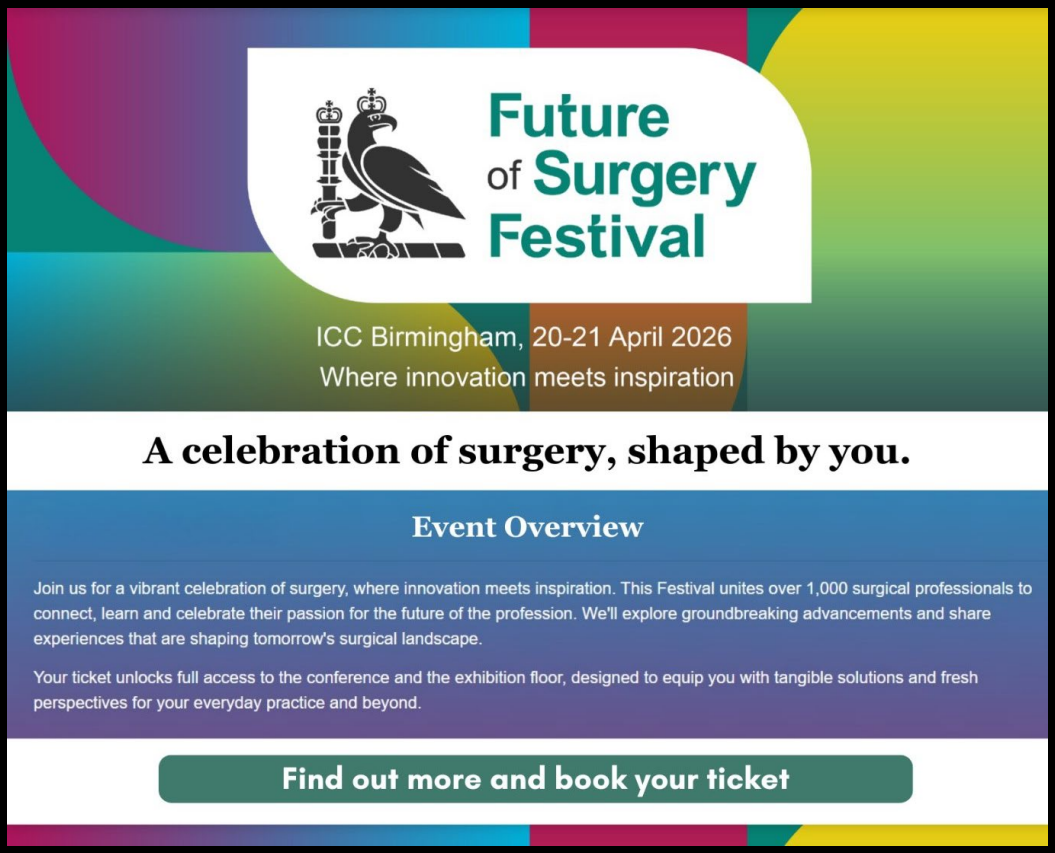
Details Here

16th - 17th May 2026: Advanced Upper Gastrointestinal Robotic Surgery Course

Details Here

27th - 28th Nov 2026: European Hernia Society (EHS) Advanced Open Cadaveric Hernia Course

Details Here



Upcoming Abstracts Deadline ⏰

26th Jan 2026: ASGBI Congress Abstract Submission Deadline

Submit Here

2nd Feb 2026: ACPGBI Annual Meeting Abstract Submission Deadline

Submit Here

13th Feb 2026: The Upper Gastrointestinal Surgical Society (TUGSS) Global Virtual Conference

Submit Here

Research Opportunity

Excited to take your research to the next level? Apply for the RCS England 1-year Research Fellowship.

Details Here

Wellbeing in Surgery

with Lily Mills, MA Wellbeing Lead

First and foremost:

Happy New Year! ASGBI MA hope you have a fantastic 2026

No Surgeon Is an Island: The Power of Connection in Surgical Wellbeing

January often brings a natural pause: a moment to reflect on the year just passed and to think about how we want the months ahead to look. In surgery, this reflection can extend beyond individual goals to the teams we work within every day. Who supports us on difficult lists or long on-calls? Who do we turn to after a challenging case? Our working relationships shape not only how we practise, but how we feel at work.

Surgery is often described as a team sport, yet many surgeons experience their working lives in isolation. Long hours, rota gaps and increasing service pressures can quietly erode opportunities for connection—with colleagues, mentors and even with ourselves. Over time, this isolation can have a significant impact on wellbeing.

Strong professional relationships are a protective factor against stress and burnout. Informal conversations in theatre coffee rooms, shared reflection after a challenging case, or simply feeling known within a team all contribute to a sense of belonging. These moments may seem small, but they matter. Feeling connected reminds us that we are not carrying the weight of responsibility alone.

Connection also has a role in patient safety. Teams that communicate well and trust one another are better equipped to manage complexity, uncertainty and error. Creating space for open discussion—particularly after difficult outcomes—supports both learning and emotional processing.
Rebuilding connection does not require major structural change. Checking in on a colleague, acknowledging a tough on-call, or making time for shared breaks can shift team culture in meaningful ways. Leadership at all levels can model this by prioritising kindness, curiosity and inclusion.

In a profession defined by collective effort, wellbeing grows strongest when it is shared. Supporting one another is not a distraction from good surgical practice—it is central to it.
As Wellbeing Lead, I would like to challenge readers this January to pause and reflect on their own support at work. Who do you rely on when the pressure is high and just as importantly, who might be relying on you? Small, intentional acts of support can make a significant difference. By looking after one another, we strengthen not only our teams, but our profession.

As always, stay informed, stay engaged, stay well!
Lily

Equality, Diversity and Inclusion

with Marwa Jama, MA EDI Lead

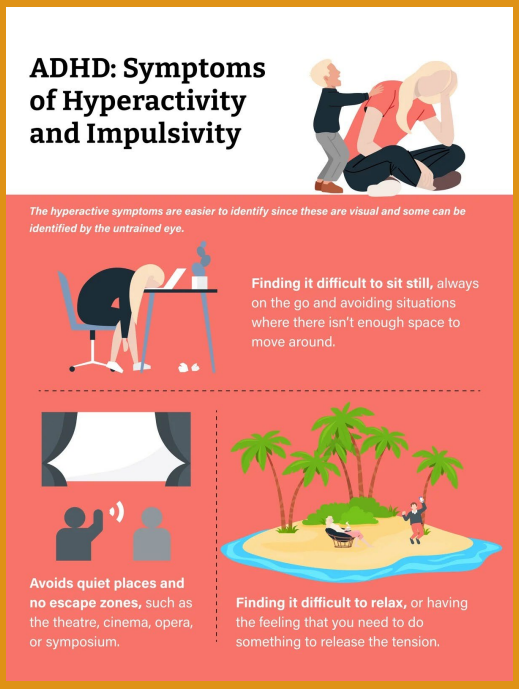
ADHD and Surgeons

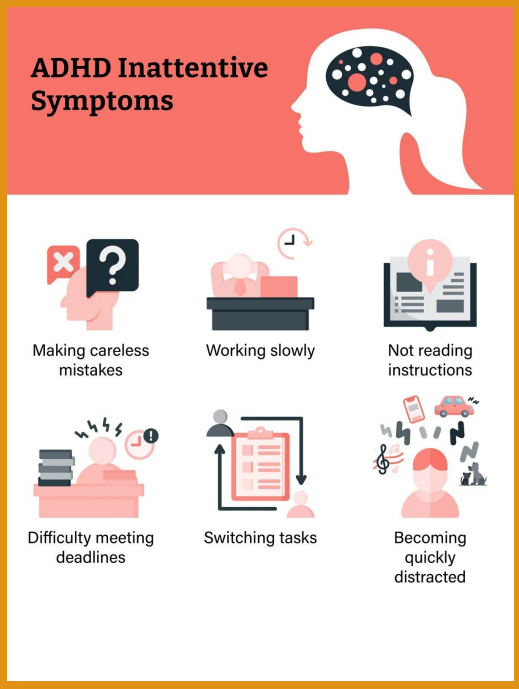
“Great under pressure”, “laser- focussed”, “dynamic” and “ambitious”

Words you might find in any MSF, MCR or recommendation letter for a surgeon. These, however, are also words you could find in an ADHD assessment.
While Attention Deficit Hyperactivity Disorder (ADHD) is something not many would link to surgeons, researchers have found a higher incidence amongst medics in general and specifically surgeons.
If I ask you about ADHD, many of you will think of that one impulsive kid at school or your parents telling you to stop fidgeting cause it made you “look like you had ADHD”. Outdated, incorrect and even stigmatising views that do not line up with the reality of ADHD.
In reality, ADHD can manifest as a great ability to work at a pace with multiple events happening at the same time or the ability to focus hours on a single task as long as is challenging. But it also brings higher

rates of anxiety and stress. While the low sleep needs or hyperfocus can make a surgical career appealing, ADHD can also cause struggles to finish tasks or create difficulty in conversations. It also creates anxiety around “being different” or experiencing failure at tasks that seem simple to peers.

Do you feel like you might belong to the 31% of surgeons who have ADHD? Get tested to get the support you need to be able to thrive both at work and at home!





Medical Student Corner

with Parwaaz Upadhyay, MA Medical Student Rep

Asking Questions in Theatre: A General Surgery Guide for Medical Students

For many students, the General Surgery theatre is intimidating: fast-paced and full of moments where it feels like the wrong time to speak. But theatre is also where surgical thinking becomes visible—if you know how and when to ask.

Timing matters more than the question itself. In general surgery, there are predictable “high-cognitive-load” moments: port placement, identifying anatomy, controlling bleeding, and performing an anastomosis. These are observation zones. Better moments to ask are during exposure, after planes are established during dissection, while waiting for pathology, during stapling or closure, or when the team is repositioning. A simple “Is now an okay time to ask something?” shows awareness and is

almost always appreciated.

Ask about decisions, not just anatomy. You can learn anatomy from a textbook; theatre is where you learn judgement from a surgeon's point of view.

Strong general surgery questions often sound like:
- "What made this an open rather than laparoscopic case?"
- "At what point would you convert?"
- "Why is this anastomosis better than another?"
- "Why did you choose these sutures for closure"

These questions show you're thinking like a surgeon rather than trying to display knowledge. It also displays your interest, which is key in being allowed to do more in the operating theatre and gaining rapport with your mentors.

Use the case to anchor your questions. General surgery is broad, but cases often follow specific themes —such as acute abdomen, malignancy, sepsis, or obstruction. Asking case-specific questions ("Why no primary anastomosis here?" or "What makes this appendix complicated?") is far better than abstract ones.

Know who to ask. Consultants often enjoy big-picture questions; registrars are excellent for practical ones ("How do you identify the ureter here?"). Scrub nurses and ODPs are invaluable for workflow and instruments — learning from the whole team is important, not just the surgeons.

Don't mistake silence for professionalism. Standing quietly in the corner doesn't equal engagement. One or two thoughtful questions, asked at the right time, will do more for your learning and how you're remembered than an hour of silent observation. You will get much more out of your timetabled theatre sessions by showing interest, no matter if you like surgery or not.

The operating theatre doesn't need to be a mindless, timetabled session, and it's not a performance. It's a learning space where we can all gain something. Be curious, be situationally aware, and don't be afraid to ask, just ask well.

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